SMSO Policy Manual
COVERAGE FOR OUT OF NETWORK SERVICE REQUESTS

Executive Sponsor:	Chief Medical Officer
Issuing Department:	Clinical Management
Gate Keeper:	Director, HSM Clinical Management

COMPLIANCE STATEMENT:

Enforcement:	All members of the workforce are responsible for compliance with this policy. Failure to abide by the requirements of this policy may result in corrective action, up to and including termination. Workforce members are responsible for reporting any observed violations of this policy.
Review Schedule:	This policy will be reviewed and updated as necessary and no less than every two years.
Monitoring and Auditing:	The Issuing/Collaborating Department(s) is responsible for monitoring compliance with this policy.
Documentation:	Documentation related to this policy must be maintained for a minimum of 10 years.

Applies to:

- ☒ SummaCare
- ☐ Summa Management Service Organization (SMSO)
- ☒ Apex
- ☒ Summa Insurance Company

Line of Business:

- ☒ Commercial Groups
- ☐ Medicare Supplemental
- ☒ Off-Exchange
- ☒ Medicare
- ☒ On-Exchange
- ☒ Self-Funded

1.0 Purpose:

1.1 To define the circumstances for which SummaCare covers out of network services at an in network benefit level.

1.2 To ensure members and providers that SummaCare follows and adheres to all federal and state guidelines pertaining utilization and prior authorizations.

2.0 Policy:

2.1 SummaCare will cover out of network services at the in-network benefit level when the service is not available in network, not available in network in a timely manner based upon the member's condition, or when the distance to reach the in-network provider is beyond 30 miles and there is an out of network provider located within the 30 miles. This policy applies to all lines of business.

2.2 For Medicare Advantage (MA) members, coverage decisions follow Medicare rules and regulations pertaining to MA plans, as well as federal and state regulations, and the member's evidence of coverage (EOC) document. When appropriate, relevant current clinical guidelines, SummaCare's internal policies/procedures and drug formularies may be utilized in the absence of Medicare guidance

2.3 For non-Medicare members, coverage decisions follow appropriate federal and state requirements and the member's evidence of coverage (EOC) document. Additionally, SummaCare's internal policies/procedures, and drug formularies are followed when appropriate.

3.0 Procedure:

3.1 Medically necessary services for eligible members in a Medicare, Commercial or Self-Funded plan with an Out of Network benefit will be reviewed at the In Network benefit level if one or more of the following conditions is met:

3.1.1 The service is not available from any In Network provider.

3.1.2 The In Network provider does not have the expertise or equipment to perform the service as determined by the SummaCare Medical Director.

3.1.3 The service cannot be performed by an In Network provider within a clinically appropriate time frame as determined by the SummaCare Medical Director.

3.1.4 The service cannot be provided by an In Network provider located within 30 miles from the member's home.

3.1.5 Services will be covered at the In Network benefit level for up to 90 days. Approval/Authorization of additional services beyond 90 days would require additional clinical and network review.

3.2 Director, HSM Clinical Management, has the authority and responsibility for the activities in this policy or procedure.

3.3 The Issuing Dept. is responsible for monitoring/enforcing the compliance with this policy.

3.3.1 Compliance will conduct periodic reviews to monitor and audit compliance with this policy.

4.0 References:

4.1 Source of the policy (regulatory citation, accreditation standard, internal standard)

4.1.1

4.1.2 For Medicare Advantage Members: Center for Managed Care: Chapter 17 Benefits and Beneficiary Protections; F120.5; Code of Federal Regulations (CFR)422.101; CFR 422.138; CFR 422.202; CFR 422.112; CFR 422.137

4.2 Are there any references to other documents, regulations, or intranet locations?

4.2.1 None

4.3 Are there other policies that work in conjunction with this policy?

4.3.1 Transitions of Care

4.4 Replaces (if applicable):

4.4.1 None

5.0 Definitions:

5.1 Out of Network: A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out of network providers are providers that are not employed, owned, or operated by our plan.

5.2 Pre-service Medical Necessity Review is the process of determining the medical necessity of a proposed procedure, surgery, or treatment (including pharmacological intervention) or service relative to approved criteria. It takes into consideration the appropriateness of location, frequency, intensity and scope of care and service. This process may be carried out telephonically, electronically, or in-person.

5.3 “Provider” is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. “Network Providers” have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called “plan providers”.

6.0 Key Words or Aliases (Optional):

6.1 Coverage for out of network service requests

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