Clinical Policy: Out of Network and Non-emergent Out of State Services

Reference Number: IL.CP.MP.528
Last Review Date: 11/2023

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Provider	A person or organization enrolled with the health plan to provide covered services to a participant
Provider Network	A network of providers and agencies that have entered into a contract or agreement with the health plan to provide enrollees with a broad array of community based supports and resources
Out of Network Services	Services rendered by physicians, hospitals, or other healthcare providers who are not part of Meridian's network of contracted providers
Out of State Services	Services rendered by a provider and/or facility that is not within the contracted state, and is not contracted with MERIDIAN or the contracted state's Medicaid
Emergency Services	Inpatient or outpatient hospital services that are necessary to prevent death or serious impairment of health and, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services
Post-Stabilization Care	Covered services related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition
Continuity of Care Period	A transitional period of time allowed (90 Days) upon enrollment of a new member to a health plan in which the plan will allow continued access to an out of network provider(s) in order to maintain consistency in an active course of treatment of medical conditions that may have existed prior to the member's enrollment with the plan.

In order to provide the highest quality of care to our members, Meridian Health Plan offers benefit packages in all lines of business that are founded on a Health Maintenance Organization (HMO) structure. As an HMO plan, care must be received from an IN network provider in order to be eligible for coverage, unless certain criteria are met as described throughout this policy. Meridian will ensure that any medically necessary services or items that are unavailable in the network are made available to members.

Policy/Criteria

I. It is the policy of MeridianHealth affiliated with Centene Corporation® that out of network and non-emergent out of state services are **medically necessary** for the following indications:
   A. **Mental Health Services:**

i. Meridian is only responsible for coverage of outpatient mental health services. All other mental health services are not covered
ii. Out of network services that do not require prior authorization:
    1. Emergency Care up to the point of stabilization
    2. Urgent Care
iii. Out of Network services that require prior authorization:
    1. Post-stabilization services
    2. All other services

B. **Out of Country Services:**
    i. Requests for items or services located outside of the United States are not a covered benefit, per Federal Regulation 42 USC 1396a (80),. https://www.ssa.gov/OP_Home/ssact/title19/1902.htm
C. **Out of Network Services that require prior authorization:**
    i. Post-stabilization services
    ii. All other services
D. **Out of Network/Out of State services that are eligible for coverage without prior authorization:**
    i. Emergency care up to the point of stabilization, including Urgent care
    ii. Emergency admissions (notification is required within one business day)
    iii. Behavioral Health Emergency Services and Emergency Admissions
E. **Additional Out of Network services that are eligible for coverage without prior authorization:**
    i. Family planning services (does not include pregnancy terminations)
    ii. Preventative services
    iii. Services delivered when a member is in the Continuity of Care period

If the above conditions do not exist, prior authorization is required

F. **In State, Out of Network – All** of the following criteria must be met for coverage of out of network services:
    i. Services requested must be benefit eligible
    ii. Services requested must be medically necessary and are subject to applicable clinical criteria review; ***and***
    iii. One or more of the following criteria must be met for coverage of out of network services:
        1. The service, practitioner, or specialist is not available within the Meridian network
        2. The member is within a continuity of care period (90 Days) and engaged in an active course of treatment with the provider
        3. The provider is not part of the network but is the main source of a service to the member
        4. The member is engaged in an active course of treatment with the provider at time of enrollment or otherwise prior to Meridian coverage and continuity of this care is essential to successful outcomes

5. The only provider available to the member does not, because of moral or religious objections, provide the service the member seeks.
6. Related services must be performed by the same provider and all of the services are not available within the Network.
7. The service was for kidney dialysis obtained at a Medicare-certified dialysis facility and member was temporarily outside our service area
8. IDHFS determines other circumstances that warrant Out-of-Network treatment.

G. **Out of State, In Network - <u>All</u>** of the following criteria must be met for coverage of out of state services:
   i. Services requested must be benefit eligible
   ii. Services requested must be medically necessary and are subject to applicable clinical criteria review
   iii. There are no reasonably accessible in network providers/facilities within the state/service area that can appropriately treat the member's condition

H. **Out of State, Out of Network**: **<u>All</u>** of the following criteria must be met for coverage of out of state, out of network services:
   i. Services requested must be benefit eligible
   ii. Services requested must be medically necessary and are subject to applicable clinical criteria review
   iii. The out of state provider must be licensed and/or certified by the appropriate standard setting authority
   iv. The out of state provider must agree to accept payment based on the contracted state's Medicaid fee screen; ***and***
   v. One or more of the following:
      1. The member's health would be endangered if s/he were required to travel to the applicable contracted state
      2. The services requested are not available in the State or borderland areas

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description

CPT®* Codes	Description

HCPCS ®* Codes	Description

ICD-10-CM Diagnosis Codes that Support Coverage Criteria
+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description

Reviews, Revisions, and Approvals	Revisions Date	Approval Date
Original approval date		08/29/08
Annual Review	11/2021	12/2021
Annual Review	11/2022	12/2022
Annual Review	11/2023	01/2024

References

1. Illinois Health and Family Services. General Policies and Procedures, Chapter 100. (Version Date: September, 2017). https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/Chapter100GeneralHandbook.pdf
2. State Medicaid Directors Letter (SMDL) #07-010, August 15, 2007: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD081507.pdf

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health

plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.