MEDICAL COVERAGE POLICY **SERVICE: Out of Network Requests**	
Policy Number:	**261**
Effective Date:	**03/01/2025**
Last Review:	**02/10/2025**
Next Review:	**02/10/2026**

Important note: *Unless otherwise indicated, medical policies will apply to all lines of business. Medical necessity as defined by this policy does not ensure the benefit is covered. This medical policy does not replace existing federal or state rules and regulations for the applicable service or supply. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan documents. See the member plan specific benefit plan document for a complete description of plan benefits, exclusions, limitations, and conditions of coverage. In the event of a discrepancy, the plan document always supersedes the information in this policy.*

SERVICE: Out of Network Requests

PRIOR AUTHORIZATION: Required

POLICY: Please review the plan's EOC (Evidence of Coverage) or Summary Plan Description (SPD) for details. See specific plans below for appointment wait time standards. Specific maximum time and distance standards may be found in the reference links for each type of plan.

Note: Unless otherwise indicated (see below), this policy will apply to all lines of business.

For Medicare plans, please refer to appropriate Medicare references regarding Out of Network Request guidance. CFR Title 42, Chapter IV, Subchapter C, Part 438 / Subpart D, 438.206 Availability of Services and CFR Title 42, Chapter IV, Subchapter C, Part 438, Subpart B, 438.68 Network Adequacy Standards.

Plans are required to maintain a network sufficient to provide adequate access to covered services to meet the needs of the members. If the provider network is unable to furnish necessary services, covered under the contract, to a particular enrollee, the plan must adequately and timely cover these services out of network for the enrollee, for as long as the plan's provider network is unable to provide them. Plans must meet and require its network providers to meet State standards for timely access to care and services.

1. **Outpatient mental health and substance use disorder** (adult and pediatric) – within state established timeframes but no longer than 10 business days from the date of request
2. **Primary care** (adult and pediatric) – within state established timeframes but no longer than 15 business days from the date of request
3. **Obstetrics and gynecological** - within state established timeframes but no longer than 15 business days from the date of request
4. All other – chosen in an evidence-based manner within state established timeframes.

For Medicaid plans, please refer to appropriate Medicaid references regarding Out of Network Request guidance. Uniform Managed Care Terms & Conditions - 8.1.3.1 Appointment Accessibility.

Through its Provider Network composition and management, the MCO must ensure that the following standards for appointment accessibility are met. The standards are measured from the date of presentation or request, whichever occurs first. This includes the timeliness requirements that our in-network providers must be able to see our Medicaid/CHIP members.

1. **Emergency Services** - must be provided upon Member presentation at the service delivery site, including at non-network and out-of-area facilities
2. **Urgent Condition** - including urgent specialty care and behavioral health services, must be provided within 24 hours; treatment for behavioral health services may be provided by a licensed behavioral health clinician
3. **Primary Routine Care** - must be provided within 14 Days
4. **Specialty Routine Care** - must be provided within 21 Days
5. **Specialty Therapy Evaluations** - must be provided within 21 Days of submission of a signed referral. If an additional evaluation or assessment is required (e.g., audiology testing) as a condition for authorization of therapy evaluation services, the additional required evaluation or assessment should be scheduled to allow the Specialty Therapy evaluation to occur within 21 Days from date of submission of a signed referral
6. **Initial outpatient behavioral health visits** - must be provided within 14 Days (this requirement does not apply to CHIP Perinate)
7. **Community Long-Term Services and Supports** - must be initiated within 7 Days from the start date on the Individual Service Plan as outlined in Section 8.3.4.1 or the eligibility effective date for non-waiver LTSS unless the referring provider, Member, or STAR+PLUS Handbook states otherwise
8. **Pre-natal care** - must be provided within 14 Days for initial appointments except for high-risk pregnancies or new Members in the third trimester, for whom an initial appointment must be offered within five Days, or immediately, if an emergency exists. Appointments for ongoing care must be available in accordance to the treatment plan as developed by the provider
9. **Preventive health services**
    a. **Members less than 6 months of age** must be provided within 14 Days
    b. **Members 6 months through age 20** must be provided within 60 Days
    c. **Annual adult well checks and preventive health services** for members 21 years of age or older must be offered within 90 Days
    d. CHIP Members should receive preventive care in accordance with the American Academy of Pediatrics (AAP) periodicity schedule.
    e. Medicaid Members should receive preventive care in accordance with the Texas Health Steps periodicity schedule.
    f. MCOs must encourage new members 20 years of age or younger to receive a Texas Health Steps checkup within 90 Days of enrollment. For purposes of this requirement, the terms “New Member” is defined in Chapter 12 of the UMCM
    g. **Case Management** for children and pregnant women services must be provided to members within 14 days

For Federally Facilitated Exchange Plans, the following appointment wait time standards apply (2023 Final Letter to Issuer in the Federally-facilitated Exchanges)

1. **Behavioral Health** – within 10 business days
2. **Primary Care (Routine)** – within 15 business days
3. **Specialty Care (Non-Urgent)** – within 30 business days

For all other plans, the **Texas Department of Insurance** requires that HMOs arrange for covered health care services, including referrals to specialists, to be accessible to enrollees on a timely basis upon request. Individual plans contracts may vary in the number of days permissible to arrange for covered health care services for non-urgent conditions. When no specific duration is listed to arrange for covered health care services, the following guidance may be used (House Bill 3359, Relating to Network Adequacy Standards)

1. **Routine care** – within 3 weeks
2. **Behavioral Health (routine)** – within 2 weeks
3. **Child preventive care** – within 2 months
4. **Adult preventative care** – within 3 months

General considerations for Out-of-Network services (based on state and federal guidance when plans for Medicare and Medicaid do not provide specific guidance) needed for medically necessary care of a member may be considered necessary in **one or more** of the following situations:

A. **Continuity of Care** [1,2] allows members to receive services for specified conditions from an out of network provider with whom care for that condition has already been established and discontinuation could result in harm, as indicated by **one or more** of the following:
   1. **Member newly enrolled** within ninety (90) days of the request *(documentation should include member's effective date)* and **one or more** of the following:
      a. Member is past the **24th week of pregnancy** and needs continuation of care through postpartum period (6 weeks post-delivery)
      b. Member has an **acute condition** (sudden onset) in which provider continuity may prevent a recurrence or worsening of the conditions under treatment as indicated by **one or more** of the following:
         i. Acute exacerbation of chronic disease (e.g., asthma, COPD)
         ii. Post-operative or other post-service treatment (e.g., follow-up emergency care visit for illness or injury)
      c. Member has a chronic condition (long term) for which provider continuity may prevent a recurrence or worsening of the condition under treatment as indicated by **one or more** of the following:
         i. Previous staged surgical procedures (e.g., cleft palate repair)
         ii. Newly diagnosed or relapsed cancer with active (ongoing) oncology treatment (e.g., to complete current chemotherapy cycle)
      d. Other Request (provide detailed documentation)

2. **Treating provider termed** with BSWHP within ninety (90) days of the request [3] *(documentation should include the providers termination date)* and members have medical circumstances that prevent transfer to a network provider, as indicated by **one or more** of the following:
   a. Member is past the **24th week of pregnancy** and needs continuation of care through postpartum period (6 weeks post-delivery)
   b. Member has an **acute condition** (sudden onset) in which provider continuity may prevent a recurrence or worsening of the conditions under treatment as indicated by **one or more** of the following:
      i. Acute exacerbation of chronic disease (e.g., asthma, COPD)
      ii. Post-operative or other post-service treatment (e.g., follow-up emergency care visit for illness or injury)
   c. Member has a chronic condition (long term) for which provider continuity may prevent a recurrence or worsening of the condition under treatment as indicated by **one or more** of the following:
      i. Previous staged surgical procedures (e.g., cleft palate repair)
      ii. Newly diagnosed or relapsed cancer with active (ongoing) oncology treatment (e.g., to complete current chemotherapy cycle)
   d. Other Request (provide detailed documentation)

B. **BSWHP Network Gap** confirmed *(documentation must include provider directory research or other resource information (e.g., telephonic contacts, Provider Directory search))* and **one or more** of the following:
   1. The requested out-of-network provider is located **within mileage limit (according to mileage tool)** of the member and **ALL** of the following:
      - Confirmed, per research, that an in-network provider is not available within the distance limit
      - Confirmed, per research, that an in-network provider is not available within a reasonable timeframe [4,8]
      - Request is for 6 months or less [10]
   2. The requested out-of-network provider is located **more than mileage limit (according to mileage tool)** from the member and **ALL** of the following:
      - Confirmed, per research, that an in-network provider is not available at an equal distance or less to the out of network provider
      - Confirmed, per research, that an in-network provider is not available within a reasonable timeframe [5]
      - Request is for 6 months or less [11]
   3. Out-of-state, out-of-network providers maybe considered on a case-by-case basis if in-state, out-of-network providers are not available to treat a member's condition

C. **Emergent or urgent** [6,7,12] admission and member is not stable for transition to a contracted facility

Coverage for a second or additional procedures will be allowed when the above criteria are met for medical necessity.

PPO, or tiered plans, that have out-of-network benefits will not require OON referrals. OON services may require authorization IF the services are listed on the Prior Authorization list. If member is requesting in-network benefits from an OON provider. Follow above procedure.

FOOTNOTES:

B. Typical Coverage Span
   1. **Non-Pregnant members:** Only approve 1-2 visits for continuity of care for 90 days from the member's effective date or provider's term date**.**
   2. **Pregnant members:**
      a. > 24 weeks approve through delivery plus follow-up checkup within the six-week period after delivery.
      b. < 24 weeks follow non-pregnant guidelines.
   3. **Therapy:** Only approve 4 weeks of therapy.
   4. If provider does not agree to the above number of visits or duration, reviewer must send to MD for review.

C. ALL OON requests should only be approved for a 6-month date span

D. **ALL continuity of care** approvals **MUST** be sent to Case Management for help transitioning in network

E. Exception for terminated provider related to loss of licensure (e.g., fraud)

F. Member should be transferred in network once stable, if indicated.

G. Number of visits shall be adjusted if date span is adjusted (i.e., If provider is requesting 2 visits x 1 year and agrees to 6-month date span, authorization should be adjusted to 1 visit x 6 months)

BACKGROUND:

Out of network requests often arise because the Member or their network Primary Care Physician (PCP) believes that the medical service required is not available within the network. This policy outlines the criteria that need to be met in order for an out of network request to be certified for medical services that are considered either standard of care.

Definitions:

A. BSWHP considers an active course of treatment when members are receiving active treatment for an acute condition in which provider continuity may prevent a recurrence of worsening of the condition under treatment and interfere with anticipated outcomes. Treatment typically involves

regular visits with a practitioner to monitor the status of an illness or disorder, provider direct treatment, prescribe medication or other treatment or modify treatment protocol.

1. An example of a qualifying condition may be treatment for an acute exacerbation of chronic asthma requiring ongoing treatment whereas monitoring for chronic asthma may not meet the above definition.
2. Members who are post-operative post-treatment or have begun a staged cycle of surgical procedures (e.g., cleft palate repair)
3. Oncology request: Members engaged in an ongoing course of treatment (e.g. radiation therapy or chemotherapy). Determinations may be approved through the current course of treatment, generally 6-12 months.

B. Emergency care services
   1. Inpatient or outpatient (hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility) 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.
   2. Require stabilization of medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's condition, sickness, or injury is of such a nature that failure to get immediate medical care could:
      a. Place the individual's health in serious jeopardy
      b. Result in serious impairment to bodily functions
      c. Result in serious dysfunction of a bodily organ or part
      d. Result in serious disfigurement, OR
      e. For a pregnant woman, result in serious jeopardy to the health of the mother and/or the fetus

C. Urgent care services - services furnished within 12 hours in order to avoid the likely onset of an emergency medical condition.

POLICY HISTORY:

Status	Date	Action
New	07/30/2020	New policy
Reviewed	07/22/2021	No changes
Reviewed	07/28/2022	No changes
Reviewed	12/29/2023	Added more detailed definitions and language to further clarify different sections. Added references to specific subchapters in Code of Federal Regulations. Formatting changes, beginning and ending note sections updated to align with CMS requirements and business entity changes
Reviewed	03/11/2024	Corrected the Last Review dates and Next Review Dates.

Reviewed	01/12/2025	Added hyperlinks to references for appointment wait time standards for Medicare, federally facilitated exchange plans, and for all other plans. Clarified language in several sections. Added definitions for emergency care and urgent care services.

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. The health plan will continue to review clinical evidence related to this policy and may modify it at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available, and they are not included in the list, please forward the reference(s) to the health plan so the information can be reviewed by the Medical Coverage Policy Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.

1. HHSC UMCC 8.1.3.2 Access to Network Providers
2. HHSC UMCC 8.1.3.1 Appointment Accessibility
3. UMCC 8.2.1 Continuity of Care and Out-of-Network Providers
4. UMCC 8.1.23.1 Cost Sharing – CHIP
5. 28 TAC §11.1607 Accessibility and Availability Requirements
6. TIC Subtitle C, Chapter 843, Subchapter I, Section Sec. 843.309. Contracts with Physicians or providers: Notice to Certain Enrollees of Termination of Physician or Provider participation in plan
7. TIC Subtitle C, Chapter 843, Subchapter I, Sec. 843.362. Continuity of Care; Obligation of HMO
8. Tex. Admin. Code §353.4 – Managed Care Organizations Requirements Concerning Out-Of-Network Providers – please see (b)(2)
9. 28 TAC §11.506 (15) http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=T&app=9&p_dir=F&p_rloc=169798&p_tloc=14979&p_ploc=1&pg=2&p_tac=&ti=28&pt=1&ch=11&rl=506
10. Code of Federal Regulations Title 42, Chapter IV, Subchapter C, Part 438, Subpart D, §438.206 http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf
11. Code of Federal Regulations, Title 42, Chapter IV, Subchapter C, Part 438, Subpart D, 438.206 Availability of Services
12. Code of Federal Regulations, Title 42, Chapter IV, Subchapter C, Part 438, Subpart B, 438.68 Network Adequacy Standards
13. Medicare Benefit Policy Pub 100-2 https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r206bp.pdf
14. House Bill 3359, Relating to Network Adequacy Standards https://legiscan.com/TX/text/HB3359/id/2819992/Texas-2023-HB3359-Enrolled.html
15. 2023 Final Letter to Issuer in the Federally-facilitated Exchanges https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/final-2023-letter-to-issuers.pdf

***Note**:*
Health Maintenance Organization (HMO) products are offered through Scott and White Health Plan dba Baylor Scott & White Health Plan, and Scott & White Care Plans dba Baylor Scott & White Care Plan. Insured PPO and EPO products are offered through Baylor Scott & White Insurance Company. Scott and White Health Plan dba Baylor Scott & White Health Plan serves as a third-party administrator for self-funded employer-sponsored plans. Baylor Scott & White Care Plan and Baylor Scott & White Insurance Company are wholly owned subsidiaries of Scott and White Health Plan. These companies are referred to collectively in this document as Baylor Scott & White Health Plan.

RightCare STAR Medicaid is offered through Scott and White Health Plan in the Central Texas Medicaid Rural Service Area (MRSA); FirstCare STAR is offered through SHA LLC dba FirstCare Health Plans (FirstCare) in the Lubbock and West MRSAs; and FirstCare CHIP is offered through FirstCare in the Lubbock Service Area.