**Medical Coverage Policy |** Out-of-Network Services Requests

**EFFECTIVE DATE:** 02|05|2024
**POLICY LAST REVIEWED:** 02|07|2024

## OVERVIEW

This policy documents the review process and criteria when a member, or a provider on behalf of a member, is requesting services from a non-contracted/out-of-network provider and is requesting that the services be considered at the member's in-network benefit level.

This policy is applicable to Commercial Products only.

## MEDICAL CRITERIA

**Commercial Products**

Covered services from non-contracted/out-of-network healthcare providers are medically necessary and would be considered at the member's in-network benefit level when one of the following criteria is met:

- Services are determined to be urgent or emergent
- There is not a contracted/in-network provider within the health plans network that has the expertise, training, access to, or the ability to provide the covered services that are requested by the member and which are medically necessary
- A newly enrolled member that is at 24 weeks of pregnancy or greater and the obstetrical provider is a non-contracted/out-of-network provider
- A newly enrolled member that is in an active course of treatment***** with a non-contracted provider.

*****Active treatment is defined as when a member is receiving active treatment for an acute condition in which provider continuity may prevent a recurrence of worsening of the condition under treatment and interfere with anticipated outcomes. Treatment typically involves regular visits with a practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment, or modify treatment protocol.

a. An example of a qualifying condition may be treatment for an acute exacerbation of chronic asthma requiring ongoing treatment whereas monitoring for chronic asthma may not meet the above definition.
b. Members who are post-operative post-treatment or have begun a staged cycle of surgical procedures (e.g. cleft palate repair)
c. Oncology request: Members engaged in an ongoing course of treatment (e.g. radiation therapy or chemotherapy). Determinations may be approved through the current course of treatment.

For plans with tiered networks where the Subscriber Agreement includes a process for requesting coverage of higher-tier provider services at the lower-tier benefit level, covered healthcare services from the higher-tier provider are medically necessary and covered at the lower-tier benefit level when the following criterion is met:

- There is not a lower-tier provider within the health plan's network that has the expertise, training, access to or the ability to provide the covered services that are requested by the member and which are medically necessary, within a reasonable timeframe for the member's condition.

## PRIOR AUTHORIZATION

Prior authorization is recommended for Commercial Products for services other than the behavioral services requests listed below.

## NOTIFICATION OF ADMISSION PROCESS FOR BEHAVIORAL HEALTH SERVICE REQUESTS

A medical necessity review is not required when a member, or a provider on behalf of a member, is requesting services from a non-contracted/out-of-network provider and is requesting that the services be considered at the member's in-network benefit level. Instead, notification to Blue Cross and Blue Shield of Rhode Island (BCBSRI) within 48 hours of admission and within 48 hours after discharge is required for the following levels of care to ensure correct claims processing:

- Inpatient mental health and substance use disorder treatment
- Inpatient withdrawal management (detoxification)
- Crisis Stabilization (CSU)
- Residential mental health and substance use disorder treatment
- Partial hospitalization for mental health and substance use disorder treatment

For more information, please contact BCBSRI Behavioral Health Utilization Management at 1-800-274-2958.

## POLICY STATEMENT

**Commercial Products**

Covered services, other than behavioral health services, rendered by a non-contracted/out-of-network provider are processed at the members in-network benefit level when the criteria above are met.

Requests for out-of-network services, other than behavioral health services, should be submitted to the Utilization Management department. Please fill out the form below, along with any other information instructed within the form, and fax it to (401) 272-8885.

Out of Network Request Form *Refer to "Out of Network Request Form" listed under section, "Coordination of Care"

## COVERAGE

Benefits may vary between groups/contracts. Please refer to Subscriber Agreement for the applicable out-of-network coverage.

## CODING

Not applicable

## RELATED POLICIES

Not applicable

## PUBLISHED

Provider Update, February 2024
Provider Update, July 2023
Provider Update, July/August 2022
Provider Update, July 2021
Provider Update, June 2020
Provider Update, December 2019

## REFERENCES

Not applicable