blue california
Promise Health Plan

Policy Title: Out of Network Services		POLICY #: 70.2.16 Line of business: ALL	
Department Name: Utilization Management	**Original Date** 5/98	**Effective Date** 5/19	**Revision Date** 12/18
Department Head: Sr. Director, UM		**Date: 3/21**	
Medical Services/P&T Committee: (If Applicable) PHP CMO		**Date: 3/21**	

PURPOSE

To provide an agreement process between a non-contracted provider and Blue Shield of California Promise Health Plan (Blue Shield Promise) 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 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.

PROCEDURE

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.

2. When the provider is identified as a non-contracted network provider, all attempts shall be made to re-direct the member to a contracted provider who can provide similar care. In some instances, attempts shall 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 shall 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 shall 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 shall attach the FSAF to the hard copy of the Authorization Referral Form.

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

8. Requests for out of network referrals shall be process within the standard or urgent timeframe based on the urgency 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.

9. Processing of LOAs shall be monitored to ensure there are no unnecessary delays in the provision of requested service of care.
    a. The UM staff shall ensure the approved LOA is executed within 5 calendar days for routine request.
    b. The UM staff shall ensure the approved LOA is attended to in an urgent manner and shall be executed within 24 hrs of the requested date.
    c. A report of outstanding LOAs is generated on a weekly basis and shall be forwarded to the UM Manager/designee who will then facilitate the completion of the process with Credentialing PNO, or Contracting.
    d. Each UM Coordinator shall track the LOAs and shall record for timeliness of the request and approval, including provider and member notification.
    e. LOAs that do not meet the timeframe for approval shall be forwarded to the UM Manager/designee for follow-up with Provider Network Operations, Contracting and Credentialing Departments.
    f. The outstanding LOA may also be referred to the Chief Medical Officer if the approval cannot be resolved in a timely manner.
    g. The non-executed LOAs shall be recorded and tracked for reasons of non-approval.
    h. The LOA log shall be forwarded to the UM Manager/designee for trending and identification of potential areas of improvement.

10. Criteria for selection of the appropriate non-contracted provider are described in UM P&P 10.2.100.25 – Accessing Terminated or Non-Participating Provider for Continuity of Care.

REFERENCES