Harvard Pilgrim Health Care | TUFTS Health Plan

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

Effective: January 1, 2023

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

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products;
☒ Tufts Health Plan Commercial products;
CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product);
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans;
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan;
☒ Tufts Health Unify* – OneCare Plan (a dual-eligible product);
*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

Senior Products

☐ Harvard Pilgrim Health Care Stride Medicare Advantage;
☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product);
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product);
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product);

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

Overview

These guidelines provide the prior authorization standard when the 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 Commercial Plans, 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. Without such prior authorization, Commercial Plans HMO/EPO Members, limited network product (e.g. Select Network Plan) Members and 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.

The following are links to clinical coverage criteria included in this MNG:

Out-of-Network Coverage at the In-Network Level of Benefits for all Commercial products and Tufts Health Public Plans products

In addition, for Members of Commercial Plans and Tufts Health Direct, coverage with out-of-network providers may be available for new Members with certain conditions and for current Members who are in treatment with providers who leave the plan's network. Temporary coverage to facilitate transitions of care may be authorized pursuant to the Continuity of Care criteria as noted below in the following sections:

Continuity of Care Criteria for Commercial Plans and Tufts Health

New Member

Active/Current Members

Requests for prior authorization must be submitted to the Plan on the Out of Network Coverage at the In-Network Level of Benefits form on the **Harvard Pilgrim Health Care** and **Tufts Health Plan** provider websites.

Clinical Guideline Coverage Criteria

Out-of-Network Coverage at the In-Network Level of Benefits (for all Commercial products and Tufts Health Public Plans products)

The 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 **One** of 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 **One** of the following:

   a. The Member has a rare medical condition and there is no in-network provider with the necessary specialization, training, or expertise to provide treatment; **OR**

   b. The Member requires a specialized medical procedure for which there is no in-network provider with the necessary specialization, training, or expertise to perform the procedure; **OR**

   Note: For the above two criteria, the 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.

   c. 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; **OR**

   d. 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; **OR**

   e. In-network providers with the clinical expertise required to address the Member's diagnosis or medical condition are not reasonably available within the 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 the Member's condition or clinical need; **OR**

   Note: Availability standards may differ according to clinical acuity and plan/product. These may be found in applicable plan payment policies which are located on the Harvard Pilgrim Health Care and Tufts Health Plan provider websites;

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; **OR**

3. Prior to enrolling in the plan, a 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; **OR**

4. Members may be allowed transition visits in specific **continuity of care** scenarios as noted below. Please see the Member's benefit document for applicable **continuity of care** provisions.

Continuity of Care Criteria for Commercial Plans and Tufts Health Direct

Coordination and appropriate continuation of health care is required when a participating health care provider or facility of a Member with a qualifying condition leaves the plan network or the Member with a qualifying condition is new to the plan

and has an established relationship with out-of-network providers. Requests for continuity of care for a transitional period are subject to clinical review for medical necessity, appropriateness, and safety.

New Members and Continuity of Care for Commercial Plans and Tufts Health Direct

New Members may need a period of transition of care for a defined period of time, which allows the Member to stay with their current providers and treatments until they can transition care to in-network providers.

New Members may receive medically necessary transitional treatment with out-of-network providers in **One** of the following situations:

1. New Member enrolled in a Massachusetts plan may continue to see their primary care provider (PCP) for up to 30 days after enrollment; **OR**

2. New Member enrolled in a Massachusetts plan that is receiving active medical treatment when their membership becomes effective may be authorized to continue treatment with out-of-network provider(s) for up to 30 days after enrollment to facilitate transition and minimize disruption of care. Active treatment is defined as regular visits to the practitioner for monitoring the status of an illness or disorder that has not stabilized, providing direct treatment, prescribing medication or other treatment, or modifying a treatment protocol; **OR**

    a. New Member enrolled in a Maine plan and receiving active medical treatment may continue medically necessary treatment with the out-of-network provider(s) for up to 60 days after enrollment; **OR**

3. Member actively receiving behavioral health services when their membership becomes effective may be authorized to continue treatment with out-of-network provider(s) for up to 90 days in most situations to facilitate transition and minimize disruption of care; **OR**

    a. Members enrolled in a New Hampshire plan may continue medically necessary treatment with out-of-network provider for up to 1 year after enrollment; **OR**

    b. Continued coverage for outpatient psychotherapy may be authorized beyond this transitional period pursuant to the criteria outlined in #3 above for out-of-network coverage at the in-network level of benefits. (See language that states “Prior to enrolling in the Plan, a Member initiated outpatient psychotherapy treatment…”); **OR**

4. New Member is pregnant in second or third trimester (i.e., beyond 12 weeks gestation). Member may continue care with the out-of-network provider through the completion of postpartum care (up to six weeks post-delivery); **OR**

5. New Member is terminally ill (defined as life expectancy < 6 months) and receiving hospice or palliative care. Member may continue treatment with the out-of-network provider(s) until death.

Active/Current Members and Continuity of Care (Provider or Facility Disenrollment) for Commercial Plans and Tufts Health Direct

Current Members who are under the care of a provider or facility who leaves the health plan network for reasons unrelated to fraud, quality of care, or other criminal activity, may be eligible for continuity of care. Continuity of care allows existing Members to receive services at in-network coverage levels for specified medical and behavioral services for a certain period of time as indicated below.

Members may receive medically necessary continuing treatment with out-of-network providers when **One** of the following is met:

1. Members enrolled in a Massachusetts plan, may continue to see their PCP for up to 30 days after the provider terminates; **OR**

2. Members enrolled in a Rhode Island plan and undergoing an active course of treatment may continue coverage with their out-of-network provider for up to one year; **OR**
3. Members enrolled in a New Hampshire plan may continue to see their disenrolled provider or facility for 60 days following the contract termination date[1]; **OR**

[1] The continued access period may be extended for an additional 60 days at the discretion of the New Hampshire Commissioner of Insurance.

4. All commercial Members who are Continuing Care Patients may have continued coverage with a terminated provider beginning from the provider/facility termination date or the date the termination notice is provided to the Member (whichever is later). A Continuing Care Patient is defined as **One** of the following:
    a. Member who is undergoing an active course of treatment may continue to see their provider or facility until the earlier of 90-days or the date on which such individual is no longer a Continuing Care Patient. An active course of treatment includes the following:

        i. Member who is undergoing a course of institutional or inpatient care from the provider or facility; **OR**

        ii. Member who has a nonelective surgery scheduled from the provider or facility, including receipt of postoperative care from such provider or facility with respect to such a surgery; **OR**

        iii. Member who has a serious and complex condition(s) defined as follows:
            a. An acute illness whereby the condition is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; **OR**

            b. A chronic illness or condition that is life-threatening, degenerative, potentially disabling, or congenital, and which requires specialized medical care over a prolonged period of time.

        Note: Serious and complex conditions may include conditions such as heart attack, stroke, acute exacerbation of a chronic or disabling illness, etc. Stable conditions (diabetes, arthritis, allergies, hypertension, asthma), routine treatment for minor illness, routine exams and health assessments do not qualify as acute and chronic conditions.

    b. Member is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility. Member may continue treatment with the disenrolled practitioner or facility through the period up to and including six weeks of postpartum visits immediately following childbirth; **OR**
    c. Member is terminally ill (defined as life expectancy < 6 months) and is receiving treatment for such illness from such provider or facility. Member may continue such treatment through death.

Continuity of Care for Massachusetts Commercial Members in Tiered or Limited Network Plans

Newly enrolled members of a fully-insured individual or small group tiered or limited network product in an active course of treatment where disruption would pose an undue hardship may be eligible for coverage of continued active treatment at a lower cost sharing level when such treatment is being received at a comprehensive cancer center, pediatric hospital, or pediatric specialty unit.

Providers must submit the Continuity of Care Review for Members of Tiered or Limited Network Plans Request Form and a letter of medical necessity which addresses **ALL** of the following criteria:

1. The Member must be in an active course of treatment defined as treatment that is:
    a. Treatment delivered following an inpatient stay or outpatient procedure and designed to assure recovery/rehabilitation; **OR**
    b. 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;

AND

2. The facility must be in the highest cost-sharing tier or not in the limited network;

AND

3. The Member's treatment began prior to May 1, 2012 or the Member's employer offers only a choice of limited, regional, or tiered provider network plans and the course of treatment is not available from another tiered network;

AND

4. The treatment being provided is not available from another provider in network of the Member's health plan;

AND

5. Disruption in the course of treatment would pose an undue hardship to the Member.

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.
- For Tufts Health Unify Members, out-of-network ambulance services may be used for facility to facility transfers when the transferring facility deems it medically necessary.

References:

1. "No Surprises Act" of the 2021 Consolidated Appropriations Act, Pub. L. No. 116-260, 134 Stat. 1182, Division BB, § 109. July 13, 2022. Available at: https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf. Accessed on 5/23/2022.
2. Maine Stat. Title 24-A, c. 56-A, § 4303. Available at: Title 24-A, §4303: Plan requirements (mainelegislature.org). Accessed 8/2022.
3. Massachusetts Regulations, 211 CMR 153: Continuity of care access to comprehensive cancer centers, pediatric hospitals, and pediatric specialty units for small group health benefit plans that utilize limited, regional, or tiered provider networks. Available at:
4. Massachusetts Regulations, 211 CMR 153: Continuity of care access to comprehensive cancer centers, pediatric hospitals, and pediatric specialty units for small group health benefit plans that utilize limited, regional or tiered provider networks | Mass.gov. Accessed 8/6/2022.
5. Rhode Island Health Insurance Regulations, 230-RICR-20-30-9.9 (Provider Contracting and Due Process). Available at: https://ohic.ri.gov/sites/g/files/xkgbur736/files/documents/230-RICR-20-30-9_SOS_Final_Effective12-16-18.pdf. Accessed 8/15/2022.
6. New Hampshire Revised Statutes Title XXXVII – Insurance Title 420-J - Managed Care Law Section 420-J:7-d - Continued Access to Care Subsequent to a Provider Contract Termination. Available at: NH Rev Stat § 420-J:7-d (2020). Accessed 10/12/2022.

Approval And Revision History

November 1, 2022: Reviewed by the Medical Policy Approval Committee (MPAC) for integration purposes with Harvard Pilgrim Health Care; effective January 1, 2023.

Subsequent endorsement date(s) and changes made:

- December 1, 2022: Reviewed by MPAC, renewed without changes

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. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

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.