CarePartners of Connecticut MEDICARE ADVANTAGE

Medical Necessity Guidelines

Out-of-Network Coverage at the In-Network Level of Benefits and Continuity of Care

Effective: July 9, 2024

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

Applies to:

☒ CarePartners of Connecticut Medicare Advantage HMO plans, Fax 857-304-6463
☒ CarePartners of Connecticut Medicare Advantage PPO plans, Fax 857-304-6463

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

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 CarePartners of Connecticut Medicare Advantage plans, for non-emergent/non-urgent out-of-network services to be covered at the in-network level of benefit, prior authorization must be obtained.

Requests for prior authorization for Care Partners of Connecticut Members must be submitted to the Plan on the 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) 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 are the basis for coverage determinations where available. For this guideline, the following federal regulation was consulted: 42 CFR 422.112(b).

Table of Contents

Clinical Guideline Coverage Criteria

General Out-of-Network Coverage at the In-Network Level of Benefits

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 CarePartners of Connecticut 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.

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.

*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.

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.

Approval And Revision History

April 17, 2024: Reviewed by the Medical Policy Approval Committee (MPAC) new MNG created for benefit guidance

Subsequent endorsement date(s) and changes made:

- April 19, 2024: Reviewed by Utilization Management Committee, 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.

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.