Slide 1: Tufts Health Plan

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Slide 2: 1B. Medical Necessity Definition

Medically necessary is defined as:

- Member reasonably needs the services to prevent, diagnose, or treat a medical condition or to maintain his/her current overall health status.
- Services, supplies, or drugs meet accepted standards of medical practice
- There is no appropriate alternative service suitable for the member.

Medical Necessity Guidelines (MNGs): Written guidelines used by THPP to facilitate consistent medical necessity determinations for coverage

- Developed by the Medical Policy department in collaboration with practicing community providers and THP Medical Directors.
    - Reviewed and approved by the Integrated Medical Policy Advisory Committee (IMPAC); composed of the Manager of Medical Policy, Medical Directors, and Clinical Services staff.

    - MNGs are responsive to the latest scientific evidence, clinician input, and standards adopted by national accreditation organizations & regulatory/government entities.
    - MNGs are developed also using Medicare National Coverage Determinations (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCA) as well as other guidelines published by Medicare Administrative Contractor (MAC – Noridian Healthcare Solutions for MA).
- Policies are reviewed annually and updated to reflect the latest evidence based guidelines. MNGs are regularly evaluated for the consistency with which they are applied.

Slide 3: 2A. DME Authorization Process

Throughout the process, the care manager acts as an advocate and navigator for members.

***Note**: the following is shown in a flow chart with arrows, and dotted-line arrows, in between showing the progression. The numbers refer to the comments below the chart.*

Member/Care Team Identify DME needs

1. Does request require PA?
   No, Implement services *(as applicable)*
   Yes, Care Team Submits DME request to THPP
2. THPP UM Clinician reviews request against MNGs
   *Medical Director review**

Make service determination notify member & Care Team

3. Care Team follows up with member

1. Most types of DME requests are covered and don't require prior authorization (PA).
    - DME requiring PA includes but is not limited to: speech generating devices (SGD), adaptive strollers, CPAP machines, and power wheelchairs.
    - Authorization process is documented at each step from request to decision letter.
2. THPP UM requests additional information as needed through an RFMI** process
    - THPP UM has direct access to member care plans and connection points with CBH CMs
    - This may include care team outreach to validate how request reflects member needs and goals
3. Member follow-up includes appeal and grievance process overview, and care manager advocacy (as needed).

*Reviewed if medical necessity cannot be determined under Medicare, Medicaid, or THPP Medical Necessity Guidelines
**RFMI- Request for more information

Slide 4: 2B. Medical Necessity Determination Process

How does your plan manage a seamless, integrated Medicare / Medicaid approval process to ensure that members' access to DME isn't delayed by Medicare denial?

- In reviewing PA requests, THPP applies whichever standard is least restrictive and most favorable to the member.
- Denials are only determined once lack of Medical Necessity under ALL guidelines is established.
- The Member's Care Plan and unique needs are inputs in the decision-making process.
- Requests outside established MNGs are referred to Medical Director for consideration and further consultation with the Sr. Medical Director

Note: the following is shown in a flow chart with arrows in between showing the progression based on the answer given.

Approved Under **Medicare**?
Yes, Service Request Approved
No, go to next question
Approved Under **Medicaid**?
Yes, Service Request Approved
No, go to next question
Approved Under **THPP MNGs**?
Yes, Service Request Approved
No, go to next question
Approved by **Medical Director Review**?
Yes, Service Request Approved
No, Service Request denied due to medical necessity

**Workflow is specifically focused on how medically necessity guidelines are applied and is not meant to be exhaustive*

Slide 5: 3A. DME Authorization Flexibility

What criteria do you use to determine what DME to provide for One Care members using flexible dollars/UM guidelines to maximize independence – including independence to engage in the community in meaningful ways?

***Note**: the following is shown in a diagram with Additional UM Flexibility in the center and an outer circle holding three functions. There are arrows radiating from the center of the circle to the functions and arrows connecting one function to the other, all showing the flow of information.*

- **Proactively limiting PA requirements** where appropriate to support member centeredness
- **Regular clinical review** between THPP and Cityblock clinical leadership allows for collaboration on specific cases
- **Medical Director holistic[1] review** outside of standard MNGs.
  If appropriate, may approve additional services[2] to prevent more costly or invasive therapies

1. *In close collaboration with UM clinicians and Care Managers consider member health care needs (per care plan), including factors such as: presence of co-morbidities, progress of treatment, psychosocial situation (including social determinants of health), home and community environment, & availability of services in the local delivery system.*

2. *Additionally, THPP does everything possible, consistent with 130 CMR 630.000 [Home- and Community-Based Services Providers Regulations (home modifications)], to provide accessibility adaptations that would enable the participant to function with greater independence within their home.*

Slide 6: 3B. Addressing Health Equity

What criteria or process is used during the UM evaluation to ensure there is equity in what DME members (with same and similar diagnosis / medical / independence needs) have access to regardless of where they are in MA (region), and what provider type is requesting the DME (for example PCP versus Community Health provider).
What systems do you have in place to ensure African Americans and other minority populations (e.g. immigrants), are receiving the same DME as their White counterparts? For example, are you developing data collection systems to ensure that, all things being equal, African Americans with C-4 quadriplegia are provided tilt and recline systems at the same rate is their white counterparts?

Consistent application of MNGs- At least annually, Utilization Management clinical reviewers participate in an inter-rater reliability (IRR) assessment.

- The IRR assessment evaluates the consistency with which individual UM clinical reviewers apply evidence-based criteria. This process aims to ensure:

    - A consistent approach to UM decision-making in the interpretation of clinical coverage criteria or benefit documents
    - That THPP is providing consistent benefits across membership.

End to end PA tracking- For DME that requires PA, THPP tracks the request authorization process from initial receipt to decision letter mailing.

- UM reviews data to ensure timeliness of service and adherence to process across membership.

Slide 7: Appendix

There is no content on this slide

Slide 8: Appendix: Utilization Management Definitions

Durable Medical Equipment (DME)*: Equipment or supplies that provides therapeutic benefits to a member for use in their own home to address a need related to a certain medical condition and/or illness. Examples of DME items include *wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers*. Requests for DME can include equipment, training, repair, and modification.

Prior Authorization (PA):
Some services require approval from THPP before they can be provided

- **Approvals:** A request is granted with no changes made. This is inclusive of any approvals following an appeal.
- **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 by provider or duplicative of a service already approved/received
    - Maximum benefit reached
    - Request for out-of-network provider with in-network options available first
    - Medical necessity criteria not met

**According to Commonwealth of Massachusetts MassHealth Regulations (130 CMR 409.000)*

Slide 9: Appendix: Medical Necessity Definition

Durable Medical Equipment is distinctive from Medical/Surgical Supplies
***Note**: the following is shown in a table.*

Definitions*
Durable Medical Equipment (DME)

- Is fabricated primarily and customarily to fulfill a medical purpose
- Is generally not useful in the absence of illness or injury
- Can ***withstand repeated use over an extended period***
- Is appropriate for use in the member's home

- Examples: *wheelchairs, crutches, powered mattress systems, IV infusion pumps*

Medical and Surgical Supplies

- Are fabricated primarily and customarily to fulfill a medical or surgical purpose
- Are generally not useful in the absence of illness or injury
- Are ***generally not reusable and are disposable***
- Are used in the treatment or diagnosis of specific medical conditions
- Examples: *wound dressing, tracheostomy kit*

**According to Commonwealth of Massachusetts MassHealth Regulations (130 CMR 409.000)*

Slide 10: Appendix: Key Resources

Tufts UM leverages multiple resources and standards to ensure determinations are member centric and evidence based. This process balances data-based population health level best practices and individualized

***Note**: the following is shown in an inverted triangle diagram starting wide with Medicare Guidelines at the top to a focused Care Plan at the bottom. To the right of the diagram is an arrow showing the progression from Evidence Based Population Level Guidance to Individual level context and goals.*

The steps in the triangle diagram include:

- Medicare Guidelines

- MassHealth Guidelines
- MNGs
- Care Plan

Slide 11: Appendix: Case Study

Member

Mr. A* is a 40 year old member with a health condition that limits his mobility. Although he is able to use his walker to ambulate at home and in his neighborhood, his local grocery store is too far for him to comfortably walk to. Mr. A expressed to his Care Manager that he's thankful that transportation is made available to him to go to the grocery store, but he wishes to be more independent and visit more frequently.

Request

Mr. A's Care Team submits a request for a Power Scooter on his behalf.

- Initial UM review identifies Mr. A's mobility limitations as sufficiently and safely resolved by his walker, and so the request would be denied under existing regulations.
    - The request is sent to a Medical Director for further review.
- Medical Director reviews the request and Mr. A's care plan, noting his goals of maintaining independence and visiting his local grocery store more often.
- The request is approved, as a Power Scooter would promote the member's wellbeing and meet his goals currently unaddressed by his walker

**Mr. A is not a real THPP member but is reflective of our process and population*