Medical Management

Medical Management Program
The goal of the medical management program is to monitor and manage the delivery of health care services to ensure that all services meet CMS coverage criteria. The Tufts Medicare Preferred HMO Care Manager is an integral part of the Tufts Medicare Preferred HMO medical management program. Physicians and other providers are responsible for:

- Sharing clinical information (including, but not limited to, discharge summaries, test results and medication records) in a timely manner to facilitate coordination and continuity of care
- Abiding by plan precertification policies providing timely notification of acute inpatient and skilled nursing facility admissions, collaborating with the Tufts Medicare Preferred HMO care manager to coordinate and oversee the delivery of each Tufts Medicare Preferred HMO member’s medical services
- Responding promptly to quality of care concerns raised either concurrently or retrospectively.

The medical management program’s scope encompasses all health care delivery activities across the continuum of care, including inpatient admissions to hospitals, acute rehabilitation facilities and skilled nursing facilities (SNF), home care services, outpatient care and office visits.

Tufts Medicare Preferred HMO Medical Management
For Tufts Medicare Preferred HMO, the medical group and their associated health care team, medical director, primary care physician and specialists are expected to manage and direct the medical management of the members assigned to their group. Each medical group is responsible for developing their individual group’s medical management program.

Roles and Responsibilities

Health Care Team
The health care team consists of a group of health care professionals including:

- The group’s medical director
- Primary care providers and their office staff
- All other providers associated with the medical group, including physician specialists, preferred skilled nursing facility and home health care providers
- The Tufts Medicare Preferred HMO Care Manager

Care Management
Tufts Medicare Preferred HMO medical groups who perform the medical management of their Tufts Medicare Preferred HMO members, provide a care manager for each member. Tufts Health Plan performance consultants provide oversight of the care management processes for the externally-managed members. For the remainder of medical groups, Tufts Health Plan will provide care management resources to support the medical management of its members. The Tufts Medicare Preferred HMO care manager is an integral part of the medical management program. The Tufts Medicare Preferred HMO care manager collaborates with the medical group to provide a standardized, integrated care management experience.

Role of the Care Manager
The Tufts Medicare Preferred HMO care manager works with the primary care provider (PCP)/attending provider/Tufts Health Plan Medicare Preferred medical director to coordinate and oversee the delivery of a member’s medical services.
The care manager follows the National Standards of Practice for care management and performs the following job functions:

- Assesses the member’s needs and collaborates with member/families and health care providers to develop realistic, achievable goals and plan of care
- Facilitates delivery of necessary skilled care services in the appropriate settings and monitors member progress
- Re-evaluates and revises the member’s plan of care and goals in collaboration with the member/family/ representative and health care team
- Refers the member to appropriate care management/disease management programs, based on identified criteria
- Records all pertinent information to support the goals and overall plan of care for services delivered to the member across the continuum, using Tufts Health Plan approved documentation guidelines
- Recognizes and reports quality of care issues (QI Occurrences) to facilitate resolution
- Follows up with member’s progress post skilled care and services, as applicable.

**Medical Management Program Activities**

The medical group organizes and conducts ongoing medical management meetings, and the care manager is an integral part of these meetings. The care manager and medical management team are instructed to consult Medicare coverage guidelines as well as the member’s Evidence of Coverage (EOC) when determining coverage of benefits.

The care manager, in collaboration with the health care team, ensures that the member receives appropriate care and services in a timely, cost-effective manner by conducting concurrent and retrospective review for the following services:

- Acute inpatient hospitalization, utilizing InterQual® criteria
- Acute inpatient rehabilitation
- Extended care and skilled nursing services
- Home care services
- Hospice care
- Community-based services.

**Medical Management Meetings**

The Medical Management Committee requires the following:

Membership of the committee must include the medical group’s medical director and the associated PCPs, as well as office staff and Tufts Medicare Preferred HMO care manager. Other Tufts Health Plan staff must have the opportunity to participate in medical management meetings as appropriate.

- Regularly scheduled meetings of the management committee must be held to discuss the medical management of Tufts Medicare Preferred HMO membership. The suggested meeting schedule is weekly.
- The medical director must act as or assign an alternate physician to be chairman of the committee meetings.
- The medical management committee must have a process in place to handle urgent referral requests and other medical management issues requiring a physician decision that need to be made prior to the next meeting.

**Utilization Review**

Federal and state regulatory agencies and accrediting bodies establish regulations and standards that govern utilization management functions. When utilization review is conducted, the decision time frame and notifications must adhere to the requirements outlined in the **Utilization Review Determination Time Frame** for Tufts Medicare Preferred HMO members.

This resource for staff engaged in the utilization management (UM) decision-making process outlines the required time frame for rendering coverage decisions and providing verbal and written notifications to the member and provider. Tufts Health Plan Utilization Management Policies and plan documents assist the care manager, physicians and other providers in planning and managing care with efficiency and high quality standards.
The process for conducting initial utilization review determinations for requests for coverage applies to all individuals performing utilization review of the Tufts Medicare Preferred HMO product. This process will be followed when reviewing prospective, concurrent and retrospective coverage of inpatient and outpatient services. All initial utilization review should be conducted on a case-by-case basis.

The following list provides examples of when utilization review can be performed prior to an admission or during a hospital stay or other course of treatment for standard or non-urgent situations:

- Elective surgery
- Referrals to specialists
- Initial requests for skilled nursing, rehabilitation or home care services
- New requests for home care-type services
- Organization determination.

**The Medical Group’s Responsibility in Utilization Review**

The medical group must:

- Evaluate inpatients via telephone or by conducting on-site reviews using standardized criteria for utilization management and quality improvement:
- Utilize Medicare coverage guidelines and the member’s EOC in determining coverage decisions
- Monitor ongoing specialized outpatient care provided by specialists, home care agencies or outpatient clinics, including laboratory, DME and other services
- Direct members with complex health care or social needs to the appropriate community support services
- Conduct annual health risk assessment review following the initial enrollment review to maintain an updated record of available insurance benefits for each member
- Issue organization determinations according to Tufts Medicare Preferred HMO guidelines. For more information, refer to the Prior Authorizations chapter
- Participate in an annual assessment of their utilization management systems.

**Urgent and Emergency Care**

Although authorization is not required, urgent or emergency care, including inpatient and outpatient care, involves coordination by the PCP/medical group/care manager of urgent and emergency services. Emergencies and urgent care that occur out of the service area should be reported to the out of area care manager.

**Urgent Care**

*Urgently needed care* is medical attention needed for an unforeseen illness or injury in which the member’s health is not in serious danger, but it is not reasonable given the situation for the member to get medical care from his or her PCP or other plan providers. Urgent care services are covered services provided when an enrollee is temporarily absent from the Tufts Health Plan Medicare Preferred service area (or under unusual and extraordinary circumstances, provided when the enrollee is in the service area but the organization’s provider network is temporarily unavailable or inaccessible).

**Tufts Medicare Preferred HMO Coverage Rules**

**Urgently needed care in the plan’s service area**

If the member is in the plan’s service area and has a sudden illness or injury that is not a medical emergency, the member should call his/her PCP or listen for instructions if the PCP’s office is closed. There will always be a doctor on call to help.

Hearing or speech-impaired members with TTY/TDD machines may also call the Massachusetts Relay Association at 800.439.0183 (TTY/TDD 800.439.2370) for assistance contacting their PCP after hours. We expect that members get such care from plan providers. In most cases, Tufts Health Plan will not pay for urgently needed care that a member receives from a non-plan provider while the member is in the plan’s service area.

**Urgently needed care outside the plan’s service area**

Authorization is not required for urgently needed care outside the Plan’s service area. If the member is treated for an urgent care condition while out of the service area, Tufts Health Plan prefers that they return to the service area to receive follow-up care through their PCP. However, Tufts Medicare
Preferred HMO will cover follow-up care provided from non-plan providers outside the plan’s service area as long as the care the member is getting still meets the definition of “urgently needed care.”

Tufts Medicare Preferred HMO cannot restrict access to urgently needed care to a certain place of service (e.g., outpatient clinics). Urgently needed services can be rendered in any Medicare-certified clinical setting (e.g., a provider’s office). Tufts Health Plan will refer members to their PCP if they call requesting clinical guidance prior to receiving urgent or non-urgent out-of-area care.

Urgent care that occurs outside the service area should be reported to the out-of-area care manager. The out-of-area care manager will follow urgent cases that occur outside the 30-mile radius from the PCP’s home hospital (with the exception of groups that have an alternate arrangement) while the member remains inpatient and when receiving follow-up care services within 14 calendar days of an urgent/emergent episode. Refer to Financial Programs for additional information regarding the 30-mile radius payment rule. Members who call with questions regarding follow-up care more than two weeks after receiving urgent care will be referred back to the PCP.

Emergency Services
An emergency medical condition is one brought on by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of the individual (2) serious impairment to bodily function, or (3) serious dysfunction of any bodily organ or part.

Emergency services are covered services given by any qualified provider and that are needed to evaluate or stabilize an emergency medical condition.

Emergency care that occurs outside the Tufts Medicare Preferred HMO service area should be reported to the out-of-area care manager. The out-of-area care manager will follow all emergency cases that occur outside the 30-mile radius from the PCP’s home hospital (the 30-mile rule is defined as 30 miles from the PCP’s office for some groups) within the first two weeks of the member receiving emergent or urgent out of area care. See Financial Programs for additional information regarding the 30-mile radius payment rule. Members who call with questions regarding follow-up care more than two weeks after receiving emergent or urgent care will be referred back to the PCP.

Post-Stabilization Care
Post-stabilization services are covered services that are related to an emergency medical condition and that are provided after a member is stabilized, and provided either to maintain the stabilized condition, or under certain circumstances, to improve or resolve the member’s condition. As a Medicare Advantage organization, Tufts Medicare Preferred HMO must cover post-stabilization care services obtained within or outside the network that:

- Are pre-approved by a plan provider or other Tufts Medicare Preferred HMO representative
- Are not pre-approved by a plan provider or other Tufts Medicare Preferred HMO representative, but are administered to maintain the member’s stabilized condition within one hour of a request to the Medicare Advantage organization for pre-approval of further post-stabilization care
- Are not pre-approved by a plan provider or other Tufts Medicare Preferred HMO representative, but are administered to maintain, improve or resolve the enrollee’s stabilized condition if:
  - Tufts Health Plan does not respond to the request within 1 hour
  - Tufts Health Plan cannot be contacted
  - The Tufts Medicare Preferred HMO representative and treating provider cannot reach an agreement concerning the member’s care and a plan provider is not available for consultation. In this situation, Tufts Health Plan must give the treating provider the opportunity to consult with a plan provider. The treating provider may continue with care of the member until a plan physician is reached or one of the following criteria is met:
    - Tufts Medicare Preferred HMO’s coverage for post-stabilization care services that it has not pre-approved ends when one of the following occurs:
      - A plan provider assumes responsibility for the member’s care through transfer
      - A plan provider with privileges at the treating hospital assumes responsibility for the member’s care.
      - Tufts Health Plan and the treating provider reach an agreement concerning member’s care.
      - The member is discharged.
InterQual Criteria
InterQual criteria\(^1\) are applied to all medical and surgical acute inpatient admissions. The criteria may be applied by the care manager to assist in determining the most appropriate level of care for Tufts Medicare Preferred HMO members.

These criteria are based on the use of the severity of illness and/or the intensity of service being provided. In general, the severity of illness criteria are used for the day of admission and the intensity of service criteria are applied to continued stay days. However, both sets of criteria are flexible and can be used at any point during an acute stay.

InterQual criteria are used by the care manager to facilitate communication with the provider about a member’s health status for the coordination of care. These criteria do not replace Medicare coverage guidelines and are not to be used by the provider when making coverage determinations for a Tufts Medicare Preferred HMO member. Medicare coverage guidelines must be used when making coverage determinations. InterQual is for screening purposes only.

HMO Coverage Resources
As a Medicare Advantage Organization, Tufts Medicare Preferred HMO must cover all services and items covered by Original Medicare. Coverage information (including effective date) that providers receive concerning Original Medicare also applies to Tufts Medicare Preferred HMO. Tufts Medicare Preferred HMO providers must refer to CMS coverage guidelines when making coverage determinations for those services.

To determine which services/items are covered in addition to what is covered under Original Medicare, providers should also refer to the most current version of the Tufts Medicare Preferred HMO Summary of Benefits and Evidence of Coverage (EOC).

Medicare Coverage Guidelines
As a Medicare Advantage Organization, Tufts Medicare Preferred HMO must, at a minimum, provide coverage for all services and items covered by Medicare.

Tufts Health Plan uses National Coverage Determinations (NCDs), Medicare interpretive manuals (e.g., the Medicare Benefit Policy Manual), and Local Coverage Determinations (LCDs) to make coverage determinations for Tufts Medicare Preferred HMO members. NCDs, Medicare interpretive manuals and LCDs are available on the Centers for Medicare & Medicaid Services (CMS) website.

Tufts Health Plan Medical Necessity Guidelines do not replace Medicare coverage guidelines and are not to be used by providers when making coverage determinations for Tufts Medicare Preferred HMO members, except for services that are covered by Tufts Medicare Preferred HMO as a supplemental benefit.

National Coverage Determinations (NCDs)
National Coverage Determinations are developed by CMS to describe the circumstances for Medicare coverage nationwide for a specific medical service, procedure or device. NCD are binding on all Medicare Advantage plans as well as other Medicare contractors (such as carriers and fiscal intermediaries).

- NCDs are located in the Medicare NCD Manual
- The NCD Manual is updated via NCD Transmittals
- NCDs are also accessible through the Medicare Coverage Database

Interpretive Manuals
Coverage provisions in interpretive manuals are instructions that are used to further define when and under what circumstances services may be covered (or not covered). Coverage information can be found via the CMS Online Manual System in the following interpretative manuals:

- Medicare Benefit Policy Manual
- Medicare Managed Care Manual
- Medicare Program Integrity Manual

\(^1\)InterQual criteria are used for screening purposes only and are not used for medical necessity determinations.
Local Coverage Determinations (LCDs)

An LCD is a decision issued by a fiscal intermediary or carrier to cover (or not cover) a particular service on an intermediary-wide or carrier-wide basis.

**Note:**
- LCDs cannot restrict or conflict with NCDs or coverage provisions in interpretative manuals
- LCDs are binding on Medicare Advantage Organizations
- LCDs are accessible through the Medicare Coverage Database

Providers must adhere to the LCDs associated with the following contractors that have jurisdiction in Massachusetts:
- Durable Medical Equipment (DME MAC): NHIC as of 7/1/06: [DME MAC LCDs](#)
- Part B Carrier: National Government Services
- Part A Fiscal Intermediary: Jurisdiction is dictated by which contractor the hospital bills for fee-for-service

**Case by Case Review**

If there is no national policy or the national policy is purposefully vague and the applicable contractor does not have an LCD, providers should review the case on an individual case basis using Medicare’s existing national guidance and any other LCDs in Massachusetts, if available. If there are no other LCDs in Massachusetts, contact the Program Manager in Medical Policy who will contact the applicable contractor for input.

**Medicare Coverage Database**

Users can search the Medicare Coverage Database for additional information.

**Additional Information**

If you have coverage-related questions or would like to request a printed copy of any of the above guidelines, contact the member’s Tufts Medicare Preferred HMO care manager or Provider Relations at 800.279.9022. If you have questions regarding what Tufts Medicare Preferred HMO covers in addition to Medicare, refer to the Tufts Medicare Preferred HMO Summary of Benefits and Evidence of Coverage (EOC) available on the Tufts Health Plan Medicare Preferred member website.

**Veterans Administration (VA) Coverage**

Information regarding services provided at Veterans Administration facilities is included in the following manuals:
- Medicare Managed Care Manual, Chapter 7 – Payment to Medicare + Choice (M+C) Organizations, section 165, “Special Rules for M+C Payments to Department of Veteran Affairs Facilities.”
- Medicare Benefit Policy Manual, Chapter 16 – General Exclusions from Coverage, section 50, “Items and Services Furnished, Paid for or Authorized by Governmental Entities – Federal, State, or Local Governments.”
Medical Group Name

Utilization Committee

Date: ________________

**AGENDA**

1. Acute Inpatients
   ________________________________________________________________

2. SNF Admissions:
   ________________________________________________________________

3. DME Requests:
   ________________________________________________________________

4. New Members High Risk:
   ________________________________________________________________

5. Elective Surgeries
   ________________________________________________________________

6. OOP Requests:
   ________________________________________________________________

7. Member Self-Referrals:
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8. Emergency Room:
   ________________________________________________________________

9. Referrals:
   ________________________________________________________________

10. Homecare Referrals:
    ________________________________________________________________

Cat Scan/MRIs:
   ________________________________________________________________

Last reviewed 01/2017. Chapter revision dates may not be reflective of actual policy changes.