

**Part I: Member & Provider Communications, Instructions & Letter Templates**

Title	Definition	Written Notice Should be Sent When:	Written Notice Delivery Method & Timeframes	Written Notice Requirements
<p><b><u>Important Message from Medicare (IM)</u></b></p> <p><b>CMS Standard Notice</b></p> <p><b>*OMB approval No.0938-0692</b></p> <p><b>*Form No. CMS-R-193</b></p>	<p>The Important Message provides information to members about the Quality Improvement Organization (QIO) hospital appeal process, the member's right to an expedited determination, associated liability regarding the discharge and the right to receive detailed information about the decision to discharge them from the hospital.</p> <p><b>Note:</b> Masspro is the QIO in this region.</p>	<ul style="list-style-type: none"> <li>▪ To all Medicare beneficiaries, including all Tufts Medicare Preferred HMO members, admitted to a hospital, regardless of whether or not the member disagrees with the discharge decision.</li> <li>▪ <b>The Important Message is issued <u>by the hospital</u>.</b></li> </ul>	<ul style="list-style-type: none"> <li>▪ Hospitals must issue the IM within 2calendar days of admission, and must obtain the signature of the member or representative.</li> <li>▪ Hospitals must issue a copy of the signed notice as far in advance of discharge as possible, but not more than 2 calendar days before discharge.</li> </ul>	<ul style="list-style-type: none"> <li>▪ The name, address and telephone number (including TTY) of the hospital must be included in the header.</li> <li>▪ The member's name, ID number attending physician and date of the notice must be included.</li> <li>▪ Physician concurrence is required.</li> <li>▪ The member or representative must sign and date the notice, and they retain the original.</li> </ul> <p><b>Note:</b> The Important Message is a standardized notice. Hospitals are not allowed to deviate from the content of the notice except where indicated.</p>

Title	Definition	Written Notice Should be Sent When:	Written Notice Delivery Method & Timeframes	Written Notice Requirements
<p><b><u>Detailed Notice of Discharge (DNOD)</u></b></p> <p><b>CMS Model Notice</b></p> <p>*OMB approval No.0938-1019 *Form No. CMS-10066</p> <p><b>H2256_2011_299 File and Use 2/15/11</b></p> <p><b>Tracked by Appeals &amp; Grievances</b></p>	<p>Detailed written notice issued to the member or authorized representative who appealed through Masspro. The notice provides a detailed explanation of why both the hospital and Tufts Medicare Preferred are in agreement with the member's doctor, and believes that the member's inpatient hospital services should end on the date indicated on the notice.</p> <p><b>Note:</b> Upon admission and prior to discharge, hospitals are required to issue to members the Important Message (IM1, and IM2). The Important Message informs the member of their planned discharge date, and gives them their Masspro appeal rights. If a member or their authorized representative files the hospital discharge appeal through Masspro, Tufts Medicare Preferred must generate, and have the hospital issue to the member/authorized representative the Detailed Notice of Discharge.</p>	<ul style="list-style-type: none"> <li>▪ Member/authorized representative does not agree with the hospital discharge decision, and they have filed a hospital discharge appeal through Masspro.</li> <li>▪ Masspro will contact both the hospital and Tufts Health Plan Medicare Preferred to notify them of the hospital discharge appeal request.</li> <li>▪ Tufts Health Plan Medicare Preferred Appeals &amp; Grievances will contact the appropriate Case Manager (CM), Delegated Case Manager (DCM), and Mental Health Care Manager (MHCM) to inform them of the hospital discharge appeal.</li> <li>▪ The CM/DCM/MHCM will fill out a <b>Hospital Discharge Summary Form</b>, and return it to Tufts Medicare Preferred Appeals &amp; Grievances so that the DNOD can be generated.</li> </ul>	<p>Delivered by the hospital to the member, or to the authorized representative as soon as possible but <i>no later than 12:00 PM</i> the day after Tufts Medicare Preferred was notified of the appeal request by Masspro.</p> <p><b>Note:</b> If a hospital discharge appeal is requested through Masspro, the member is protected from liability until 12:00 PM of the day following the day the Masspro decision is rendered.</p>	<p>The Detailed Notice of Discharge must;</p> <ul style="list-style-type: none"> <li>▪ Describe in simple terms the facts surrounding the decision to discharge the member</li> <li>▪ Explain why services are no longer necessary</li> <li>▪ Describe relevant Medicare coverage rules, instructions, or other policies</li> <li>▪ Use facts specific to the member and relevant to the coverage determination</li> </ul>

Title	Definition	Written Notice Should be Sent When:	Written Notice Delivery Method & Timeframes	Written Notice Requirements
<p><b><u>Notice of Denial of Medical Coverage (NDMC)</u></b></p> <p><b>Standard Notice H2256_2011_298 File and Use 2/14/2011</b></p> <p><b>*OMB approval No.0938-0829</b>  <b>*Form No. CMS-10003-NDMC</b></p> <p><b>Tracked by Precertification</b></p>	<p>Pre-Service/concurrent written notice to inform the member or their representative of a denied request for a service or item. The notice must include the specific reason for the denial.</p>	<ul style="list-style-type: none"> <li>▪ Member requests future/concurrent services and/or equipment</li> <li>▪ Member believes services should continue</li> <li>▪ SNF exhaustion of benefits where the member has exhausted their 100-day benefit)</li> <li>▪ When previously approved services are decreased</li> <li>▪ Medical Group has verbally informed member of their denial of coverage decision</li> <li>▪ Service requests to visit an out-of-plan/non-contracting specialist when there is a comparable in-plan/contracted specialist</li> <li>▪ Requests for non-covered DME items</li> <li>▪ Requests to rent or purchase durable medical equipment (DME) in a SNF</li> <li>▪ Homecare services when the Medical Group determines that the member does not meet the CMS criteria</li> <li>▪ Requests for medical and mental health inpatient admissions when services are not authorized</li> </ul> <p><b><i>All UM denials should have supporting clinical documentation sent with them</i></b></p>	<p><b>Instructions for Medical Group</b></p> <p><u>Standard Request Timeframe:</u>  Verbally notify a member within 5-calendar days of the initial request. The Medical Group submits the Denial of Coverage &amp; Expedited Approval Form, via fax, to Tufts Health Plan Precertification ASAP, but must be within 5-calendar days of the initial request. THP MP will mail the NDMC letter to the member within 14 calendar days, and provide copies to the member and the, PCP.</p> <p><u>Expedited Request Timeframe:</u>  Verbally notify a member of the decision within 24 hours of the initial request. The Medical Group submits the Denial of Coverage &amp; Expedited Approval Form, via fax, to Tufts Health Plan Medicare Preferred Appeals and Grievances ASAP, but must be within 24 hours of the initial request. Tufts Health Plan Medicare Preferred will hand deliver (fax) if member is in facility or mail to members within 72 hours, and provide copies to the PCP .</p>	<p>Notice requirements:</p> <ul style="list-style-type: none"> <li>▪ Signature of physician who made the organization determination (stamp NOT acceptable) on the THP MP Denial of Coverage &amp; Expedited Approval Form.</li> <li>▪ Member's appeal rights</li> <li>▪ Date of the last covered day must be clearly stated, if applicable</li> <li>▪ <b>Specific and detailed explanation</b> why the medical service or items are being denied</li> <li>▪ Description of any applicable Medicare Coverage rule or any other applicable Tufts Medicare Preferred HMO policy upon which the denial decision was based. Resources include: <ul style="list-style-type: none"> <li>✓ Medicare <i>Coverage Issues Manual</i> @ <a href="http://www.cms.hhs.gov/manuals/cmstoc.asp">http://www.cms.hhs.gov/manuals/cmstoc.asp</a></li> <li>✓ Medicare <i>Intermediary Manual</i>, Addendum A: section 3722.1 for SNF rationale codes</li> <li>✓ Tufts Medicare Preferred HMO benefit documents (Evidence of Coverage, Summary of Benefits)</li> </ul> </li> </ul>

Title	Definition	Written Notice Should be Sent When:	Written Notice Delivery Method & Timeframes	Written Notice Requirements
<p><b><u>Notice of Medicare Non-Coverage (NOMNC)</u></b></p> <p><b>Standard Notice NOMNC H2256_2011_266 HMO</b></p> <p><b>Form # CMS- 10095-NOMNC</b>  <b>Exp Date 8/31/2010</b>  <b>OMB approval # 0938-0910</b></p> <p><b>Tracked by Appeals &amp; Grievances at the time of an appeal</b></p>	<p>Advanced written notice to inform the member, who is receiving services from a Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehab Facility (CORF), that covered care is ending.</p>	<ul style="list-style-type: none"> <li>▪ Physician has determined the member no longer meets the SNF/HHA/CORF criteria for coverage at a skilled level of care</li> <li>▪ Member agrees or disagrees with the discharge plan</li> </ul> <p><b>Note:</b> NOMNCs should not be issued for SNF exhaustion of benefits. THP MP/Medical Group or provider should issue an NDMC, by filling out a Denial of Coverage &amp; Expedited Approval Form and sending it to Tufts Health Plan Medicare Preferred Appeals &amp; Grievances.</p>	<p>Delivered by the SNF/HHA/CORF provider to the member or to the member's authorized representative.</p> <p>Notification is minimally:</p> <ul style="list-style-type: none"> <li>▪ Two (2) days prior to the last covered day for SNF/CORF</li> <li>▪ If admission is anticipated to be less than 2 days, provide notice on the day of admission.</li> <li>▪ Next to the last visit for HHA services</li> </ul> <p><b><u>Member Receipt</u></b></p> <ul style="list-style-type: none"> <li>▪ If the member refuses to sign, the notice is still valid as long as the provider documents that the notice was given, and that the member refused to sign. The refusal should be witnessed on the signature page and filed, document a copy of the form was left with the member.</li> <li>▪ If member is unable to sign, the notice must be delivered to and signed by the member's authorized representative. If a representative is not available to receive and sign the notice the plan or provider must document the reason for employing an alternative to validate delivery to the member.</li> <li>▪ Verbal notification is considered valid when documentation in the medical record of the date &amp; time of the telephone call to the authorized representative explaining the contents of the NOMNC and appeal rights is completed. The written notice must follow the verbal notification.</li> <li>▪ There must be 3 documented attempts to verbally notify the member or authorized representative followed by a certified mailing of the NOMNC letter on the date of the verbal notification. The effective date of the receipt is the date indicated on the return receipt. If no call back is received, resend the notice or make an additional attempt to verbally notify the member/ authorized representative.</li> </ul>	<p>The NOMNC must:</p> <ul style="list-style-type: none"> <li>▪ Accurately 'count' from date of notice to the effective date (minimum of 2 days prior notice to the last covered day).</li> <li>▪ Correctly display facility and plan name, address and phone number.</li> <li>▪ Identify the services being terminated.</li> <li>▪ Use at least 12-point font.</li> <li>▪ Be signed by the member/authorized representative or include notation that member/auth. representative refused to sign or was unable to sign. Authorized representatives may be notified by telephone if personal delivery is not immediately available. In this case the auth. representative must be informed of the contents of the notice, the call must be documented on the notice, a copy of the notice must be filed in the member's medical record and the original notice must be mailed to the auth. representative.</li> <li>▪ Be dated</li> <li>▪ Describe the appeals process, including how to contact Masspro.</li> <li>▪ Accurately indicate Masspro's name and telephone number (1-800-252-5533)</li> <li>▪ Be delivered on time (on or before 2 calendar days prior to the effective date the coverage of services will end at the SNF or CORF or the next to last HHA visit.</li> </ul>

Title	Definition	Written Notice Should be Sent When:	Written Notice Delivery Method & Timeframes	Written Notice Requirements
<p><b><u>Detailed Explanation of Non-Coverage (DENC)</u></b></p> <p><b>Standard Notice H2256_2011_265 File and Use 1/23/2011</b></p> <p>Form # CMS 10095-DENC  <b>OMB Approval No. 0938-0910</b></p> <p><b>Tracked by Appeals &amp; Grievances</b></p>	<p>The DENC is a standardized written notice that provides specific and detailed information to the Medicare member of why their SNF, HHA, or CORF services are ending. Tufts Health Plan Medicare Preferred is required to send a copy of the DENC to the member/provider (with a copy provided to Masspro.</p>	<ul style="list-style-type: none"> <li>▪ Notice is provided when the Masspro accepts the request for a SNF/HHA/CORF (Fast-Track) Appeal.</li> <li>▪ Tufts Health Plan Medicare Preferred must submit a DENC along with the requested components of the member's medical record to Masspro no later than the close of business the day Masspro notifies Tufts Health Plan Medicare Preferred that a Fast-Track appeal was filed, or close of business the day before the member's discharge, whichever is later.</li> <li>▪ Tufts Health Plan Medicare Preferred Appeals &amp; Grievances will contact the appropriate Case Manager (CM), or Delegated Case Manager (DCM) to inform them of the SNF/HHA/CORF discharge appeal.</li> <li>▪ The CM/DCM will fill out a <b>SNF/HHA/CORF Discharge Summary Form</b>, and return it to Tufts Health Plan Medicare Preferred Appeals &amp; Grievances so that the DENC can be generated.</li> </ul> <p><b>Note:</b> The SNF/HHA/CORF provider is required to submit the requested components of the medical record within the requested timeframe. If the provider fails to submit the requested components of the medical record within the required timeframe, Tufts Health Plan Medicare Preferred may administratively deny the impacted days.</p>	<p>Delivered by an on-site CM/DCM, courier or contracted facility via fax to the member and Masspro no later than close of business (typically 4:30 P.M.) of the day of Masspro's notification of the appeal request, or the day before the effective date coverage ends, whichever is later.</p> <p>The delivery must be documented.</p> <p><b>Note:</b> If the member is receiving non-residential services and requests that the organization provide the DENC through e-mail or facsimile, then Tufts Health Plan Medicare Preferred will document and accommodate the request.</p>	<p>Notice requirements:</p> <ul style="list-style-type: none"> <li>▪ Type of Service denied</li> <li>▪ A specific and detailed explanation why services are either no longer reasonable and necessary or otherwise no longer covered;</li> <li>▪ Relevant facts to make the determination</li> <li>▪ Facts specific to the member and relevant to the coverage determination that are sufficient to advise the member of the applicability of the coverage rule or policy to the member's case.</li> <li>▪ Description of any applicable Medicare Coverage rule or any other applicable Tufts Medicare Preferred HMO policy upon which the denial decision was based. Resources include: <ul style="list-style-type: none"> <li>✓ Medicare <i>Coverage Issues Manual</i> @ <a href="http://www.cms.hhs.gov/manuals/cmstoc.asp">http://www.cms.hhs.gov/manuals/cmstoc.asp</a></li> <li>✓ Medicare <i>Intermediary Manual</i>, Addendum A: section 3722.1 for SNF rationale codes</li> <li>✓ Tufts Medicare Preferred HMO plan benefit documents (Evidence of Coverage, Summary of Benefits)</li> </ul> </li> </ul>

Title	Definition	Written Notice Should be Sent When:	Written Notice Delivery Method & Timeframes	Written Notice Requirements
<p><b><u>Medicare Advantage (MA) Reinstatement of Skilled Services Letter</u></b></p> <p>Reinstatement H2256_2011_331</p> <p>Issued by Case Management</p>	<p>Written letter to explain why denied SNF, Hospital, or Home Care <b>services are being reinstated.</b> (For the same benefit period).</p>	<p>Provided when prospective, concurrent, or retrospective review of the member's medical record reveals:</p> <ul style="list-style-type: none"> <li>▪ Coverage of skilled care is/was medically necessary</li> <li>▪ Required notification timeframe(s) not met</li> </ul>	<p>Delivered by the Medical Group or Tufts Health Plan Medicare Preferred to the member by mail.</p>	<p>Notice requirements:</p> <ul style="list-style-type: none"> <li>▪ Effective date of reinstatement</li> <li>▪ Date of original denial notice</li> <li>▪ Who to contact with questions</li> </ul>

Title	Definition	Written Notice Should be Sent When:	Written Notice Delivery Method & Timeframes	Written Notice Requirements
<p><b><u>Notice of Denial of Medicare Prescription Drug Coverage</u></b></p> <p><b>Standard Notice Pharm NDMCH2256_2011_30 9_S0655_2011_132 File and Use 2/26/2011</b></p> <p><b>OMB Approval No. #0938-0976 Form No CMS 10146</b></p> <p><b>Tracked by Clinical Review</b></p>	<p>Written notice issued when THP MP denies a Part D plan member's request for prescription drugs for all denial reasons.</p>	<p>The Notice of Denial of Medicare Prescription Drug Coverage is sent when Tufts Health Plan Medicare Preferred decides not to provide or pay for a requested benefit, in whole or in part. This decision is considered an adverse coverage determination. If Tufts Health Plan Medicare Preferred makes an adverse coverage determination, it must provide the member with a written denial notice that includes his or her appeal rights.</p> <p>Tufts Health Plan Medicare Preferred must provide a Notice of Denial of Medicare Prescription Drug Coverage when THP MP:</p> <ul style="list-style-type: none"> <li>▪ Makes an unfavorable organization determination for decisions to cover a drug</li> <li>▪ Determines that a drug is not medically necessary</li> <li>▪ Determines that a drug is excluded</li> <li>▪ Makes an unfavorable decision regarding a tier-exception, formulary exception, or cost sharing request</li> <li>▪ Determines that a prior authorization requirement has not been met</li> </ul>	<p>The Notice of Denial of Medicare Prescription Drug Coverage must be sent within 72 hours from the time the request is received for standard requests, and within 24 hours from the time the request is received for expedited.</p> <p>*Tufts Health Plan Medicare Preferred may make its initial notification orally. However, when Tufts Health Plan Medicare Preferred makes an adverse coverage determination, in whole or in part, Tufts Health Plan Medicare Preferred must provide written notice of the determination using the Notice of Denial of Medicare Prescription Drug Coverage. Therefore, if Tufts Health Plan Medicare Preferred first makes its adverse notification orally, the Notice of Denial of Medicare Prescription Drug Coverage must be mailed within 3 calendar days of the oral notification.</p>	<p>Notice requirements (Standard Notice):</p> <ul style="list-style-type: none"> <li>▪ The denied prescription drug(s) that were requested by the member or physician must be listed on the notice.</li> <li>▪ Tufts Health Plan Medicare Preferred must provide a specific reason and detailed explanation of why the prescription drug is being denied, including a description of any applicable Medicare coverage rule or any other applicable Part D plan policy upon which the denial decision was based. Tufts Health Plan Medicare Preferred's explanation must be written in a manner calculated to be understood by the member.</li> <li>▪ Right to appoint a representative in order to appeal</li> <li>▪ Description &amp; timeframes of both the standard &amp; expedited redetermination processes</li> </ul>

Title	Definition	Written Notice Should be Sent When:	Written Notice Delivery Method & Timeframes	Written Notice Requirements
<p><b><u>Tier or Formulary Exception Authorization Letter</u></b></p> <p>Tufts Health Plan created, CMS approved</p> <p>Exception Authorization Letter H2256_2010_239_S06 55_2010_193 3/10/2010</p> <p>Tracked by Clinical Review</p>	<p>Written notice Tufts Health Plan Medicare Preferred developed to notify members/providers when it has approved either a tier or formulary exception request.</p>	<p>Used when Tufts Health Plan Medicare Preferred makes a favorable organization determination regarding a member or provider's request for an exception to Tufts Medicare Preferred HMO's tiered cost-sharing structure, or formulary.</p> <p>The letter informs the member/provider of what was specifically approved, and for how long the approval is in place for.</p>	<p>The Tier or Formulary Exception Authorization Letter must be sent within 72 hours from the time the request is received for standard requests, and within 24 hours from the time the request is received for expedited.</p>	<p>Notice requirements:</p> <ul style="list-style-type: none"> <li>▪ The name of the drug, and the date of request</li> <li>▪ The tier-level or co-payment amount that the drug is approved for</li> <li>▪ The date that the authorization is good through, with a qualifier that the drug must be physician prescribed.</li> </ul>
<b>Extension and Did Not Meet Criteria Notices</b>				
<p><b><u>Standard Organization Determination Extension Letter</u></b></p> <p>Tufts Health Plan created, CMS approved</p> <p>Standard Organization Determination Extension Letter H2256_2004_137-HMO</p> <p>Tracked by Appeals &amp; Grievances</p>	<p>Written notice, when justified, used to inform of an extension of up to 14-calendar days to make a standard (non-urgent) initial organization determination when additional information is needed.</p>	<p>Provided when justification can be demonstrated by:</p> <ul style="list-style-type: none"> <li>▪ Decision delay is in the interest of the member</li> <li>▪ Member requests extension</li> <li>▪ Need exists for additional information, diagnostic tests or medical evidence from a non-contracted provider</li> </ul> <p><b>Note:</b> Notice is used in a situation such as:</p> <ul style="list-style-type: none"> <li>▪ A request for a second opinion, or</li> <li>▪ A request for additional diagnostic testing.</li> </ul>	<p>Delivered by Tufts Health Plan Medicare Preferred Appeals &amp; Grievances to the member/authorized representative by mail.</p>	<p>The Standard Organization Determination Extension Letter <u>must include:</u></p> <ul style="list-style-type: none"> <li>▪ Reason for the delay</li> <li>▪ Time allotted to obtain additional information</li> <li>▪ Information about the member &amp; Tufts Health Plan Medicare Preferred plan responsibilities during the extension period</li> <li>▪ Member grievance rights</li> </ul>

Title	Definition	Written Notice Should be Sent When:	Written Notice Delivery Method & Timeframes	Written Notice Requirements
<p><b><u>Expedited Organization Determination Extension Letter</u></b></p> <p>Tufts Health Plan created, CMS approved</p> <p>Expedited Organization Determination Extension Letter H2256- 2004_136-HMO</p> <p>Tracked by Appeals &amp; Grievances</p>	<p>Written notice, when justified, used to inform of an extension of up to 14-calendar days to make an expedited (urgent) initial organization determination when additional information is needed.</p>	<p>Provided when justification can be demonstrated by:</p> <ul style="list-style-type: none"> <li>▪ Decision delay is in the interest of the member</li> <li>▪ Member requests extension</li> <li>▪ Need exists for additional information, diagnostic tests or medical evidence from a non-contracted provider</li> </ul> <p><b>Note:</b> Notice is used in a situation such as when information from an out-of-plan provider is not complete, or is not received within the allowed timeframe to decide upon a member's request for coverage.</p>	<p>Delivered by Tufts Health Plan Medicare Preferred Appeals &amp; Grievances to the member by courier, hand delivered by CM/DCM or faxed to facility with hand delivery to member.</p>	<p>Expedited Organization Determination Extension Letter <u>must include:</u></p> <ul style="list-style-type: none"> <li>▪ Reason for the delay</li> <li>▪ Time allotted to obtain additional information</li> <li>▪ Information about the member &amp; Tufts Health Plan Medicare Preferred responsibilities during the extension period</li> <li>▪ Member grievance rights</li> </ul>

Title	Definition	Written Notice Should be Sent When:	Written Notice Delivery Method & Timeframes	Written Notice Requirements
<p><b><u>Does Not Meet Expedited Organization Determination Criteria Letter</u></b></p> <p><b>Tufts Health Plan created, CMS approved</b></p> <p><b>Does Not Meet Expedited Organization Determination Criteria Letter H2256-2006-246- for part C</b></p> <p><b>H2256_2010_165_H06 55_2010_140 for part D</b></p> <p><b>Tracked by Appeals &amp; Grievances</b></p>	<p>Written notice used to inform members, or their authorized representatives, that their request for an expedited organization determination does not meet the necessary time-sensitive criteria and that it will be processed under the standard timeframe.</p> <p>Note: Medicare definition of 'time sensitive' is a situation where the time frame of the standard decision process could jeopardize the life or health of the member, or could jeopardize the member's ability to regain maximum function.</p>	<p>Provided when:</p> <ul style="list-style-type: none"> <li>▪ Organization determination request does not meet the Medicare time-sensitive criteria</li> <li>▪ Standard organization determination timeframe is appropriate</li> </ul>	<p>Delivered by Precertification to the member by courier, hand delivered by CM/DCM or faxed to facility with hand delivery to member, when applicable.</p>	<p>Notice requirements:</p> <ul style="list-style-type: none"> <li>▪ Member's right to file a fast grievance regarding the decision not to expedite</li> <li>▪ Member's right to resubmit the request with the support of a physician. If physician support received the request would be considered expedited at that time</li> <li>▪ Informs the member that the request will follow the standard organization determination timeframe</li> <li>▪ Medicare's definition of "time sensitive"</li> </ul> <p>Note: Medicare definition of 'time sensitive' is a situation where the time frame of the standard decision process could jeopardize the life or health of the member, or could jeopardize the member's ability to regain maximum function.</p>

Title	Definition	Written Notice Should be Sent When:	Written Notice Delivery Method & Timeframes	Written Notice Requirements
<p><b><u>Not Expedited Appeal Criteria Letter</u></b></p> <p><b>Tufts Health Plan created, CMS approved</b></p> <p><b>Not Expedited Appeal Criteria Letter H2256-2004-140 for part C</b></p> <p><b>H2256_2010_165_H06 55_2010_140 for part D</b></p> <p><b>Tracked by Appeals &amp; Grievances</b></p>	<p>Written notice to inform the member, based on the information available, their expedited appeal request <b>did not meet</b> Medicare's definition of 'time sensitive' and thus will be processed through the standard appeals process.</p> <p><b>Note:</b> Medicare definition of 'time sensitive' is a situation where the time frame of the standard decision process could jeopardize the life or health of the member, or could jeopardize the member's ability to regain maximum function.</p>	<p>Sent to a member or authorized representative to inform them that their expedited appeal request does not meet the 'time sensitive' criteria, will not be processed through the expedited appeals process, but will be processed as a standard appeal, and will follow the standard appeal timeframe.</p>	<p>Delivered by Tufts Health Plan Medicare Preferred Appeals &amp; Grievances to the member/auth. representative by courier, hand delivered by CM/DCM or faxed to facility with hand delivery to member/auth. representative, when applicable.</p>	<p>Notice requirements:</p> <ul style="list-style-type: none"> <li>▪ Member's grievance rights</li> <li>▪ Medicare's definition of "time sensitive"</li> </ul> <p>Note: Medicare definition of 'time sensitive' is a situation where the time frame of the standard decision process could jeopardize the life or health of the member, or could jeopardize the member's ability to regain maximum function.</p>
<b>Payment &amp; Educational Letters</b>				

Title	Definition	Written Notice Should be Sent When:	Written Notice Delivery Method & Timeframes	Written Notice Requirements
<b>Member Transfer from PCP Panel for Cause (Non-Compliance) Letters</b>				
<p><b><u>Non-Compliance Of Physician Treatment Plan Template #1 (applicable to HMO only)</u></b></p> <p>Tufts Health Plan created, CMS approved H2256_2010_241</p> <p>Tracked by THP MP Customer Relations Department</p>	<p>Template letter # 1 informs the member/authorized representative they are not following the PCP's recommended plan of care.</p>	<p>Provided when the member's behavior is interfering with the PCP's ability to provide effective treatment.</p>	<p>Delivered by the Medical Group or PCP by mail to the member/authorized representative, with a copy to Tufts Health Plan Medicare Preferred Letter #1 is <u>sent to the member on two separate occasions, with a reasonable time period between each letter</u>, for the member to demonstrate treatment plan compliance.</p>	<p>Notice requirements:</p> <ul style="list-style-type: none"> <li>▪ Specific description of member's behavior</li> <li>▪ Dates of occurrence(s)</li> <li>▪ Recommendation of the behavior needed to achieve treatment plan compliance</li> <li>▪ Member grievance information</li> </ul> <p>Letter is used in a situation such as the following:</p> <ul style="list-style-type: none"> <li>▪ Member fails to demonstrate compliance with PCP visits</li> <li>▪ The treatment plan involves appointments every other week for wound eval &amp; treatment</li> <li>▪ PCP's office staff calls to remind the member in advance of each appointment.</li> </ul>

**Part II: Tufts Medicare Preferred HMO Payment Policies Denial Types**  
**Applies to HMO product, contracting providers and facilities**

Definition of Denial type	Denial Type and letter	Tufts Medicare Preferred HMO Product and Payment Responsibility	Timeframe Requirements
<p><b>Delay Days</b>  A “delay day” is defined as a day a member spends in a facility waiting for medically necessary diagnostic testing, treatments, therapies (including physical therapy), consultations, surgical /other procedures, or test results. The delay represents an interruption in evaluation or treatment which results in a longer length of stay than if the care had been efficiently provided and/or arranged, and may result in a denial of payment.</p>	<p><b><i>Delay Day denial letter</i></b></p>	<p>Tufts Medicare Preferred HMO members admitted to per diem hospitals.</p> <p>Facility responsible, provider responsible or both</p> <p>Member not responsible.</p>	<p><u>Concurrent and / or retrospective review</u> completed within 48 hours of learning about the delay and when all necessary information is received. Applies to all Medicare Preferred HMO products paid on a Per Diem payment.</p> <p>Decision and verbal notice must be given to the provider within 24 hours from the time the case manager receives all necessary information.</p> <p>Goal: Send denial letter within 1 business day of decision but no later than 5 business days.</p> <p>Notification to pre-certification department of denial code AL on case close out within (1) business day of decision</p>
<p><b>Lack of Information</b>  To administer the Tufts Medicare Preferred HMO, Tufts Health Plan needs to receive clinical information in a timely manner. We will deny payment of claims when the provider fails to provide the requested clinical information to Tufts Medicare Preferred and/or its delegate, as soon as possible, but generally no later than noon the next business day following the request. However, in rare circumstances, the provider may be asked to provide the information in a shorter timeframe. Failure to provide the requested clinical information within the requested timeframe for the <u>continued stay</u> review will result in a denial of payment to the provider. Since the case review was in process, TUFTS HEALTH PLAN denies only the date the clinical information was due. Tufts Health Plan will only consider payment for services rendered on or after the date all necessary information is received. If clinical information is received after a denial is issued, Tufts HP will only consider payment for services rendered on or after the date all necessary information is received.</p>	<p>Lack of information</p> <p>2 letters:  1)DRG or  2) Per diem/per service payment</p>	<p>Medicare Preferred HMO providers or facilities, paid per diem or DRG, all levels of care.</p> <p>Facility/provider (for HHA) responsible,</p> <p>Member not responsible.</p>	<p><u>Concurrent admission review</u> all facilities, all levels of care, both DRG and Per Diem, within 24 hours of when the case is identified and all the necessary information is not received.</p> <p><u>Concurrent continued stay reviews</u> in cute per diem facilities paid a per diem rate, skilled nursing facilities and home care.</p> <p>1. Initial request -Fax request for clinical information to the provider by 10:00am. For admission and continued stay reviews. For PPO or cases with no admission events request information within (1) hour of notification of admission.</p> <p>2. If the clinical information is not received by noon of the next business day following request (or within 24 hours from time of original request) then denial may be rendered.</p>

Definition of Denial type	Denial Type and letter	Tufts Medicare Preferred HMO Product and Payment Responsibility	Timeframe Requirements
<p>DRG: If facility is paid by DRG, the entire admission will be denied.</p>			<p>Providers must appeal for past dates of service. Verbal notice must be provided at time of decision</p> <p>Goal: Send the denial letter within 1 business day of decision but no later than 5 business days.</p> <p>Notification to pre-certification department of denial code HO on case close out within (1) business day of decision</p>
<p><b>Acute admissions that do not meet inpatient payment level</b></p> <p>Claims for acute admissions will be denied if it is determined that the services provided did not meet InterQual criteria for inpatient level of payment. The hospital may bill for the outpatient services provided during that admission.</p> <p>Claims for continued stay in a per diem acute facility will be denied if it is determined that the continued services do not meet InterQual criteria for inpatient level of payment.</p>	<p><b>Acute payment level</b></p> <p><b>No denial letter</b></p>	<p>Medicare Preferred HMO medical/surgical admissions.</p> <p>Facility responsible.</p> <p>Member not responsible.</p>	<p><u>Pre-service requests</u> for admission by a member will be reviewed to determine if the admission will meet InterQual criteria. Pre-service admission reviews will be done as expeditiously as possible. If a member does not meet criteria and the admission is denied a NDMC letter will be issued to the member</p> <p><u>Concurrent admission review</u> completed within 48 hours of identifying the case. If case did not meet criteria for admission case manager will negotiate for observation payment.</p> <p><u>Retrospective admission review</u> completed within 48 hours of identifying the case. (Member still inpatient or discharged). If case did not meet criteria for admission case manager will negotiate for observation payment.</p> <p><u>Concurrent inpatient review</u> for subsequent days in per diem facility, done each business day to determine if member continues to meet criteria. Denial for each day identified that member did not meet criteria</p> <p>Notification to pre-certification department of denial code FI with exact dates of service being denied on case close out within (1) business day of decision.</p>

Refer to the Tufts Health Plan [website](#) for complete policy descriptions.