Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:

Out-of-Network Coverage at the In-Network Level of Benefits and Continuity of Care (All Plans)

Effective: July 9, 2024

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	Yes ☒ No ☐
Notification Required If REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; 800-232-0816
☒ Tufts Health Plan Commercial products; 617-972-9409
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); 888-415-9055
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
☒ Tufts Health One Care-- A dual-eligible product; 857-304-6304

Senior Products

☒ Harvard Pilgrim Health Care Stride Medicare Advantage; 866-874-0857
☒ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-673-0965
☒ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-673-0965
☒ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-673-0965

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

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, Dual Eligible, and Senior Products, 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, Public Plan Members will not be covered for non-emergent out-of-network services and PPO/POS Members will be covered for such services only at the out-of-network/unauthorized level of benefits.

Note: For Tufts Health Together, and Dual Eligible Plans (Tufts Health One Care and Tufts Health Senior Care Options) prior **authorization is not required for Continuity of Care criteria, which is listed on pages 4 and 5.** Prior authorization is only required for general out-of-network services, as noted in the below section, "General Out-of-Network Coverage at the In-Network Level of Benefits for all Plans".

Requests for prior authorization for Members must be submitted on the: Out-of-Network Coverage at In-Network Level of Benefits and Continuity of Care Prior Authorization Form and Out-of-Network Coverage at In-Network Level of Benefits and Continuity of Care Prior Authorization Form. The Plan uses guidance from the Centers for Medicare and Medicaid Services

(CMS) and MassHealth for coverage determinations for its Dual Product Eligible plan members and CMS for its Medicare Advantage plan members. CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals and MassHealth Medical Necessity Determinations are the basis for coverage determinations where available. For this guideline, the following federal regulation was consulted: 42 CFR 422.112(b).

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Medical Necessity Guideline Coverage Criteria

General Out-of-Network Coverage at the In-Network Level of Benefits (for all Commercial, Public Plan, Dual Eligible Plans, and Senior 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;
        i. 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 Point32Health 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.

Commercial Plans and Tufts Health Direct

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.

Continuity of Care for New Members

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 continue 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 out-of-network 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.

Continuity of Care (Provider or Facility Disenrollment) for Active/Current Members

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**
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:
            - 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**
            - 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.

Massachusetts Commercial Members in Tiered or Limited Network Plans

Continuity of Care for New Members

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 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;
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.

Tufts Health Together

Continuity of Care for New Members (Prior authorization is not required)

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

Members new to the plan 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 continue treatments until they can transition care to in-network providers.

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

1. Member may continue to see their primary care provider (PCP) for up to 30 days after enrollment; **OR**
2. Member who is currently receiving treatment may continue to see their provider or facility until the earlier of 30 days or the date on which such individual is no longer a Continuing Care Patient. A Continuing Care Patient is defined below to include:
    a. Member is hospitalized and receiving inpatient care for a medical or behavioral health condition; **OR**
    b. Member has significant health care needs or complex medical conditions*; **OR**
    c. Member is receiving ongoing services such as dialysis, home health, chemotherapy and /or radiation therapy; **OR**
    d. Member is a child in the care or custody of DCF, and youth affiliated with DYS (either detained or committed); **OR**
    e. Member actively receiving outpatient behavioral health services or substance use disorder care (including ABA Services for autism spectrum disorder or Early Intensive Behavioral services) may be authorized to continue treatment for up to 90 days; **OR**
        i. Continued coverage for out-of-network 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**
    f. Member is pregnant. Member may continue care with the out-of-network provider through delivery and completion of postpartum care and visits (up to six weeks post-delivery); **OR**
3. Member that has previously received a prior authorization for an MCO covered service that was previously approved by MassHealth, an Accountable Care Partnership Plan, MCO, or commercial plan may continue to receive that care for up to 30 days after enrollment. Covered services include but are not limited to:
    a. Scheduled surgeries
    b. Out of area specialty surgeries
    c. Durable Medical equipment (DME), prosthetics, orthotics, and supplies
    d. Physical therapy (PT), Occupational Therapy (OT), or Speech Therapy (ST)
    e. Nursing home admissions

***Note**: Significant health care needs or complex medical conditions may include care for 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 complex medical conditions.

Tufts Health RITogether

Continuity of Care for New Members

Members new to the plan 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 continue treatments until they can transition care to in-network providers.

1. New Members receiving medical treatment may continue medically necessary treatment with out-of-network provider(s) for up to 180 days.

Senior Products and Dual Eligible Plans (For Dual Eligible Plans, prior authorization is not required)

Continuity of Care for New Members

Members new to the plan or new to Medicare 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 continue treatments until they can transition care to in-network providers.

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

1. Member may continue to see their primary care provider (PCP) for up to 90 days after enrollment; **OR**

2. Member that is receiving an active course of treatment* and/or after starting a course of treatment** when their membership becomes effective may be authorized to continue treatment for up to 90 days after enrollment.
3. In addition, for Dual Eligible plans only, members receiving treatment may continue to see their provider or facility in the following situations:
    a. Member is pregnant. Member may continue care with the out-of-network provider through delivery and completion of postpartum care and visits (up to six weeks post-delivery).
    b. Member is hospitalized and receiving inpatient care for a medical or behavioral health condition may continue to receive out of network care as long as medically necessary.

*Active course of treatment refers to a course of treatment in which a patient is actively seeing the provider and following the course of treatment.

**Course of treatment refers to a prescribed order or ordered course of treatment for a specific individual with a specific condition that is outlined and decided upon ahead of time with the patient and provider. A course of treatment may but is not required to be part of a treatment plan.

Limitations

1. All out of network services will be subject to ongoing utilization and/or medical necessity review.
2. Prior Authorization is not required for services rendered in an emergent situation, regardless of location within or outside the service area or network status.
3. Without authorization pursuant to this policy, members in Medicare HMO or SCO plans will only be covered for emergency or urgent services out-of-network, whether inside or outside of the service area.
4. For Tufts Health One Care Members, out-of-network ambulance services may be used for facility to facility transfers when the transferring facility deems it medically necessary.

References:

1. Department of Health and Human Services, CMS. Federal Register; Vol. 88, No. 70 Rule and Regulations. Published April 12, 2023. Available at 2023-07115.pdf (govinfo.gov). Accessed February 28, 2024.
2. Centers for Medicare & Medicaid Services, HH Code of Federal Regulations; Access to Services; 42 CFR 422.112(b). Available at eCFR :: 42 CFR 422.112 -- Access to services. Accessed April 2, 2024.
3. Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, 134 Stat. 1182, Division BB, § 109. July 13, 2022. Available at: No Surprises Act of the 2021 Consolidated Appropriations Act | Federal Trade Commission (ftc.gov) Accessed March 20, 2024.
4. Maine Stat. Title 24-A, c. 56-A, § 4303. Available at: Title 24-A, §4303: Plan requirements (mainelegislature.org). Accessed April 8, 2024.
5. Massachusetts Regulations, 211 CMR 153, 2012: 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: 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 April 8, 2024.
6. Commonwealth of Massachusetts Executive Office of Health and Human Services Office of Medicaid. MassHealth All Provider Bulletin 363 March 2023. Available at download (mass.gov). Accessed March 20, 2024.
7. 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 4/8/2024.
8. 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: New Hampshire Statutes - Table of Contents (state.nh.us). Accessed April 8, 2024.

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:

- September 20, 2023: Reviewed at MPAC, renewed without changes
- November 2023: Rebranded Unify to One Care and updated overview effective January 1, 2024
- December 1, 2023: Reviewed and Approved by the Utilization Management Committee for Tufts Health One care effective January 1, 2024.
- April 17, 2024: Reviewed by MPAC, noted no prior authorization needed for MATogether, Tufts Health One Care,

and Tufts Health Senior Care Options for continuity of care effective July 9, 2024

- April 19, 2024: Reviewed by Utilization Management Committee, renamed to Out of Network Coverage at the In Network Level of Benefits and Continuity of Care (All Plans), Harvard Pilgrim Stride, Tufts Medicare Preferred (HMO and PPO) and Tufts Senior Care Options checked off as applicable Lines of Business. Note added that prior authorization is not required for MA Together, Tufts Health One Care, and Tufts Senior Care Options for continuity of care effective July 9, 2024

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.