



## Provider Payment Dispute Policy

Applies to the following Tufts Health Plan products:

- Tufts Health Plan Commercial (including Tufts Health Freedom Plan)<sup>1</sup>
- Tufts Medicare Preferred HMO (a Medicare Advantage product)
- Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

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The following payment policy applies to Tufts Health Plan contracting providers. For information on Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options, click [here](#).

Refer to the [CareLink<sup>SM</sup> Provider Payment Dispute Policy](#) for information on how to dispute CareLink claims.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the [Professional Services and Facilities Payment Policy](#).

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

### OVERVIEW

A provider has the right to file a payment dispute if he or she disagrees with a claim decision regarding the denial or compensation of a claim. Providers may submit disputes and corrected claims online using the secure Provider [website](#) or via mail using the [Request for Claim Review Form \(v1.1\)](#).

Forms must be submitted with all required information, as denoted by asterisks (\*). Incomplete forms will be returned to the submitting provider for completion and resubmission. Processing the request will be delayed until all the information is returned to Tufts Health Plan.

Do not highlight, as it may appear blacked out when scanned and may delay the processing of the dispute(s). A separate dispute form must be submitted for each adjustment along with any supporting documentation.

**Note:** Cloned documentation (i.e., information that is duplicated across patient documentation that is not specific to the encounter and/or member) does not meet medical necessity requirements and will not be accepted as evidence of the service billed.

### PROVIDER PAYMENT DISPUTES

#### **Limitation of Dispute Process**

Tufts Health Plan will consider payment disputes and adjustment requests for Commercial claims with dates of service within the current year, and the two previous calendar years, for the following disputes:

- The level of compensation
- Claims denied for no referral when a referral was obtained
- Claims denied for lack of prior authorization or inpatient notification

**Note:** This deadline does not apply to Uniformed Service Family Health Plan (USFHP) or to CareLink when Cigna is the primary administrator.

#### **Corrected Claims and Disputes of Duplicate Claim Denials**

Corrected claims and provider payment disputes of duplicate claim denials must be received no later than 180 days from the date of the original adjudication. Corrected claims and duplicate claim denial disputes received after that time will not be considered.

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<sup>1</sup> Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink<sup>SM</sup> when Tufts Health Plan is the primary administrator.

### **Late Charges**

Services submitted after initial submission of the claim are considered late charges. Late charges applied to Tufts Health Plan Commercial claims must be submitted within 90 days of the date of service (for outpatient claims) or date of discharge (for inpatient or institutional claims.)

## **SUBMITTING A PAYMENT DISPUTE**

### **Online Claim Adjustments**

Registered providers may submit claim adjustments using the secure Provider website. Providers who are not registered users of the website may register via the Provider [login](#) page.

Follow the instructions when submitting online claim adjustments. After the transaction has been completed, providers will receive a tracking number as confirmation. Providers submitting paper documentation that corresponds to an online claim adjustment must submit the online tracking sheet so that the claim is processed accurately.

**Note:** Some claims may not be adjustable online. If a claim cannot be adjusted online, a message will appear indicating the claim is not adjustable. Refer to the section below regarding submitting claim adjustments via mail.

### **Claim Adjustments Submitted via Mail**

Refer to the [Request for Claim Review Mailing Information](#) document for the correct mailing address to submit disputes to Tufts Health Plan.

Tufts Health Plan requires the [Request for Claim Review Form \(v1.1\)](#) for Commercial provider payment disputes submitted by mail. This form can be found in the [Forms](#) section of the Provider Resource Center and on the HCAS [website](#).

- Forms must be submitted with all required information, as denoted by asterisks (\*). Incomplete forms will be returned to the submitting provider for completion and resubmission.
- If the original claim was denied, enter the Tufts Health Plan denial code in the 'Denial Code' field (do not use HIPPA message codes)
- Supporting documentation must be single-sided
- Disputes submitted without the [Request for Claim Review Form \(v1.1\)](#) will be rejected and returned to the submitter.

Adjustments can be requested when submitting a dispute by mail for the following reasons:

### **Corrected Claim Adjustments**

- When submitting a corrected claim adjustment via mail, attach a written explanation (single sided only) of the requested changes or a corrected claim to the Explanation of Payment (EOP) and the [Request for Claim Review Form \(v1.1\)](#). The claim number to be adjusted should be circled and sent to the correct address.

### **Claims Denied for No Referral**

- For all HMO and POS claims paid at the unauthorized benefit level or denied for no referral, attach a copy of the referral or the referral number to the EOP and circle the claim number to be adjusted.

### **Process for Submitting Corrected Claims via EDI**

Claim corrections submitted by electronic data interchange (EDI) for late charges (Frequency Code 5), replacement claims (Frequency Code 7) and voided claims (Frequency Code 8) must include the original Tufts Health Plan claim number submitted in the 837 in the following format: **Loop 2300 Claim Information/REF – Payer Claim Control Number/REF01=F8 and REF02**. Corrections submitted by EDI that do not include the original claim number will be rejected.

Providers should follow existing submission guidelines when submitting corrected claims. Corrected claims submitted by EDI will also be rejected in the following circumstances:

- If the original claim is in process and has not been adjudicated
- If an adjustment to the original claim is currently in process
- If the correction request is received after the submission deadline.

### **Claims Denied for Lack of Prior Authorization or Inpatient Notification**

- Submit a typed, case-specific letter of appeal with the necessary supporting clinical documentation.

- Attach a copy of the claim and the EOP.
- Include pertinent information in your appeal: an explanation as to why the proper procedure to obtain inpatient notification or prior authorization was not followed or an explanation and evidence of how the proper procedure was followed. Tufts Health Plan considers relevant supporting documentation to be a copy of the provider's original information faxed/submitted to Tufts Health Plan and relevant medical records. If authorization is applicable, please include the authorization number received verbally or in writing from Tufts Health Plan.

### **Compensation/Reimbursement Appeals**

- Submit a typed letter of medical necessity (LOMN) explaining why the service was necessary.
- Attach the EOP and circle the claim to be reviewed.
- Submit all supporting documentation in the form of invoices, operative notes, office notes, radiology/pathology report(s) or any necessary medical record information for a fee adjustment request.

### **Appeals for Unlisted Procedure Code Denials**

- Appeals for denials resulting from the billing of an unlisted procedure code must include operative notes that identify the service(s) performed associated with the unlisted code.
- The portion of the operative notes that identifies the unlisted service must be underlined (do not highlight). If operative notes are not underlined to indicate the services performed, the submitter will be notified by letter that the appeal will not be reviewed.
- Providers submitting unlisted or miscellaneous drug codes not currently covered by a HCPCS code must include an invoice with the claim that includes the drug name, appropriate National Drug Code (NDC) number and dosage. For more information, refer to the FDA [National Drug Code Directory](#)

Refer to the [Unlisted and Not Otherwise Classified Codes Payment Policy](#) for more information on unlisted procedure codes.

### **PROOF OF TIMELY FILING**

The filing deadline is 90 days from the date of service (for professional or outpatient claims) and 90 days from the date of hospital discharge (for inpatient or institutional claims). To be considered for review, payment disputes received after the filing deadline must be submitted within 90 days of the EOP on which the claim originally denied. A request for reconsideration received more than 90 days past the deadline will not be considered.

### **Coordination of Benefits**

When a member has multiple insurance plans, the filing deadline for claims submission is 90 days from the date of the primary insurer's EOP.

If submitting electronically when Tufts Health Plan is the secondary payer, primary insurer payment information must be submitted in Loops 2320, 2330 and 2430.

If submitting on paper, the EOP from the primary insurer must be submitted with the claim when Tufts Health Plan is the secondary payer.

- For paper claim submissions, carefully circle or asterisk the member's name on the EOP.
- Do not highlight the information. Highlighting causes the data to be blacked out in the scanning process.
- Submit the claim with the EOP from the primary insurer to the correct initial claim submission address.

### **Funds Retracted by another Carrier**

To ensure timely payment, submit the claim with the other carrier's retraction statement within 90 days of date on retraction statement.

### **Submitting Proof of Timely Filing for a Paper Submission**

Attach documented proof of timely submission to the EOP and circle the claim to be adjusted.

The following are considered acceptable proof of timely submission:

- Copy of EOP from the primary insurer that shows timely submission from the date that carrier processed the claim

- Computer printout of patient account ledger that shows the date that the member was billed, when insurance information is not made available by the member
- Copy of EOP from another carrier— if the member did not identify him/herself as a Tufts Health Plan member at the time of service
- Copy of a personal injury protection (PIP) letter received by Tufts Health Plan within 90 days of the date on the letter
- Copy of a Workers' Compensation denial received by Tufts Health Plan within 90 days of the date of the denial
- Copy of claim form returned by Tufts Health Plan with imprinted 12-digit number at the bottom of the claim form. The first five digits indicate the date (Y/MM/DD)<sup>2</sup>. Refer to the [Commercial Provider Manual](#) for information on the paper claim submission requirements.

**Note:** If acceptable proof of timely submission is received, the claim will be reprocessed. When the disputed claim is reprocessed, a subsequent denial may be generated. In this instance, a new dispute must be submitted with the appropriate documentation since each denial is based on the current message code on the claim.

#### Submitting Proof of Timely Filing for an EDI Submission

Providers who submit their claims electronically through a clearinghouse, MD On-Line or directly to Tufts Health Plan must send their EDI acceptance report, which indicates proof of timely submission.

Acceptance of an EDI claim as evidenced by a Tufts Health Plan claim number will be required as proof of timely submission.

Circle the claim that is disputed on both the report(s) and the EOP. Details on the report requirements are listed below:

EDI Through	Reports Required for Proof of Timely Submission	Report Detail
<b>Direct to Tufts Health Plan</b> One or the other required	Claims acceptance summary report <b>or</b> Claims acceptance detail report	Claims accepted at Tufts Health Plan by claim number
<b>Change Healthcare™/ WebMD/Envoy</b> One or the other required	Provider claim status report (RPT-10) <b>or</b> Special handling/unprocessed claims report (RPT-11)	Claims accepted at Tufts Health Plan by claim number
<b>Change Healthcare™/ WebMD/Healthwire</b> One or the other required	Provider claim status report (RPT-10) <b>or</b> Special handling/unprocessed claims report (RPT-11)	Claims accepted at Tufts Health Plan by claim number
<b>Capario</b>	INS (insurance) response report	Claims accepted at Tufts Health Plan by claim number
<b>MD On-line</b>	Acceptance report in your <b>LinkMail Box</b>	Claims accepted at Tufts Health Plan by claim number

Reports must show receipt at Tufts Health Plan, either through direct submission, MD On-Line or a clearinghouse. If a report indicates a rejection at the clearinghouse, the claim will not be considered for reprocessing. It is the provider's responsibility to review all reports from the clearinghouse and/or Tufts Health Plan and review any rejected claims at that time. Rejections must be corrected and received by Tufts Health Plan within 90 days of the date of service (for outpatient claims) or date of discharge (for inpatient or institutional claims) in order to be considered for payment.

#### DOCUMENT HISTORY

- May 2019: Clarified 'Denial Code' field on Request for Claim Review Form must contain Tufts Health Plan denial codes; removed reference to Claims Submission Policy (retired)
- December 2018: Clarified paper submission instructions
- June 2018: Template updates
- March 2018: Added cloning language

<sup>2</sup> Applies to Commercial members only

- May 2017: Updated Request for Claim Review Form link
- February 2017: Added existing billing requirements for unlisted drug code denials
- November 2016: Emdeon name updated to Change Healthcare™
- July 2016: Separated Commercial policy content, clarified billing guidelines and dispute process, template updates
- September 2015: Template conversion, template updates
- February 2015: Added information regarding online claim submission through MD On-Line
- January 2015: Updated proof of filing and COB language, added information regarding disputing claims when funds are retracted by another carrier, added link to the Request for Claim Review Mailing Information document, template updates
- November 2014: Added requirements for submitting commercial payment disputes, effective for January 1, 2015, template updates
- July 2014: Updated EDI language, template updates.
- May 2014: Added information regarding proof of timely submissions effective July 1, 2014.
- February 2014: Updated referral and claims information for SCO members, template updates.
- September 2013: Template conversion
- May 2013: Added information regarding the submission of corrected claims, provider payment disputes of duplicate claim denials and late charges effective for claims adjudicated on or after July 1, 2013. Template conversion.
- January 2013: Added information regarding Tufts Health Plan Senior Care Options.
- September 2012: Added information regarding the submission of late charges and voiding or cancelling a claim.
- April 2012: Updated CareLink disclaimer language.
- November 2011: Policy reviewed. Reformatted for clarity, added information about online claim adjustments, template updates made.
- January 2011: Added effective for appeals received on or after January 1, 2011, appeals for denials resulting from the billing of an unlisted procedure code must include operative notes that identify the service(s) performed associated with the unlisted code.
- November 2010: Added information regarding appeals for unlisted claim denials.
- July 2010: Added effective for claims adjudicated on or after October 1, 2010, corrected claims and provider payment disputes of duplicate claim denials must be received no later than one year from the date of the original adjudication. Corrected claims and duplicate claim denial disputes received after that time will not be considered.
- February 2010: Added effective for claims adjudicated on or after April 1, 2010, payment disputes for claims received after the filing deadline must be submitted within 90 days if 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 the following under Provider who submit paper claims: Copy of claim form returned by Tufts Health Plan with imprinted 12-digit number at the bottom of the claim form. The first 5-digits indicate the date (Y/MM/DD). **Note:** Providers must send only a copy of the returned claim image to Tufts Health Plan as proof of timely filing. Refer to the Claims Submission Policy for information on the paper claim submission requirements.
- March 2008: Added Online Claim Adjustment information.
- August 2007: Added Reimbursement Rate Request information.
- July 2007: Clarified that the deadline of dispute process does not apply to Uniformed Service Family Health Plan (USFHP) and added electronic submission information within the COB section.

#### **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 a provider/facility did not comply with this payment policy, Tufts Health Plan will expect the provider/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<sup>SM</sup> 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.