Medical Policy
Out of Network Providers

Document Number: 029

	Commercial and Health Connector/Qualified Health Plans	MassHealth	PPO Plan
Authorization required	X	X	
No notification or authorization			*X
Not covered			

*Members insured under AllWays Health Partners' PPO plan are able to access services from non-preferred providers under the conditions of their plan coverage. Service being accessed may be subject to prior authorization.

Overview

This document describes the guidelines AllWays Health Partners utilizes to authorize non-urgent care from an out-of-network (OON) provider for HMO (Commercial and Health Connector/Qualified Health Plans) and MassHealth plan members.

Coverage Guidelines

AllWays Health Partners works with members and providers to facilitate continuity of care and uninterrupted access to medically necessary covered services from providers with the appropriate qualifications and expertise to meet the health needs of the member. AllWays Health Partners also ensures that members requiring access to services are not subject to unnecessary risk through redirection to a network provider to receive services either in part or whole.

To authorize OON services, AllWays Health Partners may require the OON provider to sign a letter of agreement (LOA). In addition, OON providers must coordinate with AllWays Health Partners regarding payment and also communicate with the member in his or her primary language.

For Behavioral health services see United Behavioral Health (Optum).

AllWays Health Partners provides equitable access to all of its network providers and provides access to OON providers under the following circumstances:

1. For new members:
   A. They may continue to receive care from a primary care provider (PCP) for up to 30 days from the date of enrollment;
   B. They may continue to receive care to treat or manage an acute or chronic condition for up to 30 days from the date of enrollment;
   C. MassHealth members in any trimester of pregnancy, may continue to receive care with the treating provider in conjunction with said pregnancy through the postpartum period;
   D. Commercial and QHP members in the second or third trimester of a pregnancy, may continue to receive care with the treating provider in conjunction with said pregnancy through the postpartum period;

   E. If they have a terminal illness, they may continue to receive care by a provider who is treating or managing the terminal illness up to the member's death; or
   F. If they are hospitalized at the time of enrollment may continue hospital-based care that is medically necessary.
2. When an individual provider voluntarily terminates their AllWays Health Partners contract:
   A. If the provider is a PCP, the member can continue to receive care for up to 30 days following the effective date of termination;
   B. If the provider is actively treating or managing an acute or chronic medical condition, the member can continue to receive care for up to 90 days or until the current period of active treatment has ended, whichever comes first;
   C. MassHealth members in any trimester of pregnancy, may continue to receive care with the treating provider in conjunction with said pregnancy through the postpartum period;
   D. Commercial and QHP members in the second or third trimester of a pregnancy, may continue to receive care with the treating provider in conjunction with said pregnancy through the postpartum period; or
   E. If the provider is caring for a member with a terminal illness in relation to treatment of the terminal illness, the member can continue to receive care until their death.
3. In the absence of a network provider with the qualifications and expertise matching the member's health care needs for medically necessary services covered under the terms of health plan for as long as treatment is medically indicated or until a network provider becomes available.
4. For MassHealth members, consideration is given if not all related, medically necessary services are available in-network, and the treating provider(s) determines the member would be subjected to unnecessary risk if they received services separately.
5. For MassHealth members, when access to a network provider is unavailable per the general area/distance and travel guidelines.
6. When delays in accessing a network provider – other than those attributed to the member – would cause disruption of care for medically necessary services covered under member's health plan.
7. Limited follow-up care is authorized after OON emergency care to stabilize the member's condition or until the member can safely return to the network without deterioration in clinical condition, or permanent impairment of health.

Note:

For AllWays Health Partners' PPO plan, members are able to access services from a non-preferred provider under the conditions of their plan coverage. Out-of-pocket costs are generally higher for non-preferred providers. Regardless of a provider's network status, services may be subject to prior authorization.

For AllWays Health Partners HMO plans, any cost sharing will remain the same for authorized OON providers.

For AllWays Health Partners MassHealth Plans:

- When a member enrolls, AllWays Health Partners may honor medically necessary prior authorizations made by the member's previous health plan beyond the initial 30 days of enrollment unless AllWays Health Partners determines that it is not medically necessary to honor such authorization.

No prior authorization is required for the following services when rendered by an OON provider:

1. Emergency room visits;
2. Emergency inpatient admissions, AllWays Health Partners requires notified within 24 hours or by the next business day; each subsequent day of care requires prior authorization;
3. Individual medically necessary covered services rendered as part of an emergency inpatient stay or emergent ambulatory surgical day procedure. All elective admissions and ambulatory surgical day procedures require prior authorization;
4. Laboratory services associated with emergency care and urgent care (except for those laboratory services under Prior Authorization, Notification and Referral Guidelines); or
5. Family planning (MassHealth members only)

Exclusions

AllWays Health Partners does not authorize or reimburse services rendered by an OON provider when:

A. The criteria above are not met;
B. They are not covered under the member's health plan regardless of the network status of the provider;
C. A qualified network provider is available, and a newly enrolled member wishes to continue to receive care beyond the timeframes noted above;
D. The member has traveled outside of the AllWays Health Partners enrollment area despite the fact that the need for the requested service was reasonably foreseeable;
E. The member is physically able to safely travel back to the service area without intractable pain, or deterioration or permanent impairment of health;
F. The OON provider was not prior authorized (PPO plan excluded);
G. AllWays Health Partners has previously terminated the OON provider's contract due to quality deficiencies or fraud; or
H. For commercial and Health Connector/QHP members, services that don't meet **Coverage Conditions** **HEALTH POLICY COMMISSION CMR 3.000: HEALTH INSURANCE CONSUMER PROTECTION, 958.3000** **listed under definitions.**
I. **For MassHealth members only; All services rendered outside the United States and its territories are not covered benefits for MassHealth members.**

Definitions

Distance and travel Guidelines (MassHealth members only):

AllWays Health Partners defines reasonable travel time from a member's residence as follows:

1. Obstetrical/gynecological and specialist services: available within 20 miles or 40 minutes.
2. Rehabilitation hospital services: available within 30 miles or 60 minutes.
3. Acute inpatient services: available within 20 miles or 40 minutes.

4. Urgent Care Services: available within 15 miles or 30 minutes travel time.
   Note: Emergency care, urgent care, and emergent acute admissions do not require prior authorization.
5. Other physical health services are services in accordance with usual and customary community standards for accessing care.

Coverage Conditions, 958 HEALTH POLICY COMMISSION CMR 3.000: HEALTH INSURANCE CONSUMER PROTECTION, 958.3000:

(1) A carrier may condition coverage of continued treatment by a physician or nurse practitioner under 958 CMR 3.500 through 3.502, upon the provider's agreeing:

(a) To accept reimbursement from the carrier at the rates applicable prior to the notice of disenrollment as payment in full;

(b) To not impose cost sharing with respect to the insured in an amount that would exceed the cost sharing that could have been imposed if the provider had not been disenrolled;

(c) To adhere to the quality assurance standards of the carrier and to provide the carrier with necessary medical information related to the care provided; and,

(d) To adhere to such carrier's policies and procedures, including procedures regarding referrals, obtaining prior authorization, and providing treatment pursuant to a treatment plan, if any, approved by the carrier.

(2) A carrier may condition coverage of treatment by a physician or nurse practitioner under 958 CMR 3.503 upon the provider's agreeing:

(a) To accept reimbursement from the carrier at the rates applicable to participating providers as payment in full;

(b) To not impose cost sharing with respect to an insured in an amount that would exceed the cost sharing that could have been imposed if the provider participated in the carrier's network;

(c) To adhere to the quality assurance standards of the carrier and to provide the carrier with necessary medical information related to the care provided; and

(d) To adhere to the carrier's policies and procedures, including procedures regarding referrals, obtaining prior authorization, and providing treatment pursuant to a treatment plan, if any, approved by the carrier.

(3) Nothing in 958 CMR 3.500 through 3.502 or 3.504 shall be construed to require the coverage of benefits that would not have been covered if the provider involved had remained a participating provider. Nothing in 958 CMR 3.503 shall be construed to require coverage of benefits that would not have been covered if the physician or nurse practitioner involved was a participating provider.

Medically Necessary or Medical Necessity:

1. **MassHealth**

In accordance with 130 CMR 450.204, medically necessary services are those services:

(a) Which are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the enrollee that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and
(b) For which there is no other medical service or site of service, comparable in effect, available, and suitable for the enrollee requesting the service, that is more conservative or less costly; and
(c) That are of a quality that meets professionally recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality.

2. **Division of Insurance**
Health care services that are consistent with generally accepted principles of professional medical practice as determined by whether:
(a) The service is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual;
(b) Is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
(c) For services and interventions not in widespread use, is based on scientific evidence.

3. **Health Connector**
Medically necessary or medical necessity health care services that:
Are consistent with generally acceptable principles of professional medical practice as determined by whether:

a) The service is the most appropriate available supply or level of service for the enrollee in question considering potential benefits and harms to the individual;
    1) Is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
    2) For services and interventions not in widespread use, is based on scientific evidence; and
b) Are the least intensive and most cost effective available.

Out of Network Provider: Care or services delivered by providers who are not part of AllWays Health Partners' network.

Postpartum Period: The period following delivery usually between 21 and 56 days after delivery when the mother has a postpartum checkup.

Terminally Ill or Terminal Illness: An illness that is likely, within a reasonable degree of medical certainty, to cause one's death within six months.

Voluntary Provider Termination: Termination occurs based on the provider's decision not to continue his/her participation with AllWays Health Partners after having provided prior written notice as specified in the provider's contract.

Related Policies

- Out of Network Provider Services Provider Payment Guidelines

Effective

July 2020: Changes made to coverage guidelines. Distance and Travel Guidelines section changed. Reference updated.
August 2019: Annual update. References updated.
July 2018: Annual update.
January 2018: Revised prior authorization exclusion language to clarify that no prior authorization is required for laboratory services associated with emergency care and urgent care. Added Exclusion I.
December 2016: Annual update
December 2015: Effective date

References

211 CMR 52.00: Managed Care Consumer Protections and Accreditation of Carriers

958 CMR: Health Policy Commission, CMR 958.300: HEALTH INSURANCE CONSUMER PROTECTION

NCQA 2019 Standards and Guidelines for the Accreditation of Health Plans, MED 1C, D

MassHealth ACO Contract Section: 2.14.B.3.c

MassHealth CarePlus Contract between EOHHS and AllWays Health Partners

HEDIS 2019 description for Prenatal and Postpartum Care (PPC)