Medical Necessity Guidelines: Out-of-Network Coverage at the In-Network Level of Benefits (All Plans)

Effective: October 21, 2020

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	**Yes ☒ No ☐**

Applies to:
COMMERCIAL Products
☒ Tufts Health Plan Commercial products; Fax: 617.972.9409
☒ Tufts Health Freedom Plan products; Fax: 617.972.9409
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products
☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404
☒ 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.

SENIOR Products
- 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

OVERVIEW

These guidelines provide the prior authorization standard when Tufts Health Plan is responsible for determining whether it is medically necessary for the Member to receive services from an out-of-network provider.

For Members of Public Plans products, Direct, Together, Unify and RITogether, for out-of-network services to be covered at the in-network level of benefit, prior authorization must be obtained from Tufts Health Plan for all out-of-network services.

Without such prior authorization, Commercial Plans HMO/EPO Members, limited network product (e.g. Select Network Plan) Members and Tufts Health Plan Public Plan Members will not be covered for out-of-network services and PPO/POS Members will be covered for such services only at the out-of-network/unauthorized level of benefits.

A directory of in-network providers can be located here.

Requests for prior authorization must be submitted to Tufts Health Plan on the Out–of Network Coverage Prior Authorization Form.

CLINICAL COVERAGE CRITERIA

Tufts Health Plan will only grant prior authorization requests for coverage of medically necessary services with an out-of-network provider at the In-Network Level of Benefits in the following limited circumstances:

1. The clinical expertise required to address the specific health care needs of the Member is not available from any in-network provider, as evidenced by any of the following:
   - The Member has a rare medical condition or requires a specialized medical procedure for which there is no in-network provider with the necessary specialization, training, or expertise to provide treatment or perform the procedure. Tufts Health Plan will consider the opinion and recommendation of an in network specialty provider that it is medically necessary for the Member to receive such services by an out-of-network specialist provider.

- The Member's primary language is one that the treating in-network provider does not speak and no in-network provider speaks, and it is the treating provider's opinion that treatment is highly likely to be compromised due to the language barrier and the insufficiency of translation services available in the service area.
- The Member is a resident in a nursing home, or inpatient in a skilled nursing facility and cannot travel and in-network providers are not available to treat the Member in that setting.
- In-network providers with the clinical expertise required to address the Member's diagnosis or medical condition are not reasonably available within Tufts Health Plan's geographic access standards or within the availability standards of the Member's plan:

  – The geographic access standard is 30 miles from the Member's primary residence or at a reasonable distance based on member's condition or clinical need.

Note: Availability standards may differ according to clinical acuity and plan/product. These may be found in applicable plan payment policies on tuftshealthplan.com.

2. A Member, who was treated by an out-of-plan specialist provider in an emergency department and including an inpatient admission as a direct result of that emergency department treatment, will be permitted up to 2 follow-up visits with the treating out-of-network specialist provider.
3. Prior to enrolling in Tufts Health Plan, a Tufts Health Plan Member initiated outpatient psychotherapy treatment with a licensed out-of-plan provider and that out-of-plan provider attests that failure to continue treatment with that out-of-plan provider is highly likely to lead to significant harm to the Member as evidenced by, but not limited to, recent psychiatric hospitalization and/or suicidal or homicidal intent, or life threatening clinical destabilization. All out of network outpatient psychotherapy treatment will be subject to ongoing medical necessity review to determine if these coverage guidelines continue to be met.
4. Newly enrolled Members are allowed transition visits in specific **continuity of care** scenarios. Please see the Member's benefit document for applicable **continuity of care** provisions.

LIMITATIONS

- All out of network services will be subject to ongoing utilization and/or medical necessity review.
- Prior Authorization is not required for services rendered in an emergent situation, regardless of location within or outside the service area.
- As noted above, for Tufts Health Plan Commercial Plans Members, coverage of outpatient dialysis from an out-of-network provider is subject to prior authorization and will be determined by an authorized reviewer at Tufts Health Plan using the following criteria: Medical Necessity Guidelines: Out of Network Outpatient Dialysis at the In Network Level of Benefits.

REFERENCES

1. Not applicable

APPROVAL HISTORY

October 11, 2017: Reviewed by the Integrated Medical Policy Advisory Committee for effective date of January 1, 2018

Subsequent endorsement date(s) and changes made:

- 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
- December 4, 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.