MEDICAL COVERAGE POLICY	
SERVICE: Out of Network Requests	
Policy Number:	**261**
Effective Date:	**09/01/2020**
Last Review:	**07/30/2020**
Next Review Date:	**07/30/2021**

Important note:
Unless otherwise indicated, this policy will apply to all lines of business.
Even though this policy may indicate that a particular service or supply may be considered medically necessary and thus covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage (EOC) or Summary Plan Description (SPD) to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Medicare-linked plan members, this policy will apply unless there are Medicare policies that provide differing coverage rules, in which case Medicare coverage rules supersede guidelines in this policy. Medicare-linked plan policies will only apply to benefits paid for under Medicare rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the CMS website. Similarly, for Medicaid-linked plans, the Texas Medicaid Provider Procedures Manual (TMPPM) supersedes coverage guidelines in this policy where applicable.

SERVICE: Out of Network Requests

PRIOR AUTHORIZATION: Not applicable.

POLICY: Please review the plan's EOC (Evidence of Coverage) or Summary Plan Description (SPD) for coverage details.

For Medicare plans, please refer to appropriate Medicare LCD (Local Coverage Determination). If there is no applicable LCD, use the criteria set forth below.

For Medicaid plans, please confirm coverage as outlined in the Texas Medicaid TMPPM.

Out-of-Network services needed for medically necessary care of a member may be considered necessary in **1 or more** of the following situations:

A. Continuity-of-Care [1,2] indicated by **1 or more** of the following:

1. **Member newly enrolled** within ninety (90) days of this request *(documentation should include member's effective date)* and **1 or more** of the following:
    - Member is past the **24th week of pregnancy** and needs continuation of care through postpartum period.
    - Member has an **acute condition** in which provider continuity may prevent a recurrence or worsening of the conditions under treatment as indicated by **1 or more** of the following:
        - Acute exacerbation of chronic disease (e.g. asthma)
        - Post-operative or other post-service treatment (e.g. follow-up emergency care visit)
        - Previous staged surgical procedures (e.g. cleft palate repair)
        - Ongoing oncology treatment (e.g. to complete current chemotherapy cycle)
        - Other Request (provide detailed documentation)

2. **Treating provider termed** with SWHP/FirstCare within ninety (90) days of this request [3] *(documentation should include the providers termination date)* and **1 or more** of the following:
    - Member is past the **24th week of pregnancy** and needs continuation of care through postpartum period
    - Member has an **acute condition** in which provider continuity may prevent a recurrence or worsening of the conditions under treatment as indicated by **1 or more** of the following:
        - Acute exacerbation of chronic disease (e.g. asthma)
        - Post-operative or other post-service treatment (e.g. follow-up emergency care visit)
        - Previous staged surgical procedures (e.g. cleft palate repair)
        - Ongoing oncology treatment (e.g. to complete current chemotherapy cycle)
        - Other Request (provide detailed documentation)

B. SWHP/FirstCare Network Gap confirmed *(documentation must include provider directory research or other resource information (e.g. telephonic contacts, Provider Directory search))* and **1 or more** of the following:

1. The requested out-of-network provider is located **within mileage limit (according to mileage tool)** of the member and **ALL** of the following:
    - Confirmed, per research, that an in-network provider is not available within the distance limit
    - Confirmed, per research, that an in-network provider is not available within a reasonable timeframe [4,8]
    - Request is for 6 months or less [10]
2. The requested out-of-network provider is located **more than mileage limit (according to mileage tool)** from the member and **ALL** of the following:
    - Confirmed, per research, that an in-network provider is not available equi-distance or less to the out of network provider
    - Confirmed, per research, that an in-network provider is not available within a reasonable timeframe [5]
    - Request is for 6 months or less [11]

C. Emergent or urgent [6,7] admission and member is not stable for transition to a contracted facility

Coverage for a second or additional procedures will be allowed when the above criteria meets for medical necessity.

PPO, or tiered plans, that have out-of-network benefits will not require OON referrals. OON services may require authorization IF the services are listed on the Prior Authorization list. If member is requesting in-network benefits from an OON provider. Follow above procedure.

Footnotes:

1. **Approval Notes: Non-Pregnant members:** Only approve 1-2 visits for continuity of care for 90 days from the member's effective date or provider's term date**. Pregnancy:** >24 weeks approve through delivery plus follow-up checkup within the six-week period after delivery. <24 weeks follow non-pregnant guidelines. **Therapy:** Only approve 4 weeks of therapy. **If provider does not agree to this number, reviewer must send to MD for review.**
2. **ALL** continuity of care approvals **MUST** be sent to Case Management for help transitioning in network
3. Exception for terminated provider related to loss of licensure e.g. fraud
4. TDI requires that HMOs arrange for covered health care services, including referrals to specialists, to be accessible to enrollees on a timely basis upon request and consistent with: **3 weeks for routine, 2 months for child preventive, and 3 months for adult preventative**
5. TDI requires that HMOs arrange for covered health care services, including referrals to specialists, to be accessible to enrollees on a timely basis upon request and consistent with: **3 weeks for routine, 2 months for child preventive, and 3 months for adult preventative**
6. "Emergency care" means health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's condition, sickness, or injury is of such a nature that failure to get immediate medical care could:(A) place the individual's health in serious jeopardy;(B) result in serious impairment to bodily functions;(C) result in serious dysfunction of a bodily organ or part;(D) result in serious disfigurement; or(E) for a pregnant woman, result in serious jeopardy to the health of the fetus.
7. Member should be transferred in network once stable, if indicated.
8. Medicaid plans TMPPM 8.1.3.1 appointment accessibility

   Through its Provider Network composition and management, the MCO must ensure that the following standards for appointment accessibility are met. The standards are measured from the date of presentation or request, whichever occurs first. This includes the timeliness requirements that our in-network providers must be able to see our Medicaid/CHIP members.

   a. Emergency Services must be provided upon Member presentation at the service delivery site, including at non-network and out-of-area facilities.
   b. An Urgent Condition, including urgent specialty care and behavioral health services, must be provided within 24 hours; treatment for behavioral health services may be provided by a licensed behavioral health clinician.
   c. Primary Routine Care must be provided within 14 Days.
   d. Specialty Routine Care must be provided within 21 Days.
   e. Specialty Therapy evaluations must be provided within 21 Days of submission of a signed referral. If an additional evaluation or assessment is required (e.g. audiology testing) as a condition for authorization of therapy evaluation services, the additional required evaluation or assessment should be scheduled to allow the Specialty Therapy evaluation to occur within 21 Days from date of submission of a signed referral;
   f. Initial outpatient behavioral health visits must be provided within 14 Days (this requirement does not apply to CHIP Perinate);

g. Community Long-Term Services and Supports for Members must be initiated within seven Days from the start date on the Individual Service Plan as outlined in Section 8.3.4.1 or the eligibility effective date for non-waiver LTSS unless the referring provider, Member, or STAR+PLUS Handbook states otherwise;

h. Pre-natal care must be provided within 14 Days for initial appointments except for high-risk pregnancies or new Members in the third trimester, for whom an initial appointment must be offered within five Days, or immediately, if an emergency exists. Appointments for ongoing care must be available in accordance to the treatment plan as developed by the provider;

i. Preventive health services including annual adult well checks for Members 21 years of age or older must be offered within 90 Days; and

j. Preventive health services for Members less than 6 month of age must be provided within 14 Days. Preventive health services for Members 6 months through age 20 must be provided within 60 Days. CHIP Members should receive preventive care in accordance with the American Academy of Pediatrics (AAP) periodicity schedule. Medicaid Members should receive preventive care in accordance with the Texas Health Steps periodicity schedule. MCOs must encourage new Members 20 years of age or younger to receive a Texas Health Steps checkup within 90 Days of enrollment. For purposes of this requirement, the terms “New Member” is defined in Chapter 12.4 of the UMCM.[I] 8.1.3.1 Appointment Accessibility

9. (vacant)

10. Reminder to adjust number of visits if date span is adjusted. i.e. If provider is requesting 2 visits x 1 year and agrees to 6-month date span, authorization should be adjusted to 1 visit x 6 months.

11. Reminder to adjust number of visits if date span is adjusted. i.e. If provider is requesting 2 visits x 1 year and agrees to 6-month date span, authorization should be adjusted to 1 visit x 6 months.

OVERVIEW:

Out of network requests often arise because the Member or their network Primary Care Physician (PCP) believes that the medical service required is not available within the network. This policy outlines the criteria that need to be met in order for an out of network request to be certified for medical services that are considered either standard of care.

Definitions:

SWHP/FirstCare considers an active course of treatment when members are 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, provider direct treatment, prescribe medication or other treatment or modify treatment protocol.

1. 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.

2. Members who are post-operative post-treatment or have begun a staged cycle of surgical procedures (e.g. cleft palate repair)

3. 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, generally 6-12 months.

Typical coverage span:

- Non-Pregnant members: Only approve 1-2 visits for continuity of care for 90 days from the member's effective date of provider's term date.
- Pregnancy: >24 weeks approve through delivery plus follow-up checkup within the six-week period after delivery. <24 weeks follow non-pregnant guidelines.
- Therapy: Only approve 4 weeks of therapy.
- Important: If provider does not agree to this number, reviewer must send to MD for review.
- ALL requests: OON requests should only be approved for a 6-month date span
- ALL continuity of care approvals should be sent to Case Management for help transitioning in network

CODES:

Important note:

CODES: Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.

CPT Codes:	
CPT Not Covered:	
ICD10 codes:	
ICD10 Not covered:	

CMS:

POLICY HISTORY:

Status	Date	Action
New	07/30/2020	New policy

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. The health plan will continue to review clinical evidence related to this policy and may modify it at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to the health plan so the information can be reviewed by the Medical Coverage Policy Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.

1. HHSC UMCC 8.1.3.2 Access to Network Providers
2. HHSC UMCC 8.1.3.1 Appointment Accessibility
3. UMCC 8.2.1 Continuity of Care and Out-of-Network Providers
4. UMCC 8.1.23.1 Cost Sharing - CHIP
5. 28 TAC §11.1607 Accessibility and Availability Requirements
6. TIC Subtitle C, Chapter 843, Subchapter I, Section Sec. 843.309. Contracts with Physicians or providers: Notice to Certain Enrollees of Termination of Physician or Provider participation in plan

7. TIC Subtitle C, Chapter 843, Subchapter I, Sec. 843.362. Continuity of Care; Obligation of HMO
8. Tex. Admin. Code §353.4 – Managed Care Organizations Requirements Concerning Out-Of-Network Providers – please see (b)(2)
9. 28 TAC §11.506 (15) http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=T&app=9&p_dir=F&p_rloc=169798&p_tloc=14979&p_ploc=1&pg=2&p_tac=&ti=28&pt=1&ch=11&rl=506
10. Code of Federal Regulations Title 42, Chapter IV, Subchapter C, Part 438, Subpart D, §438.206 http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf