Medical Coverage Policy | Out-of-Network Services Requests

EFFECTIVE DATE:10|01|2022
POLICY LAST UPDATED: 07|06|2022

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 members 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 members 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 with 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 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, provider 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 Product

POLICY STATEMENT

Commercial Products

Covered 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 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

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, July/August 2022
Provider Update, July 2021
Provider Update, June 2020
Provider Update, December 2019
Provider Update, October 2018

REFERENCES

Not applicable