PROVIDER
UPDATE
AUGUST 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 pertaining to Tufts Health Public Plans products (including Tufts Health Direct, Tufts Health Together 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 October 1, 2017:

60-DAY NOTIFICATIONS

Artificial Pancreas Device Systems

Tufts Health Plan will require prior authorization for coverage of an artificial pancreas device system. This change is documented in the Medical Necessity Guidelines for Artificial Pancreas Device Systems.

AccuBoost® Therapy for Breast Cancer

AccuBoost therapy for breast cancer (noninvasive image-guided breast brachytherapy [NIBB]) will be added to the Medical Necessity Guidelines for Noncovered Investigational Services, as it has been determined to be experimental/investigational.

Continuous Glucose Monitoring Systems

Tufts Health Plan will update its medical necessity criteria for continuous glucose monitoring systems to provide clarification and to remove a specific limitation. These changes are documented in the Medical Necessity Guidelines for Continuous Glucose Monitoring Systems.

Procedures for the Treatment of Benign Prostatic Hypertrophy

Tufts Health Plan will require prior authorization for coverage of prostatic urethral lift (e.g., Urolift®). This change is documented in the Medical Necessity Guidelines for Procedures for the Treatment of Benign Prostatic Hypertrophy.

Hospice Services

The Medical Necessity Guidelines for Hospice Services will provide additional clarification for coverage of hospice levels of care. This change is documented in both the Medical Necessity Guidelines for Hospice Services and the Commercial Hospice Payment Policy.

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

Noncovered Investigational Services

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

- Dexamethasone intravitreal implant (Ozurdex®, Allergan, Inc.) for the treatment of diabetic macular edema
- Iluvien® (fluocinolone acetonide intravitreal implant, Alimera Sciences, Inc.) for the treatment of diabetic macular edema
- CyPass Micro-Stent®
- Anser VDZ® Test (Prometheus Laboratories) for monitoring vedolizumab treatment of Crohn's disease
- Ovarian Cancer Focus Panel (Fulgent Diagnostics)
- ToxProtect™ (Genotox Laboratories)
- PGxOne™ Plus (Admera Health)
- miraDry® (Miramar Labs®, Inc.) for the treatment of hyperhidrosis
- Skeletal dysplasia ciliopathy NGS panel (Connective Tissue Gene Tests)
- Focal and Segmental Glomerulosclerosis (FSGS) Evaluation (Athena Diagnostics®)

PHARMACY COVERAGE CHANGES FOR SENIOR PRODUCTS

As a reminder, effective for fill dates on or after May 1, 2017, Tufts Health Plan made the following changes to its formulary:

- Pradaxa® was moved to noncovered status. This change applies to members initiating a new course of treatment. Members currently using this medication can continue to fill prescriptions through December 31, 2017.
- Eliquis® was added to the formulary on the Preferred Brand Tier. (Prior authorization is not required.)

These changes apply to Tufts Medicare Preferred HMO, Tufts Medicare Preferred PDP and Tufts Health Plan Senior Care Options.

COMMERCIAL PHARMACY COVERAGE CHANGES

New Prior Authorization Programs

Effective for fill dates on or after October 1, 2017, Tufts Health Plan will require prior authorization for coverage of Neulasta® (pegfilgrastim). In order for a member to continue or start treatment with Neulasta (pegfilgrastim), the prescribing provider must request coverage through the medical review process as outlined in the Pharmacy Medical Necessity Guidelines for Neulasta (pegfilgrastim).

The names of the chemotherapeutic drugs in the regimen your patient is currently or planning on receiving, as well as any risk factors, are required to be submitted with the request. Tufts Health Plan's prior authorization criteria utilize the National Comprehensive Cancer Network guidelines to help determine whether a specific chemotherapy regimen is categorized as high or intermediate risk for febrile neutropenia. Requests for prior authorization will not be reviewed until the effective date of October 1, 2017.

Viscosupplements for Knee Osteoarthritis

Effective for fill dates on or after October 1, 2017, Tufts Health Plan will update its prior authorization criteria for viscosupplements for knee osteoarthritis. This change is documented in the Pharmacy Medical Necessity Guidelines for Viscosupplementation for Osteoarthritis.

Note: Tufts Health Plan covers Euflexxa® as its preferred viscosupplement. Noncovered viscosupplements will be approved only upon documented failure of Euflexxa.

Tier Changes

Effective for fill dates on or after October 1, 2017, Tufts Health Plan will move the following medications to Tier 3 for its large group Commercial formularies: Tazorac 0.1% cream, Strattera® and Renvela®.

Effective for fill dates on or after October 1, 2017, Tufts Health Plan will move the following medications to Tier 4 for its 4-Tier Commercial formularies:

- Somavert®
- Northera®
- Juxtapid®
- Ofev®
- Xyrem®
- Nilandron®
- Nilutamide
- Fareston®
- Venclexta™
- Cometriq®
- Imbruvica®
- Sabril®
- Cerdelga®
- Valchlor®
- Jadenu®
- Exjade®
- Iclusig®
- Lynparza™
- Zydelig®
- Matulane®
- Caprelsa®

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OTHER COVERAGE UPDATES

Over-the-Counter Differin

Tufts Health Plan has added over-the-counter (OTC) Differin 0.1% gel to Tier 1 for all Commercial formularies. In order to process the claim through the prescription drug benefit, which may lower the member's out-of-pocket cost, members will need a prescription for OTC Differin. To ensure the member receives coverage for the OTC medication, please specify OTC Differin on the prescription.

STANDARD FORMS FOR PHARMACY PRIOR AUTHORIZATION REQUESTS

To determine which prior authorization form to use based on state and product, refer to the Commercial Pharmacy Medication Prior Authorization Submission Guide.

Standard Forms for MA-Based Commercial Products

As previously communicated and effective for dates of service on or after February 1, 2017, Tufts Health Plan now accepts only the Standard Form for Medication Prior Authorization Requests 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. Tufts Health Plan also accepts the MA standard form for members of other Commercial products, with the exception of Tufts Health Freedom Plan products.

Refer to **Submitting Prior Authorization Requests to Tufts Health Plan** for information on how to submit these forms.

Tufts Health Freedom Plan Only

As previously communicated and effective for prescription drug requests submitted on or after July 1, 2017, Tufts Health Plan began accepting 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 December 31, 2017, Tufts Health Plan will no longer accept the existing Tufts Health Plan Universal Pharmacy Programs Request Form for members of Tufts Health Freedom Plan products, 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.

Refer to **Submitting Prior Authorization Requests to Tufts Health Plan** for information on how to submit these forms.

Hepatitis C Medications and Synagis

As previously communicated by Tufts Health Plan, Chapter 176O Section 25 of the Massachusetts General Laws 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). Tufts Health Plan will accept only these specific standard forms for fully insured MA-based Commercial members once the effective date and other pertinent details are released in the DOI bulletin. At this time, no action is required from providers.

Submitting Prior Authorization Requests to Tufts Health Plan

Prior to submitting the MA standard form, NH standard form, hepatitis C medications form or Synagis 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. Any additional supporting documentation relevant to the prescription drug request may be included or attached to the applicable standard form (as indicated on each form) and should be submitted using the existing mail and fax channels.

Note: To determine which form to use based on state and product, refer to the Commercial Pharmacy Medication Prior Authorization Submission Guide.

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.

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.

CLAIM EDITS EFFECTIVE OCTOBER 1

The following claim edits are effective for dates of service on or after October 1, 2017. 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 Tufts Health Plan 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:

- Evaluation and management
- Laboratory and pathology
- Orthotics and prosthetics
- Outpatient
- Radiology (imaging and radiation oncology)
- Surgery

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

COMMERCIAL (INCLUDING TUFTS HEALTH FREEDOM PLAN)

Tufts Health Plan will implement the following claim edits for Commercial products (including Tufts Health Freedom Plan):

- Anesthesia
- Durable medical equipment
- Physical therapy

These edits are documented in the applicable Commercial payment policies.

SENIOR PRODUCTS

The following claim edits apply to Tufts Medicare Preferred HMO and Tufts Health Plan SCO products:

Outpatient Claim Edits

Tufts Health Plan will implement new outpatient claim edits. These edits will be documented in the Tufts Medicare Preferred HMO/Tufts Health Plan SCO Outpatient and Outpatient Surgery Facility payment policies, and the Drugs and Biologicals Payment Policy.

DRUGS AND BIOLOGICALS CLAIM EDITS

Effective for dates of service on or after October 1, 2017, Tufts Health Plan will implement additional claim edits for drugs and biologicals. These edits will apply to Commercial (including Tufts Health Freedom Plan), Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options products.

Tufts Health Plan's policies regarding drugs and biologicals are derived from evaluation of drug manufacturers' prescribing information and the following sources:

- AMA's CPT Manual
- CMS and CMS HCPCS Level II Manual
- National Comprehensive Cancer Network Drugs & Biologics Compendium™
- National Government Services, Inc. website
- Micromedex® and DRUGDEX®

These policies support appropriate diagnosis codes, indications, dosages and frequencies. In some instances, off-label indications will also be allowed where there is evidence of efficacy.

This information is documented in the Drugs and Biologicals Payment Policy.

CHANGES TO TUFTS HEALTH PLAN'S SECURE PROVIDER WEBSITE

Tufts Health Plan will soon make updates to its secure Provider website for Commercial (including Tufts Health Freedom Plan), Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options products.

As part of this change, Tufts Health Plan will implement a new registration process with improved self-service features. This new process will be available for new and existing providers who have not yet registered for the secure Provider website, and for those already registered who are interested in taking advantage of the new process and features. More information will be available in the coming months.

If you have not yet registered for the secure Provider website, you may register via the existing process until the new registration process is available to providers. Information on how to register using the existing process is available on Tufts Health Plan's public Provider website. For questions about registration, please contact Provider Services at 888.884.2404.

RHODE ISLAND RULES AND REGULATIONS REGARDING OPIOIDS

The Rhode Island Department of Public Health has recently updated the *Rules and Regulations for Pain Management, Opioid Use and the Registration of Distributors of Controlled Substances in Rhode Island [R21-28-CSD],* which were originally promulgated in March 2015.

These regulations apply to patients considered "initiates," individuals who have not had an opioid in the past 30 days. Section 3.3 of the regulation limits the initial prescription of opioids to 20 doses and no more than 30 morphine milligram equivalents per day, and it also prohibits the prescribing of long-acting or extended-release opioids, like methadone, for acute pain. Section 3.5 of these regulations requires prescribers to review the Prescription Data Monitoring Program (PDMP) prior to prescribing an opioid to an initiate.

Tufts Health Plan's Utilization Management program supports the new rules and regulations for pain management and opioid use set forth by the RI Department of Health.

These new rules will affect all members enrolled in RI-based Commercial products, regardless of the member's state of residence or whether services are rendered in MA, RI or NH.

COMMERCIAL PHYSICIAN, OUTPATIENT HOSPITAL FEE SCHEDULES TO BE UPDATED

Tufts Health Plan reviews its Commercial physician and outpatient hospital fee schedules quarterly to ensure that they are current, comprehensive and consistent with industry standards to the extent supported by its systems. In most cases, changes involve adding fees for new or existing codes to supplement the fees already on the fee schedule.

The next update will occur on October 1, 2017. Changes may involve both new and existing CPT and HCPCS codes, and will include the planned quarterly update to physician immune globulin, vaccine and toxoid fees.

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

Detailed information about changes to existing fee schedules will be distributed to provider organization and hospital leadership. Independent physicians who have questions about fee schedule changes should contact Tufts Health Plan's Network Contracting Department at 888.880.8699, ext. 52169.

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, the American Medical Association and NCCI. 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.

YOUR ACTION REQUIRED: GET UPDATES FASTER ONLINE

As previously announced, beginning August 1, 2016, Tufts Health Plan began a transition to distribute its *Provider Update* newsletter by email. If you have not yet registered to receive *Provider Update* by email, providers 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 August 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

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, a change of street address (including suite number, if applicable), a change of phone number (including direct department line and extension, if applicable), 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.

HOW TO UPDATE YOUR INFORMATION

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

You can check your 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

You can check your 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.

FRAUD, WASTE AND ABUSE HOTLINE

Have you ever seen indications that a patient might be using a Tufts Health Plan ID card fraudulently? Have patients reported receiving excessive, nonordered, or unnecessary medications or medical supplies? Have patients ever given you information about questionable billing practices by other providers? Have you been made aware or do you suspect that a patient may be seeking a prescription for a non-legitimate medical purpose, or abusing the pharmacy benefit?

If you have concerns like these, Tufts Health Plan has a hotline for you to report concerns about possible health care fraud. The hotline was established to help Tufts Health Plan's providers, members and vendors who have questions, concerns and complaints related to possible wasteful, fraudulent or abusive activity.

You can call the Tufts Health Plan Fraud, Waste and Abuse Hotline to report your concerns 24 hours a day, 7 days a week, at 877.824.7123. You may identify yourself or report anonymously. The information you provide will be forwarded to Tufts Health Plan's Compliance Department within one business day for your concerns to be addressed.

BEHAVIORAL HEALTH UPDATES

ALCOHOL OR SUBSTANCE USE DISORDER FOLLOW-UP VISITS

The NCQA has established standards recommending that a medical or behavioral health provider who diagnoses a patient with an alcohol or substance use disorder (SUD) schedule a follow-up visit within 14 days of the initial visit, with two additional follow-up visits occurring within 30 days of the original diagnosis. This standard of care complies with the HEDIS initiation of treatment for alcohol and other drug dependence measurement, an important quality benchmark supported by Tufts Health Plan.

Tufts Health Plan's Behavioral Health Department is available to provide support for members dealing with alcohol dependence and SUDs. Case management programs are also available to provide support, including assistance with engaging in and adhering to a behavioral health plan of care or a SUD recovery plan. For help locating a behavioral health provider or to learn more about the case management programs available to members facing these issues, contact Tufts Health Plans' Behavioral Health Department at 800.208.9565, or 800.547.5186 for Tufts Health Freedom Plan members.

Providers can also refer members to Tufts Health Plan's Behavioral Health Alcohol and Substance Use brochure, available on Tufts Health Plan's public Member website.

Appropriate Coding Information for Alcohol Dependence and SUDs

- It is important that all claims for patients with a SUD diagnosis include the appropriate substance use diagnosis code to denote alcohol or substance use disorder or dependence.
- Refer to the following codes that denote alcohol or substance use disorder or dependence: F10.20 (alcohol dependence), F11.20 (drug dependence) and F10.10 (nondependent abuse of drugs).
- When submitting a claim for a follow-up visit, include the SUD diagnosis on the claim.
- For patients who are appropriately using long-term medication for pain management or other conditions, SUD diagnosis codes should not be included on claims.
- Refer to code Z79.891, which denotes long-term current use of opiate analgesic.
- Diagnosis code F10.21 is used for a patient with a history of alcohol dependence that is not currently active.

DIAGNOSIS AND TREATMENT OF DEPRESSION AND ANTIDEPRESSANT MEDICATION MANAGEMENT

Depression Screening

Many patients who experience depression often do not complain of a depressed mood, but instead complain of multiple unexplained physical ailments such as fatigue, pain, sleep disturbances or eating disturbances. The risk of depression is higher in individuals with serious medical conditions such as diabetes and cancer, and in survivors of heart attacks and strokes.

In order to improve treatment of depression, Tufts Health Plan recommends that providers screen all patients for depression, and provide or refer follow-up treatment, when appropriate. The use of a valid screening tool, such as the PHQ-2 or PHQ-9, can be important in helping to determine the most appropriate treatment. The PHQ screeners are simple, self-administered tools that can provide valuable information. More information about the PHQ screeners and obtaining them in different languages is available online.

Antidepressant Medication Management

Many patients look to their PCPs to treat their depression. For some patients, prescribing antidepressant medication is the most appropriate treatment. The NCQA has identified the following components of effective treatment:

- A patient who has begun taking a new antidepressant should continue to take the medication as prescribed for the entire 12-week acute phase of treatment.
- For the continuation phase of treatment, the patient should continue to take the antidepressant medication for the following six months.

The NCQA recommends that as treatment begins, providers monitor the patient's response to medication on a regular and frequent basis. Educating your patient about the medication – including what to expect and possible side effects; encouraging attendance at all follow-up appointments; and providing support, even in the form of a follow-up phone call – may help with your patient's adherence to the prescribed medication routine.

Both a guide to treating depression in the primary care setting and an educational brochure on depression are available on Tufts Health Plan's public website.

If you or your patients have questions or need assistance with locating a behavioral health provider, call Tufts Health Plan's Behavioral Health Department at 800.208.9565, or 800.547.5186 for Tufts Health Freedom Plan members.

Reporting Depression Diagnoses

It is important to accurately report a depression diagnosis on claims. To distinguish between major depression and situational or milder forms of depression, refer to the current ICD-10 codes to ensure that the most appropriate diagnosis code is submitted on claims.

BEHAVIORAL HEALTH PROVIDER AVAILABILITY

To assist members and facilities seeking behavioral health providers for Tufts Health Plan members, Tufts Health Plan wants to know when behavioral health providers have current availability to see new patients.

If you are a behavioral health provider and have availability to see new patients within the next two weeks, please email mh_providers@tufts-health.com with your name, credentials, address, phone number, general availability and a brief description of the types of patients you see. Tufts Health Plan will maintain a list of the information submitted and will update this information as providers submit changes. Tufts Health Plan will share this information with members and facilities who call seeking behavioral health providers.

Note: Though Tufts Health Plan shares provider availability information with those seeking behavioral health providers, this does not guarantee you will gain additional patients.

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Behavioral Health Provider Diversity Survey

Tufts Health Plan's Behavioral Health Department has developed a diversity survey in response to member requests to accommodate certain needs and preferences of members with diverse backgrounds.

Periodically, Tufts Health Plan receives requests for assistance from members looking to identify behavioral health providers who can cater to their preferences regarding language spoken, ethnicity or other demographics. Research has shown that patient engagement with outpatient psychotherapy, adherence to clinician recommendations and clinical outcomes are best when members of diverse backgrounds are treated by providers who share some elements of those backgrounds or who have previous experience working successfully with those specific demographics.

In an effort to accommodate member preferences, Tufts Health Plan has posted this diversity survey in the Behavioral Health section of the public Provider website. A letter notifying providers of the survey was also mailed with information on how providers can access and complete the survey. If you have already completed this survey, we ask that you do so again, as survey questions have recently been updated. Survey response is strictly voluntary. Tufts Health Plan will maintain any information submitted and will share that information only with members who identify and request certain preferences regarding diversity.

PLAN UPDATES

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 the Provider Services USFHP queue at 800.818.8589.

REMINDER: CHECK PHARMACY MEDICAL NECESSITY GUIDELINES FOR PRIOR AUTHORIZATION CRITERIA

To prevent delays in coverage review and to ensure you are including all appropriate information when submitting prior authorization requests, providers are reminded to check pharmacy medical necessity guidelines, available in the Resource Center of the public Provider website.

REMINDER: QUITWORKS OFFERS FREE SMOKING CESSATION ASSISTANCE

QuitWorks is a free, evidence-based smoking-cessation service (developed by the Massachusetts Department of Public Health). QuitWorks links MA, NH and RI health care providers and their patients with their state's telephone-based cessation services.

QuitWorks offers many services to your patients, including:

- Multisession telephonic counseling
- Nicotine replacement therapy supplied by QuitWorks (if appropriate)
- Educational materials
- Links to online and community resources

Providers may refer any MA, NH and RI resident to QuitWorks and can receive enrollment and outcome reports that detail the status of their patients.

Translation services and a TTY line for the deaf and/or hard of hearing are available.

For more details, referral forms and other helpful resources, call 1-800-QUIT-NOW (1-800-784-8669) or visit the appropriate QuitWorks website:

- MA: quitworks.makesmokinghistory.org
- NH: quitworksnh.org
- RI: quitworksri.org

REMINDER: SUBMITTING PROVIDER PAYMENT DISPUTES

Tufts Health Plan encourages providers to use the Online Claim Adjustment Tool, available on Tufts Health Plan's secure Provider website, as their primary means of submitting claim adjustment requests to Tufts Health Plan; however, some claims may not be adjustable online.

Note: Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options (SCO) claims cannot be adjusted online at this time.

Tufts Health Plan has adopted the Request for Claim Review Form (v1.1) as our standard form for submitting a payment dispute via mail. This form can be found in the Resource Center on Tufts Health Plan's public Provider website and on the Mass Collaborative website.

Tufts Health Plan would like to remind providers submitting payment disputes of the following guidelines:

- Payment disputes must be separated by product and denial reason, and sent to the appropriate post office box. (For address and mailing information, refer to the Request for Claim Review Form Mailing Information.) When filling out the form, do not highlight any content, as text may appear blacked out when scanned, which may delay the processing of the dispute. Make sure to list a valid claim number and message code (if applicable). This must match what is listed online or on the Explanation of Payment. (**Note:** If the claim number does not match, the submitter will be notified by letter that the dispute will not be reviewed.)
- The appropriate review reason must be chosen to avoid unnecessary rejections.
- A separate dispute form must be submitted for each adjustment along with any supporting documentation. All incomplete submissions will be returned. (**Note:** If more than one claim number is listed, the submitter will be notified by letter that the dispute will not be reviewed.)
- Appeals for denials resulting from the billing of an unlisted procedure code must include operative notes that identify the service(s) performed associated with the unlisted code. The portion of the operative notes that identifies the unlisted service must be underlined. Operative notes that are not underlined to indicate the service performed may delay consideration of payment. (**Note:** For Commercial products, if the services performed are not underlined, the submitter will be notified by letter that the appeal will not be reviewed.)
- New/original (i.e., previously unprocessed) claims may not be included with your payment dispute forms. Only documentation that supports the claims being disputed should be enclosed. Refer to the Claims Submission Policy for information related to the submission of new/original claims.
- Disputes of claims denied for receipt past the filing deadline must include acceptable proof of timely submission.

For acceptable forms of proof of timely submission and additional information about submitting payment disputes, refer to the Provider Payment Dispute policies for both Commercial and Tufts Medicare Preferred HMO/Tufts Health Plan SCO.

PROVIDER

UPDATE

NEWS FOR THE NETWORK | TUFTS Health Plan

FOR MORE INFORMATION

- tuftshealthplan.com/provider
- Provider Services Department: **888.884.2404**
- Provider Relations Department: **800.279.9022**

WHAT'S INSIDE ...

TUFTS Health Plan

705 Mount Auburn Street, Watertown, MA 02472 | **tuftshealthplan.com**