Update

Provider Update

May 2016

News for the Network

This issue includes information for Tufts Health Plan Commercial, Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options and Tufts Health Freedom Plan 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 and Tufts Health Freedom Plan products and are effective for dates of service on or after July 1, 2016:

Lower Limb Prostheses – Micro Knee
Tufts Health Plan will no longer routinely cover lower limb prostheses for members with intolerance to test socket fitting and/or wear due to residual limb issues, including but not limited to intractable pain, joint contractures and skin/wound complications, as such an intolerance will likely predict a poor outcome with a permanent prosthetic. This change is documented in the Limitations section of the Medical Necessity Guidelines for Lower Limb Prostheses – Micro Knee.

Occupational Therapy for Attention Deficit/Hyperactivity Disorder
Tufts Health Plan will no longer routinely cover occupational therapy treatment for children with attention deficit/hyperactivity disorder (ADHD) (e.g., skill-enhancing training such as motor-perceptual training, cognitive-perceptual training, handwriting training, self-care training and social skills training), as it has been determined to be investigational. This change is documented in the Limitations section of the Medical Necessity Guidelines for Occupational Therapy.

Genetic and Molecular Diagnostic Testing
Tufts Health Plan will no longer routinely cover duplicate genetic tests for an inherited condition unless there is uncertainty about the validity of the existing test result. Genetic testing panels, if authorized in accordance with the prior authorization process for genetic testing, will be covered only for the number of genes or test(s) that are reasonable to obtain necessary information for therapeutic decision making, and not for the entire panel. Clarification of molecular diagnostics and genetic testing will be added, and MDs with expertise in targeted disease can request molecular diagnostic testing. Additional criteria added will require genetic counseling by a board-certified genetic counselor or a MD geneticist.

Tufts Health Plan will require that patient history, physical examination and conventional diagnostic testing have not resulted in a definitive diagnosis of suspected disorder. This change is documented in the Medical Necessity Guidelines for Genetic and Molecular Diagnostic Testing.

Bariatric Surgery
Coverage of bariatric surgery using InterQual® criteria has been added for members ≥ 13 and < 18 years of age for the following adolescent bariatric surgery procedures:

- Adjustable gastric banding
- Roux-en-Y gastric bypass (RYGB)
- Sleeve gastrectomy

This change is documented in the Medical Necessity Guidelines for Bariatric Surgery.

Fetal MRI
Prior authorization will be required as part of the NIA High-Tech Imaging Program for the following procedures:

- 74712: Magnetic resonance (e.g., proton) imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation
- 74713: Magnetic resonance (e.g., proton) imaging, fetal, including placental and maternal pelvic imaging when performed; each additional gestation (list separately in addition to code for primary procedure)

Refer to the High-Tech Imaging Program Prior Authorization Code Matrix in the Commercial Imaging Professional Payment Policy.

Provider Update Available Online

This issue and past issues of Provider Update are available in the News section at tuftshealthplan.com/provider.
Coverage Updates for Commercial Products
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myRisk®
A Myriad myRisk® Hereditary Cancer test will be covered with prior authorization. Refer to Medical Necessity Guidelines for Genetic Testing: BRCA-Related Breast and/or Ovarian Cancer Syndrome (formerly known as Genetic Testing: Multi-site BRCA3, Single-Site BRCA1 or BRCA2, & BART™) or the InterQual Clinical Evidence Summary for Lynch Syndrome.

Vision Therapy
Tufts Health Plan may authorize coverage of up to a total of 30 visits per lifetime, when medically necessary. Refer to the Medical Necessity Guidelines for Vision Therapy.

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

- Right heart catheterization with implantation of wireless pressure sensor in the pulmonary artery, including any type of measurement, angiography, imaging supervision, interpretation and report (C9741)
- Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components (C2624) (e.g., CardioMEMS™ HF System)
- Repetitive transcranial magnetic stimulation (rTMS) for the treatment of tinnitus (90867, 90878 when billed with H93.11 tinnitus, right ear, H93.12 tinnitus, left ear, H93.13 tinnitus, bilateral, H93.19 tinnitus, unspecified ear)
- Balloon dilation of eustachian tubes (no specific code available)
- FerriScan® - MRI measurement of liver iron concentration (no specific code available)
- Ultrasound bone density measurement and interpretation, peripheral site(s), any method (CPT 76977)

Change in Submitting Claims for Non-Contracting Nurse Practitioners
As a reminder, nurse practitioners (NPs) who have not signed a contract with Tufts Health Plan may render medically necessary covered services to Tufts Health Plan members provided they are collaborating with a Commercial contracting Tufts Health Plan provider. These claims must be submitted by the collaborating provider.

Effective for dates of service on or after July 1, 2016, any contracting collaborating provider who submits claims for a non-contracting NP must include the SA modifier on the claim. Reimbursement will be 85% of the applicable physician fee schedule and is consistent with reimbursement for contracting NPs.

This change applies to Commercial and Tufts Health Freedom Plan products and is documented in the Commercial Nurse Practitioner Professional Payment Policy.

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 July 1, 2016. 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: This does 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.

Genetic Testing and Laboratory Claim Edits Effective July 1
Effective for dates of service on or after July 1, 2016, Tufts Health Plan will implement additional claim edits for genetic testing and laboratory procedures. These edits will apply to Commercial, Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options and Tufts Health Freedom Plan products. These policies support appropriate diagnosis codes, frequencies, age limitations and correct coding.

Tufts Health Plan’s policies regarding genetic testing and laboratory procedures are derived from the following sources:

- AMA’s CPT Manual
- National and Local Coverage Determinations

This information is documented in both the Commercial and Tufts Medicare Preferred HMO/Tufts Health Plan Senior Care Options Laboratory payment policies.

Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options Recoding Policy
Effective for dates of service on or after July 1, 2016, Tufts Health Plan will not add, remove or replace modifiers or procedure codes on submitted claims. These changes are based on coding guidelines defined in the American Medical Association’s CPT Manual and CMS’ HCPCS Level II Manual. Inappropriately coded claims will deny.

This change will be documented in the Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options Evaluation and Management Professional Payment Policy.
Provider Update to Be Electronic Only Effective August 1

Beginning August 1, 2016, Tufts Health Plan will distribute its quarterly Provider Update newsletter by email only and will no longer mail print copies to providers.

In order to receive the August 1 issue of Provider Update by email, all providers must register a valid email address with Tufts Health Plan no later than July 1, 2016. This requirement applies to all providers, including current registered users of the secure Provider website as well as those who have previously submitted an email address to Tufts Health Plan for any reason. Office staff, provider organization and hospital leadership can also register to receive Provider Update by email.

Register Your Email Address
To register your email address, go to the News section at tuftshealthplan.com/provider/news, and click “Register to Receive Provider Update by Email.”

Note: This email address will be used for required notifications only and will not change your login credentials to the secure Provider website.

Past issues and articles featured in Provider Update will continue to be available in the News section on Tufts Health Plan’s public Provider website, as they are today.

Change in Process for Submitting Corrected Claims

Effective for dates of submissions on or after September 26, 2016, claim corrections submitted by electronic data interchange (EDI) for late charges (Frequency Code 5), replacement claims (Frequency Code 7) and voided claims (Frequency Code 8) must include the original Tufts Health Plan claim number. The original claim number should be submitted in the 837 in the following format: Loop 2300 Claim Information/REF – Payer Claim Control Number/REF01=F8 and REF02. Corrections submitted by EDI that do not include the original claim number will be rejected.

Providers should follow existing submission guidelines when submitting corrected claims. Corrected claims submitted by EDI will also be rejected in the following circumstances:

- If the original claim is in process and has not been adjudicated
- If an adjustment to the original claim is currently in process
- If the correction request is received after the submission deadline:
  - Corrected claims must be submitted within 180 days of the date of the original adjudication.
  - Late charges must be submitted within 90 days of the date of service (for outpatient claims) or date of discharge (for inpatient claims.)

This change applies to all Tufts Health Plan Commercial and Tufts Health Freedom Plan products claim corrections except for CareLinkSM when Cigna is the primary administrator. It does not apply to Tufts Medicare Preferred HMO or Tufts Health Plan Senior Care Options corrected claims.

This change is documented in the Provider Payment Dispute Policy.

Inpatient Notification Phone Line to Be Discontinued Effective July 1

As previously communicated and effective for dates on or after July 1, 2016, Tufts Health Plan will no longer accept notification for inpatient admission by phone. The phone line currently used to submit these notifications will be discontinued at close of business on June 30, 2016.

Providers should notify Tufts Health Plan of inpatient admissions using any of the following channels:

- 278 batch EDI transactions
- Secure Provider website
- Fax (617.972.9590)

This change applies to providers of Commercial, Tufts Health Freedom Plan, Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options (SCO) products.

Providers submitting inpatient notifications for members of Tufts Health Public Plans products (i.e., Tufts Health Direct, Tufts Health Together and Tufts Health Unify) should continue to submit using the existing channels they use today.

Note: Providers submitting notifications for members of Commercial, Tufts Health Freedom Plan, Tufts Medicare Preferred HMO and Tufts Health Plan SCO should not use the telephone number in place for Tufts Health Public Plans products.

Tufts Health Plan requires an inpatient notification for any Tufts Health Plan member who is being admitted for inpatient care regardless of whether Tufts Health Plan is the primary or secondary insurer.

Note: Inpatient notification does not take the place of a referral and/or prior authorization requirements for a service.

All elective surgical inpatient notifications require a valid diagnosis code and inpatient procedure code, or CPT code. Surgical day care (SDC) and observation stays do not require a notification to Tufts Health Plan for Commercial, Tufts Health Freedom Plan, Tufts Medicare Preferred HMO and Tufts Health Plan SCO products. An SDC and observation notification is still required for Tufts Health Public Plans products. If an SDC or observation stay converts to an inpatient stay, providers must notify Tufts Health Plan about the inpatient stay within 24 hours of the change.
Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options

New Outpatient Facility Claim Edits
Effective July 1

Tufts Health Plan updates its claims adjudication system at regular intervals to implement industry-standard payment edits and to more closely align with CMS, National Correct Coding Initiative and specialty society guidelines.

Effective for dates of service on or after July 1, 2016, Tufts Health Plan will implement new outpatient claim edits. These edits will apply to Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options, and will be documented in the Outpatient Facility Claim Edits document within the Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options Outpatient Surgery Facility Payment Policy.

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) guidelines, specialty society guidelines, evaluation of drug manufacturers’ package label inserts, and the National Correct Coding Initiative (NCCI.)

Procedure and diagnosis codes undergo annual and quarterly revision by CMS, the American Medical Association and NCCI. As these revisions are made public, Tufts Health Plan will update its system to reflect these changes during the second calendar quarter of 2016.

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

Commercial Pharmacy Coverage Changes

Criteria Changes for Juxtapid® (lomitapide) and Kynamro® (mipomersen)
Effective for prior authorization requests received on or after July 1, 2016, Tufts Health Plan will implement changes to its medical necessity guidelines for Juxtapid (lomitapide) and Kynamro (mipomersen). Tufts Health Plan requires the following additional criteria to be met before Juxtapid (lomitapide) or Kynamro (mipomersen) will be covered:

The member has demonstrated an inadequate response to an appropriate trial with, or has a contraindication to, Repatha™ (evolocumab.)

Note: This requirement does not apply to members under the age of 13.

Repatha (evolocumab) is the preferred medication for homozygous familial hypercholesterolemia as an adjunct to diet and other LDL-lowering therapies in members who require additional lowering of LDL-C. Repatha (evolocumab) must be obtained through our designated specialty pharmacy, Caremark Specialty, at 800.237.2767. Prior authorization and quantity limitations apply.

These changes are documented in the Pharmacy Medical Necessity Guidelines for Juxtapid and Kynamro at tuftshealthplan.com/provider. Copies are also available upon request by calling Provider Services.

Prior Authorization Required for Evzio® (naloxone HCl injection)

Effective for fill dates on or after July 1, 2016, Tufts Health Plan will require prior authorization for coverage of Evzio (naloxone HCl injection.)

The prior authorization criteria will apply to all new prescriptions and refills. The prescribing provider must request coverage through the medical review process subject to the Pharmacy Medical Necessity Guidelines for Evzio® (naloxone HCl injection.)

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 their ability to accept new patients, street address, phone number or 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, Tufts Medicare Preferred HMO and Tufts Health Plan SCO Providers: You can check your current practice information by going to the Find a Doctor search. If that information is not correct, please update it as soon as possible by completing the 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: You can check your current practice information by going to the Find a Doctor search. If that information is not correct, please update it as soon as possible by completing the medical Provider Information Form or the Behavioral Health Provider Information Form, available in the Provider Forms section of the Resource Center, and returning it by fax or mail, as noted on the form.
Cotiviti Healthcare to Review Medical Pharmacy Claims

As part of our ongoing efforts to continuously manage the increasing cost of pharmacy claims, otherwise payable under the medical benefit, Tufts Health Plan has selected Cotiviti Healthcare to review medical pharmacy claims post payment to determine whether claims have been submitted accurately and are being reimbursed correctly.

As part of this effort, Cotiviti will help confirm that submitted claims accurately represent the services provided to Tufts Health Plan members and that they also comply with industry standards, rules, laws, regulations and contract requirements. As a result, providers might be contacted by Cotiviti to validate information billed on a claim.

This notification applies to Tufts Health Plan Commercial and Tufts Health Freedom Plan products.

Tufts Health Plan Adopts Clinical Practice and Preventive Health Guidelines

Tufts Health Plan encourages providers to review the following updated clinical practice and preventive health guidelines that were recently reviewed and approved:

- Adult and pediatric immunizations
- Diabetes
- Chronic obstructive pulmonary disease (COPD)
- Human immunodeficiency virus (HIV)

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

For additional information about these and Tufts Health Plan’s other clinical practice and preventive health guidelines, refer to Guidelines | Clinical Practice Guidelines in the Resource Center at tuftshealthplan.com/provider.

Reminder: Change in Process for Outpatient Psychotherapy Services

As previously communicated by letter and effective for dates on or after March 26, 2016, Tufts Health Plan changed its administration process for outpatient psychotherapy services. Initiation of new episodes of psychotherapy services continues to require notification. However, the process to request continued services has changed from an authorization process to a notification process.

As part of this change, providers are no longer required to routinely submit documentation of medical necessity to request authorization for continued services. Providers must instead notify Tufts Health Plan via the existing secure Provider website and IVR notification channels, as they do today for initial requests. There are no longer clinical questions when notifying Tufts Health Plan of continued services.

This change applies only to members of Tufts Health Plan Commercial and Tufts Health Freedom Plan products that require prior authorization. Outpatient psychotherapy processes for Tufts Health Plan Commercial PPO plans, Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options and Tufts Health Public Plans products remain unchanged at this time.

Tufts Health Plan continues to evaluate its process and will keep providers informed of any additional changes, should changes occur.

Update to Change in Requirements for Part D Prescribers

As previously communicated, CMS will require physicians and eligible professionals who write prescriptions for Part D drugs to be enrolled in Medicare in an approved status or have a valid opt-out affidavit on file for their prescriptions to be covered under Part D. This requirement was to be effective on June 1, 2016, but CMS is now delaying the requirement until February 1, 2017, to give physicians and eligible professionals additional time to complete their enrollment activities. If a physician or eligible professional is not enrolled in Medicare or does not have a valid opt-out affidavit beginning on February 1, 2017, his or her patients’ prescription drug claims cannot be processed and will be denied by their Part D plan.

To avoid claims being denied, physicians and eligible professionals who prescribe Part D drugs must submit their Medicare enrollment application or opt-out affidavits to their Medicare Administrative Contractors. CMS strongly encourages that the application or opt-out affidavit be submitted to the Medicare Administrative Contractor before August 1, 2016 to provide sufficient time to process the application or opt-out affidavit. Please refer to the CMS website at go.cms.gov/PrescriberEnrollment for more information.

Find Current Pharmacy Information on the Web

For the most current information regarding the Tufts Health Plan pharmacy benefit - including tier changes, online formularies and descriptions of pharmacy management programs - go to the Pharmacy section of our website.

Pharmacy information on our website is updated regularly. Check Pharmacy Updates for postings of formulary changes, notification of new pharmacy programs, and important information about drug recalls and alerts from the FDA or drug manufacturers.

Copies of information regarding our pharmacy management programs can also be provided upon request by calling Provider Services at 888.884.2404.
Reminder: Pharm Denial Must Be Billed to CVS Caremark

As a reminder, Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options providers should not bill members for claims that are denied as “PHARM.” These claims must be submitted to CVS Caremark on a CMS-1500 form and mailed to the following address for processing:

Caremark Medicare Vaccine Processing
P.O. Box 52193
Phoenix, AZ 85072-2193

The following vaccines are covered under Medicare Part B:

- Influenza
- Pneumococcal
- Hepatitis (B only if patient is considered moderate- to high-risk)

- Other vaccines, when directly related to the treatment of an injury or direct exposure to a disease or condition, such as:
  - Rabies virus
  - Tetanus Toxoid
  - Antivenin sera

All other vaccines, such as Zostavax® and TDAP, are covered only under Medicare Part D.