Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:

Inpatient Acute Level of Care (including Skilled Nursing Facility and Subacute Care)

Effective: July 1, 2024

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below	Yes ☒ No ☐
Notification Required IF REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

Commercial Products

☐ Harvard Pilgrim Health Care Commercial products; 800-232-0816
☐ Tufts Health Plan Commercial products; 617-972-9409
CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
☐ Tufts Health One Care– A dual-eligible product; 857-304-6304

Senior Products

☒ Harvard Pilgrim Health Care Stride Medicare Advantage; 888-609-0692
☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-673-0965
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-673-0965
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-673-0965

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Overview

Inpatient Acute Level of Care

Inpatient Acute Medical Admissions include items and services furnished to an inpatient, including room and board, nursing care and related services, diagnostic and therapeutic services and medical and surgical services.

Notification is required for urgent, emergent admissions to an acute care facility for members enrolled in Harvard Pilgrim Stride℠ Medicare Advantage Plans (HMO & POS) products. Prior authorization is required for elective (non-urgent/emergent) admissions. See Prior Authorization Request Form.

Skilled Nursing Facilities

Skilled nursing facilities (SNF) provide facility-based skilled nursing care and related services for patients recovering from illness or injury, and rehabilitation services (e.g., physical therapy, occupational therapy, speech therapy) for individuals with musculoskeletal, neurological, complex medical, amputee, stroke and/or pulmonary conditions. Patients who require short-term SNF care do not need to stay in an acute care hospital but are unable to safely care for themselves at home; the goal of SNF care is to provide the appropriate therapeutic interventions to facilitate independence, and to discharge the patient to the least restrictive (most independent) living environment.

Subacute care facilities provide facility-based skilled nursing and rehabilitation services to individuals with serious illness or injury who do not require hospital level of care (e.g., acute hospitalization, inpatient rehabilitation, long-term acute care) but require a more intensive level of service than can sagely be provided at SNF level of care.

SNF and subacute care facilities must be fully equipped and capable of providing required care and have appropriate state licensure and accreditation/certification from an appropriate accrediting organization (e.g., the Joint Commission for the Accreditation of Healthcare Organizations/JCAHO).

SNF and subacute care services must be ordered under a plan of care established and reviewed regularly by the attending physician, and provided directly by, or under the supervision of qualified skilled technical or professional health personnel (RNs, LPNs and/or licensed physical, occupational or speech therapists). Services are considered skilled if the inherent complexity of the service is such that it only can be performed safely/effectively by, or under the supervision of, licensed nursing or rehabilitation personnel. (A service that might ordinarily be considered non-skilled may be considered skilled in situations where, due to the patient's condition or medical complications, skilled nursing or rehabilitation personnel are required to perform or supervise the care or observe the member).

Clinical Guideline Coverage Criteria

Inpatient Acute Level of Care

Harvard Pilgrim Stride℠ (HMO & POS) policies are based on medical science and relevant information including current Medicare benefit coverage (including Medicare Benefit Policy Manual, National and Local Coverage Determinations for the jurisdiction in which the care is rendered), and Harvard Pilgrim Stride℠ (HMO & POS) Medicare Advantage Plan materials. Harvard Pilgrim Health Care (HPHC) utilizes the current editions of Change Health Care InterQual® Level of Care criteria: Acute Pediatric and Acute Adult InterQual® Level of Care in reviewing the appropriateness of admissions to acute inpatient facilities. InterQual® Criteria is available as part of the initial and concurrent review process for Inpatient Acute Care coverage for Adults and Pediatrics.

Skilled Nursing Facilities

Harvard Pilgrim Stride℠ (HMO & POS) policies are based on medical science and relevant information including current Medicare benefit coverage (including Medicare Benefit Policy Manual, National and Local Coverage Determinations for the jurisdiction in which the care is rendered), and Harvard Pilgrim Stride℠ (HMO & POS) Medicare Advantage Plan materials. Harvard Pilgrim Health Care (HPHC) also utilizes the current edition of Change Health Care InterQual® Level of Care criteria: Subacute & SNF Criteria in reviewing the appropriateness of admissions to Skilled Nursing Facilities. InterQual® Criteria is available as part of the prior authorization and concurrent review process for Subacute & SNF admissions.

Change Healthcare InterQual® Criteria are nationally recognized medical necessity criteria developed by a clinical research staff, which includes physicians, registered nurses, and other health care professionals. The clinical content of the criteria is annually reviewed, updated, and validated by a national panel of clinicians and medical experts, including those in community and academic practice settings, as well as within the managed care industry throughout the United States.

Please complete Extended Care Facility (ECF) Prior Authorization Form and submit via secure fax 617-509-4207. For details see the Stride Medicare Advantage Authorization and Notification Policy in our Provider Manual. In some cases, clinical documentation may be required to complete a medical necessity review. Please submit required documentation via secure fax 617-509-4207.

To Obtain InterQual® Criteria

Providers may contact the Medicare Advantage Provider Service Center at 1-888-609-0692 to request a copy of the criteria.

Background and Disclaimer

InterQual® are Medical Necessity Guidelines developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. Harvard Pilgrim Health Care will make coverage decisions using Medicare benefit coverage (including the Medicare Benefit Policy Manual, National and Local Coverage Determinations for the jurisdiction in which the care is rendered), InterQual® guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven 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 HPHC service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations.

We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revision.

Medical Necessity Guidelines apply to Harvard Pilgrim Stride SM (HMO) Medicare Advantage Plans when Harvard Pilgrim Healthcare conducts utilization review unless otherwise noted in this guideline or in the Member's benefit documentation. Coverage may vary depending on the terms of the benefit documentation. If a discrepancy exists between a Medical Necessity Guideline and the member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this guideline is not a guarantee of payment, or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures and claims editing logic.

Approval And Revision History

October 2020: Reviewed by the Medical Policy Clinical Committee (MPCC), annual review; added InterQual Criteria; clarified language on when criteria should be used. Addition of instructions for submitted requests and requesting a copy of criteria

Subsequent endorsement date(s) and changes made:

- July 2021: Reviewed by MPCC, renewed without changes
- July 20, 2022: Reviewed by Medical Policy Approval Committee (MPAC), renewed without changes
- November 16, 2023: Reviewed by MPAC, template updated, effective January 1, 2024
- December 1, 2023: reviewed and approved by UM Committee effective January 1, 2024
- June 13, 2024: Reviewed by UM Committee, combined Inpatient Acute Level of Care and Skilled Nursing Facilities into one MNG effective July 1, 2024
- June 20, 204: Reviewed by MPAC, combined Inpatient Acute Level of Care and Skilled Nursing Facilities into one MNG and 2024 InterQual Upgrade, effective July 1, 2024

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven 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 our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.