Utilization Management Guidelines

Introduction
Tufts Health Plan’s utilization management (UM) guidelines are intended to help 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
- Coordinating 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 as 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 and outpatient care
- Home care services
- 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 UM Program:

- 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.

MNGs are 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
- Description of the member’s appeal rights and how to initiate an appeal

**Written notice of denial of payment requirements:** The written notice includes but is not limited to:

- The specific clinical rationale for the denial
- A description of the member’s presenting symptoms or condition, diagnosis, and treatment interventions
- Description of the provider appeal rights and how to initiate an 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.

**Note:** The reconsideration process is not a prerequisite to the formal standard and expedited appeals processes.

If an adverse determination is made, Tufts Health Plan notifies the treating practitioner or his/her office staff by phone to inform them that a Medical Affairs Department practitioner 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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1 Applies to Massachusetts plans only.
Utilization Management Guidelines

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.

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

The Medical Affairs Department physicians will conduct all outbound communication within standard business hours and 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 unrestricted 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 is required for all elective, urgent and emergency admissions to acute care, extended care/long-term acute care, acute rehabilitation and skilled nursing facilities. All inpatient admissions require inpatient notification prior to services being rendered, except for urgent or emergency care. Admitting providers and facilities are responsible for notifying Tufts Health Plan, following the procedures outlined in the [Authorizations] chapter of the Commercial Provider Manual and in accordance with the following time frames:

• Elective admissions must be reported no later than five business days prior to admission
• Urgent or emergency admissions must be reported by 5 p.m. the next business day following admission.

For facilities under a diagnosis-related group (DRG) arrangement, authorization for coverage of DRG inpatient services is determined using Tufts Health Plan and nationally-recognized medical necessity guidelines and criteria published by Truven Health Analytics. For facilities under a non-DRG arrangement, an authorized initial length of stay and an authorized end date will be assigned for inpatient admissions.

Note: An inpatient notification is a condition of payment and does not take the place of referral or prior authorization requirements for services; it is subject to eligibility² and benefit verification.

Prospective utilization review for coverage of inpatient services is conducted for selected procedures, diagnoses or facilities. These include, but are not limited to:

• 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: Except as otherwise required by law, BH/SUD intermediate levels of care require authorization through the Behavioral Health Department. For additional information, refer to the Authorization Policy on the Tufts Health Plan website.

Prospective and Concurrent Utilization Review of Inpatient Services

Decision and notification time frames are described in detail in the Tufts Health Plan Commercial 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

² Eligibility may be subject to retroactive reporting of disenrollment.
Utilization Management Guidelines

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

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.

**Note:** 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 timeframe 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 compensation levels, Tufts Health Plan may also conduct reviews of some inpatient services (e.g., requests for inpatient services upon review may be able to be provided at an outpatient level of care, such as observation or surgical day care). Tufts Health Plan also conducts reviews to determine whether the services are provided or arranged in an efficient manner. Refer to the payment policies on the public Provider website for information regarding these types of reviews. These policies are intended to provide Tufts Health Plan providers and facilities with information on benefits, billing, and compensation for services. To ensure accurate claims processing, providers must follow these policies and/or distribute to their 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
Commercial Condition Management Programs

Tufts Health Plan offers a variety of clinical programs to support adult, pediatric and pregnant members with preventive health, chronic conditions and complex medical needs. Eligible members are primarily identified for condition management through medical and pharmacy claims, physician referral or via self-referral. Members can also be identified through their participation in the Complex Care Management program.

The care management programs are available to members of 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 on eligible member benefits.

- Adult Immunization
- Asthma
- Chronic Kidney Disease (CKD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Complex Care Management
- Coronary Artery Disease (CAD)
- Diabetes
- End Stage Renal Disease (ESRD)
- Healthy Birthday
- Heart Failure
- Smoking Cessation
- Tufts Health Priority Newborn Care
- Weight Management

Refer to the Condition Management page for more information on the programs available to members.

Identification of Members

Tufts Health Plan identifies medically complex members at risk for future hospitalization or high health care costs through predictive software and direct referrals.

- Physicians, nurse practitioners, medical directors, BH 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 (condition 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, or may also self-refer.

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
Referral for all Commercial Care Management programs

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

- Call: 888.766.9818 ext. 53532
- Fax: 617.972.9470
- Email: PriorityCareReferral@tufts-health.com

Leave the member’s name, Tufts Health Plan ID number, member phone number 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**

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 member:

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.

Last updated 01/2018. Chapter revision dates may not be reflective of actual policy changes.