MEDICAL POLICY

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Medical Policy Title	**Out-of-Network Services**
Policy Number	**11.01.13**
Current Effective Date	**January 23, 2025**
Next Review Date	**January 2026**

Our medical policies are based on the assessment of evidence based, peer-reviewed literature, and professional guidelines. Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract. (Link to Product Disclaimer)

POLICY STATEMENT(S)

I. For the purposes of this policy, "in-network" is determined based on the member's subscriber contract and whether the member's subscriber contract is included under the health care provider's participation agreement. To make a coverage decision with respect to a service that is out-of-network for a member, the member's subscriber contract and any required network adequacy standards must be applied.

II. The following definitions and clarifications are also relevant in making coverage decisions:

A. Emergency Condition

An Emergency Condition is 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 **ANY** of the following conditions:

1. placing the health of the person afflicted with such condition or, with respect to a pregnant woman, 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;
2. serious impairment to such person's bodily functions;
3. serious dysfunction of any bodily organ or part of such person;
4. serious disfigurement of such person.

B. Emergency Services

Emergency Services, with respect to an Emergency Condition, are:

1. a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Condition; **AND**
2. within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required to stabilize the patient, i.e., with respect to an Emergency Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the

patient from a facility or, in the case of a pregnant woman, to deliver a newborn child (including the placenta).

C. In-Network Services

Covered services provided by a Participating Provider and, if required by the member's subscriber contract, provided, arranged or authorized in advance by the member's primary care provider. In-Network Services are covered at the in-network benefit level, which generally has the lowest cost-sharing obligation for the member.

D. Network Adequacy Standards

Network Adequacy Standards are the requirements, set forth in the New York Insurance and Public Health Laws, regarding the Health Plan's obligation to ensure that its provider network is adequate to meet the health needs of its members and provide an appropriate choice of providers sufficient to render the services covered under the member's subscriber contract. Network adequacy standards apply to all insurance products, including health maintenance organization (HMO), point-of-service (POS), preferred provider organization (PPO), exclusive provider organization (EPO), and indemnity contracts and certificates, including stand-alone dental and vision policies and student health insurance policies; and to Article 47 self-funded municipal cooperative plans. Similar standards apply to Medicare Advantage products. Network Adequacy Standards do not apply to self-funded health plans other than Article 47 plans, unless their plan documents include such standards.

E. Non-Participating Provider (Out-of-Network Provider)

A facility, professional provider, or ancillary provider (e.g., laboratory, pharmacy, or durable medical equipment supplier) that does not have a contract with the Health Plan or, under some products, any other Blue Cross and/or Blue Shield Plan, to provide health services under a member's subscriber contract is a Non-Participating (or Out-of-Network) Provider. Some providers may have a contract with the Health Plan for only particular products and are Non-Participating Providers for all other products. Members generally have a higher cost-share when they receive services from a Non-Participating Provider.

F. Out-of-Network Services

Covered services that are provided by a Non-Participating Provider are Out-of-Network Services. Not all products include coverage for non-emergent Out-of-Network Services. When a member's subscriber contract includes coverage for Out-of-Network Services, and the member chooses to receive a non-emergent covered service from a Non-Participating Provider, benefits are generally provided at the out-of-network benefit level.

G. Out-of-Network Referral

If there is no Participating Provider with the appropriate training and experience to treat a member, or when Network Adequacy Standards require it, the Health Plan must authorize a referral to a Non-Participating Provider, and the Non-Participating Provider's services must be covered at the member's in-network benefit level. An Out-of-Network Referral must be made available to any member covered under an HMO, POS, PPO, EPO, or indemnity

contract or certificate, including a stand-alone dental or vision policy, a student health insurance policy, or under an Article 47 self-funded municipal cooperative plan. Similar Out-of-Network Referral requirements are applicable to Medicare Advantage plans. Out-of-Network Referral requirements do not apply to self-funded health plans other than Article 47 plans, with the exception of referrals for preventive care services under the Affordable Care Act that are unavailable in-network.

H. Participating Provider (In-Network Provider)

A facility, professional provider, or ancillary provider (e.g., laboratory, pharmacy, or durable medical equipment supplier) that has a contract with the Health Plan or, under some products, any other Blue Cross and/or Blue Shield Plan, to provide health services under a member's subscriber contract is a Participating Provider (or In-Network Provider). Some providers may have a contract with the Health Plan for only particular products and are Participating Providers for only those products. A list of Participating Providers and their locations is available on our website or upon your request to the Health Plan. The list will be revised from time to time by the Health Plan.

I. Service Area

The geographic area, designated by the Health Plan and, if required, approved by the New York State Department of Health, in which we will arrange and/or provide benefits to our members, as described in the member's subscriber contract.

J. Surprise Bill

A bill for covered health care services, other than emergency services, received by a member for services provided under **EITHER** of the following circumstances:

1. The services are performed by a non-participating physician at a participating hospital or ambulatory surgical center, where a participating physician is unavailable; or are performed by a non-participating physician without the member's knowledge or when unforeseen medical services arise at the time the health care services are provided. A bill received for health care services when a participating physician is available, but the member has elected to obtain services from a non-participating physician, is not a Surprise Bill.
2. The services are performed by a Non-Participating Provider, where the services were referred by a participating physician to the Non-Participating Provider without the 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 Plan. For purposes of a Surprise Bill, 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 service performed when a Participating Provider refers the member to a Non-Participating Provider when a referral is required under the member's subscriber contract.

K. 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 Services. Urgent Care is typically available after normal business hours, including evenings and weekends. Urgent Care is covered within or outside our Service Area, when rendered by a participating or non-participating physician or free-standing Urgent Care facility, subject to the provisions of the subscriber member contract. Please refer to the Schedule of Benefits section of the member's contract for cost-sharing requirements, day or visit limits, and any preauthorization, referral, or notification requirements that apply to these benefits.

III. In-Network Benefits for Contracts Covering In-Network and Out-of-Network Services:

A. Services are medically necessary for coverage at the In-network benefit level under **ANY** of the following circumstances:

1. The member receives an Out-of-Network Referral authorizing medically necessary Non-Participating Provider Services at the in-network benefit level (Refer to Policy Statement II.G. Out-of-Network Referral);
2. The member receives Emergency Services from a Non-Participating Provider to stabilize and treat an Emergency Condition. This does not include follow-up or routine care provided in a hospital emergency department;
3. The member's subscriber contract specifically includes language which covers specific care/treatment at the in-network benefit level for the services received from a Non-Participating Provider;
4. For members with a positive or negative diagnosis of malignancy, coverage may be provided for a second medical/surgical opinion received from a Non-Participating Provider, 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. (Refer to Corporate Medical Policy #10.01.10 Second Medical and Surgical Opinions);
5. Coverage may be available for a Surprise Bill (as defined in Policy Statement II.J.), when all of the requirements for reimbursement are met (e.g., benefits are assigned to the Non-Participating Provider in writing).

IV. In-Network Benefits for Contracts Not Providing Out-of-Network Benefits:

A. In-network benefits may also be available for care or services received from a Non-Participating Provider under **ANY** of the following circumstances:

1. Coverage may be provided for compassionate reasons, for covered, medically necessary care or services, including office visits and associated treatment (e.g., chemotherapy), received outside the Health Plan's Service Area, for a member with life-threatening disease (e.g., malignancy, end-stage renal disease requiring hemodialysis) for up to four (4) weeks per contract year;
2. Coverage may be provided for monitoring and/or care, received while a member is outside the Health Plan's Service Area, which is required to assure the stability of a member with a high-risk condition and active treatment issues (e.g., severe heart failure, complicated hypertension) for up to four (4) weeks per contract year;
3. Coverage may be provided for Emergency Services or Urgent Care;
4. For members with a positive or negative diagnosis of malignancy, coverage may be provided for a second medical/surgical opinion received from a Non-Participating Provider, 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 (Refer to Corporate Medical Policy #10.01.10 Second Medical and Surgical Opinions);
5. The member has an Out-of-Network Referral authorizing medically necessary Non-Participating Provider Services at the in-network benefit level (Refer to II.G. Out of Network Referral);
6. Coverage may be available for a Surprise Bill (as defined in Policy Statement II. J.) when all of the requirements for reimbursement are met (e.g., benefits bare assigned to the Non-Participating Provider in writing);
7. Except under the above circumstances, the following services are generally not covered when rendered by a Non-Participating Provider: routine care or services the need for which could reasonably be foreseen (e.g., physical examinations, screening tests, regularly scheduled laboratory tests such as routine monitoring of anticoagulation therapy); services provided to a member or dependent living away from home, such as a college student; and therapies/treatments or subsequent visits when a member began treatment with a Participating Provider (e.g., continuation of physical therapy).

V. Continuing Care

A. For a member in an ongoing, medically necessary course of treatment with a Participating Provider who leaves the network, coverage is available for continued, ongoing treatment from this now Non-Participating Provider for up to 90 days, or, if a member is pregnant, through postpartum care. 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 by this now Non-Participating Provider will not be covered.*

B. For members new to the Health Plan and engaged in an ongoing, medically necessary course of treatment with a Non-Participating Provider, coverage is available for services performed by the Non-Participating Provider for up to 60 days from the effective date of the member's subscriber contract. The ongoing course of treatment must be for a 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. Members are responsible for any in-network cost sharing applicable to these services.*

*Please refer to the following website for Medicaid Managed Care Postpartum Care timeframes: [accessed 2024 Nov 22]. Available from:

https://health.ny.gov/health_care/medicaid/program/update/2023/no06_2023-03.htm#postpartum

VI. Behavioral Health Episode of Continuing Care for Managed Medicaid, Health and Recovery Plan, and Dual-Special Needs Plan Members:

For a member in an ongoing, medically necessary course of ambulatory mental health treatment, other than ambulatory detoxification and withdrawal services, with a New York State Office of Mental Health (OMH) Licensed Provider who is a Non-Participating Provider or with a OMH Licensed Provider who leaves the network, coverage will be available for services performed by the Non-Participating Provider for 24 months after a member product change or 24 months after the change in the network status of the provider when ALL of the following criteria are met:

A. The services were provided in the same geographic area;

B. The services were provided at least twice during the six (6) months preceding January 1, 2023, by the same provider; and

C. The services are for the treatment of the same or related behavioral health condition.

Please refer to the following website for more information:

New York State Department of Health [Internet]. Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract. March 1, 2019 [accessed 2024 Dec 03]. Available from: https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf

RELATED POLICIE(S)

Not Applicable

POLICY GUIDELINE(S)

I. Preauthorization requirements do not apply to Emergency Services.

II. Coverage is not provided at the in-network benefit level 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, that are not utilized by Participating Providers qualified to treat a member's health condition, 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.

III. If there is a request for OON Referral and Health Plan can find a qualified and available par provider, Health Plan will deny the request for OON referral.

DESCRIPTION

In general, HMO and EPO products cover only services rendered by Participating Providers. POS and PPO contracts provide different levels of benefits, depending on whether the provider is a Participating Provider or Non-Participating Provider.

In-network benefits are provided for covered services that a member receives from a Non-Participating Provider when the member has an Out-of-Network Referral, or services were rendered under a Surprise Bill. In-network benefits may also be provided, under specific conditions, for covered services received from a Non-Participating Provider when a member is traveling or temporarily residing outside of our Service Area for work, recreation, or education (for example, college students). Coverage of services other than Emergency Services is subject to applicable preauthorization requirements.

Members covered under comprehensive products (i.e., products that provide major medical-type benefits, rather than limited benefits) may request review of the denial of a request for a referral to a Non-Participating Provider through the grievance review process by submitting specific information from a physician regarding the lack of training and experience of available Participating Providers. Medical Review staff will review the information submitted and identify Participating Providers, if any, with the appropriate training and experience to treat the member's condition. A Medical Director will make the determination to uphold or overturn a denial of a request for referral to a Non-Participating Provider.

For Emergency Services and Surprise Bills, members are only responsible for applicable in-network cost-sharing. Balance billing for Emergency Services and Surprise Bills is subject to review by an independent dispute resolution entity.

SUPPORTIVE LITERATURE

Not Applicable

PROFESSIONAL GUIDELINE(S)

Not Applicable

REGULATORY STATUS

Refer to Centers for Medicare and Medicaid Services (CMS) and Coverage For NYS Medicaid Managed Care/Harp Product Members Sections

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
	Not Applicable

HCPCS Codes

Code	Description
	Not Applicable

ICD10 Codes

Code	Description
	Not Applicable

REFERENCES

Not Applicable

SEARCH TERMS

Out-of-Area Services, Out-of-Network Services

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Based upon review, Out-of-Network Services are not addressed in National or Regional Medicare coverage determinations or policies. However, the Medicare Benefit Policy Manual Chapter 16_General Exclusions from Coverage addresses Services Not Provided within the United States (Section 60) [accessed 2024 Dec 11].

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.

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.
- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) 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.
- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION

Committee Approval Dates

08/26/04, 02/23/06, 02/28/08, 02/26/09, 06/24/10, 04/28/11, 04/26/12, 04/25/13, 04/24/14, 04/23/15, 04/28/16, 06/22/17, 04/26/18, 06/27/19, 08/27/20, 09/16/21, 09/15/22, 06/22/23, 01/18/24, 01/23/25

Date	Summary of Changes
01/23/25	Annual review; policy statement added addressing the Behavioral Health Episode of Continuing Care for Managed Medicaid, Health and Recovery Plan, and Dual-Special Needs Plan Members.
01/01/25	Summary of changes tracking implemented.
01/22/04	Original effective date