Referral, Authorization and Notification Policy

Applies to the following Tufts Health Plan products:

☒Tufts Health Plan Commercial (including Tufts Health Freedom Plan)[1]

☒Tufts Medicare Preferred HMO (a Medicare Advantage product)

☒Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

The following policy applies to Tufts Health Plan contracting providers rendering outpatient and inpatient services that require referrals, authorizations and/or notifications.

In addition to the specific information contained here, providers must adhere to the policy information outlined in the Professional Services and Facilities Payment Policy.

Note: Audit and disclaimer information is located at the end of this document.

POLICY

Tufts Health Plan covers medically necessary, appropriately authorized services consistent with the member's benefit document. To ensure the quality of member care, Tufts Health Plan monitors authorization, medical necessity, and appropriateness and efficiency of services rendered. Certain services require a referral, prior authorization and/or inpatient notification to confirm that the member's primary care provider (PCP), Tufts Health Plan, or an approved vendor on behalf of Tufts Health Plan has approved the member's specialty care and/or inpatient services.

Providers should submit referrals, prior authorization, and/or inpatient notifications in accordance with the requirements and time frames outlined in the Commercial and Senior Products Provider Manuals. Refer to the payment policies and medical necessity guidelines to determine specific referral, prior authorization and/or inpatient notification requirements for services.

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that the appropriate authorization has been obtained. Claims submitted to Tufts Health Plan that do not have the appropriate authorization(s) on file will deny.

REFERRALS

A referral assures the specialist that the PCP has authorized the member's care and allows the specialist's claims to adjudicate properly. The member's PCP may authorize a referral to a specialist within the member's network for medically necessary services that are consistent with the member's benefit document.

Note: Providers rendering specialty care services are subject to prior authorization requirements for specific items and/or services.

Commercial Products

Referrals are required for the following plan types. Members with these plans must select a PCP within their network to coordinate specialty care services:

- Health Maintenance Organization (HMO)
- Exclusive Provider Option (EPO)
- Point-of-Service (POS) members seeking specialty care at the in-network level of benefits[2]

Referrals are **not** required for the following plan types. These members do not need to select a PCP:

- Preferred Provider Option (PPO)
- Tufts Medicare Complement (TMC)
- Medicare Complement Plan (MCP)

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[1] Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink℠ when Tufts Health Plan is the primary administrator.

[2] POS members may choose to obtain services without a referral in or outside of the Tufts Health Plan network using their unauthorized level of benefits.

Note: Referral requirements vary by plan design. For additional information, refer to Our Plans.

Members with a select network must request prior authorization through the Precertification Operations Department for out-of-network services. In these instances, the authorized reviewer for the member's medical group is required to sign off on requested services.

Tufts Medicare Preferred HMO/Tufts Health Plan SCO
Refer to the Referrals chapters of the Tufts Medicare Preferred HMO and Tufts Health Plan SCO Provider Manuals for more information on referral requirements and processes.

PRIOR AUTHORIZATION

Prior authorization is required for certain procedures, drugs, items, and/or supplies that require medical necessity or utilization review either through Tufts Health Plan or select approved vendors. Services that require prior authorization may also require a referral to the rendering specialist.

Pharmacy Prior Authorization Requests
Certain prescription medications may require prior authorization. Providers must submit the appropriate Pharmacy Prior Authorization Request Form for coverage requests under both the prescription drug benefit and the medical benefit. Refer to the Pharmacy Program chapter of the Commercial Provider Manual for more information on specialty pharmacy programs. Refer to the pharmacy medical necessity guidelines for Commercial and Tufts Medicare Preferred HMO/Tufts Health Plan SCO to determine which prescription drugs have prior authorization requirements.

Commercial Products
Refer to the medical necessity guidelines in the Resource Center to determine which services require prior authorization and which department is responsible for review.

Note: TMC and MCP members require prior authorization for services once all Medicare benefits have been exhausted or if the member requests out-of-network services.

The following require prior authorization through an approved vendor on behalf of Tufts Health Plan:

- Cardiac
- Joint Surgery
- Outpatient High-Tech Imaging
- Sleep Studies and PAP Therapy

Tufts Medicare Preferred HMO/Tufts Health Plan SCO
Refer to the Tufts Medicare Preferred HMO and Tufts Health Plan SCO prior authorization lists for specific procedures, services, and/or items that require prior authorization.

Refer to the Prior Authorizations chapters of the Tufts Medicare Preferred HMO and Tufts Health Plan SCO Provider Manuals for a complete description of authorization requirements.

Sleep Studies
Sleep studies for Tufts Medicare Preferred HMO members require prior authorization through eviCore healthcare, Tufts Health Plan's sleep benefits manager. Refer to the Sleep Studies and PAP Therapy Prior Authorization Program for more information.

Note: For Tufts Health Plan SCO members, prior notification is required to the Tufts Health Plan SCO care manager for sleep studies and sleep equipment (e.g., PAP therapy equipment and related supplies). Refer to the Tufts Health Plan SCO Notification List for to identify specific items and services that require notification. Contact Senior Products Provider Services at 800.279.9022 to identify the appropriate Tufts Health Plan SCO care manager.

NOTIFICATION

As a condition of payment, Tufts Health Plan requires an approved inpatient notification for any member being admitted for inpatient care, regardless of whether Tufts Health Plan is the primary or secondary insurer. Inpatient notification must be on file for all providers to be compensated for services rendered while the member is inpatient. Physician claims will be denied if an inpatient notification is not submitted to Tufts Health Plan.

Note: An inpatient notification does not take the place of prior authorization requirements for a service.

Commercial Products
Refer to the Authorizations chapter of the Commercial Provider Manual for a complete description of inpatient notification requirements and submission channels.

Note: TMC and MCP members require inpatient notification for services once all Medicare benefits have been exhausted.

Tufts Medicare Preferred HMO/Tufts Health Plan SCO
Refer to the Tufts Medicare Preferred HMO and Tufts Health Plan SCO notification lists for specific services/items that require inpatient notification.

Refer to the Notifications chapters of the Tufts Medicare Preferred HMO and Tufts Health Plan SCO Provider Manuals for a complete description of inpatient notification requirements and submission channels.

CARELINK (COMMERCIAL)

Depending on plan design, prior authorizations and/or inpatient notifications may need to be submitted to either Tufts Health Plan or Cigna. Refer to the CareLink chapter of the Commercial Provider Manual and the Working with CareLink grid for more information on how to determine the member's primary administrator. Refer to the CareLink Prior Authorization List to determine which services require prior authorization or contact Cigna directly at 800.88CIGNA (800.882.4462).

Note: Pharmacy prior authorization requests are reviewed by Cigna using Tufts Health Plan's medical necessity criteria.

ADDITIONAL RESOURCES

Obstetrics/Gynecology Professional Payment Policy
Newborn Payment Policy
Inpatient Behavioral Health/Substance Abuse Payment Policy
Inpatient DRG Payment Policy
Inpatient Non-DRG Payment Policy

DOCUMENT HISTORY

- September 2018: Policy reviewed by committee; removed NIA language and linked to appropriate landing pages; clarified existing referral, authorization, and notification processes; added definitions of each type of authorization
- June 2018: Template updates;
- May 2018: Added in-network specialist requirements for Tufts health Freedom Plan members, effective for dates of submission on or after July 1, 2018
- March 2018: Updated USFHP inclusion in NIA's Joint Surgery Program effective April 1, 2018
- March 2017: Updated notification process for outpatient behavioral health services
- January 2017: Template updates
- November 2015: Policy reviewed, no content changes
- September 2015: Template conversion, template updates
- July 2015: Updated name change to eviCore healthcare, template updates
- May 2015: Added information regarding the Spinal Conditions Prior Authorization Program, effective for dates of service on or after August 1, 2015
- April 2015: Template updates
- January 2014: DRG information added, template updates
- October 2013: Notification policy reviewed, minor content changes, template updates
- September 2013: Template conversion
- January 2013: Template updates.
- May 2012: Policy reviewed. Minor content and formatting changes made for clarity, template updates.
- July 2011: Added prior authorization information regarding provider responsibility.
- October 2010: Added the following: **Effective January 1, 2011**, when medically appropriate, a home sleep study or a facility-based test to diagnose obstructive sleep apnea will be authorized. Providers must request prior authorization for sleep studies by contacting CareCore National, our sleep benefits manager. Requests for prior authorizations sent to the Tufts Health Plan Precertification Department will not be processed. DME suppliers and sleep centers dispensing CPAPs, BiPAPS, and related supplies are required to obtain authorization from Care Core National for new and existing PAP users. **Note**: Sleep study providers must be an AASM-

accredited, board-eligible Independent Diagnostic Facility and tests must be read by a board certified sleep specialist.
- December 2009: Changed referral supplier from Moore Wallace Inc. to W.B. Mason.
- March 2009: Clarified preregistration process for Commercial members.
- May 2008: Clarified that PHCS PPO members need to use AHH to preregister inpatient services.
- February 2008: Added Tufts Medicare Preferred information
- July 2005: Policy originated

AUDIT AND DISCLAIMER INFORMATION

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that an office/facility did not comply with this payment policy, Tufts Health Plan will expect the office/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan's audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLink℠ for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna's provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.