THE OHIO STATE UNIVERSITY
HEALTH PLAN

Subject: Out of Network and Tier Exceptions

Effective Date: 7/94
Revision Date: 9/22

DESCRIPTION:

Certain qualifying events, in addition to emergency care, may require an approval of non-network services or a network tier exception. 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 or changes to a lower network tier. Additionally, certain geographical areas may lack adequate access to specific specialties. This policy establishes guidelines for authorization of out of network services and tier exceptions.

CRITERIA:

Out of Network:

Existing members making plan changes during open enrollment have the 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.

Employees electing medical coverage due to a qualifying event also 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. However, if an employee elects a plan with no out of network benefits after a qualifying event, OSUHP will authorize non-network services according to the guidelines below.

When a provider leaves the OSU Health Plan statewide network (either by choice or through OSUHP termination), a new employee elects coverage or there is a plan change after a qualifying event, 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>Network Tier Exceptions:</u>

Each participating provider in the OSU Health Plan network will be considered either a Premier Network provider or a Standard Network provider. For a member to receive the highest level of benefits, Premier Network providers must be utilized. Notification to disrupted members will be provided allowing sufficient time to transition to a Premier Network provider if desired. Therefore, most members will not qualify for a tier exception. Exceptions may be made if one of the following criteria is met:

- Obstetrics:
    - Tier exception will be allowed for pregnancies that were established* with a Standard Network Provider prior to notification of the change in network status. Exception will extend through the postnatal visit (approximately 6 weeks postpartum).
- Surgical:
    - Tier exception will be allowed for elective surgeries with a Standard Network Provider prior to notification of the network changes when surgery will occur within 90 days of the date of notification. Exception will extend through the post-operative global period (up to 90 days depending on type of surgery).
- 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.

New employees who established care* with a Standard Network provider prior to electing coverage through OSUHP will qualify for a network tier exception according to the following guidelines:

- 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 member's effective date.

* Established care is defined as a condition (including pregnancy) diagnosed and/or documented by the provider. Services must have been rendered within the previous 12 months to be considered a continuation/transition of care.

Upon authorization of a network tier exception, a letter will be sent to the member and provider. This communication letter explains the expectations that the care will be completed within the time frame specified. To continue to receive the higher level of benefit, the provider and patient will work together during the period to transition to a Prime Network provider. After the authorization has expired, ongoing services will be covered according to the benefit levels described in The Ohio State University Faculty and Staff Health Plan Specific Plan Details Document (SPD).

Geographical Requests:

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 outside 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.

Please note: 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)**
Acupuncture	60
Acute Inpatient Hospitals	25
Allergy and Immunology	60
Cardiac Catheterization Services	120
Cardiac Surgery Program	120
Cardiology	35
Cardiothoracic Surgery	75
Chiropractor	60
Critical Care Services – Intensive Care Units (ICU)	120
Counseling Services	20
Dermatology	45
Diagnostic Radiology	60
Endocrinology	75
ENT/Otolaryngology	60
Gastroenterology	45
General Surgery	35
Gynecology, OB/GYN	20
Infectious Diseases	75
Inpatient Psychiatric Facility Services	75
Laboratory	20
Mammography	60
Nephrology	60
Neurology	45
Neurosurgery	75
Occupational Therapy	60
Oncology - Medical, Surgical	45
Oncology - Radiation/Radiation Oncology	75
Ophthalmology	35
Orthopedic Surgery	35
Outpatient Dialysis	50
Outpatient Infusion/Chemotherapy	60
Physiatry, Rehabilitative Medicine	60
Physical Therapy	60
Plastic Surgery	75
Podiatry	45
Primary Care	20
Psychiatry	45
Pulmonology	45
Rheumatology	75
Skilled Nursing Facilities	60
Speech Therapy	60
Surgical Services (Outpatient or ASC)	60
Urology	45
Vascular Surgery	75

Emergency Services:

Refer to *MMPP 18.0 Unscheduled Admissions through the Emergency Department at Out of Network Facilities* for services provided by non-network or Standard 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 Standard or Prime network provider
- Tier exception for members who have been dismissed from a Prime network provider
- Exceptions for ancillary services related to a network exception (for example, labs sent out of network or to a standard provider). According to the SPD, it is the member's responsibility to confirm the network status of all providers (physicians, labs, etc.), including those to whom you are referred, in order to ensure coverage under the medical plan.

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

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. (2021). The Ohio State University Faculty and Staff Health Plans Specific Plan Details Document. https://hr.osu.edu/wp-content/uploads/medical-spd.pdf.