

Medical Necessity Guidelines: Continuity of Care Review for Members of Tiered or Limited Network Plans: Massachusetts

Effective: October 21, 2020

Prior Authorization Required	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
If <u>REQUIRED</u> , submit supporting clinical documentation pertinent to service request.	
<p>Applies to: COMMERCIAL Products <input checked="" type="checkbox"/> Tufts Health Plan Commercial products; Fax: 617.972.9409 <input type="checkbox"/> Tufts Health Freedom Plan products; Fax: 617.972.9409 <ul style="list-style-type: none"> CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization TUFTS HEALTH PUBLIC PLANS Products <input type="checkbox"/> Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 888.415.9055 <input type="checkbox"/> Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055 <input type="checkbox"/> Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404 <input type="checkbox"/> Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304 *The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.</p> <p>SENIOR Products <ul style="list-style-type: none"> Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List </p>	

OVERVIEW

The purpose of this guideline is to determine if the Member qualifies for the payment of a lower cost share.

Effective May 1, 2012, Members of a fully-insured non-group or small group product in an active course of treatment for a serious disease where disruption (newly enrolled in tiered or limited network product) would pose an undue hardship to the patient, may be eligible for the coverage of continued active treatment at a lower cost sharing level as mandated by 211 CMR 153.00 when receiving active treatment at one of the following comprehensive cancer centers, pediatric hospitals or pediatric specialty units:

Comprehensive Cancer Center

- Dana Farber Cancer Institute

Pediatric Hospital

- Children’s Hospital Boston
- Shriners Hospitals for Children - Boston
- Shriners Hospitals for Children - Springfield

Pediatric Specialty Unit

- Floating Hospital for Children at Tufts Medical Center
- Nashoba Valley Medical Center
- Massachusetts Eye and Ear Infirmary

For the purposes of these guidelines, *Undue Hardship* is defined as circumstances that:

- Could endanger life, cause suffering or pain, or cause physical deformity or malfunction; or
- Require the Member to undertake a substantial change in recommended treatment for covered Health Care Services; or
- Require the Member to receive covered Health Care Services from multiple providers/facilities in an uncoordinated manner which will significantly worsen the Member’s Serious Disease.

For the purposes of these guidelines, *Serious Disease* is defined as a condition that is life threatening or is likely to lead to serious or permanent disability if left untreated, such as cancer or cystic fibrosis.

CLINICAL COVERAGE CRITERIA

Tufts Health Plan may cover care provided for Members with a fully-insured non-group or small group product that is tiered or has a limited network at a lower cost sharing level as mandated by 211 CMR 153.00.

A letter of medical necessity which addresses the following must be submitted by the Member's provider. Please use the [Continuity of Care Review for Members of Tiered or Limited Network Plans: Massachusetts Request Form](#).

In addition the following criteria must be met:

1. ADMINISTRATIVE (all)

- a. The Member began active treatment prior to becoming enrolled in the tiered or limited network product.
- b. The hospital must be in the highest cost-sharing tier or not in the limited network
- c. The Member's treatment began prior to May 1, 2012 **OR** the Insured's employer offers the Insured only a choice of Limited, Regional, or Tiered Provider Network Plans and the course of treatment is not available from another tiered network provider.
- d. The Member is receiving care at one of the following facilities:
 - 1) For Members age 18 or over:
 - Dana Farber Cancer Institute
 - 2) For Members under the age of 18 years old:
 - Dana Farber Cancer Institute
 - Children's Hospital Boston
 - Shriners Hospitals for Children - Boston
 - Shriners Hospitals for Children - Springfield
 - Floating Hospital for Children at Tufts Medical Center
 - Nashoba Valley Medical Center
 - Massachusetts Eye and Ear Infirmary

2. MEDICAL (all)

- a. The Member must have a Serious Disease and began active treatment prior to becoming enrolled.
- b. The Member must be in an active course of treatment defined as treatment that is:
 - 1) Delivered following an inpatient stay or outpatient procedure and designed to assure recovery/rehabilitation; or
 - 2) Continuity of care for a Serious Disease that requires periodic diagnostic studies or adjustment of medications or treatments no less frequently than every six months.
- c. The Member's health care provider is providing the Member with an active course of treatment that is not available from another provider in the Provider Network of the Member's Health Plan Benefit
- d. Disruption in the course of treatment would pose an undue hardship

LIMITATIONS

The following do not meet the medical necessity guidelines, and therefore coverage will not be authorized:

- Services considered preventative in nature
- Services provided for the monitoring or surveillance of the Member's condition following the completion of the treatment protocol for the Serious Disease
- Clinical trials, experimental treatments, off-label use for products, or products not approved by the Food and Drug Administration, except insofar as coverage is mandated as set forth in M.G.L. c. 175, § 110L, c. 176A, § 8X, c. 176B, § 4X and c. 176G, § 4P

ATTACHMENT

Continuity of Care Review for Members of Tiered or Limited Network Plans: MA Request Form

APPROVAL HISTORY

July 11, 2012: Reviewed by the Integrated Medical Policy Advisory Committee (IMPAC)

Subsequent endorsement date(s) and changes made:

- May 8, 2013: Reviewed by IMPAC, no changes
- November 19, 2014: Reviewed by IMPAC, renewed without changes
- August 12, 2015: Reviewed by IMPAC, renewed without changes
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- September 14, 2016: Reviewed by IMPAC, renewed without changes
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- August 9, 2017: Reviewed by IMPAC, renewed without changes
- October 10, 2018: Reviewed by IMPAC, renewed without changes
- October, 2018: Template and disclaimer updated
- October 16, 2019: Reviewed by IMPAC, renewed without changes
- October 21, 2020: Reviewed by IMPAC, renewed without changes
- November 24, 2020: Fax number for Unify updated

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.

[Provider Services](#)