Referring to Out-of-Network Providers Policy

Applies to the following Tufts Health Plan products:

- ☒ Tufts Health Plan Commercial[1]
- ☒ Tufts Medicare Preferred HMO (a Medicare Advantage product)[2]
- ☒ Tufts Medicare Preferred PPO (a Medicare Advantage product)[2]
- ☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)[2]

Applies to the following Tufts Health Public Plans products:

- ☒ Tufts Health Direct (a Massachusetts Qualified Health Plan [QHP]; a commercial product)
- ☒ Tufts Health Together (a 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 following payment policy applies to Tufts Health Plan contracting providers who provide and/or arrange for outpatient and inpatient services.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the Professional Services and Facilities Payment Policy.

Note: Audit and disclaimer information is located at the end of this document.

POLICY

Tufts Health Plan covers medically necessary out-of-network services, in accordance with the member's benefits.

Providers are expected to direct members to in-network Tufts Health Plan providers when arranging for services related to a member's care.

Tufts Health Plan does not cover services rendered by out-of-network or non-contracting providers unless the services are emergent, prior authorization has been obtained, or in the unusual circumstance that the services are not available from an in-network provider. Referring or directing members to out-of-network providers may have the unintended consequence of subjecting the member, provider group, or Tufts Health Plan to:

- Nonordered, unnecessary or excessive services, and the attendant cost of such services
- Unreasonable costs, "balance billing" and other unanticipated financial exposure

In such circumstances, Tufts Health Plan may, in accordance with its audit policy, hold the referring or directing provider accountable for the consequences of such referral. In this case, Tufts Health Plan reserves the right to recover, by offset or otherwise, any financial loss. Providers will be notified of Tufts Health Plan's concerns and proposed resolution. Providers will be given 30 days to respond to the concerns and appeal any proposed resolution. When grounds exist to believe that a delay may impair Tufts Health Plan's rights, Tufts Health Plan may take remedial measures on an expedited basis.

Note: POS and PPO members who receive services from an out-of-network provider will be covered at an unauthorized/out-of-network level of payment.

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[1] Commercial products include HMO, POS, PPO, and CareLink℠ when Tufts Health Plan is the primary administrator.
[2] Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

GENERAL BENEFIT INFORMATION

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting Provider Services.

Note: There is no member responsibility for covered services for Tufts Health Plan SCO, Tufts Health Unify, Tufts Health Together, or Tufts Health RITogether members.

REFERRAL/PRIOR AUTHORIZATION/NOTIFICATION REQUIREMENTS

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained. For more information, refer to the Referral, Prior Authorization, and Notification Policy.

Providers are expected to direct members to in-network providers when arranging for services related to the member's care, regardless of if Tufts Health Plan requires a referral for the services.

Before directing members to a provider, refer to the Find a Doctor search to check whether or not the provider is in-network for the member's specific plan. In addition, any provider who sees a Senior Products member must be a Medicare Participating Provider, if they are going to bill Medicare.

Note: If a member is on a limited-network plan, the referring or directing provider must confirm that the provider to whom the member is being referred is both a contracting provider and a participating provider for the member's limited network. Refer to the Find a Doctor search to confirm.

Members with a Select network (Commercial) must request prior authorization through the Precertification Operations Department for out-of-network services even if the provider has submitted an authorized out of network referral signed by the authorized reviewer for the member's medical group. Refer to the Referrals, Authorizations and Notifications chapter of the Commercial Provider Manual for more information on referral and authorization requirements and processes.

For coverage of medically necessary specialty care services rendered outside of the Tufts Health Plan network, authorization by an authorized physician reviewer is required. For more information on medical necessity, refer to the Medical Necessity Guidelines in the Provider Resource Center. Prior to submitting a referral request to an authorized reviewer, the PCP must confirm that a specialist or facility within the Tufts Health Plan network cannot provide a comparable level of care.

Referrals to providers outside of the Tufts Health Plan network cannot be submitted electronically (Commercial and Senior Products).

BILLING INSTRUCTIONS

Unless otherwise stated, Tufts Health Plan follows industry-standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers, and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. For more information, refer to the Professional Services and Facilities Payment Policy.

Use of noncontracting labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, Tufts Health Plan may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

Continuity of Care Requirements

Commercial and Tufts Health Direct

Effective for dates of service on or after January 1, 2023, if Tufts Health Plan approves an active or current member's continued access to a practitioner or facility that is no longer in the member's network, the practitioner or facility must:

- accept payment from Tufts Health Plan (and applicable cost-sharing from the member) as payment in full for such items and services in accordance with the same terms and conditions under the plan had such contract termination not occurred; and
- continue to adhere to all Tufts Health Plan policies, procedures, and quality standards with respect to such member and such items/services in the same manner as if such contract termination had not occurred.

COMPENSATION/REIMBURSEMENT INFORMATION

Providers are compensated according to the applicable network contracted rates and applicable fee schedules, regardless of the address where the service is rendered. For additional information, refer to the Professional Services and Facilities Payment Policy.

ADDITIONAL RESOURCES

- Medical Necessity Guidelines: Out-of-Network Coverage at the In-Network Level of Benefits
- Medical Necessity Guidelines: Out-of-Network Outpatient Dialysis at the In-Network Level of Benefits

DOCUMENT HISTORY

- December 2022: Updated continuity of care provider requirements applicable to Commercial and Tufts Health Direct members
- October 2021: Reviewed by committee; no changes
- September 2020: Reviewed by committee; added Tufts Health Public Plans and Senior Products applicability; added content from Out-of-State Facility and Professional Payment Policy (THPP) and retired
- June 2018: Template updates
- February 2017: Posted

AUDIT AND DISCLAIMER INFORMATION

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan's audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLink℠ for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna's provider agreements with respect to CareLink members. Tufts Health Plan reserves the right to amend a payment policy at its discretion.