THE OHIO STATE UNIVERSITY
HEALTH PLAN

Subject: Out of Network Exceptions Policy

Effective Date: 07/1994
Revision Date: 08/2018

DESCRIPTION:

Certain qualifying events, in addition to emergency care, may require an approval of non-network services. This includes transition of care for members receiving services from a non-network provider, such as when a member is new to OSU Health Plan or a provider leaves the network. Additionally, certain geographical areas may lack adequate access to specific specialties. This policy establishes guidelines for authorization of out of network services.

CRITERIA:

Out of Network:

New employees electing medical coverage have the responsibility to understand health plan benefits and limitations and to make an informed decision when electing a medical plan. This includes consideration of the network status of their established providers. Therefore, if a new employee elects a plan with no out of network benefits, OSUHP will not authorize non-network services after the plan's effective date. Exceptions may be considered for employees who are moving from a different geographical location while establishing care with network provider(s) in the area. These will be reviewed on an individual basis.

Change in coverage may occur during the open enrollment period or during the plan year if there is a qualifying status change. It is the member's responsibility to understand health plan benefits and limitations and to make an informed decision when electing a change in coverage. This includes consideration of the network status for their established providers. Therefore, if a member elects a plan with more restrictive network requirements, non-network services will not be authorized after the new plan's effective date.

When a provider leaves the OSU Health Plan statewide network, the following guidelines apply for members who have established care*****:

- Obstetrics:
  - Through the postnatal visit (approximately 6 weeks postpartum)
- Outpatient behavioral health:
  - 90 days or 12 visits (whichever comes first)
- Outpatient medical:
  - 90 days
  - Includes primary care and specialists
- Outpatient therapy (PT/OT/ST):
  - 90 days or 12 visits (whichever comes first)
- Surgical:
  - During the post-operative global period for the procedure performed, up to 90 days
- Other:

- Members with cancer currently undergoing treatment (chemotherapy, radiation, surgical intervention) will be reviewed on a case by case basis.
- Transplant candidates or recipients in need of ongoing care due to complications will be reviewed on a case by case basis.

This transition period will start on the date the member was notified of the network change or the provider's termination date, whichever comes first.

* Established care is defined as a condition (including pregnancy) diagnosed and/or documented by the provider prior to notification of the provider's termination. If no notification is provided, the condition must be diagnosed and documented prior to the provider's termination date. These services must also have been rendered within the previous 12 months to be considered a continuation/transition of care.

Upon authorization for this benefit, a letter will be sent to the member and provider. This communication letter explains the transition period and the expectations that the results of treatment during the Transition Period will be:

- Care will be completed within the time frame specified.
- The provider and patient will work together during the period to transition to a network provider. OSU Health Plan case managers can assist in identifying network providers who can assume treatment and ongoing care of the member.
- A formal request for extension beyond the specified time frame can be submitted. Each case will be given individual consideration in order to provide the appropriate care for the member. If a network provider can meet similar clinical, demographic and geographic considerations, the request will be denied. The member will be advised of the network providers available to assume their treatment and ongoing care. In the event of a denial of an extension, the member has the right to submit an appeal to the OSUHP Benefits Appeals Committee.

<u>Geographical Requests:</u>

The OSU Health Plan provides a statewide network for members. However, in certain geographical locations there may be a lack of specific specialties. The OSU Health Plan will consider approval of non-network services when there are no network providers in a given specialty within a specified number of miles from the member's home zip code (Table 1). In this circumstance, consideration will be given for a provider who falls inside the specified radius of the member's home zip code. If the out of network provider requested is located further away than the network standard, OSU Health Plan will determine if there are network providers who can meet similar clinical and geographic conditions. If a network provider can meet the same requirements, the request will be denied.

Table 1 does not apply to requests for out of network services due to sub-specialties or specific types of treatments. For these requests, OSUHP will evaluate all network providers within the state of Ohio to determine if the specific services are available. If a network provider can meet similar requirements, the request will be denied.

All requests for network coverage outside the state of Ohio will require a letter of medical necessity from a network provider documenting the rationale behind the referral as well as medical records supporting the request. Each case will be given individual consideration. If a network provider within Ohio has a similar clinical specialty, the request will be denied. In the event of a denial, the member has the right to submit an appeal to the OSUHP Benefits Appeals Committee.

Table 1. Maximum Distance Requirements

Specialty	**Distance (Miles)**
Primary Care	20
Allergy and Immunology	60
Cardiology	35
Chiropractor	60
Dermatology	45
Endocrinology	75
ENT/Otolaryngology	60
Gastroenterology	45
General Surgery	35
Gynecology, OB/GYN	60
Infectious Diseases	75
Nephrology	60
Neurology	45
Neurosurgery	75
Oncology - Medical, Surgical	45
Oncology - Radiation/Radiation Oncology	75
Ophthalmology	35
Orthopedic Surgery	35
Physiatry, Rehabilitative Medicine	60
Plastic Surgery	75
Podiatry	45
Psychiatry	45
Pulmonology	45
Rheumatology	75
Urology	45
Vascular Surgery	75
Cardiothoracic Surgery	75
Acute Inpatient Hospitals	60
Cardiac Surgery Program	120
Cardiac Catheterization Services	120
Critical Care Services – Intensive Care Units (ICU)	120
Outpatient Dialysis	50
Surgical Services (Outpatient or ASC)	60
Skilled Nursing Facilities	60
Diagnostic Radiology	60
Mammography	60
Physical Therapy	60
Occupational Therapy	60
Speech Therapy	60
Inpatient Psychiatric Facility Services	75
Outpatient Infusion/Chemotherapy	60

Emergency Services:

Refer to *MMPP 18.0 Unscheduled Admissions through the Emergency Department at Out of Network Facilities* for services provided by non-network providers as a result of an admission through the emergency department.

EXCLUSIONS:

The following services are not covered by OSU Health Plan (not all-inclusive):

- Copying or obtaining medical records
- Out of network exception for members who have been dismissed from a network provider

PRIOR AUTHORIZATION INSTRUCTIONS: Prior authorization required for all out of network requests for members on Prime Care Advantage or Prime Care Connect.

INDICATIONS FOR NURSE APPROVAL: Individual consideration based on clinical documentation submitted with request.

REASONS FOR PHYSICIAN REVIEWER DENIAL: After careful review of clinical information, it is determined that the member can receive treatment/care by a network provider.

REFERENCES AND ATTACHMENTS:

CMS. (1/10/18). HSD Reference File. Retrieved from https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html

OSU. (2018). The Ohio State University Faculty and Staff Health Plans Specific Plan Details Document. https://hr.osu.edu/wp-content/uploads/medical-spd.pdf. Accessed May 4, 2018.