BlueCross BlueShield of Vermont
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Out of Network Services
Corporate Medical Policy

File Name: Out of Network Services
File Code: UM.OON.01
Origination: 10/2004
Last Review: 07/2018
Next Review: 07/2019
Effective Date: 11/01/2018

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.

Within the Plan(s) networks, there are community specialists as well as two University affiliated academic tertiary care centers, Dartmouth Hitchcock Medical Center (DHMC) and University of Vermont Medical Center (UVMC) for these disciplines.

Policy

When services or procedures are covered at the in network benefit level

Services and/or procedures may be covered at the in network level of benefit when **any** of the following apply:

A. Urgent and emergent out of network services will be authorized if the urgent or emergent circumstances are verified and the out of network services are considered medically necessary by the Plan.

B. Out of network specialty care will be authorized for members to obtain covered services from contracted or non-contracted healthcare providers within or outside the service area of the member's health benefit plan, 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.

- The Plan will assist the member by locating a provider that is contracted, otherwise affiliated, or willing to arrange a single case agreement, and that has the appropriate training and experience that are medically necessary to meet the particular healthcare needs of the member.

- If no provider meeting the specifications is available and accessible to the member on a timely basis, the Plan shall provide the member with coverage for services from a non-contracted provider. Coverage shall be consistent with the terms and conditions for coverage of services obtained from a contracted provider within the service area (as outlined in the members certificate of coverage or employer benefit plan). There shall be no additional liability to the member.

C. 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. The services must be medically necessary and be covered under the health benefit plan if the member were able to access care from contracted providers within the service area. It also must be medically necessary that the services be provided promptly, locally, and not delayed until the member's return to the service area. If the prior approval request does not include information indicating the nature and timeframe of the member's temporary status and the reason the services are medically necessary and need to be provided out of network, the information will be requested prior to making a benefit determination.

   NOTE: Temporarily Residing Out of State applies only to members who are ALREADY located outside of the state at the time of the request. It is not intended to allow a member to move outside of the state with the sole purpose of seeking medical treatment.

   - The Plan will assist the member by locating a provider in the member's location that is contracted, otherwise affiliated, or willing to arrange a single case agreement, and that has the appropriate training and experience that are medically necessary to meet the particular healthcare needs of the member.

   - If no provider meets these specifications, the Plan will:

     - Provide clear notice to the member that they may be liable for any balance between the amount paid or reimbursed by the Plan and the non-contracted provider's charges.

     - Provide the member with coverage consistent with the terms and conditions in the subscriber's certificate or benefit plan, if the certificate or benefit plan allows for coverage of service outside of the service area, or if the certificate or benefit plan does not ordinarily allow for coverage of the service outside of the service area.

D. Out of network mental health and/or substance abuse specialty care will be authorized for members to obtain covered services from a non-contracted healthcare provider(s) while the member is actively transitioning from an out of network provider to an in network provider.

- For a prescribing psychiatric provider, the Plan will allow up to one (1) year for a member to transition from an out of network provider to an in network provider.

- For a psychotherapist (including, but not limited to: LICSW, MD, APRN, MHC, LADC, LMFT and PA), the Plan will allow up to two (2) months for a member to transition from an out of network provider to an in network provider.

- For services requiring certified specialized training that is diagnosis specific (ie: Exposure Response Prevention for Obsessive Compulsive Disorder), the Plan will allow up to six (6) months for a member to transition from an out of network provider to an in network provider.

When services or procedures are not covered at the in network benefit level

- Appropriate services are or were available with a network provider
- Prior approval is required but not obtained
- Elective procedures and surgeries that can safely and effectively be performed by network providers upon return to the network
- Preventive services, routine office visits and associated diagnostic services
- Routine immunizations

Regulatory status

Rule 9-03

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.

An approved referral authorization for members of the New England Health Plan (NEHP) is required. A prior approval for Access Blue New England (ABNE) members is required. 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.

Eligible providers

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

Approved by BCBSVT Medical Directors Date Approved

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