Authorization Policy

The following policy applies to Tufts Health Plan contracted providers rendering outpatient and inpatient services. This policy applies to Commercial\(^1\) products (including Tufts Health Freedom Plan). For Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options, click here.

In addition to the specific information contained here, providers must adhere to the policy information outlined in the professional payment policies for Commercial and Tufts Medicare Preferred HMO/Tufts Health Plan SCO products, located in the Provider Resource Center or on the Payment Policies page.

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

**INTRODUCTION**

To ensure the quality of member care, Tufts Health Plan is responsible for monitoring authorization, medical necessity, and appropriateness and efficiency of services rendered. Certain services require a referral or prior authorization to confirm that the member’s primary care provider (PCP) or Tufts Health Plan has approved the member’s specialty care services.

**DEFINITIONS**

**Inpatient Notification**

An inpatient notification is notification to Tufts Health Plan via web or fax that a member is being admitted for inpatient care regardless of whether Tufts Health Plan is the primary or secondary insurer. Inpatient notification is completed by the facility where the member is scheduled to be admitted or may be completed by the specialist provider.

**Prior Authorization**

A prior authorization is a process assisting the health plan to determine medical necessity and appropriateness of health care services under the applicable health benefit plan. Services that may require prior authorization may be surgical services, items of DME, drugs etc.

**Referral**

A referral verifies that the PCP has approved the member’s care to that provider. It is the responsibility of the PCP to indicate the number of visits and type of specialty care service approved.

**GENERAL BENEFIT INFORMATION**

Services and subsequent payment are pursuant to the member’s benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to our secure Provider website or by contacting Provider Services.

**REFERRAL REQUIREMENTS**

**CareLink\(^{SM}\)**

Refer to the Authorization Requirements for CareLink members section of this document.

**HMO and Exclusive Provider Option (EPO)**

Members are required to select a PCP to coordinate specialty care. A referral is required from the member’s PCP for most specialty care services (refer to the exceptions list on the following page).

**Point of Service (POS)**

Members have the option of utilizing authorized or unauthorized levels of benefits. POS members are required to select a PCP to coordinate specialty care at the authorized level of benefits. Members utilizing the authorized level of benefits are required to obtain a referral from their PCP for in-network specialty care services (refer to the exceptions list in this document). Members may choose to obtain services without a referral in or outside of the Tufts Health Plan network using their unauthorized level of benefits.

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\(^1\) Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink\(^{SM}\) when Tufts Health Plan is the primary administrator.
Preferred Provider Option (PPO)
Members are not required to select a PCP to coordinate their care and there are no referral requirements for these products.

Tufts Medicare Complement (TMC)
The TMC plan is a managed care plan (HMO) that complements a member's Medicare coverage. Members are required to select a PCP to coordinate specialty care.

Medicare Complement Plan (MCP)
The MCP plan is a POS or PPO plan that complements a member's Medicare coverage. Members are not required to select a PCP and referrals are not required for specialty care services.

For additional information regarding our plans, refer to Our Plans.

PCP REFERRAL MANAGEMENT
The PCP coordinates the referral management process for all HMO, EPO, and POS members utilizing their authorized level of benefits. It is the responsibility of the PCP to ensure that the member is directed to the appropriate specialty care provider. Referrals should be coordinated prior to services being rendered.

A referral verifies that the PCP has authorized the member's care to that provider. It is the responsibility of the PCP to indicate the number of visits and type of specialty care service authorized. A referral is valid in the Tufts Health Plan system until one or all of the following criteria are met:

- The approved number of visits is used
- A specified time frame up to one year from the date of referral
- The member’s benefit limit has been met
- The member is no longer eligible

Note: In some instances, the PCP may indicate a specific date range for the member to receive specialty care services. In these instances, the referral is only valid for the specified date range indicated on the referral. The date range specified may not exceed one year from the date of issuance.

Exception List for Commercial Members
PCPs are not responsible for writing a referral for the following specialty care services; however other authorization may be required:

- Abortion
- Behavioral health and substance use disorder services
- Annual routine gynecological exam and follow-up services
- Chiropractic services
- Durable medical equipment
- Emergency department services
- Home health care
- Imaging
- Laboratory
- Observation
- Obstetrical care
- Oral surgery
- Routine eye exam

Note: The exceptions listed above apply to PCP referrals only.

Prior authorization by Tufts Health Plan may still apply for these specialty care services. Providers rendering the specialty care services are subject to prior authorization requirements as a condition of payment. Refer to the Clinical Resources section of the Resource Center to determine which services require prior authorization.

Services Provided without a PCP Referral
Tufts Health Plan requires members to obtain referrals in accordance with the member's benefit document. Many offices have patients sign waiver forms to confirm the member understands this policy. An example of a referral waiver form is located in the Forms section of the Resource Center.

Out of Plan Care
Note: This does not apply to out of plan behavioral health services.

In the rare instance that it is necessary for a HMO or EPO member to be treated by a provider who does not participate in the Tufts Health Plan network, except with respect to products or services that do not require referral authorization as noted, the paper referral form must be filled out and signed by a PCP and the Authorized Reviewer associated with the PCP’s Provider Organization. For PCPs who are
not associated with a provider organization, the authorized reviewer is a Tufts Health Plan medical director.

Prior to submitting a referral request to an authorized reviewer, the PCP should confirm that a specialist or facility in the Tufts Health Plan network could not provide a comparable level of care. Referrals that require authorized reviewer approval should be sent directly to the attention of the authorized reviewer before forwarding to Tufts Health Plan.

The authorized reviewer is responsible for reviewing referrals issued to specialty care providers who are not affiliated with Tufts Health Plan or for out of area specialty care services. The authorized reviewer will either approve and sign the referral form or offer an appropriate in-plan provider option.

**Urgent Out of Area Care**
The PCP is not required to issue a referral for treatment of unforeseen illness or injury while a member is temporarily outside of the service area. A member may be seen at a provider’s office, walk-in clinic or emergency department. Members are encouraged to call their PCP to coordinate any follow-up care.

**Emergency Department Services**
Referrals are not required for a member seeking emergency care treatment in the emergency department (ED). If a member is admitted to an inpatient setting from the ED, an inpatient notification is required. Refer to the [Emergency Department Services Payment Policy](#) for more information.

**Behavioral Health and Substance Use Disorder Services**
Behavioral health (BH) providers are responsible for submitting notifications for outpatient BH services from the Behavioral Health Department within 30 days of the first visit of an HMO, EPO or POS member.

Providers can submit initial and continuing notifications for outpatient services by using one of the options below:
- Log in to the secure Provider website
- By calling 800.208.9565 to use the interactive voice response system (IVR) or to speak with a Behavioral Health Coordinator

**Note:** The member, the PCP or the BH provider may call the Behavioral Health Department to submit a notification. Both the member and BH provider will receive confirmation of the initial notification submission in writing.

For more information regarding outpatient behavioral health services, refer to the [Outpatient Behavioral Health/Substance Use Disorder Professional Payment Policy](#) on our website.

Refer to the [Guide for Completing Behavioral Health Service Requests Using IVR](#) for additional information on how to submit authorization requests through the IVR System.

**REFERRAL AND AUTHORIZATION SUBMISSION OPTIONS**
Providers are encouraged to submit referrals and authorizations through Tufts Health Plan’s secure website. Refer to the [Electronic Services](#) section of our website for information regarding additional self-service options.

**Note:** Referrals to providers outside of the Tufts Health Plan network may not be submitted electronically.

**Paper Referral Submission Option**
Providers have the option of submitting referrals using Tufts Health Plan paper referral forms. Referral forms must be ordered through W.B. Mason by completing a [Supply Order Form](#). Instructions for filling out and submitting a paper referral are documented on the back of the referral form.

**REFERRAL INQUIRY OPTIONS**
Providers may check the status of an existing referral by using [Referral Status Inquiry](#) on the Tufts Health Plan secure website.
- The referral status inquiry tool provides the status of any referral submitted to Tufts Health Plan regardless of how the referral was initially submitted.
CORRECTIONS TO REFERRALS
To request an adjustment to a referral that is already in the Tufts Health Plan system, the PCP must contact the Provider Services Department for assistance.

Tufts Health Plan cannot adjust a referral based on the specialist’s request. If the specialist would like to request an adjustment to a referral, the specialist should follow-up directly with the member’s PCP.

PRIOR AUTHORIZATION
Tufts Health Plan requires prior authorization for certain services, drugs, devices and equipment as a condition of payment. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

Refer to the Clinical Resources section of the Resource Center to determine which services require prior authorization and which department that is responsible for review.

Authorization for services, drugs, devices and equipment is based on InterQual® criteria or on medical necessity guidelines.

Medical Necessity Guidelines are established and based on current literature review, including InterQual, consultation with practicing physicians in the Tufts Health Plan service area who are medical experts in the particular field, the policies of government agencies such as the FDA, and standards adopted by national accreditation organizations. The guidelines are revised and updated annually, or more frequently as new evidence becomes available that suggests needed revisions.

Medical Necessity Guidelines and InterQual criteria are used in conjunction with the member’s benefit plan document and in coordination with the provider recommending the service, drug, device or supply.

Prior Authorization through the Precertification Operations Department
To obtain authorization for a service, device or equipment requiring prior authorization through our Precertification Operations Department, the provider must submit the appropriate clinical documentation for review. As a condition of payment, the treating provider is required to submit documentation of medical necessity for services requiring authorization through the Precertification Operations Department. Documentation should detail:

- The member’s diagnosis
- Planned treatment, including medical rationale for the service requested
- All pertinent medical information available for review.

When the use of an InterQual SmartSheet is required, it may be submitted without additional supporting documentation unless specifically indicated.

Note: Fax prior authorization requests to Precertification Operations Department at 617.972.9409.

Providers can log on to the Tufts Health Plan secure website to see these authorizations in real-time 24 hours a day, 7 days a week. Providers not web-enabled or registered on the secure Provider website at the time of submission may request a faxed copy of their authorization.

Private Health Care Systems Members
For authorization information and/or prior authorization requirements for members using the Cigna PPO or PHCS Healthy Directions (also known as Multiplan Travel) networks, contact American Health Holding for the PHCS network or Tufts Health Plan Provider Services for the Cigna PPO network.

Prescription Medications
Certain prescription medications require prior authorization. For requests regarding prescription medications that have coverage limitations, the provider may submit the appropriate clinical documentation supporting why this medication should be prescribed, on the Tufts Health Plan Universal Pharmacy Medical Review Request Form prior to rendering services.

Refer to the Pharmacy section of our website for information about Pharmacy Management Programs.

Care Management Department
Tufts Health Plan requires prior authorization for certain services and items. Services requiring prior authorization through care management are generally categorized as:

- Transplants (except corneal)
- Certain durable medical equipment (DME) and/or supplies
Admissions to acute rehabilitation hospitals, skilled nursing facilities and long term acute care facilities

Prior to initiating or continuing services requiring prior authorization, providers must submit clinical information to support the medical necessity of the service.

Refer to the Commercial Acute Care Hospital Care Management List to identify the care manager responsible for reviewing the request for services.

For a more comprehensive list of services that require prior authorization through the Care Management Department, refer to the Clinical Resources section of the Resource Center.

PRIOR AUTHORIZATION: OUTPATIENT HIGH-TECH IMAGING SERVICES
Tufts Health Plan requires providers to obtain authorization prior to requesting high-tech imaging services in an outpatient setting. Depending on the member’s product, providers must call either NIAMagellanSM or Cigna.

The following services require prior authorization:

- CT/CTA
- MRI/MRA
- PET scan
- Nuclear cardiology

It is the ordering provider’s responsibility to obtain prior authorization before scheduling appointments for Tufts Health Plan members. Rendering providers will need to ensure that all tests for Tufts Health Plan members have the required authorization number before the service is performed. Both professional and technical claims for which there is no authorization number will be denied and the member may not be billed for the service associated with the denied claim.

Note: Diagnostic imaging services performed in the emergency room, observation, and inpatient settings do not require prior authorization. Emergency CT/CTA, MRI/MRA, PET scan or Nuclear Cardiology procedures rendered at a location site other than a hospital emergency department (ED) require notification to NIA within two business days of the service.

At this time, the prior authorization program for high-tech imaging services does not apply to CareLink, Uniformed Services Family Health Plan, Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options and MCP members.

Refer to the Imaging Services Facility Payment Policy, the Imaging Services Professional Payment Policy or the Imaging Program Prior Authorization Management Guide for additional information.

PRIOR AUTHORIZATION: INTERVENTIONAL PAIN MANAGEMENT, SPINAL SURGERY AND JOINT SURGERY
Providers must request prior authorization for interventional pain management, lumbar and cervical spine surgeries, and joint surgery through NIA. Providers may contact NIA for prior authorization through RadMD.

Note: services rendered as part of ED, observation, or services rendered in a hospital inpatient setting are not subject to prior authorization.

Refer to the Spinal Conditions Management Program for more information. For a list of CPT codes subject to prior authorization, refer to the Spinal Conditions Management and Joint Surgery Program Prior Authorization Code Matrix.

Note: The prior authorization program for Spinal Condition Management Program does not apply to CareLink, Uniformed Services Family Health Plan and MCP members.

PRIOR AUTHORIZATION: SLEEP STUDIES
Tufts Health Plan requires providers to obtain prior authorization prior to performing sleep studies. When medically appropriate, a home sleep study or a facility-based test will be authorized. Providers must request prior authorization for sleep studies by contacting eviCore healthcare, our sleep benefits manager. Requests for prior authorizations sent to the Tufts Health Plan Precertification Department will not be processed. If prior authorization is requested but denied by eviCore healthcare, a letter will be sent to the member and provider with appeal information.
DME suppliers and sleep centers dispensing PAP Therapy and related supplies are required to obtain authorization from eviCore healthcare 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.

**INPATIENT NOTIFICATION PROCESS**

Inpatient notification can be performed 24 hours a day, 7 days a week by:

- Logging in to our secure Provider [website](#)
- Submitting an inpatient notification electronically via New England Healthcare EDI Network (NEHEN). Providers must be a NEHEN member.
- Faxing an [Inpatient Notification Form](#) to the Inpatient Admissions Management Team
- Urgent and emergent admissions after business hours or on weekends and holidays are subject to the same inpatient notification criteria.

As a condition of payment, Tufts Health Plan requires an approved inpatient notification for any member who is being admitted for inpatient care regardless of whether Tufts Health Plan is the member’s primary or secondary coverage.

For facilities with a non-DRG arrangement, an authorized start date of initial length of stay and an authorized end date will be assigned for approved admissions.

For facilities with a DRG arrangement, the status of authorized will be assigned for approved admissions.

**REQUIRED INPATIENT NOTIFICATION TIME**

Admitting providers and hospital admitting departments share the responsibility for notifying Tufts Health Plan in accordance with the following timelines:

- Elective admissions **must** be reported no later than five business days prior to admission.
- Urgent or emergent admissions **must** be reported by 5 p.m. the next business day following admission.

If or when the date of an elective admission/procedure changes after the completion of an inpatient notification, contact the Precertification Operations Department to report the new date of admission to ensure accurate claims processing.

When an admission is reported, Tufts Health Plan performs the following steps as part of the inpatient notification process:

- Confirms the presence of a referral to a specialist, if applicable; an inpatient notification number cannot be issued without a PCP's authorization, if required, when the service is elective
- Verifies member eligibility
- Screens for coverage/benefit exclusions and procedures requiring prior authorization
- Requests clinical information from the hospital or admitting provider if, based on the diagnosis or inpatient procedure code submitted, the services do not meet criteria for inpatient level of care
- Identifies the admission so that the appropriate care manager may begin early identification of potential discharge needs for the member
- Assigns an inpatient notification number to the provider.

**Note:** An approved inpatient notification number is a condition of payment.

For a complete description of Tufts Health Plan’s Commercial authorization and notification requirements, refer to the [Authorizations](#) chapter within the Tufts Health Plan Commercial Provider Manual.

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

The following information is required when notifying Tufts Health Plan in reference to a member seeking inpatient care:

- Member's name
- Member’s Tufts Health Plan identification (ID) number
- Hospital name
- Attending provider name
• Date of admission and/or service
• Primary and any additional diagnoses and procedure information.

Note: For BH admissions, Tufts Health Plan contracts with designated facilities (DFs) to provide and coordinate emergency, inpatient and intermediate levels of care for BH/SUD services for certain products. DFs are responsible for notifying Tufts Health Plan of inpatient admissions and/or coordinating alternatives, when appropriate.

Refer to the Behavioral Health section of our website for a complete list of Designated Facilities. Refer to the Inpatient Behavioral Health/Substance Use Disorder Facility Payment Policy for additional information. An inpatient notification submitted via fax is available for viewing on the provider website.

For Facilities with DRG Arrangement:
When the notification process is complete, a coverage decision on the admission will be communicated. The authorization for coverage confirms the request for inpatient admission.

Initial determination for inpatient coverage will be based on data from Truvan Health Analytics and InterQual criteria. Additional clinical information may be requested to support care management and transition of care needs.

For Facilities with non-DRG Arrangement:
When the inpatient notification process is complete, an authorized initial length of stay will be communicated as well as the authorized end date. The authorized end date is the date the authorized length of stay ends for the acute inpatient admission.

The initial length of stay is based on the validity of the following:
• Member benefit and eligibility status
• Procedure
• Diagnosis
• Other medical information pertinent to the admission

The initial length of stay will be based on data from Truvan Health Analytics and InterQual criteria.

Note: The accuracy of the length of stay assignment depends on the completeness and accuracy of the information submitted by the provider at the time of notification.

For continued stay authorization, refer to the inpatient payment policies on our website.

Authorization/Notification Requirements for CareLink Members
Tufts Health Plan and Cigna have formed an alliance to offer CareLink. CareLink is an open access health plan offering with no referral requirements and both in-network and out-of-network benefits. CareLink members have access to the Tufts Health Plan provider network in Massachusetts and Rhode Island (Tufts Health Plan’s service area) and the Cigna provider network in the remaining 48 states (Cigna’s service area).

The administrative services for CareLink accounts are shared between Tufts Health Plan and Cigna; however, one is selected to serve as the primary administrator for each particular CareLink account. The administrative lead performs most plan administrative functions including claim adjudication. The member’s ID card is uniquely branded to indicate each primary administrator.

Precertification/authorization of inpatient admissions is similar to inpatient notification in that it is a notification process. However, precertification also includes a coverage process and applies to some outpatient services, e.g., observation.

Elective Admissions
The following outlines the elective precertification process for CareLink members:
• Elective admissions must be reported no later than five business days prior to admission. To initiate the precertification process, providers should contact Cigna by calling the number on the back of the member’s identification card.
• Coverage determinations are based upon eligibility, specific benefit language, and relevant clinical information, which establish the medical necessity of the service or procedure.
Facilities with DRG Arrangement
When the notification process is complete, the provider will receive a coverage letter indicating the coverage decision on the admission. The authorization for coverage confirms inpatient level of care.

Facilities with non-DRG Arrangement
If the coverage request is approved, the provider will receive a coverage letter indicating the dates of service and the length of stay authorized for coverage with respect to the requested procedure. If the inpatient stay exceeds the number of days authorized for coverage, the CareLink care manager will review the inpatient stay concurrently to determine whether coverage for additional days should be approved.

Emergent Admissions
The following outlines the emergent precertification process for CareLink members:

- Urgent or emergent admissions must be reported by 5 p.m. on the next business day following admission. To initiate the precertification process, the facility should contact Cigna by calling the number on the back of the member's identification card.
- Coverage determinations are based upon eligibility, specific benefit language, and relevant clinical information, which establish the medical necessity of the service or procedure.

Emergent Admissions for Facilities with DRG Arrangement
When the notification process is complete and the request is approved, the requesting facility will be notified of the admission coverage decision by phone. The authorization for coverage confirms inpatient level of care.

Emergent Admissions for Facilities with non-DRG Arrangement
The number of days approved for coverage is based on factors including the clinical guidelines and the individual circumstances surrounding each request. If the precertification of coverage request is approved, the requesting facility will be notified of the coverage decision by phone. If the inpatient stay exceeds the number of days authorized for coverage, the CareLink care manager will review the inpatient stay concurrently to determine whether coverage for additional days should be approved.

The following are required when requesting a precertification for a CareLink member:
- Member name and ID number
- Member date of birth
- Diagnosis description and ICD-CM code
- Description and code for procedure, service or item to be precertified (CPT-4 or HCPCS)
- Place of service and level of care (inpatient or outpatient)
- Name of requesting provider
- Name of servicing provider, vendor or facility
- Additional insurance coverage information (if applicable)
- Date of injury (if applicable)
- Anticipated length of stay if an inpatient place of service is requested.

Prior Authorization for CareLink Members
Prior authorization, also referred to as precertification for CareLink members, is required for certain services, drugs, devices and equipment in order to be covered for CareLink members. Refer to the CareLink Prior Authorization List in the Clinical Resources section of the Tufts Health Plan website to determine which services require prior authorization or contact Cigna at directly at 800.882.CIGNA or 800.882.4462.

Behavioral Health Services
Cigna Behavioral Health (CBH), Tufts Health Plan or another entity may administer BH services based on employer plan design. The member's identification card will indicate where the member should be directed for these services. Refer to the Inpatient Behavioral Health/Substance Use Disorder Facility Payment Policy or the Outpatient Behavioral Health/Substance Use Disorder Payment Policy for additional information.

High-Tech Imaging Services
Prior authorization is required for CareLink members in need of high-tech imaging services. Cigna will perform utilization management for MA and RI contracting providers as part of this high-tech imaging program.
To identify if prior authorization is required for outpatient services, refer to the back of the member’s identification card. If outpatient prior authorization is required, high-tech imaging prior authorization requirements apply. If the identification card is not available, contact Cigna directly at 800.88.CIGNA (800.882.4462).

Refer to the Imaging Services Facility Payment Policy or the Imaging Services Professional Payment Policy for additional information.

**Note:** Providers can contact Cigna by calling their national customer service number at 800.88.CIGNA (800.882.4462) or refer to Cigna’s website for questions about medical management policies.

**ADDITIONAL RESOURCES**
- Obstetrics/Gynecology Professional Payment Policy
- Newborn Payment Policy
- Inpatient Behavioral Health/Substance Abuse Payment Policy
- Inpatient DRG Payment Policy
- Inpatient Payment Policy

**DOCUMENT HISTORY**
- 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 billing guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, Tufts Health Plan will expect your office/facility to refund all payments related to non-compliance. For more information about Tufts Health Plan’s audit policies, refer to our website.

This policy provides information on Tufts Health Plan claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction 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 guidelines when applicable, adherence to plan policies and procedures and claims editing logic.

This policy does not apply to Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options, Tufts Health Public Plans or the Private HealthCare Systems (PHCS) network (also known as MultiPlan). Providers in the New Hampshire service area are subject to Cigna’s provider agreements with respect to CareLink members.