Claims Submission 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 payment policy applies to Tufts Health Plan contracting providers.

This policy also contains claims submission addresses for CareLink℠ Shared Administration and CareLink when Cigna is the primary administrator.

Refer to the Provider Payment Dispute Policy for information on how to dispute claims.

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

UNLISTED PROCEDURE CODES CLAIMS SUBMISSION

- Submit the most appropriate unlisted procedure code(s) available on an official, paper claim form.
- Submit supporting clinical documentation to accurately describe the unlisted procedure code(s). Unlisted procedure codes submitted without documentation will be denied.
- Submission of proper medical documentation describing the procedure is required for payment.
- Electronic claims for unlisted procedure codes will be denied, as attachments are not accepted electronically at this time.

ELECTRONIC CLAIMS SUBMISSION

Requirements

Tufts Health Plan encourages direct electronic submission to the Plan, though also accepts claims submitted through clearinghouses. Claims submitted directly to Tufts Health Plan must be in HIPAA-compliant standard 837 format and include all required information in order to be accepted. Tufts Health Plan recommends providers include the appropriate taxonomy code for the services rendered. Refer to our 837 companion guide for additional information.

When required information is missing, Tufts Health Plan or the clearinghouse will reject the claim as incomplete and the time for claims submission will NOT be extended. If an electronic claim is rejected, providers must resubmit a completed electronic claim no later than **90 days** from the date of service/date of discharge for all Commercial products and no later than **60 days** from the date of service/date of discharge for Tufts Medicare Preferred HMO and Tufts Health Plan SCO products.

Note: Claims that require supporting documentation cannot be submitted electronically.

Required Fields

- Policy number (member ID number including suffix)
- Member last name, first name, address, date of birth and gender
  - **Note**: Each Tufts Health Plan member is uniquely identified; therefore Tufts Health Plan strongly recommends treating all members as subscribers and submitting member ID in Element NM109 of Loop 2010 BA.
- Insured/subscriber last name, first name and street address
- Each claim must include: diagnosis code, date of service, rendering provider, place of service, procedure code, days/units, type of service and line item charges

Data Verification

If any of the following data is invalid, the claim will reject and be reflected on reports that are sent back to the submitter.

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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.

- Member ID number and date of birth on the claim must match the member ID and date of birth in the Tufts Health Plan system
- Admit/refer/rendering ID must be an NPI number on file with Tufts Health Plan
- Billing/pay to provider (payee) ID must be an NPI number on file with Tufts Health Plan
- Primary diagnosis must be a valid ICD-CM diagnosis code

Electronic Claims Reports

- Providers who submit directly to Tufts Health Plan will receive detail and summary reports within 24–48 hours
- Providers who submit via a clearinghouse to Tufts Health Plan will receive specific summary reports within 48–72 hours
- Providers are set up to receive the reports by way of the submitter that the provider is using to submit claims, according to the most current information on file with Tufts Health Plan. It is the provider's responsibility to obtain these reports and review the acceptances and rejections. Failure to correct information for a rejected claim may result in denials and/or rejections from Tufts Health Plan's claims system.

Tufts Health Plan offers online claim submission to its providers through MD On-Line, now part of ABILITY® Network. This option is available for professional claims only for all Tufts Health Plan products. For more information, refer to the Electronic Services section of our website.

Additional Electronic Submission Information

For specific inquiries on submitting electronic claims, either directly to Tufts Health Plan or through a clearinghouse, contact the EDI Operations Department by telephone at 888.880.8699, ext. 54042, or by email at EDI_operations@tufts-health.com. Refer to the Electronic Services page to download:

- EDI Submission set-up form
- Companion documents for submitting HIPAA standard electronic claims directly to Tufts Health Plan

PAPER CLAIMS SUBMISSION

Tufts Health Plan encourages direct electronic claim submission, but also accepts paper claim submissions.

Paper claims must be submitted on official, standard red claim forms. Black-and-white versions of claim forms (including photocopied versions, faxed versions, and resized representations that do not replicate the scale and color of the form required for accurate OCR scanning) are not accepted and will be returned to the address listed in Box 33 (on CMS-1500 forms) or Box 1 (on UB-04 forms) with a request to resubmit on the proper claim form.

To avoid a filing deadline denial:

- **Commercial:** Rejected paper claims must be resubmitted within 90 days from the date of service for professional or outpatient services, or within 90 days from the date of discharge from an inpatient facility.
- **Tufts Medicare Preferred HMO and Tufts Health Plan SCO:** Rejected paper claims must be resubmitted within 60 days from the date of service for professional or outpatient services or within 60 days from the date of discharge from an inpatient facility.

Paper claims should be submitted to the appropriate addresses below:

<table>
<tr>
<td>HMO, TMC, POS, EPO, MCP, PPO or Navigator by Tufts Health Plan
P.O. Box 9163
Watertown, MA 02471-9163</td>
<td>Tufts Medicare Preferred HMO and Tufts Health Plan SCO
P.O. Box 9183
Watertown, MA 02471-9183</td>
</tr>
<tr>
<td>MultiPlan
P.O. Box 9163
Watertown, MA 02471-9163</td>
<td>Uniformed Services Family Health Plan
P.O. Box 9195
Watertown, MA 02471-9195</td>
</tr>
<tr>
<td rowspan="2">Cigna CareLink
*The appropriate address is located on back of ID card
P.O. Box 5200
Scranton, PA 18505-5200
or
P.O. Box 182223
Chattanooga, TN 37422-7223</td>
<td>Tufts Health Plan CareLink
Primary and Shared Administration
P.O. Box 9163
Watertown, MA 02471-9163</td>
</tr>
<tr>
<td>Group Insurance Commission (GIC)
P.O. Box 9185</td>
</tr>
</table>

	Watertown, MA 02471-9185

Paper Claim Submission Requirements

Tufts Health Plan does not waive requirements for completing mandatory fields on paper claim forms. Those fields are noted in the detailed specifications for submitting UB-04 and CMS-1500 (2/12) claims in the Tufts Health Plan Provider Manuals, available in the Resource Center.

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

Tufts Health Plan will process up to four diagnosis pointers per claim line.

- Diagnosis pointers must be entered in priority order (primary, secondary condition) for proper adjudication. Up to 12 diagnosis codes will be accepted on the CMS-1500 (2/12) form.
- 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's signature (CMS-1500 (2/12) Box 31)

FILING DEADLINE POLICY

Tufts Health Plan must receive claims according to the following timelines:

Commercial (HMO, EPO, POS, PPO, Tufts Health Freedom Plan and CareLink[2])

- For professional/outpatient services, within 90 days from the date of service
- For inpatient/institutional services, within 90 days from the date of hospital discharge

Tufts Medicare Preferred HMO and Tufts Health Plan SCO

- For professional or outpatient services, within 60 days from the date of service
- For inpatient/institutional services, within 60 days from the date of hospital discharge

Note: Tufts Medicare Complement (TMC), Medicare Complement Plan (MCP), and Tufts Medicare Preferred Supplement plans do **not** have a filing deadline.

TMC and MCP: Claims must first be submitted to Medicare as the primary insurer and then submitted to Tufts Health Plan as the secondary insurer, along with the Medicare explanation of benefits (EOB).

Tufts Medicare Preferred Supplement: Claims must be submitted to Medicare as the primary insurer and then are automatically submitted to Tufts Health Plan by Medicare as crossover claims.

Coordination of Benefits

Commercial Products

When a member has multiple insurance plans, the filing deadline for claims submission is 90 days from the date of the primary insurer's explanation of benefits (EOB). The EOB from the primary insurer must be submitted with the claim when Tufts Health Plan is the secondary payer.

Members may not be billed for services that have denied for exceeding the filing deadline. Requests for review and adjustment of a claim denied for receipt over the contracted filing deadline will be accepted for up to 90 days from the EOB date on which the claim was denied. Provider payment disputes for reconsideration of filing deadline beyond 90 days from the denial date of the claim will not be considered.

Tufts Medicare Preferred HMO and Tufts Health Plan SCO

When a member has multiple insurance plans, the filing deadline for claims submission is 60 days from the date of the primary insurer's EOB. The EOB from the primary insurer must be submitted with the claim when Tufts Health Plan is the secondary payer.

Members may not be billed for services that have denied for exceeding the filing deadline. Requests for review and adjustment of a claim denied for receipt over the contracted filing deadline will be

[2] CareLink claims submitted by Cigna providers outside of Massachusetts and Rhode Island are subject to the filing deadlines as outlined in the provider's contract with Cigna.

accepted for up to 120 days from the date of denial. Provider payment disputes for reconsideration of filing deadline beyond 120 days from the denial date of the claim will not be considered.

ADDITIONAL INFORMATION

Services and subsequent payment are based on the member's benefit plan document. Benefit specifics should be verified prior to initiating services by logging on to the secure Provider website or contacting Commercial Provider Services or Senior Products Provider Relations.

Effective for dates of submission on or after August 1, 2018, Tufts Health Plan will reject claims for Tufts Medicare Preferred HMO and Tufts Health Plan SCO members that are submitted with a duplicate diagnosis code. If rejected, providers must resubmit the claim within the applicable filing deadlines as outlined above.

DOCUMENT HISTORY

- June 2018: Template updates
- May 2018: Added claim rejection language effective for dates of submission in August 2018
- June 2017: Clarified existing filing deadline for Cigna providers
- January 2017: Template updates
- October 2016: Added taxonomy code information
- September 2015: Template conversion
- June 2015: Template updates
- February 2015: Added information regarding online claim submission through MD On-Line
- January 2015: Updated mailing information effective November 2014
- October 2014: Added information on process for submission of unlisted procedure codes
- May 2014: Updated policy about paper claims submissions; template updates.
- January 2014: Updated claims addresses for Commercial products; template updates.
- September 2013: Template conversion
- January 2013: Added information regarding Tufts Health Plan SCO.
- May 2012: Added information for diagnosis pointers effective for Commercial claims adjudicated on or after July 1, 2012.
- November 2011: Reviewed policy; added information on additional senior products; added coordination of benefits information, reformatted for clarity, template updates.
- November 2010: Added the following information: Tufts Medicare Supplement claims are automatically submitted to Tufts Health Plan by Medicare as crossover claims.
- September 2010: Updated policy to reflect 90 day time-deadline for the appeal of filing deadline denials.
- July 2010: Added effective October 1, 2010, all paper CMS-1500 and UB-04 claims must be submitted on standard red claim forms
- January 2010: Removed references to the Tufts Medicare Preferred PPO product. Added effective for claims adjudicated on or after April 1, 2010, payment disputes for Commercial claims received after the filing deadline must be submitted within 90 days of the SOA on which the claim originally denied. A request for reconsideration of a filing deadline denial date will not be considered
- November 2009: Added revised and restated paper claim submission requirements effective November 16, 2009
- August 2009: Changed PHCS claims submission address to MultiPlan
- October 2007: Added CareLink Primary Administration claims submission address, removed Liberty by Tufts Health Plan
- July 2007: Added PHCS claims submission address, electronic claims submission and coordination of benefits filing deadline information

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.