Individual Consideration Services Payment Policy

Applies to the following Tufts Health Public Plans products:

☐Tufts Health Direct – Health Connector

☐Tufts Health RITogether – A RI Medicaid Plan

☒Tufts Health Together – Includes MassHealth Plan and Accountable Care Partnership Plans

☐Tufts Health Unify – OneCare Plan

The following payment policy applies to Tufts Health Plan contracting providers who render services for Tufts Health Public Plans products.

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 individual consideration (IC) services. Tufts Health Plan determines the compensation rate for an IC service based on receipt or nonreceipt of an invoice.

DEFINITION

Individual consideration (IC) is a designation for codes where neither MassHealth nor Tufts Health Plan have established a specific compensation rate.

BILLING AND COMPENSATION

Tufts Health Plan reserves the right to request an invoice on all IC-designated services.

Claims Submitted With Invoice

Tufts Health Plan compensates for 100 percent of the invoice cost per unit, unless otherwise contracted. Tufts Health Plan does not compensate separately for handling or delivery charges.

Note: Claims with invoices must be submitted as paper claims. Invoices are not accepted electronically.

Claims Submitted Without Invoice

Tufts Health Plan compensates for IC services at one of the following rates:

- The designated compensation rate defined by the Tufts Health Plan provider contract.
- The designated compensation rate in the corresponding MassHealth regulation.
- 50 percent of billed charges if neither a Tufts Health Plan contract nor MassHealth regulation has established a specific compensation rate. Tufts Health Plan may consider additional compensation for these claims after receiving an invoice. Formal appeal with clinical documentation may be required to consider additional compensation.

DOCUMENT HISTORY

- July 2018: Process clarified for claims submitted with supporting documentation
- March 2018: Template updates
- February 2017: 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 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 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.