Referral, Prior 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)[2]
- ☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)[2]

Applies to the following Tufts Health Public Plans products:

- ☒ Tufts Health Direct (a Massachusetts Qualified Health Plan [QHP]; a commercial product)
- ☒ Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plans)
- ☒ Tufts Health RITogether (a Rhode Island Medicaid Plan)
- ☒ Tufts Health Unify (OneCare Plan; a dual-eligible product)

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

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.

POLICY

Tufts Health Plan covers medically necessary, appropriately authorized services in accordance with the member's benefits. 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, Senior Products and Tufts Health Public Plans Provider Manuals. Refer to the payment policies and medical necessity guidelines in the Resource Center to determine specific referral, prior authorization and/or inpatient notification requirements for services.

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 the secure Provider portal or by contacting Provider Services.

Note: There is no member responsibility for covered services for Tufts Health Plan SCO, Tufts Health Unify, Tufts Health Together or Tufts Health RITogether members.

REFERRALS

Certain plans may require referrals to access coverage for specialist services. The member's PCP may authorize a referral to an in-network specialist for medically necessary services that are consistent with the member's benefit document. When required, a referral assures the specialist that the PCP has authorized the member's care and allows the specialist's claims to adjudicate properly. It is the responsibility of the PCP to indicate the number of visits and type of specialty care services approved.

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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] Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

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

Note: A referral does not take the place of prior authorization.

Commercial Products

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

- Health Maintenance Organization (HMO)
- Exclusive Provider Option (EPO)
- Point-of-Service (POS) for specialty care coverage at the in-network level of benefits[3]
- Select network

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

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

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.

Referral exclusions for Commercial products

Tufts Health Plan does not require a PCP referral for the following services, including, but not limited to:

- Ancillary care:
  - Laboratory services
  - Radiology services **Note:** Some radiology services require prior authorization. Please refer to the Imaging Services Payment Policy for more information.
  - Anesthesia services **Note:** Some anesthesia services require prior authorization. Please refer to the Anesthesia Services Payment Policy for more information.
- Obstetric and gynecological care rendered by a contracting obstetrician, gynecologist, certified nurse midwife, or family practitioner:
  - Annual preventive gynecologic health examinations, including care deemed medically necessary by the practitioners listed above
  - Maternity care
  - Medically necessary evaluations and resultant health care services for acute or emergency gynecologic conditions
- Covered practitioner services provided in an inpatient setting (place-of-service 21)
- Outpatient behavioral health services rendered by licensed, in-network behavioral health providers
- Services rendered in emergency department (ED), qualified urgent care center, or limited service clinic (e.g., MinuteClinics), including independent laboratory services ordered by these facilities
- Chiropractic services. Refer to the Chiropractic Services Payment Policy for more information.
- Oral surgery
- Dialysis
- Observation procedure codes

Refer to the Referrals, Authorizations and Notifications chapter of the Commercial Provider Manual for more information on referral requirements and processes.

Senior Products

Refer to the Referrals, Authorizations and Notifications chapter of the Senior Products Provider Manual for more information on referral requirements and processes.

Referral exclusions for Senior Products

Tufts Health Plan does not require a PCP referral for the following services, including, but not limited to:

- Ancillary care:

[3] 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.

    - Laboratory services
    - Radiology services **Note:** Some radiology services require prior authorization. Please refer to the Imaging Services Payment Policy for more information.
    - Anesthesia services **Note:** Some anesthesia services require prior authorization. Please refer to the Anesthesia Services Payment Policy for more information.
- Obstetric and gynecological care rendered by a contracting obstetrician, gynecologist, certified nurse midwife, or family practitioner:
    - Annual preventive gynecologic health examinations, including care deemed medically necessary by the practitioners listed above
    - Maternity care
- Covered practitioner services provided in an inpatient setting (place-of-service 21)
- Services rendered in emergency department (ED), qualified urgent care center, or limited service clinic (e.g., MinuteClinics), including independent laboratory services ordered by these facilities

Tufts Health Together, Tufts Health Unify and Tufts Health Direct

Certain services may require a referral to confirm that the member's primary care providers (PCPs) have recommended the member's specialty care services. A referral verifies that the PCP believes the services are necessary for the member's care. Refer to the Referrals, Authorizations, Notifications chapter of the Tufts Health Public Plans Provider Manual for more information on referral requirements and processes.

Referral exclusions for Tufts Health Together, Tufts Health Unify and Tufts Health Direct

Tufts Health Plan does not require a PCP referral for the following services, including, but not limited to:

- Ancillary care:
    - Laboratory services
    - Radiology services **Note:** Some radiology services require prior authorization. Please refer to the Radiology Imaging Services Payment Policy for more information.
    - Anesthesia services **Note:** Some anesthesia services require prior authorization. Please refer to the Anesthesia Services Payment Policy for more information.
- Obstetric and gynecological care rendered by a contracting obstetrician, gynecologist, certified nurse midwife, or family practitioner:
    - Annual preventive gynecologic health examinations, including care deemed medically necessary by the practitioners listed above
    - Maternity care
    - Medically necessary evaluations and resultant health care services for acute or emergency gynecologic conditions
- Covered practitioner services provided in an inpatient setting (place-of-service 21)
- Outpatient behavioral health services rendered by licensed, in-network behavioral health providers
- Services rendered in emergency department (ED), qualified urgent care center, or limited service clinic (e.g., MinuteClinics), including independent laboratory services ordered by these facilities
- Chiropractic services. Refer to the Chiropractic Services Payment Policy for more information.

Effective for dates of service on or after January 1, 2021, Tufts Health Direct will not require referrals for specialty care.

Tufts Health RITogether

Tufts Health RITogether does not require referrals for specialty care. However, PCPs are responsible for referring members to an in-network specialist, when appropriate. A PCP referral is not required for in-network or out-of-network routine and preventive services related to women's health.

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. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained.

Pharmacy Prior Authorization Requests

Certain prescription medications may require prior authorization as indicated in the Pharmacy Medical Necessity Guidelines in the Provider Resource Center. Refer to the pharmacy medication prior authorization grids for Commercial and Tufts Health Public Plans to determine the appropriate Pharmacy Prior Authorization Request Forms for coverage requests under both the prescription drug benefit and the medical benefit.

Refer to the Referrals, Authorizations and Notifications chapter of the Senior Products Provider Manual or the Pharmacy chapter of the Commercial or the Tufts Health Public Plans Provider Manuals for additional information.

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.

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

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

CareLink

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: Medical, behavioral health and pharmacy prior authorization requests are reviewed by Cigna using Tufts Health Plan's medical necessity criteria. Refer to the appropriate Medical Necessity Guidelines for more information.

Senior Products

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 chapter of the Senior Products Provider Manual for a complete description of authorization requirements.

Sleep Studies

The following applies to sleep studies for Senior Products:

- 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.
- For Tufts Health Plan SCO members, 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 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.

Tufts Health Public Plans

Some services require prior authorization. For services that require prior authorization, refer to the medical and behavioral health benefit summary grids or appropriate Medical Necessity Guidelines.

INPATIENT NOTIFICATION

As a condition of payment, Tufts Health Plan requires 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 submitted via electronic submission on the secure Provider portal or by faxing a completed Inpatient Notification Form to the Precertification Operations Department. No other forms will be accepted. Incomplete forms will be returned to the submitting provider for completion and resubmission. Processing the request will be delayed until all required information is returned to Tufts Health Plan. Elective admissions must be reported no later than five business days prior to admission. Urgent or emergency admissions must be reported within one business day of the admission.

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

Refer to the Referrals, Authorizations and Notifications chapters of the Commercial, Senior Products or Tufts Health Public Plans Provider manuals for a complete description of inpatient notification requirements and submission channels.

Tufts Medicare Complement (TMC) and Medicare Complement Plan (MCP) members require inpatient notification for services once all Medicare benefits have been exhausted.

Senior Products

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

BILLING INSTRUCTIONS

Unless otherwise stated, Tufts Health Plan follows industry standard coding guidelines. Refer to current coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers and their usage. For more information refer to the Professional Services and Facilities Payment Policy.

Tufts Health Plan will deny claims if prior authorization, referral and/or inpatient notification have not been obtained or submitted for a specialty appointment or inpatient service when required.

ADDITIONAL RESOURCES

- Commercial Provider Manual
- Senior Products Provider Manual
- Tufts Health Public Plans Provider Manual
- Use of Out-of-Network Providers Policy
- MNG: Out-of-Network Coverage at the In-Network Level of Benefits (All Plans)

DOCUMENT HISTORY

- October 2020: Referrals are not required for specialty care for Tufts Health Direct, effective for dates of service on or after January 1, 2021
- July 2020: Policy reviewed; added content applicable to Tufts Health Public Plans from retired Specialty Services Payment Policy
- 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

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℠ 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.