Select Health

CODING/REIMBURSEMENT POLICY

DETERMINING ALLOWED AMOUNTS FOR OUT-OF-NETWORK CLAIMS FOR COMMERCIAL PLANS

Policy # 96

Implementation Date: 4/24/24
Review Dates:
Revision Dates:

Disclaimer:
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Advantage (Medicare/CMS), and Select Health Community Care (Medicaid/CHIP) plans. Refer to the "Policy" section for more information.

Description

This policy applies to Allowed Amounts for Out-Of-Network Covered Services provided by a Nonparticipating Provider for members enrolled in a commercial plan.

COMMERCIAL PLAN POLICY

A. Determination of Allowed Amounts for Out-Of-Network Covered Services

Select Health will set Allowed Amounts for Covered Services provided by a Nonparticipating Provider using the following methodology:

1. The Allowed Amounts will be determined separately for each state in which the member's plan is offered (except as provided below). For example, for plans offered in Utah, the Allowed Amounts for out-of-network Covered Services will be determined using Utah data, only, and such Allowed Amounts will be applied to covered out-of-network claims no matter where the member obtains the services.

2. The methodology for determining the Allowed Amounts will be the same general methodology for all Covered Services.

3. The Allowed Amounts for out-of-network Covered Services will be a percentage of billed Covered Services. To determine the percentage of billed services that will be the Allowed Amount, Select Health will review claims from Participating Providers. Select Health will determine the average percentage of billed amounts that Participating Providers receive for the same categories of services, which are set forth below. The Allowed Amount for out-of-network Covered Services will be set at the average percentage of billed amounts that Select Health pays Participating Providers (the "Out-of-Network Rate").

4. The Out-of-Network Rate will be calculated separately for the categories set forth below. For each category, claims within that category will be aggregated in order to determine the Out-of-Network Rate:

    a. Mental Health/Substance Use Disorder professional services

    b. Mental Health/Substance Use Disorder inpatient services

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c. Mental Health/Substance Use Disorder outpatient services (including DME, labs, and home health, etc.)

d. Medical/Surgical professional services

e. Medical/Surgical inpatient services

f. Medical/Surgical outpatient services (including DME, labs, and home health, etc.)

B. Data

Out-of-Network Rates will be determined annually. Select Health will use claims data from Participating Providers for dates of service over a 24-month period ending December 31st of each year. Select Health will allow for six months of claims run-out, until June 30th of each year, before performing the calculations described in this policy. The Out-of-Network Rates will be effective in Select Health's claim processing system as of September 1st of each year. The first date on which the Out-of-Network Rates will be effective is September 1, 2024.

The Participating Provider data that will be used to determine the Out-of-Network Rate will be data from the particular Select Health network that has the largest number of Participating Provider claims for the Covered Services during the 24-month period set forth above. All Participating Provider claims in commercial plans, regardless of lines of business (e.g., individual, small employer, large employer, etc.) will be included.

In the event Select Health does not have claims data for that 24-month period in a particular state, or Select Health does not have a sufficient number of members or claims data, Select Health will use claims data for that 24-month period from all the states in which members' plans are offered.

C. Other

Agreements with Participating Providers may begin, terminate, or change at any point during any given year. Select Health will review Allowed Amounts for out-of-network Covered Services provided by a Nonparticipating Provider annually. Updates to Allowed Amounts for out-of-network services will be made within a reasonable period after the annual review.

D. Exceptions

1. Covered Services for which other pricing is available to Select Health. If the Covered Services are received from a Nonparticipating Provider that is out-of-area/out-of-state, and the Nonparticipating Provider accepts rates pursuant to an agreement with one of Select Health's vendors, affiliates, or contracted parties (e.g., UHC, Multiplan, etc.), then Select Health will set the Allowed Amount for the Covered Services according to such agreement.

2. Pharmacy claims.

3. Covered Services that are governed by the No Surprises Act, or other state or federal law that regulates the pricing for such Covered Services.

4. Covered Services where Select Health negotiates a different rate with the Nonparticipating Provider. If the Nonparticipating Provider agrees to accept a different rate for the Covered Services, then the Plan may, at its sole discretion, negotiate and agree to a rate or rate(s) with the Nonparticipating Provider, including without limitation in a single case agreement, in which instance the Nonparticipating Provider must agree not to balance-bill the member.

5. Claims for Covered Services under any Medicare Advantage, Medicaid, or CHIP Plan.

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SELECT HEALTH ADVANTAGE (MEDICARE/CMS)

This policy does not apply to Select Health Advantage plans.

SELECT HEALTH COMMUNITY CARE (MEDICAID)

This policy does not apply to Select Health Community Care plans.

Disclaimer
This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult with appropriate healthcare providers to obtain needed medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's individual benefit plan that is in effect at the time services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

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Members may contact Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Coverage Policy may call Select Health Provider Relations at (801) 442-3692.

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