Use of Out-of-Network Providers Policy

Applies to the following Tufts Health Plan products:

☒Tufts Health Plan Commercial (including Tufts Health Freedom Plan)[1]

☐Tufts Medicare Preferred HMO (a Medicare Advantage product)

☐Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting providers providing and/or arranging 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.

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

POLICY

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

Unless certain conditions are met, Tufts Health Plan does not cover services performed by out-of-network providers. Tufts Health Plan reserves the right to hold the referring or directing provider financially responsible for inappropriately referring, authorizing or directing care to out-of-network providers.

DEFINITIONS

In-network provider: Providers who both contract with Tufts Health Plan and also participate with the Tufts Health Plan member's specific plan (i.e., contracting and participating providers).

Out-of-network provider: Providers who do not contract with Tufts Health Plan or who do not participate with the Tufts Health Plan member's specific plan (i.e., noncontracting and nonparticipating providers).

Note: If a member is on a Select, Spirit or other 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 Select, Spirit or limited network.

COVERAGE AND BILLING INFORMATION

Tufts Health Plan does not cover services rendered by out-of-network providers unless the services are considered to be 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, at-risk 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 you, 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 go out-of-network will be covered at an unauthorized/out-of-network level of payment.

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[1] Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink℠ when Tufts Health Plan is the primary administrator.

DIRECTING CARE - AUTHORIZATION

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.

Providers are expected to direct members to in-network providers when arranging for services related to the member's care, regardless if Tufts Health Plan requires a referral for the services. Examples of such services include, but are not limited to:

- Anesthesia
- Dialysis
- Durable medical equipment
- Imaging
- Laboratory
- Pathology
- Nonemergency transportation

For more information on these services, refer to the respective payment policy in the Provider Resource Center.

For coverage of medically necessary specialty care services rendered outside of the Tufts Health Plan network, authorization by an authorized physician reviewer is required. 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. For more information, refer to the Authorization Policy.

ADDITIONAL RESOURCES

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

DOCUMENT HISTORY

- 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 an office/facility did not comply with this payment policy, Tufts Health Plan will expect the office/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. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.