8 Utilization Management Program and Coverage Resources

The goal of the medical group Utilization Management (UM) Program is to monitor and manage the delivery of health care services to ensure that all services meet Tufts Health Plan Medicare Preferred HMO (Tufts Medicare Preferred HMO) coverage criteria.

Primary care physicians (PCPs) and specialists are expected to do the following:

- Participate fully with the medical group and Tufts Medicare Preferred HMO to share clinical information concerning members under their care
- Abide by plan preregistration policies concerning acute inpatient, skilled nursing facility (SNF) and surgical day-care cases
- Cooperate with and assist the Tufts Medicare Preferred HMO case manager (CM) concerning discharge planning activities
- Respond promptly to outpatient, inpatient or home care utilization concerns raised either concurrently or retrospectively as a result of the utilization review process

The Utilization Management Program's scope encompasses all health care delivery activities including inpatient/skilled nursing facility (SNF) care, outpatient care, office and home care.

UM Roles and Responsibilities

The Health Care Team

The health care team is a group of health care professionals including:

- The group's medical director
- Primary care providers and their office staff
- All other providers associated with that medical group
- The Tufts Medicare Preferred HMO case manager

The Tufts Medicare Preferred HMO case manager is an integral part of the case management and Quality Assurance (QA) meetings with the medical group and acts as a liaison between the medical group and Tufts Medicare Preferred HMO.

Case Management

Tufts Health Plan (Tufts HP) will make available the services of a registered nurse who will be known as a case manager and who will perform case management services for a medical group's members.

Definition of Case Management

Case management is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes.

Case Management Society of America

The Case Manager

Case managers provide case management services. The CM also develops a relationship with the patient and family and includes them in all aspects of the plan of care. The case manager works with the health care team to:

- Develop realistic, achievable patient goals
- Monitor patient progress
- Reevaluate patient care goals
- Update the case-management-care plan in collaboration with the health care team
- Record all pertinent information that supports the overall plan of care and services delivered to the patient across the continuum using Tufts Health Plan approved documentation guidelines

The Tufts Medicare Preferred HMO CM performs concurrent and retrospective case management services for:

- Acute hospital inpatient
- Inpatient rehabilitation
- Extended-care/skilled nursing facilities
- Home care/DME (Durable Medical Equipment)

The Tufts Medicare Preferred HMO CM collaborates with the health care team to facilitate patient discharge planning and to ensure that the patient receives appropriate services in a timely, cost-effective manner. The CM monitors quality of care events, appropriate level of care issues, and facilitates the patient's services (inpatient and outpatient) throughout the health care continuum.

Utilization Management Committee

UM Activities

The medical group conducts ongoing Utilization Management activities coordinated by a Tufts Medicare Preferred HMO case manager. These activities may include the following:

- A prospective review of elective admissions and proposed procedures or tests.
- Concurrent review of inpatient acute, chronic, skilled nursing facility (SNF), or rehabilitation care and home care services.
- Retrospective review of inpatient acute, chronic, skilled nursing facility (SNF), or rehabilitation care and home care services.

UM Meetings

The medical group must hold regularly scheduled Utilization Management meetings. See samples of the meeting agenda and minutes in Figure 8-1 and Figure 8-2. The UM Committee requires the following:

- At least one physician from the medical group must be available daily for review of urgent referral requests and other UM issues.
- Tufts Medicare Preferred HMO representatives must be allowed to participate in the medical group Utilization Management Committee meeting, as appropriate.
- Minutes must be kept of all meetings, and the results of all reviews – approvals and denials – must be documented and communicated to appropriate parties.

Prospective and Concurrent Utilization Review

When prospective or concurrent review is conducted, decision time frames and notification requirements are outlined in the *Tufts Health Plan Utilization Management Policy Manual*.

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 service requests for inpatient and outpatient services.

All initial utilization review should be conducted on a case-by-case basis. The following list shows examples of when utilization review can be performed prior to an admission, during a hospital stay or other course of treatment for standard or nonurgent situations:

- Elective surgery
- Referrals to specialists
- New requests for homecare type services; initial requests for SNF, Rehabilitation or Homecare services
- DME; DME requiring clinical evaluation

To determine if a request should be submitted for expedited review, refer to the *Expedited Review Log* and the *Expedited Review Log Instructions* in *Grievances, Organization Determinations, and Appeals*.

Medical Group Review

The medical group must do the following:

- Evaluate inpatients via telephone or on-site review using standardized criteria for Utilization Management and Quality Improvement
- Monitor ongoing specialized outpatient care provided by specialists, home care agencies or outpatient clinics including laboratory, durable medical equipment (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. See additional information in *Grievances, Organization Determinations, and Appeals*.
- Participate in an annual assessment of their utilization management systems.

Figure 8-1: Utilization Committee Agenda - Sample Format

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: ____________ ____________
   ____________ ____________
8. Emergency Room: ____________ ____________
   ____________ ____________
9. Referrals: ____________ ____________
   ____________ ____________
10. Homecare Referrals: ____________ ____________
    ____________ ____________
11. CatScans/MRIs: ____________ ____________
    ____________ ____________

Figure 8-2: Utilization Committee Minutes - Sample Format

Utilization Management Committee
Meeting Minutes

Confidential:

Proceedings, Report and Records of Medical Peer Review Committee

Date: ________________

Attendees:

Member	ID#	Issue	Committee Decision Follow-Up

Respectfully,

Chairman

Urgent/Emergency Care

Although authorization is not required, urgent or emergent care involves coordination by the PCP/medical group/case manager of urgent and emergency services, including inpatient and outpatient care.

Emergencies and urgent care that occur out of the service area should be reported to the case manager. Case managers assist the medical group with concurrent review, discharge planning and, when appropriate, in-plan transfers for all out-of-network inpatient admissions.

Emergency Medical Condition

An emergency medical condition is a condition 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 or, in the case of a pregnant woman, the health of the woman or her unborn child, (2) serious impairment to bodily function, or (3) serious dysfunction of any bodily organ or part.

Emergency Services

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

Urgently Needed Services

Covered services provided when an enrollee is temporarily absent from the Medicare Advantage[1] plan's 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) when such services are medically necessary and immediately required (1) as a result of unforeseen illness, injury, or condition; and (2) it was not reasonable given the circumstances to obtain the services through the organization offering the Medicare Advantage plan.

Post Stabilization Care

In most cases, if the emergency physicians determines that a member does not have an emergency medical condition, Tufts Medicare Preferred HMO will not cover any additional care that a member receives if they are seeing nonplan providers.

However, if a member has had an emergency medical condition, Tufts Medicare Preferred HMO will cover medically necessary services prior to and after the time the nonplan provider requests authorization until one of the following occurs:

- A plan provider assumes responsibility for the member's care.
- Tufts Medicare Preferred HMO agrees with the nonplan provider on a treatment plan for the member.
- Under the circumstances the member is discharged.

Further information is available in the Tufts Medicare Preferred HMO *Evidence of Coverage (EOC)*.

[1] Formerly Medicare+Choice (M+C)

Modified AEP Criteria

Tufts Health Plan modified Appropriateness Evaluation Protocol (AEP) criteria are used for all medical and surgical acute inpatient admissions and subsequent inpatient days. The criteria may be applied by the case manager to ascertain the most appropriate level of care for all commercial and Tufts Medicare Preferred HMO members. See Figure 8-3 through Figure 8-17.

The 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. There are specific criteria for adult medical, surgical, and pediatric members (age 0 – 18 years). Each criterion consists of a letter and a number that should be entered into the case manager’s documentation.

The Tufts Health Plan modified AEP criteria are used by the case manager to facilitate communication with the physician 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 physician when making coverage determinations for Tufts Medicare Preferred HMO members. Medicare coverage guidelines must be used when making coverage determinations and are available at http://cms.hhs.gov/.

Note: AEP criteria are used for screening purposes only and are not used for medical necessity determinations.

Figure 8-3: Tufts Health Plan Modified AEP Criteria[1] (page 1 of 15)

MEDICAL/SURGICAL CRITERIA
FOR USE IN PATIENTS OVER 18 YEARS OF AGE

SEVERITY OF ILLNESS

M 1. Acute onset of unconsciousness or disorientation
APP ***Use for coma and active disorientation. Not used for TIA unless the symptoms (i.e.: confusion) are unresolved upon admission.***

M 2. Symptomatic with Pulse rate abnormalities requiring hospital monitoring:
< 50 per minute
> 140 per minute
APP ***Documented signs and symptoms include hypotension, dizziness, syncope, and dyspnea. ~ Pulse less than 50 causing symptoms***

M 3. Blood pressure abnormalities requiring hospital monitoring:
Systolic < 90 or >230 mm. Hg.
Diastolic < 50 or >120 mm. Hg.
APP ***Apply when consecutive blood pressure readings over a period of several hours are documented as abnormal according to baseline.***

M 4. New loss of sight or hearing
APP ***Persistent loss of vision or hearing within 24 hours in the absence of Trauma. Most often applied when cause for the loss of vision/hearing is unknown.***

M 7. Active bleeding with existing or imminent hemodynamic instability
APP ***When patient is actively bleeding and imminently hemodynamically unstable with any of the following signs and symptoms: tachycardia, dyspnea, dropping Hct, orthostatic vital signs.***

M 8A Severe electrolyte/blood gas abnormality (any of the following):
Na <124 or >153 mEq/L
K <2.5 or >6.0 mEq/L
HCO_3 <20 or >36 mEq/L **(unless chronic level)**
Blood pH <7.30 or >7.50
APP ***Can be used for diabetic in alkalosis or acidosis. Excludes chronically abnormal high C02 (i.e.: COPD)***

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Figure 8-4: Tufts Health Plan Modified AEP Criteria[1] (page 2 of 15)

M 8B — Depressed Blood Count: (either of the following)
- New WBC < 2K and fever over 100.5
- Platelets < 20K with treatment planned (transfusion platelets, parenteral chemotherapy, IVIG)
- ANC <1000

APP — ***Used for transplant patients and patient receiving chemotherapy.***

M 9. — Acute or progressive sensory, motor, circulatory, or respiratory **impairment sufficient to incapacitate** the patient (inability to move, feed, breathe, etc.) **NOTE: Must also meet Intensity of Service Criteria in order to certify. Do not use for back pain.**

APP — ***In order to use M9, intensity of services must also be present. Can be used CVA, Fractures, COPD but the patient must be functionally incapacitated***. This could include major trauma.

M 9A — For nonsurgical Back Pain Admissions: **Consider Observation Setting or alternative out patient management**
Inpatient observation is required due to significant and increasing neurologic impairment believed to be due to nerve root compression

APP — ***Consider Observation or alternative setting for back pain. If admitted, worsening neurologic impairment must be documented.***

M 9B — **Consider Observation Setting or alternative outpatient management.** Failure of home traction and oral analgesia.

APP — ***Non-Surgical Back pain admitted for parenteral meds Observation or alternative setting such as SNF should be considered. Parenteral Medications should be used at least every 4 hours. (OR HOME/OP TREATMENT MAY BE APPROPRIATE)***

M 10. — EKG evidence of acute ischemia with suspicion of new MI

APP — ***Documented EKG changes. Clinical hx of ischemic chest pain of 20 or more minutes.***

M10A — ***Elevated levels of serum cardiac enzymes (troponin, CPK, LDH, and myoglobin) per lab standards.***

M 11. — Wound breakdown, dehiscence or evisceration

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Figure 8-5: Tufts Health Plan Modified AEP Criteria[1] (page 3 of 15)

APP — ***Used for documented concern about wound infection with progression to dehiscence with or without risk of evisceration.***

M 12. — Blood glucose level <50 or >300 (persistent after treatment) **and** acidosis (blood pH <7.30) or hyperosmolarity per lab standards.
NOTE: This criteria is not applicable to pregnant diabetic patients.

APP — ***Used for diabetics with abnormal sugar and acidosis or hyperosmolar state.***

M 23. — Fever of at least 101° rectally (or 100° orally), **and fever is being actively evaluated or treated.**

APP — ***Used for fever above 100:***

- ***progress notes document fever and need for continued hospitalization***
- ***diagnostic studies pending awaiting treatment decision***
- ***diagnostic studies and/or treatment unable to be safely provided in an alternate setting***
- ***wound (as documented) is progressively worsening***

Do not use this criteria for observation of fever, consider Skilled Nursing at home, referral to MD Reviewer and Discharge Planning.

M 24. — Coma – unresponsiveness for at least one hour except as caused by postictal state

APP — ***Used when there is ongoing neuro evaluation with unresolved confusion or periods of syncope.***

M 22. — EKG evidence of acute ischemia

APP — ***Used with ongoing cardiac evaluation or stabilization such as telemetry or medication adjustment.***

M 25. — Acute confusional state not due to alcohol withdrawal

APP — ***Used to address post-anesthesia confusion, drug reactions with resolving confusion.***

M 26. — Acute hematologic disorders (significant cytopenia or cytosis, e.g. thrombocytopenia, leukocytosis)

APP — ***Used for chemo patients with little or no improvement in blood counts, extremes in WBC – ie., 2K or 25K, echymosis or bleeding.***

M 27. — Progressive acute neurologic difficulties

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Figure 8-6: Tufts Health Plan Modified AEP Criteria[1] (page 4 of 15)

APP	***Worsening CVA's, cord compression from tumor, symptoms requiring a continued diagnostic work up. Not appropriate for chronic, medical or post surgical residual back disorder/pain.***
M 28.	Occurrence of a documented new MI or stroke
APP	***This criteria is used for ongoing cardiac/neuro diagnostic evaluation and/or stabilization in a patient admitted with acute Stroke or MI. No other signs or problems are evident.***

Other

M 47.	Refer to Attending/Medical Director. Met criteria but intensity of services greater than warranted by severity of Illness/Symptoms as described in chart.
APP	***Used where intensity of service may not meet inpatient criteria and medical evaluation by the Attending and/or Medical Director is appropriate.***

INTENSITY OF SERVICES

M 14.	Vital sign monitoring every two hours or more often (includes telemetry) over a 24 hour period. ***Consider Observation Setting***
APP	***Admitted to telemetry for: Acute chest pain or arrhythmia potentially compromising hemodynamic stability i.e., RAF, Frequent PVC's, Neuro vital signs at least every two hours for full 24 hours.***
M 15.	Chemotherapy requiring continuous observation for life-threatening toxic reactions. ***Consider Observation Setting***
APP	***Use for chemotherapy requiring bolus IV hydration with consecutive days of treatment greater than 24 hours.*** **Specific chemotherapy protocols such as treatment of brain tumors or lymphoma and for chemotherapy agents such as high dose methotrexate and initial dose of bleomycin.**
M 16.	Treatment in ICU
APP	***Use for care available only in the ICU.***
M 19.	Surgery or procedure scheduled within 24 hours requiring pre-operative use of equipment, facilities, or procedure available only in hospital setting. **Not used for pre-op days prior to elective surgery**
APP	***o Not used for elective pre op days.***

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Figure 8-7: Tufts Health Plan Modified AEP Criteria[1] (page 5 of 15)

	o Used for upon admission to tertiary facility when transferred from the Community Hospital for procedure ie, cardiac cath, CABG.
M 29.	Procedure in operating room that day requiring inpatient stay
APP	***Procedure in operating room that day requiring inpatient stay. Not used for SDC or outpatient procedures done in O.R.***
M 30.	Scheduled for procedure in operating room the next day, medically unstable or complex patient admitted for emergency/urgent surgery who require preop stabilization
APP	***Not used when scheduling is a problem due to OR booking delays.***
M 33.	Biopsy of internal organ that day with associated risk of bleeding. **Exception: biopsies of Liver Biopsy, Lung, Kidney or bone marrow aspiration**
M 37.	Treatment requiring frequent dose adjustments under direct medical supervision (consider alternate level of care if otherwise stable)
APP	***Used for loading doses and ongoing medication regulation requiring inpatient care. Examples:*** ***• Daily coumadin adjustment to therapeutic range when a wide fluctuation is present otherwise adjustment can be done at home*** ***• Daily cardiac med adjustments*** ***• Insulin adjustments according to blood levels at least 4 times daily***
M 38.	Close medical monitoring by a physician (observations must be documented in patient record).
APP	***Most often used when a patient is in ICU, meeting other criteria.***
M 41.	Parenteral therapy - intermittent or continuous IV fluid with any medically necessary supplements (electrolytes, medications)
APP	***o May be used for TPN, Platelets, Lipids, ABX, and PCA*** ***o IVABX ~ should consider alternative level of care for infusion when medically stable.*** ***Not used if po intake is adequate (500cc per 8 hours)*** ***Not used for KVO (50cc per hour or less)*** ***<u>Consider IV only as outpatient</u>***

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Figure 8-8: Tufts Health Plan Modified AEP Criteria[1] (page 6 of 15)

M 42.	Continuous monitoring of vital signs, at least every 30 minutes, for at least four hours **(includes telementary/ICU)**
APP	***Used for patients requiring telemetry while undergoing diagnosis and evaluation of arrhythmias, ongoing cardiac evaluation for rule out MI, syncopal episodes.*** ***Not used for concussion (consider observation)***
M 43.	IM and/or SC injections at least three times daily not legitimately replaceable by oral route
APP	***Used for sliding scale insulin with blood glucose monitoring at least QID*** ***Not used if switched to po that day and presently pain controlled*** ***(Consider outpatient)***
M 44.	Intake and output measurements directly related to the treatment plan (I+ O alone is not sufficient reason for inpatient)
APP	***May be used for: advancing diet (liquid to regular, initiating of tube feeds, restoration of ileostomy/colostomy function, medication induced diuresis, electrolyte imbalance, fluid restriction and pertinent chemistry. For example refractory vomiting, postural hypotension, and fluid overload***
M 45.	Major wound and drainage care requiring hospital level of services
APP	***May be used for chest tubes, t-tubes, advancing penrose, Hemovacs'/Jackson Pratt's with drainage or, wound care with packing and large amount of drainage, where care can not be safely administered in an alternate setting or unsuccessful outpatient treatment plan.***
M46	Close medical monitoring under the physician's direction. **(If needed for more than 24 hours discuss reassessment plan for level of care)**
APP	***May be used for:*** • ***Transmission precautions*** • ***Total bedrest due to medical instability, unable to move to alternative level of care*** • ***Aggregate of Services: Weak, debilitated patient requiring multiple therapies***

Other

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Figure 8-9: Tufts Health Plan Modified AEP Criteria[1] (page 7 of 15)

M 47.	Refer to Attending/Medical Director. Met criteria but intensity of services greater than warranted by severity of Illness/Symptoms as described in chart.
APP	***Used where intensity of service may not meet inpatient criteria and medical evaluation by the Attending and/or Medical Director is appropriate.***

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Figure 8-10: Tufts Health Plan Modified AEP Criteria[1] (page 8 of 15)

SURGICAL
DAY OF ADMISSION CRITERIA

S1	Surgical procedure performed on the day of admission

Pre-operative criteria are used for Tufts Medicare Preferred HMO members. Pre-operative days for commercial members are reviewed by the Pre-registration Department.

Special pre-operative evaluation/treatment, available only on an inpatient basis

S3	Parenteral medications not potentially available orally
S4	Extensive enemas via Home Health Services not feasible
S5	Procedures such as angiography, endoscopy, myelography, not to be done as part of the planned surgery and not feasible as out-patient
S6	Dialysis or exchange transfusions, usually patient is on chronic dialysis on outside

Patient Conditions Which Could Necessitate O.R. Delays In Hospitalized Patients

S7	Suspicion of ongoing or recent myocardial infarction
S8	Uncontrolled or unstable angina pectoris
S9	New or complex arrhythmia
S10	Uncompensated chronic heart failure
S11	New stroke not completed
S12	Transient ischemic attacks
S13	Unrelieved bronchospasm

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Figure 8-11: Tufts Health Plan Modified AEP Criteria[1] (page 9 of 15)

S14	Documented deterioration of chronic obstructive lung disease with unsafe blood gas levels
S15	Unexpected anemia requiring transfusion or explanation pre-operatively
S16	New granulocytopenia (<1500/mm^3) or thrombocytopenia (<100,00/ mm^3) requiring explanation pre-operatively
S17	Severe thrombocytopenia or lack of other clotting factors (e.g., prothrombin) not correctable in time (<24 hours). Switch from Coumadin to Heparin necessary preoperatively. Protime on morning of admission at or below acceptable anticoagulant level
S18	Uncontrolled diabetes mellitus
S19	Severe (Cr > 5.0 Mg/dl) or new azotemia
S20	Sever liver dysfunction, other than clotting (transsminase 5x upper limit of laboratory normal)
S21	Uncontrolled hyperthyroidism or severe hypothyroidism
S22	Unstable lab values that could impact surgical outcome
S24	New confusion or coma
S26	Uncontrolled seizures
S28	Active infection, other than that for which surgery is planned
S29	Unexplained fever, if not related to need for surgery

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Figure 8-12: Tufts Health Plan Modified AEP Criteria[1] (page 10 of 15)

PEDIATRIC CRITERIA
USE FOR AGES birth - 18

Severity of Illness

P1	Sudden onset of unconsciousness (coma or unresponsiveness) or disorientation.
P2	Acute or progressive sensory, motor, circulatory, or respiratory embarrassment sufficient to incapacitate the patient (inability to move, feed, breathe, urinate, etc.)
P3	Acute loss of sight or hearing.
P4	Acute loss of ability to move body part.
P5	Persistent unexplained fever.
P6	Active bleeding with hemodynamic changes
P7	Wound dehiscence or evisceration.
P8	Severe electrolyte/acid-base abnormality
P60	Acute hematological disorders with significant change from baseline values.
P10	Pulse rate outside accepted parameters for age.
P11	Blood pressure outside accepted parameters for age.
P61	Respiratory rate outside normal ranges and not responsive to outpatient treatment
P13	Acute episode of Seizure activity and not responsive to outpatient treatment.
P14	Cardiac arrhythmia
P15	Asthma or croup not responsive to outpatient treatment

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Figure 8-13: Tufts Health Plan Modified AEP Criteria[1] (page 11 of 15)

P16	Dehydration not responsive to outpatient treatment
P17	Encopresis not responsive to outpatient treatment
P18	Other physiologic problem (document diagnosis in notes as part of clinical review)
P19	Suspected or actual child abuse.
P21	Need for special observation or close monitoring of behavior, for nutritional disorders with physiological changes including alterations of baseline laboratory values. This may include initial infusion of enteral therapy.
P22	Surgery or procedure requiring general or regional anesthesia.
P23	Surgery or procedure requiring use of equipment, facilities, available only in a hospital.
P24	Treatment in an ICU
P25	Vital sign monitoring every 2 hours or more often (may include telemetry).
P26	I.V. medications and/or fluid replacement unable to be administered in alternate setting (does not include tube feedings or KVO's)
P27	Use of Chemotherapeutic agents with specific pediatric protocols unable to be administered in an alternate setting.

Other

P47.	Refer to Attending/Medical Director. Met criteria but intensity of services greater than warranted by severity of Illness/Symptoms as described in chart.
APP	***Used where intensity of service may not meet inpatient criteria and medical evaluation by the Attending and/or Medical Director is appropriate.***

Intensity of Services

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Figure 8-14: Tufts Health Plan Modified AEP Criteria[1] (page 12 of 15)

P30	Invasive procedure requiring frequent monitoring. May consider less intensive setting.
P39	Any test requiring strict dietary control. May consider less intensive setting.
P43	Respiratory therapy services-need for frequent or continuous respiratory care. May consider less intensive setting.
P44	Parenteral therapy-intermittent or continuous IV fluid with any supplementation (electrolytes, protein, medications). May consider less intensive setting.
P46	IM and/or SC injections at least four times daily. May consider less intensive setting.
P48	Major surgical wound and drainage care (e.g., chest tubes, T-tubes, hemovacs, Penrose drains).
P49	Traction for fractures, dislocations or congenital deformities. May consider less intensive setting.
P52	Hematological instability requiring transfusion. May consider less intensive setting.
P56	Frequent assessment and treatment for anaphylactic or toxic reactions to drugs, alcohol or other environmental factors, unresponsive to outpatient management.

Other

P47.	Refer to Attending/Medical Director. Met criteria but intensity of services greater than warranted by severity of Illness/Symptoms as described in chart.
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Figure 8-15: Tufts Health Plan Modified AEP Criteria[1] (page 13 of 15)

OBSERVATION CRITERIA

Medical services, treatment and diagnostic studies are provided under observation at a hospital level of care with the expectation that patient stabilization will occur in less than 24 hours. Services provided require frequent evaluation of symptoms, efficacy of treatment, and/or ongoing diagnostic work up.

Conditions Appropriate for Observation Services

This list is intended to be suggestive of conditions usually appropriate for observation services and does not exclude the use of other diagnoses for observation when clinically appropriate.

ADULT MEDICAL

- Abdominal pain without a surgical abdomen
- Anemia, unspecified
- Angina
- Asthma
- Bronchitis
- Cellulitis
- Chest pain
- Dehydration
- Diabetes Mellitus without electrolyte imbalance
- Dizziness
- Fever of unknown origin
- Gastritis
- Gastroenteritis
- Gastrointestinal bleeding
- Medical back
- Meningitis, rule out viral
- Migraine headaches
- New onset seizures
- Phlebitis, rule out
- Pneumonia
- Pyelonephritis, acute
- Renal colic/kidney stone
- Renal failure, chronic
- R/O sepsis

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Figure 8-16: Tufts Health Plan Modified AEP Criteria[1] (page 14 of 15)

- Syncope, questionable etiology
- Upper limb dislocations
- Upper limb closed fractures

REFERENCES:

A. Literature References:

B. Internal Resources:
Authors: Marjorie Callahan, R.N., Rita Pinto, B.S., R.N., Eileen Soucy, B.A., R.N., and Daniel Wallace, B.A., B.S.N., R.N.

C. Other Tufts Health Plan Resources: Anton Dodek, M.D., Tufts Health Plan Assistant Medical Director – Pediatrics, and Beverly Loudin, M.D., F.A.C.O.G., Tufts Health Plan Medical Director, Women's Health and Health Programs.

D. Related Tufts Health Plan Policies:

E. Relevant State Mandates: n/a

F. Specialty Advisory Committee/ Specialty Consultant Review:
Robert Brodie, M.D. 03/17/03
Robert S. Janett, M.D. 03/14/03
Robert S. Weinstein, M.D. 03/09/03

G. Clinical Services Medical Technology Assessment Review: 03/07/03

APPROVING BODIES AND DATES OF APPROVAL:

This AEP Criteria has been updated & modified by Tufts Health Plan according to current standards of practice and is subject to change without notice at any time.
COPIES MAY BE SUPPLIED UPON REQUEST.

[1] AEP criteria are used for screening purposes only and are not used for medical necessity determinations.

Figure 8-17: Tufts Health Plan Modified AEP Criteria[1] (page 15 of 15)

Medical Directors Committee 03/05/03
Care Management Steering Committee 03/06/03

STATEMENT REGARDING MEDICAL NECESSITY COVERAGE GUIDELINES

Medical Necessity Coverage Guidelines have been developed for determining coverage for Tufts Health Plan benefits and are published to provide easy access and a better understanding of the basis upon which coverage decisions are made. They are used in conjunction with a member's benefit document and in coordination with the member's physician(s). Tufts Health Plan makes coverage decisions on a case by case basis considering the individual member's health care needs. Medical Necessity Coverage Guidelines are developed for selected therapeutic or diagnostic services found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the Tufts Health Plan service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations.
Tufts Health Plan revises and updates Medical Necessity Coverage Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

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Coverage Resources

Providers in the Tufts Medicare Preferred HMO network must refer directly to Medicare coverage policies and to the most current Tufts Medicare Preferred HMO *Evidence of Coverage (EOC)* and to the *Summary of Benefits* when making coverage decisions.

Medicare Coverage Policies

Two types of Medicare coverage policies are available:

- *National Coverage Determinations (NCDs)*
- *Local Coverage Determinations (LCDs)* - previously known as Local Medical Review Policies (LMRPs)

As a Medicare Advantage plan, Tufts Medicare Preferred HMO must cover all services and benefits covered by Medicare. Coverage information (including effective date) that you receive concerning original Medicare also applies to Tufts Medicare Preferred HMO.

National Coverage Determinations (NCDs)

The Centers for Medicare and Medicaid Services (CMS) explains NCDs through program manuals, which can be accessed at http://cms.hhs.gov/manuals/.

The key manuals for coverage include:

- *Medicare National Coverage Determinations Manual*
- *Medicare Coverage Issues Manual*
  (being replaced by the *Medicare National Coverage Determinations Manual*)
- *Medicare Program Integrity Manual*
- *Medicare Benefit Policy Manual*

CMS updates program manuals through program transmittals. Transmittals summarize instructions to update a particular CMS manual, emphasizing what is changed, added or clarified, and to provide any background information useful in implementing the instructions.

Local Coverage Determinations (LCDs)

CMS contractors (for example, insurance carriers and intermediaries) develop and issue local coverage determinations (LCDs) to provide guidance to the public and the medical community within a specified geographical area.

LCDs supplement an NCD or explain when an item or service will be considered covered if there is no NCD. LCDs cannot contradict an NCD.

Providers can access our region's LCDs at the following website addresses:

- Durable Medical Equipment (DMERC) A: Health Now New York, Inc. at http://www.tricenturion.com
- Medicare, Part B: National Heritage Insurance Company (NHIC) at http://www.medicarenhic.com/index.shtml
- Medicare, Part A: Associated Hospital Service (AHS) at http://www.ahsmedicare.com

• Medicare, Part A: Empire Medicare Services at http://www.empiremedicare.com
• Medicare, Part A: Mutual of Omaha at http://www.mutualmedicare.com

Medicare Coverage Database

In December 2002 CMS launched the Medicare Coverage Database that can be accessed at http://cms.hhs.gov/coverage/. Users can search:

- National Coverage Determinations (NCDs)
- National Coverage Analyses (NCAs)

  These documents support the national coverage determination process.

- Local Coverage Determinations (LCDs)

  Note: The LCD section of the Medicare Coverage Database is only updated monthly. Therefore, the most current information for this region can be accessed via the websites listed in *Local Coverage Determinations (LCDs)*.

Additional Information

If you have coverage-related questions, contact your Tufts Medicare Preferred HMO Case Manager or the Tufts Medicare Preferred HMO Provider Customer Relations Department at 1-800-279-9022.

If you have questions about what Tufts Medicare Preferred HMO covers in addition to what Medicare covers, refer to the Tufts Medicare Preferred HMO *Evidence of Coverage (EOC)* and *Summary of Benefits* as follows:

• Individual Summary of Benefits at http://www.tuftshealth.com/secure_horizons/pdf/2005BenSum-Ind.pdf
• Employer/Group Summary of Benefits at http://www.tuftshealth.com/secure_horizons/pdf/2005BenSum_grp.pdf
• Individual Evidence of Coverage (EOC) at http://www.tuftshealth.com/secure_horizons/pdf/EOCind.pdf
• Group Evidence of Coverage (EOC) at http://www.tuftshealth.com/secure_horizons/pdf/EOCgroup.PDF

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 Skilled Nursing Facility Manual*, Chapter 2 - Coverage of Services, section 280.3, "Items and Services Furnished, Paid For or Authorized by Government Entities-Federal, State Or Local Governments"