CATASTROPHIC ILLNESS IN CHILDREN RELIEF FUND COMMISSION

POLICY/ADMINISTRATIVE PROCEDURE

SUBJECT: Reasonable Rates and Out-of-Network Providers
EFFECTIVE DATE: April 5, 2023
AUTHORITY: N.J.A.C. 10:155-1.11(a)(5) Commission Minutes: April 5, 2023 August 5, 2020 (Closed) April 14, 2021 (Closed) February 1, 2023 (Closed)

I. POLICY STATEMENT:

N.J.A.C. 10:155-1.11(a)(5) states that the State Office of the Catastrophic Illness in Children Relief Fund shall "determine the reasonableness of provider and vendor charges." To assist the Commission in determining the level of assistance to be provided for any application, the State Office must determine what portion of charges, including those partially covered by an applicant's health coverage plan, are reasonable and customary for purposes of reimbursement by the Fund.

The Fund does not have a comprehensive database with reasonable rates for every service the Fund may be asked to reimburse. For applicant children who hold comprehensive health coverage and receive services normally reimbursed by health coverage plans, the Commission assumes that the amount allowed by the child's health coverage plan is reasonable. Reasonable rates for other services not typically covered by health coverage programs are described in other Commission policies.

For children with comprehensive health coverage, the Commission will reimburse services (in accordance with all other applicable Commission rules and regulations) as follows:

1. For services obtained **within the applicant child's health coverage network**, the following expenses are considered potentially reimbursable:

    a. All copays, coinsurance, and deductibles the family owes or has already paid out-of-pocket; and

    b. Charges for services determined medically necessary by the Commission that exceed a benefit limit, whether a visit, a day or a dollar limit, established by the applicant child's health coverage plan.

2. For services obtained **outside the applicant child's health coverage network** (i.e., out-of-network services, also known as services provided by a non-participating provider or facility), the following expenses are considered potentially reimbursable:

    a. Charges for non-ambulatory services (e.g., inpatient services at a hospital);

    b. Charges for emergent, urgent, or inadvertent ambulatory services;

    c. Applicable coinsurance, and deductibles for out of network ambulatory services for applicant children with coverage through a Point of Service (POS) plan or Preferred Provider Organization (PPO); and

    d. Charges for services determined medically necessary by the Commission that exceed a benefit limit established by the applicant child's health coverage plan.

3. If not covered by paragraphs (1) or (2) above, the Commission does not consider expenses that would be otherwise typically covered by a health coverage plan as reimbursable by the Fund. Specifically, **for ambulatory services rendered outside the applicant child's health coverage network**, the following are not covered:

    a. All charges for applicant children with coverage through an Exclusive Provider Organization (EPO) or Health Maintenance Organization (HMO); and

    b. Charges that exceed the amount allowed by the health coverage plan for applicant children with coverage through a POS or PPO plan.

II. DEFINITIONS:

- **Ambulatory services**: Medical services performed on an outpatient basis, without admission to a hospital or other facility. Ambulatory care is provided in settings such as dialysis clinics, ambulatory surgical centers, hospital outpatient departments, and the offices or other practice sites of physicians and other health professionals.

- **Balance billing**: When an out of network provider bills the patient for the difference between the provider's billed charge and the plan's allowed amount. For example, if the provider's charge is $100 and the plan's allowed amount is $70, the provider may bill the patient for the $30 difference. There is never balance billing associated with services from an in network provider.

- **Comprehensive health coverage**: Plans that cover a wide range of health services (also known as major medical health insurance). Common commercial plan types include EPO, HMO, POS, and PPO plans. NJFamilyCare provides comprehensive health coverage. Limited-benefit plans, which include critical illness plans, indemnity plans (policies that only pay a pre-determined amount, regardless of total charges), and "hospital cash" policies, are not considered comprehensive health coverage.

- **Emergency**: A medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that a prudent lay person, who possesses an average

knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in: 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; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists where: there is inadequate time to effect a safe transfer to another hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or the unborn child (N.J.A.C. 11:24A-1.2).

- **Exclusive Provider Organization (EPO)**: Except for emergency and urgent care, EPO plans require a covered person to use the services of network providers. If a person covered under an EPO plan *voluntarily* decides to use the services of an out-of-network provider, the EPO will not cover the services.

- **Health Maintenance Organization (HMO)**: A type of health insurance plan no out-of-network benefits. Except for emergency and urgent care, HMO plans require a covered person to use the services of network providers. If a person covered under an HMO plan *voluntarily* decides to use the services of an out-of-network provider, the HMO will not cover the services.

- **Inadvertent care**: Health care services that are covered under a managed care health benefits plan that provides a network; and provided by an out-of-network health care provider in the event that a covered person utilizes an in-network health care facility for covered health care services and, for any reason, in-network health care services are unavailable in that facility. "Inadvertent out-of-network services" shall include laboratory testing ordered by an in-network health care provider and performed by an out-of-network bio-analytical laboratory (N.J.S.A. 26:2SS-3).

- **Non-ambulatory services**: Services performed on an inpatient basis, with admission to a hospital or other facility. Charges associated with those services may include facility room and board charges, physician charges including surgeon charges, anesthesia charges, radiology and imaging charges, etc.

- **Point of Service (POS)**: A POS plan provides coverage for the services of network providers as well as the services of out-of-network providers. Generally, the out-of-pocket cost to a person covered under a POS plan will be less if the person uses the services of a network provider rather than the services of an out-of-network provider.

- **Preferred Provider Organization (PPO)**: A PPO plan provides coverage for the services of network providers as well as the services of out-of-network providers. Generally, the out-of-pocket cost to a person covered under a PPO plan will be less if the person uses the services of a network provider rather than the services of an out-of-network provider.

- **Urgent care claim:** any claim for medical care or treatment with respect to which application of the time periods for making non-urgent determinations, in the judgment of a prudent layperson who possesses an average knowledge of health and medicine, could seriously jeopardize the life or health of the covered person or

the ability of the covered person to regain maximum function, or which, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim (N.J.A.C. 11:24A-1.2).

III. PROCEDURE:

A. For services obtained **within the applicant child's health coverage network**:

1. Calculate the amount payable by the Fund for the service as the sum of the deductible, copay, and coinsurance applied to the service by the family's health coverage plan.

2. Enter this amount as the "verified amount" for determining eligibility for the Fund.

3. Apply caps, reductions, and/or family responsibility as described in other policies and procedures to determine the amount payable by the Commission for the service.

4. "Reason for Assistance" should be listed as "Co-Pays/Deductibles/Coinsurance."

B. For services denied by a child applicant's health coverage plan as exceeding a benefit limit:

1. Determine whether the service should be covered by the Fund, including medical necessity.

2. Apply the amount the family owes to the provider or vendor plus any prior payments by the family to the provider or vendor, excluding payments from any other source, as "verified amount" for purpose of determining eligibility for the Fund.

3. Determine a reasonable rate for the service provided. If the HCPCS/ CPT code(s) of the service(s) provided are available (on either the explanation of benefits (EOB) or provider bill):

   a. Determine the Medicare Administrative (MAC) Locality where the service was provided. For New Jersey, the MAC Locality is **1240201** (Northern NJ) for the following counties: Bergen, Essex, Hudson, Hunterdon, Middlesex, Morris, Passaic, Somerset, Sussex, Union, and Warren. All other counties (Rest of New Jersey) are coded as **1240299**. If provided outside of New Jersey, search for the appropriate MAC locality.

   b. Using the information determined in steps 1 and 2 along with the date of service, use the Medicare Physician Fee Schedule Look-up Tool available at https://www.cms.gov/medicare/physician-fee-schedule/search/overview to determine the limiting charge for the service.
      i. Select the year of the date of service
      ii. If searching for more than one code, select "List of HCPCS Codes" under "HCPCS Criteria" to enter up to five different codes, or select "Range of HCPCS Codes" to enter a range.

iii. Select "Specific Locality" under "MAC Option" and then select the appropriate MAC locality.
    1. **Note:** if the service was provided in a hospital setting, use the "facility limiting charge;" if provided outside a hospital or similar facility (i.e., in a physician's office) use the "non-facility limiting charge."

If no HCPCS/ CPT code is available for the service, the State Office shall determine the nature of the service and present to the Service Eligibility & Medical Advisory committee or the Commission for determination of a reasonable rate.

4. Enter the reasonable rate, minus non-reimbursable payments, as the payable amount in the application processing system.

5. "Reason for Assistance" should include "Exceed Maximum Benefits."

C. For non-ambulatory services rendered outside the child applicant's health coverage network:

1. If the expense is allowed by the health coverage plan, follow the procedure in section A above for services obtained within the child applicant's health coverage network. "Reason for Assistance" should include "Non-Participating Provider."

2. If the expense is not allowed by the health coverage plan, follow the procedure in section B above for services that exceed a benefit limit. "Reason for Assistance" should be listed as "Expenses Not Covered Under Health Plan" and "Non-Participating Provider."

D. For ambulatory services rendered outside the child applicant's health coverage network where the plan type is a POS or PPO:

1. Apply the amount the family owes to the provider or vendor plus any prior payments by the family to the provider or vendor, excluding payments from any other source, as "verified amount" for purpose of determining eligibility for the Fund.

2. Calculate the amount payable by the Fund for the service as the sum of the deductible, and coinsurance applied to the service by the family's health coverage plan.

3. Apply caps, reductions, and/or family responsibility as described in other policies and procedures to determine the amount payable by the Commission for the service.

4. "Reason for Assistance" should be listed as "Co-Pays/Deductibles/Coinsurance" and "Non-Participating Provider."

IV. <u>COMMISSION BACKGROUND</u>:

On September 20, 2019, the Commission released an advisory bulletin noting that "state law and regulation preclude any payment for ambulatory services received from out-of-

network providers or facilities, where the use of out-of-network provider or facility by a child with comprehensive health coverage was not inadvertent, urgent, or due to an emergency."

On August 5, 2020, the Commission clarified that copays, coinsurance, and deductibles for out of network expenses should be considered reimbursable by the Commission, since cost sharing is applied to the allowed charge as determined by the plan, while costs balance-billed to the family should be subject to the Commission's reasonable rate determination.

On April 14, 2021, the Commission discussed how to determine the reasonable rate for application expenses provided at out-of-network providers where the billed charges exceed the maximum rate allowed by the applicant's health coverage plan or were uncovered by the health coverage plan. The Commission directed the State Office to calculate the reasonable rate using the Centers for Medicare and Medicaid Services Medicare Fee Schedule for Professionals available at https://www.cms.gov/medicare/physician-fee-schedule/search/overview, subtracting any payments made by the health plan. If the health plan paid more than the Medicare rate, the payable amount by the Fund for that service would be $0.

On February 1, 2023, the Commission clarified that, when a family's health plan allows the use of an out-of-network provider, the Commission will not authorize payments that exceed the health plan's allowed amount for voluntary use of out-of-network providers (i.e., ambulatory services that are not urgent, emergent, or inadvertent).

This policy and procedure codifies that guidance for use by the State Office for services that are priced by the applicant family's health coverage plan and/or Medicare, where the health coverage plan allows the use of non-participating (out-of-network) providers. Reasonable rates and caps for other services (e.g. therapy or funeral expenses) are described in other Fund policies.

PREPARED BY: **Christian Heiss**
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