

Tufts Health Plan Medicare Preferred Organization Determination & Notice Instructions

Title	Definition	Written Notice Should be Sent When:	Written Notice Delivery Method & Timeframes	Written Notice Requirements
<p><u>Important Message (IM) from Medicare</u></p> <p>CMS Standard Notice</p> <p>*OMB approval No.0938-0692</p> <p>*Form No. CMS-R-193</p>	<p>The IM provides information to members about the Quality Improvement Organization (QIO) hospital appeal process, the members 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>Note: Masspro is the QIO in this region.</p>	<ul style="list-style-type: none"> ▪ To all Medicare beneficiaries, including all Tufts Medicare Preferred members, admitted to a hospital, regardless of whether or not the member disagrees with the discharge decision. ▪ The IM is issued <u>by the hospital</u>. 	<ul style="list-style-type: none"> ▪ Hospitals must issue the IM within 2 calendar days of admission, and must obtain the signature of the member or representative. ▪ 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. 	<ul style="list-style-type: none"> ▪ The name, address and telephone number (including TTY) of the hospital must be included in the header. ▪ The member's name, ID number, attending physician and date of the notice must be included. ▪ Physician concurrence is required. ▪ The member or representative must sign and date the notice, and they retain the original. <p>Note: The IM is a standardized notice. Hospitals are not allowed to deviate from the content of the notice except where indicated.</p>
<p><u>Detailed Notice of Discharge (DNOD)</u></p> <p>CMS Model Notice</p> <p>*OMB approval No.0938-1019</p> <p>*Form No. CMS-10066</p>	<p>Detailed written notice issued to the member or authorized representative who appealed through Masspro. The notices provides a detailed explanation of why both the hospital and Tufts Medicare Preferred are in agreement with the member's doctor, and believe that the member's inpatient hospital services should end on the date indicated on the notice.</p>	<ul style="list-style-type: none"> ▪ Member/authorized representative does not agree with the hospital discharge decision, and they have filed a hospital discharge appeal through Masspro. ▪ Masspro will contact both the hospital and Tufts Medicare Preferred to notify them of the hospital discharge appeal request. 	<p>Delivered by the hospital to the member, 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>The Detailed Notice of Discharge must:</p> <ul style="list-style-type: none"> ▪ Describe in simple terms the facts surrounding the decision to discharge the member ▪ Explain why services are no longer necessary

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<p>H2256-2007-176-HMO H2229-2007-116- PPO Tracked by Appeals & Grievances</p>	<p>Note: Upon admission and prior to discharge, hospitals are required to issue to members the IM (IM1, and IM2). The IM 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 (DNOD).</p>	<ul style="list-style-type: none"> ▪ Tufts Medicare Preferred Appeals & 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. ▪ The CM/DCM/MHCM will fill out a <i>Hospital Discharge Summary Form</i>, and return it to Tufts Medicare Preferred Appeals & Grievances so that the DNOD can be generated. 	<p>Note: 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>	<ul style="list-style-type: none"> ▪ Describe relevant Medicare coverage rules, instructions, or other policies ▪ Use facts specific to the member and relevant to the coverage determination
<p><u>Notice of Denial of Medical Coverage</u> <u>(NDMC)</u> Standard Notice H2256-2008-163-HMO H2229-2008-107-PPO *OMB approval No.0938-0829 *Form No. CMS-10003-NDMC Tracked by Appeals & Grievances</p>	<p>Pre-Service/concurrent written notice to inform the member of a denied request for a not medically necessary, non-inpatient medical service. Denial reason can be not a covered service or not medically necessary.</p>	<ul style="list-style-type: none"> ▪ Member requests future/concurrent services and/or equipment ▪ Member believes services should continue (including SNF exhaustion of benefits) ▪ Medical Group has verbally informed member of their denial of coverage decision ▪ Service requests to visit an out-of-plan/non-contracting specialist when there is a comparable in-plan/contracted specialist ▪ Requests for non-covered DME items 	<p>Instructions for Medical Group <u>Standard Request Timeframe:</u> Verbally notify a member within 10-calendar days of the initial request. The Medical Group submits the Denial of Coverage & Expedited Approval Form, via fax, to Tufts Medicare Preferred Appeals & Grievances ASAP, but must be within 10-calendar days of the initial request. Tufts Medicare Preferred will mail the NDMC letter to the member within 14 calendar days, and provide copies to the Medical Group Medical Director, PCP and requested provider (if applicable).</p>	<p>Notice requirements:</p> <ul style="list-style-type: none"> ▪ Signature of physician who made the organization determination (stamp NOT acceptable) on the THP MP Denial of Coverage & Expedited Approval Form. ▪ Member's appeal rights ▪ Date of the last covered day must be clearly stated, if applicable ▪ Specific and detailed explanation why the medical service or items are being denied

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		<ul style="list-style-type: none"> ▪ Requests to rent or purchase durable medical equipment (DME) in a SNF ▪ Homecare services when the Medical Group determines that the member does not meet the CMS criteria. <p>Note: All UM denials should have supporting clinical documentation sent with them</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 & Expedited Approval Form, via fax, to Tufts Medicare Preferred Appeals and Grievances ASAP, but must be within 24 hours of the initial request. Tufts Medicare Preferred will hand deliver if member is in facility or mail to members within 72 hours, and provide copies to the Medical Group Medical Director, PCP and requested provider (if applicable).</p>	<ul style="list-style-type: none"> ▪ Description of any applicable Medicare Coverage rule or any other applicable Tufts Medicare Preferred policy upon which the denial decision was based. Resources include: <ul style="list-style-type: none"> ✓ Medicare Coverage Issues Manual @ http://www.cms.hhs.gov/manuals/cmstoc.asp ✓ Medicare Intermediary Manual, Addendum A: section 3722.1 for SNF rationale codes ✓ Tufts Medicare Preferred benefit documents (Evidence of Coverage, Summary of Benefits)

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<p><u>Notice of Medicare Non-Coverage (NOMNC)</u></p> <p>Standard Notice</p> <p>NOMNC H2256-2008-164-HMO NOMNC H2229-2008-108-PPO</p> <p>Form # CMS- 10095 <u>Exp Date 8/31/2010</u></p> <p>OMB approval # 0938-0910</p> <p>Tracked by Appeals & Grievances</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"> ▪ Physician has determined the member no longer meets the SNF/HHA/CORF criteria for coverage at a skilled level of care ▪ Member agrees or disagrees with the discharge plan <p>Note: NOMNCs should not be issued for SNF exhaustion of benefits. Tufts Medicare Preferred/Medical Group or provider should issue an NDMC, by filling out a Denial of Coverage & Expedited Approval Form and sending it to Tufts Medicare Preferred Appeals & 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"> ▪ Two (2) days prior to the last covered day for SNF/CORF ▪ If admission is anticipated to be less than 2 days, provide notice on the day of admission. ▪ Next to the last visit for HHA services <p>Member Receipt</p> <p>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, and a copy should be provided to the member.</p>	<p>The NOMNC must:</p> <ul style="list-style-type: none"> ▪ Accurately 'count' from date of notice to the effective date (minimum of 2 days prior notice to the last covered day). ▪ Correctly display facility and/or plan name, address and phone number. ▪ Identify the services being terminated. ▪ Use at least 12-point font. ▪ 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.

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			<p>If member is unable to sign, the notice must be delivered to and signed by the member's 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.</p> <ul style="list-style-type: none"> ▪ Verbal notification is considered "valid" when documentation in the medical record of the date & 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. ▪ 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. 	<p>In this case, the authorization 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 authorization representative. The notice should:</p> <ul style="list-style-type: none"> ▪ Be dated ▪ Describe the appeals process, including how to contact Masspro. ▪ Accurately indicate Masspro's name and telephone number (1-800-252-5533) ▪ 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. <p>Note: All NOMNCs should be faxed within 7 days of being issued to the member to Tufts Medicare Preferred Appeals & Grievances Department 1-617-972-9516.</p>

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<p><u>Detailed Explanation of Non-Coverage (DENC)</u> Standard Notice</p> <p>DENC H2256-2008-155-HMO DENC H2229-2008-103-PPO</p> <p>OMB Approval No. 0938-0910</p> <p>Tracked by Appeals & Grievances</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 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"> ▪ Notice is provided when the Masspro accepts the request for a SNF/HHA/CORF (Fast-Track) Appeal. ▪ Tufts 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 Medicare Preferred that a Fast-Track appeal was filed, or close of business the day before the member's discharge, whichever is later. ▪ Tufts Medicare Preferred Appeals & Grievances will contact the appropriate CM, or DCM to inform them of the SNF/HHA/CORF discharge appeal. ▪ The CM/DCM will fill out a SNF/HHA/CORF Discharge Summary Form, and return it to Tufts Medicare Preferred Appeals & Grievances so that the DENC can be generated. <p>Note: 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, THP MP 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>Note: If the member is receiving non-residential services and requests that the organization provide the DENC through e-mail or facsimile, then Tufts Medicare Preferred will document and accommodate the request.</p>	<p>Notice requirements:</p> <ul style="list-style-type: none"> ▪ Type of Service denied ▪ A specific and detailed explanation why services are either no longer reasonable and necessary or otherwise no longer covered; ▪ Relevant facts to make the determination ▪ 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. ▪ Description of any applicable Medicare Coverage rule or any other applicable Tufts Medicare Preferred policy upon which the denial decision was based. Resources include: <ul style="list-style-type: none"> ✓ Medicare Coverage Issues Manual @ http://www.cms.hhs.gov/manuals/cmstoc.asp ✓ Medicare Intermediary Manual, Addendum A: section 3722.1 for SNF rationale codes ✓ Tufts Medicare Preferred plan benefit documents (Evidence of Coverage, Summary of Benefits)

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<p><u>Medicare Advantage (MA) Reinstatement of Skilled Services Letter</u></p> <p>Reinstatement H2256-2006-127-HMO</p> <p>Reinstatement H2229-2006-80-PPO</p> <p>Tracked by Case Management</p>	<p>Written letter to explain why denied SNF, Hospital, or Home Care services are being reinstated. (For the same benefit period).</p>	<p>Prospective, concurrent, or retrospective review of the member's medical record reveals:</p> <ul style="list-style-type: none"> ▪ Coverage of skilled care is/was medically necessary ▪ Required notification timeframe(s) not met 	<p>Delivered by the Medical Group or THP MP to the member by mail.</p>	<p>Notice requirements:</p> <ul style="list-style-type: none"> ▪ Effective date of reinstatement ▪ Date of original denial notice ▪ Specific reason for reinstatement from the choices listed on the Addendum list which is attached to the MA Reinstatement of Skilled Services Letter (Insert only one paragraph that is specific to the services being reinstated) ▪ Who to contact with questions
<p><u>Notice of Denial of Medicare Prescription Drug Coverage</u></p> <p>Standard Notice</p> <p>Pharm NDMC H2256-2006-205-HMO</p> <p>Pharm NDMC H2229-2006-139-PPO</p> <p>OMB Approval No. #0938-0976</p> <p>Tracked by Clinical Review</p>	<p>Written notice issued when Tufts Medicare Preferred 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 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 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 Medicare Preferred must provide a Notice of Denial of Medicare Prescription Drug Coverage when THP MP:</p> <ul style="list-style-type: none"> ▪ Makes an unfavorable organization determination for decisions to cover a drug ▪ Determines that a drug is not medically necessary 	<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 Medicare Preferred may make its initial notification orally. However, when Tufts Medicare Preferred makes an adverse coverage determination, in whole or in part, Tufts Medicare Preferred must provide written notice of the determination using the Notice of Denial of Medicare Prescription Drug Coverage. Therefore, if Tufts 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:</p> <ul style="list-style-type: none"> ▪ The denied prescription drug(s) that were requested by the member or physician must be listed on the notice. ▪ Tufts 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 Medicare Preferred's explanation must be written in a manner calculated to be understood by the member.

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		<ul style="list-style-type: none"> ▪ Determines that a drug is excluded ▪ Makes an unfavorable decision regarding a tier-exception, formulary exception, or cost sharing request ▪ Determines that a prior authorization requirement has not been met 		<ul style="list-style-type: none"> ▪ Right to appoint a representative in order to appeal ▪ Description & timeframes of both the standard & expedited predetermination processes
<p><u>Tier or Formulary Exception Authorization Letter</u></p> <p>Tufts Health Plan created, CMS approved</p> <p>Exception Authorization Letter</p> <p>H2256-2006-99-HMO</p> <p>Exception Authorization Letter</p> <p>H2229-2006-51-PPO</p> <p>Tracked by Clinical Review</p>	<p>Written notice Tufts Medicare Preferred developed to notify members/ providers when it has approved either a tier or formulary exception request.</p>	<p>Used when Tufts Medicare Preferred makes a favorable organization determination regarding a member or provider's request for an exception to Tufts Medicare Preferred'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"> ▪ The name of the drug, and the date of request ▪ The tier-level or co-payment amount that the drug is approved for ▪ The date that the authorization is good through, with a qualifier that the drug must be physician prescribed.
<i>Extension and Did Not Meet Criteria Notices</i>				
<p><u>Standard Organization Determination Extension Letter</u></p> <p>Tufts Health Plan created, CMS approved</p> <p>Standard Organization Determination Extension Letter</p>	<p>Written notice, when justified, to request 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"> ▪ Decision delay is in the interest of the member ▪ Member requests extension ▪ Need exists for additional information, diagnostic tests or medical evidence from a non-contracted provider 	<p>Delivered by Tufts Medicare Preferred Appeals & 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"> ▪ Reason for the delay ▪ Time allotted to obtain additional information ▪ Information about the member & THP MP plan responsibilities during the extension period ▪ Member grievance rights

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<p>H2256-2004-137-HMO Standard Organization Determination Extension Letter H2229-2005-049-PPO Tracked by Appeals & Grievances</p>		<p>Note: Notice is used in a situation such as:</p> <ul style="list-style-type: none"> ▪ A request for a second opinion, or ▪ A request for additional diagnostic testing. 		
<p><u>Expedited Organization Determination Extension Letter</u> Tufts Health Plan created, CMS approved Expedited Organization Determination Extension Letter H2256-2004-136-HMO Expedited Organization Determination Extension Letter H2229-2005-019-PPO Tracked by Appeals & Grievances</p>	<p>Written notice, when justified, to request an extension of up to 72-hours 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"> ▪ Decision delay is in the interest of the member ▪ Member requests extension ▪ Need exists for additional information, diagnostic tests or medical evidence from a non-contracted provider <p>Note: 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 Medicare Preferred Appeals & 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"> ▪ Reason for the delay ▪ Time allotted to obtain additional information ▪ Information about the member & Tufts Medicare Preferred responsibilities during the extension period ▪ Member grievance rights

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<p><u>Does Not Meet Expedited Organization Determination Criteria Letter</u></p> <p>Tufts Health Plan created, CMS approved</p> <p>Does Not Meet Expedited Organization Determination Criteria Letter H2256-2006-246-HMO</p> <p>Does Not Meet Expedited Organization Determination Criteria Letter H2229-2006-163-PPO</p> <p>Tracked by Appeals & Grievances</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"> ▪ Organization determination request does not meet the Medicare time-sensitive criteria ▪ Standard organization determination timeframe of 14-days is appropriate 	<p>Delivered by Tufts Medicare Preferred Appeals and Grievances 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"> ▪ Member's right to file a fast grievance regarding the decision not to expedite ▪ 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 ▪ Informs the member that the request will follow the standard organization determination timeframe ▪ Medicare's definition of "time sensitive" <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><u>Not Expedited Appeal Criteria Letter</u></p> <p>Tufts Health Plan created, CMS approved</p> <p>Not Expedited Appeal Criteria Letter H2 256-2004-140-HMO</p>	<p>Written notice to inform the member, based on the information available, their expedited appeal request <i>did not meet</i> Medicare's definition of 'time sensitive' and thus will be processed through the standard appeals process.</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 Medicare Preferred Appeals and 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"> ▪ Member's grievance rights ▪ Medicare's definition of "time sensitive"

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<p><u>Not Expedited Appeal Criteria Letter</u></p> <p>Tufts Health Plan created, CMS approved</p> <p>H2229-2005-038-PPO</p> <p>Tracked by Appeals & Grievances</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>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>
<u>Payment & Educational Letters</u>				
<p><u>Notice of Financial Liability (applicable to HMO only)</u></p> <p>Tufts Health Plan created, CMS approved</p> <p>H2256-2004-36 Notice of Financial Liability</p>	<p>Notice explains the potential for member liability of payment of covered services and/or diagnostic tests from a THP MP contracted provider.</p> <p>Issued by in-plan specialty provider. Absence of this notice will result in claim denial reason code "NRWVR" (No Referral Waiver on File).</p>	<p>Provided when:</p> <ul style="list-style-type: none"> ▪ Contracted Tufts Medicare Preferred service provider has no evidence of PCP prior approval/referral and thus payment is questionable ▪ Member requests contracted service provider to deliver service(s) without obtaining prior PCP approval/referral 	<p><u>Delivered by the Tufts Medicare Preferred contracted service provider to the member.</u></p>	<p>Notice requirements:</p> <ul style="list-style-type: none"> ▪ Member appeal rights ▪ Signature of the member/authorized representative ▪ Name of member's PCP ▪ Estimated charge for the service <p>Note: The Provider Referral/Authorization Waiver Requirement letter (ML6528027/PRS 1/2004) informed the provider about the Notice of Financial Liability template and the responsibility to inform the member of the potential for liability of payment of services before each service is rendered.</p>

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<i>Member Transfer from PCP Panel for Cause (Non-Compliance) Letters</i>				
<p><u>Non-Compliance Of Physician Treatment Plan Template #1 (applicable to HMO only)</u></p> <p>Tufts Health Plan created, CMS approved</p> <p>Non-Compliance of Physician Treatment Plan Letter #1</p> <p>H2256-2006-248</p> <p>Tracked by Tufts Medicare Preferred 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 Medicare Preferred. Letter #1 is <u>sent to the member on two separate occasions</u>, with a reasonable time period between each letter, for the member to demonstrate treatment plan compliance.</p>	<p>Notice requirements:</p> <ul style="list-style-type: none"> ▪ Specific description of member's behavior ▪ Dates of occurrence(s) ▪ Recommendation of the behavior needed to achieve treatment plan compliance ▪ Member grievance information <p>Letter is used in a situation such as the following:</p> <ul style="list-style-type: none"> ▪ Member fails to demonstrate compliance with PCP visits ▪ The treatment plan involves appointments every other week for wound evaluation & treatment ▪ PCP's office staff calls to remind the member in advance of each appointment.

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<p><u>Impaired Patient/Physician Relationship Non-Compliance Letter #2 (applicable to HMO only)</u></p> <p>Tufts Health Plan created, CMS approved</p> <p>H2256-2006-249</p> <p>Tracked by Tufts Medicare Preferred Customer Relations Department</p>	<p>Template letter #2 informs the member of the PCP's decision to terminate care due to member's continued non-compliance with the treatment plan.</p>	<p>Provided when:</p> <ul style="list-style-type: none"> ▪ Member continues to be non-compliant with recommended treatment plan and ▪ After a reasonable period of time from the issuance of a second letter #1 	<p>Delivered by the Medical Group or PCP by mail to the member/authorized representative, with a copy to Tufts Medicare Preferred.</p>	<p>Notice requirements:</p> <ul style="list-style-type: none"> ▪ Specific description of member's behavior ▪ Dates of occurrence ▪ PCP's recommendation to select another PCP ▪ PCP's statement of availability to the member until their care has been transferred ▪ Member grievance information <p>Letter is used in a situation such as the following:</p> <ul style="list-style-type: none"> ▪ Member continues to miss PCP appointments, ▪ Member refuses alternative plan to allow a HCA into their home for dressing changes ▪ Member fails to return PCP telephone calls

Applies to HMO and PPO products, contracting providers and facilities v. 12/10/07

Definition of Denial Type	Denial Type and Letter	Tufts Medicare Preferred Product and Payment Responsibility	Timeframe Requirements
<p><u>Delay Days</u> 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>Delay Day denial letter</p>	<p>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><u>Lack of Information</u> To administer the Tufts Medicare Preferred products, 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>DRG: If facility is paid by DRG, the entire admission will be denied.</p>	<p>Lack of information</p> <p>2 letters: 1)DRG or 2) Per diem/per service payment</p>	<p>Medicare Preferred HMO and PPO 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> <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</p>

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			<p>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><u>Acute admissions that do not meet inpatient payment level</u></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>Acute payment level</p> <p>No denial letter</p>	<p>Medicare Preferred HMO, PPO acute med/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 [Web site](#) for complete policy descriptions.