blue california
Promise Health Plan

| Policy Title: Reimbursement to Out-of-Plan Providers | | POLICY #: 70.2.12<br>Line of business: ALL | |
|---|---|---|---|
| **Department Name:**<br>Utilization Management | **Original Date**<br>11/97 | **Effective Date**<br>5/19 | **Revision Date**<br>12/18 |
| **Department Head: Sr. Director, UM** | | **Date: 3/21** | |
| **Medical Services/P&T Committee: (If Applicable) PHP CMO** | | **Date: 3/21** | |

## PURPOSE

To ensure timely, appropriate, and accurate reimbursement processes for out-of-plan providers that have rendered services to Blue Shield of California Promise Health Plan (Blue Shield Promise) members.

## POLICY

Some health care services allow Blue Shield Promise members to self-refer for out-of-plan services. Additionally, Blue Shield Promise providers may refer members' out-of-plan for specialty physician and other services. These services will be reimbursed in accordance to the following provisions.

### Provisions

- Authorization
    - Reimbursement of out-of-plan providers for carved-out, in-plan, and out-of-plan member choice services (i.e., family planning, sexually transmitted disease treatment, HIV testing and counseling, and sensitive services) not requiring prior authorization (self-referral):
    - Reimbursement for these services will be based at the maximum Medi-Cal allowable, or otherwise, a more specific negotiated rate between the provider and Blue Shield Promise.
- Reimbursement of out-of-plan providers for services requiring authorization:
    - Authorization should be obtained from the delegated Utilization Management entity (Blue Shield Promise or Practicing Provider Group) and an authorization number received.
    - Services provided should not exceed the scope of the authorization, except in the case of an emergency.
    - The authorization number should be included with the claim
- Services are billed to Blue Shield Promise, unless otherwise indicated

- Services being billed should not exceed the scope of self-referral (number or type of visits) or authorization. If services beyond the scope of self referral or authorization are billed, the services are subject to medical and claims administrative review for payment decision

- If a provider disagrees with a payment decision, the provider may grieve the decision through the claims appeal process. The provider will be notified, when the claim is denied, of his/her right to submit a grievance.
- If after the grievance process the provider still disagrees with the decision, he/she may submit an administrative grievance appeal to LA Care Health Plan.
- Billings submitted as a "clean claim" should be paid within the agreed upon time frame, or if no time frame is agreed upon, no later than 45 days after receipt of the claim by the Blue Shield Promise Claims Department or Medical Group/IPA claims department if there is delegation to that level.
- Confidential services for which the member has refused to consent to the sharing of information must be billed using appropriate billing forms and accompanied by documentation that the member refused to sign a consent for release of information. Since billing information is the basis of our encounter data collections system for out-of-plan providers, the resulting encounter data set in these cases will be incomplete for purposes of reporting, tracking, trend analysis, and quality tracking and coordination of care analysis.
- Unless otherwise indicated as reflected in the provision of confidentiality and or member's written determination not to release information, a claim must be accompanied by specified clinical information and the encounter data set.
- Blue Shield Promise will implement a system of tracking all reimbursements to out-of-plan providers through billing data in the encounter data set, which include the following elements:
    - Dates of service
    - Billing date
    - Payment status (paid on time, paid late, or pending)
    - Payment date
    - Provider
    - Service provider
    - Diagnosis

**REFERENCES**