Out of Network Coverage
Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Out of Network Coverage		
MNG #: 106	☒ **SCO** ☒ **One Care** ☐ **MA Medicare Premier** ☐ **MA Medicare Value** ☐ **RI Medicare Preferred** ☐ **RI Medicare Value** ☒ **RI Medicare Maximum**	**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
Last Revised Date: 12/14/23	**Next Annual Review Date:** 5/05/2023; 12/14/24	**Retire Date:**

OVERVIEW:

As indicated in the CCA One Care Member Handbook, Senior Care Options (SCO) Evidence of Coverage or RI Medicare Maximum/Dual Eligible Special Needs Plan Evidence of Coverage, Commonwealth Care Alliance (CCA) requires prior authorization (PA) for all Out of Network (OON) services except for emergency care, emergency behavioral health care, urgent 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 Out of Network Provider Policy for OON reimbursement policies found on the CCA Payment Policy website.

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.

Out of Network Coverage
Medical Necessity Guideline

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"

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

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.
Service Area – A geographic area where Member must live to join a particular health plan. For plans that limit which doctors and hospitals Member may use, it is also generally the area where Member can get routine (non-emergency) services.

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

DECISION GUIDELINES:

Clinical Coverage Criteria:

Commonwealth Care Alliance (CCA) follows applicable Medicare and Medicaid regulations and uses InterQual Smart Sheets, 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.

Clinical Coverage Criteria for One Care and SCO Members:

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:

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.

b. Access barriers for receiving care from an INN provider. CCA must ensure that it's 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. 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.
3. 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.

Clinical Coverage Criteria for RI Medicare Maximum Members:

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 Evidence of Coverage (Medicare Maximum), CCA may provide OON exceptions in the following situations

Out of Network Coverage
Medical Necessity Guideline

The Member requires Plan covered specialized medical care **and** there are no specialists the CCA provider network that provide this care; or2. Kidney dialysis services provided at a Medicare certified dialysis facility when Member is temporarily outside the plan's service area **or** when Member's provider for dialysis service is temporarily unavailable or inaccessible.

OON Providers should refer to the CCA Out of Network Provider Policy for OON reimbursement policies found on the CCA Payment Policy website.

PRIOR AUTHORIZATION:

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not signify that the service described by the code is a covered or non-covered health service. 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. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. 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).

OON Prior authorization is not required for:

1. Emergency care, emergency behavioral health care, urgent care out of the CCA service area, urgent care sought inside the CCA service area when a CCA-contracted provider is unavailable or inaccessible, and out-of-area renal dialysis services.
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. Members covered under a CCA Medicare Advantage Preferred, Premier or Value Plan.

REGULATORY NOTES:

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. This MNG references the specific regulations, coverage, limitations, service conditions, and/or prior authorization requirements in the following:

Medicare Managed Care Manual, Chapter 4. §20.2 – Definitions of Emergency and Urgently Needed Services. Accessed 11/22/23.

Out of Network Coverage
Medical Necessity Guideline

RELATED REFERENCES:

1. Institute of Medicine (US) Committee on a Comprehensive Review of the HHS Office of Family Planning Title X Program; Stith Butler A, Wright Clayton E, editors. A Review of the HHS Family Planning Program: Mission, Management, and Measurement of Results. Washington (DC): National Academies Press (US); 2009. 2, Overview of Family Planning in the United States. Available from: https://www.ncbi.nlm.nih.gov/books/NBK215219/

Disclaimer

This Medical Necessity Guideline is not a rigid rule. As with all of 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.

ATTACHMENTS:

EXHIBIT A:	
EXHIBIT B	

REVISION LOG:

REVISION DATE	DESCRIPTION
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.

Out of Network Coverage
Medical Necessity Guideline

APPROVALS:

David Mello, DO	Senior Medical Director
CCA Senior Clinical Lead [Print]	**Title [Print]**
David Mello	12/22/23
	Date
Click here to enter text.	
CCA Senior Operational Lead [Print]	**Title [Print]**
Signature	**Date**
Nazlim Hagmann, MD	Chief Medical Officer
	Title [Print]
Nazlim Hagmann	12/22/23
Signature	**Date**