Utilization Management Guidelines

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. Refer to this chapter for information about:

Role of Plan Provider

Plan providers are expected to cooperate 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
- 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 and requests that arise during the process of conducting utilization review (including the member appeals and grievances processes), care management, and quality improvement processes
- Complying with confidentiality requirements as detailed in the Providers chapter

Refer to the Providers chapter for information regarding 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 Executive Officer (CEO). 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 including but not limited to:

- Inpatient and outpatient care
- Home care services
- Prescription drugs
- Assisted reproductive technologies (ART)
- Durable medical equipment (DME)
- Select elective surgical procedures
- Outpatient physical, occupational, and speech therapy
- Out-of-network referrals
- Transplants

Behavioral health services (inclusive of both mental health and substance use disorder (MH/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 and Clinical Criteria

Tufts Health Plan authorizes coverage of medically necessary services that:

- Prevent, diagnose, alleviate, correct, or cure the worsening of conditions that endanger a member's life, cause suffering or pain, threaten to cause or aggravate a disability, or result in illness or infirmity
- Cannot be replaced with a less intensive level of care
- Are substantiated by clinical records
- Meet professional health care standards
- Are covered benefits as set forth in the member's plan document

Tufts Health Plan uses the following medical necessity guidelines and criteria for covered benefits and services:

- InterQual® is the primary source to determine medical necessity and appropriateness of treatment

When criteria are not available in InterQual, determination is based on Tufts Health Plan Medical Necessity Guidelines (MNGs). Tufts Health Plan determines benefit coverage for the benefits described in each member's product description by using MNGs to determine the medical necessity and appropriateness of health care services under the applicable health benefit plan. These utilization review MNGs are:

- Developed and reviewed with input from specialty consultants, actively practicing physicians, and specialty physicians and other providers
- Developed in accordance with standards adopted by national accreditation organizations and regulatory and government entities
- 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 and characteristics of the local delivery system
- Evaluated at least annually for the consistency with which those involved in utilization review apply the MNGs in the determination of coverage

MNGs are available on the Point32Health 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 the interrelated committees:

Medical Technology Assessment Committee consists of Medical Policy Department staff and Tufts Health Plan medical directors for Medical Policy and Medical Directors for the divisions who manage the process described above for review of new and emerging technologies or medical services. Recommendations are reviewed by the Integrated Medical Policy Advisory Committee (IMPAC).

Medical Specialty Policy Advisory Committee (MSPAC) consists of Tufts Health Plan Medical Affairs Department physicians, Medical Policy Department staff and external specialist physicians who provide input on medical necessity guidelines and make recommendations regarding new and emerging technologies and procedures, as well as new uses of existing technologies and procedures. MSPAC members make a recommendation regarding the safety and efficacy of the new technologies and medical interventions and also provide annual review of the existing MNGs. The recommendations of this committee are presented at the Tufts Health Plan Integrated Medical Policy Advisory Committee (IMPAC) meeting for decision making.

Medical Policy Approval Committee (MPAC) is a decision-making body for medical and behavioral health services. This internal committee is chaired by the Senior Manager of Medical Policy and consists of representatives from many departments within Health Care Service who are responsible for providing input on coverage recommendations, MNGs and utilization review (UR) activities for medical and behavioral health services. The Tufts Health Plan Chief Medical Officers (CMOs), including the Senior Vice President and CMO, and representatives from the Medical Policy, Precertification Operations, Appeals and Grievances, Behavioral Health, and Pharmacy departments and others make up this committee. Topics requiring review that cannot be addressed at the MSPAC meetings are brought to this committee.

Led by the Tufts Health Plan's Senior Vice President and CMO, the above referenced committees make the final determinations as to whether the procedure, service or supply will be covered and if so, whether coverage will be subject to prior authorization. The program managers for products in the Medical Policy Department are responsible for the development of the MNGs associated with these coverage decisions.

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 (excluding holidays). 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)

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

For all Commercial products, except Preferred Provider Organization (PPO), the PCP uses referrals to direct and manage member access to most specialty care based on clinical need. Using electronic or written referrals 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. **Note:** Members do not require referrals for outpatient BH services.

There are certain outpatient services that Tufts Health Plan clinical reviewers will review and manage through prior authorizations. These include, but are not limited to, the following:

- All services included on the prior authorization list
- Assisted reproductive technology (ART)
- Continuation of home health care services (after the initial 30 days)
- Oral surgery
- Some outpatient BH/SUD services, such as ABA (Applied Behavioral Analysis), Psychological and Neuropsychological Testing, rTMS (Repetitive Transcranial Magnetic Stimulation)
- Outpatient physical, occupational, and speech therapy
- Certain out-of-network requests
- Select durable medical equipment (DME)
- 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.

Behavioral Health Intermediate Levels of Care Service Review

Intermediate behavioral health services are mental health and substance use disorder services that are more intensive than traditional outpatient behavioral health services and less intensive than 24-hour hospitalization. For most intermediate services, in-network providers are required to provide notification to the plan typically after the first day/visit of treatment and Tufts Health Plan will conduct concurrent review for the continuation of services.

Services requiring notification and concurrent review include, but are not limited to, the following:

- Partial hospital programs
- Intensive Care Coordination (ICC) – Massachusetts Plans ONLY

Inpatient Services Review

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. Elective inpatient medical admissions require notification prior to services being rendered. Urgent or emergency medical and behavioral health admissions require notification within two business days of admission. Concurrent review is required following the initial notification period.

Admitting providers and facilities are responsible for notifying Tufts Health Plan, following the procedures outlined in the Referrals, Prior Authorizations and Notifications chapter.

Late notifications from a non-DRG facility will be reviewed from the date of notification forward. Late notifications from a DRG facility will be subject to a penalty reduction of the DRG payment. For more information, refer to the Inpatient Facility Payment Policy.

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 eligibility[1] and benefit verification.

Prospective utilization review of prior authorization for coverage of non-BH 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

Medical Care Management and Discharge Planning

Inpatient managers and Utilization Management Coordinators staff the Inpatient Services Department. Inpatient utilization management is performed utilizing clinical information received by telephone, fax, or direct EMR access using nationally recognized clinical criteria, the Inpatient Manager performs a clinical review and refers the review to a Tufts Health Plan Medical Affairs Department physician for secondary review, if necessary. Inpatient Managers also assist with discharge planning and redirecting members 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 department visits, are referred to the Case Management Department. Additional programs following discharge 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 renders is a "criteria-not-met" determination which 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.

Payment determinations, such as observation level of payment is made using Observation Stay Payment Policy.

[1] Eligibility may be subject to retroactive reporting of disenrollment.

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 writing, 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 Services that are Noncovered or Provided without Referral or Authorization section of the Referrals, Authorizations and Notifications chapter.

To effectively perform telephonic or faxed reviews, Tufts Health Plan needs to receive clinical information within the time frame to meet regulatory and accreditation requirements. Access to the facility EMR removes this administrative requirement of the facility but must be provided to THP by the facility.

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 Point32Health 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.

Behavioral Health Care Management and Discharge Planning

Behavioral health clinicians and non-clinical utilization management coordinators (UMC) staff the behavioral health UM program. Using nationally recognized clinical criteria and THP's medical necessity standards, the BH clinicians conduct concurrent clinical review for acute care, extended care, and BH/SUD intermediate levels of care. the concurrent review process is focused on evaluating whether the member is receiving medically necessary care, receiving treatment or services in the appropriate level of care, and receiving proper transfer and discharge planning if transitioning to another facility, treatment program, or being discharged to home.

To effectively perform telephonic or faxed reviews, Tufts Health Plan needs to receive all required clinical information within the requested time frame to meet regulatory and accreditation requirements (see Data Requirement Section of this chapter).

BH clinicians may refer a case to Medical Affairs if upon evaluation, the case does not appear to meet medical necessity standards. A Medical Affairs psychiatrist or other appropriately licensed BH clinicians will conduct an independent clinical review and make a determination.

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 writing, 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.

Referral to BH Case Management Programs

If during a case review, a BH clinician has identified non-medical and/or social issues that may be a barrier to care, or that a member may benefit from a BH case management program, they will refer the member to our BH case management program for additional follow up and assistance (See BH Case Management Program section of this chapter). Tufts Health Plan providers can also refer members to Behavioral health Care Managers by calling 888-884-2404.

Data Requirements: Clinical Information

Tufts Health Plan Utilization Reviewers require relevant clinical information in order to evaluate whether request meets the standards for medical necessity. The data collection gathered through patient records or by verbal and written information received by the physician may include but is not limited to the following:

- 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

Determinations of Coverage

Tufts Health Plan's UM decision and notice requirements are consistent with applicable state and federal laws and regulations and accreditation standards. Refer to the Utilization Review Determinations Timeframes chapter 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

Peer-to-Peer/Reconsideration Review Process

A Medical Affairs, Utilization Management practitioner, or Pharmacy Utilization Management Department practitioner or their designee is available by phone for providers to discuss denials (adverse determinations) based on medical necessity. Denial notices include contact information and instructions about how to arrange a peer-to-peer or reconsideration (where applicable). This process enables the servicing or requesting physician to communicate directly with the Plan physician or practitioner who rendered the decision, or a designee if the practitioner is not available. As part of the peer-to-peer or reconsideration process, further clinical justification or additional information may be provided.
Note: The peer-to-peer or reconsideration process is not a prerequisite for a formal standard or expedited appeal.

Initiating the Request

To submit a peer-to-peer request for a pharmacy or medical drug, call 888-766-9818. Peer-to-peer requests for pharmacy services are not currently available via the online Peer-to-Peer Request Form.

To submit a peer-to-peer request for denials issued by one of our vendors, contact the appropriate vendor:

- **Evolent Health:** 800-642-7543
- **Carelon:** 855-574-6476
- **Progeny:** 888-832-2006
- **OncoHealth:** 877-222-2021
- **eviCore:** 888-511-0401

To submit a peer-to-peer or reconsideration request for medical or behavioral health denials:

- **Online:** For non-Pharmacy requests, you may submit the Peer-to-Peer Request Form. The online form is available on the provider website.
- **Call:** You may also call the Utilization Management department at 1-888-766-9818, ext. 54276 to request a peer-to-peer review.

Once a peer-to-peer request is received, a Plan physician or practitioner will contact the requesting or servicing provider, or their office staff, to discuss the denial.

- In accordance with the Massachusetts requirements, providers have the option to request a reconsideration of an initial or concurrent denial of coverage decision. The reconsideration shall occur within one business day after the receipt of the request and shall be conducted between the provider rendering the service and the review will be conducted by 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 who was not involved in the initial decision.

Note: The processes described above do not apply to prior authorization requests denied by clinical vendors contracted by the Plan to manage the prior authorization process for services on behalf of the Plan.

General Guidelines for Submitting a Peer-to-Peer/Reconsideration Request

- Submit requests **only** for denials based on medical necessity.
  Note: If a request is denied for administrative or benefit reasons—such as member ineligibility, service date issues, or non-covered benefits—a peer-to-peer review isn't available. You must go through the appeals process for benefit or administrative denials.
- When requesting a peer-to-peer review using the Peer-to-Peer Request Form, submit a separate form for each request. Forms containing information about multiple members are not accepted due to Health Insurance Portability and Accountability Act (HIPAA) concerns.
- If you or the member file an appeal, a peer-to-peer review cannot be completed. Instead, if you filed the appeal, you will be asked if you want to withdraw the appeal and complete the peer-to-peer request instead. If the member filed the appeal, their permission is required to withdraw the appeal.

- Refer to the instructions in the denial letter to request either a peer-to-peer review or appeal the denial.

Upon receipt, the peer-to-peer or reconsideration process shall occur within one business day.

- When possible, the Medical Director or Clinical Reviewer responsible for the initial decision conducts the peer-to-peer or reconsideration review.
  - If the original decision-maker is not available, a designated clinical reviewer may conduct the review.

If the peer-to-peer or reconsideration process does not reverse the adverse determination, the provider or member may pursue the expedited or standard appeal process.

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 (refer to the Behavioral Health section below for a list of behavioral health-related programs). Eligible members are primarily identified for condition management through medical and pharmacy claims, physician referral or 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. Programs are provided at no cost to the member and participation has no impact on eligible member benefits. Descriptions for the programs listed below may be found on the Member Wellness section of the website.

- 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

Identification of Members

Tufts Health Plan identifies medically complex members at risk for future hospitalization or high health care costs through predictive software and/or 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: Priority_Care_Referral@point32health.org

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 Care Management Programs

Referrals for the following behavioral health care management programs can be made by calling the Behavioral Health Department at 888-884-2404.

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 their family. For additional information, contact the Substance Use Disorder Navigator at 617-972-9400, ext. 54013.

Emergency Services

Definition

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 affect 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.

Refer to the Emergency Department Services Payment Policy for more information regarding ED services.

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 inpatient notification processes must be followed. The member’s PCP will be notified, if on file.
- 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, Tufts Health Plan 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.

Continuity of Care

Tufts Health Plan continues to support the care of members by applying the continuity of care principles as well as any regulatory requirements regarding continued care by a provider in order to minimize disruption of an ongoing episode of care and to ensure uninterrupted access to medically necessary services. Continuity of Care refers to the presence of an existing clinical relationship pertaining to the treatment of an ongoing clinical episode of acute care between the Member and Provider under certain specific conditions.

Providers who are leaving the Tufts Health Plan network for reasons unrelated to fraud or quality of care, and are currently treating a Tufts Health Plan member, should assist their patient by completing the Out-of-Network Coverage at In-Network Level of Benefits and Continuity of Care Prior Authorization Form.

Existing Members

Tufts Health Plan may allow members to be covered for continued treatment with a terminated practitioner in specific circumstances. This does not apply to members seeking coverage for continued treatment with a practitioner who has been involuntarily terminated for quality-related reasons (per the Quality of Care Committee (QOCC), including professional review actions, or fraud. Members whose providers have been terminated due to quality-related reasons or fraud can contact Tufts Health Plan for assistance in locating a new provider.

Requests for continuity of care for a transitional period are subject to clinical review for medical necessity, appropriateness, and safety. Continuity of care allows existing Members to receive services at in-network coverage levels for specified medical and behavioral services for a certain period of time as indicated in the Medical Necessity Guidelines: Out-of-Network Coverage at the In-Network Level of Benefits (All Plans).

PCP Disenrollment

Tufts Health Plan will inform members at least 30 days in advance of a PCP disenrollment. Members may continue to see their PCP for up to 30 days after disenrollment.

New Member

Tufts Health Plan will allow newly enrolled members to be covered for continued treatment with a non- participating practitioner in specific circumstances to facilitate transition and minimize disruption of care. Tufts Health Plan will provide coverage for continued services at in-network coverage levels for specified medical and behavioral services for a certain period of time as indicated in the Medical Necessity Guidelines: Out-of-Network Coverage at the In-Network Level of Benefits (All Plans).

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04/12/24	updated Outpatient Services Review section with revision to home health care services.
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