blue california Promise Health Plan	POLICY & PROCEDURE UTILIZATION MANAGEMENT	
Policy Title: Out of Network Services – Cal MediConnect		
Policy No: 90.2.28	**Original Date: 11/15**	
Effective Date: 12/18	**Revision Date: 12/18**	**Revision No: 1**
Department Head: **Date:**	**Medical Services/P&T Committee:** **Date:**	
P&P Committee: **Date:**	**Scope of Coverage:** **UM**	

PURPOSE:
To provide an agreement process between a non-contracted provider and Blue Shield Promise Health Plan Utilization Management (UM) Department when a member is in need of a referral to a non-participating provider.

POLICY:

It is the policy of Blue Shield Promise Health Plan to use contracted/participating providers for services rendered to its members. This requirement is necessary to ensure appropriate credentialing and compliance with health plan utilization management and quality management programs. Out of network referrals shall be obtained in the event of variations in clinical practice standards, procedures and diagnostics beyond the scope of in-network providers or if there is an unavailable in-network provider within the members geographical location. If the service required is not an emergency, the approval to use a provider must be made by Blue Shield Promise's Medical Director. Blue Shield Promise does not allow use of non-participating providers strictly for member convenience. Blue Shield Promise evaluates its provider panel periodically to adequately assess the need for specialists in all medical specialties.

PROCEDURES:

1. Blue Shield Promise shall use non-contracted/participating providers under the following conditions:
    a. Member required emergency care in a non-participating facility and was seen by a non-participating provider.
    b. Member requires care or a second opinion by a specialist not available in network.
    c. Member requires procedures and diagnostic services that are not available within the network.
    d. Member continuity of care, as required by DPL 15-003, is required.

2. When the provider is identified as a non-contracted network provider, all attempts will be made to re-direct the member to a contracted provider who can provide similar care (exception continuity of

care). In some instances attempts will be made to utilize network IPA Specialist if a needed specialist is not available through the Blue Shield Promise Direct Contract list of specialists.

3. In the event that using an out of network provider is necessary, UM staff will complete a letter of agreement (LOA) request form and obtain approval from the Medical Director or designee.

4. Once the LOA request is approved by the Medical Director or designee, the UM staff will forward the LOA request form to the Provider Network Operations (PNO) Department to negotiate a one-time service agreement.

5. The attached FEE SCHEDULE AGREEMENT FORM (FSAF) is used as a letter of agreement by the PNO Dept. The form shall include the CPT codes, provider's current license, DEA #, and board certification.

    a. The provider shall not collect from the member any payment or co-insurance amount greater than the established amount for in-network services.

6. Upon receipt of the returned signed form, the Utilization Management Department will attach the FSAF to the hard copy of the Authorization Referral Form.

7. The information will then be filed in the prior authorization filing system.

8. Requests for out of network referrals shall be processed within the standard timeframe based on the status of the request. Refer to UM P&P 10.2.11 Authorization, Denial, Pending, Deferral, and/or Modification Notification and 70.2.50 Prior Authorization review and Approval Process.

AUTHORITIES AND REFERENCES:

- Welfare & Institution Code §14185(b),
- Health and Safety (H&S) Code §1373.96