Out of Network Specialists

Policy ID:	HHO-DE-MP-1182
Approved By:	Highmark Health Options – Market Leadership
Provider Notice Date:	12/15/2021; 03/01/2023
Original Effective Date:	01/15/2022; 04/01/2023
Annual Approval Date:	11/10/2021; 11/30/2022
Last Revision Date:	11/10/2021; 11/30/2022
Products:	Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1 of 3

Disclaimer

Highmark Health Options medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

POLICY STATEMENT

Highmark Health Options may provide coverage under medical surgical benefits of the Company's Medicaid products for medically necessary out of network specialists.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness, or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

The qualifications of the policy will meet the standards of the National Committee for Quality Assurance (NCQA) and the Delaware Department of Health and Social Services (DHSS) and all applicable state and federal regulations.

DEFINITIONS

Highmark Health Options (HHO) – Managed care organization serving vulnerable populations that have complex needs and qualify for Medicaid. Highmark Health Options members include individuals and families with low income, expecting mothers, children, and people with disabilities. Members pay nothing to very little for their health coverage. Highmark Health Options currently services Delaware Medicaid: Delaware Healthy Children Program (DHCP) and Diamond State Health Plan Plus members.

PROCEDURES

1. Prior authorization is required.

2. Out of Network Specialists: State of Delaware Mandate 18 Del C. Sections 3348 & 3564 (2002)

    a. Applies to every risk (insured) policy which designates network physicians or providers, or preferred physicians or providers--referred to collectively as "network providers."
    b. If medically necessary covered services are not available through network providers or the network providers are not available within a reasonable period of time on the request of a network provider within a reasonable period, referral to a non-network physician or

provider shall be allowed and the non-network physician or provider will be reimbursed at a previously agreed-upon or negotiated rate.
In such circumstances, the non-network physician or provider may not balance bill the insured. Such a referral shall not be refused unless the carrier obtains a review by a physician in the same or a similar specialty as the physician to whom a referral is sought and the review concludes that the referral is not reasonably related to the provision of medically necessary services.

c. If direct access to health care specialists is not allowed, a procedure by which members can obtain a standing referral to a health care specialist must be implemented.
d. The procedure:
    i. Shall provide for a standing referral to a specialist if the member's network provider determines that the member needs continuing care from the specialist; and
    ii. May require the carrier's approval of an initial treatment plan designed by the specialist containing (i) a limit on the number of visits to the specialist, (ii) a time limit on the duration of the referral, and (iii) mandatory updates on the member's condition.
    iii. Approval shall not be withheld unless a decision by a qualified physician that the treatment sought in the treatment plan is not reasonably related to the appropriate treatment of the member's condition.
e. Within the treatment period, referred to in subsection (d)(2) the specialist shall be permitted to treat the member without a further referral from the network provider and may authorize such further referrals, procedures, tests, and other medical services as the network provider would otherwise be permitted to provide or authorize.

3. Referral and network availability

   Excepting self-funded account plans with specific contract language to the contrary, this policy shall apply to all benefit plans and all business arrangements (insured and self-funded). It is important to review applicable self-funded contracts and/or benefit booklet language.

   If a network provider, on behalf of a member whose benefit plan requires authorization/certification for referrals, requests coverage for out-of-network provider services, the referral must be provided if:

   a. The services are medically necessary; and
   b. The services cannot be provided by a network provider within a reasonable amount of time.

4. Post-payment audit statement

   The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by Highmark Health Options at any time pursuant to the terms of your provider agreement.

REIMBURSEMENT

Participating facilities will be reimbursed per their Highmark Health Options contract.

Reference

Delaware Code Title 18. Chapter 33, § 3348 and § 3564. January 1, 2017

POLICY UPDATE HISTORY

11/10/2021	Approved in Medical Policy Committee
11/2021	Approved in QI/UM
11/30/2022	Approved in Medical Policy Committee
12/2022	Approved in QI/UM