# Payment Policy CPP_20
## Use of Non-Network Providers

BlueCross BlueShield of Vermont
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**Last Review**: August 2024
**Next Review**: August 2025
**Effective Date**: September 1, 2024

# Description

This policy applies to providers contracted with Blue Cross VT that refer a member to, or order services from, a different provider for services or items ("Referring Providers"). In general, we expect Referring Providers to direct members to Network Providers when arranging for services related to a member's care. Members have an expectation that a Referring Provider will order from Network Providers for follow-up services (such as laboratory tests) or refer the member to a Network Provider for follow-up care. Since referring members to or ordering services from non-Network Providers may have the unintended consequence of subjecting the member or Blue Cross VT client (i.e., self-insured employer group) to non-ordered, unnecessary, or excessive services and the attendant costs, as well as unreasonable costs, balance billing, and other unanticipated financial exposure, the intent of this policy is to avoid unnecessary costs and services; it is not the purpose of this policy to dissuade providers from referring members to or ordering medically necessary Covered Services. This policy articulates our expectations regarding the use of non-Network Providers and clarifies how we intend to enforce Referring Providers' contractual requirements in that regard.

# Policy & Guidelines

### Definitions

Capitalized terms used in this policy are defined by the provider's contract with Blue Cross VT. For ease of reference, the definitions for certain terms are provided below.

**Covered Service:** The health care services for which a member is eligible under the member's benefits.

**Emergency:** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonable expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or (b) serious impairment of bodily functions; or (c) serious dysfunction of any body organ or part.

**Emergency Medical Services:** With respect to an Emergency, (a) a medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. §1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available

to the emergency department to evaluate such emergency medical condition; and (b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as required under section 1867 of the Social Security Act (42 U.S.C. §1395dd) to stabilize the patient.

**Medically Necessary Services:** Health care services, including diagnostic testing, preventive services and aftercare, that are appropriate in terms of type, amount, frequency, level, setting, and duration to the member's diagnosis or condition, which are informed by generally accepted medical or scientific evidence and consistent with generally accepted practice parameters as recognized by health care professions in the same specialties as typically provide the procedure or treatment, or diagnose or manage the medical condition and which are informed by the unique needs of the individual patient and presenting situation, and (a) help restore or maintain the member's health; or (b) prevent deterioration of or palliate the member's condition; or (c) prevent the reasonably likely onset of a health problem or detect an incipient problem.

**Order:** A request that a Referring Provider submits (electronically, in writing, or by other means) to a specific service entity for labs, imaging, or other services.

**Network Provider:** A facility, professional, or other provider that has (a) entered into an agreement with Blue Cross VT, either directly or through a physician-hospital organization, provider organization, or hospital, to provide Covered Services to members, and (b) has met all applicable Blue Cross VT credentialing requirements. References to "Participating Providers" are included in this definition.

**Prior Approval:** Authorization for services or items that have been deemed by us to be medically necessary. For a member to receive benefits, the Prior Approval must have been provided before services are rendered, or items provided, by the provider. The request for Prior Approval must contain sufficient information such that Blue Cross VT is able to make a determination without requesting additional information; an incomplete request for Prior Approval may result in is denying the request for approval of the services. Sufficient information includes a completed prior authorization form and relevant clinical information needed to determine medical necessity of the request, based on our medical policies and clinical guidelines.

**Referral or Refers:** Contact by the Referring Provider (electronically, in writing, by phone, or by other means) to another provider arranging for an appointment or services from that other provider.

**Referring Provider:** The provider contracted with Blue Cross VT that refers a member to a different provider for services or items or orders services for a member from a different provider.

## Policy

We expect Referring Providers to refer members to or order services from Network Providers when arranging for services related to a member's care. For purposes of this policy, "Network Providers" includes those providers contracted directly with Blue Cross VT, and, for members whose benefit plans cover services rendered by providers located outside of Vermont that are contracted with the local Blue Plan (also referred to as providers in the Blue Card network), "Network Providers" includes providers contracted with their local Blue Plans.

We acknowledge there may be circumstances where a provider does not make a formal referral to or order from a provider but recommends a specific provider or a list of providers in a conversation with the member. We expect a provider to make best efforts to identify Network Providers when making such recommendations, but we understand that a provider may not have the opportunity to confirm participation status prior to making the recommendation. To minimize the chance that a member will unknowingly utilize the services of a non-Network Provider, the provider making the recommendation should remind the member to check benefits with his or her insurance company before proceeding. Additionally, a reminder to check benefits should be included in any patient handouts or lists.

Providers should refer members to or order services from Network Providers except where the following circumstances apply:

1. Blue Cross VT has granted Prior Approval, or
2. For Emergency Medical Services, or
3. The member specifically requests referral or orders submitted to a non-Network Provider, and the Referring Provider documents that request in the medical record and reminds the member that additional cost share amounts may apply, or
4. There is no Network Provider available to provide the medically necessary Covered Service, and the Referring Provider obtains any necessary Prior Approval for the service should the Referring Provider knowingly refer a member to a non-Network Provider. Blue Cross VT or an independent external review process (conducted pursuant to Vermont law) will determine whether the Plan does not have a contracted provider with appropriate training and experience to provide the services that are medically necessary to meet the particular health care needs of the member.

When a Referring Provider refers a member to or orders services from a non-Network Provider and has not met the requirements set forth in this policy, we will first notify the Referring Provider and offer education about Network Provider options as well as the impact of referring to or ordering from those non-Network Providers. In the event of repeated or deliberate non-compliance with this policy, we reserve the right to recover from the Referring Provider amounts that commensurate with amounts Blue Cross VT's client (i.e., self-insured employer group) or the member incurs as damages, up to $1,000.00. In this context, "damages" means amounts that exceed either what Blue Cross VT's client would have paid a Network Provider for the service or what the member would have owed as cost share for services if rendered by a Network Provider. In the event we recover funds, we will reimburse Blue Cross VT's client or the member up to the amount of incurred damages or $1,000.00, whichever is less. If we exercise our right to recover, the Referring Provider will be notified of our concerns and proposed resolution, and the Referring Provider will be given thirty (30) days to respond.

## Exceptions

The following scenarios fall outside the scope of this policy:

1. A Referring Provider advises a member to seek follow-up care but does not give a referral or order to a specific provider, and the member elects to use a non-Network Provider for care.

2. A Referring Provider mentions a non-Network Provider but notifies the member that such provider may not be a Network Provider and cautions the member about the risks of using a non-Network Provider.
3. A Referring Provider gives a member a list of Network Provider options for follow-up care and recommends the member check with the member's insurance company to confirm provider participation and benefits, but the member disregards that list and utilizes a non-Network Provider.
4. A Referring Provider refers to a non-Network Provider, following the requirements outlined above, but that non-Network Provider subsequently orders tests or other services from additional non-Network Providers.
5. A Referring Provider submits a request to us for Prior Approval, we deny the request, and the member nevertheless decides to utilize the services of the non-Network Provider.
6. Scenarios involving care rendered to members of other Blue Plans.

### Provider Billing Guidelines and Documentation

Before directing members to a provider for services or items, the Referring Provider should consult the Find-a-Doctor search tool or National Doctor and Hospital Finder to check whether the provider is participating with the member's plan.

## Benefit Determination Guidance

Payment for services is determined by the member's benefits. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Eligible services are subject to applicable member cost sharing such as co-payments, co- insurance, and deductible.

**Federal Employee Program (FEP):** Members may have different benefits that apply. For further information, please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

**Inter Plan Programs (IPP):** In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (Blue Cross VT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment, it is important to verify the member's benefits **prior** to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

**Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.**

## Eligible Providers

This policy applies to all providers/facilities contracted with the Plan's Network (participating/in-network) and any non-participating/out-of-network providers/facilities.

## Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure adherence with the guidelines stated in the payment policy. If an audit identifies instances of non-adherence with this payment policy, Blue Cross VT reserves the right to recover all non-adherence payments.

## Legislative and Regulatory Guidelines

VERMONT RULE H-2009-03: CONSUMER PROTECTION AND QUALITY REQUIREMENTS FOR MANAGED CARE ORGANIZATIONS (*With specific attention to* PART 5: ADDITIONAL REQUIREMENTS IF THERE ARE ANY RESTRICTIONS OR INCENTIVES PERTAINING TO MEMBER USE OF CONTRACTED OR CERTAIN OTHER PROVIDERS)

## Related Policies (not applicable)

## Document Precedence

The Blue Cross VT Payment Policy Manual was developed to provide guidance for providers regarding Blue Cross VT payment practices and facilitates the systematic application of Blue Cross VT member contracts and employer benefit documents, provider contracts, Blue Cross VT corporate medical policies, and Plan's claim editing logic. Document precedence is as follows:

1) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the member contracts or employer benefit documents, the member contract or employer benefit document language takes precedence.
2) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and provider contract language, the provider contract language takes precedence.
3) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and corporate medical policy, the corporate medical policy takes precedence.
4) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the Plan's claim editing solutions, the Plan's claim editing solution takes precedence.

# Policy Implementation/Update Information

This policy was originally implemented on June 1, 2019.

| Date of Change | Effective Date | Overview of Change |
|---|---|---|
| August 1, 2024 | September 1, 2024 | Payment policy reviewed with no substantive changes made. However, Policy was moved to a new layout and legislative reference made to Vt. Rule H-2009-03 in the section titled “Legislative and Regulatory Guidelines”. References to “Participating Providers” were changed to “Network Providers” including the Policy title. |

**Approved by** **Update Approved: 08/01/2024**

Tom Weigel, MD, Chief Medical Officer