Prior Authorizations

The following care and services require prior authorization by Tufts Medicare Preferred HMO:

- Certain Part B or Part D drugs\(^1\)
- Select durable medical equipment (DME), prosthetics, and medical supplies
- Select home- and community-based services
- Nonroutine dental services
- Hearing aids, supplies, and repairs
- Nonemergent transportation
- Select mental health services

Please refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List for a complete listing of non-pharmacy services, items and supplies that require prior authorization.

Prior Authorization Process for Medications

Requests for prior authorization for coverage determination and exceptions (CDE) should be faxed to the Pharmacy Utilization Management Department at 617.673.0956.

Formulary

A formulary is a list of covered drugs selected for Tufts Medicare Preferred HMO in consultation with a team of health care providers. This list represents the prescription therapies believed to be a necessary part of a quality treatment program. Tufts Medicare Preferred HMO will cover drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Tufts Medicare Preferred HMO network pharmacy, and other plan rules are followed. If approved, the Tufts Medicare Preferred HMO member will be covered for the drug. An appeal process exists for denied requests. For more information about pharmacy grievances and appeals, please see the Appeals and Grievances chapter of this manual.

Note: Some Part D drugs obtained at out of network pharmacies are covered by Tufts Medicare Preferred HMO, as required by CMS and Federal Regulations (Chapter 6 of Medicare Prescription Drug Benefit Manual, 10.2, in accordance with 42CFR 423 124)

Pharmacy Plan Management Programs

The following section contains descriptions of the Pharmacy management programs: prior authorization (PA), step therapy prior authorization (STPA), and quantity limitations (QL).

Prior Authorization Required

The PA process encourages rational prescribing of drug products with significant safety and/or financial concerns. A provider can submit a request for coverage based on a member’s medical need for a particular drug. If approved, the Tufts Medicare Preferred HMO member will be covered for the drug. An appeal process exists for denied requests.

Quantity Limit Applies

Because of potential safety and utilization concerns, Tufts Medicare Preferred HMO has placed dispensing limitations on a small number of prescription drugs (for additional information, see our formulary on the Tufts Health Plan website). This means that the pharmacy will only dispense a

\(^1\) Please refer to the Tufts Medicare Preferred HMO formulary for a complete list of drugs that require prior authorization.
certain quantity of a drug within a given time period. These quantities are based on recognized standards of care, such as FDA recommendations for use. If a member needs a quantity greater than the program limitation, their provider can submit a request for coverage under the Medical Review Process, also known as a formulary exception request. If approved, the Tufts Medicare Preferred HMO member will be covered for the quantity requested. An appeal process exists for denied quantity limit requests.

**Step Therapy Prior Authorization Applies**

Step therapy is an automated form of prior authorization that uses claims history for approval of a drug at the point of sale. Step therapy programs help encourage the clinically proven use of first-line therapies and are designed to ensure the utilization of the most therapeutically appropriate and cost-effective agents first, before other treatments may be covered. Members who are currently on drugs that meet the initial step therapy criteria will automatically be able to fill their prescriptions for a stepped medication. If the member does not meet the initial Step Therapy criteria, the prescription will deny at the point of sale with a message indicating that PA is required. Providers may submit PA requests to Tufts Medicare Preferred HMO for members who do not meet the step therapy criteria at the point of sale under the medical review process. If approved, the member will be covered for the drug. An appeal process exists for denied requests.

**Comprehensive Formulary**

The Tufts Medicare Preferred HMO comprehensive formulary includes the Part D formulary approved by the Centers for Medicare & Medicaid Services (CMS).

**Exception Requests**

If the provider requests a formulary exception for a member, he/she must provide a statement to support the request. The provider can submit the request using a Universal Pharmacy Medical Review Request Form or the Medicare Part D Coverage Determination Request Form.

The form requests information regarding diagnosis and what other drug, if any, has been prescribed for the diagnosis and why it has not worked. The provider can submit the form in two ways:

- Fax the completed form to: 617.673.0956
- Mail the completed form to:

  Tufts Medicare Preferred HMO
  705 Mount Auburn Street
  Watertown, MA 02472
  Attention: Pharmacy Utilization Management Department

The provider can also provide an oral supporting statement by calling Provider Relations at 800.279.9022 (TTY 800.208.9562), Monday through Friday, 8 a.m.–8 p.m.

All standard coverage determination requests must be made within 72 hours from the time that the plan receives the request with supporting statement from the prescribing provider.

All expedited coverage determination requests must be made within 24 hours from the time that the plan receives the request with supporting statement from the prescribing provider.

Both standard coverage determinations and expedited coverage determinations can be sent to the Tufts Health Plan Pharmacy Utilization Management department.

**Medicare Part D Transition**

During the first 90 calendar days of membership for new members or the first 90 calendar days of the calendar year for members who were in the plan the previous year, the plan can offer a temporary 30-day supply of a drug when the drug is not on the plan’s current formulary or when it has been restricted in some way. If the member receives a transition fill, Tufts Medicare Preferred HMO will send a letter to the provider and the member detailing the nature of the temporary supply.

**Medications Covered by Original Medicare (Medicare Part B)**

Tufts Medicare Preferred HMO provides coverage for all drugs and biologicals that are covered by Original Medicare Part B.
Note: Medications covered by Original Medicare (Part B) are not part of the member’s Part D prescription drug benefit. In general, Part B covered drugs fall in the following categories:

- Drugs billed by providers and typically provided in providers’ offices
- Drugs billed by pharmacy suppliers and administered through durable medical equipment (DME), e.g., respiratory drugs given through a nebulizer
- Drugs billed by pharmacy suppliers and self-administered by the patient (e.g., immunosuppressive drugs and some oral anti-cancer drugs)
- Separately billable drugs provided in hospital outpatient departments
- Separately billable ESRD drugs

Vaccines

Some vaccines are covered under Part B and others are covered under Part D. When vaccines are covered under Part D, the administration costs will be reimbursed under Medicare Part D. The information below clarifies the Medicare Part B and Part D coverage for vaccines.

**Part B Vaccines (including flu, pneumonia, and Hepatitis B when members are at moderate to high risk)**

The provider must administer the vaccine and bill Tufts Medicare Preferred HMO on a medical claim form.

**Part D Vaccines — Prescription**

The provider gives the member a prescription or calls the prescription into the pharmacy.

The member picks up prescription from the pharmacy, pays the copayment and brings vaccine to the appointment for administration.

Vaccines can also be administered at local retail network pharmacies for members with a prescription. Certified pharmacists can administer the vaccine in the store, the member pays the appropriate copayment and the pharmacist processes the claim through the CVS Caremark claim system.

**Part D Vaccines — “Buy & Bill”**

“Buy & Bill” is an alternative process for all vaccines covered under Part D. As required by CMS, Tufts Medicare Preferred HMO handles all vaccines that are covered under Medicare Part D as follows:

**Part D Vaccines - Member Reimbursement**

The member receives the vaccine from the provider, pays the provider for the immunization, and then submits a member reimbursement request to CVS Caremark for reimbursement. To avoid placing an undue financial burden on the member, this is not the preferred method of obtaining payment for the vaccine.

**Direct Claim Submission to the Pharmacy Benefits Manager**

If the provider dispensed a vaccine that is covered under Medicare Part D and/or administered that vaccine in the office, the following steps must be completed by the provider:

1. Complete a CMS-1500 claim form and include:
   - The drug name and NDC for each vaccine administered
   - The administration code and drug name for each vaccine
   - To submit the claim to CVS Caremark Part D Services for reimbursement, send the claim form to:
     
     Caremark Medicare Vaccine Processing
     PO BOX 52193
     Phoenix, AZ 85072-2193
   
2. Collect the copayment, if applicable
3. After receiving the claim, CVS Caremark processes it and returns reimbursement to the provider with an explanation of payment, including any beneficiary’s cost share for collection.
4. CVS Caremark continues to process vaccine claims within the normal Medicare Part D timeframe (normally within 30 calendar days).
Medication Therapy Management Program

Tufts Medicare Preferred HMO members may be eligible for the Medication Therapy Management (MTM) Program. Eligible members are automatically enrolled in the program and are offered a one-to-one telephone consultation with a clinical pharmacist. Information gathered during this process, along with pharmacy claims and clinical notes from the provider (when made available) are used to develop clinical recommendations where appropriate. Pharmacist recommendations are faxed to the provider for consideration. Members will receive an individualized written summary of the consultation and comprehensive medication review (CMR) by mail. CMRs are offered at least once a year.

In addition, targeted medication reviews (TMR) are done to assess medication use, monitor unresolved issues, and identify new drug therapy problems. These TMRs are performed on a quarterly basis with any recommendations sent to the provider via fax. Participation in the program is voluntary and a member can disenroll at any time.

Appeals and Grievances for Pharmacy Benefits

Timelines for grievances and appeals for pharmacy benefits may differ from those surrounding pre-service coverage reviews (also known as coverage determinations and organization determinations). For more information regarding appeals and grievances, refer to the Appeals and Grievances chapter of this Provider Manual.

Services Not Requiring Prior Authorization

Services not requiring an authorization include the following:

- **Emergency services** - Covered inpatient or outpatient services that are furnished by any provider who is qualified to furnish emergency services and needed to evaluate or stabilize an emergency medical condition.
  
  Emergency medical conditions manifest themselves 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 one of the following:
  - Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
  - Serious impairment to bodily functions
  - Serious dysfunction of any bodily organ or part

- **Urgently needed services** - Covered services provided when a member is temporarily absent from the Tufts Medicare Preferred HMO service area when such services are medically necessary and immediately required for the following reasons
  - As a result of unforeseen illness, injury, or condition
  - It was not reasonable given the circumstances to obtain the services through Tufts Medicare Preferred HMO

- **Emergency behavioral health care**

- **Observation care** - care by an attending provider who admits a member for observation, or care by a provider who is consulting for a member in observation

- **Renal dialysis services, in and out of the service area**

- **Direct-access women’s services**

- **Qualifying clinical trials** – Original Medicare covers routine costs of qualifying clinical trials. Once members join a Medicare-approved clinical research study, they are covered for routine items and services provided as part of the study, including:
  - Room and board for a hospital stay that Medicare would pay for even if the member was not in a study.
  - An operation or other medical procedure if it is part of the research study.
  - Treatment of side effects and complications of the new care.

Original Medicare pays most of the cost of the covered services provided as part of the study. After Medicare has paid its share of the cost for these services, Tufts Medicare Preferred HMO
pays the rest. As for all covered services, members will pay nothing for the covered services provided in the clinical research study.

For Tufts Health Plan to pay for its share of the costs, the member needs to submit a request for payment. With that request, the member will need to send a copy of Medicare Summary Notices or other documentation that shows what services provided as part of the study.

When the member is part of a clinical research study, neither Medicare nor Tufts Medicare Preferred HMO will pay for any of the following:

- Generally, Medicare will not pay for the new item or service that the study is testing, unless Medicare would cover the item or service even if the member were not in a study.
- Items and services that the study gives the member or any participant for free.
- Items or services provided only to collect data, and not used in direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if the medical condition would normally require only one CT scan.

A member does not need to obtain a referral or prior authorization to join a clinical trial and is not required to see in-network providers. However, it is recommended that the member inform Tufts Medicare Preferred HMO before he/she starts a clinical trial. This notification allows Tufts Health Plan to track the member’s health care services. *If the member participates in a study that Medicare has not approved, the member will be responsible for paying all costs for their participation in the study.* Further information regarding clinical trials is included in these publications:

- Medicare Clinical Trial Policies
- Medicare National Coverage Determination Manual, Chapter 1, Part 4, Section 310.1, “Routine Costs in Clinical Trials”

**Transplants**

- All Medicare-covered transplants do not require prior authorization from Tufts Medicare Preferred HMO or from the PCP/medical group.
- Members may be referred for evaluation of appropriateness for transplant by either the PCP or by a specialist to whom the PCP initially referred the member.
- The PCP must supply the referral for the specialist at the transplant center for claims payment.
- Once a member is deemed to be appropriate for a transplant, the inpatient notification process must be done according to the plan's timeframe guidelines. Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List.
- All heart, lung, heart-lung, liver, intestinal, kidney, and pancreas transplants be performed at a Medicare-approved facility. Tufts Medicare Preferred HMO will not pay for services rendered at a non-Medicare-approved facility. Refer to the Tufts Medicare Preferred HMO Medicare-Approved Facility List for additional information.

For more information regarding transplants, refer to the Transplant Payment Policy.

**Policies for Pre-Service Organization Determinations including Services Requiring Prior Authorization and Benefit Exhaustions**

The term "organization determination" is a Centers for Medicare and Medicaid Services (CMS) term used to describe coverage decision made by the Plan. The Plan’s processes may include prior authorization requests for services addressed in this chapter, and other coverage decisions described below such as benefit exhaustions. CMS has very specific regulations related to organization determinations. Tufts Medicare Preferred HMO expects contracted providers will be in compliance with these regulations.

The following services and topics are covered in this chapter:

- Overview of the providers role
- Prior authorization/Organization Determination process
- Benefit exhaustions
- Member initiated requests for an organization determination
Overview of Providers Role

- Refer member to Customer Relations at 800.901.7000 to request an organization determination if the member disagrees with a treatment decision or plan of care.
- Respond to requests for clinical information in a timely manner to ensure that Tufts Medicare Preferred HMO can make coverage decisions in compliance with CMS organization determination requirements.
- Participate in discussions with Tufts Health Plan medical directors and clinicians as needed to discuss coverage requests.
- Be knowledgeable about CMS requirements related to organization determinations and the associated Tufts Health Plan processes described in this chapter.
- Participate in process update training provided by the Plan.

Prior Authorization/Organization Determination Process

Certain DME, diagnostic procedures, and Part B medications require prior authorization from the Plan.

- For a current list of procedures, services, and items requiring prior authorization, see the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List.
- For services requiring prior authorization (excluding Part B medications), providers may fax requests to the Precertification Operations Department at 617.972.9409.
- Prior authorization requests for all medications (both Part B and Part D) should be submitted to the Pharmacy Utilization Management Department. Refer to the Pharmacy section earlier in this chapter for more information.
- Provider inquiries related to the prior authorization process may be made via Provider Relations at 800.279.9022.
- DME providers are encouraged to collect all required supporting documentation as outlined in CMS guidelines prior to submitting requests. All necessary documentation should be included at the time of the request in order to make a timely decision.

The prior authorization process includes the following steps that Tufts Medicare Preferred HMO takes:

- Validating that the requestor is approved to make a request.
- Establishing whether the request is expedited or standard as defined under CMS regulations.
- Collecting and reviewing the applicable coverage documents such as Medicare regulations, the Evidence of Coverage; and clinical documentation to support medical necessity submitted by the provider.
- Ensuring that the decision is made and that the member and provider are notified within the CMS required time frames (see below).

Who can Request an Organization Determination

Coverage requests (organization determinations) can be made to Tufts Medicare Preferred HMO by the member, the member’s authorized representative, or the provider on the member’s behalf.

Organization Determination Time frames

CMS has strict regulations around decision timeframes and notice requirements for the Plan to meet when an organization determination is requested. Tufts Medicare Preferred HMO policies and procedures are designed to meet the requirements.

The member, member’s representative or provider may request that the Plan expedite an organization determination when the member or his/her provider believes that waiting for a decision under the standard timeframe could place the member’s life, health or ability to regain maximum function in serious jeopardy.

The Plan must notify the member of the determination as expeditiously as the member’s condition requires but not later than the expiration of the timeframes below:

- For expedited organization determination requests the member must be notified of the decision no later than 72 hours from the time of the request.
- For standard organization determination requests, the member must be notified of the decision no later than 14 calendar days from the time of the request.

An extension to the above time frames may be requested under certain limited circumstances as defined by CMS.
Please refer to the Tufts Health Plan Utilization Management Manual for details about the CMS requirements related to adjudication time frames and notice requirements.

**Prior Authorization Process Overview**

In order to process an organization determination, the Plan must review and collect all the necessary supporting documentation to make a decision.

- The documentation may include but not be limited to the member’s Evidence of Coverage, Medicare regulations (including national or local coverage decisions), MassHealth guidelines, and clinical documentation submitted by the provider.
- It is expected that all Medicare certified providers be familiar with the coverage regulations related to the services that they order and / or provide. For this reason it is expected that providers will submit coverage requests with sufficient clinical documentation for the Plan to make a timely decision.
- If a request is received with insufficient clinical information to make a decision, the Plan will send a request for more information (RFMI) letter via fax to the provider, or call the provider in expedited cases.
  - The RFMI letter includes the specific clinical information that is being requested and how to submit it. The letter will also include a due date by which the information must be received by the Plan in order to process the request within regulatory requirements.
  - In general, providers are asked to respond to these requests by the end of the next business day. CMS requires that organization determinations be completed within strict regulatory timeframes so if there is no timely response from the provider to the RFMI request, follow up outreach calls to the provider office and group medical director/IDN leader will be made.
  - Please note that RFMI letters will be directed to the treating provider except for out of plan and out of referral circle services that require a referral. Requests for more information for out of plan and out of referral circle requests will be directed to the centralized contact specified by each medical group for such requests, and not the primary care provider.

Once all the necessary documentation is on hand, the Plan will make an organization determination. The member and provider will be notified verbally and in writing of the decision, according to regulations.

In the event of an adverse determination (denial), the decision may be appealed (reconsideration). Medicare does not allow for a peer-to-peer discussion of the decision in lieu of filing an appeal. Refer to the Appeals and Grievances chapter of this Provider Manual for additional information about the appeal process.

Additional information about the utilization management program is available on-line in the Plan’s Utilization Management Program Manual. The provider may also contact the Provider Relations Department at 800.279.9022 for other questions.

**Note:** The above overview does not represent the complete Medicare regulations for organization determinations. Please refer to the Medicare Managed Care Manual, Chapter 13 at [cms.gov](http://cms.gov) for complete information about the organization determination requirements under Medicare.

**Benefit Exhaustions**

Certain services, such as skilled nursing facility, inpatient rehabilitation and long term acute care hospital, may have benefit limitations under the Plan. When a member is actively receiving these services, and prior to the exhaustion of their benefit, the member must be notified in writing that their benefit will be exhausted as of a certain date.

The medical group care manager must notify the Plan in advance of the benefit exhaustion so a letter can be generated and the member notified according to CMS requirements. In order for the member to receive timely notice, the letter will be written by the Plan and must be delivered to the member in the facility, or their authorized representative.

The following information should be faxed to the Precertification Operations Department at 617.673.0955 or 617.972.9409:
Member name, identification number and date of birth.
• Name, phone number and relationship to the member for the member’s authorized representative, if applicable.
• Name of facility and level of care (SNF, acute rehab, LTAC)
• Date of last covered day
• Name and phone number for medical group care manager
• Name, phone and fax numbers for the facility care manager who will facilitate delivery of the notice to the member.

Member-Initiated Requests for Organization Determinations

Members (or their authorized representatives) may make a pre-service request for an organization determination for any procedure, service, or supply regardless of whether or not that service requires prior authorization. The same organization determination timeframe, notice and process requirements are in effect for all member initiated requests as those described above in the Prior Authorization section.

Although it is encouraged, members are not required to discuss their request with their provider before contacting the Plan. Members who have not discussed the requested coverage with their provider are educated about the plan design and the benefit of discussing treatment options with their PCP who is familiar with their health condition.

Whenever any member contacts Tufts Medicare Preferred HMO to request coverage of a service, the request indicates that the member believes that Tufts Medicare Preferred HMO should provide, or pay for, the service. Thus, the request constitutes a need for an organization determination.

For example, members most often contact the Plan to request organization determinations when they have had a disagreement with their provider about a treatment decision (in whole or in part) such as getting a referral to go outside the referral circle or out of plan to receive services; and levels of care related to an acute rehab or a skilled nursing facility. If a provider declines to give a service that a member has requested, or if the provider offers alternative services, that itself is not considered an organization determination (the provider is making a treatment decision). In this situation the member may contact Tufts Medicare Preferred HMO by calling the Customer Relations department to request an organization determination for coverage of the services in question, or the provider may request the organization determination on the member’s behalf.

When there is a disagreement between the member and provider with a provider’s decision to deny a service or course of treatment, in whole or part, the provider must inform the member of the right to contact the Plan and request an organization determination.

When a member initiates a request for an organization determination the Plan will outreach to the PCP or attending physician to request clinical information, unless sufficient information can be provided directly by the member at the time of the request.

In the event that the member makes an organization determination for a referral, the Precertification Operations Department clinician will outreach to the group medical director or IDN leader to request applicable clinical documentation. Outreach will be in the form of a faxed Request For More Information Letter (RFMI) which will explain the member’s request, the specific information being requested to complete the review, and the deadline by which the information must be returned to the Plan. Responding by the deadline is expected so the Plan can make a timely decision in compliance with CMS regulations. Phone calls will also be made in expedited cases.

The member, member’s PCP and attending provider (if known) will be notified of the organization determination outcome verbally and/or in writing according to CMS regulations.

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