Coverage for PANDAS/PANS

Massachusetts Division of Insurance

May 2024

**Agency Mission**

“The primary mission of the Division of Insurance (DOI) is to monitor the solvency of its licensees [property/casualty, life/annuity and health] in order to promote a healthy, responsive and willing marketplace for consumers who purchase insurance products.

Protection of consumer interests is of prime importance to the Division and is safeguarded by providing accurate and unbiased information so consumers may make informed decisions and by intervening on behalf of consumers who believe they have been victimized by unfair business practices.”

**Statute for PANDAS/PAN**

Chapter 260 of the Acts of 2020 amended Massachusetts laws to add provisions to

* + M.G.L. c. 175, §47NN (applying to commercial insurance companies;
	+ M.G.L. c. 176A, §8OO; M.G.L. c. 176B, §4OO (applying to BCBSMA); and
	+ M.G.L. c. 176G, §4GG (applying to HMOs).

The statutory provisions require insured health plans to cover PANDAS/PANS.

The mandate applies to insured health plans that are issued to individuals and employment-based groups in Massachusetts and certain fully insured health plans issued outside of Massachusetts that have Massachusetts members.

**Health Care Access Bureau (M.G.L. c. 26, sec 7A)**

Bureau within the DOI responsible for

* administration of the Division's statutory and regulatory authority for oversight of the small group and individual health insurance market;
* oversight of affordable health plans, including coverage for young adults; and
* dissemination of appropriate information to consumers about health insurance coverage and access to affordable products.

**Health Care Access Bureau Guidance**

The Division issued Bulletin 2021-06 to notify insurance carriers that Chapter 260 of the Acts of 2020 requires insurance carriers to cover “treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome including, but not limited to, the use of intravenous immunoglobulin therapy…” (hereinafter referred to as “PANDAS and PANS”).

In Bulletin 2021-06, the Division further instructed carriers to

* notify providers and consumers about PANDAS and PANS coverage;
* update administrative processes to enable members to access PANDAS and PANS coverage;
* identify providers within their networks to treat PANDAS and PANS.

The Division also identified in Bulletin 2021-06 that if networks do not provide adequate access to providers, the Carriers are to cover medically necessary PANDAS and PANS when services are provided by out-of-network providers until such time that the Carrier contracts for in-network providers to deliver care.

**Statute**

The noted statute does **NOT** apply to persons covered under the following:

 government programs (e.g., Medicare and Medicaid Programs);

 most plans issued outside Massachusetts;

* + - * Many MA residents work for an employer that is headquartered in another state and offers employee benefits through its headquarters.
			* Out-of-state employer plans generally are subject to the state law where the coverage was issued

 or self-funded employment-sponsored group health plans.

* + - * Many large employers self-fund employee health benefits – pay the benefits from their own resources - rather than buying insured plans from insurance carriers.
			* These plans are exempt from state insurance laws under federal ERISA statutes.

Individuals can contact their employers’ human resource representative or their insurance Carrier to understand whether they are in an insured health benefit plan that is subject to the protections of the law.

**MANAGED CARE PROCESSES**

Many health plans use "utilization review" to decide whether certain services or access to certain providers is necessary for a patient according to their medical standards.

Medical necessity guidelines are developed according to section 16 of M.G.L. c. 176O and medical necessity guidelines utilized by a carrier in making coverage determinations shall be:

* 1. developed with input from practicing physicians and participating providers in the carrier's or utilization review organization's service area;
	2. developed under the standards adopted by national accreditation organizations;
	3. updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and
	4. evidence-based, if practicable. In applying such guidelines, a carrier shall consider the individual health care needs of the insured.

The law also notes that “medical necessity guidelines criteria shall be applied consistently by a carrier or a utilization review organization and made easily accessible and up-to-date on a carrier or utilization review organization's website.”

**Bureau of Managed Care (M.G.L. c. 176O, sec 2)**

Responsible under M.G.L. c. 176O, sec 2 to review carriers

1. Utilization review;
2. Quality management and improvement;
3. Credentialing;
4. Preventive health services;
5. Access to pain management services, including non-opioid and non-pharmaceutical service options;
6. Access to behavioral health services, chronic disease management and primary care services via telehealth;
7. Evidences of Coverage;
8. Contracts with network providers;
9. Provider directories;
10. Adequacy of networks; and
11. Disclosure information.

**Accreditation Review**

Every two years, staff within the Bureau of Managed Care review the managed care processes of each Massachusetts insurance carrier for utilization review, quality assurance, and credentialing.

Staff review all evidence of coverages, provider directory materials and consumer disclosures for compliance with state laws.

When there are material changes to any processes, insurance carriers are to submit these changes for review with compliance with managed care regulations.

**Utilization Review Decisions**

If an insurance carrier makes a determination that a requested service or provider is not medically necessary, the plan may deny or reduce payments. For some health plans, this medical necessity decision is made before treatment. For other health plans, the decision is made when the company gets a bill from the provider.

When submitting a request, the insurance carrier will expect that the request includes sufficient information from a clinician to identify why the procedure is medical necessary for the covered person. When the request is complete, the insurance carrier is expected to respond to the request within 2 business days of obtaining all necessary information.

If an insurance company decides that a service is not medically necessary, it must send a letter explaining the reasons for the decision. The letter should also explain the right to file a grievance or appeal, and how to file this request.

**Internal Grievance Protections**

A managed care plan must allow a consumer or provider to file for an appeal whenever the plan determines that a service is not medically necessary. The appeal may be filed by calling, writing, or faxing the grievance to the company.

The managed care company must send you a notice within fifteen days, acknowledging receipt of the appeal. It must complete its internal appeal within 30 business days - unless you agree to an extension. The managed care company must send you a written decision about the appeal within 30 business days.

**External Review Protections**

If the insurance carrier denies an internal review, the consumer or provider has the right to file for an external review with the Office of Patient Protection (OPP). When the insurance company sends the denial letter, it should also send forms that you can submit to the OPP.

If an individual files for an external appeal of a denied service, the OPP arranges for an independent external review within 45 days. If OPP overturns the insurance carrier’s denial, the company is required to provide coverage for the denied service.

**Coverage Offered Through Networks of Providers**

Most Massachusetts health carriers sponsor coverage through a network of health care providers and are expected to maintain an adequate network of providers to treat all covered benefits. Each managed care health plan is expected to maintain a list of providers available to treat PANS and PANDAs, that list must be readily available to consumers, providers, and other parties.

“[if] Carriers’ networks do not currently include adequate access to providers who can treat PANDAS and PANS, then Carriers are to cover medically necessary PANDAS and PANS services from out-of-network providers on an in-network basis until such time that an adequate network is developed.”

The Division responds to complaints about network access and when it has determined that a network is inadequate, it has notified carriers that they need to provide access to services from out-of-network providers.

**Complaints**

If any individual believes that any insured health plan is not complying with the requirements of Chapter 260, the individual should file a complaint with the Division of Insurance, through [DOI Insurance Complaint Submission Form | Mass.gov](https://www.mass.gov/forms/doi-insurance-complaint-submission-form) or by calling the Division of Insurance at (617) 521-7794.