This issue includes information for Tufts Health Public Plans products (including Tufts Health Direct, Tufts Health Together and Tufts Health Unify). For information pertaining to Tufts Health Plan Commercial (including the Tufts Health Freedom Plan), Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options products, refer to the Tufts Health Plan Provider Update newsletter.

60-DAY NOTIFICATIONS

Addition of Prior Authorization Requirements for Neulasta

Effective for fill dates on or after October 1, 2017, Tufts Health Direct will require prior authorization for coverage of Neulasta (pegfilgrastim). The prior authorization criteria will apply to current users as well as new starts. If you feel your Tufts Health Direct members should continue on Neulasta, you must request prior authorization through the medical review process subject to the pharmacy medical necessity guidelines for Neulasta. To submit a prior authorization request, please fill out the Massachusetts Standard Form for Medication Prior Authorization Requests and fax or mail it to the pharmacy utilization management team as directed on the form.

The names of the chemotherapeutic drugs in the regimen your Tufts Health Direct member is currently on or planning on receiving, as well as any risk factors, are required to be submitted with the request. Tufts Health Public Plans’ prior authorization criteria utilize National Comprehensive Cancer Network guidelines to help determine if a specific chemotherapy regimen is categorized as high or intermediate risk for febrile neutropenia. Please note that requests for prior authorization will not be reviewed until the effective date of October 1, 2017.

Over-the-Counter Differin Added to OTC List for Tufts Health Together

Tufts Health Public Plans has added over-the-counter (OTC) Differin 0.1% gel to the Tufts Health Together OTC drug list. Tufts Health Together members are required to have a prescription in order to process the claim through their prescription drug benefit. To ensure the member receives coverage for the OTC product, please specify OTC Differin on the prescription.

Over-the-Counter Differin Added to Tier 1 for Tufts Health Direct

Tufts Health Public Plans has added over-the-counter (OTC) Differin 0.1% gel to Tier 1 of the Tufts Health Direct formulary. Tufts Health Direct members are required to have a prescription in order to process the claim through their prescription drug benefit. To ensure the member receives coverage for the OTC product, please specify OTC Differin on the prescription.

Reminder: Check Pharmacy MNGs for Specific Prior Authorization Criteria

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

Register Your Email for Provider Update

Tufts Health Public Plans is now distributing its provider newsletter by email.* To receive Provider Update, all contracted providers and anyone else who wishes to receive future issues via email must complete the online registration form.

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 by indicating the division(s) of Tufts Health Plan with which the provider participates.

* To request print copies of this newsletter, please call the provider services team at 888.257.1985.

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Prior Authorization for Viscosupplements for Knee Osteoarthritis

Effective for fill dates on or after October 1, 2017, Tufts Health Public Plans will update its prior authorization criteria for coverage of viscosupplements for knee osteoarthritis. This change is documented in the pharmacy medical necessity guidelines for Viscosupplementation for Knee Osteoarthritis.

Please note: Tufts Health Public Plans covers Euflexxa as its preferred viscosupplement. Noncovered viscosupplements will only be approved upon documented failure of Euflexxa.

The prescribing provider must request prior authorization through the medical review process subject to the pharmacy medical necessity guidelines for Viscosupplementation for Knee Osteoarthritis. To submit a prior authorization request, please fill out the Massachusetts Standard Form for Medication Prior Authorization Requests and fax or mail it to the pharmacy utilization management team as directed on the form. Please note that requests for prior authorization will not be reviewed until the effective date of October 1, 2017.

Pharmacy Coverage Changes for Tufts Health Unify

As a reminder, effective for fill dates on or after May 1, 2017, Tufts Health Public Plans 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 Health Unify only.

Coverage Updates

Effective October 1, 2017, there are changes to the medical necessity guidelines referenced below for Tufts Health Direct and Tufts Health Together. Refer to the Provider Resource Center for more information about each guideline. (To access the medical necessity guidelines in the Provider Resource Center, select “Tufts Health Public Plans” from the menu titled “Please Select a Division.” Click on the “Guidelines” category. Then click on “Medical Necessity Guidelines.”)

Artificial Pancreas Device Systems

Tufts Health Public Plans 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 Public Plans 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 Public Plans 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

The medical necessity guidelines for hospice services will provide additional clarification for coverage of hospice levels of care, as it applies to Tufts Health Direct. This change is documented in the medical necessity guidelines for Hospice Services.

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Other Coverage Updates

Noncovered Investigational Services

The following items have been added to the list of Noncovered Investigational Services for Tufts Health Direct and Tufts Health Together:

- Dexamethasone intravitreal implant (Ozurdex, Allergan, Inc.) for the treatment of diabetic macular edema
- Iluvien (fluocinolone acetonide intravitreal implant, Alimera Sciences) 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)

Claim Edits Effective October 1, 2017

The following claim edits are effective for dates of service on or after October 1, 2017, and apply to Tufts Health Direct, Tufts Health Together and Tufts Health Unify products. These policies are derived from the Centers for Medicare & Medicaid Services, the American Medical Association Current Procedural Terminology Manual, the Healthcare Common Procedure Coding System, ICD-10, nationally-accredited societies and Tufts Health Public Plans policy.

Tufts Health Public Plans will implement claim edits on the following:

- Anesthesia
- Allergy testing
- Dermatology
- Durable medical equipment
- Radiology (imaging and radiation oncology)
- Evaluation and management
- Laboratory and pathology
- Outpatient
- Physical therapy

These edits are documented in the Tufts Health Public Plans Claim Edits - Effective October 1, 2017 payment policy.

Max Units for Outpatient Facilities Effective October 1, 2017

Effective for dates of service on or after October 1, 2017, Tufts Health Public Plans has assigned a maximum number of units for every procedure code that may be billed when a member receives services on a single day. If the number of units billed exceeds the maximum number of units allowed for the service, Tufts Health Public Plans will compensate only the maximum number of units allowed. The unit(s) assigned is subject to change and may be subject to adjustment based on the diagnosis associated with the procedure code submitted. The unit assigned is not a guarantee of payment. This policy applies to all outpatient facility claims for all services.

These changes apply to Tufts Health Direct, Tufts Health Together and Tufts Health Unify.

Update Your Practice Information

Providers are reminded to regularly notify Tufts Health Public Plans of any changes to their contact or member panel information, such as a change in their ability to accept new patients, street address, phone number or any other change that affects their availability to members. For Tufts Health Public Plans to remain compliant with regulatory requirements, it is important that these changes be communicated in writing as soon as possible and that members have access to the most current information in the Provider Directory.

How to update your information:

You can check your current practice information by going to the Find a Doctor, Hospital or Pharmacy tool. If that information is not correct, please update it as soon as possible by completing the Medical Provider Information Form or Behavioral Health Provider Information Form. Provider information forms are available in the forms section of the Provider Resource Center at tuftshealthplan.com/provider. Send your form via fax to 857.304.6311 or via email to provider_data_request@tufts-health.com as noted on the form.

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Correct Coding Reminder
As a routine business practice, claims are subject to payment edits that are updated at regular intervals and generally based on the Centers for Medicare & Medicaid Services (CMS), including the National Correct Coding Initiative (NCCI). Payment edits are also based on 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 received, Tufts Health Public Plans will update its system to reflect the changes.

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

If you have any questions, please call us at 888.257.1985.

Drugs and Biologicals Claim Edits Effective October 1, 2017

Effective for dates of service on or after October 1, 2017, Tufts Health Public Plans will implement additional claim edits for drugs and biologicals. These edits will apply to Tufts Health Direct, Tufts Health Together and Tufts Health Unify products.

Tufts Health Public Plans’ policies regarding drugs and biologicals are derived from evaluation of drug manufacturers’ prescribing information and the following sources:

- The Centers for Medicare & Medicaid Services (CMS) and the CMS HCPCS Level II Manual
- National Comprehensive Cancer Network Drugs & Biologics Compendium
- National Government Services Inc. website
- Micromedx 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. These edits are documented in the Tufts Health Public Plans Claim Edits - Effective October 1, 2017 payment policy

Did You Know...
Visit the Pharmacy section of Tufts Health Plan’s public provider website at tuftshealthplan.com/provider for the most current pharmacy benefit information, including tier changes, online formularies and descriptions of pharmacy management programs. Pharmacy information on our website is updated regularly. Check pharmacy updates for postings of formulary changes, notification of new pharmacy programs and information about certain drug recalls and alerts from the FDA or drug manufacturers.

Also available on our website is other important business information, such as updates to our Quality Improvement Program and progress to meeting goals, complex case management (CCM) information including access to CCM, disease management programs and services, Clinical Practice Guidelines, Utilization Management Criteria/ Guidelines, the Provider Manual and Members’ Rights and Responsibilities.

Copies of the above information can also be mailed upon request by calling the provider services team at 888.257.1985.

ADMINISTRATIVE UPDATES

Standard Hepatitis C Medications and Synagis Prior Authorization Forms

Massachusetts General Laws require, among other things, that health insurance carriers use standard prior authorization forms when reviewing requests for both hepatitis C medications and Synagis for commercial products, including Tufts Health Direct.

The Mass Collaborative, an organization of health plans, provider organizations and professional associations, has developed these standard prior authorization request forms, and the forms have been approved by the Massachusetts Division of Insurance (DOI). These forms standardize the prior authorization process for providers. The use of these forms is required for all Massachusetts health plans and providers.

The effective date of these forms and other pertinent details are dependent upon the DOI’s bulletin release. More information will become available in the coming months.

Changing a Member’s PCP via Tufts Health Provider Connect

Tufts Health Public Plans is pleased to announce that our providers can now change a member’s PCP assignment (per the member’s request) electronically via our secure Tufts Health Provider Connect portal.

To access this new feature, you must be a registered Tufts Health Provider Connect user. If you have not yet registered, start a user account on the Tufts Health Provider Connect website by clicking the “New User Registration” link. A step-by-step PCP Change User Guide is available in our Provider Resource Center.

We hope this feature saves you valuable administrative time and makes your experience more efficient.

If you have any questions, please call us at 888.257.1985.

Clinical Practice Guidelines Online

Providers can find clinical practice guidelines online in the Provider Resource Center at tuftshealthplan.com/provider.

Disease Management Program

Our disease management program is designed to assist with coordination and care for certain chronic conditions: asthma, diabetes, chronic obstructive pulmonary disease and/or heart failure. Visit our disease management program web page to learn more about our program and how to refer members directly to a program. Our disease management program can help Tufts Health Direct and Tufts Health Together members with asthma, diabetes, chronic obstructive pulmonary disease and/or heart failure. A diabetes program is also offered to Tufts Health Unify members.
Submitting the Standard Form for Medication Prior Authorization Requests

As previously communicated and effective for dates of service on or after February 1, 2017, providers are required to use the Massachusetts Standard Form for Medication Prior Authorization Requests finalized by the Massachusetts Division of Insurance for all coverage determination and exception requests for Tufts Health Direct and Tufts Health Together members.

Providers are encouraged to attach any additional supporting documentation relevant to the medical necessity criteria to the standard form (as indicated on the form). Providers should submit the form using the existing mail and fax channels that are indicated on our Massachusetts Standard Form for Medication Prior Authorization Requests web page and the chart below.

This chart indicates the appropriate forms for Tufts Health Public Plans products:

<table>
<thead>
<tr>
<th>Form</th>
<th>Tufts Health Direct</th>
<th>Tufts Health Together</th>
<th>Tufts Health Unify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts Standard Form for Medication Prior Authorization Requests</td>
<td>Massachusetts Standard Form for Medication Prior Authorization Requests</td>
<td>Universal Pharmacy Programs Request Form</td>
<td></td>
</tr>
<tr>
<td>Fax</td>
<td>617.673.0988</td>
<td>617.673.0988</td>
<td>617.673.0956</td>
</tr>
<tr>
<td>Mail</td>
<td>Tufts Health Plan</td>
<td>Attn: Pharmacy Utilization Management Department 705 Mount Auburn Street Watertown, MA 02472</td>
<td></td>
</tr>
</tbody>
</table>

Before submitting the applicable form to Tufts Health Public Plans, providers should refer to Tufts Health Public Plans’ coverage policies, member benefits and pharmacy medical necessity guidelines. This information is available in the Provider Resource Center.

Before submitting prior authorization requests to Tufts Health Public Plans and before rendering services, providers are reminded to check the member’s ID card to identify the plan in which the member is enrolled. Providers also should check member benefits and cost-share amounts using Tufts Health Provider Connect or other self-service channels, even for members seen on a regular basis.

If you have any questions, call us at 888.257.1985.

Tufts Health Provider Connect Portal Changes

Tufts Health Public Plans is integrating a new medical management system, MedHOK, into Tufts Health Provider Connect, our secure provider portal. With the same single sign-on you use today to view eligibility, claims and authorization status, there is a seamless connection to enter the integrated MedHOK system. You will be able to use MedHOK to complete a request for coverage of inpatient and outpatient services, attach documentation and, in some cases, receive an immediate review determination and approval online. All authorization request history will still be available in Tufts Health Provider Connect.

Please look for an upcoming announcement about the MedHOK launch date on Tufts Health Provider Connect. A MedHOK user guide is available on Tufts Health Provider Connect and in the Provider Resource Center.

If you are not already a user, please consider using Tufts Health Provider Connect for your hospital admissions and outpatient coverage requests. New users may register here. Use these links for our updated user authorization form and for our Tufts Health Provider Connect Reference Guide.

If you have any questions, please call us at 888.257.1985.
Reminder: Behavioral Health Providers
You can submit authorization requests for outpatient behavioral health services through Tufts Health Provider Connect, our secure provider portal. This feature is available for your Tufts Health Direct, Tufts Health Together and Tufts Health Unify members. Requests can be submitted 24/7 through our automated process. You will receive an immediate approval response if you meet the required criteria. The automated process eliminates the need for faxing and results in a quicker, more efficient experience for your office staff.

Tufts Health Provider Connect login credentials are required to submit outpatient authorization requests online. New users may register here. Use these links for our updated user authorization form and for our Tufts Health Provider Connect Reference Guide. If you have any questions, please call us at 888.257.1985.

Reminder: QuitWorks Offers Free Smoking-Cessation Assistance
QuitWorks is a no-cost, evidence-based smoking-cessation service developed by the Massachusetts Department of Public Health. QuitWorks links Massachusetts, New Hampshire and Rhode Island health care providers and their patients with their state's telephone-based cessation services.

QuitWorks offers many services to your patients, including:
- Multi-session telephonic counseling
- Nicotine replacement therapy supplied by QuitWorks (if appropriate)
- Educational materials
- Links to online and community resources

Providers may refer any Massachusetts, New Hampshire and Rhode Island resident to QuitWorks. Providers can receive enrollment and outcome reports that detail the status of their patients.

Translation services and a TTY line for your patients who are 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:
- Massachusetts: quitworks.makesmokinghistory.org
- New Hampshire: quitworksnh.org
- Rhode Island: quitworksri.org

Alcohol or Substance Use Disorder Follow-Up Visits
The National Committee for Quality Assurance (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 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 Public Plans.

Tufts Health Public Plans’ behavioral health team is available to provide support for members dealing with alcohol 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. To learn more about the case management programs available to members facing these issues, contact Tufts Health Public Plans’ behavioral health team at 888.257.1985. You can use our Find a Doctor, Hospital or Pharmacy tool to help a member locate a behavioral health provider.

Providers can also refer members to Tufts Health Public Plans’ Behavioral Health Alcohol and Substance Use brochure.

Appropriate Coding Information for Alcohol and SUDs
- It is important that all claims for patients with an 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 the treatment of depression, Tufts Health Public Plans 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 are looking to their PCPs to treat their depression. For some patients, prescribing antidepressant medication is the most appropriate treatment. The National Committee for Quality Assurance (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.

As treatment begins, the NCQA recommends that 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 Public Plans’ behavioral health team at [888.257.1985](#).

Reporting Depression Diagnoses

It is important to accurately report a depression diagnosis on claims. To distinguish between major depression or 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.

Diabetes Screening for Patients With Schizophrenia or Bipolar Disorder

According to the American Diabetes Association (ADA) and the American Psychiatric Association (APA), patients with schizophrenia or bipolar disorder have an increased risk of developing type 2 diabetes. This risk is even higher for patients who are taking antipsychotic medications. The ADA and APA advise that all patients with schizophrenia or bipolar disorder be screened for diabetes. Based on ADA and APA guidelines, Tufts Health Plan recommends annual screenings for diabetes using an HbA1C or glucose test for our members who are taking antipsychotic medications.

Diabetes Monitoring for Patients With Schizophrenia

Diabetes is seen in one of five patients with schizophrenia. According to the American Diabetes Association (ADA) and American Psychiatric Association (APA), besides the high risk of diabetes, patients with schizophrenia have an increased risk of other metabolic abnormalities. ADA and APA guidelines specify baseline and interval monitoring of glucose and lipid parameters for patients taking antipsychotic medications. Based on these guidelines and National Committee for Quality Assurance requirements, Tufts Health Plan recommends annual testing for low-density lipoprotein cholesterol (LDL-C) and HbA1C for members with schizophrenia who are also diagnosed with diabetes.

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