BlueCross BlueShield of Vermont
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USE OF NON-PARTICIPATING PROVIDERS

Corporate Payment Policy

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Document Precedence

The Blue Cross and Blue Shield of Vermont ("BCBSVT") Payment Policy Manual was developed to provide guidance for providers regarding BCBSVT payment practices and facilitates the systematic application of BCBSVT member contracts and employer benefit documents, provider contracts, BCBSVT corporate medical policies, and BCBSVT's claim editing solution. Document precedence is as follows:

1) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and the member contracts or employer benefit documents, the member contract or employer benefit document language takes precedence.
2) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and provider contract language, the provider contract language takes precedence.
3) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and corporate medical policy, the corporate medical policy takes precedence.
4) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and BCBSVT's claim editing solution, BCBSVT's claim editing solution takes precedence.

Payment Policy

Description

This policy applies to providers contracted with BCBSVT that Refer a Member to, or Order services from, a different provider for services or items ("Referring Providers"). In general, BCBSVT expects Referring Providers to direct Members to Participating Providers when arranging for services related to a Member's care. Members have an expectation that a Referring Provider will Order from Participating Providers for follow-up services (such as laboratory tests) or Refer the member to a Participating Provider for follow-up care. Since Referring Members to or Ordering services from non-Participating Providers may have the unintended consequence of subjecting the Member or BCBSVT client (i.e., self-insured employer group) to non-ordered, unnecessary, or excessive services and the attendant costs, as well as unreasonable costs, balance billing, and other unanticipated financial exposure, the intent of this policy is to avoid unnecessary costs and services; it is not the purpose of this policy to dissuade

providers from Referring Members to or Ordering Medically Necessary Covered Services. This policy articulates BCBSVT's expectations regarding the use of non-Participating Providers and clarifies how BCBSVT intends to enforce Referring Providers' contractual requirements in that regard.

Definitions

Capitalized terms used in this policy are defined by the provider's contract with BCBSVT. For ease of reference, the definitions for certain terms are provided below.

Covered Service: The health care services for which a member is eligible under the member's benefits.

Emergency: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonable expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or (b) serious impairment of bodily functions; or (c) serious dysfunction of any body organ or part.

Emergency Medical Services: With respect to an Emergency, (a) a medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. §1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as required under section 1867 of the Social Security Act (42 U.S.C. §1395dd) to stabilize the patient.

Medically Necessary services: Health care services, including diagnostic testing, preventive services and aftercare, that are appropriate in terms of type, amount, frequency, level, setting, and duration to the member's diagnosis or condition, which are informed by generally accepted medical or scientific evidence and consistent with generally accepted practice parameters as recognized by health care professions in the same specialties as typically provide the procedure or treatment, or diagnose or manage the medical condition and which are informed by the unique needs of the individual patient and presenting situation, and (a) help restore or maintain the member's health; or (b) prevent deterioration of or palliate the member's condition; or (c) prevent the reasonably likely onset of a health problem or detect an incipient problem.

Order: A request that a Referring Provider submits (electronically, in writing, or by other means) to a specific service entity for labs, imaging, or other services.

Participating Provider: A facility, professional, or other provider that has (a) entered into an agreement with BCBSVT, either directly or through a physician-hospital organization, provider organization, or hospital, to provide Covered Services to members, and (b) has met all applicable BCBSVT Credentialing requirements.

Prior Approval: Authorization for services or items that have been deemed by BCBSVT to be Medically Necessary. For a member to receive benefits, the Prior Approval must have been provided before

services are rendered, or items provided, by the provider. The request for Prior Approval must contain sufficient information such that BCBSVT is able to make a determination without requesting additional information; an incomplete request for Prior Approval may result in Plan denying the request for approval of the services. Sufficient information includes a completed prior authorization form and relevant clinical information needed to determine medical necessity of the request, based on BCBSVT medical policies and clinical guidelines.

Referral or Refers: Contact by the Referring Provider (electronically, in writing, by phone, or by other means) to another provider arranging for an appointment or services from that other provider.

Referring Provider: The provider contracted with BCBSVT that Refers a member to a different provider for services or items or Orders services for a Member from a different provider.

Policy

General

BCBSVT expects Referring Providers to Refer Members to or Order services from Participating Providers when arranging for services related to a Member's care. For purposes of this policy, "Participating Providers" includes those providers contracted directly with BCBSVT, and, for Members whose benefit plans cover services rendered by providers located outside of Vermont that are contracted with the local Blue Plan (also referred to as providers in the Blue Card network), "Participating Providers" includes providers contracted with their local Blue Plans.

BCBSVT acknowledges there may be circumstances where a provider does not make a formal Referral to or Order from a provider but recommends a specific provider or a list of providers in a conversation with the Member. BCBSVT expects a provider to make best efforts to identify Participating Providers when making such recommendations, but BCBSVT understands that a provider may not have the opportunity to confirm participation status prior to making the recommendation. To minimize the chance that a Member will unknowingly utilize the services of a non-Participating Provider, the provider making the recommendation should remind the Member to check benefits with his or her insurance company before proceeding. Additionally, a reminder to check benefits should be included in any patient handouts or lists.

Providers should Refer Members to or Order services from Participating Providers except where the following circumstances apply:

(1) BCBSVT has granted Prior Approval, or
(2) For Emergency Medical Services, or
(3) The Member specifically requests Referral or Orders submitted to a non-Participating Provider, and the Referring Provider documents that request in the medical record and reminds the Member that additional cost share amounts may apply, or
(4) There is no Participating Provider available to provide the Medically Necessary Covered Service, and the Referring Provider obtains any necessary Prior Approval for the service should the Referring Provider knowingly Refer a Member to a non-Participating Provider. BCBSVT or an independent external review process (conducted pursuant to Vermont law) will determine

whether Plan does not have a contracted provider with appropriate training and experience to provide the services that are Medically Necessary to meet the particular health care needs of the Member.

When a Referring Provider Refers a Member to or Orders services from a non-Participating Provider and has not met the requirements set forth in this policy, BCBSVT will first notify the Referring Provider and offer education about Participating Provider options as well as the impact of Referring to or Ordering from those non-Participating Providers. In the event of repeated or deliberate non-compliance with this policy, BCBSVT reserves the right to recover from the Referring Provider amounts that are commensurate with amounts BCBSVT's client (i.e., self-insured employer group) or the Member incurs as damages, up to $1,000. In this context, "damages" means amounts that exceed either what BCBSVT's client would have paid a Participating Provider for the service or what the Member would have owed as cost share for services if rendered by a Participating Provider. In the event BCBSVT recovers funds, BCBSVT will reimburse BCBSVT's client or the Member up to the amount of incurred damages or $1,000, whichever is less. If BCBSVT exercises its right to recover, the Referring Provider will be notified of BCBSVT's concerns and proposed resolution, and the Referring Provider will be given thirty (30) days to respond.

Exceptions

The following scenarios fall outside the scope of this policy:

(1) A Referring Provider advises a Member to seek follow-up care but does not give a Referral or Order to a specific provider, and the Member elects to use a non-Participating Provider for care.
(2) A Referring Provider mentions a non-Participating Provider but notifies the Member that such provider may not be a Participating Provider and cautions the Member about the risks of using a non-Participating Provider.
(3) A Referring Provider gives a Member a list of Participating Provider options for follow-up care and recommends the Member check with the Member's insurance company to confirm provider participation and benefits, but the Member disregards that list and utilizes a non-Participating Provider.
(4) A Referring Provider refers to a non-Participating Provider, following the requirements outlined above, but that non-Participating Provider subsequently orders tests or other services from additional non-Participating Providers.
(5) A Referring Provider submits a request to BCBSVT for Prior Approval, BCBSVT denies the request, and the Member nevertheless decides to utilize the services of the non-Participating Provider.
(6) Scenarios involving care rendered to Members of other Blue Plans.

Benefit Determination Guidance

Payment for services is determined by the Member's benefits. It is important to verify the Member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the Member's benefit.

Eligible services are subject to applicable Member cost sharing such as co-payments, co-insurance, and deductible.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the Member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the Member's benefit.

Inter Plan Programs (IPP): In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (BCBSVT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a Member's Blue Plan must honor. A Member's Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A Member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A Member's Blue Plan can only determine whether services rendered to their Members are eligible for benefits. To understand if a service is eligible for payment it is important to verify the Member's benefits **prior** to providing services. In certain circumstances, the Member may be financially responsible for services beyond the benefit provided for eligible services.

Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

Provider Billing Guidelines and Documentation

Before directing Members to a provider for services or items, the Referring Provider should consult the Find-a-Doctor search tool or National Doctor and Hospital Finder to check whether the provider is participating with the Member's plan.

National Drug Code(s)

Health Care Procedure Coding System (HCPCS) codes related to chemotherapy drugs, drugs administered other than oral method, and enteral/parenteral formulas may be subject to National Drug Code (NDC) processing and pricing. The use of NDC on medical claims helps facilitate more accurate payment and better management of drug costs based on what was dispensed and may be required for payment. For more information on BCBSVT requirements for billing of NDC please refer to the provider portal at http://www.bcbsvt.com/provider-home for the latest news and communications.

Eligible Providers

This policy applies to all providers rendering services to BCBSVT Members.

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Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the payment policy. If an audit identifies instances of non-compliance with this payment policy, BCBSVT reserves the right to recoup all non-compliant payments.

Policy Implementation/Update Information

New Policy effective September 2019
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Approved by **Date Approved:** 02/24/2020

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