PROVIDERS

General Responsibilities

Tufts Health Plan providers agree to comply with all state or federal laws and regulations applicable to Tufts Health Plan products in arranging or providing for services to any member.

Providers must also comply with Tufts Health Plan's contractual obligations, such as requests for information necessitated by government contracting requirements.

Contracted providers must accept the applicable financial arrangements set forth in the financial exhibits of their contracts as full compensation for such health services. Contracting providers may only collect applicable deductibles, coinsurance or copayments from members, as specifically provided in the applicable product description, as well as fees for services that the provider provides on a fee-for-service basis that are not covered by the applicable product description where the member has specifically agreed in writing in advance to pay these noncovered services.

Note: Tufts Health Plan does not allow the use of a so-called "waiver" to circumvent or override the provider's obligations under the applicable participation agreement with regard to services covered under the member's plan. By way of illustration and not limitation, the waiver is of no validity when applied to missed filing deadlines, provider's failure to comply with authorization requirements and/or attempts to collect payments other than applicable copayments, coinsurance or deductibles.

Use of noncontracting labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances,

Tufts Health Plan may hold the ordering provider accountable for any inappropriate behavior on the part of the noncontracting lab that has been selected.

Telehealth Responsibilities

Providers shall adhere to the following standards when delivering medically necessary care via telehealth:

- For an initial appointment with a new patient, review the patient's relevant medical history and any relevant medical records with the patient before initiating the delivery of any service
- For existing provider-patient relationships review the patient's medical history and any available medical records with the patient during the service
- Prior to each patient appointment, ensure the same services standards can be delivered as in-person care and in compliance with the provider's licensure regulations and requirements, programmatic regulations, and performance specifications related to the service (e.g., accessibility and communication access)
- If the appropriate standard of care or other requirements for providing requested care via telehealth cannot be met, make this determination prior to the delivery of treatment, notify the patient of this, and advise the patient to instead seek appropriate in-person care
- Ensure patients the same rights to confidentiality and security as provided in face-to-face services, to the extent feasible, and inform patients of any relevant privacy considerations prior to providing services via telehealth
- Follow consent and patient information protocols consistent with the protocols followed during in-person visits as well as any telehealth specific protocols
- Inform patients of the location of the provider rendering services via telehealth (i.e., distant site) and obtain the location of the patient (i.e., originating site)
- Inform the patient how to see a clinician in-person in the event of an emergency or otherwise

Uniformed Services Family Health Plan

US Family Health Plan is a health plan sponsored by the Department of Defense, serving eligible military families, for which Tufts Health Plan acts as a subcontractor in providing administrative services. US Family Health Plan members are easily identified with the US Family Health Plan logo on the identification card. Providers rendering services to US Family Health Plan members are subject to TRICARE reimbursement policies and regulations. For information on TRICARE's reimbursement policies and regulations, refer to the TRICARE Reimbursement Manual. For more information on Tufts Health Plan's relationship with US Family Health Plan, refer to the Uniformed Services Family Health Plan overview page.

Provider Update

The *Provider Update* is Tufts Health Plan's monthly newsletter for providers, hospital administrators and ancillary providers in the Tufts Health Plan network. *Provider Update* is Tufts Health Plan's primary vehicle for providing 60-day notifications and other critical business-related information to providers.

Tufts Health Plan distributes its *Provider Update* newsletter by email and via the News section of the Tufts Health Plan public Provider website. To receive *Provider Update* by email, providers must register by completing the online registration form, available in the News section of the Tufts Health Plan public Provider website. Providers who routinely visit the public Provider website for updates and who prefer not to receive *Provider Update* by email will have the opportunity to indicate that preference on the online registration form.

This requirement applies to all contracting providers, including, but not limited to, providers who are currently registered users of the secure Provider website as well as those who have previously submitted an email address to Tufts Health Plan for any reason. Office staff and provider organization and hospital leadership can also register to receive *Provider Update* by email. Office staff may also register a provider on his or her behalf by using the provider's name, email address and NPI, and indicating the divisions of Tufts Health Plan with which the provider contracts.

Individuals who register to receive *Provider Update* by email are responsible for keeping their email addresses

and contact information updated. To update information that was previously submitted through the online registration form, providers should resubmit the online registration form with updated information.

Note: Providers who have registered to receive *Provider Update* by email but are still not receiving it must check their spam folder or check with their organization's system administrator to ensure the organization's firewall is adjusted to allow for receipt of *Provider Update* (sender: providerupdate@tufts-health.com).

Current and recent past issues, as well as the articles featured in *Provider Update* are available in the News section of the Tufts Health Plan public Provider website.

Fraud, Waste and Abuse

Providers must comply with federal and state laws and regulations designed to prevent, identify and correct fraud, waste and abuse (FWA). If a provider becomes aware of a questionable practice by a Tufts Health Plan provider or member that may indicate possible health care fraud, Tufts Health Plan has established a hotline to help Tufts Health Plan's members, providers and vendors who have questions, concerns and/or complaints related to possible fraudulent, wasteful or abusive activity.

Providers may call the Tufts Health Plan Fraud Hotline to report concerns 24 hours a day, 7 days a week at 877-824-7123. Callers may self-identify or choose to remain anonymous. Information provided will be forwarded within one business day to the Tufts Health Plan Compliance Department.

Confidentiality of Member Medical Records

Tufts Health Plan requires that providers comply with all applicable laws relating to the confidentiality of member medical records, including, but not limited to, the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA).

To meet Tufts Health Plan confidentiality requirements, providers must do the following:

- Maintain medical records in a space staffed by office personnel
- Maintain medical records in a locked office and/or password-protected electronic file(s) when staff is not present
- Prohibit unauthorized review and/or removal of medical records
- Maintain and adhere to policies and procedures regarding patient confidentiality

Tufts Health Plan monitors providers' compliance with its confidentiality policies through clinical quality reviews and audits.

Tufts Health Plan may require providers, upon request, to provide member medical information and medical records for the following purposes:

- Administer Tufts Health Plan's health benefit plans, such as claims payment, coordination of benefits, subrogation, enrollment, eligibility verification, reinsurance and audit activities
- Manage care, including but not limited to utilization management (UM) and quality improvement (QI) activities
- Carrying out member satisfaction procedures described in member benefit documents
- Participate in reporting on quality and utilization indicators, such as Health Plan Employer Data and Information Set (HEDIS®)
- Comply with all applicable federal and state laws

Providers are responsible for obtaining any member consents or releases that are necessary beyond those that Tufts Health Plan has already acquired through the enrollment process or the member benefit documents. Tufts Health Plan maintains and uses member medical information in accordance with Tufts Health Plan's confidentiality policies and procedures.

Note: A member consent/authorization to release medical records to Tufts Health Plan for the purpose of an appeal is not necessary.

Medical Record Charges

Tufts Health Plan periodically requests medical records from providers for a variety of business reasons. Providers are responsible for producing copies of the requested medical record(s) within a timeline consistent with industry standards and within reasonable time frames to meet appeals and grievance, accreditation and/or government or regulatory timelines. Medical records will be provided at no additional cost to Tufts Health Plan.

The use of a third-party vendor to produce copies of medical records is the responsibility of the provider who has contracted with said vendor. The provider will intervene if a vendor withholds any medical records for payment.

Quality Improvement (QI) Activities

Providers/practitioners must cooperate with the Tufts Health Plan's QI activities to:

- Improve the quality of care and services and the members' experiences, including the collection and evaluation of data and participation in Tufts Health Plan's QI programs
- Allow Tufts Health Plan to collect and use performance measurement data
- Assist Tufts Health Plan in improving clinical and service measures

Primary Care Providers (PCPs)

The PCP must be able to provide integrated, accessible, health care services and be accountable for addressing a large majority of personal health needs, developing a sustained partnership with patients, and practicing in the context of the family and the community.

The following encompasses a common set of proficiencies for all PCPs:

- Training in a primary care discipline or significant additional training in primary care subsequent to training in a nonprimary care discipline
- Periodic assessment of the asymptomatic patient
- Screening for early disease detection
- Evaluation and management of acute illness
- Ongoing management of patients with established chronic diseases
- Coordination of care among specialists, including acute hospital care and long-term care
- Assessment and either management or referral of patients with more complex problems needing the diagnostic and therapeutic tools of a medical specialist or other professional
- Any provider designated as a PCP must devote a significant percent of his or her clinical time to a practice that encompasses the above list of proficiencies.

Note: This definition was adapted from the *Report on Primary Care* from the Institute of Medicine, 1996. Individual consideration may be given for specialists to serve as PCPs under particular circumstances at the individual provider unit level.

Responsibilities

PCPs are responsible for monitoring the care of their Tufts Health Plan members to provide quality and cost-efficient medical management. Successful management and coordination of a member's medical services likely results in medical and financial success for the provider unit.

Responsibilities of the PCP include, but are not limited to, the following:

- **Routine preventive care:** includes physical examinations, immunizations, hypertension and cancer screening, and pap smears
- **Health education:** includes safety and nutrition counseling, family planning unless specifically excluded in the member's benefit booklet, and other counseling as needed
- **Specialty care:** The PCP arranges most specialty care for members. For medically necessary specialty care services outside of the Tufts Health Plan network, authorization by the provider reviewer is required. Refer to Our Plans for product-specific information.
- **Urgent and emergency care:** includes coordination of emergency services and inpatient and outpatient care. Report emergencies that occur out of the service area to Tufts Health Plan.

Membership Report

Providers may access their Membership Report through the secure Provider portal. The membership report includes the names of members who have chosen the provider as their PCP, and additions to and deletions from a PCP's panel.

Closing and Opening a Panel

PCPs may close their practices to new members for reasons such as maternity leave or other similar absences; however, the PCP cannot close a panel for only selected plans and payers.

The provider must notify the Tufts Health Plan Provider Information Department, in writing, within 90 days or within the timeframe outlined in the provider's agreement with Tufts Health Plan, if otherwise indicated. During the 90-day transition period, members are still allowed to select the provider as their PCP. For mailing information, refer to the Provider Information Change Form.

Even though a panel may be closed, members who have been appearing on a provider's monthly member list are still in the PCP's panel. These members must be treated or directed to appropriate specialists, even if the provider has not treated them prior to the panel closure.

To reopen the panel, the provider must notify the Provider Information Department in writing and include in the letter the date the panel will reopen.

Temporary Transfer of Responsibility

Provider agreements obligate PCPs to establish and maintain coverage 24 hours a day, 7 days a week. However, personal illness, sabbatical or maternity leave are examples of times when brief withdrawal from a practice and temporary transfer of this responsibility may be necessary.

In the event the provider must withdraw from his or her practice for a planned period of time (e.g., maternity leave), Tufts Health Plan, at its discretion, may agree that a *locum tenens* practitioner may be engaged by the PCP to provide coverage for a limited period of time. The provider must arrange for this coverage and provide Tufts Health Plan with written notice of temporary transfer of responsibility to a *locum tenens* practitioner acceptable to Tufts Health Plan (see *Locum Tenens* Policy below).

The provider must include in the arrangement with the *locum tenens* practitioner the ability to terminate, without cause and effective upon notice, the *locum tenens* practitioner's provision of services with respect to Tufts Health Plan members.

If the intended interruption will exceed 60 days, Tufts Health Plan may close the provider's panel, since absence beyond two months may not allow for direct patient management. Sustained periods of unavailability also are not in the best interest of our members, as they are unable to access their chosen PCP.

If a PCP's temporary transfer of responsibility beyond 60 days involves unique circumstances, they must contact the Tufts Health Plan Credentialing Department directly.

Leave of Absence Policy

Tufts Health Plan requires a practitioner to notify Tufts Health Plan if they are taking a leave of absence (LOA) for longer than 60 calendar days. At a minimum, this notification must include the dates and the general reason

for the LOA (sabbatical, medical reason, etc.). Practitioners must notify Tufts Health Plan regarding a pending LOA as soon as possible.

Practitioners who will be taking a LOA must arrange for coverage by another participating practitioner in the Tufts Health Plan network. All covering arrangements must be acceptable to Tufts Health Plan.

Arrangements for coverage by a nonparticipating practitioner (e.g., *locum tenens*) may be considered. These arrangements must have Tufts Health Plan's prior approval and must be consistent with established policies and procedures.

If the LOA is scheduled for **six months or less**, Tufts Health Plan will confirm the conclusion of the LOA by contacting the practitioner's office to confirm the leave has ended. If the LOA is concluded within six months, the practitioner LOA status will be removed and will reflect their prior status.

If the LOA is scheduled for **longer than six months**, Tufts Health Plan reserves the right to terminate the practitioner from the network based upon continuity of care issues. In addition, if a practitioner's recredentialing is due during the LOA and the practitioner does not complete his or her recredentialing materials, Tufts Health Plan reserves the right to terminate the practitioner from the network based upon contractual noncompliance.

Covering Provider

The covering provider is responsible for emergent or urgent care only. Follow-up treatment must always occur with the member's PCP or a Tufts Health Plan specialist.

All Tufts Health Plan participating providers have contractually agreed to be accessible to members 24 hours a day, 7 days a week. If a provider is not available, they are responsible for maintaining appropriate provider coverage. Tufts Health Plan requires that all covering providers be contracted and credentialed; exceptions may be granted based on geographic availability. A written notification of the termination or addition of providers for a covering doctor should be sent to the Provider Information Department in a timely manner.

Locum Tenens Policy

Tufts Health Plan requires that *locum tenens* providers with the potential to treat a Tufts Health Plan member be enrolled. Provider organizations wishing to enroll *locum tenens* providers should have the provider submit the following forms:

- HCAS enrollment form
- Release & attestation form
- IPA endorsement form
- W9 (for payment purposes)

If the *locum tenens* provider will be covering for Tufts Health Plan members, the provider should also include the Tufts Health Plan endorsement form. Enrollment will be valid for up to six months. If a *locum tenens* provider's services are required by the IPA/PHO for more than six months, the *locum tenens* provider may be required to execute an appropriate contract with the IPA/PHO and be fully credentialed.

Note: *Locum tenens* practitioners will not be listed in the Tufts Health Plan directory and are not permitted to have a panel.

Removing a Tufts Health Plan Member from a Panel

Provider Requests to Disengage from Member

Under rare circumstances, a provider may feel that it is no longer appropriate to act as a PCP for a Tufts Health Plan member. The provider must send a written notice to the member and a copy to Tufts Health Plan's Member and Provider Services Department, explaining the reason for the decision. The provider is required to provide urgent care for up to 30 days so the member has time to select a new PCP.

The written notice may be sent to:

Tufts Health Plan Member and Provider Services
PO Box 9170
1 Wellness Way
Canton, MA 02021

When the member and Provider Services Department receives the letter, a letter will be sent to the member notifying them when the PCP will be removed from their plan and instructing them to select a new PCP.

If a provider has a member on their panel but believes they are not a patient and does not have contact information for the member, the provider should contact the Provider Services Department at 888-884-2404. A Provider Services representative will provide the member's contact information.

Member Inappropriately Selects Provider

A member may inadvertently select a PCP whose practice is closed to new members or who has agreed to accept only established patients. If a member selects a PCP who is only accepting established patients, Tufts Health Plan will assign the member to the requested PCP, even if the established patient indicator is not present on the enrollment transaction.

If a provider realizes they have been inappropriately selected as a member's PCP, the provider must immediately notify Provider Services at 888-884-2404 and assume the role of PCP for that member on an interim basis until the member selects a new PCP. If notification is not received, the member is deemed part of the provider's panel.

Specialist Provider

The specialist provider within the Tufts Health Plan network is expected to provide quality, cost-efficient health care to Tufts Health Plan members. The specialist's primary responsibility is to provide authorized medical treatment to members who have an electronic or written referral from their PCP or as otherwise authorized by Tufts Health Plan.

If a specialist feels that additional treatment is required and they cannot provide these services, the specialist is responsible for contacting the member's PCP and suggesting that the PCP provide the member with an alternative referral, when applicable.

When POS members see a Tufts Health Plan or non-Tufts Health Plan specialist without a referral (i.e., they exercise their right to use their unauthorized level of benefits), the specialist may provide medical treatment without the PCP's authorization. In these instances, the member is responsible for an applicable copayment or deductible and coinsurance.

Specialists are required to provide 90 days prior notice of termination of their participation with Tufts Health Plan, both to Tufts Health Plan and to members who have been or are currently under the ongoing care of said specialist, unless a different time period or other arrangement has been agreed upon in the applicable health services agreement.

Physician Reviewer

Many provider units appoint a physician reviewer to oversee utilization management within the provider unit. Some provider units designate more than one reviewer for specialty consultations, such as pediatrics or obstetrics. Physician reviewers are available for clinical consultations and serve as a resource for availability of in-network services. Physician reviewers work cooperatively with Tufts Health Plan care managers to facilitate care management of members through the continuum of care.

With outpatient treatment, a physician reviewer's role will vary according to the member's plan. Depending on the site of care, both PCP and physician reviewer approval may be required. For care to be rendered at an out-of-plan facility, the physician reviewer's authorization is required. Refer to the Prior Authorization through the Behavioral Health Department section of the Referrals, Prior Authorizations and Notifications chapter for information on outpatient behavioral health services.

Note: If the member is on a select/limited network plan, services from an out-of-plan or out-of-network provider

require Tufts Health Plan review and approval, even if both the PCP and physician reviewer have approved the request. Specialty care providers outside the select/limited network must fax the completed Out-of-Network Coverage at In-Network Level of Benefits Prior Authorization Form to Tufts Health Plan's Precertification Operations Department at 617-972-9409 prior to services being rendered.

Physician reviewers also are involved with inpatient cases. If elective services are to be performed at an out-of-plan facility, the PCP must contact the physician reviewer in advance for approval.

Members enrolled in a Tufts Health Plan Preferred Provider Organization (PPO) may access services without the direction of a PCP or physician reviewer. Refer to Our Plans for product-specific information.

Nurse Practitioners and Physician Assistants

Nurse practitioners (NPs) and physician assistants (PAs) may elect to either bill under a supervising or collaborating physician or contract directly with Tufts Health Plan. NPs and PAs may not do both (i.e., bill under a supervising/collaborating physician as well as contract independently). Independently credentialed and contracted NPs/PAs may be listed in provider directories and may hold a panel if they practice as a PCP.

As permitted by state law, NPs/PAs who work under the auspices of a licensed physician may bill for covered services under the supervising physician's identification number, provided that the supervising physician and/or facility (e.g., hospital) have met all applicable requirements.

It is the responsibility of the collaborating provider to educate the NP/PA on all Tufts Health Plan policies, procedures and guidelines. The collaborating provider is responsible for maintaining appropriate state licensing information and proof of appropriate professional malpractice liability insurance coverage for all NPs/PAs under their supervision.

For billing and authorization information, refer to the Nurse Practitioner and Physician Assistant Payment Policy.

Practitioner Treatment of Self and Family Members

Practitioners may not receive compensation for any treatment of themselves or a family member. Family members include a spouse (or equivalent), parent, child, sibling, parent-in-law, son/daughter-in-law, step-parent, step-child, step-sibling, or other relative permanently residing in the same residence as the practitioner.

Note: The definition of a family member is adopted from the Board of Registration in Medicine Regulations, 243 CMR 2.07: "General Provisions Governing the Practice of Medicine."

Chaperones for Office Examinations

Tufts Health Plan practitioners should have an office policy regarding chaperones for examinations relating to the breast and genital area, including rectal exams. It is suggested that practitioners offer all patients the option of the presence of a chaperone during such exams.

The policy should address the following elements:

- **Documentation:** Will there be written documentation of the chaperone being offered and the patient's response?
- **Communication:** How is the policy communicated to patients and when in the visit is the chaperone offer made?
- **Types of exams:** For which exams will chaperones be offered?

The chaperone policy applies to all practitioners, regardless of gender.

Summary of the Credentialing Process

Tufts Health Plan credentials affiliated practitioners when they join the Tufts Health Plan network and at a minimum every three years thereafter, in accordance with state, federal, regulatory, and accrediting agency requirements. Credentialing standards are applied uniformly for behavioral-health and non-behavioral health

practitioners that are applying to the Tufts Health Plan Commercial network. Refer to the Credentialing and Contracting Overview section of the public Provider website for more information.

Provider Requirements

For initial credentialing and recredentialing, each practitioner is required to comply with the Tufts Health Plan Credentialing Program and submit the following information to Tufts Health Plan via email to Tufts_Health_Plan_Credentialing_Department@point32health.org, RIProviderEnrollment@point32health.org for Rhode Island practitioners or to the designated credentialing verification organization for review as indicated below:

- Complete all required fields specified in CAQH ProView™ and notify the Credentialing Department when the application is complete
- Sign and date the health services agreement (initial credentialing only) and any other contract documents and email to Tufts Health Plan
- Sign W-9 form (initial credentialing only) and email to Tufts Health Plan
- Current malpractice insurance information and email to Tufts Health Plan

Practitioners are notified of their recredentialing request through CAQH ProView, allowing enough time for each practitioner to complete the information online by his or her recredentialing date. Tufts Health Plan credentials according to the birthdate cycle (people born in an even year are recredentialed in the month of their birthdate every even year (e.g., 1960, 1962, etc).

Primary Hospital Requirements

Each MD and DO must indicate their primary hospital on the credentialing application when applicable. For initial credentialing, Tufts Health Plan queries that hospital for an assessment of the practitioner's performance, as mandated by state regulation. During recredentialing, the hospital is queried again. The practitioner must notify Tufts Health Plan in writing of changes in primary hospital affiliation.

Tufts Health Plan Requirements

Along with the credentialing information specified in CAQH ProView, Tufts Health Plan reviews the following information prior to the final assessment of each practitioner in states other than Rhode Island:

- Licensure status in applicable states
- DEA/CDS certificate, if applicable
- Board certification status
- Malpractice insurance coverage, dates and amount
- Work history (initial only)
- Information obtained from the National Practitioner Data Bank
- Education and training (initial only)
- Medicare/Medicaid sanctions
- State disciplinary actions
- Medicare opt-out
- System of Award Management (SAM) sanctions
- Medicare Preclusion sanction

For Rhode Island practitioners, along with the credentialing information specified in CAQH ProView, Tufts Health Plan reviews the following information prior to the final assessment of each practitioner:

- Provider demographics including name and current mailing address
- Current valid license, registration or certificate in Rhode Island or other state as applicable
- History of any revocation, suspension, probationary status or other disciplinary action regarding provider's license, registration or certificate
- Clinical privileges at a hospital, as applicable
- Valid Drug Enforcement Agency and Controlled Substance certificate/registration and/or other state or federal verification to prescribe controlled substances (if applicable)
- Evidence of board certifications

- Evidence of malpractice/professional liability insurance
- History of professional liability claims and description of any settlements or judgements paid to a claimant in connection with a professional liability claim

The Quality of Care Committee (QOCC), a board-level quality committee chaired by a Tufts Health Plan employed physician (or by the QOCC's designated medical director[s]) reviews practitioners who are being credentialed or recredentialed.

Practitioners cannot see Tufts Health Plan members without the following:

- Review and completion of all applicable required data by the practitioner
- The approval by the Chair of QOCC or approved Tufts Health Plan medical director of the practitioners' credentialing or recredentialing file

Note: For initial credentialing applicants, practitioners are deemed in-network based upon the credentialing effective date or the contract effective date, whichever is later. Per regulations, Tufts Health Plan is not allowed to backdate credentialing effective dates.

If the contract provides for credentialing activities by a first-tier or downstream entity, the first-tier or downstream entity must meet all applicable Tufts Health Plan credentialing requirements, including Tufts Health Plan's review of medical professionals' credentials or reviewing, preapproving and auditing the credentialing process.

Practitioners' Rights and Responsibilities

Practitioners have the right, upon written request, to:

- Review Tufts Health Plan's credentialing policies and procedures
- Be informed of the status of their credentialing or recredentialing application by contacting the Credentialing Department via the following:
  Phone: 617-972-9495
  Fax: 617-972-9591
  Email: Tufts_Health_Plan_Credentialing_Department@point32health.org; RIProviderEnrollment@point32health.org for Rhode Island practitioners
  Mail: Tufts Health Plan
  Attn: Credentialing Department
  1 Wellness Way
  Canton, MA 02021
- Review information submitted to Tufts Health Plan for purposes of credentialing or recredentialing, including information obtained by Tufts Health Plan from any outside source, such as a malpractice carrier, state license board, or the National Practitioner Data Bank (NPDB).
  - Notwithstanding the foregoing, Tufts Health Plan is not required to reveal the information source if the information was not obtained for the purpose of meeting Tufts Health Plan's credentialing requirements.
  - Providers are not entitled to review references, recommendations or information that is peer-review privileged or any information which by law Tufts Health Plan is prohibited from disclosing.
- Receive notification if credentialing information obtained from sources other than the practitioner varies substantially from the credentialing information provided to Tufts Health Plan by the practitioner.
- Correct erroneous information submitted by other parties within 10 days of receipt. **Note:** If Tufts Health Plan obtains or receives information during the credentialing process that varies substantially from the information provided in the application, Tufts Health Plan will notify the provider of the discrepancy. Providers have the right to review any information submitted in support of the credentialing application and to correct erroneous information other parties provide (excluding peer-review information). To submit corrections to the Credentialing Department, email Tufts_Health_Plan_Credentialing_Department@point32health.org; RIProviderEnrollment@point32health.org for Rhode Island practitioners.
- There is no right of appeal from an initial credentialing determination by the QOCC except when required by applicable state or federal law.

In the event the QOCC votes to take disciplinary action, the practitioner is entitled to notice consisting of a written statement of the reasons for the action and, if applicable, has the right to appeal such action by filing a written appeal within 30 calendar days of receipt of the statement of reasons.

The practitioner is entitled to be represented by an attorney or other representative of the practitioner's choice. In the event that new information becomes available, the practitioner may submit new information up until the Appeals Committee meeting.

Each committee member must engage in a fair and impartial review of the practitioner's appeal. No committee member may be an economic or geographic competitor of the reviewing practitioner. The committee member should not be employed by or act in the capacity of a Tufts Health Plan board member or otherwise be a representative of Tufts Health Plan.

The decision of the Appeals Committee is final. The practitioner will be provided with written notification of the appeal decision, which contains the specific reasons for the decision.

Hospital Credentialing

Tufts Health Plan credentials hospitals when they join the Plan and are recredentialed every three years in accordance with National Committee for Quality Assurance (NCQA) standards.

Requirements for Initial and Recredentialing

For initial and recredentialing, each hospital is assessed for quality. The hospital must be accredited by an applicable accrediting agency acceptable to Tufts Health Plan such as the Joint Commission, the American Osteopathic Association, or the National Integrated Accreditation for Health Care Organizations. The hospital must have a current state license. The hospital will be reviewed for Medicare and Medicaid sanctions and, for recredentialing, quality events will be reviewed. Tufts Health Plan may review additional information reasonably deemed pertinent to credentialing, including a site visit.

The QOCC or its designee reviews all hospitals that are being credentialed or recredentialed and may request additional information pertinent to its credentialing of the hospital.