Out of Network Coverage
Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Out of Network Coverage		
MNG #: 106	**☒ CCA Senior Care Options (HMO D-SNP) (MA)** **☒ CCA One Care (Medicare-Medicaid) (MA)**	**Prior Authorization Needed?** **☐ Yes** **☒ Yes (only in certain situations. See this MNG for details)** **☐ No**
Clinical: ☒	**Operational:** ☒	**Informational:** ☐
Benefit Type: **☒ Medicare** **☒ Medicaid**	**Approval Date:** 5/05/2022; 12/14/23	**Effective Date:** 8/23/2022; 12/14/23; 1/1/25
Last Revised Date: 12/14/23; 11/14/24; 1/1/25	**Next Annual Review Date:** 5/05/2023; 12/14/24; 11/14/25	**Retire Date:**

OVERVIEW:

As indicated in the Commonwealth Care Alliance (CCA) One Care Member Handbook and Senior Care Options (SCO) Evidence of Coverage, Commonwealth Care Alliance requires prior authorization (PA) for all Out of Network (OON) services except for emergency care, emergency behavioral health care, urgently needed care when not available in network, out of service area renal dialysis services, Family Planning services for One Care Members, and services rendered under the Continuity of Care Period. This Medical Necessity Guideline provides the standards by which CCA reviews requests for OON exceptions.

OON Providers should refer to the CCA Payment Policy: Out of Network Provider Reimbursement Guidance. https://www.commonwealthcarealliance.org/wp-content/uploads/2022/10/CCA-Payment-Policy_Out-of-Network-Provider.pdf

DEFINITIONS:

Continuity of Care: The period Member can continue to receive current service(s) after becoming a CCA member. The Continuity of Care period is valid until comprehensive assessment and Individualized Care Plan are completed, or until the plan-specific Continuity of Care period expires, usually within the first 90 days of becoming a member.

Emergency Care: When a member, or any other prudent layperson with an average knowledge of health and medicine, believes that an individual has a medical condition, mental or physical, manifesting itself by acute medical symptoms that require immediate medical attention to prevent loss of life, serious impairment to bodily functions or serious dysfunction of a bodily part. The medical symptoms may be an illness, injury, severe pain, or a medical or mental condition that is quickly getting worse.

Family Planning services: According to the World Health Organization (WHO), family planning is defined as "the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility"

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Network providers: Network providers are providers who work with the health plan.

Out-of-network provider/Out-of-network facility: A provider or facility that is not employed, owned, or operated by CCA and has not agreed to work with CCA to provide covered services to members of the Plan.

Specialist: A provider who provides healthcare for a specific disease or part of the body. Examples include cardiologist, oncologist and orthopedic surgeon.

Urgent Care: Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an emergency condition, but that are the result of an unforeseen illness, injury, or condition for which medically necessary services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent care does not include Primary Care services or services provided to treat an emergency condition.

Urgently needed care: Care received for a sudden illness, injury, or condition that is not an emergency but needs care right away. Member can get urgently needed care from out-of-network providers when network providers are unavailable, or member cannot get to them. An urgently needed service is a non-emergency situation requiring immediate medical care but given member's circumstances, it is not possible or not reasonable to obtain these services from a network provider.

Service Area: A specific geographic area covered by a CCA health plan (some plans accept members only if they live in a certain area). For plans that limit which healthcare providers and hospitals a member may use, it is also generally the area where member can receive routine (non-emergency) services.

Specialist: A healthcare provider who provides healthcare for a specific disease or part of the body

DECISION GUIDELINES:

Prior authorization is **not** required for the following out of network services:

1. Emergency care, emergency behavioral health care, urgently needed care out of the CCA service area, urgently needed care sought inside the CCA service area when a CCA-contracted provider is unavailable or inaccessible, and prior authorization is not required for services provided by a network provider or for dialysis provided by an out-of-network provider when member is temporarily out of the service area.
2. Family planning services from any MassHealth-contracted Family Planning Services Provider in and out of the provider network **(Massachusetts One Care Members only)**.
3. Services rendered during the Continuity of Care Period (when Member first joins CCA).
4. Kidney dialysis services provided by a Medicare-certified facility when the Member is outside CCA's service area or when Member's provider for dialysis service is unavailable or inaccessible for a short period of time.

ALL other OON services require prior authorization.

Clinical Coverage Criteria One Care and SCO:

CCA will review each request for an OON exception on an individual basis to determine the medical necessity of the request. As outlined in the CCA Member Handbook (One Care) and Evidence of Coverage (SCO), CCA may provide OON exceptions in the following situations:

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1. When the CCA provider network is unable to provide necessary covered services to a particular Member, CCA must cover these services OON for the Member for as long as CCA or CCA's provider network is unable to provide them. For example, this includes, but is not limited to any of the following:
    a. The clinical specialty and expertise needed to care for Member's specific condition or health care need is not available from the CCA provider network. Scenarios that may fall under this category include:

        i. The Member has a rare medical condition or requires a specialized medical procedure for which there is no in-network (INN) provider with the necessary specialization, training, or expertise to provide evaluation, treatment, or perform the procedure. CCA will consider this circumstance when it is the opinion and recommendation of an INN specialty provider that the referral to an OON specialist provider is both medically necessary and the specialty care cannot be provided by a comparable INN provider.
        ii. INN providers with the clinical expertise to address the Member's medical condition are not reasonably available within CCA's network adequacy standards. https://www.commonwealthcarealliance.org/ma/wp-content/uploads/2021/05/GuidanceVerificationNetworkProviderDirectory_2-2.pdf

    b. Access barriers for receiving care from an INN provider. CCA must ensure that its network providers provide physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities. Scenarios that may fall under this category include:
        i. The Member requires a timely/urgent service, and the Member is unable to access INN providers for this service within a reasonable time frame.
        ii. An INN provider does not speak the Member's primary language and there is no INN provider available that speaks the language. CCA will consider this circumstance when it is the treating provider's opinion that treatment will likely be compromised due to a combination of the language barrier, treatment required to address the Member's condition, and/or inadequate traditional translation services (in-person and telephonic/video). The Member's CCA care team should support the Member in identifying INN alternatives, if any.
        iii. An INN provider is not accessible due to inadequate accommodations for Member's disability and the Member's CCA care team is unable to identify accessible INN alternatives.
2. Unusual circumstances: CCA may approve OON exceptions in any of the following circumstances:
    a. The Member or an INN treating specialist requests a second opinion from an OON provider. As outlined in the SCO Evidence of Coverage table, the Member's PCP/care team must be involved in helping to arrange a second opinion from an out-of-network provider, at no cost to the Member
    b. The Member is a resident in a nursing home or skilled nursing facility, cannot travel, and INN providers are not available to treat the Member in their current setting.
    c. Follow-up after emergency OON specialist care, such as in the Emergency Department or a resulting inpatient admission. CCA may authorize up to 3 (three) follow-up visits with an OON specialty provider in these circumstances.

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RELATED REFERENCES:

1.Medicare Managed Care Manual, Chapter 4. §20.2 – Definitions of Emergency and Urgently Needed Services. Accessed November 5, 2024. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c04.pdf

2. 42 CFR § 422.111: Disclosure Requirements. Accessed November 4, 2024. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.111

Disclaimer

Commonwealth Care Alliance (CCA) follows applicable Medicare and Medicaid regulations and uses evidence based InterQual© criteria, when available, to review prior authorization requests for medical necessity. This Medical Necessity Guideline (MNG) applies to all CCA Products unless a more expansive and applicable CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or state-specific medical necessity guideline exists. Medical Necessity Guidelines are published to provide a better understanding of the basis upon which coverage decisions are made. CCA makes coverage decisions on a case-by-case basis by considering the individual member's health care needs. If at any time an applicable CMS LCD or NCD or state-specific MNG is more expansive than the criteria set forth herein, the NCD, LCD, or state-specific MNG criteria shall supersede these criteria.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. This Medical Necessity Guideline is subject to all applicable Plan Policies and Guidelines, including requirements for prior authorization and other requirements in Provider's agreement with the Plan (including complying with Plan's Provider Manual specifications).

This Medical Necessity Guideline is not a rigid rule. As with all CCA's criteria, the fact that a member does not meet these criteria does not, in and of itself, indicate that no coverage can be issued for these services. Providers are advised, however, that if they request services for any member who they know does not meet our criteria, the request should be accompanied by clear and convincing documentation of medical necessity. The preferred type of documentation is the letter of medical necessity, indicating that a request should be covered either because there is supporting science indicating medical necessity [supporting literature (full text preferred) should be attached to the request], or describing the member's unique clinical circumstances, and describing why this service or supply will be more effective and/or less costly than another service which would otherwise be covered. Note that both supporting scientific evidence and a description of the member's unique clinical circumstances will generally be required.

REVISION LOG:

REVISION DATE	DESCRIPTION

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1/1/25	CCA products updated. Language applicable to previous products removed. Coverage of dialysis moved to Decision Guidelines section.
11/14/24	Template update. Definitions added. Clarification of prior authorization requirement for OON kidney dialysis.
12/31/23	Utilization Management Committee approval
12/14/23	Clinical coverage criteria updated for One/Care/SCO and added for RI Medicare Maximum to align with Evidence of Coverage and Member handbooks. MNG not applicable to MAPD, refer to OON Payment Policy. Definitions updated.

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