

MEDICAL POLICY

MEDICAL POLICY DETAILS	
Medical Policy Title	OUT OF AREA/OUT OF NETWORK SERVICES
Policy Number	11.01.14
Category	Contract Clarification
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Product Disclaimer	<ul style="list-style-type: none"> • <i>If a product excludes coverage for a service, it is not covered, and medical policy criteria do not apply.</i> • <i>If a commercial product (including an Essential Plan product) or a Medicaid product covers a specific service, medical policy criteria apply to the benefit.</i> • <i>If a Medicare product covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.</i>

POLICY STATEMENT

- I. For the purposes of this policy, the network is defined by the member's contract. To make a coverage decision involving an out of network or out of area service, the member's contract should be consulted before referring to this policy. Not all member contracts or certificates provide Out-of-Network benefits.
- II. Practitioner/provider networks can be defined in practitioner/provider contractual arrangements and/or geographic terms and/or member contracts and certificates. To the extent clarification is needed after one or more of these agreements is consulted, the following definitions and clarifications apply:
 - A. **Emergency condition.** An emergency condition means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:
 1. Placing the health of the person afflicted with such condition (or, with respect to pregnant women, the health of the woman or her unborn child, in serious jeopardy or, in the case of a behavioral condition placing the health of the person or others in serious jeopardy, or
 2. Serious impairment to such person's bodily functions, or
 3. Serious dysfunction of any bodily organ or part of such person, or
 4. Serious disfigurement of such person.
 - B. **In-Network Benefits.** In-Network benefits apply when a member's care is provided by Participating Providers in the applicable network and, if required by the member's contract, provided, arranged or authorized in advance by the member's Primary Care Physician. Members should always consider receiving health care services first through the in-network benefits.
 - C. **Non-Participating Provider.** A facility or provider that does not have a contract with us for a given product, to provide health services to members. (Also referred to as an **Out-of-Network Provider**). Members will pay more to see a Non-Participating Provider.
 - D. **Out-of-Network Benefits.** Out-of-Network Benefits apply when the member's contract provides these benefits and the member chooses to receive a covered service from a Non-Participating Provider.
 - E. **Participating Provider.** A facility or provider that has a contract with us for a given product, to provide health services to members. (Also referred to as an **In-Network Provider**). A list of Participating Providers and their locations is available on our website or upon your request to us. The list will be revised from time to time by us.
 - F. **Service Area.** The geographic area, designated by us and approved by the State of New York, in which we will arrange and/or provide benefits to our members as described in the applicable member contract or certificate.

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- G. **Surprise Bill.** A bill for health care covered services, other than emergency services, received by:
1. A member for services performed by a non-participating physician at a participating hospital or ambulatory surgical center, where a participating physician is unavailable or a non-participating physician performs services without the member's knowledge, or unforeseen medical services arise at the time the health care services are performed. A bill received for health care services when a participating physician is available and the member has elected to obtain services from a non-participating physician is not a surprise bill.
 2. A member for services rendered by a non-participating provider, where the services were referred by a participating physician to the non-participating provider without explicit written consent of the member acknowledging that the participating physician is referring the member to a non-participating provider and that the referral may result in costs not covered by the health care plan. For purposes of surprise bills, a referral to a non-participating provider occurs when:
 - a. Health care covered services are performed by a non-participating provider in the participating physician's office or practice during the course of the same visit;
 - b. The participating physician sends a specimen taken from the member in the participating physician's office to a non-participating laboratory or pathologist; or
 - c. For any other Covered Services performed when a participating provider refers the member to a non-participating provider when referrals are required under the member's contract.

H. **Urgent care.** Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care is typically available after normal business hours, including evenings and weekends. Urgent Care is covered in or out of Our Service Area.

1. In-Network. We Cover Urgent Care from a participating Physician or a participating Urgent Care Center.

2. Out-of-Network. We Cover Urgent Care from a non-participating Urgent Care Center or Physician.

Please refer to the Schedule of Benefits section of the member's contract for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

- III. Except as set forth in this policy, In-Network benefits are not provided for care or services received from Non-Participating Providers, including routine care or service needs that could reasonably be foreseen (e.g., physical examinations, screening tests, regularly scheduled laboratory tests such as routine monitoring of anticoagulation therapy); including services for members or dependents living away from home, such as college students, and including therapies/treatments or subsequent visits when the member began treatment with participating practitioners/providers (e.g., continuation of physical therapy).
- IV. Coverage at an In-Network benefit level is available for care/services received from practitioners and facilities who are Non-Participating Providers for emergency conditions and acute follow up care for the emergency condition including services included in the global surgical package for emergency surgery. Examples are heart attacks, poisoning, and multiple traumas.
- V. In-Network benefits may be available for care/services received from practitioners and facilities who are Non-Participating Providers, depending on the terms of the member's contract, for the following:
- A. Urgent or emergent care for conditions that require immediate definitive care that develop while the member is outside the Service Area. Referral and prospective approval by the health plan may be required by the member's contract or certificate.
 - B. For members covered under contracts that do not provide Out-of-Network benefits, when either of the following apply:
 1. for compassionate reasons, medically necessary care covered under the contract while outside of the Service Area, including office visits and associated treatment (e.g., chemotherapy) for members with life-threatening disease (e.g., malignancy, patients with end stage renal disease requiring hemodialysis) for up to four weeks per contract year, or

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2. monitoring and/or care by a practitioner while outside of the Service Area required to assure stability of members with high-risk conditions and active treatment issues (e.g., severe heart failure, complicated hypertension) for up to four weeks per contract year.
- C. For members with a positive or negative diagnosis of malignancy, second medical/surgical opinions, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer upon referral of a Participating Provider.
- D. For medically necessary treatment when expertise is not available from participating providers/practitioners.
- E. For surprise bills (*as defined in Policy Statement II.G.*) when a member completes an Assignment of Benefits form issued by the New York State Department of Financial Services (DFS).
- F. For a member in an ongoing medically necessary course of treatment with an in-network provider who leaves the network, continued ongoing treatment with the out-of-network provider for up to 90 days, or if a member is in second or third trimester of pregnancy, for delivery and postpartum care related to delivery. If the provider was terminated by the health plan due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the provider's ability to practice, continued treatment will not be covered with the provider.
- G. For members new to the health plan and engaged in an ongoing, medically necessary course of treatment with an out-of-network provider, services performed by the out-of-network provider for up to 60 days from the effective date of the member contract. The ongoing course of treatment must be life-threatening disease or condition or a degenerative and disabling condition or disease. The ongoing course of treatment may also be pregnancy. For members in their second or third trimester of pregnancy, in-network benefits may be applied through delivery and postpartum care related to delivery.

Refer to Corporate Medical Policy #10.01.10 regarding Second Medical and Surgical Opinions.

POLICY GUIDELINES

- I. Preauthorization requirements do not apply to emergency services.
- II. Coverage is not provided for services rendered by Non-Participating Providers for variations of surgical methods, adjunct procedures or enhancements (e.g., computerized or robotic components), including less invasive techniques, unless there is published scientific evidence that the variation or additional technology results in incrementally improved results over the surgical methods available in network or as directed by an external appeal agent.

DESCRIPTION

In general, Health Maintenance Organization (HMO) contracts and Exclusive Provider Organization (EPO) contracts cover only services provided by Participating Providers. Point of Service (POS) and Preferred Provider Organization (PPO) contracts provide different levels of coverage depending on whether the provider is a Participating Provider or Non-Participating Provider.

In-Network Benefits are provided for emergent care received by Non-Participating Providers. Other services may be covered as In-Network benefits when received by Non-Participating Providers under specific conditions when members are traveling or temporarily residing out of the Service Area for work, recreation, or education; for example, college students or where there are no in-network providers with the appropriate training and experience to treat the member's condition. Coverage, with the exception of emergency care, is subject to applicable preauthorization requirements.

For policies issued on and after March 31, 2015, members covered under comprehensive products may appeal the denial of a request for a referral to an out-of-network provider through the utilization review process by submitting specific information from a physician regarding the lack of training and experience of available in-network providers.

For policies issued on and after March 31, 2015, for physician emergency services and assigned surprise bills, members are only responsible for applicable in-network cost sharing. Health Plans are required to ensure that members are held harmless from balance billing for emergency services, and may request review by an independent dispute resolution entity

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to avoid paying charges. For assigned surprise bills, providers are prohibited from balance billing members and may request a review of the Health Plan's payment by an independent dispute resolution entity if it is not satisfied with the Health Plan's payment.

KEY WORDS

Out of Area Services, Out of Network Services

CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS

Based upon review, Out of Area and Out of Network Services are not addressed in a National or Local Medicare coverage determination or policy. However, the Medicare Benefit Policy Manual, Chapter 16, General Exclusions from Coverage addresses Services Not Provided within the United States (Section 60). Please refer to the following website for Medicare Members: <http://www.cms.hhs.gov/manuals/Downloads/bp102c16.pdf>.

COVERAGE FOR NYS MEDICAID MANAGED CARE/HARP PRODUCT MEMBERS

Coverage is not provided for services that are not urgent or emergent outside of New York State when services are available in New York State. The Plan contracts with a network of health care practitioners and providers to provide health care services for Medicaid Managed Care members. Care must be received by contracted network providers to be covered by the Plan. Exceptions to this requirement are based on medical necessity, outlined in the above policy, and must be approved by a Health Plan Medical Director.