Quick Reference Guide: Out-of-Network Provider Resource Guide

Note: All Tufts Health Plan provider documentation is updated regularly. For the most current information, providers should view all documentation online here and avoid printing.

TUFTS HEALTH PLAN AND ZELIS

Tufts Health Plan works with Zelis, a healthcare and financial technology company, to price all claims from out-of-network providers. Out-of-network providers do not need to submit a claim to Zelis. They should submit the claim directly to Tufts Health Plan, and Tufts Health Plan will send the claim electronically to Zelis for pricing. Out-of-network providers can submit a claim to Tufts Health Plan electronically or by paper on a CMS-1500 and UB-04 claim form.

Note: If you do not agree with how a claim has been priced, you have the option to appeal with Zelis. To initiate an appeal with Zelis or ask a question about Zelis pricing, contact Zelis directly at 866.489.9444.

DENIED CLAIMS

Providers should call Tufts Health Plan regarding denied claims. Provider Services contact information for each product is:

- Commercial Provider Services (Commercial products, including Tufts Health Freedom Plan): 888.884.2404
- Senior Products Provider Services (Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options [SCO]): 800.279.9022
- Massachusetts Tufts Health Public Plans Provider Services (Tufts Health Direct, Tufts Health Unify, and Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans): 888.257.1985
- Rhode Island Tufts Health Public Plans Provider Services (Tufts Health RITogether): 844.301.4093

Note: If the member is on a select/limited network plan, services from an out-of-plan or out-of-network provider require Tufts Health Plan review and approval.
Note: For Tufts Health Public Plans, all out-of-network services require prior authorization.

SUBMIT A PAPER CLAIM

All paper CMS-1500 and UB-04 claims must be submitted on standard red claim forms. Black and white versions of these forms, including photocopied versions, faxed versions and/or resized representations of the form that do not replicate the scale and color of the form required for accurate OCR scanning, will not be accepted and will be returned with a request to submit on the proper claim form.

Submitted forms deemed incomplete will also be rejected and returned to the submitter. The rejected claim and a letter stating the reason for rejection will be returned to the submitter, and a new claim with the required information must be submitted for processing.

For additional information, refer to the Claims Requirements, Coordination of Benefits and Payment Disputes section of the Commercial, Senior Products or Tufts Health Public Plans Provider Manual.

For claims for all products (including Tufts Health Freedom Plan):

- Diagnosis codes must be entered in priority order (primary, secondary condition) for proper adjudication. Up to 12 diagnosis codes will be accepted on the CMS-1500 form, but consistent with our current policy, only the first code will be used for claim processing.
- Providers should submit industry-standard codes on all paper claims.

- Paper claims will be rejected and returned to the submitter if required information is missing or invalid. Common omissions and errors include, but are not limited to, the following:
  - Illegible claim forms
  - Member ID number
  - Date of service or admission date
  - Provider signature (box 31 in CMS-1500 form)
  - Provider Tax ID

If a claim is rejected, the provider must resubmit a corrected claim no later than 90 days from the date of service for all Commercial products. Paper claims should be submitted on industry-standard paper claim forms, with all required fields completed accurately and clearly. All paper claims must be submitted on an original red claim form.

Note: Unreadable claims may be returned to the submitting provider. Paper claims should be submitted to the addresses outlined below:

Plan	Address
HMO, TMC, POS, EPO, MCP, PPO or Navigator™ by Tufts Health Plan	P.O. Box 178 Canton, MA 02021-0178
Cigna PPO or PHCS Healthy Directions (also known as MultiPlan Travel)	
CareLink℠ (primary and shared administration)	
Cigna CareLink℠ **Note:** the appropriate address is located on the back of the member ID card	P.O. Box 5200, Scranton, PA 18505-5200 **OR** P.O. Box 182223, Chattanooga, TN 37422-7223
Group Insurance Commission (GIC)	P.O. Box 178 Canton, MA 02021-0178
US Family Health Plan (USFHP)	P.O. Box 495 Canton, MA 02021-0495
Tufts Health Public Plans (THPP)	P.O. Box 8115 Park Ridge, IL 60068-8115
Tufts Health Medicare Preferred HMO and Tufts Health Plan Senior Care Options (SCO)	P.O. Box 518 Canton, MA 02021-0518

SUBMIT A CLAIM ONLINE

Please refer to the Electronic Claim Submission Frequently Asked Questions here.

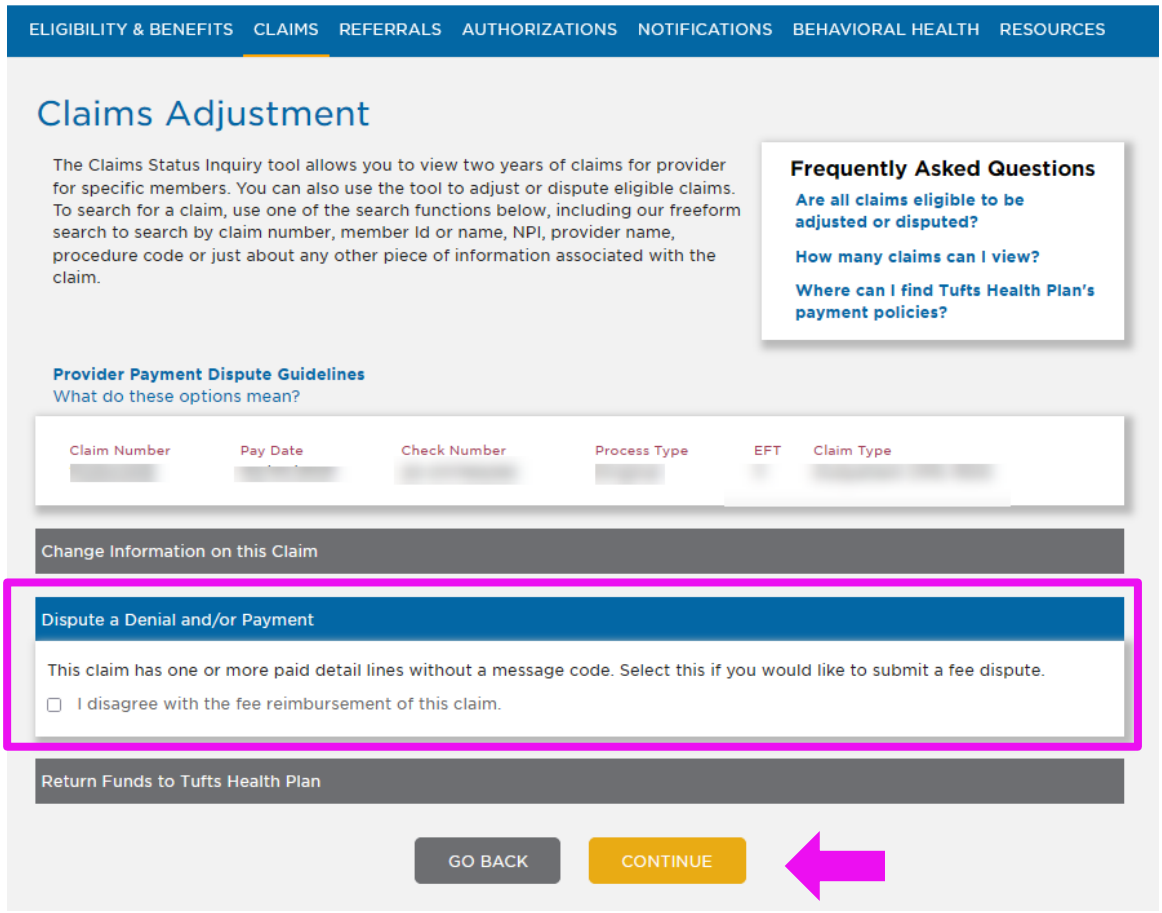
Note: Both paper and electronic Commercial and Tufts Health Public Plans claims should be received by Tufts Health Plan, as evidenced by a Tufts Health Plan claim number, within 90 days from the date of service (for outpatient or professional claims) or the date of discharge (for inpatient or institutional claims). For Tufts Health Plan Senior Care Options (SCO) and Tufts Medicare Preferred HMO claims, within 60 days from the date of service.

SUBMIT DISPUTES AND APPEALS ON THE SECURE PROVIDER PORTAL

The steps to submit any dispute that is not related to the Zelis denials and message codes on pages 1-4 of this guide, providers should follow the following steps:

Step 1: If providers need to dispute a denial and/or payment, select "Dispute a Denial and/or Payment" from the Claims Adjustment menu on the secure Provider portal and click "Continue."

Step 2: The main menu selection expands to display any message codes listed on the claim. If there are claim lines where there is no message code, an option to dispute a reimbursement will display.



Step 3: Select the message code and/or fee reimbursement you are disputing and click "Continue." **Note:** You may select any combination of codes or fee disputes on a particular claim as needed.

Step 4: The Claim Adjustment Dispute Entry screen displays detailed requirements needed for the dispute you have selected. The Adjustment Comments box must be filled out with information indicating the rationale for the dispute. For most disputes, supporting documentation is required. Electronic files may be attached by clicking the "BROWSE" button. If you want to attach a supporting document to your claim adjustment, you can include the following file types, up to 5MB each: .txt, .pdf, .doc, .xls, .tif or .jpg

If you would like to send paper documents, refer to the instructions in Tufts Health Plan's Provider Dispute Policy for Commercial (including Tufts Health Freedom Plan), CareLink℠, Senior Products, Tufts Health Public Plans, which are available in the Resource Center on Tufts Health Plan's public Provider website. Mailed submissions must include a "tracking sheet" (i.e., confirmation page) on top of any documents that are being mailed to support an online claim adjustment request.

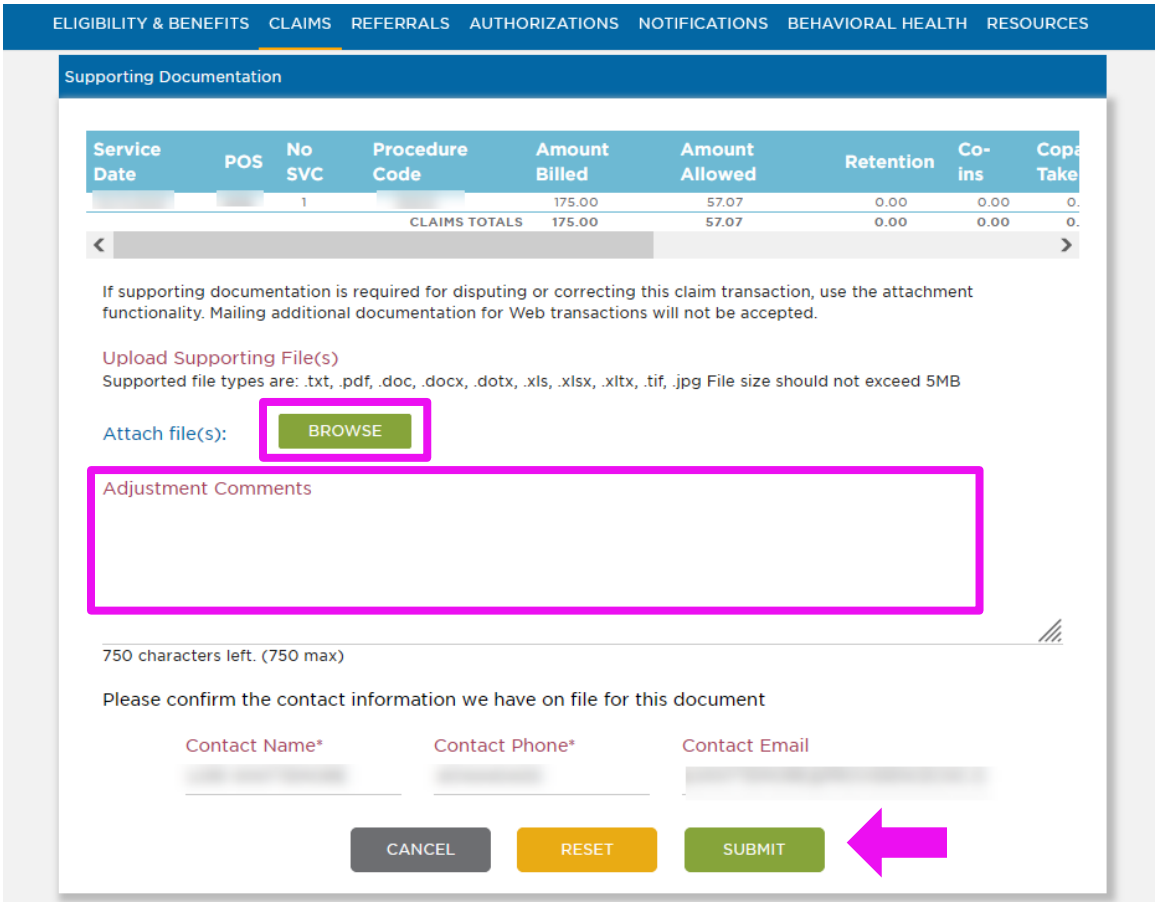
Do **not** attach a Provider Payment Dispute form to documents that support an online claim adjustment. **Note**: You may elect to submit documents both electronically and by mail.

Step 5: Review the information you entered in the Adjustment Comments box and confirm that you have selected a method to submit supporting documents. Once this is complete, click "Submit."

Step 6: Once you have submitted the dispute request, a confirmation page displays your tracking number for the dispute.

Note: If you are mailing supporting documents, print the confirmation page and attach it as a tracking sheet.

To submit a dispute with notes, go to:



ONLINE TOOLS FOR PROVIDERS

The Tufts Health Plan website has two distinct sections for providers: the public Provider website and the secure Provider portal.

Public Provider Website

Tufts Health Plan's public Provider website includes Behavioral Health tools and resources for providers and the Provider Resource Center, which includes:

- Forms*
- Medical necessity guidelines
- Payment policies
- Pharmacy programs
- Provider manuals
- Training and education
- News

Note: To access forms specific to behavioral health, performance specifications, prior authorization guidelines and more filter by the Behavioral Health category in the Provider Resource Center on the public Provider website. Commonly used forms include:

- Applied Behavioral Analysis (ABA) Autism Spectrum Disorder Prior Authorization Form – can be used by both in-network and out-of-network providers
- Outpatient Services Requiring Prior Authorization

Secure Provider Portal

Tufts Health Plan's secure Provider portal is a web-based self-service application, where providers can:

- View eligibility and benefits
- Make a claims status inquiry
- Make a referral submission and inquiry
    - **Note**: If a Tufts Health Plan Senior Care Options (SCO) member sees an out-of-network provider, that member needs to obtain a referral from a PCP. More information is available here.
- Make a prior authorization submission and inquiry
- Make an inpatient notification submission and inquiry
- Adjust a claim online

If you are a provider that has never used the secure Provider portal for other Tufts Health Plan lines of business, you will need to register. If you have not yet registered for the secure Provider portal, refer to Tufts Health Plan's public Provider website for registration instructions. Providers contracting with Commercial products (including Tufts Health Freedom Plan), Tufts Health Public Plans products and/or Senior Products, who have an existing account on the secure Provider portal, do not need to register for access again.