# Medical Necessity Guidelines:
# Level of Care, Inpatient (Medical/Surgical)

*Effective: October 21, 2020*

| **Prior Authorization Required**<br>If REQUIRED, submit supporting clinical documentation pertinent to service request. | **Yes ☒ No ☐** |
|---|---|

**Applies to:**

**COMMERCIAL Products**

☒ Tufts Health Plan Commercial products; Fax: 617.972.9409

☒ Tufts Health Freedom Plan products; Fax: 617.972.9409

- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

**TUFTS HEALTH PUBLIC PLANS Products**

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055

☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055

☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404

☒ Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304

*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

**SENIOR Products**

- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List
- Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

**Note:** While you may not be the provider responsible for obtaining prior authorization or providing notification, as a condition of payment you will need to make sure that prior authorization has been obtained or notification has been provided.

Tufts Health Plan requires inpatient notification for certain inpatient admissions. Facilities may also be required to submit clinical documentation for authorization of continued inpatient stays. Please consult the Tufts Health Plan Commercial Provider Manual or the Tufts Health Public Plans Provider Manual for notification and clinical documentation submission requirements. Information on authorization and notification requirements is also available in the payment policies for the services listed below; these policies are available in the Provider Resource Center on the Tufts Health Plan website.

Tufts Health Plan uses InterQual® criteria for determining medical necessity for the following levels of care:

- **Acute inpatient services**
- **SNF services**
- **Rehabilitation services**

McKesson InterQual® Criteria are nationally recognized medical necessity criteria developed by a clinical research staff, which includes physicians, registered nurses, and other health care professionals. The clinical content of the criteria is annually reviewed, updated, and validated by a national panel of clinicians and medical experts, including those in community and academic practice settings, as well as within the managed care industry throughout the United States.

Tufts Health Plan requires the use of an InterQual SmartSheet to obtain prior authorization for select inpatient and outpatient surgeries and procedures and select durable medical equipment. Please see the specific medical necessity guidelines for these services, available in the Provider Resource Center on the Tufts Health Plan website.

## APPROVAL HISTORY

September 14, 2016: Reviewed by the Integrated Medical Policy Advisory Committee (IMPAC).

Subsequent endorsement date(s) and changes made:

- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- June 14, 2017: Reviewed by IMPAC, renewed without changes
- October 10, 2018: Reviewed by IMPAC, renewed without changes
- October, 2018: Template and disclaimer updated
- October 16, 2019: Reviewed by IMPAC, renewed without changes
- October 21, 2020: Reviewed by IMPAC, renewed without changes
- November 4, 2020: Fax number for Unify updated

## 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.

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.

Provider Services