

## Medical Necessity Guidelines: Pre-Operative Day Authorization

Effective: October 21, 2020

<b>Prior Authorization Required</b> If <u>REQUIRED</u> , submit supporting clinical documentation pertinent to service request.	<b>Yes</b> <input checked="" type="checkbox"/> <b>No</b> <input type="checkbox"/>
<p><b>Applies to:</b></p> <p><b>COMMERCIAL Products</b></p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Tufts Health Plan Commercial products; Fax: 617.972.9409</li> <li><input checked="" type="checkbox"/> Tufts Health Freedom Plan products; Fax: 617.972.9409</li> <li>• CareLink<sup>SM</sup> – Refer to <a href="#">CareLink Procedures, Services and Items Requiring Prior Authorization</a></li> </ul> <p><b>TUFTS HEALTH PUBLIC PLANS Products</b></p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 888.415.9055</li> <li><input checked="" type="checkbox"/> Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055</li> <li><input checked="" type="checkbox"/> Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404</li> <li><input type="checkbox"/> Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304</li> </ul> <p>*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.</p> <p><b>SENIOR Products</b></p> <ul style="list-style-type: none"> <li>• Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the <a href="#">Tufts Health Plan SCO Prior Authorization List</a></li> <li>• Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the <a href="#">Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List</a></li> </ul>	

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

### OVERVIEW

This guideline establishes the procedures and guidelines for the authorization of pre-operative inpatient hospital days for certain clinical scenarios. This document addresses bowel preparation, angiogram, parenteral drug intervention (coumadin conversion) and intravenous hydration.

### CLINICAL COVERAGE CRITERIA

All requests for coverage of pre-operative inpatient hospital days will require review and prior authorization by a Tufts Health Plan precertification nurse, using the following guidelines. Requests that do not meet these guidelines for coverage will be reviewed with a Tufts Health Plan medical director.

A Tufts Health Plan precertification nurse may authorize coverage for a pre-operative inpatient hospital day for Members undergoing one of the following procedures who meet **one** of the clinical guidelines listed below:

- **Pre-operative inpatient day for bowel preparation:**
  - Member requires a bowel preparation that must be administered through a nasogastric tube. Examples of these types of situations include the following:
    - a. A child unwilling or unable to take the bowel preparation by mouth.
    - b. An adult who has been unable to tolerate (or been ineffectively prepared by) two different outpatient preparation regimens administered orally and/or with enemas/cathartics.
  - Member has a medical condition that requires intensive treatment and/or ongoing skilled monitoring during the bowel preparation (e.g., requires central venous pressure monitoring of fluid status, frequent vital sign monitoring, or frequent assessment of blood electrolytes), such that bowel preparation cannot be done safely in the home.
  - Member has an anatomic abnormality requiring ongoing skilled care during the bowel preparation that is beyond the scope of a visiting home care nurse (e.g., stomas, fistulas, or pouches that require irrigation via catheters and/or collecting systems).
  - Member with possible partial bowel obstruction.

- **Pre-operative inpatient hospital day for angiogram:**
  - Angiography pre-operatively for an inpatient surgical procedure.
  - Infants less than one year with cyanotic heart disease or sickle cell anemia.
  - For IV hydration prior to angiogram when the Member is diabetic with creatinine of 1.7 or higher or when member is not diabetic with creatinine of 3.5 or higher.
- **Pre-operative day for coumadin to heparin conversion:**
  - Member requires one pre-operative day for conversion of coumadin to IV heparin with monitoring of clotting times prior to an inpatient surgical procedure.

**Note:** If more than one day requested, refer case to a Medical Director.
- **Pre-operative day for intravenous hydration:**
  - Member requires intravenous hydration prior to a liver resection
- **Pre-operative day for intravascular monitoring and/or interventions (including intravenous medications, fluids, electrolytes, a-lines):**
  - Member at risk for or has hemodynamic instability, fluid and/or electrolyte abnormalities or renal insufficiency.

#### **LIMITATIONS**

None applicable

#### **APPROVAL HISTORY**

December 1, 2009: Reviewed by Medical Policy Medical Affairs and approved for December 1, 2009 effective date. This MNG replaces Document #1035202, which was retired December 2009.

Subsequent endorsement date(s) and changes made:

- December 2010: Reviewed by Medical Policy, no changes
- December 14, 2011: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC), no changes
- December 12, 2012: Reviewed by IMPAC, no changes
- December 11, 2013: Reviewed by IMPAC, renewed without changes
- September 17, 2014: Adopted by Tufts Health Plan – Network Health Commercial Plans and Tufts Health Plan – Network Health Medicaid Plans.
- November 19, 2014: Reviewed by IMPAC, renewed without changes
- August 12, 2015: Reviewed by IMPAC, renewed without changes
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- September 14, 2016: Reviewed by IMPAC, renewed without changes
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- August 9, 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 24, 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.

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