Utilization Management Guidelines

The Commercial Provider Manual applies to Commercial products (including Tufts Health Freedom Plan).

Introduction
Tufts Health Plan’s utilization management (UM) guidelines are intended to help physicians, hospitals, and other providers plan and manage care in an efficient manner with high quality standards.

Role of Plan Provider
Plan providers are expected to coordinate fully with reviewers and Tufts Health Plan staff when sharing clinical information concerning members under their care. This includes the following:

- Following authorization procedures for inpatient notification as outlined in the Authorization Policy
- Following policies for services subject to prior authorization
- Cooperating with hospital and Tufts Health Plan staff concerning care management and discharge planning activities
- Responding within the requested timeframe regarding questions that arise during the process of conducting utilization review (including the member appeals process) and care management
- Complying with confidentiality requirements detailed in the Providers chapter of this manual

Refer to the Providers chapter in this manual for information regarding the provider appeal process and confidentiality of member medical records.

Utilization Management Program
Tufts Health Plan’s Utilization Management Program includes the evaluation of requests for coverage by determining the medical necessity, appropriateness and efficiency of the health care services under the applicable health benefit plan. UM services will be provided where licensed or permissible under state and federal law, or other regulatory authority.

The Senior Vice President/Chief Medical Officer (CMO) has senior level executive responsibility for UM and reports directly to the President and Chief Operating Officer (COO). Plan providers supply input to the program through consultative and ad hoc provider groups brought together to help develop specific programs.

The staff within the Utilization Management Program reviews coverage requests for the following services:

- Inpatient care
- Outpatient care
- Home care
- Prescription drugs
- Assisted reproductive technologies (ART)
- Durable medical equipment (DME)
- Select surgical procedures
- Behavioral health services, including both behavioral health and substance use disorder (BH/SUD) services

Tufts Health Plan adheres to the following guidelines when administering its Utilization Management Program:

1 Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is the primary administrator.
• It is the responsibility of the attending provider to make clinical decisions regarding medical treatment. These decisions must be made consistently with generally accepted principles of professional medical practice and in consultation with the member.
• It is the responsibility of Tufts Health Plan to determine benefit coverage based on the member's benefit document. Tufts Health Plan uses medical necessity guidelines/utilization review criteria, if applicable, to evaluate requests for coverage.
• All utilization review decisions to deny coverage are made by qualified, licensed physicians, or when appropriate and when allowable by law, by licensed health care professionals with expertise in the specialty for which services are being requested.

**Note:** Doctoral-level psychologists can render denial of coverage decisions for BH/SUD services unless the requesting provider is a licensed physician; in which case, a licensed physician must render the denial of coverage decision.

• Tufts Health Plan does not compensate individuals conducting utilization review for issuing denials of coverage, and it does not provide financial incentives for UM decision-makers to encourage denials of appropriate coverage. Financial incentives for utilization review do not encourage decisions that result in underutilization. UM decision-making is based on medical necessity, applicable coverage guidelines and appropriateness of care and service.

### Medical Necessity Guidelines
Tufts Health Plan determines benefit coverage for the benefits described in each member’s product description by using Medical Necessity Guidelines (MNGs) to determine the medical necessity and appropriateness of health care services under the applicable health benefit plan. These utilization review MNGs are:

- Developed with input from Tufts Health Plan practicing physicians and external specialty physicians
- Developed in accordance with standards adopted by national accreditation organizations and regulatory agencies
- Reviewed on an annual basis and updated as new treatments, applications and technologies are adopted as generally accepted professional medical practice
- Evidence-based, if such evidence is available
- Applied in a manner that considers the individual health care needs of the member

Tufts Health Plan also utilizes some commercially purchased criteria. The use of these criteria is also reviewed in the manner described above.

Tufts Health Plan’s MNGs do not replace Medicare Coverage Guidelines and are not to be used by providers when making coverage determinations for Commercial members. MNGs are available on the public Provider website or by calling Provider Services at 888.884.2404 to request a printed copy.

### Medical Technology Assessment Process
The Tufts Health Plan Medical Technology Assessment Process evaluates emerging and new uses of existing technologies and medical interventions, including those for behavioral health services, to determine safety and effectiveness. Tufts Health Plan uses information gathered from the Hayes, Inc. Technology website and Hayes Reports, published/peer-reviewed scientific literature, national consensus guidelines, the FDA, other regulatory bodies, and internal and external expert consultative sources in its evaluation efforts.

The process involves two interrelated committees:

- The Medical Specialty Policy Advisory Committee (MSPAC) consists of Tufts Health Plan Medical Affairs Department physicians and external specialist physicians who evaluate new technologies and procedures, as well as new uses of existing technologies and procedures, for safety and effectiveness. The committee’s findings are discussed by the Medical Affairs Department Physician for Medical and Payment Policy and members of the Medical Policy Department.
- The Medical Affairs Medical Policy Committee (MAMP) consists of Tufts Health Plan Medical Affairs Department physicians and representatives from the Medical Policy, Precertification Operations, Appeals and Grievances and Pharmacy Departments. Topics requiring review that cannot be addressed at the MSPAC meeting are brought to this committee.
In consultation with Tufts Health Plan’s CMO, the above-referenced committees make the final determinations as to whether the procedure, service or supply will be a covered benefit and if so, whether coverage will be subject to prior authorization. The program manager for Commercial products and the Medical Policy Department are responsible for the development of the MNGs associated with these coverage decisions.

**Time Frames for Utilization Review Determinations of Coverage**

Tufts Health Plan’s UM decision and notice requirements are developed consistent with applicable state and federal laws and regulations and accreditation standards. Refer to the [Utilization Review Determinations Timeframe for Commercial Products](#) for information about decision and notification time frames.

**Written Notice of Authorization of Coverage**

Authorization notices contain a reference number and the appropriate dates and/or number of days/units of services authorized. Notices for continuation of services indicate the number of days, units, or services approved.

**Written Notice of Denial of Coverage Determination Requirements**

The written notification of a denial of coverage determination based upon medical necessity includes:

- The specific clinical rationale for the determination
- A description of the member’s presenting symptoms or condition, diagnosis, and treatment interventions
- Alternative treatment options/services covered under the member’s plan, if any
- A description of the member's appeal rights and how to initiate an appeal

**Written Notice of Denial of Payment Requirements**

The written notice outlines the reasons for payment denial and the instructions on how to initiate a provider appeal.

**Reconsideration**

Providers have the opportunity to seek reconsideration of an initial or concurrent denial of coverage decision from a board-certified, actively practicing, clinical peer reviewer in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review. This reconsideration process occurs within one working day of the receipt of the request and is conducted between the provider rendering the service and the clinical peer reviewer or clinical peer designated by the clinical peer reviewer if said reviewer cannot be available within one working day. If the denial of coverage determination is not reversed by the reconsideration process, the provider may pursue the appeals process on behalf of the member. The reconsideration process is not a prerequisite to the formal standard and expedited appeals processes.

When an adverse determination is made, Tufts Health Plan will notify the treating provider or his/her office staff by phone to inform them that a Medical Affairs Department physician or his/her designee is available to discuss the decision.

For prospective and concurrent adverse determinations for members covered under a Massachusetts fully insured plan, if the peer-to-peer conversation does not resolve differences of opinion, the provider may request the opportunity to seek reconsideration of the initial adverse determination.

Tufts Health Plan will facilitate the reconsideration process with a Massachusetts board-certified, actively practicing physician or healthcare professional of the same or similar specialty that typically manages the medical condition, procedure, or treatment, who was not involved in the initial adverse determination. The reconsideration process will occur within one business day of the request. If the initial adverse determination is overturned upon reconsideration, written notice of the decision will be sent.

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2 Applies to Massachusetts providers only.
If the reconsideration process does not reverse the adverse determination, the provider or member may pursue the expedited or standard appeal process. The reconsideration process is not a prerequisite to the expedited or standard appeal process.

Access and Coverage System for Medical Affairs Department Physicians
A Tufts Health Plan Medical Affairs Department physician will be available either in person or readily accessible by telephone to perform utilization review (UR) or other clinical consults for all Tufts Health Plan’s UM staff. This coverage will be provided Monday through Friday from 8:30 a.m. to 5 p.m. in accordance with Tufts Health Plan’s standard business hours. Additional coverage is provided in accordance with individual account contracts.

Weekend coverage for Medicare D pharmacy expedited requests is provided on Saturday and Sunday from 8 a.m. to 5 p.m.

Tufts Health Plan Medical Affairs Department physicians are available within one business day to discuss coverage determinations with the attending physician or ordering provider.

Tufts Health Plan Medical Affairs Department physicians will conduct all outbound communication within standard business hours. These physicians will identify themselves by name, title, and organization name when initiating or returning calls regarding UM issues.

Role of Provider Unit Physician Reviewers (Massachusetts and New Hampshire)
Many provider units have a physician reviewer. The physician reviewer works collaboratively with Tufts Health Plan care managers and Medical Affairs Department physicians to facilitate care management of Tufts Health Plan members throughout the continuum of care.

Tufts Health Plan physician reviewers are expected to:
- Be health care professionals who are qualified, as determined by the Plan, to render a clinical opinion about clinical conditions and treatments under review; physician reviewers are also required to maintain an active unrestrictive license as a medical or osteopathic doctor
- Receive training from Tufts Health Plan personnel regarding Tufts Health Plan policies and procedures
- Serve as a resource for primary care providers (PCPs) and specialty care physicians in the provider unit regarding resources that are available within Tufts Health Plan and the medical community
- Review and authorize/deny out of area service requests by Provider Units for members using Tufts Health Plan MNGs/approved commercially purchased criteria

Outpatient Services Review
Outpatient service review is performed in a number of ways. For all Commercial products, except Preferred Provider Organization (PPO), the PCP directs and manages member access to most specialty care based on clinical need. Using electronic or written authorization to a specialist, the PCP specifies the maximum number of times that a member can be seen for evaluation, testing, and treatment. The specialist is expected to communicate findings to the PCP and seek authorization for further treatment and, if necessary, additional referrals.

In addition, Tufts Health Plan reviews and manages certain outpatient services. These include the following:
- All services included on the prior authorization list
- Assisted reproductive technology (ART)
- Home care
- Oral surgery
- Outpatient BH/SUD services
- Outpatient physical, occupational, and speech therapy
- Select durable medical equipment (DME)
- Select injectable drugs
• Select pharmacy medications
• Select surgical procedures

**Retrospective Code Review**
Utilization reports are used to retrospectively review outpatient services. These reports identify aberrant patterns of care. Further analysis occurs and action steps are taken with the provider unit as indicated. Broad claims issues are also identified and administratively addressed by the Plan.

**Inpatient Notification**
Inpatient notification of all elective, urgent and emergency admissions, at acute hospitals and extended care/long-term acute care, acute rehabilitation and skilled nursing facilities is required for all Commercial products.

For facilities under a diagnosis-related group (DRG) arrangement, the inpatient notification process applies the Truven Health Analytics tables.

For facilities under a non-DRG arrangement, an authorized initial length of stay and an authorized end date will be assigned for inpatient admissions.

An inpatient notification does not take the place of a referral or prior authorization requirements for a service and is subject to eligibility\(^3\) and benefit verification.

Prospective utilization review for coverage of inpatient services is conducted for selected procedures, diagnoses or facilities. These include review of the following:

• Transplants
• Preoperative inpatient hospital days (for facilities with a non-DRG arrangement only)
• Selected procedures and diagnoses to determine appropriateness and/or place of service
• Admissions resulting in an initial length of stay of zero days
• All extended care inpatient admissions.

**Note:** All intermediate levels of care require registration through the Behavioral Health Department.

For additional information, refer to the [Authorization Policy](#) on our website.

**Prospective and Concurrent Utilization Review of Inpatient Services**
Decision and notification time frames are described in detail in the Tufts Health Plan [Utilization Review Determinations Time Frames](#).

**Medical Care Management and Discharge Planning**
Registered nurse care managers and Care Management care coordinators staff the Care Management Department. Care management, including UM, is performed for contracting facilities either by telephone or on-site. Using nationally recognized clinical criteria, the care manager performs inpatient review and determines whether the case should be referred to a Tufts Health Plan Medical Affairs Department physician for review. Care managers also coordinate coverage decisions for discharge planning and assist with transition to contracted providers for the most appropriate next level of care. Members with multiple comorbidities and/or complex care needs, or those who are likely to incur future hospitalizations or emergency room visits, are referred to the Tufts Health Priority Care triage for possible enrollment. Additional programs following discharge care management include Healthy Birthday and Transition to Home, detailed in the Commercial Care Management section of this chapter.

Medical necessity criteria are used to evaluate the following:

• Severity of the member’s illness
• Type and intensity of the service provided
• Level of care

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\(^{3}\) Eligibility may be subject to retroactive reporting of disenrollment.
An example of an inpatient coverage determination that Tufts Health Plan performs is a “criteria-not-met.” A “criteria-not-met” determination is a request for inpatient level of care that does not meet medical necessity criteria for the requested level of care. Such cases are referred to a Tufts Health Plan Medical Affairs Department physician for a coverage determination. This determination may result in a denial of coverage to the member and, consequently, a denial of payment to the hospital and/or physician.

Coverage denial decisions do not preclude the member from obtaining a service or supply, or the provider from recommending them to the member. Clinical decisions regarding the member’s care are solely the responsibility of the member and the attending provider. However, the provider will be held financially liable for the noncovered service/supply unless the member specifically agrees in advance to pay for the service/supply. The provider’s agreement with the member must meet the terms of the provider health agreement through which the provider participates with Tufts Health Plan.

Documentation that the member has agreed in advance to pay for these noncovered services is subject to review by Tufts Health Plan. Refer to the sample waiver language in the Authorizations chapter of this manual.

To effectively perform telephonic reviews, Tufts Health Plan needs to receive clinical information within the requested time frame to meet regulatory and accreditation requirements. Failure to provide the requested clinical information within the requested time frame will result in a denial of payment to the provider (administrative denial). In such instances, the member cannot be billed for the denied claim.

To determine correct reimbursement levels, Tufts Health Plan also conducts reviews of some inpatient services. For example, requests for inpatient services upon review may be able to be provided at outpatient level of care, such as observation or surgical day care. In addition, Tufts Health Plan conducts reviews to determine whether the services are provided or arranged in an efficient manner. For information regarding these types of reviews, refer to the Payment Policies on our website. These policies are intended to provide Tufts Health Plan’s providers, and both inpatient and outpatient facilities, with information on benefits, billing, and reimbursement for services. To ensure accurate claims processing, it is recommended that providers follow these documented policies and/or distribute to office staff on a regular basis.

Data Requirements: Clinical Information

- Clinical information to support the appropriateness and level of service proposed
- History of presenting problem
- A clinical exam
- Diagnostic testing results
- Treatment plans and progress notes
- Patient psychosocial history
- Information on consult with treating practitioner
- Evaluations from other health care practitioners and providers
- Photographs (if applicable)
- Operative pathological reports
- Rehabilitation evaluations
- Anticipated discharge plan
- Contact person for detailed clinical information

Commercial Care Management Programs

Tufts Health Plan offers a suite of care management programs aimed at improving the quality of life for members, helping them with complex conditions such as high-risk pregnancy, stroke, multiple trauma, cancer, rare diseases, behavioral health issues, transplant and complex pediatric conditions. Our approach to care enables us to focus our efforts not only on areas where we can impact quality and cost, but also in areas where we can complement the physician’s plan of care and make the most difference in our members’ lives. The care management programs are available to all Commercial products and based on program criteria for the populations serviced. The care management programs are provided at no cost to the member, and choosing to participate, or not, has no impact to eligible member benefits.
**Referral for all Commercial care management programs:**

Refer to all Commercial care management programs by any of the following options:

- Call: 1.888.766.9818 ext. 53532
- Fax: 617.972.9470
- Email: PriorityCareReferral@tufts-health.com

Tufts Health Plan is committed to our partnership with our providers and members, and has made the following programs available:

**Complex Care Management (Tufts Health Priority Care Program)**

The Tufts Health Priority Care Program (Priority Care) is designed to optimize wellness for Commercial adult and pediatric members with the most complex of medical needs while reducing hospital admissions and emergency room visits. This telephonic program is based on a proactive complex nurse care management approach integrating comprehensive evidence-based assessment of medical, behavioral health and community needs. Collaboration on the identified care opportunities, supports development of a member centered, prioritization care management plan with achievable health goals. With a small percentage of Tufts Health Plan members accounting for a large percent of the medical costs, priority care complex nurse care manager helps focus medical management efforts on members whose care can be impacted the most. Members are supported by telephonic interventions for four to six months or more.

**Identification of Members**

We identify medically complex members at risk for future hospitalization or high health care costs through predictive software and direct referral.

- Physicians, nurse practitioners, medical directors, behavioral health staff, transition manager registered nurses (RNs) and UM RNs identify the majority of members who warrant complex care management.
- Members are identified following admission to an acute or rehabilitation hospital for a complex medical or behavioral health episode or a catastrophic medical event.
- Members who participate in the Population Health (disease management) program and have more complex care management needs are referred to Priority Care.
- Members with complex needs may be referred into Priority Care from employers, medical providers and other Tufts Health Plan programs.
- Members are welcome to self-refer as well.

Complex medical conditions include but are not limited to members with the following:

- Stroke
- Transplant
- Brain injury
- Spinal cord injuries
- Substance use disorders
- Cancer diagnoses
- Complex gastrointestinal conditions
- Chronic rare diseases such as multiple sclerosis and amyotrophic lateral sclerosis
- Pediatric complex illness
- Medical conditions complicated by significant behavioral health concerns
- Diabetes with complex complications
- Members whose diseases do not fall into these specific categories, but are likely to use a high level of medical resources

**Healthy Birthday Program**

Tufts Health Plan’s Healthy Birthday program supports the member with high-risk pregnancy due to the potential for preterm labor or those with an underlying complex medical condition. Conditions may include, but are not limited to, diabetes, cardiac disease, multiple sclerosis, gestational diabetes and hypertension.
Utilization Management Guidelines

Early identification through direct referral by the obstetrician office is the primary means of member engagement. UM RNs refer members with high-risk pregnancies when identified during an inpatient admission.

Obstetrical providers may refer to the Healthy Birthday program by any of the following options:

- **Call:** 888.766.9818 ext. 53532
- **Fax:** 617.972.9470 (OB Risk Assessment Form)
- **Email:** PriorityCareReferrals@tufts-health.com

Members may self-refer to 888.766.9818 ext. 53532. In addition, members are able to access a member-friendly self-referral OB Risk Assessment Form on tuftshealthplan.com.

This telephonic program is based on a proactive care management approach integrating comprehensive evidence-based assessment of medical, behavioral health and community needs. Collaboration on the identified care opportunities supports development of a member-centered, prioritization care management plan with achievable health goals. During telephonic outreach the obstetrical complex nurse care managers, will focus on such topics as pregnancy education, signs and symptoms of preterm labor, fetal growth and development and medical condition management during pregnancy.

**Tufts Health Priority Newborn Care Program**

Commercial members with infants admitted to a Level III or Level II NICU for an anticipated stay of greater than 72 hours are contacted by a pediatric complex nurse care manager. The complex care manager will assist the family with understanding the discharge plan and follow up medical care needs as they prepare to transition home with their baby. The complex care manager will continue transition care for the infant and family up to 30 days after discharge to home. Infants who require support beyond 30 days are enrolled in the Priority Care Program with the same complex care manager to ensure continuity of care.

**Transition to Home Program**

Members with selected medical and/or behavioral health diagnoses or conditions that are likely to result in readmission are contacted by a complex care manager within 24 to 48 hours of hospital discharge. This post-hospitalization intervention focuses on medication, discharge plan adherence and follow-through on physician appointments. Program enrollment may span 30 to 45 days. Members with greater complex medical needs are enrolled in the Priority Care Program. The Priority Care Program is not sequential. Complex members are moved to Priority Care Program as soon as identified, which is usually immediately during or post-initial contact. Members are identified and referred to the Transition to Home program by the Tufts Health Plan utilization manager RNs and on-site transition manager RNs.

Members with less complexity following inpatient discharge may receive outreach from a transition coordinator. This paraprofessional will contact the member over a period of 10 days to ensure the transition home is as expected. The transition coordinator supports activities such as scheduling of after-care visits, providing necessary community resources and connecting the member with the nurse care manager for all medical related needs.

**The Complex Care Management Intervention**

Enrolled members receive comprehensive whole person management, which allows integration and support for members’ total medical and/or behavioral health care and treatment plans. The Complex Care Manager conducts an evidence-based assessment and collaborates with the member and caregivers to identify achievable health goals, education needs, community services, and coordination of care.

In addition to intensive care management, the complex care manager employs coaching and teach-back methods to support improved self-management, influence health behaviors and improve member-physician communication. Members are screened for depression and behavioral health concerns and supported with coordination of care as needed. Throughout the program, the member and the complex care manager identify a schedule and frequency of calls tailored to the member’s needs. We contact the member’s physician throughout the program to support and integrate the physician’s plan of care.

Refer to all Commercial care management programs by any of the following options:
Chronic Kidney Condition Program
The Tufts Health Plan Chronic Kidney Condition Program is designed to improve care for members with chronic kidney disease (CKD) and end stage renal disease by reducing hospitalizations and emergency room visits. It includes the following components:

- Telephone-based care management to optimize care based on disease stage
- RN contact and individualized care plans
- Physician contact and care plan updates
- Assistance with benefits
- Referrals to other health programs and community services, as needed

The program is available to Tufts Health Plan Commercial members who have been diagnosed with CKD, stages 3 through 5. Members are identified through claims data or can be referred into the program by a care manager, physician or via self-referral.

An RN care manager, with expertise in renal management, works closely with members and their families/caregivers to complement the member’s plan of care. Members enrolled in the program receive education about kidney disease, guidance to improve self-management and facilitated care during their treatment.

Referral for all Commercial Care Management programs
Submit referrals to the Commercial care management program at 888.766.9818 ext. 53532.

Leave the member’s name, Tufts Health Plan ID number, member phone and/or email contact information, reason for referral, as well as your name and contact information.

Behavioral Health and Substance Use Disorder Care Management Programs
Referrals for the following behavioral health and substance use disorder (BH/SUD) care management programs can be made by calling the Behavioral Health Department at 800.208.9565.

Transition to Home Program
The Transition to Home Program is a resource for patients who have been recently hospitalized with a psychiatric diagnosis and require additional help to get back on their feet, follow-through with aftercare plans, or someone to talk to about any questions they may have.

Behavioral Health and Medical Integration Program
BH care management services are provided for members with coexisting medical and BH conditions. Some medical conditions can be exacerbated by BH issues and can worsen if not addressed. The BH integration program works with members to address BH issues that may be impacting their physical health.

Emergency Department Aftercare Program
In collaboration with the Behavioral Health and Medical Integration Program, Tufts Health Plan offers the Emergency Department (ED) Aftercare Program. Many members make repeated visits to the ED with medical symptoms for which a medical cause cannot be identified; often there is a BH component that has not been addressed.

In an effort to reduce unnecessary ED use and assist members with obtaining appropriate care, the ED aftercare program will assign a medical or BH care manager, as appropriate, to work with members to follow ED discharge instructions. The care manager will direct members to appropriate services to address issues that may be contributing to ED visits, and also assist with crisis planning so they are better equipped in the future to address situations that do not require a visit to the ED.

Substance Use Transitions Program
The Substance Use Transitions Program provides support to members who are in early recovery from the use of opiates, alcohol or other substances.
The program typically includes members who have recently entered or completed acute treatment in a hospital or residential treatment center for a diagnosis of a SUD. Care managers work with members to understand and follow through with aftercare plans and begin to take charge of their recovery.

The program also works with members who have recently needed medical care for an illness related to substance use. This includes members who have gone through detoxification in a medical unit, have been hospitalized due to a medical condition during which substance use problems were identified, or for medical problems that were caused or worsened by substance use. Care managers help to coordinate the different programs, providers and facilities involved with the member's care and help to establish goals and a plan to move forward.

The Tufts Health Plan Substance Use Disorder Navigator assists members, their families and their providers to find resources that will help them to keep moving forward on the road to recovery. The Navigator will provide information on treatment programs, and also community resources available to help support the member and his/her family. For additional information, contact the Substance Use Disorder Navigator at 617.972.9400, ex. 54013.

**Concurrent Adverse Determination of Inpatient Coverage (Termination of Benefits)**

Tufts Health Plan care managers may refer questions regarding the concurrent inpatient (including acute care, extended care, and BH/SUD intermediate level of care services) treatment plan to Medical Affairs Department providers. The Medical Affairs Department provider may speak with the attending provider to clarify the treatment plan or discuss the need for care management services.

Upon case referral, the Medical Affairs Department provider may conduct a concurrent inpatient utilization review coverage determination, in accordance with applicable law and accreditation standards. Concurrent adverse determinations for payment to the provider and facility may be rendered by a Medical Affairs Department provider in instances where clinical review criteria are not met. In these instances, the member is generally not held responsible for payment due to the “member hold harmless” clause in Tufts Health Plan provider contracts.

**Processing Claims for Emergency Department Services**

This section sets forth guidelines for providers and the Claims department on how to process claims for services rendered in an ED, which are covered when a member seeks care because he/she believes that his/her condition requires emergent medical attention. This can be related to a medical and/or a BH symptom or condition.

1. An ED claim is received by Tufts Health Plan via paper UB-04 or CMS 1500 form or electronic equivalent.
2. Outpatient UB-04 and CMS 1500 claims with an ED line will be entered into the claim system with an “emergency” place of service (13).
3. The referral tables in the claim system will allow these “emergency” claims with place of service 13 to pay without a referral requirement.

The claim will automatically be paid provided member eligibility and benefits on the date of service, coordination of benefits, and adherence to plan policies and procedures and claims editing logic, but is subject to audit based upon application of the “prudent layperson.”

**Definition of Emergency**

*Tufts Health Plan Commercial Products:* The following definition is generally used in connection with most Tufts Health Plan products. However, the specific Tufts Health Plan benefit document should always be consulted for the exact definitions used for a particular product or client.

**Benefit Document Definition**

An illness or medical condition, whether physical or mental, which manifests itself by symptoms of sufficient severity (including severe pain) for which the absence of prompt medical attention could reasonably be expected by a prudent layperson (who possesses an average knowledge of health and medicine) to result in:

- Serious jeopardy to the physical and/or mental health of a member or another person (or with respect to pregnant member, the member's or her unborn child's physical and/or mental health)
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Inadequate time for pregnant women experiencing contractions to effect a safe transfer to another hospital before delivery, or a threat to the safety of the member or unborn child in the event of transfer to another hospital before delivery

Some examples of illnesses or medical conditions requiring emergency care are severe pain, a broken leg, loss of consciousness, vomiting blood, chest pain, difficulty breathing, or any medical condition that is quickly worsening.

**Emergency Services “Prudent Layperson” Standards**

In accordance with applicable laws and accreditation standards, Tufts Health Plan provides coverage for emergency medical conditions that meet the “prudent layperson” standard. Tufts Health Plan benefit documents, member handbooks, policy manuals, and other printed materials clearly state that members have the option of calling the emergency telephone access number 911, or the local equivalent, or proceeding to the nearest facility whenever faced with a medical condition they believe to be an emergency. Tufts Health Plan provides coverage for medical and transportation expenses incurred as a result of emergency medical conditions that meet the “prudent layperson” standard.

**In-Plan Treatment**

If the member is in the Tufts Health Plan service area, Tufts Health Plan staff works with the provider as part of our standard UM protocol to review requests for additional medically necessary treatment. Situation examples include the following:

- If the member is being admitted for inpatient care, the Tufts Health Plan standard preregistration processes must be followed. The member’s PCP will be notified, if on file. Tufts Health Plan Precertification Operations Department staff will notify the admitting physician of the inpatient notification number.
- If the member requires outpatient services (occupational or physical therapy, BH/SUD services, etc.), Tufts Health Plan standard outpatient processes must be followed. Where applicable, PCP referral and prior authorization procedures are followed. These procedures are outlined in the Tufts Health Plan Provider Manual.
- If the member requires home health care services, a Tufts Health Plan care manager will work with the requesting provider (with authorization from the member's PCP, where applicable) to put medically necessary skilled services in place.

**Out-of-Plan Treatment**

- If the member is hospitalized outside the Tufts Health Plan service area, a Tufts Health Plan care manager will work with the treating physician and the member's family to determine the most appropriate next level of medically necessary care and coordinate its delivery and reimbursement at a place and location that Tufts Health Plan deems to be most clinically and financially appropriate at that time.
- Further, the care manager will continue to coordinate appropriate care delivery in consultation with the treating providers and the member, and at such a time as Tufts Health Plan determines it to be safe and in the best interest of the member, efforts will be made to transition the member's care to providers within the Tufts Health Plan network.