Implementation Council

Mar 8, 2022

Tufts Health Unify

One Care Rating Categories Definitions

Data is shown by rating category in this presentation. See rating category definitions below for reference:

F1 – Facility-based Care. Individuals identified as having a long-term facility stay of more than 90 days

C3 – Community Tier 3 – High Community Need. Individuals who have a daily skill need of two mor more Activities of Daily Living (ADL) limitations AND three days of skilled nursing need; and individuals with 4 or more ADL limitations

- In CY2014, C3 split into two subsets:

  C3B: for C3 individuals with certain diagnoses (e.g. quadriplegia, ALS, Muscular Dystrophy and Respirator dependence) leading to costs considerably above the average for current C3

  C3A: for remaining C3 individuals

C2 – Community Tier 2 – Community High Behavioral Health. Individuals who have chronic and ongoing Behavioral Health diagnosis that indicates a high level of service need

- In CY2014, C2 split into two subsets

  C2B: for C2 individuals with co-occurring diagnoses of substance abuse and serious mental illness

  C2A: for remaining C2 individuals

C1 – Community Tier 1 Community Other. Individuals in the community who do not meet F1, C2 or C3 criteria

Utilization Management Definitions

Approvals

A request is granted.

Approvals with Modifications (aka Partial Approvals)

A request has been granted with a decrease or substitute.

Denials

The request has not been granted. Examples include:

- Procedural denials- claim filed incorrectly or duplicative
- Member’s plan maximum benefit reached
- Request for out-of-network provider with in-network options available
- Medical necessity criteria not met

Prior Authorization – Decision Letters

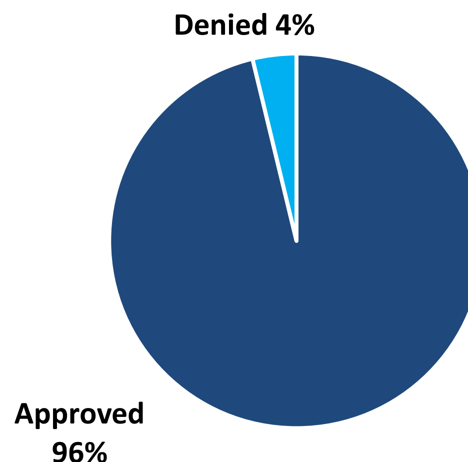
- Decision letters are sent in response to all prior authorization requests received
  - Services not requiring prior authorization do not result in a letter. Instead, the member is kept informed by their Care Partner and/or provider.
- Decision letter content depends on outcome
  - Approvals outline:
    - Services being approved as well as amount approved
  - Approvals with Modification* (*Partial Approvals only*) outline:
    - What was approved compared to the original request
    - Why we made this change
    - Member appeal rights and instructions
  - Denials outline:
    - Why we denied this request
    - Member appeal rights and instructions
- Members can appeal modifications and denials themselves, or have a care partner/trusted individual assist in the appeal process

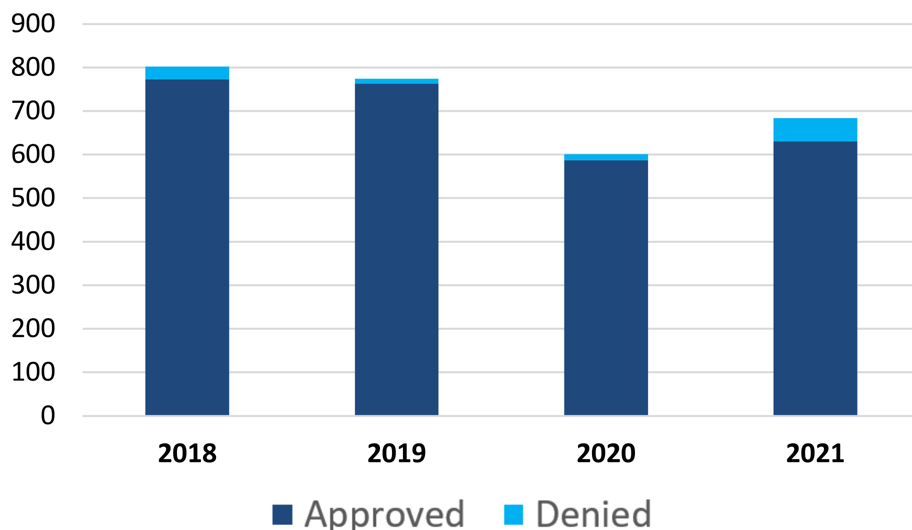
*Modifications that are considered "upgrades" are captured in the approvals category due to existing systems and processes

96% of sent DME letters are Approvals

Of the **2861 DME requests** from **1076 members** since 2018* which resulted in a decision letter**:

- **96%** were Approved
- **4%** were Denied





Year	Approved N (%)	Denied N (%)	Total
2021	630 (92%)	54 (8%)	684
2020	587 (98%)	14 (2%)	601
2019	763 (99%)	11 (1%)	774
2018	773 (96%)	29 (4%)	802
Grand Total	2753 (96%)	108 (4%)	2861

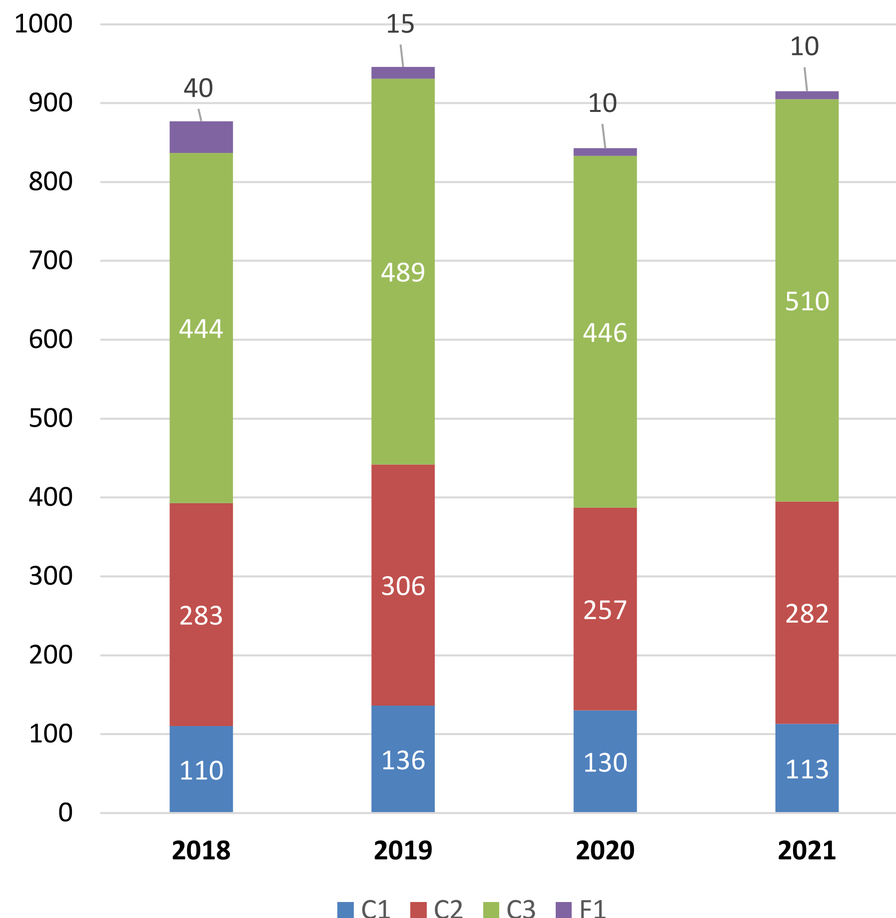
*Data reflects the time period 2018 – 2021 and is based on volume of Prior Authorization decision letters sent to members.

**Doesn't reflect volume of DME approved without requiring Prior Authorization (PA), as letters are only sent for services requiring it

DME Letters* – Rating Category

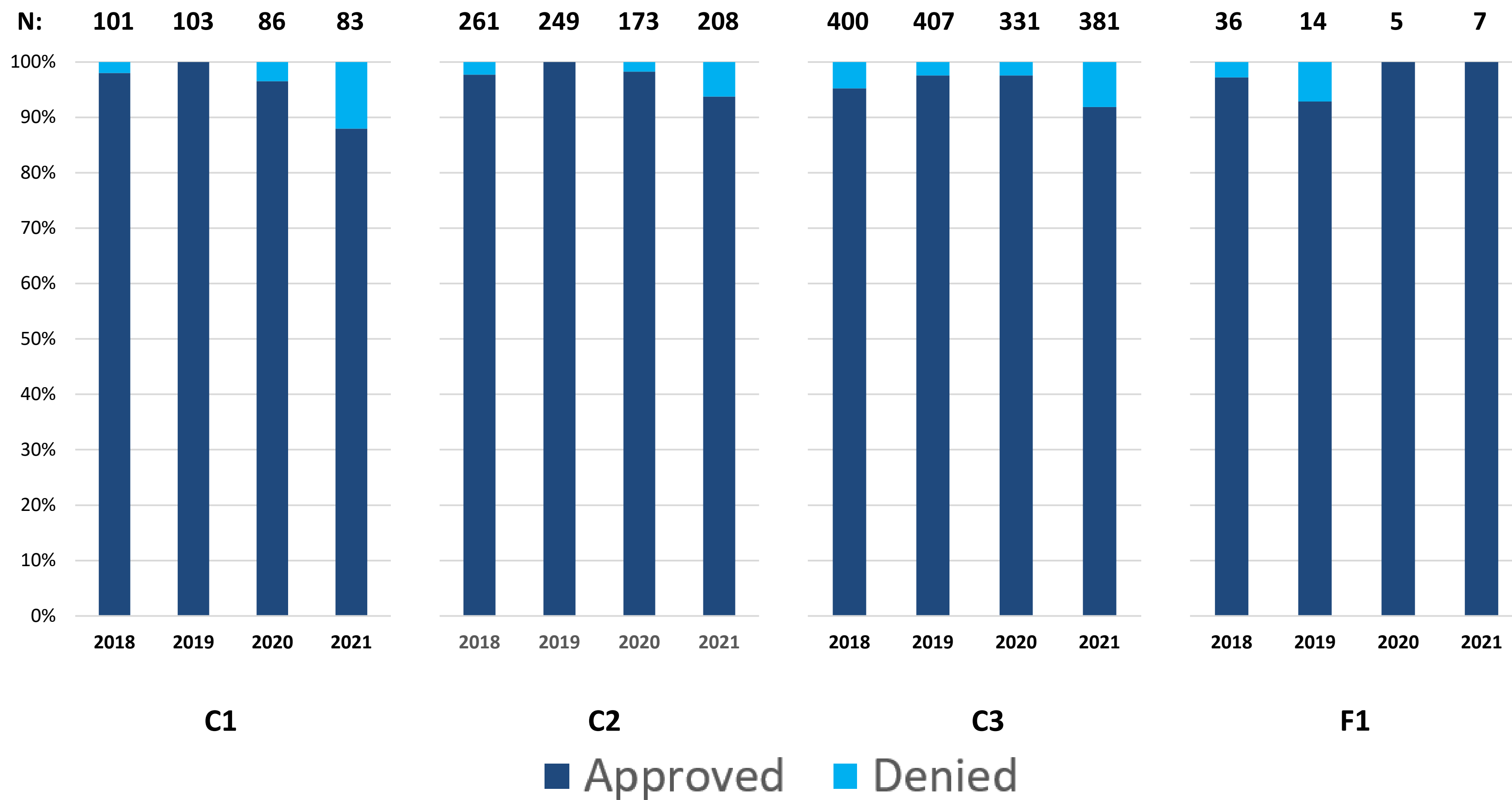
The majority of DME requests are driven by C3 members, with requests from C2 members also fairly common.

- C1: 14%
- C2: 31%
  - C2A: 26%
  - C2B: 6%
- C3: 53%
  - C3A: 49%
  - C3B: 4%
- F1: 2%



*Letters are sent for DME requiring prior authorization

DME Letters* – Year and Rating Category



*Letters are sent for DME requiring prior authorization

Appendix

UM Decision Letter Examples: Approval

Identifies and describes all services for which the member has been approved

AUTHORIZATION FOR SERVICES

January 05, 2022

ADVUMM

Member address

Member information:
Member name:
Member ID number:
Member DOB:

Provider information:
Provider name:
Provider fax:

Dear:

We reviewed your request and authorized the services listed below to be provided by . This approval only authorizes the listed services.

Authorization information:
Reference #:
Dates of service:
Diagnosis:
Description:

[FREE TEXT]

Procedure	Description	From	To	visit(s)

This authorization is not a guarantee of payment. It is your provider's responsibility to check eligibility for each date of service and to follow our current payment policy guidelines.

UM Decision Letter Examples: Partial Approval or Denial

Outlines why the service was approved with modifications or denied, including several pages describing how the member may appeal the decision

Tufts Health Unify (Medicare-Medicaid Plan) Notice of Adverse Action

Denial or Modification of a Requested Service

Date: Member number: ID #

Name:

Service:

Authorization requested:

The request for authorization of the services/items listed above was denied or changed.

We've [denied or modified] the request for payment of medical services/items listed above from your health care provider. Our decision is:

Why did we deny or change your request?

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We [denied or changed] the request for medical services/items listed above because: