BlueCross BlueShield of Vermont

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Out of Network Services
Corporate Medical Policy

File Name: Out of Network Services
File Code: 10.01.VT207
Origination: 10/2004
Last Review: 12/2021
Next Review: 12/2022
Effective Date: 02/01/2022

Description/Summary

The Plan's standard of care is for a member to have the opportunity to have his or her care managed by a board eligible or board-certified specialist or sub-specialist in the appropriate discipline recognized by the American Board of Medical Specialties as having the requisite expertise for the member's clinical condition.

Policy

When out of network services or procedures shall be covered at the in-network benefit level

Services and/or procedures shall be covered at the in-network level of benefits in the following circumstances:

A. Emergency Services. Emergent out of network services will be authorized if the emergent circumstances are verified and the out of network services are considered medically necessary by the Plan. See Emergency Services Operational Policy for more information regarding payment of emergency services and federal and state law definitions and requirements.

B. Urgent Services. Urgent out of network services will be authorized if the urgent circumstances are verified and the out of network services are considered medically necessary by the Plan. Such out of network services are to be paid at the in-network benefit level. The provider can bill the member the non-allowed amount (the difference between the allowed amount and the provider charges for the service, i.e. balance billing).

Urgent Services are defined as those health care services that are necessary to treat a condition or illness of an individual that if not treated within 24 hours presents a serious

risk of harm, or, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, could seriously jeopardize the ability of the individual to regain maximum function, or, in the opinion of a Provider with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot be adequately managed without care within 24 hours.

C. No Qualified in Network Provider. Out of network specialty care will be authorized for members to obtain covered services from non-contracted healthcare providers, when the Plan or an independent external review process (conducted pursuant to Vermont law) determines that the Plan does not have a contracted healthcare provider with appropriate training and experience to provide the services that are medically necessary to meet the particular healthcare needs of the member, subject to the utilization review procedures used by the health benefit plan, as required by and in accordance with DFR Rule. H-2009-03 at Part 5.1, if applicable.

1. In the event that there is no in-network provider capable or available in a timely manner,(as defined by Rule H-2009-03) to provide the necessary services, the Plan will assist the member by locating a provider that is contracted with a Blue Plan but is not included in the member's plan's network. If the Plan is unable to locate a provider that is contracted with a Blue Plan, the Plan will assist the member by locating a provider that is otherwise affiliated or willing to arrange a single case agreement and agree to a price for the services provided. The provider must have the appropriate training and experience that is medically necessary to meet the particular healthcare needs of the member that are unavailable in network. If the provider is unwilling to agree to a single case agreement, the Plan is responsible for ensuring that the member is not billed any difference between the providers charges for the service and the allowed amount (i.e. balance billed).

2. Coverage shall be consistent with the terms and conditions of the member's certificate of coverage or employer benefit plan as if the services were obtained from an in-network provider.

3. If a member is granted approval to see an out-of-network provider due to an administrative approval by the Plan, a case manager will contact the member immediately upon such approval to transition the member to an in-network provider. Unless criteria is met in sections A, B, C or D, the out of network authorization will not be extended beyond the service dates included in the administratively approved authorization. Additional prior approval requests shall not be granted solely on the basis of the existence of the administrative approval.

    a. As used above, "administrative approval" refers to prior approval requests that must be granted due to Plan's failure to decide on an approval request in the timeframe mandated by Rule 09-03.

D. Member Temporarily Out of Network Service Area. When a member or subscriber temporarily (a minimum of 60 days) lives, works, attends school or otherwise

temporarily resides outside of the service area at the time of the request, they may be authorized to receive out of network services. The service area is the member's network, as described in the member's certificate of coverage or employers benefit plan.

Temporarily Residing Out-of-Service Area benefits for services with out-of-network providers are only available to members who are *already* located outside of the service area at the time of the request; these protections do not apply so that a member can move to another location in order to obtain medical services. Out-of-Service Area benefit rights are not mandated outside of the United States.
In order for in-network benefits to apply in this situation, the following criteria must apply:

- The services must be medically necessary.
- The services must be necessary to provide promptly, locally, and not delayed until the member's return to the service area.
- The services must be covered under the member's health benefit plan

E. Out of Network Professional providers operating at network ambulatory/outpatient surgical centers.
    - Services will be covered at the in network benefit when the member has not signed a waiver consenting to be balance billed.

In the event a member meets the criteria above for temporarily residing outside of the network service area, the Plan shall assist the member by locating a provider in the member's location that is contracted with a Blue Plan. If the Plan is unable to locate a provider that is contracted with a Blue Plan, the Plan will assist the member by locating a provider that is otherwise affiliated or willing to arrange a single case agreement. The provider will have the appropriate training and experience that is medically necessary to meet the particular healthcare needs of the member.

If no provider that is qualified to provide the services is willing to agree to a single case agreement, the member can be balance billed. That is to say that the member can be billed by the out of network provider for any difference between the provider charges for the services and the allowed amount. However, the Plan must clearly notify the member that they may be liable for any balance between the amount paid by the Plan and the non-contracted provider's charges. Failure to provide this notification may result in the Plan being responsible for the difference between the provider charges for the services and the allowed amount.

Reference Resources

DFR Reg. H-2009-03 (rev. Jan. 12, 2017)
Blue Cross and Blue Shield of Vermont Procedures for Continuity of Care operational policy

Document Precedence

Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer's benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non- compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval is required and benefits are subject to all terms, limitations and conditions of the subscriber contract.

Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered compete, see policy guidelines above.

NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member's health plan.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP
Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

04/2005	New policy, updated to remove medical necessity language
04/2006	Minor formatting changes
04/2007	Updated with minor wording changes to match current certificate language. Reviewed by CAC July 2007.
04/2008	Formatting changes only. Reviewed by CAC 05/2008.
11/2009	Changes to language to address updated to regulatory requirements. Reviewed by CAC 01/2010
11/2010	Changes to address Rule 9-03 (formerly Rule 10) requirements
12/2015	Added language to clarify balance billing
07/2018	Reorganized policy, updated policy template. No changes to policy statement.
07/2019	If services not available in network, made it clear that our first step would be to locate a par provider. Then look at non par or single case agreement arrangements if needed. Added language confirming if we administrative approve, we'll start working with the member immediately to transition. If member reaches the end of their administrative approval window, we won't approve any more OON unless they meet criteria. Confirmed the member's service area is defined by whatever the member's network is. Removed Section D for transitioning care. The decision was that we need to adhere to what the member's benefit (network is). If they don't meet criteria in either A, B, or C, then services are denied.
10/2020	No impact to in contracted providers. Description/Summary: Removed language with explanation that DHMC and UVVMC have in network specialists. Policy Section: Urgent and emergent out of network services and procedures have been separated with each having their own descriptions. Urgent definition has been added to the policy. C. Has now become: No Qualified in Network Provider. Procedures and process has been added and defined for when there is not a qualified network provider available as defined by Rule H-2009-03. Administrative approval procedure language is also included in this section.

	D. This is a new bullet however it is not new information. Member temporarily OON Services Area. This was part of bullet C but now is D.
12/2021	No change to Policy Statement.

Eligible providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by BCBSVT Medical Directors Date Approved

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