Coverage Updates for Commercial Products

Genetic Testing
Tufts Health Plan is delaying the effective date for which Interqual® Molecular Diagnostics criteria will be used when reviewing prior authorization requests for coverage of genetic tests. Previously announced as effective November 1, 2014, the new effective date for this change is for dates of service on or after February 1, 2015.

This change will be documented in the Medical Necessity Guidelines for Genetic Testing: General Policy by November 30, 2014, and will also include procedure code updates, clinical evidence summary information and the suggested genetic testing request form.

Tufts Health Plan will retain the use of the existing Medical Necessity Guidelines for Multisite BRCA3, Single Site BRCA1 or BRCA2, and BART™, Gene Expression for Cancer of Unknown Primary (CUP), and Retinoblastoma (RB1 Mutation).

As a reminder, all requests for prior authorization of genetic testing must include documentation that includes a pedigree and letter of medical necessity from a licensed genetic counselor or MD with expertise in genetic counseling that supports the recommendation for testing based on a review of risk factors, clinical scenario and family history.

Durable Medical Equipment
Effective for dates of services on or after February 2, 2015, Tufts Health Plan will no longer use the 2011 Interqual® SmartSheets™ for DME. The 2014 Interqual SmartSheets will be available beginning on November 30, 2014.

Transgender Surgical Procedures and Transgender Surgery: Associated Procedures (Rider Option)
Guidance has recently been issued by the Massachusetts Division of Insurance relating to coverage of transgender services. Based on this guidance, Tufts Health Plan’s fully insured Massachusetts plans will now cover certain medically necessary transgender services.

Effective January 1, 2015, Tufts Health Plan will also add labiaplasty and testicular prosthesis to the list of covered surgical procedures for transgender surgical procedures. Procedures considered to be cosmetic for all members will be specifically noted as a limitation of coverage in the Medical Necessity Guidelines for Transgender Surgical Procedures.

Tufts Health Plan will also update the Medical Necessity Guidelines for Transgender Surgery: Associated Procedures (Rider Option) to change the type of document to Coverage Guidelines. Testicular prosthesis procedure has been removed from this document. These coverage guidelines for associated procedures include services that are covered only for members whose group has purchased this additional benefit.

Noncovered Investigational Services
As stated in the Tufts Health Plan Evidence of Coverage, a treatment or procedure is considered investigatory or unproven “if reliable evidence shows that prevailing opinion among experts regarding the treatment is that more studies or clinical trials are necessary to determine its safety, efficacy, toxicity, maximum tolerated dose or its efficacy as compared with a standard means of treatment or diagnosis.”

Tufts Health Plan restricts coverage to those devices, treatments or procedures for which the safety and efficacy have been proven, and which are comparable or superior to conventional therapies. Any device, medical treatment, supply or procedure for which safety and efficacy has not been established and proven is considered investigational (unproven) and is excluded from coverage.

The services and items on the Noncovered Investigational Services List have been reviewed through Tufts Health Plan’s Medical Technology Assessment process and deemed to be investigational. Refer to the Genetic Testing section of the list for added investigational genetic tests.
Claim Edits Effective January 1

The following claim edits will be effective for dates of service on or after January 1, 2015. These policies are derived from CMS and the AMA CPT Manual.

**Commercial Claims Only**

**Outpatient Services: Column I and Column II Procedure Codes**

Tufts Health Plan will not compensate for a Column I procedure code if the Column II procedure code has been previously paid. This change is documented in the commercial Outpatient Payment Policy. (This edit was previously implemented for Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options claims.)

**Modifier 24 With E&M Services**

Tufts Health Plan will not compensate for E&M services billed with modifier 24 if:
- A minor surgical procedure with a 10-day postoperative period has been billed in the previous 10 days, and the E&M service has a primary diagnosis associated to the 10-day medical or surgical service.
- A major surgical procedure with a 90-day postoperative period has been billed in the previous 90 days, and the E&M service has a primary diagnosis associated to the 90-day medical or surgical service.

These changes are documented in the commercial Evaluation and Management Professional Payment Policy.

**Observation Services**

Tufts Health Plan will not compensate for the following:
- Observation care discharge or hospital discharge day management when billed and observation or inpatient hospital care, including admission and discharge on the same day, was billed the previous day.
- Observation services when billed for more than one unit per date of service in any combination by any provider and the place of service is 21 (inpatient hospital), 22 (outpatient hospital), 23 (emergency department), or 24 (ambulatory surgical center). This change applies for professional claims only.

These changes are documented in the commercial Evaluation and Management Professional Payment Policy. (These edits were previously implemented for Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options claims.)

**Supplies Billed With a Surgical Procedure**

Tufts Health Plan will not reimburse for supplies when billed on the same date of service as a 0-., 10- or 90-day surgical procedure. This change is documented in the commercial Surgery – Professional Payment Policy.

**Antepartum Care**

- Tufts Health Plan will not compensate for antepartum care-only codes when either antepartum code has been previously billed.
- Tufts Health Plan will not compensate for the global delivery code if the provider has billed antepartum care in the last eight months.

These changes are documented in the commercial Obstetrics/Gynecology Professional Payment Policy.

**Newborn Care Services**

Tufts Health Plan will not compensate for per-day initial hospital or birthing center care E&M of a normal newborn infant admitted and discharged on the same date if the newborn has received newborn care services the previous day. This change is documented in the commercial Newborn Payment Policy.

**Tufts Medicare Preferred HMO and Tufts Health Plan SCO Claims Only**

**Wheelchair Options/Accessories**

Tufts Health Plan will not reimburse for a wheelchair option or accessory when billed without modifier KX on the same date of service as a power wheelchair base. This change is documented in the Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options Durable Medical Equipment Payment Policy.

**Power Mobility Devices**

Tufts Health Plan will not reimburse for a power mobility device when billed without modifier KX. This change is documented in the Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options Durable Medical Equipment Payment Policy.

**Nebulizers**

Tufts Health Plan will not reimburse for a noncompounded inhalation solution when billed without modifier KX. This change is documented in the Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options Durable Medical Equipment Payment Policy.

**Automatic External Defibrillators**

Tufts Health Plan will not reimburse for a wearable defibrillator or nonwearable automatic defibrillator when billed without modifier KX, GA or GZ. This change is documented in the Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options Durable Medical Equipment Payment Policy.
Effective January 1, 2015
Change in Process for Submitting Paper Provider Payment Disputes

As previously announced, Tufts Health Plan has adopted the Request for Claim Review Form as its standard for submitting provider payment disputes by mail. For disputes submitted on or after January 1, 2015, Tufts Health Plan will require the Request for Claim Review Form (v1.1) for provider payment disputes submitted by mail. (Version 1.1 can be identified as including the MassHealth checkbox.) The Provider Payment Dispute Coversheet will no longer be accepted.

The Request for Claim Review Form (v1.1) is available on the HCAS website at www.hcasma.org and in the Forms section of tuftshealthplan.com/providers.

Tufts Health Plan will scan the Request for Claim Review Form using optical character recognition (OCR) software and will no longer grant exceptions to its current policy regarding submission of paper disputes. All required information must be included on the form.

Incomplete forms will be rejected and returned to the submitter with a request to submit a corrected and completed form.

Disputes submitted by mail will be rejected if submitted without the Request for Claim Review Form (v1.1) and for the following reasons:

- Required information on the form is missing, illegible or invalid.
- More than one claim is attached to the form (a separate form is needed for each claim).
- The form is a resized representation of the Claim Review Request Form or a version other than v1.1 that cannot be read by the OCR.

Rejected disputes and a letter describing the reason for the rejection will be returned to the submitter. Rejected review requests must be resubmitted with the completed form by the appropriate submission deadline.

Tufts Health Plan’s Provider Services Department will no longer accept provider payment disputes directly and will work to assist providers with submitting commercial disputes online.

Providers should continue to use the existing process for CareLinkSM with Cigna as Primary Administrator and CareLink–Shared Administration claims.

For more information on submitting payment disputes, refer to the Provider Payment Dispute Policy at tuftshealthplan.com/providers.

Submiting Payment Disputes Online

Tufts Health Plan encourages providers to use the Online Claim Adjustment Tool on our secure Provider website as their primary means of submitting commercial claim adjustment requests and payment disputes. Additional message codes now allow more claims to be adjusted online. (Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options claims cannot be adjusted online at this time.)

Effective January 1, 2015
Annual Updates to Physician and Hospital Reimbursement

Tufts Health Plan will update its physician and hospital fee schedules effective for dates of service on or after January 1, 2015.

As in past years, Tufts Health Plan will continue, with a few exceptions, to base fees on CMS fee schedules, adjusted to achieve the contracted level of compensation.

A description of the changes to our fee schedules will be available on our website as of November 1, 2014, and will also be distributed to hospital and physician group leadership in November 2014. Please remember to consult tuftshealthplan.com/providers for information regarding changes to payment policies and edits that could also affect compensation.

Independent physicians who have questions about fee schedule changes should contact Tufts Health Plan’s Network Contracting Department at 888-880-8699, ext. 2169.

Tufts Medicare Preferred HMO and Tufts Health Plan SCO
Pharmacy Coverage Change

Effective for fill dates on or after January 1, 2015, Tufts Health Plan Medicare Preferred will require prior authorization for the following transmucosal immediate release fentanyl (TIRF) medications:

- Abstral® (fentanyl citrate) sublingual tablet
- Actiq® (fentanyl citrate) oral transmucosal lozenge and its generic equivalents
- FENTORA® (fentanyl citrate) buccal tablet
- Lazanda® (fentanyl citrate) nasal spray

According to the U.S. Food and Drug Administration, TIRF drugs are approved only for the management of breakthrough cancer pain in opioid-tolerant adult patients who are already receiving and who are tolerant to around-the-clock opioid therapy for their underlying persistent cancer pain.

Both the FDA and Centers for Medicare & Medicaid Services have strongly recommended that health plans implement controls, such as prior authorization, to confirm that these medications are being prescribed only for their FDA-approved indication. This helps ensure member safety and mitigate prescriber liability in utilizing these potent medications.
Commercial Pharmacy Coverage Changes

Noncovered Medications
Effective for fill dates on or after January 1, 2015, Tufts Health Plan will no longer routinely cover the following medications and will add these drugs to the List of Noncovered Drugs With Suggested Alternatives in its commercial formularies:

**Inhalers**
- Asmanex®
- Aerospan™
- Alvesco®
- Pulmicort Flexhaler™
- Symbicort®

**Insulins**
- Novolin®
- Novolin® N
- Novolin® R
- Novolog®
- NovoLog® Mix
- Apidra®
- Apidra® SoloStar®

**Medication to Treat Urologic Disorders**
- Oxytrol®

For a member to continue use of any of these drugs, the prescribing provider must request coverage through the medical review process subject to the Pharmacy Medical Necessity Guidelines for Noncovered Drugs With Suggested Alternatives.

Prior Authorization Required for Certain Compounded Medications
Effective for fill dates on or after January 1, 2015, Tufts Health Plan will require prior authorization for compounded medications exceeding a cost threshold of $300. For details of the criteria, refer to the Pharmacy Medical Necessity Guidelines for Compounded Medications.

For a member to continue on a compounded medication exceeding the cost threshold, the prescribing provider must request coverage through the medical review process subject to the Pharmacy Medical Necessity Guidelines for Noncovered Drugs With Suggested Alternatives.

Preferred Diabetic Test Strips and Lancets
Effective for fill dates on or after January 1, 2015, Tufts Health Plan will cover only Lifescan One-Touch® diabetic test strips and lancets. All other test strips and lancets, including but not limited to Accu-Chek®, Contour®, Embrace™, FreeStyle®, Nova Max®, Precision Xtra® and TRUEtrack® will not be covered.

For a member to continue on a noncovered brand of test strips and lancets, the prescribing provider must request coverage through the medical review process subject to the Pharmacy Medical Necessity Guidelines for Noncovered Drugs With Suggested Alternatives.

Members who fill prescriptions for diabetic test strips and lancets will receive information on how to obtain a free Lifescan blood glucose meter and how to request a new test strip prescription through the CVS Caremark Diabetic Meter Program at 800-588-4456.

Cimzia® and Stelara® Covered Under the Pharmacy Benefit Only
Effective for fill dates on or after January 1, 2015, Tufts Health Plan will no longer routinely cover the following self-injectable medications under the outpatient medical benefit:
- Cimzia (certolizumab pegol)
- Stelara (ustekinumab)

Consistent with Tufts Health Plan's coverage for self-administered medications, coverage of Cimzia and Stelara will be available only through the pharmacy benefit. Coverage for these medications will no longer be available through buy-and-bill procedures. Prior authorization for these medications will continue to be required.

Complete coverage criteria for these medications are documented in the Pharmacy Medical Necessity Guidelines for Cimzia (certolizumab pegol) and for Stelara (ustekinumab).

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.
Claim Edits Effective January 1  
continued from page 2

Tufts Medicare Preferred HMO  
2015 Benefit Changes

Cost Share Changes
Effective January 1, 2015, cost share amounts for the following services will change for certain Tufts Medicare Preferred HMO plan members:

- Primary care office visits
- Inpatient hospital
- Inpatient rehabilitation hospital
- Inpatient psychiatric hospital
- Skilled nursing facility
- Outpatient surgery
- Ambulance
- Annual routine vision exam
- Annual routine hearing exam
- DME and prosthetics
- Diagnostic radiology
- Bathroom safety items

Anatomical Modifiers
Tufts Health Plan will no longer reimburse for procedures that require an anatomical modifier when billed without an anatomical modifier. This change is documented in the Outpatient Payment Policy.

E&M Services Billed With a Surgical Procedure
Tufts Health Plan will not reimburse for E&M services performed within 10 days of a surgical procedure having a 10-day postoperative period. This change is documented in the Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options Evaluation and Management Professional Payment Policy.

Modifier 24 With E&M Services
Tufts Health Plan will not reimburse for Evaluation & Management services billed with modifier 24 if a major surgical procedure with a 90-day postoperative period has been billed in the previous 90 days and the E&M service has a primary diagnosis associated to the 90-day medical or surgical service. This change is documented in the Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options Evaluation and Management Professional Payment Policy.

Addition to the Annual Wellness Allowance
Effective January 1, 2015, members of Tufts Medicare Preferred HMO plans will be able to apply their annual wellness allowance reimbursement toward the fee for memory fitness activities such as BrainHQ from Posit Science. In addition, those members can receive a 17 percent discount on a subscription to the BrainHQ application offered by Posit Science.

Weight Management Programs
Effective January 1, 2015, Tufts Medicare Preferred HMO members can receive reimbursement for program fees on weight loss programs such as Weight Watchers®, Jenny Craig® and Nutrisystem®, and on hospital-based programs.

For more information about Tufts Medicare Preferred HMO benefit and cost-share amount changes, visit tuftshealthplan.com/providers or call Tufts Health Plan Medicare Preferred Provider Relations at 800-279-9022.

Correct Coding Reminder
As a normal business practice, claims are subject to payment edits that are updated at regular intervals and generally based on Centers for Medicare & Medicaid Services guidelines, specialty society guidelines, evaluation of drug manufacturers’ package label inserts, and the National Correct Coding Initiative.

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 fourth calendar quarter of 2014.

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

Transcutaneous Electrical Nerve Stimulation (TENS)
Tufts Health Plan will not reimburse for a form-fitting conductive garment for delivery of TENS when billed without modifier KK, GA or GZ. This change is documented in the Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options Durable Medical Equipment Payment Policy.

Anatomical Modifiers
Tufts Health Plan will no longer reimburse for procedures that require an anatomical modifier when billed without an anatomical modifier. This change is documented in the Outpatient Payment Policy.

E&M Services Billed With a Surgical Procedure
Tufts Health Plan will not reimburse for E&M services performed within 10 days of a surgical procedure having a 10-day postoperative period. This change is documented in the Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options Evaluation and Management Professional Payment Policy.

Modifier 24 With E&M Services
Tufts Health Plan will not reimburse for Evaluation & Management services billed with modifier 24 if a major surgical procedure with a 90-day postoperative period has been billed in the previous 90 days and the E&M service has a primary diagnosis associated to the 90-day medical or surgical service. This change is documented in the Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options Evaluation and Management Professional Payment Policy.

Tufts Medicare Preferred HMO Referral Requirement Changes for 2015

Home Health Care
Effective for dates of service on or after January 1, 2015, home health care services will no longer require a PCP referral. Instead, home health care services will be subject to notification requirements. It is expected that home health agencies will continue to work with the member’s care manager to coordinate the member’s care.

Palliative Care
Effective for dates of service on or after January 1, 2015, palliative care consultations will no longer require a PCP referral when services are rendered by an in-network provider.
Prior Authorization Requirements for Commercial, Tufts Medicare Preferred HMO and Tufts Health Plan SCO Members

Prior authorization requirements differ for Tufts Health Plan commercial, Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options products.

To determine if a service or an item requires prior authorization or notification, refer to the appropriate listing for the member’s product in the Clinical Resources section at tuftshealthplan.com/providers:

- Medical Necessity Guidelines: Coverage guidelines for services that require prior authorization for Tufts Health Plan commercial plan members
- Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List: Procedures, services and items that require prior authorization for members of Tufts Medicare Preferred HMO
- Tufts Health Plan Senior Care Options: Lists of services and items for which prior authorization or notification is required for Tufts Health Plan SCO members
Update Your Practice Information

All providers are reminded to review their practice and contact information currently on file with Tufts Health Plan and to update that information if needed.

To appropriately refer members to your practice, it is essential that Tufts Health Plan has your correct information. Outdated information prevents members from accessing health care services quickly. Members selecting a primary care provider need to know if their chosen provider is accepting new patients, so be sure to update your panel status if it is not listed correctly.

Providers must notify Tufts Health Plan in writing prior to closing their panels. During the transition period, members are still allowed to select the provider as their PCP. For more information about closing and opening a panel, refer to the Providers chapter in each of the commercial, Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options provider manuals.

Because we use the “best address” currently on file for mailing important communications directly to our providers, you should also ensure that we have your correct mailing address on file.

How to update your information

You can check your current practice information by going to the Provider Search section at tuftshealthplan.com/providers. If that information is not correct, please update it as soon as possible by completing the Standardized Provider Information Change Form, available in the Forms section of our website, and returning it by fax or mail as noted on the form.

Please remember to always notify Tufts Health Plan whenever you need to make changes to your contact or practice information. If you have questions, please call Tufts Health Plan’s Provider Information Department at 617-972-9495.

New Enhancement to the Secure Provider Website

Effective September 20, 2014, a new enhancement was added to Tufts Health Plan’s secure Provider website at tuftshealthplan.com/providers.

This feature will display a list of applicable pend reasons for inpatient notifications. Previously, only one pend reason was displayed. This new feature will assist providers and facilities by displaying multiple pend reasons for reference.

The secure Provider website gives providers and facilities an efficient resource to process inpatient admission notifications online. It is important to note that you can enter text into the ICD-9 diagnosis and ICD-9 procedure fields and derive the ICD-9 code(s) required for submitting inpatient admission notifications to Tufts Health Plan.

Quality and Cost Information Available to Commercial Members

To promote transparency and in compliance with Massachusetts law (Chapter 288, §54 of the Acts of 2010), Tufts Health Plan commercial members in certain products are able to view cost and quality information in the online Provider Search at tuftshealthplan.com as of October 2014.

Members must be logged in to the secure Member website to see this information. Cost information will be displayed at the individual hospital level, and physician-level information will be based on the primary provider system affiliation. Quality information will display a Top Quality Recognition symbol for hospitals whose overall quality is in the top 25 percent of our contracted Massachusetts hospitals, and for physicians whose primary affiliation is with a provider group whose overall quality is in the top 25 percent. Cost and quality designations are based on standard Massachusetts measures using the Standard Quality Measure Set, Total Medical Expense and Relative Price metrics.

Member Selection of PCPs

As noted in the Commercial Provider Manual, there are occasions when a commercial plan member might select a PCP who has an open panel but is only accepting established patients.

As part of the enrollment process, it is requested that the member indicate if he or she is an established patient of the PCP selected. However, this information is not always provided by the member.

Tufts Health Plan previously has not assigned the member to a PCP who is accepting only established patients if the member did not indicate that he or she is an established patient of the PCP selected. However, this information is not always provided by the member.

Tufts Health Plan will assign the member to the requested PCP even if the established patient indicator is not present on the transaction.

As with all provider assignments, if a provider determines that he or she has been inappropriately selected as a member’s PCP, the provider must immediately notify Provider Services at 888-884-2404 and assume the role of PCP for that member on an interim basis until the member selects a new PCP. If notification is not received, the member is deemed part of the provider’s panel.

Update Your Practice Information

All providers are reminded to review their practice and contact information currently on file with Tufts Health Plan and to update that information if needed.

To appropriately refer members to your practice, it is essential that Tufts Health Plan has your correct information. Outdated information prevents members from accessing health care services quickly. Members selecting a primary care provider need to know if their chosen provider is accepting new patients, so be sure to update your panel status if it is not listed correctly.

Providers must notify Tufts Health Plan in writing prior to closing their panels. During the transition period, members are still allowed to select the provider as their PCP. For more information about closing and opening a panel, refer to the Providers chapter in each of the commercial, Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options provider manuals.

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The secure Provider website gives providers and facilities an efficient resource to process inpatient admission notifications online. It is important to note that you can enter text into the ICD-9 diagnosis and ICD-9 procedure fields and derive the ICD-9 code(s) required for submitting inpatient admission notifications to Tufts Health Plan.
Tufts Health Plan Spirit is a limited-network plan offered to Massachusetts Group Insurance Commission (GIC) members only. Tufts Health Plan’s Spirit Network includes only those providers who have been specifically contracted to provide health care services to Tufts Health Plan Spirit members.

Tufts Health Plan Spirit members must receive all nonemergency covered services from providers who participate in the Tufts Health Plan Spirit Network. Please note that nonemergency services received from providers who do not participate in the Spirit Network are not covered, and members are financially responsible for those services.

Please be sure to confirm that you are participating with Tufts Health Plan as a Spirit provider prior to rendering services. Also, please make sure that any provider to whom you are referring a Spirit member is in the Spirit Network.

Providers who have questions regarding the networks in which they participate can check the Provider Search located at tuftshealthplan.com/providers, or contact their provider organization leadership. Members can find Spirit Network providers by using the Find a Doctor provider search at tuftshealthplan.com and choosing “Spirit” in the Select a Plan search option.

Coverage for Methadone Maintenance Treatment
Tufts Health Plan will cover methadone maintenance treatment for new or renewing Rhode Island group plans effective January 1, 2015.