Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Medical Necessity Guidelines:

Lyme Disease: Antibiotic Coverage

Effective: September 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation (electronically recommended or by fax)	Yes ☐ No ☒
Notification Required	Yes ☐ No ☒

Applies to:

- Harvard Pilgrim Health Care Commercial products
- Tufts Health Plan Commercial products
- Tufts Health Direct

We recommend submitting prior authorization electronically. If you opt to submit prior authorization requests via fax, please refer to this reference chart for the appropriate fax number (varies by product).
For details on all our products, please visit the Our Plans page on our provider website. For additional Prior Authorization and Notification details on other lines of business not listed on our Medical Necessity Guidelines page, please also reference our Prior Authorization Resources page.

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Overview

Lyme disease is a multisystem inflammatory, tick-transmitted infection caused by the spirochete bacterium Borrelia burgdorferi. Laboratory diagnosis of Lyme disease relies on serologic testing for antibodies to *Borrelia burgdorferi.* The bacterium is carried and transmitted by deer ticks (Ixodes scapularis). In 70 – 80 percent of cases, Lyme disease is characterized by the appearance of a red skin lesion (erythema chronicum migrans), which begins as a small, elevated round spot (papule) that expands to at least five centimeters in diameter. Early signs and symptoms typically occur between three and thirty days and may include low-grade fever, chills, muscle and joint aches, headache, fatigue, and swollen lymph nodes may occur in the absence of rash.

Early disseminated disease occurs within weeks to months after the tick bite and may include: severe headache and neck stiffness, additional rashes on the body, facial palsy, arthritis with sever joint pain and swelling, especially in the knees and other large joints, intermittent pain in tendons, muscles, joints and bone, heart palpitations or irregular heartbeat (Lyme carditis), dizziness or shortness of breath, inflammation of the brain and spinal cord, nerve pain and shooting pains, numbness, or tingling in the hands and feet.

Late disease, occurring months to years after the tick bite, can occur in the absence of any prior features of Lyme disease. In this stage, musculoskeletal symptoms of intermittent arthritis, neurologic disease (peripheral neuropathy or endepthoyelties), and/or cutaneous involvement may be present.

Chronic Lyme disease is a generally an unrecognized diagnosis that encompasses “a broad array of illnesses or symptom complexes for which there is no reproducible or convincing scientific evidence of any relationship to B. burgdorferi infection.” There is no reliable scientific evidence that “chronic” Lyme disease is caused by a persistent infection. It is distinct from post-treatment Lyme disease syndrome, a set of lingering symptoms which may persist after successful treatment of infection with Lyme spirochetes.[2]

According to the CDC, chronic prolonged symptoms of fatigue, body aches, or difficulty thinking can occur in 5-10% of people despite receiving antibiotic treatment. Furthermore, the CDC indicates that studies have shown that more antibiotics are unlikely to help in this chronic stage.[1] The Clinical Practice Guidelines by the Infectious Diseases Society of America,

American Academy of Neurology, and American College of Rheumatology: 2020 Guidelines for the Prevention, Diagnosis, and Treatment of Lyme Disease also recommend against additional antibiotic therapy in patients who have persistent or recurring nonspecific symptoms following recommended treatment for Lyme disease, but who lack objective evidence of reinfection or treatment failure.[3]

This guideline provides guidance regarding how the Plan will (or may) review claims submitted for long-term antibiotic treatment for Lyme disease in accordance with scientific evidence and applicable state mandates.[9,10,11,12]

Note Prior authorization is not required for initiation or continuation of any antibiotic treatment for Lyme disease.

Clinical Guideline Coverage Criteria

The Pan considers **short-term antibiotic treatment (2-4 weeks)** as reasonable and medically necessary for the treatment of Lyme disease when **BOTH** of the following are met:

1. A licensed practitioner documents the Member has Lyme disease based on the Member's clinical presentation or through confirmatory diagnostic testing. Diagnostic testing that supports a clinical diagnosis of Lyme disease is **ONE** of the following[1] (documentation must be provided by an independent, state credentialed diagnostic lab):
    a. Serologic findings by Enzyme-Linked Immunosorbent Assay (ELISA) for B. burgdorferi antibodies and immunoblot (i.e., Western blot) (FDA approved serologic assays that utilize a second EIA in place of western immunoblot assay are acceptable alternatives for the serologic diagnosis of Lyme disease); **or**
    b. Polymerase Chain Reaction (PCR) based direct detection in cerebral spinal fluid (CSF), synovial tissue or synovial fluid; **and**
2. Coverage of antibiotics for the treatment of Lyme disease must be expected, based on medical literature, to be effective in the treatment of Lyme disease; any antibiotic used to treat Lyme must have supporting literature showing that it is effective in vitro or in vivo against borrelia burgdorferi). The antibiotics currently known to be effective in the treatment of Lyme disease, and which will be reimbursable are limited to[3]:
    a. First line agents: doxycycline, amoxicillin, and cefuroxime axetil
    b. Second line agents: azithromycin, clarithromycin, erythromycin

In accordance with State Mandates [9,10,11] the Plan will provide for **long-term (> 4 weeks)** antibiotic treatment for Lyme disease when documentation confirms **ALL** the following:

1. Member must have (or have had) proven Lyme disease. "Proven Lyme disease" can be shown by the clinical diagnosis of a patient by a licensed physician, in conjunction with diagnostic testing that provides supportive data for such clinical diagnosis. Diagnostic testing (documentation must be provided by an independent, state credentialed diagnostic lab) that supports a clinical diagnosis of Lyme disease is by either serologic findings or polymerase chain reaction testing as noted by criteria in 1a or 1b above; **and**
2. A licensed practitioner may prescribe, administer or dispense long-term (> 4 weeks) antibiotic treatment for a therapeutic purpose to eliminate infection or to control a patient's symptoms upon making a clinical diagnosis that the patient has Lyme disease or displays symptoms consistent with a clinical diagnosis of Lyme disease, if such clinical diagnosis and treatment are documented in the patient's medical record by the prescribing licensed physician; **and**
3. Coverage of antibiotics for the treatment of Lyme disease must be expected, based on medical literature, to be effective in the treatment of Lyme disease; any antibiotic used to treat Lyme must have supporting literature showing that it is effective in vitro or in vivo against borrelia burgdorferi). The antibiotics currently known to be effective in the treatment of Lyme disease, and which will be reimbursable are limited to[3]:
    a. First line agents: doxycycline, amoxicillin, and cefuroxime axetil
    b. Second line agents: azithromycin, clarithromycin, erythromycin.

Note:

- Antibiotics for the treatment of Lyme disease other than those listed above as first and second line agents may be covered provided such drug is recognized for treatment of Lyme disease in one of the standard reference compendia, or in the medical literature. To receive reimbursement, prescribers must submit clinical documentation supporting the drug's effectiveness in treating Lyme disease, including the applicable literature if appropriate. Payment for Lyme disease antibiotic treatment will not be denied solely because such treatment may be characterized as unproven, experimental, or investigational
- Clinical evidence does not support the medical necessity of repeat or long-term prolonged courses (i.e., 4 weeks or more) of antibiotic therapy.[3]

Limitations

The Plan considers antibiotic treatment of Lyme or other Tick-Borne Diseases as not medically necessary when the above criteria are not met. In addition, the Plan does not cover:

1. PCR-based direct detection of B. burgdorferi in urine samples
2. Genotyping or phenotyping of B. burgdorferi
3. Determination of levels of the B lymphocyte chemoattractant CXCL13 for diagnosis or monitoring treatment
4. Capture assays for antigens in urine
5. Culture, immunofluorescence staining, or cell sorting of cell wall-deficient or cystic forms of B. burgdorferi
6. Lymphocyte transformation test
7. Quantitative CD57 lymphocyte assays
8. "Reverse Western blots"
9. Measurements of antibodies in joint fluid (synovial fluid)
10. IgM or IgG tests without a previous ELISA/EIA/IFA
11. Treatment of Lyme Borrelia infection when diagnosis is based on invalidated tests including (but not limited to):
    a. Positive Western blot in the absence of a positive or equivocal other antibody test (i.e. not using two tier testing)
    b. Western blot positivity that does not meet CDC criteria
12. Repeat PCR-based direct detection of B. burgdorferi is generally considered not medically necessary
13. Coverage for the treatment of "co-infections" with long-term antibiotics or other treatments not currently supported by the mainstream medical literature will not be covered. Usual standards of medical practice will be used to evaluate the treatment of co-infections and will require demonstrated proof that the member has the infection in question, as documented by appropriate laboratory testing; documentation must be provided by an independent, state credentialed lab. Treatment courses limited to time periods and agents known to be effective based on the usual treatment standards and the current medical literature.

Lyme Disease Testing Reference[1]:

- IgG is considered positive only when 5/10 of the following kDa bands are seen: 18, 23, 28, 30, 39, 41, 45, 58, 66, and 93 kDa. IgM is considered positive only when the IgM is performed within 4 weeks of illness onset, and when 2/3 of the following bands are seen: 23, 39, and 41 kDa.
- For the small proportion of patients who have negative or indeterminate IgM positivity, repeat testing should be performed 2-4 weeks later if suspicion remains high. In those cases, authorization for treatment with parenteral antibiotics will not be delayed pending repeat test results.

References

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10. Rhode Island General Law (RIGL). 27-20-48 Mandatory coverage for certain lyme disease treatments. http://webserver.rilin.state.ri.us/Statutes/TITLE27/27-20/27-20-48.HTM.
11. Treatment of Lyme Disease. UpToDate.com/login [via subscription only]. Published April 29, 2026. Accessed July 7, 2026.

Approval And Revision History

November 2020: Reviewed by Medical Policy Clinical Committee; overview and New Hampshire coverage updated

Subsequent endorsement date(s) and changes made:

- November 17, 2021: Reviewed by IMPAC, for integration purposes between Harvard Pilgrim Health Care and Tufts Health Plan; added note under “clinical coverage criteria” to indicate FDA approve serologic assays utilizing a second EIA in place of a western immunoblot assay are acceptable alternatives for the diagnosis of Lyme disease; under limitations, added criteria for treatment of Lyme Borrelia infection when diagnosis is based on invalidated tests
- December 21, 2021: Reviewed by Medical Policy Approval Committee (MPAC), renewed without changes
- April 7, 2022: Template updated Freedom removed
- December 1, 2022: Reviewed by MPAC, renewed without changes
- September 20, 2023: Reviewed by MPAC, renewed without changes
- November 2023: Rebranded Unify to One Care effective January 1, 2024
- October 17, 2024: Reviewed by MPAC, renewed without changes effective December 1, 2024
- November 21, 2024: Reviewed by MPAC, criteria updated to include short-term antibiotic therapy and updated time frame for long-term antibiotic therapy from 6 months to greater than 4 weeks, effective January 1, 2025
- December 13, 2024: Reviewed and approved by the UM Committee, effective January 1, 2025
- July 16, 2025: Reviewed by MPAC, removed Massachusetts reference to long-term antibiotic therapy, effective September 1, 2025
- August 13, 2025: Fax number for Senior Care Options, Tufts Medicare Preferred HMO and Tufts Medicare Preferred PPO updated; language for Carelink removed and language for Harvard Pilgrim Health Care Stride Medicare Advantage removed as an applicable product from the template
- August 20, 2025: Reviewed by MPAC for annual review, renewed without changes effective October 1, 2025
- July 15, 2026: Reviewed by MPAC for annual review, renewed without changes with administrative update to guideline template, effective September 1, 2026

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.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

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.