

## Medical Policy

### Out of Network Providers

**Policy Number:** 039

	Commercial HMO Plans	MassHealth	PPO Plan
Authorization required	X	X	
No notification or authorization			X*
Not covered			

\*Members insured under Mass General Brigham Health Plan’s 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 Mass General Brigham Health Plan utilizes to authorize non-urgent care from out-of-network (OON) providers for Commercial and MassHealth plan members.

#### Coverage Guidelines

Mass General Brigham Health Plan 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. Mass General Brigham Health Plan also ensures, in accordance with applicable laws and regulations, 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, Mass General Brigham Health Plan may require the OON provider to sign a letter of agreement (LOA) outlining payment details and also communicate with the member in his or her primary language. In addition, OON providers must adhere to Mass General Brigham Health Plan policies and procedures regarding prior Authorizations and providing services pursuant to a treatment plan, if any, approved by Mass General Brigham Health Plan. In the case of disenrolled Providers, they must also agree to accept reimbursement from Mass General Brigham Health Plan at the rates applicable prior to notice of disenrollment as payment in full, and not to 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. Failure of a Provider to agree to these conditions may result in a denial of coverage for the provided service.

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

Mass General Brigham Health Plan provides equitable access to all of its network providers and provides access to OON providers under the following circumstances:

1. For newly enrolled Commercial and Qualified Health Plan members whose employer only offered the member a choice of Carriers in which their existing PCP or an actively treating Provider was not a participating provider, Mass General Brigham Health Plan will provide coverage as follows:
  - A. A member may continue to receive care from a primary care provider (PCP) for up to 90 days from the date of enrollment.

- B. A member may continue to receive care to treat or manage an acute or serious and complex medical condition<sup>1</sup> for up to 90 days from the date of enrollment.
  - C. A member in her second or third trimester of a pregnancy, may continue to receive care with the treating provider in conjunction with said pregnancy through the first postpartum visit.
  - D. A member with a terminal illness, may continue to receive care by a provider who is treating or managing the terminal illness up to the member's death.
2. For newly enrolled MassHealth members Mass General Brigham Health Plan will provide coverage as follows:
    - A. A member may continue to receive care from a primary care provider (PCP) for up to 30 days from the date of enrollment.
    - B. A member may continue to receive care to treat or manage an acute or serious and complex medical condition<sup>1</sup> for up to 90 days from the date of enrollment.
    - C. New MassHealth members in any trimester of pregnancy may continue to receive care with the Out-of-Network treating provider in conjunction with said pregnancy through the postpartum period.
    - D. A member with a terminal illness, may continue to receive care by a provider who is treating or managing the terminal illness up to the member's death.
  3. When an individual provider is terminated for reasons unrelated to quality of care or fraud, a member may continue care as follows:
    - A. A Commercial or Qualified Health Plan member can continue to receive care with the PCP for up to 90 calendar days following the effective date of termination. A MassHealth member may continue to receive care with the PCP for up to 30 calendar days following the effective date of termination.
    - B. A Commercial, Qualified Health Plan, or MassHealth member can continue to receive care with a provider who is actively treating or managing an acute, or serious and complex<sup>1</sup> medical condition for up to 90 calendar days, or until the current period of active treatment has ended, whichever comes first.
    - C. Existing 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.
  4. 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.
  5. 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.
  6. For MassHealth members, when access to a network provider is unavailable per the general area/distance and travel guidelines.
  7. 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.

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<sup>1</sup> The term 'serious and complex condition' means, with respect to a participant, beneficiary, or enrollee under a group health plan or group or individual health insurance coverage—

(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

(B) in the case of a chronic illness or condition, a condition that is—

(i) is life-threatening, degenerative, potentially disabling, or congenital; and

(ii) requires specialized medical care over a prolonged period of time.



8. 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.

**Notes:**

\*For Mass General Brigham Health Plan's PPO plan, in-network cost sharing will apply for covered services with an authorized OON providers only during the periods approved above. After the expiration of the periods above, members are able to continue access to covered services from a non-preferred provider under the conditions of their plan coverage, however out-of-network cost sharing will apply. Out-of-pocket costs are generally higher for out-of-network providers. Regardless of a provider's network status, services may be subject to prior authorization.

For Mass General Brigham Health Plan HMO plans, in-network cost sharing will apply for covered services with an authorized OON provider.

For Mass General Brigham Health Plan MassHealth Plans:

- When a member enrolls, Mass General Brigham Health Plan may honor medically necessary prior authorizations made by the member's previous health plan beyond the initial 90 days of enrollment unless Mass General Brigham Health Plan 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. Urgent care;
2. Emergency room care;
3. Emergency inpatient admissions. Mass General Brigham Health Plan requires notification within 24 hours or by the next business day; each subsequent day of care requires prior authorization;
4. 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;
5. Laboratory services associated with emergency care and urgent care (except for those laboratory services under [Prior Authorization, Notification and Referral Guidelines](#)); or
6. Family planning (MassHealth members only)

**Exclusions**

Mass General Brigham Health Plan 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 Mass General Brigham Health Plan 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. Mass General Brigham Health Plan has previously terminated the OON provider's contract due to quality deficiencies or fraud; or
- H. For commercial 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):**

Mass General Brigham Health Plan defines reasonable travel time from a member's primary residence (as reported to the Health Plan on enrollment) 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.

##### **Special Rule for Small Group Continuity of Care Under 211 CMR 153.00**

##### **Continuity of Care Access to Cancer and Pediatric Facilities**

If a member is enrolled in a limited or tiered plan under a small employer group, the member may, in certain circumstances, be eligible for continuity of care coverage if he or she is receiving an active course of care for a serious illness that the member began before the effective date of coverage under that limited or tiered



network plan. To be eligible for this continuity of care coverage, the member must meet all the following conditions:

- The member began an active course of care for a serious illness (such as cancer or cystic fibrosis) at a comprehensive cancer or pediatric facility before the member's effective date of coverage in that limited or tiered network plan.
- The comprehensive cancer or pediatric facility is not in the Mass General Brigham Health Plan network; or, for a tiered network, the member would normally pay the highest cost sharing amount for covered services at the comprehensive cancer or pediatric facility where the member is receiving care.
- The member's active course of care, if it were disrupted, would cause an undue hardship to the member. This means, for example, a disruption could endanger the member's life, or cause the member suffering or pain, or result in a substantial change to the member's treatment plan.

If the member meets all of the conditions stated above, the member is eligible for the above coverage until the end of the 12 month period starting on the newly enrolled Subscriber's effective date of coverage in the limited or tiered network plan but only if the small employer group offers the member the choice to enroll only in the limited or tiered network plan in which the applicable comprehensive cancer or pediatric facility (a) is not part of the Mass General Brigham Health Plan network or, (b) for a tiered network plan, is at the highest cost-sharing amount and the member's care is not available from another provider in the Mass General Brigham Health Plan network.

Form and requirement below:

<https://resources.massgeneralbrighamhealthplan.org/member/CONTINUITYOFCAREATCANCERANDPEDIATRI CFACILITIESFORM%20.pdf>

**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.

**Out of Network Provider:** Care or services delivered by providers who are not part of Mass General Brigham Health Plan's network. Providers include clinicians and facilities.



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

**Serious Disease:** a condition that is life threatening or is likely to lead to serious or permanent disability if left untreated.

**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 Mass General Brigham Health Plan after having provided prior written notice as specified in the provider's contract.

#### Related Policies

- [Out of Network Provider Services Provider Payment Guidelines](#)

#### Effective

May 2024: Annual update. Clarified "primary residence" under Distance Guidelines.

May 2023: Annual update. No changes.

June 2022: Ad-hoc review. The following changes were made:

- On Page 1, #1 added verbiage "Commercial and Qualified Health Plan"
- On Page 2:
  - Number 2, edited MassHealth language to align with MassHealth requirements.
  - Number 3A, added verbiage "A Commercial or Qualified health Plan". Also added last sentence regarding MassHealth members.
  - Number 3B, added verbiage "A Commercial, Qualified Health Plan, or MassHealth".
  - Number 3C, added "Existing".

May 2022: Annual update. Under Definition section, edit made to Out of Network Provider, to clarify it includes clinicians and facilities.

January 2022: Ad-hoc review to update policy in compliance with No Surprise Act. Added definition of serious and complex medical condition. Changed timeframe from 30 to 90 days. References updated.

February 2021: Changes made to add additional regulation and defined affected membership

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

211 CMR 153.00: 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

211 CMR 52.13(3)(v): Managed Care Consumer Protections and Accreditation of Carriers, Evidences of Coverage

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

NCQA 2021 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 Mass General Brigham Health Plan

HEDIS 2019 description for Prenatal and Postpartum Care (PPC)

Public Law 116-260 - The No Surprises Act, Title XXVII of the Public Health Service Act (2020), 42 U.S.C. 300gg et seq, Part D, Section 113

