PROVIDER
UPDATE
NOVEMBER 1, 2017
NEWS FOR THE NETWORK | TUFTS Health Plan

This issue of *Provider Update* includes information for Tufts Health Plan Commercial (including Tufts Health Freedom Plan), Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options products.

For information about Tufts Health Public Plans products (including Tufts Health Direct, Tufts Health Together, Tufts Health RITogether and Tufts Health Unify), refer to the *Tufts Health Public Plans Provider Update* newsletter.

60-DAY NOTIFICATIONS

COVERAGE UPDATES FOR COMMERCIAL PRODUCTS

The following changes apply to Commercial products (including Tufts Health Freedom Plan) and are effective for dates of service on or after January 1, 2018:

60-DAY NOTIFICATIONS

Dry Needling

Dry needling will be added to the Medical Necessity Guidelines for Noncovered Investigational Services.

Out-of-Network Coverage at the In-Network Level of Benefits

Tufts Health Plan requires prior authorization for members to be covered for services from out-of-network providers at the in-network level of benefits. Without prior authorization, members of Commercial plans, including limited network plans, will not be covered for out-of-network services (since those products have no out-of-network benefits), and PPO/POS members will only be covered for such services at their plan's out-of-network/unauthorized level of benefits.

In limited special circumstances, when it is medically necessary to do so and such services are not sufficiently available in network, Tufts Health Plan may authorize members to obtain services from out-of-network providers at the in-network level of benefits. These guidelines provide the prior authorization criteria Tufts Health Plan will use to determine whether it is medically necessary for a member to receive services from an out-of-network provider.

The new criteria to be used to review requests for prior authorization are documented in the Medical Necessity Guidelines for Out-of-Network Coverage at the In-Network Level of Benefits (All Plans). Because these medical necessity guidelines will apply to both medical and behavioral health services, the Medical Necessity Guidelines for Outpatient Out-of-Plan Coverage of Behavioral Health will be retired.

Lyme Disease: Antibiotic Coverage

Tufts Health Plan has added coverage guidelines for Lyme Disease: Antibiotic Coverage.

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BROWSER NOTE

If you are using an outdated or unsupported browser, certain features on Tufts Health Plan's public website may be unavailable. For an improved user experience, we recommend upgrading your browser to the latest version of Mozilla Firefox or Google Chrome.

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OTHER COVERAGE UPDATES

The following have been added to the Medical Necessity Guidelines for Noncovered Investigational Services:

- Chimeric antigen receptor T-cell therapy/adoptive T-cell therapy
- Transmembrane activator and CAML interactor (TACI) gene, full gene analysis (Mayo Medical Laboratories)
- Image-guided intranasal sphenopalatine ganglion (SPG) block for the treatment of migraine headaches
- ABRx™ Antibiotic Resistance Panel (Diatherix Laboratories)
- Diabetes Sentry nocturnal hypoglycemia alarm
- mi-eye™ (Trice Medical) arthroscopic and endoscopic imaging system
- Genetic testing for fragile X-associated primary ovarian insufficiency

COMMERCIAL PHARMACY COVERAGE CHANGES

The following changes apply to Commercial products (including Tufts Health Freedom Plan):

New Prior Authorization Programs

Effective for fill dates on or after January 1, 2018, Tufts Health Plan will require prior authorization for coverage of the short-acting colony-stimulating factors Granix® (tbo-filgrastim) and Neupogen® (filgrastim). Zarxio® (filgrastim-sndz) will remain covered without restriction. The prior authorization criteria will apply to new prescriptions only. In order for a member to start treatment with one of these medications, the prescribing provider must request coverage through the medical review process subject to the Pharmacy Medical Necessity Guidelines for Short-Acting Colony-Stimulating Factors (Granix [tbo-filgrastim], Neupogen [filgrastim]).

For members stable on Granix (tbo-filgrastim) or Neupogen (filgrastim) who will complete their current treatment course with any of these medications in 2018, the prescribing provider can request a continuation of coverage until the end of the current cycle through the medical review process. As a reminder, Zarxio (filgrastim-sndz) is covered without restriction for eligible members. Providers should consider switching members to Zarxio (filgrastim-sndz), if appropriate. A new prescription will be required.

Changes to Existing Prior Authorization Programs

Effective for prior authorization requests submitted on or after January 1, 2018, Tufts Health Plan will have updated its medical necessity guidelines for Botulinum Toxins, Factor Products and Forteo® (teriparatide). The updated prior authorization criteria will apply to new prescriptions only. For a member to start a new course of treatment on one of these medications, the prescribing provider must request coverage through the medical review process subject to the applicable pharmacy medical necessity guidelines.

Nonpreferred Topical Corticosteroids

As previously communicated, effective for fill dates on or after April 1, 2017, Tufts Health Plan now requires prior authorization for coverage of nonpreferred topical corticosteroids. The prior authorization criteria apply to new prescriptions. In order for a member to receive coverage for a new course of treatment with a nonpreferred topical corticosteroid, the prescribing provider must request coverage through the medical review process subject to the Pharmacy Medical Necessity Guidelines for Topical Corticosteroids.

Hepatitis C

Tufts Health Plan is considering changes to coverage of drugs used for the treatment of hepatitis C, to be effective for new prescriptions filled on or after January 1, 2018 for Commercial products (including Tufts Health Freedom Plan).

More information, including a list of drugs affected by this change (if any) will be available in the full web article in Tufts Health Plan's Provider News section, prior to this date. For any questions, please call Provider Services at 888.884.2404.

Drugs Moving to Tier 3

The following changes apply to Commercial products (including Tufts Health Freedom Plan) and are effective for fill dates on or after January 1, 2018:

- Avonex (interferon beta-1a)
- adapalene (0.1%) cream
- adapalene (0.1%, 0.3%) gel
- benzoyl peroxide 9.8% foam
- benzoyl peroxide (5.3%, 6%) foam
- benzoyl peroxide 2.5% liquid wash
- chlordiazepoxide/clidinium capsules
- clindamycin 1% foam

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- clindamycin/benzoyl peroxide (1.2-5%, 1-5%) gel
- clindamycin-tretinoin gel
- diclofenac sodium 3% gel
- doxycycline hyclate DR tablets
- esgic capsules
- lidocaine 5% pad
- migergot suppository (ergotamine tartrate and caffeine)
- minocycline ER tablets
- Plegridy (peginterferon beta-1a)
- salicylic acid 6% foam
- tetracycline capsules
- tretinoin (0.04%, 0.1%) microsphere gel
- tretinoin 0.05% gel

Drugs Moving to Tier 2

The following changes apply to Commercial products (including Tufts Health Freedom Plan) and are effective for fill dates on or after January 1, 2018:

- atovaquone suspension
- benzoyl peroxide 7% liquid wash
- brimonidine 0.15% ophthalmic solution
- bromfenac 0.09% ophthalmic solution
- calcipotriene 0.005% cream
- cefixime suspension
- cefpodoxime (tablets and suspension)
- cevimeline 30mg capsules
- clindamycin 1% gel
- clindamycin 1% lotion
- colchicine 0.6mg tablets
- dantrolene capsules
- dronabinol capsules
- eplerenone tablets
- fondaparinux injections
- griseofulvin (tablets and suspension)
- itraconazole 100mg capsules
- lidocaine 5% ointment
- metaxalone tablets
- metronidazole 0.75% vaginal gel
- metronidazole 0.75% lotion
- metronidazole 1% gel
- minocycline tablets
- mycophenolate 200mg/ml suspension
- naftifine hcl (1%, 2%) cream
- neomycin/polymyxin b/ hydrocortisone ophthalmic solution
- oxiconazole nitrate cream
- pacerone 100mg tablet
- potassium chloride (10%, 20%) solution
- potassium chloride 20meq powder packet
- potassium citrate tablets
- propafenone ER capsules
- quinidine gluconate tablets
- rivastigmine transdermal patch
- tobramycin/dexamethasone ophthalmic solution
- tretinoin (0.025%, 0.05%, 0.1%) cream
- trifluridine 1% ophthalmic solution
- trospium chloride ER capsules
- vancomycin capsules
- voriconazole tablets

Drugs Moving to Noncovered Status

Effective for fill dates on or after January 1, 2018, Tufts Health Plan will no longer cover the following medications, which include drugs with interchangeable generics or therapeutic alternatives:

- Androderm®
- Androgel®
- Doryx®
- Striant®

For brand-name drugs moving to noncovered status, generic equivalents, if available, will remain covered.

For a patient to continue on one of these noncovered medications, the prescribing provider must request coverage as an exception through the medical review process subject to the Medical Necessity Guidelines for Noncovered Drugs With Suggested Alternatives.

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LARGE GROUPS

The following changes apply to Commercial products (including Tufts Health Freedom Plan) and are effective for fill dates on or after January 1, 2018:

Drugs Moving to Tier 3

Tufts Health Plan will move Alkeran® to Tier 3 for its large group Commercial formularies.

Drugs Moving to Noncovered Status

Effective for fill dates on or after January 1, 2018, Tufts Health Plan will no longer cover the following medications, which include drugs with interchangeable generics or therapeutic alternatives: Atralin®, Azor®, Benicar HCT®, Benicar®, BenzaClin®, Differin®, Duac®, Effient®, Evoclin®, Fosrenol®, Lexiva®, Lialda®, Lidoderm®, Retin-A®, Solaraze®, Testim®, Valtrex®, Vigamox® and Vogelxo™. This change applies to large group Commercial formularies only, as some of these medications were previously moved to noncovered status for small groups.

PHARMACY COVERAGE CHANGES FOR SENIOR PRODUCTS

Noncovered Drugs

Effective for fill dates on or after January 1, 2018, Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options will no longer cover a number of medications, which include drugs with interchangeable generics or therapeutic alternatives.

For brand-name drugs moving to noncovered status, generic equivalents, if available, will remain covered.

For a member to continue on one of these noncovered medications, the prescribing provider must request coverage as an exception through the medical review process subject to the Medical Necessity Guidelines for Noncovered Drugs With Suggested Alternatives.

ORAL ENTERAL FORMULAS NO LONGER COVERED UNDER PHARMACY BENEFIT

Effective for fill dates on or after January 1, 2018, Tufts Health Plan will no longer cover oral enteral formulas under the pharmacy benefit. As part of this change, members will no longer be able to obtain oral enteral formulas at retail pharmacies and must obtain them through a contracted durable medical equipment (DME) supplier in order for that medication to be covered. Applicable member cost-share for orders through a DME supplier will continue to apply.

Note: Tufts Health Plan has notified affected members of this change.

This change applies to Commercial products (including Tufts Health Freedom Plan) and is documented in the Medical Necessity Guidelines for Oral Formula: Massachusetts Products and the Durable Medical Equipment Payment Policy.

CREDENTIALING CHANGE FOR PT, OT AND ST

Effective January 1, 2018, Tufts Health Plan will no longer credential individual physical therapy (PT), occupational therapy (OT) or speech therapy (ST) providers who work in a group, clinic or facility setting and participate in Commercial (including Tufts Health Freedom Plan), Tufts Medicare Preferred HMO or Tufts Health Plan Senior Care Options products.

Tufts Health Plan will continue to credential PT, OT and ST groups, clinics or facilities, as well as individual PT, OT and ST providers who work independently and are not part of a group, clinic or facility. Credentialing materials for PT, OT and ST groups, clinics and facilities are available in the Provider Forms section of the Resource Center and will continue to be required for participation.

CLAIM EDITS EFFECTIVE JANUARY 1

The following claim edits are effective for dates of service on or after January 1, 2018. These policies are derived from CMS, the AMA CPT Manual, HCPCS, ICD-10, nationally accredited societies and Tufts Health Plan policy.

ALL PRODUCTS

The following claim edits apply to Commercial (including Tufts Health Freedom Plan), Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options (SCO) products.

Tufts Health Plan will implement claim edits on the following:

- Allergy
- Anesthesia
- Durable Medical Equipment
- Evaluation & management
- ICD-CM
- Immunization
- Laboratory & pathology
- Max Units
- Modifier
- Neurology
- Ob-gyn
- Outpatient
- Radiology (imaging & radiation oncology)
- Vision

These edits are documented in the applicable Commercial, Tufts Medicare Preferred HMO and Tufts Health Plan SCO payment policies.

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SENIOR PRODUCTS

The following claim edits apply to Tufts Medicare Preferred HMO and Tufts Health Plan SCO products and are effective for dates of service on or after January 1, 2018:

Imaging and Evaluation and Management (E&M) Edits

Tufts Health Plan will implement additional imaging and E&M claim edits. These edits will be documented in the Tufts Medicare Preferred HMO/Tufts Health Plan SCO Imaging Services Professional/Facility Payment Policy and E&M Payment Policy.

Ambulance

Tufts Health Plan will implement additional claim edits for ambulance services. These edits are documented in both the Tufts Medicare Preferred HMO/Tufts Health Plan SCO Emergency Ambulance and Transportation and Nonemergency Ambulance and Transportation payment policies.

CHANGE TO THERAPEUTIC CONTINUOUS GLUCOSE MONITORS

CMS now covers the DexComm 5® diabetic continuous glucose monitor (CGM). As a reminder, all other glucose monitors are not covered by CMS or Tufts Health Plan.

Effective for dates of service on or after January 1, 2018, Tufts Health Plan will require prior authorization for the following HCPCS codes for Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options products:

- Therapeutic CGM, K0554: Receiver (monitor), dedicated for use with therapeutic CGM system
- Supply Allowance, K0553: Supply allowance for therapeutic CGM includes all supplies and accessories (one-month supply equals one unit of service)

For information about coverage criteria, refer to the local coverage determinations (LCDs).

CHANGE TO OBSERVATION SERVICES

In an effort to be more consistent across products, Tufts Health Plan is looking at its payment policies to determine which can be combined into a single policy, when appropriate. The observation payment policies are the first to undergo this change and be combined into a single policy.

As part of this change, the revised policy will include updates to when Tufts Health Plan covers medically necessary observation services for up to 48 hours for such services provided in a hospital setting. It also lists clinical conditions that are usually covered by such services. Refer to the Observation Services Payment Policy for more information.

ENHANCEMENTS TO TUFTS HEALTH PLAN'S SECURE PROVIDER WEBSITE

As previously communicated, Tufts Health Plan will soon update its secure Provider website. This update will apply to Commercial (including Tufts Health Freedom Plan), Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Option products.

As part of this change, Tufts Health Plan will update the existing look, feel and registration process. These changes will be available to new and existing providers who have not yet registered for the secure Provider website, as well as to those providers who are currently registered and would like to benefit from new registration self-service features.

Beginning as soon as December, Tufts Health Plan will update its Claims Status Inquiry Tool and will require senior access administrators (SAAs) or access administrators (AAs) to grant existing users of the secure Provider website access to the Payee NPI in order to conduct claims transactions through the secure Provider website. In addition to this, the following two permissions will be available:

- **Claim Status Inquiry – Payee and Servicing:** Ability to view claims if the user has access to the Payee NPI and the Servicing NPI (more restrictive permissions)
- **Claim Status Inquiry – Payee Only (DEFAULT):** Ability to view claims if the user has access to the Payee NPI (broader, institutional-level permissions)

All existing users will automatically be granted permissions for Claim Status Inquiry – Payee Only. If a user requires a more restricted level of permissions, the SAA or AA must reduce the user's access to only Claim Status Inquiry – Payee and Servicing.

Should a user have been granted limited permissions and require access to additional claims, the user can utilize the IVR or call the appropriate provider call center to inquire about claim status.

ANNUAL UPDATES TO COMMERCIAL PHYSICIAN AND OUTPATIENT HOSPITAL REIMBURSEMENT

Effective January 1, 2018, Tufts Health Plan will update its Commercial physician and outpatient hospital fee schedules.

With a few exceptions, Tufts Health Plan will continue to base fees on the CMS fee schedules adjusted to achieve the contracted level of reimbursement.

Outpatient Hospitals

- Consistent with prior years, reimbursement will be based on a combination of ancillary and surgical fee schedules.
- Drug pricing will continue to be set in relation to CMS.

Physicians

- Consistent with prior years, additional funding will continue to be directed toward the reimbursement of certain primary care services when provided by a PCP or PCP/SCP, as initially modeled by CMS.
- Tufts Health Plan will allocate a higher proportion of funds compared with CMS to the following services:
  - Pathology codes
  - Radiology codes
  - ED visits with emphasis on the lower-level codes
- Tufts Health Plan will continue to base vaccine and toxoid reimbursement on CMS Part B levels when these rates are at 95 percent of average wholesale price (AWP), as indicated on the CMS Part B drug quarterly notices. When a rate for a vaccine is not AWP-based, Tufts Health Plan will set the compensation at the wholesale acquisition cost. Reimbursement for vaccines and toxoids will continue to be updated on a quarterly basis.
- As in prior years, pricing for oncology and nononcology drugs will continue to be set in relation to CMS or AWP if no CMS pricing is available.
- Tufts Health Plan will continue to reimburse for consultations, diverging from CMS.

Note: These changes do not apply to Allied Health providers.

Additional details on fee schedule changes and applicable 2018 fee schedules will be distributed to hospital and provider organization leadership. As a reminder, Tufts Health Plan maintains a comprehensive list of all nonreimbursable procedures in the Resource Center on the public Provider website.

Independent physicians who have questions about fee schedule changes should contact Tufts Health Plan's Network Contracting Department at 888.880.8699, ext. 52169.

CHANGES IN DRG VALIDATION APPEALS PROCESS

As part of an ongoing effort to ensure consistency in our programs with our hospital providers, Tufts Health Plan has selected Cotiviti Healthcare to administer the first level of appeals process for the DRG Validation Audit Program for Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options (SCO) beginning January 1, 2018.

The following changes are documented in the DRG Validation of Inpatient Hospitals Policy for Tufts Medicare Preferred HMO and Tufts Health Plan SCO:

- Providers have 60 calendar days from the date of a change determination by Cotiviti to submit a corrected claim to Tufts Health Plan. If a corrected claim is not received within 60 calendar days of the date of the determination, the claim will be denied.
- If a provider disagrees with a determination made by Cotiviti, the provider has the right to request an appeal for reconsideration. The appeal request, together with any additional supporting documentation, must be mailed to Cotiviti at the address indicated in the determination letter within 120 calendar days of the date of the claim denial.

For questions, please contact Cotiviti Provider Services at 770.379.2165, Monday through Friday from 8 a.m. to 5 p.m.

CHANGES TO JOINT SURGERY PROGRAM

Effective for dates of service on or after January 1, 2018, Tufts Health Plan will implement changes to its prior authorization program for management of joint surgery.

Tufts Health Plan has selected National Imaging Associates Inc. (NIA) to provide utilization management for coverage of hip, knee and/or shoulder surgeries. Beginning January 1, 2018, providers must request prior authorization for members (including members younger than age 18) for coverage of hip, knee and/or shoulder surgeries through NIA at radmd.com. Providers may no longer fax authorization requests for these services to Tufts Health Plan's Precertification Operations Department as of this date. Providers can begin contacting NIA on December 22, 2017 to seek prior authorization for hip, knee and/or shoulder surgeries scheduled on or after January 1, 2018.

In addition to this prior authorization requirement, an inpatient notification will continue to be required for procedures performed in an inpatient setting, according to the current process.

NIA's Joint Surgery Program includes the following:

- Diagnostic and surgical hip, knee and shoulder arthroscopy and arthrotomy
- Hip, knee and shoulder arthroplasty (including total and partial joint replacement/revision and removal)
- Knee manipulation under anesthesia

Using evidence-based criteria and guidelines, NIA will review coverage requests and provide authorizations for hip, knee and shoulder surgeries, as appropriate. For specific procedure codes requiring prior authorization beginning January 1, 2018, refer to the Spinal Conditions Management and Joint Surgery Program Prior Authorization Code Matrix on Tufts Health Plan's public Provider website. To obtain and verify authorizations or access medical necessity guidelines, log in to RadMD or call 866.642.9703.

Effective for dates of service on or after January 1, 2018, the following services will no longer require prior authorization:

- Total joint replacement/removal/revision surgery of the ankle
- Arthroscopic knee surgery, drilling for osteochondritis dissecans
- Removal of foreign body from shoulder (deep)

Note: If the service being performed also requires an inpatient admission, an inpatient notification will continue to be required. Removal of prior authorization does not remove the need for notification of an inpatient admission.

These changes apply to Commercial products (including Tufts Health Freedom Plan). For more information, refer to the Joint Surgery Program on Tufts Health Plan's public Provider website.

For questions about the Joint Surgery Program, please contact Provider Services at 888.884.2404.

2018 YOUR CHOICE TIERING UPDATE

For the 2018 Your Choice product tier placement, Tufts Health Plan has updated the underlying data used to tier hospitals and providers who render services to members covered under the Your Choice product. These data are based on the most recently available and completed quality, relative price and total medical expense information. As a result, the 2017 Your Choice tier that became effective on January 1, 2017 may change for 2018.

Tier placement occurs at the integrated provider system level, including all physicians and hospitals within a contracted provider system. For 2017 and 2018 tier placements, refer to the Find a Doctor Search on Tufts Health Plan's public Provider website.

Any provider system whose tier will change for 2018 will be notified by Tufts Health Plan via letter. Providers whose 2018 tiers will remain the same as the 2017 tiers will not be notified.

If you are contracted with Tufts Health Plan at a provider organization or integrated system level and have questions about your current tier designation, please contact your administrator.

If you are independently contracted with Tufts Health Plan and have questions about your current tier designation, please contact Provider Services at 888.884.2404.

STANDARD FORMS FOR PHARMACY PRIOR AUTHORIZATION REQUESTS

TUFTS HEALTH FREEDOM PLAN ONLY

As previously communicated, Tufts Health Plan now accepts the New Hampshire Uniform Prior Authorization Form for Prescription Drug Requests for members of Tufts Health Freedom Plan products. Effective for prescription drug requests submitted on or after January 1, 2018, Tufts Health Plan will no longer accept the Universal Pharmacy Programs Request Form, and will accept only the NH standard form. This change applies to members of Tufts Health Freedom Plan products only, regardless of the member's state of residence or whether services are rendered in MA, RI or NH.

Note: Prescription drugs are defined by the New Hampshire Insurance Department (NHID) as any drug dispensed by prescription only from a pharmacy directly to the consumer.

HEPATITIS C MEDICATIONS AND SYNAGIS®

As previously communicated by Tufts Health Plan, MA law requires that health insurance carriers use standard prior authorization forms when reviewing requests for both hepatitis C medications and Synagis for members of fully insured, MA-based Commercial products, regardless of the member's state of residence or whether services are rendered in MA, RI or NH.

Based on the work of the Mass Collaborative, these standard prior authorization request forms have been developed and approved by the MA Division of Insurance (DOI). Effective for dates of submission on or after March 11, 2018, Tufts Health Plan will accept only these specific standard forms for fully insured MA-based Commercial members. These forms will be available in the Forms section of the Resource Center on Tufts Health Plan's public Provider website beginning in December 2017, and will be accepted by Tufts Health Plan beginning at that time.

Submitting Prior Authorization Requests to Tufts Health Plan

Prior to submitting the NH standard form, hepatitis C medications form, Synagis form or MA standard form to Tufts Health Plan, providers should:

- Refer to Tufts Health Plan's coverage policies and pharmacy medical necessity guidelines, available in the Tufts Health Plan and Tufts Health Freedom Plan Provider Resource Centers. (**Note:** Supporting documentation relevant to the prescription drug request may be included with or attached to the applicable standard form, as indicated on each form, and should be submitted using the existing mail and fax channels.)
- Refer to the Commercial Pharmacy Medication Prior Authorization Submission Guide to determine which form to use based on the state and product.
- Check member benefits and cost-share amounts using Tufts Health Plan's secure Provider website or other self-service channels, even for members seen on a regular basis.

Note: To avoid delays for your patient, providers must complete and sign the standard form, and must also include all relevant supporting documentation with the request. Incomplete, blank or unsigned forms cannot be accepted.

For questions, please contact Provider Services at 888.884.2404.

TELEMEDICINE SERVICES FOR RHODE ISLAND-BASED EMPLOYER GROUPS

Effective for dates of service on or after January 1, 2018 and pursuant to the member's benefit plan, Tufts Health Plan will cover medically necessary telemedicine services for members of fully insured, RI-based products.

Note: RI-based self-insured groups may choose to elect coverage for these services upon plan renewal.

Effective for dates of service on or after January 1, 2018, Tufts Health Plan will require providers to use standard procedure codes and to append the GT modifier to the claim in order to indicate the service is being provided via telemedicine. Telemedicine services that are billed and deemed accurate and medically necessary by Tufts Health Plan will be compensated at 80 percent of the in-office rate.

This change is documented in the RI Telemedicine Services Professional Payment Policy.

CHANGES TO TUFTS HEALTH PLAN'S PROVIDER SEARCH AND TREATMENT COST ESTIMATOR TOOLS

Beginning as early as December 2017, Tufts Health Plan will update its existing Provider Search Tool (i.e., Find a Doctor search) to combine both Provider Search and Treatment Cost Estimator (TCE) applications into a single platform. The new TCE platform will be available only to Commercial members on Tufts Health Plan's secure Member website. If your patients have questions about their plan or out-of-pocket expenses, providers may direct them to the secure Member website.

Providers and members can access the Provider Search on both Tufts Health Plan's public and secure websites. The enhanced Provider Search will be available for Commercial (including Tufts Health Freedom Plan), Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options products. The updated Provider Search Tool will display provider practice information, and providers are reminded to regularly update practice information should changes occur.

For questions, contact the appropriate Tufts Health Plan Commercial or Senior Products Call Centers.

2018 BENEFIT CHANGES FOR TUFTS MEDICARE PREFERRED HMO

The following changes apply on or after January 1, 2018, to Tufts Medicare Preferred HMO members and are effective upon the member's plan renewal date:

- Premium increases of $7 on average
- Introduction of coinsurance for Part B drugs on Saver Rx only (excludes diabetic supplies, Part B vaccines and home infusion)
- Introduction of copay for therapeutic radiology services on Saver Rx and Basic
- Cost-share changes to existing benefits in both medical and prescription coverage

Note: This is a summary of changes. Before services are rendered, providers are reminded to check member benefits and cost-share amounts using Tufts Health Plan's secure Provider website or other self-service channels, even for members seen on a regular basis.

CORRECT CODING REMINDER

As a routine business practice, claims are subject to payment edits that are updated at regular intervals and generally based on CMS (including the National Correct Coding Initiative [NCCI]), specialty society guidelines and drug manufacturers' package label inserts.

Procedure and diagnosis codes undergo periodic revision by CMS (including NCCI) and the AMA. As these revisions are made public, Tufts Health Plan will update its systems to reflect these changes.

Payment policies will be updated to reflect the addition and replacement of procedure codes, where applicable.

2018 BENEFIT CHANGES FOR TUFTS HEALTH PLAN SENIOR CARE OPTIONS

The following changes apply to Tufts Health Plan Senior Care Options members and, beginning on or after January 1, 2018, are effective upon the member's plan renewal date (unless otherwise specified):

- OTC Coenzyme Q10 now covered
- Eyewear Allowance: Up to $300 per calendar year for one pair of eligible eyeglasses (frames and prescription lenses) and/or contact lenses from EyeMed providers ($180 if benefit used at nonparticipating provider). Discount will be applied at time of service, and member is responsible for the balance. **Note:** Sale items are excluded from eligibility, and this benefit may not be combined with any other store discount, coupons or promotional codes.
- Acupuncture Services: $0 for up to 20 acupuncture visits per calendar year from a licensed acupuncturist for pain management services

Note: This is a summary of changes. Before services are rendered, providers are reminded to check member benefits and cost-share amounts using Tufts Health Plan's secure Provider website or other self-service channels, even for members seen on a regular basis.

REMINDER: REGISTER TO RECEIVE *PROVIDER UPDATE* ONLINE

As previously announced, beginning August 1, 2016, Tufts Health Plan began a transition to distribute its *Provider Update* newsletter by email. Providers who have not yet registered to receive *Provider Update* by email must complete the online registration form, available in the News* section of Tufts Health Plan's public Provider website.

Providers who routinely visit the public Provider website for updates and who prefer not to receive *Provider Update* by email are given the opportunity to indicate that preference on the online registration form.

Note: Providers are responsible for keeping their contact information updated. To make updates to information that was previously submitted through the online registration form, providers should resubmit the form with the updated information.

Please let all providers in your organization know about this change, and encourage each provider to register to receive future issues by email. Office staff may also register a provider on his or her behalf by using the provider's name, email address and NPI, and indicating the divisions of Tufts Health Plan with which the provider contracts.

Note: If you have registered to receive *Provider Update* by email but are still not receiving the email blast, please check your spam folder or check with your system administrator to ensure your firewall is not preventing *Provider Update* from being delivered to your inbox.

The complete November 1, 2017 issue is also available in printable format in the News section of Tufts Health Plan's public Provider website.

*If you do not register to receive *Provider Update* by email, copies of this issue can be mailed upon request by calling 888.884.2404 for Tufts Health Plan Commercial products (including Tufts Health Freedom Plan) and 800.279.9022 for Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options products.

UPDATE YOUR PRACTICE INFORMATION

Members use Tufts Health Plan's online provider directory, i.e., Find a Doctor search, to locate physicians, specialists and allied health providers who fit their health care needs. To ensure your practice is accurately represented in the Find a Doctor search, it is critical to regularly update your provider demographic information.

Providers are reminded to notify Tufts Health Plan of any changes to their contact or panel information, such as a change in the provider's ability to accept new patients, street address (including suite number, if applicable), phone number, and any other change that affects their availability to patients. For Tufts Health Plan to remain compliant with the CMS regulatory requirements, changes must be communicated in writing as soon as possible so that members have access to the most current information in the Provider Directory.

Providers are also reminded to update their covering provider list as needed.

Note: Tufts Health Plan does not automatically add providers new to your practice to the list of covering providers; it is the provider's responsibility to update this information as needed.

HOW TO UPDATE YOUR INFORMATION

Commercial (Including Tufts Health Freedom Plan), Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options

Providers can check current practice information by looking it up in the Find a Doctor search. If the information listed is incorrect, please update it as soon as possible by completing either the Standardized Provider Information Change Form or Tufts Health Plan's Provider Information Change Form (available in the Provider Forms section of the Resource Center) and returning it by fax or mail, as noted on the form.

Tufts Health Public Plans

Providers can check current practice information by looking it up in the Find a Doctor search. If the information listed is incorrect, please update it as soon as possible by completing the Provider Information Form either for Medical Providers or for Behavioral Health Providers (available in the Provider Forms section of the Resource Center) and returning it by fax or mail, as noted on the form.

ONLINE PROVIDER PAYMENT DISPUTE SUBMISSION COMING SOON FOR SENIOR PRODUCTS

Beginning in early 2018, providers will be able to submit provider payment disputes for Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options (SCO) online through the Online Claim Adjustment Tool, available on Tufts Health Plan's secure Provider website.

Tufts Health Plan encourages providers to use the Online Claim Adjustment Tool as their primary means of submitting claim adjustment requests and payment disputes to Tufts Health Plan. Providers who are not registered users of the secure Provider website can register for access by following the process outlined on Tufts Health Plan's website.

For adjustment and payment disputes that cannot be submitted online, Tufts Health Plan has adopted the Request for Claim Review Form as its standard for submitting payment disputes by mail. This form was developed by the Mass Collaborative to streamline the review process for providers and is accepted by Tufts Health Plan and by all other health plans participating in that collaborative.

When submitting payment disputes to Tufts Health Plan by mail, all required information on the form must be completed. Incomplete submissions will be returned. A separate dispute form, along with any supporting documentation, must be submitted with each claim for which an adjustment is being requested. Provider payment disputes must be separated by product and denial reason and sent to the appropriate post office box, according to product.

WORKING WITH ABILITY® NETWORK

As previously communicated by Tufts Health Plan, MD On-Line is now part of ABILITY Network. Since 2015, Tufts Health Plan has worked with ABILITY to streamline claims processing for professional claims across all products.

As part of this collaboration, providers who continue to submit paper claims might receive a call from ABILITY to discuss the benefits of switching to electronic submission.

For more information, please contact Provider Services at 888.884.2404.

BEHAVIORAL HEALTH

REIMBURSEMENT OFFERED FOR PROOF OF BUPRENORPHINE CERTIFICATION

As part of an ongoing effort to address substance use disorders (SUDs) in members, Tufts Health Plan is offering reimbursement to providers who become certified to prescribe buprenorphine to eligible members with SUDs. This program applies to Commercial (including Tufts Health Freedom Plan), Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options products.

This Behavioral Health SUD Quality Improvement Strategy (QIS) Program will run through the 2018 calendar year. As part of this SUD QIS Program, beginning January 1, 2018, Tufts Health Plan will offer up to $100 reimbursement to the first 100 eligible providers who become certified to prescribe buprenorphine.

In order to receive reimbursement offered as part of the SUD QIS Program, providers must:

- Be a credentialed MD, doctor of osteopathy, nurse practitioner or physician assistant, and be contracted with Tufts Health Plan on the date of training
- Complete training within the 2018 calendar year
- Submit a completed Buprenorphine Training Reimbursement Form along with all required documentation (as noted on the form) during the 2018 calendar year
- Be one of the first 100 providers to complete the training and submit the form to Tufts Health Plan
- Respond within five business days, should Tufts Health Plan contact you requesting clarification

Note: Providers may not seek reimbursement for costs associated with maintaining an existing waiver or a request to increase patient limits.

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Tufts Health Plan neither requires nor endorses a specific training course. To find a training course, visit the Substance Abuse and Mental Health Services Administration's website.

Tufts Health Plan is offering this incentive to providers who have a full, unrestricted license with the Massachusetts Board of Registration in Medicine and are in good standing with all regulatory requirements concerning their license, and who are to the best of their knowledge not under investigation by Tufts Health Plan or law enforcement agencies for prescribing practices.

HEDIS® QUALITY MEASURES INVOLVING CHILDREN AND ADOLESCENTS

Attention deficit/hyperactivity disorder (ADHD) is a common psychiatric disorder affecting children and adolescents. The main characteristics of this illness are hyperactivity, impulsiveness, and inability to sustain attention or concentration. Many in this population are being prescribed ADHD medication for this illness. When managed appropriately, such medication can control ADHD symptoms. To ensure that medication is prescribed and managed correctly, the National Committee for Quality Assurance (NCQA) has stated that it is important that children and adolescents be monitored closely by the providers who are prescribing for them.

The HEDIS measurement, Follow-Up Care for Children Prescribed ADHD Medication, measures compliance in these two phases of treatment:

- **Initiation phase:** Measures the percentage of members ages 6–12 who have one follow-up visit with a provider with prescribing authority within 30 days of an initial prescription.
- **Continuation phase:** Measures the percentage of members ages 6–12 who remain on the medication for 210 days after the initial prescription, and who in addition to the visit in the initial phase have at least two follow-up visits with a provider within nine months of the initiation phase.

An ADHD brochure with helpful information for your patients can be found in the Forms + Documents section of Tufts Health Plan's public Member website for Commercial members.

HEDIS and the Use of Antipsychotic Medication for Children and Adolescents

At times, antipsychotic medication may be prescribed for some nonpsychotic conditions when psychosocial intervention is considered the more appropriate first-line treatment. The HEDIS measurement, Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics, measures compliance with psychosocial intervention occurring prior to prescribing antipsychotics to children and adolescents.

Antipsychotic medications can increase a child's risk for developing serious metabolic health complications. Use of these medications in children and adolescents has shown to be associated with weight gain and increased risk of diabetes, as well as increased LDL cholesterol and triglyceride levels and decreased HDL cholesterol levels (as reported by the American Diabetes Association).

Given these risks and the potential lifelong consequences, baseline screening and metabolic monitoring of blood glucose level and cholesterol are important to ensure appropriate management of children and adolescents on antipsychotic medications. The HEDIS measurement, Metabolic Monitoring for Children and Adolescents on Antipsychotics, measures compliance with children and adolescents who are prescribed two or more antipsychotic medications having at least one test for blood glucose and one test for cholesterol each year.

Tufts Health Plan strongly encourages all behavioral health and medical providers who are prescribing antipsychotic medications to collaborate with one another to ensure that metabolic monitoring is being done on a regular basis for this population.

If you need help finding a behavioral health provider for your patients, call 800.208.9565.
For Tufts Health Freedom Plan members, call 800.547.5186.

CHRISTIE STUDENT HEALTH DECOMMISSIONING

As previously communicated, Tufts Health Plan collaborated with Christie Student Health (CSH) to offer a student health insurance plan. At this time, Tufts Health Plan is no longer offering student health insurance plans or enrolling new members in CSH plans. As a result of this change, as of September 1, 2017, Tufts Health Plan will no longer cover services rendered to members who were previously enrolled in a CSH plan, with limited exception.

Providers should continue to submit eligible claims or adjustment requests for services rendered prior to the member's plan end date to CSH until February 28, 2018. After that date, claims or adjustment requests should be mailed directly to:

Tufts Health Plan
64 Grove St.
Watertown, MA 02472
Attn: Nikole Xerikos
Production Support Supervisor

Tufts Health Plan will only accept claims and adjustment requests submitted to the above address by mail, and will not accept other forms of submissions, including but not limited to EDI, fax and email.

Electronic provider payments will not be available after February 28, 2018. Provider payments as of March 1, 2018, will be issued by check only.

Note: The above address should be used only to mail eligible claims or adjustment requests for CSH, and should not be utilized by providers for any other reason.

Providers are reminded to check member benefits and cost-share amounts, even for members seen on a regular basis.

Providers should continue to use the existing contact channels at CSH until February 28, 2018, for questions related to CSH claims.

MEDICARE ANNUAL ELECTION PERIOD: OCT 15–DEC 7*

Now is the time to ensure your patients are enrolled in the right health insurance plan. Many adults are unaware that Medicare alone covers only 80 percent of their health care costs, which leaves them vulnerable to additional deductibles and coinsurance. Financial constraints may then prevent your patients from seeking care or keeping scheduled appointments. For more comprehensive coverage, your patients may consider a Medicare plan offered by Tufts Health Plan.

Tufts Health Plan offers several high-quality Medicare health plans, including:

- Medicare Advantage (HMO) plans with monthly premiums as low as $0 (includes Part D prescription drug coverage)
- Senior Care Options plans** with $0 monthly premium and $0 cost share for medical services and prescription drugs
- Medicare Supplement plans (for access to any doctor nationwide who accepts Medicare)

Should your patients look to you for advice, please advise them that the Medicare plan enrollment deadline is December 7, 2017. For additional questions or plan materials for display, contact peter_lacombe@tufts-health.com.

*Since this is a 5 out of 5 star-rated plan, your patients may be eligible to elect one of Tufts Health Plan's plans prior to January 1, 2018. For additional information, including online plan selection, refer to thpmp.org.

**For adults age 65 and older who are also eligible for MassHealth Standard.

TUFTS HEALTH FREEDOM PLAN: A COMMERCIAL PRODUCT

Tufts Health Freedom Plan is a Commercial product offered by Tufts Health Plan and Granite Health.

As a reminder, Tufts Health Plan Commercial providers are required to render services to members of Tufts Health Freedom Plan products, as they would to other Tufts Health Plan Commercial members. Reimbursement for services rendered to members of Tufts Health Freedom Plan products is determined by the provider's Commercial fee schedule.

Before services are rendered, providers are reminded to check member benefit and cost-share amounts using Tufts Health Plan's secure Provider website or other self-service channels, even for members seen on a regular basis.

US FAMILY HEALTH PLAN BILLING INFORMATION

When billing services for US Family Health Plan (USFHP) members, providers are reminded not to bill Medicare for services covered by USFHP.

Medicare may be billed only for services not covered by USFHP, e.g., end-stage renal disease. For such instances, Medicare should be billed first, followed by USFHP. For a list of services covered by USFHP, refer to the *TRICARE Guidelines*.

USFHP cannot compensate for claims that have been billed to and compensated by Medicare. Providers must first reimburse Medicare for any previous payment made in error, and must then bill USFHP for compensation of those services.

Any private health insurance, with the exception of Medicare Supplement plans, should be billed prior to billing USFHP. This includes federal and state employee insurances.

Providers are reminded to check the member's ID card to identify USFHP members.

For questions, contact Provider Services at 800.818.8589.

QUALITY

STAR MEASURES FOR SENIOR PRODUCTS

Tufts Health Plan uses the Healthcare Effectiveness Data and Information Set (HEDIS®) measures as a benchmark to improve the health of Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options members.

Providers are also reminded to conduct the following screenings for their patients, where appropriate:

Current Measures

- Assessment and documentation of adult BMI (patients ages 18–74)
- Blood pressure (patients diagnosed with hypertension or diabetes)
- Breast cancer screening (females ages 52–74)
- Colorectal cancer screening (patients ages 51–75)
- Comprehensive diabetes care (patients ages 18–75), including nephropathy, where appropriate
- Disease-modifying antirheumatic drug therapy for rheumatoid arthritis
- Medication reconciliation post-discharge
- Osteoporosis management (females ages 67–85 who had a fracture in 2016–2017)
- Urinary incontinence screening (**Note:** Screening and evaluation tools are available online in the *American Family Physician* journal.)

Possible Measures

- Statin therapy for patients with cardiovascular disease (males ages 21–75, females ages 40–75)
- Statin therapy for patients with diabetes (patients ages 40–75)

TUFTS HEALTH PLAN ADOPTS CLINICAL PRACTICE AND PREVENTIVE HEALTH GUIDELINES

Tufts Health Plan has recently reviewed and adopted the following new/updated clinical practice and preventive health guidelines:

- Bright Futures (pediatric)
- Chronic obstructive pulmonary disease (COPD)
- Diabetes
- Human immunodeficiency virus (HIV)
- Immunizations
- Perinatal care
- Preventive health guidelines (adult and pediatric)

These guidelines are based on the review of clinical evidence developed by nationally or regionally recognized organizations.

Tufts Health Plan's clinical practice and preventive health guidelines are available in the Guidelines section of the Resource Center on Tufts Health Plan's public Provider website.

OTHER NEWS

RHODE ISLAND INFERTILITY SERVICES

Following recent changes in RI state law, effective for dates of service on or after August 1, 2017, Tufts Health Plan now covers standard fertility preservation services when medically necessary treatment may directly or indirectly cause iatrogenic infertility. In addition, the RI requirement that a member must be married in order to be eligible to receive infertility services has also been removed. Applicable member cost-share will continue to apply.

This change applies only to Commercial fully insured groups based in RI and is documented in the Medical Necessity Guidelines for Infertility Services — Rhode Island Products.

REMINDER: EYE CARE SERVICES

Tufts Health Plan would like to remind ophthalmologists who render professional vision services in an outpatient or office setting to submit claims for routine eye and optometry medical services to EyeMed Vision Care. Ophthalmology medical services should be submitted separately to Tufts Health Plan.

This reminder applies to Commercial (including Tufts Health Freedom Plan), Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options (SCO) products, and is documented in both the Commercial and Tufts Medicare Preferred HMO/Tufts Health Plan SCO Vision Services Professional payment policies.

2017–2018 SEASONAL FLU VACCINE

Who Should Be Vaccinated?

The Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) recommends universal seasonal flu vaccination for anyone age six months and older.

According to the CDC, live attenuated influenza vaccine (LAIV4) is not recommended for use during the 2017–2018 flu season due to concerns about its effectiveness against A(H1N1)pdm09 viruses during the 2013–2014 and 2015–2016 seasons.

The CDC's ACIP voted that LAIV, also known as the "nasal spray" flu vaccine, should not be used during the 2017–2018 flu season. The ACIP continues to recommend annual flu vaccination, with either the inactivated influenza vaccine (IIV) or recombinant influenza vaccine (RIV), for everyone age six months and older.

People at High Risk

According to the CDC, the following people are at high risk for developing flu-related complications:

- Children younger than age five, but especially children younger than age two
- Adults age 65 and older
- Pregnant women (and women up to two weeks postpartum)
- Residents of nursing homes and other long-term care facilities
- American Indians and Alaskan Natives
- People who have medical conditions including:
  - Asthma
  - Neurological and neurodevelopmental conditions, including disorders of the brain, spinal cord, peripheral nerve and muscle such as cerebral palsy, epilepsy (seizure disorders), stroke, intellectual disability, moderate to severe developmental delay, muscular dystrophy or spinal cord injury
  - Chronic lung disease, such as chronic obstructive pulmonary disease (COPD) and cystic fibrosis
  - Heart disease, such as congenital heart disease, congestive heart failure and coronary artery disease
  - Blood disorders, such as sickle cell disease
  - Endocrine disorders, such as diabetes mellitus
  - Kidney disorders
  - Liver disorders
  - Metabolic disorders, such as inherited metabolic disorders and mitochondrial disorders
  - Weakened immune system due to disease or medication, such as people with HIV/AIDS or cancer, or those taking chronic steroids
  - People younger than age 19 who are receiving long-term aspirin therapy
  - People who are morbidly obese (BMI of 40 or greater)

When to Start Immunizing

The flu season can extend from October to May. Seasonal flu vaccination should begin as soon as the vaccine is available (usually early September) and continue throughout the flu season. Seasonal flu outbreaks can occur as early as October, and seasonal flu activity usually peaks in the winter (between December and February).

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Where to Get Immunized

Some locations where the flu vaccine will be available to members this year:

- Provider offices
- CVS MinuteClinics™ located in MA, NH, RI, CT and NY
- CVS/pharmacy stores in MA, RI and NH
- Participating pharmacies within the Caremark network: this expanded network is for members who receive their pharmacy benefit through Tufts Health Plan
- Any other self-pay clinic/vaccination site (member reimbursement would apply)

Note: Age restrictions may apply for vaccines administered outside the provider office.

Coverage for Seasonal Flu Vaccine

For most plans, there is no cost to the member, and copayment and deductible do not apply. If members pay out of pocket for the flu vaccine, they can submit for reimbursement from Tufts Health Plan. If members are unsure whether their plan covers flu vaccination in full and where they can get a flu vaccination, they may call a Member Services representative at the number listed on their member ID card.

Provider Reimbursement for Seasonal Vaccine Administration

Refer to Tufts Health Plan's Immunization Payment Policy for more information.

Reporting Adverse Events Following Vaccination

Visit the VAERS website at vaers.hhs.gov or call 800.822.7967.

CDC Information

- Information for Health Professionals
- Frequently Asked Flu Questions 2017–2018 Influenza Season
- Free flu resources: Materials include messaging (available in multiple languages) to address flu recommendations (free for download)
- Flu Activity and Surveillance

Reference: Centers for Disease Control and Prevention (cdc.gov/flu).

PROVIDER

UPDATE

NEWS FOR THE NETWORK | TUFTS Health Plan

FOR MORE INFORMATION

- tuftshealthplan.com/provider
- Provider Services
  888.884.2404
- Provider Relations
  800.279.9022

WHAT'S INSIDE ...

TUFTS Health Plan

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