Utilization Management Guidelines

Tufts Health Public Plans' utilization management (UM) guidelines are intended to help providers plan and manage care in an efficient manner with high quality standards. Refer to this chapter for information about:

- Utilization Management Program
- Medical Necessity Guidelines
- Outpatient Services Review
- Inpatient Hospital Review Process
- Initial Determinations
- Discharge Planning
- Concurrent Review and Expedited Coverage Authorizations
- Appealing a Denied Request for Coverage
- Peer-to-Peer Reconsideration
- Retrospective Review Policy
- Continuity of Care for Massachusetts Products
  - Current Tufts Health Direct Members
  - PCP Disenrollment
  - New Tufts Health Together "Enrollees"
  - Current Tufts Health Together (ACPP) Members
- Continuity of Care and Transitioning Between Out-of-Network and In-Network Providers (Tufts Health RITogether)
  - Existing Members
  - New Members
  - Members Transitioning from a Qualified Health Plan

Refer to the Tufts Health One Care chapter for specific utilization management guidelines for Tufts Health One Care.

Utilization Management Program

Tufts Health Public Plans' Utilization Management Program includes the evaluation of requests for coverage by determining the medical necessity, appropriateness and efficiency of the health care services under the applicable health benefit plan. UM services will be provided where licensed or permissible under state and federal law, or other regulatory authority.

The UM Program consists of the following functions:

- Prospective and concurrent utilization review (UR) of requests for coverage for inpatient admissions, inpatient and some outpatient behavioral health services, skilled nursing facility (SNF) services, long- term acute care services, acute hospital services, rehabilitation services, home care services, surgical procedures, medical technology, pharmaceuticals, some durable medical equipment, and targeted outpatient services
- The UM team may also perform discharge planning and quality measurement and improvement.

Medical Necessity Guidelines (MNGs)

The Tufts Health Public Plans medical necessity guidelines (MNGs), developed by the Medical Policy Department, adhere to standards adopted by national accreditation organizations and include input and instructions for applying the MNG from practicing specialty providers and PCPs, actively practicing practitioners in the community and Tufts Health Public Plans physicians. MNGs are the written guidelines used by Tufts Health Public Plans to determine medical necessity and appropriateness of health care services for the purpose of determining coverage under the applicable health benefit plan.

Tufts Health Public Plans' MNGs are developed to facilitate consistent medical necessity determinations for coverage. These MNGs are used for requests for coverage of select medical and behavioral health services and supplies, such as home care services, durable medical equipment (DME), select elective surgical procedures, pharmaceuticals, oral surgery, transplants and other services determined by Tufts Health Public Plans to require a medical necessity determination for coverage.

MNGs are:

- Developed or adopted with input from specialty consultants, actively practicing physicians, and specialty physicians and other providers
- Developed in accordance with standards adopted by national accreditation organizations and regulatory and government entities
- Reviewed on an annual basis and updated as new treatments, applications and technologies are adopted as generally accepted professional medical practice
- Applied in a manner that considers the individual health care needs of the member and characteristics of the local delivery system
- Evaluated at least annually for the consistency with which those involved in Utilization Review apply the MNGs in the determination of coverage
- Scientifically derived and evidence-based, if such evidence is available

Tufts Health Public Plans also utilizes some commercially purchased criteria (InterQual® criteria). The use of these criteria is also reviewed in the manner described above.

Most MNGs are available on the Tufts Health Plan public website (via the link above); printed copies are available upon request to providers by contacting Provider Services at **888-257-1985** (Massachusetts) or **844-301-4093** (Rhode Island).

Outpatient Services Review

Authorization for services, medical drugs, devices, and equipment is based on MNGs or InterQual® criteria. Any additional criteria used are referenced in the applicable MNGs. Providers rendering services to members may not have claims paid if they fail to obtain required prior authorization (PA), and claims for any related ancillary and supporting services may also deny. Additionally, for Tufts Health One Care, Medicare National Coverage Determination (NCD) and Local Coverage Determination (LCD) criteria are used for Medicare-covered services. NCD and LCD criteria are available on the CMS website at cms.gov.

All out-of-network services require prior authorization. For non-behavioral health services, the prior authorization must be initiated by the member's PCP for coverage by submitting the Out-of-Network Coverage at In-Network Level of Benefits and Continuity of Care Prior Authorization Form. Tufts Health One Care members may also initiate the coverage request by submitting this form.

Procedures and Services That Require Prior Authorization

Tufts Health Plan's prior authorization requirements are subject to change. For up-to-date information, refer to resources posted on the Prior Authorization page of the provider website.

Inpatient Hospital Review Process

Tufts Health Public Plans conducts an initial review of the clinical information of all members admitted to an inpatient facility, as well as concurrent and discharge reviews. Tufts Health Public Plans notifies the facility of approved coverage determinations and notifies the facility and admitting provider of denied coverage determinations within one business day of receiving the request.

A Tufts Health Public Plans UM physician reviews all cases that do not meet the clinical InterQual criteria used as the basis for the review. Providers are notified when a case under clinical review requires additional information to

substantiate a continued stay. All concurrent or continued stay reviews require clinical updates from the facility. Tufts Health Public Plans will complete continued stay reviews assist with discharge planning, and/or refer to care management on an as needed basis.

Members of Tufts Health Together ACPPs and Tufts Health RITogether should contact their PCP and, if applicable, their behavioral health provider within 48 hours of receiving emergency services to arrange for any necessary follow-up care.

Tufts Health Public Plans will continue to cover medically necessary services throughout the duration of the hospital stay. Tufts Health Public Plans sends providers and members a denial-of-service letter (adverse action or adverse determination) for inpatient services and a plan-specific member grievances and appeals enclosure. If the member is not yet discharged, the letter and enclosure must be given directly to the member so they can decide whether to exercise their right to appeal or file a grievance. For more information on member grievances and appeals, refer to the Rights and Responsibilities chapter.

Initial Determinations

Tufts Health Public Plans makes every effort to review an initial determination regarding a proposed admission, procedure or service requiring prior authorization. Prospective non-urgent requests will be completed within 14 calendar days for members of Tufts Health Together or Tufts Health RITogether. Tufts Health Direct member decisions will be completed within two business days of obtaining all of the necessary information, but no later than 15 calendar days. However, for Tufts Health Together, Tufts Health Direct, and Tufts Health One Care members who meet the Medicaid clinical criteria, prior authorization requests for admission to a post-acute care facility or transition to a post-acute care agency (including skilled nursing, intermediate or long-term care, rehabilitation facility, or home health agency) will be approved or denied by the next business day following receipt of required medical information. Verbal notification will be given to the provider within 24 hours of the denial determination followed up with written notification within one working day, but no later than 15 calendar days.

Prospective urgent requests for members of Tufts Health Together or Tufts Health RITogether will be completed as soon as possible, taking into account medical exigencies, but not later than 72 hours of receipt of the request. For members of Tufts Health Together or Tufts Health RITogether, the time frame can be extended an additional 14 calendar days if further information is needed to make an initial determination. The extension shall only be allowed if:

- The Provider, member or Appeal Representative requests the extension, or
- Tufts Health Public Plans can justify (to EOHHS, upon request) that:
  - The extension is in the member's interest; and
  - There is a need for additional information where: (a) There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and (b) Such outstanding information is reasonably expected to be received within 14 calendar days.
- The member is given written notice of the reason for the extension and inform the member of the right to file a Grievance if the member disagrees with that decision

For Tufts Health RITogether members, Tufts Health Plan may extend the 72-hour expedited authorization by up to 14 calendar days if the member requests an extension or if Tufts Health Plan can justify a need for the additional time and the extension is in the member's best interest.

Tufts Health Direct members' urgent requests will be completed as soon as possible taking into account medical exigencies and always within 2 working days of receipt of all information but not later than 72 hours of receipt of the request.

If coverage of an admission, procedure, facility or service is approved, the provider is notified within 24 hours and written, or electronic confirmation is sent within two business days thereafter stating the service(s) being covered. The provider must have this authorization letter before providing any service(s) requiring an authorization.

If a determination to deny, reduce, modify, or terminate coverage of an admission, continued inpatient stay or any other health care service is made, Tufts Health Public Plans will notify the provider within 24 hours and send written or

electronic confirmation to the provider and the Tufts Health Direct, Tufts Health Together ACPP or Tufts Health RITogether member within one business day thereafter.

Tufts Health Public Plans will not pay claims received from out-of-network specialists or facilities for any unauthorized services.

All UM decisions are based on appropriateness of care, availability of services and the members' coverage. Tufts Health Public Plans does not reward providers, UM clinical staff, or consultants for denying, limiting, or discontinuing care and does not offer network providers, clinical staff, or consultants' money or financial incentives to deny, limit, or discontinue medically necessary services.

For information on authorizations for Tufts Health One Care members, refer to the Tufts Health One Care chapter.

Discharge Planning for Tufts Health Together and Tufts Health One Care Members

Per Managed Care Entity (MCE) Bulletin 64, providers must assess each admitted member's current housing situation at the time of admission and as part of the general discharge planning processes to assess whether the member is experiencing or at a risk for homelessness[1]. Discharge planning staff must screen admissions data, including but not limited to age, diagnosis, and housing status within 24 hours of admission.

For any member determined by the provider to be experiencing or at a risk for homelessness, discharge planning must begin no later than 3 business days after the member's admission, unless required to begin sooner. To assist in the discharge planning process, providers must complete the following:

- Invite and encourage the member's support team[2][2] to participate in the member's discharge planning
- Determine whether a member not receiving services from the Department of Mental Health (DMH), Department of Developmental Services (DDS), or MassAbility who is also experiencing or at a risk for homelessness may be eligible to receive services from some or all of the agencies
- Determine whether any member experiencing or at a risk for homelessness has any substance use disorder and offer support as outlined in MCE Bulletin 64
- Ensure discharge planning staff are aware of and utilize available community resources to assist with discharge planning for members experiencing or at a risk for homelessness as outlined in MCE Bulletin 64
- Make reasonable effort to prevent discharges to emergency shelters of members who have skilled care needs, members who need assistance with activities of daily living, or members whose BH conditions would impact the health and safety of individuals residing in the shelter

For any member experiencing homelessness who is expected to be inpatient for fewer than 14 days, the provider must contact the emergency shelter in which the member most recently resided, if known, to discuss the member's housing options post discharge. If the member has not resided in an emergency shelter, or if the emergency shelter in which the member most recently resided is unknown, the provider must contact the local emergency shelter to discuss the member's housing options post discharge. If a member is being discharged to an emergency shelter:

- Provide at least 24 hours advance notice to the shelter prior to discharge
- Provide the member with access to paid transportation to the emergency shelter
- Ensure that the shelter has an available bed for the member. If a shelter bed is unavailable on the planned discharge date, but a bed will be available soon, the hospital should delay discharge until a bed is available. In these cases, the hospital may bill the Administratively Necessary Day (AND) rate for each such day on which the member remains in the hospital. Refer to the Inpatient Hospital Admissions Payment Policy for additional information.

[1] As defined by MCE Bulletin 64.
[2] Support team includes, but is not limited to the member, member's family, guardians, PCP, BH providers, key specialists, case managers, emergency shelter outreach or case management staff, care coordinators, and other support identified by the member.

For some members, discharge to an emergency shelter or the streets may be unavoidable. For these members, the provider must:

- Discharge the member only during daytime hours
- Provide the member a meal prior to discharge
- Ensure that the member is wearing weather appropriate clothing and footwear
- Provide the member a copy of their health insurance information
- Provide the member with a written copy of all prescriptions and at least one week's worth of filled prescription medications, to the extent clinically appropriate and consistent with all applicable federal and state laws and regulations

Concurrent Review and Expedited Coverage Authorizations

Concurrent review is utilization review conducted during a member's inpatient hospital stay or course of treatment. Concurrent reviews are typically associated with the extension of previously approved inpatient care or residential behavioral health care and involve a clinical review of the medical necessity of continued treatment. Tufts Health Plan utilizes initial utilization reviews and continues stay utilization reviews on an ongoing basis.

If the inpatient stay extends beyond the initial authorization end date, the facility or attending physician must submit additional clinical information to substantiate the member's continued stay. Concurrent urgent requests for members of Tufts Health Together or Tufts Health RITogether will be completed as soon as possible, considering medical exigencies, but no later than 72 hours of receipt of the request. Tufts Health Direct members' concurrent urgent requests will be completed as soon as possible considering medical exigencies, but no later than 24 hours of receipt of the request. Failure to submit clinical information, or the submission of clinical information that is not sufficient to support the extension request, may lead to the issuing of an adverse action/determination.

For additional information, refer to the Rights and Responsibilities chapter.

Appealing a Denied Request for Coverage

Members can appeal a denied coverage request. If a member's health or welfare could potentially be adversely affected by the adverse determination, Tufts Health Public Plans will expedite the appeal process upon request. Members may also designate the provider as their authorized representative to exercise the standard grievance and appeal rights on their behalf. Unless otherwise allowed by law, members should complete a designated representative form if they would like their provider to appeal the denial on their behalf. For more information about Tufts Health Public Plans' grievance and appeals processes, refer to the Rights and Responsibilities chapter.

Peer-to-Peer Reconsideration

If Tufts Health Public Plans has denied authorization for coverage of an inpatient admission while the member is still confined, outpatient services or an elective procedure after an initial determination or other medical necessity review determination, providers may ask Tufts Health Public Plans to reevaluate the decision. This involves a one-on-one discussion between the provider and a clinical peer reviewer about the details of your Tufts Health Together, Tufts Health RITogether or Tufts Health Direct member's case.

Tufts Health Direct and Tufts Health Together providers can submit an online Peer-to-Peer Request Form to Tufts Health Public Plans via the secure provider portal or use the IVR (**888-766-9818**; option **1**) to submit peer-to-peer reconsideration review requests.

Using the online form decreases the time it takes to file a peer-to-peer review for Medical and Behavioral Health denials and allows for additional clinical information to be attached. Providers receive confirmation that their peer-to-peer review has been submitted in real time.

Tufts Health One Care, Tufts Health RITogether and Pharmacy requests are currently not available on the Peer-to-Peer Request Form.

If Tufts Health Public Plans upholds the denial, the member may appeal the decision or may designate the provider to appeal on their behalf. Provider inquiry is not required before the member can appeal the denial. For more information on member appeals, refer to the Rights and Responsibilities chapter.

Retrospective Review Policy

To assist providers with ongoing efforts to provide Tufts Health Together, Tufts Health RITogether, Tufts Health One Care, or Tufts Health Direct members with high quality care and ensure such care is managed appropriately, Tufts Health Public Plans reserves the right to retrospectively review all services provided to members.

Continuity of Care for Massachusetts Products

Tufts Health Public Plans continues to support the care of members by applying the continuity of care principles as well as any regulatory requirements regarding continued care by a practitioner in order to minimize disruption of an ongoing episode of care and to ensure uninterrupted access to medically necessary services. Continuity of Care refers to the presence of an existing clinical relationship pertaining to the treatment of an ongoing clinical episode of acute care between the Enrollee and Practitioner under certain specific conditions.

Current Tufts Health Direct Members

Providers who are leaving the Tufts Health Plan network for reasons unrelated to fraud or quality of care, and are currently treating a Tufts Health Plan member, should assist their patient by completing the Out-of-Network Coverage at In-Network Level of Benefits and Continuity of Care Prior Authorization Form.

Tufts Health Plan may allow members to be covered for continued treatment with a terminated practitioner in specific circumstances. This does not apply to members seeking coverage for continued treatment with a practitioner who has been involuntarily terminated for quality-related reasons (per the Quality of Care Committee (QOCC)), including professional review actions, or fraud. Members whose providers have been terminated due to quality-related reasons or fraud can contact Tufts Health Plan for assistance in locating a new provider.

Requests for continuity of care for a transitional period are subject to clinical review for medical necessity, appropriateness, and safety. 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 in the Medical Necessity Guidelines: Out-of-Network Coverage at the In-Network Level of Benefits (All Plans).

PCP Disenrollment

Tufts Health Plan will inform members at least 30 days in advance of a PCP disenrollment. Members may continue to see their PCP for up to 30 days after disenrollment.

Conditions for Coverage of Continuity of Care for Tufts Health Direct Members

Tufts Health Plan may condition coverage of continued treatment upon the Provider's agreement:

- to accept reimbursement from Tufts Health Plan at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to a member in an amount that would exceed the cost sharing that could have been imposed if the Provider had not disenrolled;
- to adhere to the quality assurance standards of Tufts Health Plan and to provide Tufts Health Plan with necessary medical information related to the care provided; and
- to adhere to Tufts Health Plan's policies and procedures, including procedures regarding referrals, obtaining prior authorization, and providing services pursuant to a treatment plan, if any, approved by Tufts Health Plan.

For additional information, please refer to the medical necessity guidelines for Out-of-Network Coverage at the In-Network Level of Benefits (All Plans).

New Tufts Health Together Members ("Enrollees")

Tufts Health Public Plans will continue to authorize coverage of services for continued treatment of new enrollees to Tufts Health Together in the following circumstances:

Primary Care

Services provided by a provider who was an enrollee's previous PCP will be covered for up to 30 calendar days from date of enrollment with Tufts Health Together, if the provider agrees to the following:

- The provider cannot balance bill the enrollee; and
- The provider must adhere to the quality assurance standards and policies and procedures of Tufts Health Public Plans and is subject to the same oversight and requirements for clinical information.

Non-Primary Care

- Tufts Health Together will help ensure that enrollees currently receiving inpatient care (medical or behavioral health) from a hospital, including non-network hospitals, may continue to receive care from such hospital as long as services delivered are medically necessary. Upon notification, Tufts Health Together will make outreach efforts to contact the facility to ensure continuity of care and discharge planning.
- Tufts Health Together will ensure that, for at least 30 days after the enrollee's effective date of enrollment, new enrollees receiving outpatient medical, behavioral health or substance use disorder care may continue to seek and receive services from these providers. This includes enrollees with upcoming appointments, ongoing treatments or services, or prior authorizations. New enrollees may continue to seek and receive care from providers (including non-network) with whom they have an existing relationship with authorization from Tufts Health Together.
- For enrollees who have an existing prescription, Tufts Health Together will provide coverage for any prescribed refills of such prescription, unless Tufts Health Together has a prior authorization policy and such policy requires a prior authorization for coverage of such prescription. If a prior authorization is required for an existing prescription, Tufts Health Together will provide a minimum 72-hour supply of such medication.
- Tufts Health Together will ensure that, for at least 30 days after the effective date of enrollment, new enrollees with any of the following examples listed below may have continued access to coverage. Tufts Health Together will ensure continuity by providing new authorizations or extending existing authorization, if necessary, without regard to medical necessity criteria, for at least the required 30-day period. Tufts Health Public Plans will make sure that providers will be able to confirm or obtain any authorization, if needed, to continue such access.
  - Durable medical equipment (DME) that was previously authorized by MassHealth or a MassHealth Accountable Care Partnership Plan (ACPP);
  - Prosthetics, orthotics and supplies (POS) that were previously authorized by MassHealth or a MassHealth ACPP; and
  - Physical therapy (PT), occupational therapy (OT), or speech therapy (ST) that was previously authorized by MassHealth or a MassHealth ACPP.

Tufts Health Together will honor all prior authorizations and prior approvals for above services for the duration of such prior authorizations and prior approvals. If Tufts Health Together elects to modify or terminate a prior authorization and prior approval, these modifications will be administered as an adverse action and will follow the appeal rights policy and procedures (refer to the Rights and Responsibilities chapter), including notification to the enrollee and the enrollee's provider in question.

Special Consideration

- A pregnant enrollee who enrolls during a transition period may choose to remain with her current provider of obstetrical and gynecological services, even if such provider is not part of the ACPP network. Tufts Health Together will cover all medically necessary obstetrical and gynecological services through delivery of the child, as well as immediate postpartum care and the follow-up appointments within the first six weeks of delivery. A pregnant enrollee will be permitted to select a new provider of obstetrician and gynecological services within the applicable Tufts Health Together (ACPP) networks if she chooses to do so.
- Enrollees with autism spectrum disorder (ASD) who are actively receiving ABA Services, either through MassHealth, another Accountable Care Partnership Plan or a commercial carrier and have a current prior authorization for ABA services in place will be entitled to continuity of these services for a minimum of 90 days after such Enrollees are enrolled with Tufts Health Together ACPPs. Tufts Health Together protocol will include the use of single-case agreements, full acceptance and implementation of existing prior authorizations for ABA services and individual transition plans.
- Enrollees who are receiving ongoing services such as dialysis, home health, chemotherapy and/or radiation therapy
- Enrollees who have significant health care needs or complex medical conditions
- Enrollees who are hospitalized or are receiving treatment for behavioral health or substance abuse
- Enrollees who have received prior authorization for services including but not limited to:
  - Scheduled surgeries.
  - Out-of-area specialty services.
  - Durable medical equipment or prosthetics, orthotics, and supplies.
  - Physical therapy, occupational therapy or speech therapy; or nursing home admission.
  - All enrollees may access emergency services at any emergency room, including services from out-of-network providers and such services will be provided at no cost to the member.

Current Tufts Health Together (ACPP) Members (“Enrollees”)

Provided the provider has not terminated for quality or fraud, Tufts Health Together will continue to authorize coverage of services for continued treatment of enrollees with a terminated practitioner in the following circumstances:

Specialty care

- Enrollees who are receiving active treatment for a chronic illness or acute medical condition will be covered for continued treatment with the terminated provider through the current period of active treatment or up to 90 days, whichever is shorter.
- During the period where a denial or termination of services has occurred and the enrollee has filed an Internal Appeal (Qualified Health Plan) or a First-Level, Second-Level or Expedited Internal Appeal (MassHealth/CarePlus) on that decision
- Enrollees who are pregnant may continue with coverage for a period up to and including the first postpartum visit.
- Enrollees who are terminally ill and in the last 6 months of treatment for that terminal illness may continue treatment with the terminated provider until the enrollee’s death.

PCP

- Tufts Health Together will provide the enrollee with written notice at least 30 days prior to the termination or disenrollment of the PCP, including a description of the procedure for choosing a new PCP.
- Tufts Health Together will allow the enrollee to be covered for services consistent with Tufts Health Together' evidence of coverage and for at least 30 days following the PCP's termination or disenrollment.
- Tufts Health Together will continue coverage if the provider agrees to the following:
  - The provider cannot balance bill the enrollee; and
  - The provider must adhere to the quality assurance standards and policies and procedures of Tufts Health Together and is subject to the same oversight and requirements for clinical information had the provider not disenrolled.

Continuity of Care and Transitioning Between Out-of-Network and In-Network Providers – Tufts Health RITogether

Under the conditions below, Tufts Health Public Plans allows Tufts Health RITogether members to continue treatment with an out-of-network provider only if the provider agrees to the following:

- To accept reimbursement at the rates applicable to participating providers as payment in full;
- The practitioner cannot balance bill the member; and
- The practitioner adheres to the quality assurance standards and policies and procedures of Tufts Health Public Plans and is subject to the same oversight and requirements for clinical information. including the terms and conditions set forth in the *Tufts Health RITogether Member Handbook*.

Existing Members

With prior authorization, an existing member may continue to see providers who are no longer in the Tufts Health RITogether network (provided that the provider's disenrollment has not been for reasons related to quality of care or fraud) when the member:

- Is receiving active medical or behavioral health treatment for a chronic illness or acute condition. The member will be covered for continued treatment with the terminated provider through the current period of active treatment or for up to ninety (90) days, whichever is shorter.
- Is in the second or third trimester of pregnancy; the member may continue with coverage of a period up to and including the first postpartum visit.
- Is terminally ill and in the last six months of anticipated treatment for a terminal illness; the member may continue treatment with the terminated provider until the member's death.

When a PCP is terminated for reasons other than those related to quality or fraud, Tufts Health RITogether will:

- Provide the member with written notice within fifteen (15) calendar days after receipt or issuance of the termination or disenrollment of the PCP (or a provider the member saw on a regular basis), including a description of the procedure for choosing a new PCP
- Allow the member to be covered for services consistent with the *Tufts Health RITogether Member Handbook*.

New Members

A new member to Tufts Health RITogether, with a pre-existing relationship, may continue to see that non-contracted provider when there is an existing prior authorization with the provider for whom the authorization was granted for up to 180 days or for a longer duration, if specified in the existing prior authorization.

Specialty Care

Continuity of care coverage for transitioning members between out-of-network and in-network providers exists when a new member:

- Is in the second or third trimester of pregnancy; the member may continue with coverage for a period up to and including the first postpartum visit.
- Is terminally ill and in the last six (6) months of treatment for that terminal illness; the member may continue treatment with the terminated provider until the member's death.
- Is receiving active medical or behavioral health treatment for a chronic illness or acute condition; the member will be covered for continued treatment with the existing out-of-network provider for up to six (6) months from the date of enrollment, or for a longer duration, if specified in the existing prior authorization.
- At the end of the transition period, the member is required to transition to an in-network provider.

Primary Care

Services provided by a member's previous out-of-network PCP are covered for up to six (6) months from the enrollment effective date with Tufts Health RITogether. At the end of the transition period, the member is required to transition to an in-network provider.

Members Transitioning from a Qualified Health Plan

Tufts Health RITogether allows a transitional period of at least ninety (90) days following a member's effective date of enrollment with Tufts Health RITogether, when the member can demonstrate that they were covered by a Qualified Health Plan (QHP) for at least one day during the 90 days preceding enrollment.

- Tufts Health RITogether will honor all existing prior authorizations authorized by the member's former QHP and for which the provider shows evidence of the prior authorization which would still be in effect if the member was still covered by his or her former QHP
- Tufts Health RITogether will make formulary exceptions to all eligible former QHP members to honor existing pharmacy prior authorizations by allowing the member to refill or renew any prescription which the member had received through their former QHP.
- Tufts Health RITogether will allow the member to continue seeing out-of-network providers on an in-network basis if:
  - The provider was a part of the member's QHP network, and
  - The member had been in the care of that provider for a period of at least six (6) months.

PUBLICATION HISTORY

01/01/24	Updated plan name to Tufts Health One Care
06/12/24	Replaced "National Imaging Associates, Inc./NIA" with "Evolent"; administrative edits to TOC
07/19/24	Removed reference to "Quick Reference Guide: Tufts Health Public Plans Durable Medical Equipment Prior Authorization" in the "Services Requiring Prior Authorization" section; updated link to "MassHealth Durable Medical Equipment and Medical Supplies General Prescription and Medical Necessity Review Form"
01/01/25	Updated Concurrent Reviews and Expedited Coverage Authorizations section; administrative edits
04/01/25	Administrative updates to the Peer-to-Peer Reconsideration section; administrative edits
04/04/25	Updated Initial Determinations section
01/01/26	Updated to remove all Tufts Health Together MCO references
04/07/26	Removed statement that clinical peer reviewer will contact provider within one business day of request
07/01/26	Removed reference to Community Partners (CP) related to a member's support team due to end of CP program.
08/01/26	Moved Enteral Nutrition to Services Not Requiring Prior Authorization section; updated IVR option for Peer-to-Peer requests.
10/01/26	Removed lists of services that do and do not require prior authorization and added link to "Prior authorization" page of the provider website as reference.
11/01/26	Updated reference to MassAbility.