

Provider Payment Dispute 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.

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

Providers have the right to file a payment dispute if they disagree with a claim decision regarding the denial or compensation of a claim. Providers may submit disputes and corrected claims via mail.

PROVIDER PAYMENT DISPUTES

Limitation of Dispute Process

Tufts Health Plan will consider payment disputes and adjustment requests for claims with dates of service within the current year, and the two previous calendar years from EOP date, for the following disputes, which include, but are not limited to:

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

Corrected Claims and Disputes of Duplicate Claim Denials

Corrected claims and provider payment disputes of duplicate claim denials must be received no later than 60 days from the date of the original adjudication. Any payment disputes received after that time will not be considered.

Late Charges

Services submitted after initial submission of the claim are considered late charges. Late charges applied to Tufts Health Plan 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

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 provider payment disputes. This form can be found in the [Forms](#) section of the Provider Resource Center and on the HCAS [website](#).

- All required information must be included on the form. Any supporting documentation must be single sided.
- Disputes submitted without the official Request for Claim Review Form (v1.1) will be rejected and returned to the submitter.

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

- **Corrected Claim Adjustments**

When submitting a corrected claim adjustment, 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 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.

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.
- 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](#)

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 60 days of the EOP on which the claim originally denied. A request for reconsideration received more than 60 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 60 days from the date of the primary insurer's EOP.

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 60 days of date on retraction statement.

Submitting Proof of Timely Filing

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
- 277 transaction report to direct submitters or clearinghouse
- 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 60 days of the date on the letter
- Copy of a Workers' Compensation denial received by Tufts Health Plan within 60 days of the date of the denial

Note: See claims chapter of the Provider Manuals for [MA](#) and [RI](#) 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 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.

Reports must show receipt at Tufts Health Plan, through direct submission.

DOCUMENT HISTORY

- December 2018: Clarified paper submission instructions
- June 2018: Document created

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 an 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 CareLinkSM 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.