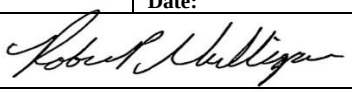
Procedure #: 724-13	**Title:** Processing Out of Network Claims		
Issue Date: 1/1/2016	**Next Review Date:** 05/02/2021	**Last Review Date:** 05/02/2020	**Last Revised Date:** 9/22/2019
Author: Jennifer Robinson, Claims and Quality Control	**Executive Sponsor:** Robert Mulligan, President & CEO	**Sponsor Signature:** 	

When accessing PHI or other sensitive information, employees must at all times abide by the Company's Minimum Necessary Privacy Policy and only access or use such information to the extent necessary to perform the tasks set forth in this procedure. If an employee is unsure whether or not certain information is necessary to complete a particular task, the employee should contact his or her manager. Language about the Company's Minimum Necessary Policy is located in HIPAA Privacy Policies.

All documentation required under this procedure shall be retained in accordance with the applicable time period specified in Company's Record Retention Policy.

1. PURPOSE & APPLICATION

The purpose of this document is to define the process of adjusting specific out-of-network claims when an in-network provider is not accessible or available.

2. SCOPE

This procedure applies to all out-of-network provider claims where the services are emergent in nature or where no network providers are available within a specific area or time frame, in accordance with Renaissance access and availability standards as defined in 6.1.1.1.

3. PRIMARY CUSTOMER(S) OF THE PROCEDURE

Operations Specialists

4. RELATED DOCUMENTS AND FORMS

5. DEFINITIONS

5.1 Emergent Care – will include procedure code D0140, D3221 and D9110

5.2 In-Network Provider (PPO Provider) - a preferred provider Dentist who has entered into a contract to provide Covered Services for pre-negotiated fees that the Dentist has agreed to accept as payment in full.

5.3 Out-of-Network Provider (Non-PPO Provider) - a Dentist who has not entered into a contract to provide Covered Serviced for pre-negotiated fees.

6. PROCEDURE

6.1 If a call is received from a member, prior to receiving services, including emergent services, who is unable to access a PPO Provider within the access standards set forth below, the following steps must be taken.

6.1.1 Verify using member's zip code that no In-Network Providers are located within the set accessibility standards.

6.1.1.1 Accessibility Standards for General and Specialist

6.1.1.1.1 Urban – 1 in 15 miles

6.1.1.1.2 Suburban – 1 in 30 miles

6.1.1.1.3 Rural – 1 in 45 miles

6.1.2 If providers are available, verify with the member that services cannot be received from a PPO Provider within the wait time guidelines set forth in step 6.2

6.1.2.1 Document the details in the member's record in Enterprise Portal.

6.1.3 If no PPO providers are accessible, let the member know that the plan will cover services by a Non-PPO Provider at the same benefit level as it would for a PPO Provider. Follow step 6.3

6.1.4 If a call is received from a member, after services are performed for emergent services rendered by a Non-PPO Provider the above verifications will be performed. If no PPO providers were accessible at the time of service, let the member know that the plan will cover services by a Non-PPO Provider at the same benefit level as it would a PPO Provider. Follow step 6.3.

6.2 If a call is received from a member, prior to receiving services, who is unable to access a PPO Provider within the appointment wait times set forth below, the following steps must be taken.

6.2.1 Obtain provider name, contact information, and length of wait time for the appointment.

6.2.1.1 Wait Time Standards for all States

6.2.1.1.1 General Dentist and Specialist – 6-8 weeks

6.2.1.1.2 Emergent Care – 24-48 hours

6.2.1.2 Connecticut Wait Time Standards

6.2.1.2.1 General Dentist – 10 business days

6.2.1.2.2 Specialist – 15 business days

6.2.1.2.3 Emergent Care – 24-48 hours

6.2.2 If no PPO providers are available, let the member know that the plan will cover services by a Non-PPO Provider at the same benefit level as it would a PPO Provider. Follow step 6.3.

6.3 If a PPO Provider cannot be located within the accessibility or appointment wait time standards set above, the member should be forwarded to a Supervisor (or Manager if Supervisor not available).

6.3.1 Upon receipt the Supervisor will verify, using member's zip code, that no PPO Providers are available within the accessibility standards and/or appointment wait time standards

6.3.2 If a PPO Provider still cannot be located or is not available the Supervisor should:

6.3.2.1.1 Document the details in the member's record in Enterprise Portal and apply a route to the members account. Claim will be paid according to step 6.6.

6.4 If a call is received from a Non-PPO Provider, prior to the member receiving emergent services, who is not within the access or appointment wait time standards the following steps must be taken.

6.4.1 Verify using member's zip code that no PPO Providers are located within these standards.

6.4.2 If not PPO Providers are located, request that the provider fax the claim to the general fax number once services are completed.

6.4.3 Route to Team Lead (or Manager if Team Lead is not available) to apply a route condition to the member's file.

6.5 If a call is received from a Non-PPO Provider, prior to the member receiving services other than emergent, who is not within the Access or appointment wait time standards, the following steps must be taken.

6.5.1 Verify using member's zip code that no PPO Providers are located within these standards.

6.5.2 If a PPO Provider cannot be located within the accessibility or appointment wait time standards, the provider should be forwarded to a Supervisor (or Manager if Supervisor is not available). Follow step 6.3

6.6 Paying the Claim

6.6.1 When the claim is received on a members file with a route condition, it will be routed to the Claims Department for manual pricing and processing.