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## INTRODUCTION

### Purpose of This Manual

Tufts Health Plan developed this manual to supply our providers and their office staff with details on certain products, policies, and procedures of Tufts Health Plan. The Commercial Provider Manual applies to Commercial<sup>1</sup> products (including Tufts Health Freedom Plan). Tufts Health Plan requires that providers and their staff read, abide by, and reference this manual as necessary.

For more information on Tufts Health Plan Senior Products or Tufts Health Public Plans policies and procedures, refer to the 2020 [Senior Products](#) or [Tufts Health Public Plans](#) provider manuals.

**Note:** The information contained in this Provider Manual is subject to change and may be periodically updated throughout the year to reflect information, including, but not limited to, changes in law, rule, regulation, and/or requirement of any applicable state or federal agency, industry updates, or other business decisions that may affect how providers do business with Tufts Health Plan. Providers should also refer to their contracts for specific compensation provisions and may contact Commercial Provider Services at 888.884.2404 with additional questions.

### Overview of Tufts Health Plan

Tufts Health Plan is designed to arrange for comprehensive health care services to its members and encourage appropriate treatment and efficient use of medical services. Tufts Health Plan offers eligible employer groups and individual enrollees a range of products and plan designs. Refer to the [Our Plans](#) section of the public Provider website for overviews of individual products.

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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.

## Department Directory

When contacting Tufts Health Plan, use the following directory or the [Provider Contact Information](#) page to identify the most appropriate department to call.

Department	Contact	Responsibility
<b>Inpatient Management</b>		
Inpatient Manager	888.766.9818	<ul style="list-style-type: none"> <li>• Concurrently reviews Tufts Health Plan members admitted to inpatient facilities</li> <li>• Coordinates and authorizes discharge plans, including rehabilitation, skilled nursing facility (SNF) or chronic hospital placement, home health care, home therapies, and durable medical equipment (DME)</li> </ul>
Specialty inpatient manager	888.766.9818	<ul style="list-style-type: none"> <li>• Facilitates discharge planning</li> <li>• Provides ongoing coordination of services through the continuum of illness of medically complex cases</li> <li>• Acts as plan liaison for members, families, providers and vendors of ancillary services</li> <li>• Manages complex cases</li> <li>• Performs out-of-network hospital reviews and discharge planning</li> <li>• Manages high-risk obstetrics, pediatrics, neonatology, transplants, HIV/AIDS, disabilities, rehabilitation nursing, and oncology cases</li> </ul>
<b>Behavioral Health Department</b>		
Behavioral Health outpatient clinical coordinator and service representative	800.208.9565	<ul style="list-style-type: none"> <li>• Manages requests for outpatient behavioral health and substance use disorder (BH/SUD) services</li> <li>• Coordinates members' access to inpatient BH/SUD services</li> </ul>
Behavioral Health care manager	800.208.9565	<ul style="list-style-type: none"> <li>• Facilitates discharge planning for members hospitalized at designated facilities (DFs)</li> <li>• Monitors quality of care at behavioral health DFs</li> </ul>
<b>Precertification Operations Department</b>		
Precertification Operations clinical staff	617.972.9409 (fax)	Conducts utilization management review of outpatient services that require prior authorization, including, but not limited to, elective surgeries, medical benefit medications and procedures
Intake coordinator (Inpatient Admissions)	617.972.9590 (fax) or 800.843.3553 (fax)	Processes inpatient admission notification requests for Commercial members
<b>Liability and Recovery</b>		

Department	Contact	Responsibility
<a href="#">Coordination of Benefits (COB)</a>	617.972.1098	<ul style="list-style-type: none"> <li>Investigates and verifies dual health coverage</li> <li>Determines primary and secondary coverage</li> <li>Investigates and verifies workers' compensation claims</li> <li>Adjusts COB, workers' compensation, and Tufts Health Plan Medicare Complement (TMC) claims</li> </ul>
<b>Network Management and Contracting</b>		
Network Contracting and Performance Management (NCPM)	800.442.0422, ext. 52169	<p><b>Contract Manager</b></p> <ul style="list-style-type: none"> <li>Negotiates contracts with provider organization leadership</li> </ul> <p><b>Contract Specialist</b></p> <ul style="list-style-type: none"> <li>Ensures contract terms are implemented in appropriate Tufts Health Plan systems</li> <li>Fosters and maintains provider network relationship</li> </ul> <p><b>Associate Contract Specialist</b></p> <ul style="list-style-type: none"> <li>Processes operational changes</li> </ul>
Allied Health Contracting	617.972.9411	<ul style="list-style-type: none"> <li>Negotiates and administers contracts for all ancillary services, including but not limited to skilled nursing facilities, inpatient rehabilitation hospitals, and home care services</li> <li>Evaluates prospective ancillary providers and assesses need for additions and changes to the contracting provider network</li> <li>Monitors contract compliance and performs utilization review of contracts</li> </ul>
Provider Information	888.306.6307	<ul style="list-style-type: none"> <li>Facilitates change of provider practice or payment information status</li> <li>Facilitates provider terminations</li> </ul>
Provider Credentialing	888.306.6307	Processes new credentialing and recredentialing applications for providers and certain ancillary providers
<b>Provider Services</b>		
Provider Services	888.884.2404	<p>Providers should call this number for the following issues:</p> <ul style="list-style-type: none"> <li>Inquiries regarding paid or in-process claims</li> <li>Interpretation of member benefits</li> </ul>
<b>Provider Education</b>		
Provider Education	<a href="mailto:Provider_Education@tufts-health.com">Provider_Education@tufts-health.com</a> 888.306.6307, option 7	<p>Offers the following educational programs that are designed to help providers learn about products, policies and procedures and online self-service tools:</p> <ul style="list-style-type: none"> <li>Training videos</li> <li>Webinars</li> <li>In-person and live-streamed presentations</li> <li>Customized on-site meetings</li> </ul>
<b>Claims</b>		

<b>Department</b>	<b>Contact</b>	<b>Responsibility</b>
EDI Operations	888.880.8699, ext. 54042	<ul style="list-style-type: none"><li>• Makes inquiries concerning electronic claims files</li><li>• Sets up electronic services</li></ul>

## CARELINK<sup>SM</sup>

Tufts Health Plan and Cigna have partnered together to offer CareLink, a national open-access PPO plan that provides both in- and out-of-network benefits. CareLink is offered to eligible employer groups residing in each service area and provides nationwide access to over 900,000 providers and 6,000 facilities.

CareLink members have access to the Tufts Health Plan provider network in Massachusetts and Rhode Island, and the Cigna provider network in the remaining 48 states. Tufts Health Plan contracting providers in Massachusetts and Rhode Island participate in the CareLink offering and are available to provide health care services for CareLink members at the in-network level of benefits. In states other than Massachusetts and Rhode Island, Cigna-contracting providers may provide in-network covered services for CareLink members. For providers in Massachusetts and Rhode Island who have agreements with both Tufts Health Plan and Cigna, the terms of the Tufts Health Plan provider agreement apply. Similarly, the Cigna agreement applies to services provided to CareLink members by contracting providers outside Massachusetts and Rhode Island.

The administrative services for CareLink accounts are shared between Tufts Health Plan and Cigna; however, one payer serves as the primary administrator for each CareLink account sold. The primary administrator performs the majority of the functions associated with administering the plan for the employer group, including benefits and claims adjudication.

The primary administrator for CareLink accounts is responsible for:

- Sales and overall account management/employer reporting (enrollment files and ID card distribution)
- Enrollment and premium billing
- Claims receipt, processing and adjudication
- Member services
- Provider services (**Note:** disputes related to contractual issues are resolved by the health plan that holds the contract with the provider)

### General Information

CareLink provides coverage for appropriately authorized, medically necessary covered services at the in- and out-of-network level of benefits, subject to applicable cost share.

Members are not required to select a primary care provider (PCP); as such, referrals are not required for specialty care services. Members may have a cost share differential for services performed by a PCP versus services performed by a specialist.

Prior authorization (precertification) and/or inpatient notification requirements apply for certain procedures and/or diagnoses. For additional information, refer to the [CareLink Prior Authorization page](#) on the Tufts Health Plan website or contact Cigna directly at 800.CIGNA24 (800.244.6224) to identify specific services that have authorization/notification requirements.

CareLink members are easily identified by the CareLink logo on the front of the ID card. The Tufts Health Plan and Cigna logos may appear on the ID cards and the employer group may be listed. Refer to the [Working with CareLink](#) grid for more information on how to determine the member's primary administrator and which entity to contact for specific plan processes.

### Shared Administration

CareLink—Shared Administration is offered specifically to unions and Allied Trade employer groups. Tufts Health Plan, Cigna and the union office share administrative functions e.g., claims processing (Tufts Health Plan), medical management (Cigna) and claims adjudication (Allied Trade employer group). CareLink Shared Administration members have access to the Tufts Health Plan provider network in Massachusetts and Rhode Island, and the Cigna provider network in the remaining 48 states. The member identification number appears on the card with the logos of Tufts Health Plan, Cigna and the member's union.

Like all other self-funded groups, these employer groups select their own benefits. Services and subsequent payments are based on the member's eligibility and union plan benefit. Detailed benefit coverage and claims

status inquiry can be verified by contacting the union office, which can be found on the member's Tufts Health Plan ID card. Providers may log in to the secure Provider [website](#) or use EDI to obtain eligibility information only for these members.

CareLink—Shared Administration covers appropriately authorized, medically necessary covered services at the in-network and out-of-network level of benefits, which are subject to applicable cost share.

**Note:** Pharmacy prior authorization requests are reviewed by CVS Caremark using Tufts Health Plan's medical necessity criteria.

## Claims Submission

Electronic claim submission for both CareLink—Shared Administration and Tufts Health Plan as primary administrator should be sent to Tufts Health Plan. Electronic claim submissions for Cigna as primary administrator may be sent to either Cigna or Tufts Health Plan. If submitting paper claims, refer to the address on the back of the member's CareLink ID card for the appropriate claims mailing address; this address is specific to individual members and allows for timely claim adjudication.

Cigna's EDI specifications and Tufts Health Plan's [payment policies](#) apply when submitting claims electronically to Cigna. Tufts Health Plan's EDI specifications and payment policies apply when submitting claims electronically to Tufts Health Plan. The HIPAA-compliant 835 remittances can be obtained from Cigna.

When Cigna is the primary administrator for the account, CareLink claims appear on Cigna's explanation of payment (EOP) along with other Cigna claims, but have a specific message code identifying the Tufts Health Plan network.

If Cigna is the primary administrator and Tufts Health Plan receives CareLink claims electronically, they will not be assigned a Tufts Health Plan claim number. The submitter report from Tufts Health Plan will confirm receipt of the claim as a CareLink claim. Providers should contact Cigna at 800.CIGNA24 (800.244.6224) or use Cigna's self-service [website](#) to track the claim status.

## CareLink—Shared Administration

Submit all claims to Tufts Health Plan (electronic submission is preferred) or mail claims (red claim form is required) to the address on the back of the member's ID card. Tufts Health Plan will price all claims, at fee schedule, for contracting Massachusetts and Rhode Island providers, and Cigna will price claims for contracting providers in the remaining states. Tufts Health Plan sends all claims to the union office for further adjudication. The union office sends out checks and corresponding explanations of payment.

## Authorization Requirements

### Behavioral Health Services

Cigna Behavioral Health (CBH), Tufts Health Plan or another entity may administer BH services based on employer plan design. The member's identification card will indicate where the member should be directed for these services. Refer to the BH/SUD [inpatient](#) and [outpatient](#) payment policies for additional information.

### High-Tech Imaging Services

Prior authorization is required for CareLink members in need of high-tech imaging services whose plans require outpatient authorizations. Cigna performs utilization management for MA and RI contracting providers as part of this high-tech imaging program.

To identify if prior authorization is required for outpatient services, refer to the back of the member's ID card. If prior authorization is required, high-tech imaging prior authorization requirements apply. If the identification card is not available, contact Cigna at 800.88.CIGNA (800.882.4462).

Refer to the imaging services [professional](#) and [facility](#) payment policies for additional information.

**Note:** Providers may contact Cigna by calling 800.88CIGNA (800.882.4462) or refer to Cigna’s [website](#) for questions about medical management policies.

### Inpatient Notification

Inpatient notification is required for all elective, urgent and emergency admissions to acute care, extended care/long-term acute care, acute rehabilitation and skilled nursing facilities, regardless of whether Tufts Health Plan is the primary or secondary insurer. Inpatient notification should be submitted prior to services being rendered, except for urgent or emergency care. Inpatient notification should be completed by the facility where the member is scheduled to be admitted or may be completed by the specialist provider.

**Note:** An inpatient notification is a condition of payment and does not take the place of prior authorization requirements for services; it is subject to eligibility and benefit verification.

#### ***Required Inpatient Notification Time Frame***

Admitting providers and hospital admitting departments are responsible for notifying Cigna for CareLink members in accordance with the following timelines:

- Elective admissions must be reported no later than one week prior to admission
- Urgent or emergent admissions must be reported within 48 hours (or on the next business day if on a weekend/holiday)

Providers should contact Cigna by calling the number on the back of the member’s ID card.

**Facilities with DRG arrangements:** The provider will receive a letter indicating the coverage decision when the notification process is complete. The authorization for coverage confirms inpatient level of care.

**Facilities with non-DRG arrangements:** The number of days approved for coverage is based on multiple factors, including the clinical guidelines and the individual circumstances surrounding each request. If approved, the requesting facility will be notified of the coverage decision by phone. If the inpatient stay exceeds the number of days authorized for coverage, the CareLink care manager will review the inpatient stay concurrently to determine whether coverage for additional days should be approved.

Providers should contact their assigned CareLink utilization management registered nurse if the member’s inpatient stay is anticipated to exceed the authorized length of stay.

Requests for continued authorization are not required for admission paid under a diagnosis-related group (DRG) payment methodology once the admission receives an authorized status. The member’s CareLink care manager may review the member’s status and anticipated discharge plan throughout the admission to assist with discharge planning.

**Note:** Providers can call Cigna’s national customer service number at 800.CIGNA24 (800.244.6224) or visit Cigna’s [website](#) for questions about medical management policies.

### Notification for CareLink—Shared Administration

Inpatient notification for members who have a CareLink Shared Administration plan is managed through CareAllies. Notification of an inpatient admission or observation admissions is a requirement for payment. Refer to the [Working with CareLink](#) grid for specific precertification requirements.

### Prior Authorization (Precertification)

To help ensure the quality of member care, Tufts Health Plan and Cigna are responsible for monitoring authorization, medical appropriateness, and cost efficiency of services rendered. Certain services for CareLink members require precertification to confirm that the plan has approved the member’s specialty care services. The precertification process assists the health plan in determining medical necessity and appropriateness of health care services under the applicable health benefit plan. Services that may require precertification may be surgical services, items of durable medical equipment, drugs, etc.

The plan design for some members requires prior authorization for inpatient services only, while the plan design



for other members requires prior authorization for both inpatient and outpatient services. Cigna will provide precertification services for Tufts Health Plan-contracting providers in Massachusetts and Rhode Island.

Requests for precertification and/or inpatient notification must be submitted to the proper entity, based on the information on the back of the member's identification card.

Precertification is required for certain procedures and services for CareLink members. The procedures and services that require precertification for CareLink plans are determined jointly by Tufts Health Plan and Cigna. For services provided in Massachusetts and Rhode Island by Tufts Health Plan contracting providers, CareLink precertification requirements are a subset of services that will also require precertification. CareLink providers outside of Massachusetts and Rhode Island in the Cigna network must obtain precertification as required by Cigna for coverage. Refer to the [CareLink Procedures Requiring Prior Authorization](#) page for more information.

**Note:** Call Cigna at 800.CIGNA24 (800.244.6224) to confirm which procedures require prior authorization for CareLink members.

## Transplants

In Massachusetts and Rhode Island, the CareLink transplant network is comprised of the Tufts Health Plan's designated transplant facilities. Outside of Massachusetts and Rhode Island, the CareLink transplant network is Cigna's LIFESOURCE network and can be found on their [website](#).

## PHARMACY PROGRAM

### Tufts Health Plan Pharmacy Programs

#### Pharmacy and Therapeutics Committee

Tufts Health Plan manages the pharmacy program by evaluating the safety, efficacy and cost-effectiveness of drugs. A pharmacy and therapeutics (P&T) committee, consisting of pharmacists and physicians who represent various clinical specialties, reviews the clinical appropriateness of drugs for inclusion in the formulary and approves the criteria (Pharmacy Medical Necessity Guidelines) for drugs in a pharmacy program, such as prior authorization (PA), step therapy (ST), quantity limitations (QL), designated specialty pharmacy (SP) and designated specialty infusion (SI) programs. A drug coverage committee (DCC) consisting of Tufts Health Plan staff is responsible for clinical and financial decision-making, and makes drug coverage and formulary management decisions with consideration to the information provided by the P&T Committee.

The Tufts Health Plan formularies are developed by a panel of providers and clinical pharmacists. The formularies include key agents within selected therapeutic classes. These agents offer comparable safety and efficacy, yet are more cost-effective than similar agents. Complete lists of covered drugs, including specialty drugs included in the SP program, are available on Tufts Health Plan's website.

#### Tiered Pharmacy Copayment Programs

Tiers are subject to change throughout the year. When a drug becomes available in generic form, its brand-name counterpart may move to a higher tier or non-covered (NC) status. When a prescription drug becomes available over the counter, Tufts Health Plan may discontinue coverage of that drug. The most up-to-date listing of covered drugs and copayment tiers are available on Tufts Health Plan's Commercial [formularies](#). The formularies also contain information about drugs included in Tufts Health Plan pharmacy programs described below.

#### **3-Tier Pharmacy Copayment Program**

Under the 3-Tier Pharmacy Copayment Program, all covered drugs, including specialty medications, are placed on one of three tiers. The 3-tier program gives members and physicians a wide range of drug product choices when a prescription is written. It is important for the member and provider to work together to determine which drug is most appropriate.

- **Tier 1:** Medications on this tier have the lowest member cost-sharing amount
- **Tier 2:** Medications on this tier have a higher member cost-sharing amount
- **Tier 3:** Medications on this tier have the highest member cost-sharing amount

**Note:** Most generic drugs are covered on tiers 1 and/or 2.

#### **4-Tier Pharmacy Copayment Program**

If the member's plan includes a 4-tier copayment design, providers have the option to write a prescription for any covered prescription drug. There may be instances when only a Tier 4 drug is appropriate, which will require a higher cost share from the member.

The 4-tier copayment program contains drugs obtained through the Designated Specialty Pharmacy (SP) Program. Drugs that are part of this program include but are not limited to medications used in the treatment of infertility, hepatitis C, growth hormone deficiency, multiple sclerosis, rheumatoid arthritis, and cancers treated with oral medications.

The 4-tier program places all covered prescription drugs into one of the following tiers. Most generic drugs are covered on tiers 1 and/or 2.

- **Tier 1:** Medications on this tier have the lowest member cost-sharing amount
- **Tier 2:** Medications on this tier have a higher member cost-sharing amount

- **Tier 3:** Medications on this tier have a higher member cost-sharing amount
- **Tier 4:** Medications on this tier have the highest member cost sharing amount; limited to a 30-day supply

**Note:** Infertility drugs are not included in the 4-Tier copayment program for members of Commercial Rhode Island plans. Members who receive prior authorization for coverage of infertility drugs will pay a 20% coinsurance for each drug they utilize.

### “Dispense as Written” Prescriptions (DAW)

In most instances, Tufts Health Plan members who are prescribed a brand-name drug will receive the generic at the pharmacy and will pay the applicable tier cost share for that generic, unless the prescriber writes a “dispense as written” or “no substitutions” prescription for a brand-name drug, in which case the Tufts Health Plan member may pay the member cost share amount applicable to the brand name drug. In New Hampshire and Rhode Island, the member may elect to fill the brand product and pay a higher member cost share amount if the brand product is covered. In Massachusetts, members do not have the option to self-select to fill a brand name medication.

**Note:** Medications for which there are no generic equivalents will not be affected.

### New-to-Market Drug (NTM) Evaluation Process

Tufts Health Plan delays the coverage determination of [new-to-market \(NTM\) drug products](#) until the P&T Committee has reviewed them. During the evaluation period, which starts when the drug is first available on the market, the P&T Committee reviews the safety and effectiveness of these new drug products as information becomes available. In the interim, if a physician believes a member has a medical need for the drug product, a request can be submitted under the medical review process. If you have questions regarding coverage status of a drug, call Provider Services at 888.204.2404.

### Prior Authorization Programs

The prior authorization program is in place for selected drug products that have a specific indication for use, are expensive, or pose significant safety concerns. A drug may be recommended for placement in the PA program based on various criteria, including, but not limited to:

- Has the potential to be used exclusively for cosmetic purposes
- Is not considered to be first-line therapy by medically accepted clinical practice guidelines
- Has the potential to be used outside of indications granted by the U.S. Food and Drug Administration (FDA)

Drug products under the PA program require prior approval for coverage through the Medical Review Process. For additional information, refer to Tufts Health Plan’s Commercial [pharmacy programs](#) and [pharmacy medical necessity guidelines](#) on the Provider website.

### Step Therapy Prior Authorization (STPA)

Step therapy prior authorization is an automated form of prior authorization that uses claims history for approval of a drug at the point of sale. Step therapy programs help encourage the clinically proven use of first-line therapies and are designed so that the most therapeutically appropriate and cost-effective agents are used first, before other treatments may be covered. Step therapy protocols are based on current medical findings, FDA-approved drug labeling and drug costs.

A drug is placed in a STPA program when it meets one or more of the following criteria:

- Is not considered to be first-line therapy by medically accepted clinical practice guidelines
- Has a disproportionate cost when compared to other agents used to treat the same disease or medical condition.

Some types of step therapy include requiring the use of generics before brand name drugs, preferred before

non-preferred brand-name drugs, and first-line before second-line therapies. Medications included on step one of a step therapy program are usually covered without prior authorization. All other medications subject to step therapy are not covered unless a member tries and fails one or more medications on a previous step, or is unable to tolerate, or has a contraindication to all medications on the previous step.

Members who are currently on drugs that meet the initial step therapy criteria will automatically be able to fill prescriptions for a stepped medication. If the member does not meet the initial step therapy criteria, the prescription will deny at the point of sale with a message indicating that prior authorization is required. Providers may submit prior authorization requests to Tufts Health Plan using the medical review process for members who do not meet the step therapy criteria at the point of sale or who do not have claims history in the Tufts Health Plan system. For more information, including which drugs are currently included in a STPA program, refer to the [Commercial Pharmacy](#) section of the Provider website. Step therapy requirements may be updated periodically.

### Quantity Limitations Program (QL)

The quantity limitations program restricts the quantity of a drug for which a member is covered in a given time period. It also serves to prevent high and/or inappropriate doses of medication at the point-of-sale. These quantities are based on recognized standards of care, such as FDA recommendations for use, and may be updated periodically. Physicians can prescribe the medications within the quantity limitation without having to request prior authorization. If a physician believes that a member needs a quantity greater than the program limitation, a request can be submitted under the medical review process. Refer to Tufts Health Plan's [Pharmacy Programs](#) for additional information.

### Noncovered Drugs (NC)

Certain prescription drugs are not covered because there are safe, comparably effective, less expensive alternatives available. The suggested alternatives are approved by the FDA and are widely used and accepted by the medical community to treat the same condition as those that are noncovered. Tufts Health Plan updates these lists periodically. If a physician believes that a member has a definite medical need to continue on a noncovered drug product, a request can be submitted under the Medical Review Process. Providers should contact Provider Services or refer to Tufts Health Plan's [Pharmacy Programs](#) with any questions regarding specific drugs.

### Designated Specialty Pharmacy Program (SP)

Tufts Health Plan's goal is to arrange for its members to have access to the most clinically appropriate, cost-effective services. We have designated specialty pharmacies to supply a select number of drugs used to treat complex disease states. These pharmacies specialize in providing these drugs and are staffed with nurses, coordinators and pharmacists to provide support services for members. Drugs include, but are not limited to, those used to treat Hepatitis C, growth hormone deficiency, infertility, multiple sclerosis, rheumatoid arthritis and cancers treated with oral drugs. When appropriate, other designated specialty pharmacies and drugs will be identified and added to this program.

Members can obtain up to a 30-day supply of drugs by mail from these specialty pharmacies. For questions about the designated specialty pharmacy program, refer to Tufts Health Plan's online formularies or contact Commercial Provider Services at 888.204.2404.

### Designated Specialty Infusion Program for Drugs Covered Under the Medical Benefit

The designated specialty infusion (SI) program offers clinical management of drug therapies, nursing support and care coordination to members with acute and chronic conditions. Tufts Health Plan has designated specialty infusion providers for a select number of specialized drugs and administration services.

These drugs may be administered in the home or an alternate infusion site, based on the availability of infusion centers and/or determination of the most clinically appropriate site for treatment. These drugs are covered under the member's medical benefit rather than the pharmacy benefit and generally require support services, medication dose management, and special handling, in addition to the drug administration services. Drugs include, but are not limited to, those used to treat hemophilia, pulmonary hypertension, and immune

deficiencies.

Drugs in the designated SI program are listed throughout the formulary with **SI** to indicate inclusion in the program. When appropriate, other designated specialty infusion providers and prescription drugs are identified and added to this program.

## Medical Review Process

Tufts Health Plan pharmacy programs help manage the pharmacy benefit. Requests for medically necessary exceptions to either the programs listed above or drugs on the list of noncovered drugs should be completed by the physician and sent to Tufts Health Plan. The request must include clinical information that supports why the drug is medically necessary for the member. Coverage decisions are made on a case-by-case basis considering the individual member's health care needs. Refer to the [Commercial Pharmacy Prior Authorization Submission by State](#) for information on which prior authorization form to use based on state and product.

For additional information, refer to the [pharmacy medical necessity guidelines](#) posted on the Tufts Health Plan website. If Tufts Health Plan does not approve the request, the member has the right to appeal. The appeal process is described in the member's benefit document.

## CareLink<sup>SM</sup>

Prescription drug information relevant to individual members is found on the back of CareLink ID cards. The prescription drug benefit can be administered by a variety of pharmacy benefits administrators. The member's ID card indicates where the member should be directed for these services.

**Note:** Pharmacy prior authorization requests are reviewed by the appropriate party identified in the [Working with CareLink](#) grid.

## MEMBERS

### New Members

Under most circumstances, members who enroll in Tufts Health Plan must complete a [Member Enrollment Form](#).

To confirm a member's eligibility status, providers and their office staff are required to use self-service channels to verify effective dates and copayments prior to initiating services. However, please note that the information on file may be subject to retroactive reporting of disenrollment (e.g., by the member's employer).

Members receive an identification card as well as benefit materials that contain information on plan benefits, cost-sharing amounts, exclusions, and plan policies and procedures, including the evidence of coverage (EOC), which is made available to the member upon enrollment and annually thereafter.

Depending on plan structure, members may be required to choose a primary care provider (PCP) to arrange for transfer of their medical records, and to arrange for an initial visit as appropriate. To be eligible for any and all covered services, HMO members are required to select a PCP. Without a PCP assignment, HMO members are covered only for emergency services. Refer to the [Guides and Resources](#) section of the Provider website for more specific information on working with Commercial plans.

PCPs receive a monthly report that reflects their membership, including new members. PCPs may elect to proactively contact new members appearing on this list who have not yet contacted their offices. Once a member has chosen a PCP, the provider must be prepared to address all the member's medical needs. In some cases, members require care before they have introduced themselves to the PCP's practice.

Review the member's rights and responsibilities, as they are useful when explaining to members their responsibility for adhering to certain Tufts Health Plan policies, such as not requesting unwarranted out-of-plan referrals. Member's rights and responsibilities from the member's perspective are outlined below. These apply to all products and are outlined in the member's Evidence of Coverage (EOC) or equivalent document.

### Members' Rights and Responsibilities

Tufts Health Plan distributes a Members' Rights and Responsibilities statement to members. There are separate benefit documents for HMO, Point of Service (POS), and Preferred Provider Organization (PPO) members. This reflects the different benefit options among the plans. At their own discretion, POS and PPO members may receive care from an out-of-plan provider and be covered at an unauthorized/out-of-network benefit payment level that includes any applicable deductible and coinsurance. PPO members may seek services outside the Tufts Health Plan network that will be subject to a deductible and coinsurance. In-network services may have an in-network deductible and coinsurance depending on the member's particular plan. For more information, refer to [Our Plans](#).

#### Know the Member's Rights and Responsibilities

As part of our strong commitment to quality care and customer service, Tufts Health Plan wants members to remain informed about their rights and responsibilities as Tufts Health Plan members. We developed the following list to help members get the most out of their memberships. Additional information about the grievance process, policies, procedures, and member records can be found in members' EOCs.

#### Member Rights

- Receive information about Tufts Health Plan including its services, health plan staff and their qualifications, contractual relationships, benefits, member rights and responsibilities, healthcare providers, policies, and procedures
- Be informed by their physician or other healthcare provider regarding their diagnosis, treatment, and prognosis in terms that are understandable
- Receive sufficient information from their healthcare providers to enable them to give informed consent before beginning any medical procedure or treatment
- Have a candid discussion of appropriate or medically necessary treatment options for their condition,

- regardless of cost or benefit coverage
- Participate with practitioners in decisions regarding their healthcare
  - Be treated courteously, respectfully and with recognition of their dignity and need for privacy
  - Refuse treatment, drugs or other procedures recommended by Tufts Health Plan providers to the extent permitted by law and to be informed of the potential medical consequences of refusing treatment
  - Be covered for emergency services in cases where a prudent layperson, acting reasonably, would believe that an emergency medical condition exists
  - Have reasonable access to essential medical services
  - Decline participation in or disenroll from services offered by Tufts Health Plan
  - Expect that all communications and records pertaining to their healthcare are treated as confidential in accordance with Tufts Health Plan's Notice of Privacy Practices
  - Select a doctor from Tufts Health Plan's directory of healthcare providers who is accepting new patients and expect the physician to provide covered healthcare services
  - Obtain a copy of their medical records from their providers, in accordance with the law
  - Use the Tufts Health Plan member satisfaction process described in their benefit document (which include timeliness for responding to and resolving complaints and quality issues) to voice a concern or complaint about the organization or the care it arranges and to appeal coverage decisions
  - Make recommendations regarding the organization's members' rights and responsibilities policy

### Member Responsibilities

- Treat network providers and their staff with the same respect and courtesy that members expect for themselves
- Ask questions and seek clarification to understand their illness or treatment
- Cooperate with Tufts Health Plan so that we may administer member benefits in accordance with their benefit document
- Obtain services from an in-network provider except in a medical emergency, (e.g., a serious injury, or onset of a serious condition that prevents them from calling their PCP in advance)  
**Note:** This applies to HMO and EPO members as well as POS and PPO members seeking coverage at the authorized level of benefits.
- Follow plans and instructions for care that they have agreed to with their practitioners
- Obtain appropriate authorization(s) from their Tufts Health Plan PCP before seeking care, except in the case of urgent/emergency care  
**Note:** This applies to HMO and EPO members, as well as POS members seeking coverage at the authorized level of benefits
- Keep scheduled appointments with healthcare providers or give adequate cancellation notice
- Express concerns or complaints through the Tufts Health Plan member satisfaction process described in their benefit document
- Familiarize themselves with their Tufts Health Plan benefits, policies and procedures by reading distributed materials and by calling Member Services with any questions
- Supply, to the extent possible, information needed by their healthcare providers and Tufts Health Plan and to the practitioners who provide their care
- Participate in understanding their health problems and developing mutually agreed-upon treatment goals, to the degree possible

### Confidentiality of Protected Health Information

As part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Tufts Health Plan follows federal and state regulations to safeguard the privacy of members' protected health information (PHI). Tufts Health Plan's [Notice of Privacy Practices](#) outlines member privacy rights and describes how Tufts Health Plan collects, uses, and discloses PHI. Refer to the [Legal, Security, and Privacy Practices](#) section of our website for more information.

## Patient Self Determination Act

The Federal Patient Self Determination Act requires certain facilities, including HMOs, to document whether or not a member has executed an advance directive. An advance directive is a written instruction relating to the provision of healthcare when the member is unable to communicate their wishes regarding medical treatment. This document is sometimes called a living will, healthcare proxy, or durable power of attorney for healthcare.

To ensure Tufts Health Plan’s compliance with the provisions of the Patient Self Determination Act, Tufts Health Plan requests that the following language be added to, or used with, the member’s standard intake sheet:

Have you executed an advance directive/healthcare proxy? Yes <input type="checkbox"/> No <input type="checkbox"/>
To be completed by office staff: Advance directive/healthcare proxy on file? Yes <input type="checkbox"/> No <input type="checkbox"/> Healthcare agent named in advance directive/healthcare proxy: Name: _____ Address: _____ Telephone: _____

## Member Appeals Process

Tufts Health Plan provides its members, authorized representatives, and treating providers with a process to appeal decisions concerning coverage of healthcare services. Through this process, members, authorized representatives or treating providers can request a review of decisions concerning benefits and coverage. Benefit documents provide specific information on how to access this process.

**Note:** Member appeals may be related to availability of benefits or a claim or part of the utilization management process. Therefore, response is required within the timeframe requested (which may be from one to five business days, depending on the urgency of the appeal) to any requests for additional information that may arise in the course of reviewing an appeal.

Members are initially referred to the Member Services Department, where a member specialist attempts to identify and resolve their concerns. If not satisfied, a member, a member’s authorized representative, or provider on behalf of a member, may request an appeal verbally or in writing, and send it to the Appeals and Grievances Department.

Members, a member’s authorized representative, or providers submitting an appeal on behalf of a member, may also file a verbal appeal with a member specialist, who forwards the information regarding the appeal to the Appeals and Grievances Department. If an authorized representative is acting on behalf of the member, Tufts Health Plan must receive written or verbal authorization from the member prior to initiation of the grievance. An Appeals and Grievances specialist sends a letter acknowledging the receipt of the appeal to the member and requesting provider, and also requests any necessary medical documentation to ensure a thorough review. The Appeals and Grievances specialist coordinates the investigation of the appeal and notifies the member and requesting provider in writing of the determination. A member’s PCP may be copied on the correspondence. In addition, prior to a decision being rendered, the Appeals and Grievances specialist will provide the requester with a copy of the appeal file, which will consist of all information gathered for the appeal, including but not limited to, medical records and consultations, benefit language pertaining to the coverage request and relevant claim information.

If a member of a fully-insured Massachusetts plan is not satisfied with the determination, their case could be eligible for external review by an external review agency contracted with the Health Policy Commission Office of Patient Protection, or, for certain self-insured employer groups, by an Independent Review Organization through a process coordinated by Tufts Health Plan.

A member with a fully insured Rhode Island or New Hampshire plan may have their appeal processed under rules set by the applicable state insurance commissioner (i.e., Rhode Island Office of the Health Insurance



Commissioner [[RI OHIC](#)] or the New Hampshire Insurance Division [[NHID](#)]). If the member is dissatisfied with the determination, their case could be eligible for review by the external agency approved by RI OHIC or NHID, as applicable.

## Member Grievance (Complaint) Process

Tufts Health Plan has established a forum for members to express concerns regarding their experiences with healthcare providers or Tufts Health Plan itself. The member grievance process, developed as part of Tufts Health Plan's Quality Improvement Program, allows for the documentation and investigation of member complaints. It is the member's responsibility to notify Tufts Health Plan of their concerns about their healthcare services. It is the responsibility of all network providers to participate in the quality of care review process.

If an authorized representative is acting on behalf of the member, Tufts Health Plan must receive written or verbal authorization from the member prior to initiation of the grievance. Upon receipt of a verbal or written [member grievance](#), the member is notified in writing that the complaint has been filed and is being reviewed, stating that it will be processed within 30 calendar days (unless an extension is needed and agreed to by the member).

Complaints related to clinical encounters are sent to the Quality Management (QM) Department for review and follow-up. Grievances related to specific clinical interactions or treatment interventions are addressed directly with the provider. Concerns about the office staff or services (e.g., appointment access, timeliness of processing referrals) are generally addressed with the provider's office manager.

Upon receipt of the provider's response, the grievance review team evaluates the information. All clinical grievances are reviewed by a Tufts Health Plan RN specialist and/or a Tufts Health Plan Medical Affairs Department physician. After being reviewed, the grievance is assigned a rating for degree of severity and preventability of the issue of concern. The provider is notified of the results of the review.

All clinical grievances and their respective ratings are entered into Tufts Health Plan's secured quality database for tracking and trending purposes. This data becomes part of the provider's credentialing file and is reviewed periodically.

To enable the completion of the grievance review within the specified time frame, providers are expected to respond to requests for information within five business days, as it is standard for providers to respond to Tufts Health Plan's request for information in investigating member grievances. This response time ensures that Tufts Health Plan meets its regulatory and accreditation requirements to the member and remains compliant with all state and federal requirements.

Some communication between providers and Tufts Health Plan representatives concerning the clinical review of a grievance are considered peer review-privileged information and may not be shared with members. However, members are notified in writing when the review of their grievance has been completed.

## 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.

### 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 quarterly 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. To receive *Provider Update* by email, providers must register by completing the [online registration form](#), available in the News<sup>2</sup> section of the [Tufts Health Plan](#) and the [Tufts Health Freedom Plan](#) public Provider websites. Providers who routinely visit the public Provider websites 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

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<sup>2</sup> Providers who do not register to receive *Provider Update* by email can be mailed copies of the full issue upon request by calling 888.884.2404 for Commercial products (including Tufts Health Freedom Plan).

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 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](#) and the [Tufts Health Freedom Plan](#) public Provider websites.

## 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.

### PCP Monthly Member List

Once a month, Tufts Health Plan provides each PCP with a list of all HMO and POS members who have selected him or her as their PCP. The monthly member list includes member names, 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 quickly 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 recertification is due during the LOA and the practitioner does not complete his or her recertification 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 9166  
Watertown, MA 02472

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 that case, however, 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. For outpatient behavioral health services, Tufts Health Plan provides prior authorization.

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 (NP) and physician assistants (PA) may elect to bill under their supervising or collaborating physician or they may request to have a direct contract with Tufts Health Plan. NPs and PAs may not do both,

i.e., the practitioner may not bill under a supervising/collaborating physician as well as contract independently. They must elect to always do one or the other.

NPs and PAs who are working under the auspices of a licensed physician, as permitted by state law, and for whom the provider and/or facility (e.g., hospital) have met all applicable requirements, can bill for those covered services under the supervising provider's identification number. Or, NPs and PAs may have a direct contract and be credentialed by Tufts Health Plan. Once contracted and credentialed, the NP or PA may be listed in directories and may hold a panel if they practice as a PCP.

For additional 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. Refer to the [Provider Credentialing](#) 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@tuftshealth.com](mailto:Tufts_Health_Plan_Credentialing_Department@tuftshealth.com) 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 send to Tufts Health Plan via email
- Sign W-9 form (initial credentialing only) and send to Tufts Health Plan via email

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:

- 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

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

## 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@tufts-health.com](mailto:Tuft_Health_Plan_Credentialing_Department@tufts-health.com)
  - Mail: Tufts Health Plan  
Attn: Credentialing Department  
705 Mount Auburn Street  
Watertown, MA 02472
- 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.
- Correct erroneous information submitted by another party, and Tufts Health Plan hereby notifies

practitioners of their right to correct erroneous information. Tufts Health Plan will inform the provider how and where to submit corrections.

- 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.

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.

## REFERRALS, AUTHORIZATIONS AND NOTIFICATIONS

### Overview

To help ensure the quality of member care, Tufts Health Plan is responsible for monitoring authorization, medical appropriateness, and cost efficiency of services rendered. Certain services for members enrolled in HMO and POS products require notification, a referral and/or authorization to confirm that the member's primary care provider (PCP) or Tufts Health Plan has approved the member's specialty care services. For HMO members, such authorization is a requirement for coverage, while for POS members it is a requirement for coverage at the authorized benefit level.

A referral verifies that the PCP has authorized the member's care. The PCP is responsible for indicating the number of visits and type of specialty care services authorized. In most cases, a referral is valid in the Tufts Health Plan system for one year, or until the approved number of visits or member's benefit is exhausted.

**Note:** Depending on the service, while you may not be the provider responsible for obtaining prior authorization, as a condition of payment, you will need to make sure that the prior authorization has been obtained.

### Referrals

#### Outpatient Referral Management

The PCP coordinates the outpatient referral management process to help ensure that appropriate specialty care is provided when medically necessary. With the exception of [behavioral health services](#), the PCP can authorize a standing referral to a specialist in the Tufts Health Plan network when all of the following criteria are met:

- The PCP decides that such a referral is medically necessary
- the specialist agrees to a treatment plan and provides the PCP with all necessary clinical and administrative information on a regular basis
- the health care services to be provided are consistent with the terms of the member's benefit document

A referral assures the specialist that the PCP has authorized the member's care. It also authorizes the Tufts Health Plan Claims Department to pay the specialist's claims.

Referrals are valid in the Tufts Health Plan system until one or more of the following criteria are met:

- The approved number of visits is used
- A specified time frame up to one year from the date of referral
- The member's benefit limit has been met
- The member is no longer eligible

**Note:** In some instances, the PCP may indicate a specific date range for the member to receive specialty care services. In these instances, the referral is only valid for the specified date range indicated on the referral. The date range specified may not exceed one year from the date of issuance.

#### Submitting an Outpatient Referral

Tufts Health Plan encourages electronic referral submission through our website for instantaneous receipt of a referral number. To learn more about our web-based offerings, call 888.884.2404 and select the web inquiry option, or email us at [network@tufts-health.com](mailto:network@tufts-health.com).

Tufts Health Plan uses W.B. Mason to print paper referral forms. To order referral forms, fax a completed [W.B. Mason Provider Forms Requisition](#) to W.B. Mason at 800.738.3272 or email to [tuftshealthplan@wbmason.com](mailto:tuftshealthplan@wbmason.com).

Outpatient referrals can be submitted electronically via:

- Secure Provider [website](#) — Register with Tufts Health Plan to take advantage of our online functionality
- [New England Healthcare EDI Network \(NEHEN\)](#) — Refer to the [Electronic Services](#) section of our

- website for additional information
- [Change Healthcare™](#) — Refer to Change Healthcare in the [Electronic Services](#) section of our website for additional information. All services requiring referrals can be submitted via this option.

Outpatient referrals can be submitted on paper by mailing them to the Tufts Health Plan address indicated on the front of the paper referral form. Do not fax referrals for Commercial members to Tufts Health Plan or W.B. Mason.

**Note:** Referrals authorizing more than one visit only have to be submitted once, not with each subsequent date of service billed.

The following table outlines the fields on the paper referral form and gives any special information or instructions needed to complete the form.

**Table 1: Paper Referral Form Fields**

MEMBER INFORMATION	
Field Name	Special Instructions
Member name	First, middle initial, last
Date of birth	
Date of referral	This date must precede the date of service
Member ID	Tufts Health Plan member ID number, from ID card or monthly member list
Is the member on a limited-network plan?	Search <a href="#">Select Network Plans</a> in the Provider Directory

PRIMARY CARE PROVIDER INFORMATION	
Field Name	Special Instructions
Name	PCP's full name is required
Provider NPI	PCP's full NPI is required
Address	
Phone	

SPECIALTY CARE PROVIDER INFORMATION	
Field Name	Special Instructions
Name	Provider's full name is required
Provider NPI	Provider's full NPI is required
Specialty	
Address	
Phone	
Is above provider within the member's network?	Search <a href="#">Select Network Plans</a> in the Provider Directory.

TYPE OF REFERRAL	
Field Name	Special Instructions
Tufts Health Plan provider (in-plan)	Referral made by a PCP to a specialist <b>within</b> the Tufts Health Plan network
Non-Tufts Health Plan provider (out-of-plan)	All out-of-plan referrals require PCP and physician reviewer approvals. State the diagnosis or presenting problem and list any diagnostic studies already performed, and why an in-network provider cannot provide the service(s).

TYPE OF REFERRAL	
	IPA groups that do not have a designated physician reviewer must submit these requests to Tufts Health Plan for review before providing services.
Provider outside member's limited network plan	Referrals to out-of-plan or out-of-network providers require Tufts Health Plan review. <b>Before</b> providing services to Spirit plan or other limited network plan members, specialty care providers <b>outside</b> of the Spirit or limited networks must fax a letter of medical necessity to Tufts Health Plan's Precertification Operations Department at 617.972.9409 for approval prior to providing services.

SERVICES REQUESTED (check one)	
Field Name	Special Instructions
Consultation (one visit only)	Authorizes one specialty visit
Consultation/second opinion only (one visit only)	Authorizes one second opinion visit
Consultation/diagnostic studies	Authorizes up to three visits and includes diagnostics
Consultation/diagnostic studies and treatment	Enter the specific number of visits requested. If left blank, the default allowed is one visit
Number of visits: Physical therapy	1 evaluation and 8 treatment visits
Number of visits: Occupational therapy	1 evaluation and 8 treatment visits
Number of visits: Speech therapy	Provide number of visits
Diagnostic studies to be performed at	Location where diagnostic studies must be performed

Signature of PCP	Required
Authorization Date	Required
Signature of Physician Reviewer (if applicable)	Required for referrals to non-Tufts Health Plan specialists and facilities. <b>For providers outside of the member's limited network plan, a request must be submitted to Tufts Health Plan for review.</b> IPA groups that do not have a designated physician reviewer must submit these requests to Tufts Health Plan for review before providing services.
Authorization Date	Required

### Distribution of Copies – Paper Referral Form

If the PCP office does not submit referrals electronically, the PCP office is responsible for distributing the four copies of the referral authorization form as follows:

Pink: PCP  
 Light yellow: Specialist  
 Dark yellow: Member  
 White: Use a pre-addressed envelope (available at W.B. Mason, phone 508.436.8777) to mail to Tufts Health Plan

### Referral Inquiry

Providers may check the status of an existing referral by using **Referral Status Inquiry** on the Tufts Health Plan secure Provider [website](#). The referral status inquiry tool provides the status of any referral submitted to Tufts Health Plan regardless of how the referral was initially submitted.

## Referral Adjustments

To request an adjustment to a referral that is already in the Tufts Health Plan system, the PCP must contact [Provider Services](#) for assistance. Tufts Health Plan cannot adjust referrals based on the specialist's request. If the specialist would like to request an adjustment to a referral, the specialist should follow up directly with the member's PCP.

## Services that are Noncovered or Provided without Referral or Authorization

Tufts Health Plan requires members to be responsible for obtaining referrals to the extent required under the member's benefit package. For those products requiring such referral authorization or for services that are not covered by Tufts Health Plan, many offices have patients sign acknowledgements to confirm that the member understands this policy. Refer to the Forms section of our website for Tufts Health Plan's [Agreement to Financial Liability form](#). Under the terms of providers' contracts with Tufts Health Plan, balance billing of members (i.e., attempted collection of fees for services other than a member's applicable cost share amount) is prohibited without such an advance written agreement by a member to pay for the noncovered services.

**Note:** A general type of acknowledgement (e.g., "I agree to pay for anything that my insurance does not pay for") is not considered adequate to confirm the member's understanding and acknowledgement to proceed without a required referral or necessary authorization, or that they understand it is not a covered service.

## Out-of-Plan Care

In the rare instance that it is necessary for a HMO or EPO member to be treated by a provider who does not participate in the Tufts Health Plan network (except with respect to products or services that do not require referrals), the paper referral form must be filled out and signed by a PCP and the Authorized Reviewer associated with the PCP's Provider Organization. For PCPs who are not associated with a provider organization, the authorized reviewer is a Tufts Health Plan medical director. If Tufts Health Plan is the authorized reviewer, requests must be submitted prior to providing services. Referrals reviewed by Tufts Health Plan will not be backdated.

Prior to submitting a referral request to an authorized reviewer, the PCP must confirm that a provider in the member's network could not provide a comparable level of care. Referrals that require authorized reviewer approval should be sent directly to the attention of the authorized reviewer before forwarding to Tufts Health Plan.

The authorized reviewer is responsible for reviewing referrals issued to specialty care providers who are not affiliated with Tufts Health Plan or for out of area specialty care services. The authorized reviewer will either approve and sign the referral form or offer an appropriate in-plan provider option.

Additional requirements may be in place for members of Limited Network plans. Refer to the [Paper Referral Form Fields](#) above for additional information with respect to Limited network plans.

**Note:** This does not apply to out of plan behavioral health services.

## Urgent/Emergency Out-of-Area Care

The PCP is not required to issue a referral for treatment of urgent/emergency care while a member is temporarily outside of the service area. A member may be seen at a provider's office, walk-in clinic or emergency department. Members are encouraged to call their PCP to coordinate any follow-up care.

## Behavioral Health and Substance Use Disorder Services

Behavioral health (BH) providers are responsible for submitting notifications for outpatient BH/SUD services from the Behavioral Health Department within 30 days of the first visit of an HMO, EPO or POS member.

For more information regarding outpatient behavioral health services, refer to the [Outpatient Behavioral Health/Substance Use Disorder Professional Payment Policy](#) on our website.

Refer to the Behavioral Health Self-Service User Guide in the [Guides and Resources](#) section of the public Provider website for more information on submitting authorization requests via the secure Provider website.

## Prior Authorizations

Authorization for services, drugs, devices and equipment is based on InterQual® criteria or on medical necessity guidelines.

[Medical necessity guidelines](#) are established and based on current literature review, including InterQual, consultation with practicing physicians in the Tufts Health Plan service area who are medical experts in the particular field, the policies of government agencies such as the FDA, and standards adopted by national accreditation organizations. The guidelines are revised and updated annually, or more frequently as new evidence becomes available that suggests needed revisions. Medical necessity guidelines and InterQual criteria are used in conjunction with the member's benefit plan document and in coordination with the provider recommending the service, drug, device or supply.

**Note:** Refer to the [CareLink](#) chapter for more information on the CareLink prior authorization process.

### Prior Authorization through the Precertification Operations Department

To obtain authorization for a service, device or equipment requiring prior authorization through the Precertification Operations Department, the provider must submit the appropriate clinical documentation for review. As a condition of payment, the **treating** provider is required to submit documentation of medical necessity for services requiring authorization. Documentation should detail:

- The member's diagnosis
- Planned treatment, including specific procedure codes and medical rationale for the service requested
- All pertinent medical information available for review.

Prior authorization requests should be faxed to the Precertification Operations Department at 617.972.9409. When the use of an InterQual SmartSheet is required, it may be submitted without additional supporting documentation unless specifically indicated.

For a more comprehensive list of services that require prior authorization, refer to the [Medical Necessity Guidelines](#) section of the Resource Center.

### Prescription Drugs

Certain prescription medications require prior authorization prior to rendering services. For requests regarding prescription medications that have coverage limitations, refer to the [Commercial Pharmacy Medication Prior Authorization Submission by State](#) grid.

Refer to the [Pharmacy Medical Necessity Guidelines](#) for a list of prescription drugs that require prior authorization.

## Prior Authorizations through Approved Vendors

### National Imaging Associates (NIA)

Tufts Health Plan requires providers to obtain prior authorization through NIA for the services outlined below.

#### **Outpatient High-Tech Imaging and Cardiac Services**

Providers must obtain authorization prior to requesting high-tech imaging and cardiac services in an outpatient setting. Depending on the member's product, providers must call either National Imaging Associates (NIA) or Cigna.

The following services require prior authorization:

- CT/CTA

- MRI/MRA
- PET scan
- Nuclear cardiology
- Echocardiography/stress echocardiography

It is the **ordering** provider's responsibility to obtain prior authorization before scheduling appointments for members. **Rendering** providers will need to ensure that all tests have the required authorization number before the service is performed. Both professional and technical claims for which there is no authorization number will be denied and the member may not be billed for the service associated with the denied claim.

**Note:** Diagnostic imaging and cardiac services performed in the emergency department, observation, and inpatient settings do not require prior authorization. Emergency CT/CTA, MRI/MRA, PET scan or nuclear cardiology procedures rendered at a site other than a hospital ED require notification to NIA within **two business days** of the service.

Refer to the [High-Tech Imaging](#) and [Cardiac](#) prior authorization programs and the [Imaging and Cardiac Program Prior Authorization Management Guide](#) for additional information.

### ***Spinal Conditions Management and Joint Surgery***

Providers must request prior authorization for interventional pain management, lumbar and cervical spine surgeries, and joint surgeries through NIA. Providers may contact NIA for prior authorization through [RadMD](#).

Refer to the [Spinal Conditions Management](#) and [Joint Surgery](#) program pages for more information. For a list of CPT codes subject to prior authorization, refer to the [Spinal Conditions Management and Joint Surgery Program Prior Authorization Code Matrix](#).

### Sleep Studies

Tufts Health Plan requires providers to obtain prior authorization through eviCore healthcare for sleep studies, sleep therapy and/or resupplies. Refer to the [Sleep Studies and PAP Therapy Prior Authorization Program](#) and [Sleep Studies Payment Policy](#) for more information.

## Inpatient Notification

Inpatient notification is a process that notifies Tufts Health Plan of all inpatient admissions. Tufts Health Plan covers medically necessary inpatient services when inpatient notification is given in accordance with the timeframe established by Tufts Health Plan or when applicable, the timeframe as specified by applicable law. Outpatient procedures, including surgical day care and observation services, do not require inpatient notification.

Inpatient notification does not guarantee payment by Tufts Health Plan. Refer to the [Referral, Authorization, and Notification Policy](#) for inpatient notification procedures.

### Inpatient Notification Requirements

As a condition of payment, Tufts Health Plan requires an inpatient notification for any Commercial member who is being admitted for inpatient care regardless of whether Tufts Health Plan is the primary or secondary insurer. Dependent on facility payment contract, an authorization status will be assigned which may or may not include an authorized initial length of stay and an authorized end date for admissions.

Providers may log in to Tufts Health Plan's secure Provider [website](#) to see notifications in real-time 24 hours a day, 7 days a week. If a provider is not web-enabled or registered on the Tufts Health Plan secure website at the time of submission, they may call Provider Services to obtain the inpatient notification number. When the inpatient notification process is complete, the status will be communicated via the secure Provider website. The notification number for coverage confirms the approved inpatient level of care.

**Note:** An inpatient notification does not take the place of a referral or prior authorization requirements for a service/procedure.



## Submission Channels

Providers who are registered on Tufts Health Plan's secure Provider website can request inpatient notification and attach supporting clinical information, 24 hours a day, 7 days a week using the Tufts Health Plan secure Provider [website](#) or New England Healthcare EDI Network (NEHEN), and receive a notification number upon submission in most cases. Providers who are not web-enabled or registered may fax a completed [Inpatient Notification Form](#) to the Precertification Operations Department 24 hours a day, 7 days a week at 617.927.9590 or 800.843.3553. No other forms are accepted. Forms submitted with missing or incomplete information will be returned to the submitting provider for completion and resubmission within one business day. Processing of the request will be delayed until all required information is returned to Tufts Health Plan and may be subject to late notification.

For **elective admissions**, providers must contact the Precertification Operations Department at least five business days prior to admission.

**Note:** Transfers to rehabilitation, skilled nursing facilities (SNFs) or long-term acute care (LTAC) facilities from acute medical facilities are considered elective admissions and providers must submit notification via the channels above as soon as discharge plans are made so as to not delay the transfer.

For **after-hours urgent and emergency admissions**, providers must notify the Precertification Operations Department by 5 p.m. the following business day. For urgent/emergent admissions occurring on weekends and holidays, notification must be made by 5 p.m. the next business day. The inpatient notification number will be viewable on the Provider Inquiry screen by the end of the next business day following the notification.

## Non-Diagnosis Related Group (Non-DRG) payment arrangements

When the inpatient notification process is complete, an authorization status will be communicated with the authorized initial length of stay and an authorized end date. The authorized end date is the date the authorized length of stay ends for the acute inpatient non-DRG admission or extended care (SNF, rehabilitation or LTAC) admission. Tufts Health Plan may provide authorization for coverage of a continued stay if applicable to facility payment arrangements. The inpatient notification number will remain the same throughout the acute hospital inpatient admission.

For extended care admissions, a new inpatient notification and number is created when there is a level of care change (e.g., from R1 to R2 or SNF level I to level II). Inpatient notifications submitted via fax will also be available for viewing on the provider website. The Precertification Operations Department will not routinely fax back inpatient notification numbers to providers. Continued stay requests and the accompanying clinical information must be submitted to Tufts Health Plan **by 5 p.m.** on the day of the authorized end date. Refer to the Continued Authorization section in the [Non-DRG Inpatient Facility Payment Policy](#) for additional information.

## Concurrent Review

For non DRG payment arrangements, regardless of type of approved level of care, the Tufts Health Plan care manager performs concurrent reviews using established criteria.

## Diagnosis Related Group (DRG) payment arrangements

When the inpatient notification process is complete, the inpatient notification status will be communicated. The notification number for coverage confirms that notification has been received.

Requests for continued authorization are not required for an admission paid under a DRG payment methodology once the admission receives an authorized status. Tufts Health Plan may require additional clinical information to review the member's status and anticipated discharge plan throughout the member's hospitalization.

**BH/SUD admissions:** To request additional inpatient days, providers should contact their assigned Tufts Health Plan care manager by 5 p.m. on the day of the authorized end date to review their request. An InterQual® review will be conducted to determine the medical necessity of the request.

**Extended Care Facilities:** To request additional inpatient days, submit the [Extended Care Inpatient Continued](#)

[Stay Clinical Information Form—Initial](#) and for subsequent additional days submit the [Extended Care Inpatient Continued Stay Clinical Information Form—Additional Form](#).

### Required Inpatient Notification Time

Admitting providers and hospital admitting departments are responsible for notifying Tufts Health Plan. All inpatient admissions require notification to Tufts Health Plan in accordance with the following timelines:

- Elective admissions must be reported no later than five business days prior to admission.
- Urgent or emergent admissions must be reported within one business day.

### After-Hours Urgent and Emergency Admissions

While prior authorization is not required for urgent and emergency admissions occurring after business hours, on weekends and holidays, such admissions are subject to the same notification requirements described above. Providers may use the following resources 24 hours a day, seven days a week to notify Tufts Health Plan of a member admission after hours:

Log in to the secure Provider [website](#)

Access [New England Healthcare EDI Network \(NEHEN\)](#) (the provider must be a NEHEN member)

Fax a completed [Inpatient Notification Form](#) along with supporting clinical documentation to the Precertification Operations Department at 617.972.9590 or 800.843.3553

**Note:** PPO members whose care is managed through the Private Health Care Systems (PHCS, also known as Multiplan) network are approved for inpatient services through American Health Holding (AHH). For additional information, contact [American Health Holding or call 866.415.7143](#).

### Obstetrical and Newborn Inpatient Notifications Procedure

Obstetrical admissions that will result in the planned delivery of a newborn do not require inpatient notification. Well newborns are covered under the mother's inpatient notification for delivery. Inpatient notification for sick newborns who will be staying in the hospital beyond the mother's discharge date must be performed **separately** within one business day following the discharge of the mother.

Inpatient notification is required for obstetrical admissions that are likely to exceed the mandated minimum of 48 hours for a vaginal delivery or 96 hours for a cesarean delivery. Inpatient notification is not required if emergency room or observation care occurs without an inpatient admission. Obstetrical admissions that are not for a planned delivery are subject to Tufts Health Plan's notification requirements.

Inpatient admission notification for pregnant women with multiple inpatient admissions must be performed for **each** admission up to the actual delivery.

Pregnant women must be registered with our Health Programs department for delivery by 20 weeks gestation to receive full maternity benefits. To submit an inpatient notification, complete the [Prenatal Registration Form](#) and fax it to the Health Programs Department at 617.972.9417. Refer to the [Obstetrics/Gynecology Payment Policy](#) for more information.

**Note:** Obstetrical care management services are available to assist high-risk members and manage antepartum care during their pregnancy. When the member's obstetrician completes the Prenatal Registration Form, a Tufts Health Plan care manager may enroll the member in the obstetrical care management program, if applicable.

### Rescheduled Elective Admissions

If an elective admission is rescheduled, fax the change to Precertification Operations at 617.972.9590 or 800.843.3553 within the reporting time frame guidelines outlined in the Required Inpatient Notification Time section above.

### Admission to an Out-of-Plan Facility

When an HMO member requires an elective admission to an out-of-plan facility, approval for the admission must be obtained from both the PCP and physician reviewer prior to the admission.

For HMO members assigned to a designated facility (DF), inpatient BH/SUD care must be provided or arranged by the member's DF. Admission to an out-of-plan facility within the service area requires approval from the member's DF or Tufts Health Plan. For additional benefit and eligibility information call the Tufts Health Plan Behavioral Health Department at 800.208.9565 or the member's DF.

### Payment and Denials

Only those hospital-based inpatient days of which Tufts Health Plan has been notified in accordance with requirements are eligible for payment by Tufts Health Plan. Notification of emergency admissions within the next business day (or as required by law), following hospitalization are considered to have a valid notification. Denial of payment for not following the inpatient notification policy will apply to both the hospital and related physician services. Denial of payment to physicians may be waived when the admission was the result of an emergency.

**Note:** Payment denial for lack of notification does not apply to BH/SUD admissions.

Providers who are denied payment due to lack of inpatient notification cannot bill the member. However, providers can exercise their right to dispute payment by submitting a provider payment dispute using the claim adjustments tool on the secure provider website. Providers who are not registered users of the secure website may go to the secure Provider [website](#) and follow the instructions. Providers may also submit a provider payment dispute by mailing a [Request for Claim Review Form \(v1.1\)](#) to Tufts Health Plan. Refer to the [Provider Payment Dispute Policy](#) for additional information on submitting disputes.

## Outpatient BH/SUD Services

### Coverage

Members' benefits vary according to employer group; members must refer to their evidence of coverage (EOC) or equivalent plan document to determine their specific benefits. Benefit information can also be found by logging on to the secure Provider [website](#) and checking member eligibility, by calling the Behavioral Health Department at 800.208.9565 or by calling the number listed on the member's card.

Some employer groups elect to "carve-out" inpatient and outpatient BH/SUD benefits and contract them to a separately funded and administered managed BH plan. In such situations, the BH carve-out firm is responsible for the provision and maintenance of its own BH provider network. Tufts Health Plan is not responsible for the compensation by or administration of such carve-out plans.

Carve-out information is displayed on the member's ID card: the name is on the front and the telephone number is on the back.

### Provider Responsibilities

Members whose EOC or equivalent plan document does not include coverage for out-of-network services must see a provider in the Tufts Health Plan network, except in highly unusual circumstances where the services are not available from an in-plan provider. Tufts Health Plan must review and approve any such situations in order for services to be covered. Members with out-of-network coverage must see a provider in the Tufts Health Plan network in order to obtain the authorized level of benefits. A Tufts Health Plan outpatient BH/SUD provider must notify the Tufts Health Plan Behavioral Health Department within 30 days of the member's first visit.

To submit notification, BH/SUD providers can:

- Log in to the secure Provider website
- Call 800.208.9565 to use the IVR system

**Note:** The member or the member's PCP can also provide notification. However, it is the responsibility of the contracted BH/SUD provider to ensure that notification has been given of the services.

Initiation of outpatient psychotherapy does not require medical necessity review. Providers must notify Tufts Health Plan that services have been started and a number of visits will be covered with no utilization management. To notify Tufts Health Plan of initiation or continuation of services, BH/SUD providers can use the submission channels above.

When members who have an unauthorized level of benefits use their unauthorized level of benefits by receiving services with a noncontracting provider for routine outpatient BH/SUD services, neither members nor their provider are required to notify Tufts Health Plan. However, the member is responsible for applicable cost share in accordance with their benefit plan.

If a member is discharged from a Tufts Health Plan designated facility (DF) to new outpatient services, the DF program may call a Tufts Health Plan BH staff member to request a list of contracted BH/SUD providers. The provider is responsible for providing notification. If necessary, the BH/SUD provider can subsequently request further visits from Tufts Health Plan as described above.

### Backdating Notifications

The Behavioral Health Department allows notifications to be backdated up to 30 calendar days. Members, or someone acting on a member's behalf, may provide notification for outpatient services. However, it is ultimately the responsibility of the treating provider to notify Tufts Health Plan within this time frame.

The start date for requests for continued treatment (Behavioral Health Clinical Service Request [BHCSR] requests) obtained through the Tufts Health Plan website or IVR systems can also be backdated up to 30 calendar days.

### Psychological and Neuropsychological Testing

Psychological and neuropsychological testing requires prior authorization for all products with the exception of CareLink<sup>SM</sup>. To request prior authorization, providers must complete the [Psychological and Neuropsychological Assessment Supplemental Form \(Standard Form\)](#).

### Inpatient and Intermediate Level of Care Services for BH/SUD

Tufts Health Plan provides coverage for BH/SUD inpatient, acute residential, partial hospitalization and intensive outpatient services, as defined by the member's evidence of coverage (EOC) or equivalent plan document.

Tufts Health Plan has established a Designated Facility (DF) Program for HMO members. [BH/SUD Designated Facilities](#) are a subset of Tufts Health Plan contracting facilities that are responsible for managing and coordinating both inpatient and intermediate levels of care for members in certain products.

To determine the DF that a given member must use for BH facility-based care, log on to the secure Provider website to check member eligibility, or call the Tufts Health Plan BH Department at 800.208.9565 to access the IVR.

### BH Services for Children and Adolescents

Tufts Health Plan provides coverage for Behavioral Health Child and Adolescent (BHCA) services for members up to age 19, consistent with Massachusetts regulations. Refer to the [BHCA program information](#) page for more information on these services, including provider credentialing requirements and medical necessity guidelines. More information on authorization requirements and billing specifics may be found in the [Inpatient and Intermediate BH/SUD Payment Policy](#).

### Services to Treat SUD for Members Assigned to a DF

For SUD, Tufts Health Plan covers the cost of acute treatment services, clinical stabilization services, acute residential treatment, partial hospitalization services and intensive outpatient programs provided or authorized

by the member's DF according to the member's EOC or equivalent plan document.

### Inpatient BH/SUD Inpatient Notification Procedure

Emergency admissions do not require prior authorization. However, notification is required within 24<sup>3</sup> hours of admission (or as defined by law). BH/SUD inpatient admissions are subject to the same [inpatient notification](#) protocols as other inpatient services. For admissions, urgent and emergency admissions are defined as direct admission from the facility's emergency room.

**Note:** In accordance with M.G.L. Chapter 258, Section 17N, medically necessary acute treatment and/or clinical stabilization services are covered without inpatient notification for up to 14 consecutive days for members of Massachusetts plans.

All BH/SUD admissions require benefit and eligibility review by the Behavioral Health Program.

### Intermediate Levels of Care BH/SUD Registration Procedure

All intermediate levels of BH/SUD care require authorization through the member's DF. For members not assigned to a DF, authorization is received through the Tufts Health Plan Behavioral Health Department.

Providers can obtain authorization (or when applicable laws permit, provide notification) for intermediate levels of care by calling the BH Department at 800.208.9565. DFs can notify Tufts Health Plan of an admission by logging on to the secure Provider [website](#).

### Outpatient Prior Authorization Information

Tufts Health Plan requires prior authorization for certain specialty services, drugs, devices and equipment as a condition of payment. Authorization is based on InterQual<sup>®</sup> criteria or on medical necessity criteria, as outlined in the [medical necessity guidelines](#) located in the Provider Resource Center. Medical necessity guidelines and InterQual criteria are used in conjunction with the member's benefit plan document and in coordination with the provider recommending the specialty service, drug, device or equipment.

**Note:** While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

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<sup>3</sup> 48 hours for members of Massachusetts plans.

## CLAIM REQUIREMENTS, COORDINATION OF BENEFITS AND PAYMENT DISPUTES

### General Payment Information

Tufts Health Plan processes completed claims that meet the conditions of payment and that are submitted within the time frames required. "Completed claims" have been submitted in industry-standard electronic formats with all required fields accurately entered or on industry-standard paper claim forms and are legible with all required fields accurately completed (as described in this chapter).

Additional [payment policies](#) and clinical coverage criteria are available for many specific services on Tufts Health Plan's public Provider website. To ensure accurate claims processing, providers and their office staff must follow these documented policies. For initial claims submission and additional information, refer to the [Tips for Avoiding Administrative Claim Denials](#).

### Payment of Claims

"Clean claims" must also meet the following conditions of payment:

- The billed services must be:
  - Covered in accordance with the applicable benefit document provided to Tufts Health Plan members who meet eligibility criteria
  - Provided or authorized by the member's primary care provider (PCP) or the PCP's covering provider in accordance with the applicable benefit documents, or identified elsewhere in the provider's agreement with Tufts Health Plan (if applicable), or authorized by Tufts Health Plan and in compliance with the provider agreement
  - Provided in an emergency in accordance with the member's benefit document
  - Medically necessary as defined in the member's benefit documents
- Both paper and electronic claims must be received by Tufts Health Plan, as evidenced by a Tufts Health Plan claim number, within the 90-day filing limit from the date of service (for outpatient or professional claims) or the date of discharge (for inpatient or institutional claims).
- For those inpatient admissions and transfers for which Tufts Health Plan requires notification, the notification must be submitted in accordance with Tufts Health Plan's Referral, Authorization and Notification Policy.
- The services were billed using the appropriate CPT and/or HCPCS codes or other codes assigned by Tufts Health Plan.
- In the case of professional services billed by the hospital, services were billed electronically or on CMS-1500 forms with a valid CPT/HCPCS code.

### Electronic Data Interchange

Electronic data interchange (EDI) allows providers to submit electronic transactions to Tufts Health Plan. This commonly refers to claim, referral and eligibility transactions but may be applied to other transaction types as well.

Tufts Health Plan supports a number of EDI methods for claims, including:

- Direct submission (ANSI X12N 837 claim format); for additional information, refer to the [HIPAA 837 Companion Guide](#) for direct submitters
- Submissions from a variety of external clearinghouse sources

**Note:** Prior to submitting claims to Tufts Health Plan, providers must register their National Provider Identifier (NPI) directly with Tufts Health Plan.

## Claims that Cannot Be Submitted via EDI

At this time, the following claim types cannot be loaded electronically into the Tufts Health Plan computer system:

- Providers who submit claims without a registered NPI
- Dental (ADA form), if applicable
- Pharmacy

## Receipt of Claims

### EDI Claims

The date of receipt is defined as the day the claim is processed at Tufts Health Plan, resulting in a Tufts Health Plan claim number being assigned to the claim. Proof of receipt is supported by the 277CA report, acceptance report or explanation of payment (EOP).

**Note:** Patient account ledgers are not considered appropriate proof of submission for electronic claim submissions.

### Paper Claims

The “date of receipt” of paper claims is the earlier of:

- The date indicated on a receipt of delivery signed by a Tufts Health Plan representative when paper claims are sent via hand delivery, registered mail, or some other means requiring a signed receipt. The provider must maintain a log that clearly identifies all claims requiring signed receipts included in each filing. Said log must be available for inspection by Tufts Health Plan upon reasonable notice to the provider.
- OR**
- The date the claim is recorded as received by Tufts Health Plan or three business days after the day that the claim is recorded by the provider as sent to Tufts Health Plan when claims are not sent by a means requiring a signed receipt. Such recording must be documented by means of a written log or patient account ledger maintained by the provider in the ordinary course of business. Said log or patient account ledger must be available for inspection by Tufts Health Plan upon reasonable notice to the provider.

## Paper Claim Submission Requirements

Tufts Health Plan does not waive requirements for completing mandatory fields on paper claim forms. Those fields are noted in the detailed specifications for submitting UB-04 and CMS-1500 claims in this chapter.

All paper CMS-1500 and UB-04 claims must be submitted on standard red claim forms. Black and white versions of these forms, including photocopied versions, faxed versions and/or resized representations of the form that do not replicate the scale and color of the form required for accurate OCR scanning, will not be accepted and will be returned with a request to submit on the proper claim form.

Submitted forms deemed incomplete will also be rejected and returned to the submitter. The rejected claim and a letter stating the reason for rejection will be returned to the submitter, and a new claim with the required information must be submitted for processing.

For all Commercial claims:

- Diagnosis codes must be entered in priority order (primary, secondary condition) for proper adjudication. Up to 12 diagnosis codes will be accepted on the CMS-1500 form, but consistent with our current policy, only the first code will be used for claim processing.
- Providers should submit industry-standard codes on all paper claims.
- Paper claims will be rejected and returned to the submitter if required information is missing or

invalid. Common omissions and errors include, but are not limited to, the following:

- Illegible claim forms
- Member ID number
- Date of service or admission date
- Provider signature (box 31 in CMS-1500 form)
- Provider Tax ID

If a claim is rejected, the provider must resubmit a corrected claim no later than 90 days from the date of service for all Commercial products. Paper claims should be submitted on industry-standard paper claim forms, with all required fields completed accurately and clearly. All paper claims must be submitted on an original red claim form.

**Note:** Unreadable claims may be returned to the submitting provider.

## Billing Requirements for Hospital Outpatient Services

CMS-1500 and UB-04 forms are the acceptable standard for paper billing; the ANSI X12N 837 claim transaction is the acceptable standard for electronic billing. All providers must use the most current ICD-CM diagnosis codes and valid CPT/HCPCS procedure codes, unless otherwise specified by Tufts Health Plan.

To be appropriately compensated when a hospital bills for professional services in addition to facility and ancillary services for clinic visits, including behavioral health and/or substance use disorder (BH/SUD) services, claims must be submitted on the appropriate form types, as specified below.

Service	Paper	Electronic
Facility/clinic/room charges inclusive of professional component (outpatient only)	CMS-1500	837 Professional
Facility and/or ancillary services	UB-04	837 Institutional
Emergency department (ED) professional services	CMS-1500	837 Professional
ED facility and ancillary services	UB-04	837 Institutional

## Eligibility Inquiry

Providers and their office staff should use self-service channels to verify member effective dates and cost share. Calls from offices that elect not to use a self-service tool and continue to call Provider Services for basic eligibility inquiries will be transferred to our interactive voice response (IVR) system to complete eligibility verification. The following self-service channel options are available to providers:

- Web-based eligibility status via the secure Provider [website](#)
- New England Healthcare EDI Network (NEHEN) and NEHENNET
- Status information via the provider's clearinghouse
- IVR — call 888.884.2404

## Online Adjustment Requests

Provider Services call center staff is unable to process claim adjustment requests. Registered providers may submit claim adjustments using the secure provider [website](#). Providers who are not currently registered may follow the instructions to become a registered user.

Adjustment requests can be made online for the following reasons:

- Corrected claims
- [Dispute](#) a denial or compensation amount
- Return funds to Tufts Health Plan

Follow the instructions when submitting online claim adjustments. After the transaction has been completed, providers will receive a tracking number as confirmation. If submitting supporting documentation on paper that corresponds to an online claim adjustment, include the online tracking sheet so that the claim may be properly



adjudicated.

**Note:** Some claims may not be adjustable online. If a claim cannot be adjusted online, a message will appear indicating this.

Providers who do not use the online claim adjustment tool must submit their adjustment requests via EDI<sup>4</sup> or mail by following the appropriate process outlined in the [Provider Payment Dispute Policy](#).

Claim corrections submitted by EDI for late charges (frequency code 5), replacement claims (frequency code 7) and/or voided claims (frequency code 8) must include the original Tufts Health Plan claim number. The original claim number should be 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 outlined in the [Provider Payment Dispute Policy](#) 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

## Explanation of Payment

The EOP is a weekly report of all claims that have been paid, pending or denied to that provider. This form is identified by the Tufts Health Plan logo and shading. The EOP also includes a summary of claims in process that indicates claims that Tufts Health Plan has received, but may require additional review or information before being finalized in the system. EOPs may be viewed electronically by logging on to the [PaySpan Health](#) website; electronic versions of EOPs are available for download and printing on the PaySpan website.

## Electronic Remittance Advice

Tufts Health Plan offers the 835 Health Care Claim Payment Advice through PaySpan Health. This electronic remittance advice (ERA) includes paid and denied claims submitted either via EDI or on paper forms and uses HIPAA-standard reason codes.

PaySpan Health provides support for this process. All registration and support questions for retrieving an 835 from PaySpan Health is handled by PaySpan's Health Provider Support Team via their [website](#) or by calling 877.331.7154, option 1. Provider support team specialists are available Monday–Friday from 8 a.m.–8 p.m., EST.

Table 1: EOP Field Definitions

Field Name	Explanation
Total payment summary	Breakdown of services billed
Total amount billed	Total amount billed for services
Total amount allowed	Total amount allowed for services billed listed on the EOP
Total member responsibility	Total amount of member responsibility applied for services billed
Total amount paid	Total amount paid for services billed
Total amount unpaid	Total amount unpaid for pending services only (this field excludes finalized denied services)
Patient name	Member's name
Patient ID	Member's Tufts Health Plan ID number

<sup>4</sup> Does not apply to CareLink<sup>SM</sup> claims when Cigna is the primary administrator.

Field Name	Explanation
Account	Member's account number assigned by the provider
Claim#	Tufts Health Plan assigned claim number
Provider name	Provider who rendered the service
NPI	Rendering provider's NPI number
Service date	Date of service
POS	Place of service
#Svc	Number of services
Modifiers	Modifiers billed for services
Amount billed	Amount billed
Amount allowed	Contractual reimbursement amount
Total Retention	Retention amount held until year-end to protect against incurred deficits. <b>Note:</b> This field displays only when applicable
Member responsibility	Copayment, deductible and/or coinsurance charges
Amount paid	Amount paid by Tufts Health Plan
Pay code	Most claims will be identified by a pay code and message for paid, denied and/or pending claims <b>Note:</b> Not all claims will have a pay code listed if the claim is in pending status

## Claims Follow-Up

Payspan Health generates a weekly Summary of Claims in Process report that shows all claims received to date and in the payment process. The Summary of Claims in Process report looks like the EOP reports, with the following exceptions:

- "SUMMARY OF CLAIMS IN PROCESS" appears at the top of the barred section
- Pay codes display a pending message rather than a payment or denial message

All entries on the Summary of Claims in Process report will appear on the EOP once the claim has been adjudicated. If a submitted claim does not appear on either the EOP or the Summary of Claims in Process report within 30 to 45 days, verify the claim was received by logging on to the secure Provider [website](#) or by contacting [Provider Services](#). If the website or the Provider Services Department confirms that Tufts Health Plan has not received the claim, resubmit another claim electronically or on paper to the appropriate initial claims submission address within the timely filing deadline.

## Electronic Claims Follow-Up — 999 and 277CA Reports

- Direct Submission — Reports are posted online within 72 hours of transmission to Tufts Health Plan. The reports must be reviewed for error messages daily and stored for future reference. If a claim is rejected, it must be corrected and submitted within the 90-day filing limit.
- If the claim has not appeared on your EOP or electronic remittance, review the original transmission report.
- ABILITY — Claims accepted or rejected by ABILITY can be reviewed in the provider's LinkMail Box.
  - For more information, refer to the user manual on the [ABILITY](#) website
- Clearinghouses — Clearinghouses offer the following reports:
  - Claims accepted or rejected by the clearinghouse. This report is typically available one to two business days after the electronic submission.
  - Claims accepted or rejected by Tufts Health Plan. This report is typically available through the clearinghouse three to five business days after the initial claims submission.

**Note:** Providers are responsible for retrieving transaction reports from Tufts Health Plan and the clearinghouse.

## Filing Deadline Policy

### Professional or Outpatient Services

The filing deadline for claims submission for all Commercial products is 90 days from the date of service. This includes the following products:

- Health Maintenance Organization (HMO)
- Exclusive Provider Options (EPO)
- Point of Service (POS)
- Preferred Provider Organization (PPO)
- Tufts Health Freedom Plan

### Inpatient/Institutional Services

The filing deadline for institutional claims submission for all Commercial products is 90 days from the date of hospital discharge.

### Coordination of Benefits

In the case of multiple insurance carriers, the filing limit for claims submissions is 90 days from the date of the primary insurer's explanation of benefits (EOB). The EOB from the primary insurer must be submitted with the claim when Tufts Health Plan is the secondary payer.

**Note:** Tufts Medicare Complement (TMC) and Medicare Complement Plan (MCP) do not have a filing limit.

### Filing Deadline Adjustments

Documented proof of timely submission must be submitted with the [Request for Claim Review Form \(v1.1\)](#) and payment of a claim that was previously denied due to the filing deadline.

The following are considered acceptable proof of timely submission for paper claims submissions:

- Copy of EOB/EOP from the primary insurer that shows timely submission from the date that carrier processed the claim
- Copy of patient account ledger that shows the date that the member was billed, if insurance information is not made available by the member
- Copy of EOP from another carrier if the member did not identify themselves 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 Worker's Compensation denial received by Tufts Health Plan within 90 days of the date of the denial

The following are considered acceptable proof of timely submission if the claim was submitted electronically:

- Providers who submit claims through a clearinghouse or ABILITY must send a copy of the report that shows that the claim was accepted at Tufts Health Plan with a claim number.
- Providers who submit directly to Tufts Health Plan or through a clearinghouse must send the corresponding EDI vendor or clearinghouse claim acknowledgement report or HIPAA 277CA showing that the claim was received by Tufts Health Plan as evidenced by a Tufts Health Plan claim number.

The following are not considered to be valid proofs of timely submission:

- Copy of original claim form
- Copy of transmission report indicating a rejection or error

**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 proof since each denial is based on the current message code on the claim.

### 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.

### 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 received by Tufts Health Plan within 90 days of the date of service (for professional or outpatient claims) or date of discharge (for inpatient or institutional claims).

### Retroactive Denials

Effective for behavioral health claims received on or after July 1, 2019, Tufts Health Plan may reprocess claims in accordance with our adjudication guidelines to ensure appropriate payment for services rendered. In accordance with [state law](#) governing Massachusetts-based fully insured plans and the Group Insurance Commission (GIC), Tufts Health Plan sends notification to behavioral health providers in Massachusetts and allows 30 days for a response prior to retroactively denying or adjusting claims to reduce payment for behavioral health services. If communication is not received from the provider within 30 days (15 days for coordination of benefits or worker's compensation claims), the claim will be readjusted and processed.

### Provider Compensation/Reimbursement Disputes

If a provider disagrees with the reimbursement, methodology, or maximum number of units allowed for a procedure, a payment dispute with a copy of the EOP and appropriate supporting documentation may be submitted using the online claim adjustment process described earlier in this chapter. Providers may also follow the paper dispute process outlined in the [Provider Payment Dispute Policy](#).

### Provider Payment Disputes

If a provider disagrees with Tufts Health Plan's decision regarding the denial of a claim that was not allowed due to the lack of prior authorization or inpatient notification, the provider can file a request for reconsideration, using the online claim adjustment process. If submitting a paper request for reconsideration of a denied claim, include a completed [Request for Claim Review Form \(v1.1\)](#) and follow the process outlined below.

#### Provider Payment Dispute Procedure

##### **Required documentation**

Letters requesting reconsideration must include or be accompanied by the following or the request will be returned to the provider pending receipt of the necessary information:

- A typed request detailing all information pertinent to the particular case, as well as any necessary clinical documentation
- A copy of the claim and EOP

Any pertinent information, such as an explanation indicating why the proper procedure to obtain notification or prior authorization was not followed, or an explanation and proof indicating how the proper procedure was followed

For the proper handling of written requests from any in-plan provider for reconsideration of any claim that was denied due to the lack of prior authorization or inpatient notification, refer to the [Provider Payment Dispute Policy](#).

Tufts Health Plan considers relevant supporting documentation to be the copy of the provider's original information faxed/submitted to Tufts Health Plan, as well as any relevant medical records. If authorization is applicable, include the authorization number received verbally or in writing from Tufts Health Plan.

Within 10 business days of receipt of all required documentation, a letter is sent to the provider acknowledging receipt and explaining that a written response will be forthcoming that explains the decision.

A written response outlining the decision typically is sent to the provider within 45 days of the receipt of all documentation. In certain situations, this time frame may be extended by Tufts Health Plan to allow for information gathering, chart review and/or claims adjudication.

## Coordination of Benefits

Regardless of whether Tufts Health Plan is the primary or secondary insurer, members must follow plan procedures to receive benefits. For additional information, refer to the [Coordination of Benefits Policy](#).

## Motor Vehicle Accidents

Tufts Health Plan coordinates with auto insurance coverage, including personal injury protection (PIP) and/or Medical Payment (MedPay) on claims for services rendered as a result of a motor vehicle accident (MVA).

**Members living in Massachusetts:** Motor vehicle insurance is the primary insurance until all benefits are exhausted:

- Up to \$2,000 PIP for members covered under an insured plan; or
- Up to \$8,000 PIP and MedPay for members covered under a self-insured ERISA-qualified plan
- MedPay is primary for members covered under a self-insured ERISA plan and secondary for Commercially insured plans.

**Members living in New Hampshire:** Tufts Health Plan is the primary insurance for Commercially-insured plans and secondary for members covered under a self-insured ERISA-qualified plan.

**Members living in Rhode Island/covered by Rhode Island group coverage:** Motor vehicle insurance (i.e., no-fault coverage) is the primary.

If providers choose to obtain payment from the motor vehicle insurer, they should bill the insurer directly. If further payment is requested after receiving the insurer's statement or check, providers must submit a copy of the auto carrier's documents (i.e., PIP exhaust or benefit denial letter) along with the claim(s) to Tufts Health Plan within the 90-calendar day filing deadline date from the date the statement or check was issued.

Members cannot be required to pay up front; however, if it is a motor vehicle claim, providers may bill the member's motor vehicle insurer under PIP and/or Medpay benefits.

Under the provider's Tufts Health Plan contract, providers may not balance-bill the member or file a lien against the member's third-party settlement or judgment.

**Note:** Do not bill the member or the member's attorney directly even if requested by either of them. If a provider chooses to bill the member or attorney directly, it is done so at the provider's own risk.

The following applies to claims for services rendered as a result of a motor vehicle accident:

- Claims should not be submitted beyond the filing deadline from the date on the auto insurer's notification of benefit payment, denial, or exhaustion
- Claims should be submitted with dated notification from the auto insurer that benefits have been paid, denied or exhausted
- Inpatient notification procedures for any inpatient admissions resulting from an MVA, regardless of whether or not Tufts Health Plan is the primary or secondary insurer. Refer to the Referrals, Authorizations and Notifications chapter for additional information.

**Note:** Tufts Health Plan does not routinely compensate conditional bills.

## Subrogation

Subrogation is a liability recovery activity in which medical costs that are the result of actions or omissions of a third party are recovered from the third party (and/or their insurer).

Tufts Health Plan has outsourced subrogation recovery services to The Rawlings Company in Louisville, Kentucky. As a result providers could receive correspondence from Rawlings related to duplicate claim payments (e.g., Tufts Health Plan and a motor vehicle carrier). Inquiries related to such claims should be directed to the Rawlings Company representative at the number indicated on the correspondence. All other subrogation questions must be directed to Provider Services at 888.884.2404.

## Workers' Compensation

Members who require services due to an employment-related injury or illness should have bills directed to the member's workers' compensation carrier.

### **Services Not Covered**

Tufts Health Plan does not cover or coordinate payments for employment-related injuries. If a member indicates that services received are employment related, Tufts Health Plan will deny claims related to the illness or injury, even if the member has not filed a workers' compensation case with their workers' compensation carrier, or if the proper authorization was not obtained from the workers' compensation carrier. The member is responsible for the charges. Although Tufts Health Plan may deny coverage, we may not always have the most up-to-date information regarding the carrier that will be covering the claims.

### **Collect Sufficient Information**

Providers treating a Tufts Health Plan member who has indicated the diagnosis is employment-related should collect sufficient information regarding the member's employer, in addition to the injury or illness, to submit a claim to the appropriate workers' compensation carrier. When the service is considered urgent or emergent, the member should be instructed to file a claim with his or her employer as soon as possible. In some cases, the workers' compensation carrier may require authorization for services to be covered. Please work with the member and/or workers' compensation carrier to understand the requirements.

### **When Workers' Compensation Claims Deny**

If a member seeking treatment indicates the services are employment-related and the workers' compensation carrier denies the charges as being unrelated to employment, Tufts Health Plan will consider payment when the appropriate denial from the workers' compensation carrier is submitted with the claim. Tufts Health Plan policies regarding referrals and authorizations will be applied. The denial should be on the workers' compensation carrier's letterhead and should specifically state that the injury is not related to a worker's compensation case. Filing limits apply in these cases. Claims must be sent to Tufts Health Plan within 90 days from the date of the denial from the worker's compensation carrier.

## Miscellaneous Billing Tips and Guidelines

- All paper CMS-1500 and UB-04 claims must be submitted on official red claim forms. Black and white versions of these claim forms (including photocopied versions, faxed versions, and/or resized representations of the form that do not replicate the scale and color of the form required for accurate OCR scanning) will not be accepted and will be returned to the address listed in Box 33 (on CMS-1500 forms) or Box 1 (on UB-04 forms) with a request to resubmit on the proper claim form.
- Do not highlight (e.g., on attachments). When scanned, highlighting becomes black and renders the document illegible. An alternative would be to circle the relevant information.
- New technology for scanning/imaging claims and referrals require that print is legible for a quality image (not too light or too dark). Please change ribbons regularly. It is also important for the print to be "on line." This means the type should fit within the appropriate box and that the numbers should not cross lines.

- Avoid sending carbon copies, faxes and attachments that are smaller than 8.5 by 11 inches.

## UB-04 Claims

The following pages contain information regarding UB-04 claims, including a copy of the UB-04 form, specifications for each field of the UB-04 form, and the Type column, which indicates whether a particular field is mandatory (M), optional (O) or not applicable (N/A).

**Note:** Claims that do not have all mandatory fields completed will be rejected and returned to the submitter.

### UB-04 Claim Form Field Specifications

Box	Field Name	Type	Instructions
1	Untitled	M	Enter the name and address of the hospital/provider.
2	Untitled	M	Enter the address of payee if different from the address in box 1
3a-b	Patient control number	O	3a: Enter member account number 3b: Enter medical record number
4	Type of bill	M	Enter the 3-digit code to indicate the type of bill Note: Claim will be returned if this field is not completed
5	Federal tax number	M	Enter the hospital/provider federal tax ID. <b>Note:</b> Claim will be returned if this field is not completed
6	Statement covers period	M	Enter the beginning and ending service dates of the period covered by this bill (MMDDYY). These dates are necessary on all claims. For services received on a single day, both the "from" and "through" dates will be the same. If the "from" and "through" dates differ, then Tufts Health Plan requires these services be itemized by date of service (see Box #45).
7	Untitled	N/A	Not applicable
8a	Patient Name and ID	M	8a: Enter member ID number 8b: Enter the member's last name, first name and middle initial, if any, as shown on the Tufts Health Plan member ID card
9a-e	Patient address	M	Enter the member's mailing address from the member record
10	Birthdate	M	Enter the member's date of birth (MMDDYYYY)
11	Sex	M	Indicate (M)ale or (F)emale
12	Admission date	M	Enter date of admission/visit
13	Admission hour	M	Enter the time (hour: 00-23) of admission/visit
14	Admission type	M	Enter the code indicating the type of this admission/visit
15	Admission source (SRC)	M	Enter the code indicating the source of this admission/visit
16	Discharge hour	M	Enter the time (hour: 00-23) the member was discharged
17	STAT (Patient discharge status)	M	Enter the code to indicate the status of the member as of the through date on this billing <b>Note:</b> Interim billing is not allowed and the member status cannot be member

Box	Field Name	Type	Instructions
18-28	Condition codes	O	Enter the code used to identify conditions relating to this bill can affect payer processing.
29	Accident state	M	Enter the state in which accident occurred.
30	Untitled	N/A	Not applicable
31-34	Occurrence codes and dates	M if applicable	Enter the code and associated date defining a significant event relating to this bill that can affect payer processing. <b>Note:</b> Tufts Health Plan requires all accident-related occurrence codes to be reported.
35-36	Occurrence span code and dates	O	Enter a code and the related dates ("from" and "through") that identify an event that relates to the payment of the claim
37	Untitled	N/A	Not applicable
38	Untitled	N/A	Not applicable
39-41	Value codes and amounts	N/A	Not applicable
42	Revenue code	M	Enter the most current uniform billing revenue codes.
43	Revenue description	M	Enter a narrative description that describes the services/procedures rendered. Use CPT-4/HCPCS definitions whenever possible.
44	HCPCS/Rate/HIPPS code	M	<ul style="list-style-type: none"> <li>For outpatient services, use CPT and HCPCS Level II codes for procedures, services, and supplies.</li> <li>Do not use unlisted codes. If an unlisted code is used, supporting documentation must accompany the claim</li> <li>Do not indicate rates</li> </ul>
45	Service date	M	Enter the date the indicated service was provided
46	Service Units	M	Enter the units of service rendered per procedure
47	Total charges	M	Enter the charge amount for each reported line item (negative amounts will not be accepted)
48	Noncovered charges	O	Enter any noncovered charges for the primary payer pertaining to the revenue code
49	Untitled	N/A	Not applicable
50 A-C	Payer Name	M	List all other health insurance carriers on file. If applicable, attach an EOB from other carrier.
51	Health plan ID	O	List provider number assigned by health insurance carrier
52	Rel. info (Release of information)	N/A	Not applicable
53	Asg ben (Assignment of benefits)	N/A	Not applicable
54	Prior payments (payer and member)	M	Report all prior payment for claim (negative amounts will not be accepted). Attach EOB from other carrier, if applicable.
55	Est. amount due	N/A	Not applicable
56	NPI	M	Enter valid NPI number of the servicing provider
57 a-c	Other provider ID	N/A	Not applicable
58 a-c	Insured's name	M	Enter the name of the individual who is carrying the insurance



Box	Field Name	Type	Instructions
59	P. rel (patient's relationship to insured)	M	Enter the code indicating the relationship of the member to the identified insured/subscriber.
60 a-c	Insured's unique ID	M	Enter the member's Tufts Health Plan ID number (including suffix), as shown on the member's ID card
61 a-c	Group name	M	Enter the name of the group or plan through which the insurance is proved to the insured
62 a-c	Insurance group number	M	Enter the ID number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered
63 a-c	Treatment authorization codes	O	Enter the Tufts Health Plan referral/authorization number for outpatient surgical day care services
64 a-c	Document control number	N/A	Not applicable
65 a-c	Employer name	M if applicable	Enter the name of the employer for the individual identified in box #58
66	DX version qualifier	N/A	Not applicable
67 a-q	Principal diagnosis code	M	Enter the most current ICD-CM code describing the principal diagnosis chiefly responsible for causing the admission/visit. The code must be to the appropriate digit specification, if applicable. If the diagnosis is accident-related, then an occurrence code and accident date are required. Present on admission (POA) indicator should be entered as the 8th character.
68	Other diagnosis codes	M if applicable	Enter the ICD-CM diagnosis codes corresponding to additional conditions that co-exist at the time of admission or develop subsequently. The code must be to the appropriate digit specification, if applicable.
69	Admit DX	M	Enter the ICD-CM diagnosis code provided at the time of admission as stated by the provider
70	Patient reason DX	O	Optional
71	PPS code (Prospective Payment System)	O	Optional
72	ECI (external cause of injury code)	M if applicable	Enter the ICD-CM code for the external cause of an injury, poisoning or adverse effect
73	Untitled	N/A	Not applicable
74 a-e	Principal procedure code; Other procedure code (code and date)	M	Enter the most current ICD-CM code to the appropriate digit specification, if applicable, to describe the principal procedure performed for this service billed. Also, enter the date the procedure was performed. Date must be recorded as month and day (MMDD).
75	Unlisted	N/A	Not applicable
76	Attending physician	M	Enter the ordering physician's NPI, physician's last name, first name and middle initial.
77	Operating physician	M (if applicable)	Enter the name and NPI number of the physician who performed the principal procedure
78-79	Other provider types	O	Optional

Box	Field Name	Type	Instructions
80	Remarks	O	Examples: "COB-related" or "billing for denial purposes only"
81CCa-d	Code to code	O	Optional

## Claim Specifications: CMS-1500 Claim Form

The CMS-1500 form can be used by:

- Independent providers, nonphysician practitioners, and other suppliers (e.g., laboratories, physical therapists, chiropractors, behavioral health providers, and durable medical equipment (DME) suppliers)
- Hospital outpatient/emergency departments

The professional component of services may only be billed on a CMS-1500 form for MDs, DOs, and podiatrists (with the exception of clinical services). Services performed by nonphysician practitioners (e.g., nurse practitioners, physician assistants, or certified registered nurse anesthetists) who participate in a professional group for whom the hospital does billing) should also be billed on a CMS-1500 form.

Use a UB-04 claims form if only billing the technical component of any of the services mentioned above.

Both the professional and technical/facility components for a clinic service must be billed on a CMS-1500 form as a global charge on one claim line, regardless of the type of provider. A clinic service is defined as follows:

CPT Code Range <sup>5</sup>	General Definition
99201-99215	Office or other office of professional discipline (OPD) service
99241-99245	Office or other OPD consultations
99271-99275	Confirmatory consultations
99381-99397	Preventive medicine
99401-99429	Counseling and/or risk factor reduction intervention
92002-92014	Ophthalmology

## Requirements for Completing the CMS-1500 Form

Note the following requirements for the CMS-1500 form:

1. Claims cannot be processed without completing the following fields: 1a, 2, 3, 9-14, 21, 24a, 24b, 24d, 24f, 24g 24j, 25, 27-33, 32a, 33a.
2. If using unlisted or miscellaneous codes, attach notes or a description of services rendered. Claims that are submitted with unlisted codes that do not have attachments will be denied.
3. The CMS-1500 may be prepared according to Medicare guidelines provided all mandatory fields

## Completion Instructions

The following pages contain the following information regarding CMS-1500 claims:

- A copy of the CMS-1500 form
- Specifications for each field of the CMS-1500 form
- Specifications for hospital-owned freestanding facilities are identified in Table 3. If you do not have a provider identification number specific to the freestanding site, contact Allied Health Services at 888.880.8699, ext. 43145.
- The Type column indicates whether a particular field is M (mandatory), O (optional) or N/A (not

<sup>5</sup> CPT codes are subject to change through annual updates. Follow the current CPT coding guidelines at all times.

applicable)

**Table 3: CMS-1500 Claim Form Specifications**

Box #	Field Name	Type	Instructions
1	Type of insurance coverage	O	Indicate all types of health insurance coverage applicable to this claim by checking the appropriate boxes. If the "Other" box is checked, complete box #9.
1a	Insured's ID number	M	Enter the member's current ID number exactly as it appears on the Tufts Health Plan ID card, including the appropriate suffix. Inaccurate or incomplete ID numbers causes a delay in processing the claim and can result in a denial.
2	Patient's name	M	Enter the member's last name, first name, and middle initial, if any, as shown on the member's Tufts Health Plan ID card.
3	Patient's date of birth	M	Enter the member's date of birth and sex.
4	Insured's name	M	Enter the name of the insured except when the insured and the member are the same. In those cases, enter the word SAME.
5	Patient's address	M	Enter the member's permanent mailing address and telephone number as follows: Street address City, state Zip code and phone number
6	Patient relationship to insured	M	Check the appropriate box for member's relationship to insured (check only one box)
7	Insured's address	M	Enter the insured's permanent mailing address and telephone number. When the address is the same as the member's, enter SAME.
8	Reserved for NUCC use	O	No entry required
9	Other insured's name	M	Enter the last and first name, and middle initial of the insured except when the insured is the same as shown in box #4. In these cases, enter the word SAME.
9a	Other insured's policy or group number	M	If the member is covered under another health benefit plan, enter the other insured's policy or group number.
9b	Reserved for NUCC use	O	No entry required
9c	Reserved for NUCC use	O	No entry required
9d	Insurance plan name or program name	M	Enter the other insured's insurance plan or program name. Attach primary insurer's EOB to the claim.
10a–10c	Is member's condition related to:	M	<ul style="list-style-type: none"> <li>For each category (employment, auto accident, other), enter an "X" in the YES or NO box. When applicable, attach an EOB or letter from the auto carrier indicating that personal injury protection benefits have been exhausted.</li> <li>Enter the state postal code where the auto accident occurred.</li> </ul>
10d	Claim codes	O	Enter up to 4 claim condition codes.
11	Insured's policy group or FECA #	M	If the member has other insurance, enter the insured's policy or group number
11a	Insured's date of birth and sex	M	Enter the insured's date of birth and sex if different from box #3

Box #	Field Name	Type	Instructions
11b	Other claim ID	O	Enter 2-character qualifier found in 837 electronic claims to the left of the dotted line. Enter claim number from other insured's plan to the right of the dotted line.
11c	Insurance plan name or program name	M	Enter the insurance plan or program name, if applicable. This is used to determine if supplemental or other insurance is involved. If the supplemental or other insurer is Blue Cross Blue Shield plan, provide the name of the state or geographic area, e.g., Blue Shield of (name of state).
11d	Is there another health benefit plan?	M	Check YES or NO to indicate whether there is another primary health benefit plan. For example, the member could be covered under insurance held by a spouse, parent, or some other person.
12	Patient's or authorized person's signature	M	<ul style="list-style-type: none"> <li>• If the signature is not on file, the member or authorized representative must sign and date this box.</li> <li>• If the member's representative signs, the relationship to the member must be indicated.</li> </ul>
13	Insured's or authorized person's signature	M	The insured's or authorized person's signature or "Signature on File" must be in this box to authorize payment of benefits to the participating physician or supplier.
14	Date of current illness, injury or pregnancy (LMP)	O	Enter date of current illness, injury or pregnancy in the designated MM/DD/YY space. Enter the qualifier found in the 837 electronic claim to the right of the QUAL dotted line
15	Other date	O	Enter the qualifier found in the 837 electronic claim between the dotted lines to the right of QUAL. Enter the date in the designated MM/DD/YY space.
16	Dates patient unable to work in current occupation	O	Enter the date if the member is unable to work. An entry in this field indicates employment related insurance coverage.
17	Name of referring provider or other source	O	<ul style="list-style-type: none"> <li>• Enter 2-character qualifier found in 837 electronic claims to the left of the dotted line.</li> <li>• Enter the name of the referring and/or ordering physician or other source if the member:</li> <li>• Was referred to the performing physician for consultation or treatment</li> <li>• Was referred to an entity, such as clinical laboratory, for a service</li> <li>• Obtained a physician's order for an item or service from an entity, such as a DME supplier</li> </ul>

Box #	Field Name	Type	Instructions
17a-b	Provider ID number of referring physician	O	<ul style="list-style-type: none"> <li>Enter the NPI-assigned physician ID number of the referring or ordering physician.</li> <li>Referring physician information is required if another physician referred the member to the performing physician for consultation or treatment.</li> <li>Ordering physician information is required if a physician ordered the diagnostic services, tests, or equipment.</li> <li>Inclusion of the NPI number will expedite claims processing.</li> </ul> <p><b>Note:</b> This box is mandatory for providers submitting a referral for Tufts Health Freedom Plan members</p>
18	Hospitalization dates related to current services	M	Complete this block when a medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Additional claim information (designated by NUCC)	O	Enter additional claim information
20	Outside lab	O	This item indicates whether laboratory work was performed outside the physician's office.
21	Diagnoses	M	Enter the diagnosis/condition of the member indicated by ICD-CM code number. Enter up to 12 codes in priority order (primary, secondary condition). Codes are arrayed across the box.
22	Resubmission code	O	This item identifies a resubmission code.
23	Prior authorization number	O	If applicable, enter the Tufts Health Plan inpatient notification or referral number.
24a	Date(s) of service	M	<ul style="list-style-type: none"> <li>Enter the day, month, and year for EACH service. Itemize each date of service; do not use a date range.</li> <li>For hospital-owned freestanding facilities, always enter 11 for the place of service<sup>6</sup>.</li> <li>Anesthesia providers should enter anesthesia duration in minutes with start and end times in the shaded area. Claims missing dates of service will be returned.</li> </ul>
24b	Place of service	M	Enter the appropriate HIPAA standard place of service code only. Claims missing a place of service will be returned.
24c	EMG	N/A	Check this item if the service was rendered in a hospital or emergency room.
24d	Procedure, services, or supplier	M	<ul style="list-style-type: none"> <li>Enter valid CPT/HCPCS procedure code and any modifiers.</li> <li>For hospital-owned freestanding facilities, enter valid procedure codes as per your contract with Tufts Health Plan<sup>1</sup>.</li> </ul>

<sup>6</sup> All freestanding facilities require a separate Tufts Health Plan-assigned, freestanding provider ID number in addition to an NPI number. Providers who do not have an ID number specific to the freestanding site should contact the Allied Health Contracting Department at 888.880.8699, ext. 43145.

Box #	Field Name	Type	Instructions
24e	Diagnosis pointer	M	Enter the diagnosis reference letter for up to 4 ICD-CM codes, as shown in box #21, to relate the date of service and the procedures performed to the appropriate diagnosis. Enter a maximum of four letters that refer to four diagnosis codes. If multiple services are being performed, enter the diagnosis codes warranting each service.
24f	Charge	M	Enter the charge for each listed service.
24g	Days or units	M	Enter the days or units of service rendered for the procedures reported in box #24d. For hospital-owned freestanding facilities, always enter 1 for the number of units.
24h	EPSDT family plan	O	Check this if early and periodic screening, diagnosis and treatment, or family planning services were used.
24i	ID qualifier	O	Optional
24j	Rendering provider ID#	M	Enter valid NPI number if the rendering provider is not the billing provider.
25	Federal tax number	M	Enter your physician/supplier federal tax ID, employer ID number or social security number. The claim will be returned if Federal Tax Number field is blank.
26	Patient's account number	O	Enter the member's account number that the physician's/supplier's accounting system assigned. This is an optional field to enhance member identification by the physician or supplier.
27	Accept assignment	M	Check YES or NO to indicate whether the physician accepts assignment for the claim. By accepting assignment, the physician agrees to accept the amount paid by the third party as payment in full for the encounter.
28	Total charges	M	Enter the total charges for the services, i.e., total of all charges in box 24f.
29	Amount paid	M	Enter the total amount paid on the submitted charges in box 28.
30	Reserved for NUCC use	O	No entry required
31	Signature of physician or supplier including degrees or credentials	M	Have the physician/supplier or authorized representative sign, or write "signature on file". Include the date of the signature. Note: Claims with a blank signature box will be returned.
32, 32a-b	Name and address of facility where services were rendered, NPI number	M	Enter the name and address where the services were rendered. a. Enter valid NPI number b. Enter other ID number (if applicable)
33, 33a	Physician's supplier's billing name, address, zip code, NPI number	M	Enter name and address for billing provider/supplier. Enter the NPI of the entity (payee) associated with the TIN. If no NPI for the payee, leave Box 33a blank

**Note:** Claims submitted with a discrepancy between the service line charges (Box 24f) and the total charges may be returned.

## Billing Requirements for Hospital Owned Freestanding Facilities for UB-04 and CMS 1500 Claims

Any inpatient or outpatient service associated with a hospital that meets either one of the following criteria is subject to freestanding reimbursement rates, policies, and procedures.

- If the services being rendered are not physically located with the acute care/rehabilitation/ chronic hospital building

OR

- If there is a partial or full ownership by an entity other than the acute care hospital itself. For example, if a sister company to the acute care hospital, or the holding company which owns the hospital, owns an associated inpatient or outpatient entity, the entity is considered freestanding

Notwithstanding the foregoing definition, hospital-based fees can, in certain circumstances, be the same as freestanding fees. The following table indicates when a hospital-owned freestanding facility should bill on a UB-04 claim form, a CMS-1500 claim form, 837 institutional claim, or 837 professional claim.

Facility/Service	Claim Form	Electronic Format
Outpatient facility/clinic/room charges inclusive of professional component (global billing)	CMS-1500	837 Professional
Facility and/or ancillary services	UB-04	837 Institutional
Professional physician services	CMS-1500	837 Professional

## QUALITY ADMINISTRATIVE GUIDELINES

### Quality Improvement Program

Tufts Health Plan's Corporate Quality Improvement (QI) Program is designed to facilitate member access to high-quality and culturally competent medical and behavioral health care, access to primary and specialty care, continuity and coordination of care across various health care settings. Tufts Health Plan measures and tracks key aspects of care and services, uses data-driven monitoring to identify improvement opportunities, implement interventions, and analyzes data to determine overall intervention effectiveness in improving clinical care.

These are the primary components of the program:

- Ongoing monitoring and evaluation
- Continuous QI
- Customer satisfaction
- Practitioner/provider credentialing
- Utilization management

The goals of the program are to:

- Continuously improve the quality and safety of clinical care and service, including physical and behavioral health (including substance use disorder) care, and service, including community based services and long-term services and supports (LTSS) that members receive from contracting health care providers
- Assure adequate access and availability to clinical care and services
- Increase member satisfaction
- Improve the quality of service that providers and members receive from Tufts Health Plan
- Increase provider satisfaction
- Improve the health and wellness of identified segments of the member community while responsibly managing health care costs

Tufts Health Plan evaluates success in achieving annual goals each year and document the results in the Quality Management and Improvement and Utilization Management Program Evaluations.

Providers cooperate with QI activities in order to:

- Improve the quality of care, services and the member's experience, including the collection and evaluation of data and participation in QI programs
- Allow the organization to collect and use performance measurement data
- Assist the organization in improving clinical and service measures

The Board of Directors has overall responsibility for the QI program. A Care Management Committee (CMC) is responsible for overseeing the implementation of the QI program, including the annual QI Work Plan, and for determining that funding is adequate to support program activities and goals. An annual summary of the QI work plan may be found [here](#).

- Specific positions, committees, and organizational units play a significant role in QI activities, including:
  - Quality Management Committee (QMC)
  - Quality of Care Committee (QOCC)
  - Quality Performance Improvement Team (QPIT)
  - QI work groups
  - QI project teams

Plan providers offer input into the program by participating in CMC, QOCC, and the Medical Specialty Policy Advisory Committee (Medical/Behavioral Health).



## National Committee for Quality Assurance (NCQA)

As an NCQA-accredited health plan, Tufts Health Plan adheres to NCQA standards and guidelines to measure, analyze and improve the health care services provided for members.

## Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS measures are industry-standard indicators of the quality of care health plan members receive. Tufts Health Plan evaluates HEDIS data monthly and annually to monitor trends and identify opportunities to improve care for members. Interim and annual rates are also evaluated against national and regional HEDIS benchmarks to assess the performance of provider networks.

HEDIS data is incorporated into provider performance reports, which are tools intended to drive quality improvement. Tufts Health Plan shares performance reports on several key HEDIS measures with provider practices. Providers may contact Provider Services at 888.884.2404 Monday–Friday, 8 a.m.–5 p.m. for more information.

## Consumer Assessment of Healthcare Providers and Systems (CAHPS)

CAHPS is a standardized survey that measures member experience with services provided by their health plan and its provider network. This survey addresses members' experience with care received by their providers, as well as access to and coordination of services. CAHPS survey responses are used annually to help develop action plans, performance goals, and improve strategies to ensure Tufts Health Plan is offering the highest quality of care and services to members.

## Medical Care Access Goals for Primary Care Offices

Access to medical care services is a key component of health care quality. Members must be able to access their providers, although in a life-threatening situation they are expected to obtain care at the nearest medical facility.

Tufts Health Plan recognizes the diversity with which providers handle member calls, arrange urgent care, and schedule routine care. Tufts Health Plan expects that members be heard and their medical needs met in a manner that is reasonable and provides quality medical care.

Tufts Health Plan has developed medical care access goals that all provider offices are expected to adopt and review with their office staff. The goals include suggestions that PCPs may adopt to provide better service to their patients. Many providers may have already included these suggestions in their telephone triage system.

Members periodically contact Tufts Health Plan with concerns about office waiting times, appointment availability, and similar issues. Tufts Health Plan uses these guidelines to determine whether member concerns are reasonable, and provides feedback to the members and providers as necessary.

Since the PCP is ultimately responsible for coordinating the member's care, these guidelines are not as directly pertinent to a specialist's office. They do, however, provide a sense of what is reasonable in terms of appointment dates, waiting times, telephone callback times, etc. As such, they are a good way to measure how well an office is functioning.

All medical care access goals are evaluated at least annually by Tufts Health Plan management and revised, as necessary, based on the results of access surveys and the input of plan providers.

Providing medical care is not a completely predictable experience. Emergencies and episodic increases in the demand for services, at times, overwhelm the ability of an individual office to meet each of these goals. However, in the normal course of providing medical care, primary care offices must regularly meet these expectations.

### Office Visit Appointments

- **Emergency care:** appointments scheduled on the same day as requested with an available clinician
- **Urgent care:** appointments scheduled to occur within 24 hours of request with an available clinician (or within 48 hours for Tufts Health Freedom Plan members)

- **Nonurgent symptomatic care:** appointments for nonurgent episodic illness are scheduled to occur within one week of request with an available clinician
- **Preventive care:** for history and physical check-ups with no acute illness, the PCP or other appropriately licensed clinician sees the member within 45 days of the request (or within 30 days for Tufts Health Freedom Plan members)

### Office Waiting Time

In most situations, member should not have to wait more than 30 minutes past their appointment time to be seen. If a longer wait is anticipated, staff members must explain the reason for the delay and offer to book the member for another appointment, if desired. Office staff should return any copayment if the appointment is rescheduled.

### Overflow Patients

If an office has more urgent cases than it can handle, the staff must arrange for urgent care at another site. Routine use of an emergency department in such overflow situations is not acceptable.

### Telephone Callbacks during Office Hours

Members are expected to exercise good judgment about urgent needs for service when contacting their provider outside normal office hours.

An answering service or machine answers telephones after hours. For urgent problems, an answering service offers to contact the provider or a covering provider. An answering machine provides a number through which a provider can be contacted for urgent problems. Providers normally return urgent calls within one hour.

If a provider uses a nurse triage service for telephone screening after hours, the provider must instruct the nursing staff to identify himself or herself as a nurse who is covering for a provider. The nurse must also communicate to the member that if it is a life-threatening situation, the member must hang up and either call 911 or go to the nearest emergency department, as appropriate. At the completion of the call, the nurse must verify that the member is comfortable with the nurse's advice and tell the member of his or her right to speak to the covering provider. All practitioners or providers used for covering purposes must be licensed as required by law.

**Note:** Routine use of an emergency department to supply after-hours care is not an acceptable coverage arrangement.

### Credentialing Site Visit Requirements

Provider site visits may be conducted for any of the following reasons:

- When more than one member complaint/grievance is received about a practitioner's office regarding the physical accessibility, physical appearance, adequacy of waiting and examining room space or adequacy of medical/treatment record keeping within six months
- Member satisfaction results indicate an office site may not meet Tufts Health Plan standards
- Tufts Health Plan employee reports, other concerning data and information is received from a member or provider indicating a site may not meet Tufts Health Plan standards
- Other information is required for QI purposes and cannot be reasonably collected using alternative methods
- Other circumstances as deemed necessary

Tufts Health Plan personnel or a designated representative with appropriate training will perform the site visit within two weeks of Tufts Health Plan's determination that a site visit is warranted.

Site visits resulting in deficiencies requiring a corrective action will require the practitioner to submit a corrective action plan within 30 days to the Quality Management Department. All sites receiving a failing score will be subject to a follow-up site visit within six months of the visit.

If the site still does not receive a passing score or demonstrate adequate improvements in the deficient areas from the previous visit the results will be documented. The site will continue to be visited every six months until the deficiencies are remedied, or the site receives a passing score, or it is determined that further action is required by Tufts Health Plan.

Practitioner name: _____		Provider unit: _____	
Address: _____		Other practitioners at same site (attach additional sheet if necessary): _____	
Telephone: _____		_____	
THP ID: _____		_____	
Date and time of site visit: _____		Office contact: _____	
<b>Physical accessibility</b>		<b>Physical appearance</b>	
Handicapped accessible with signage	Y <input type="checkbox"/> N <input type="checkbox"/>	Visual cleanliness	Y <input type="checkbox"/> N <input type="checkbox"/>
Ramp from parking into building	Y <input type="checkbox"/> N <input type="checkbox"/>	Adequate lighting	Y <input type="checkbox"/> N <input type="checkbox"/>
Elevator if office is on the second floor or above	Y <input type="checkbox"/> N <input type="checkbox"/>	Free of odor	Y <input type="checkbox"/> N <input type="checkbox"/>
Doorknobs are pull-down	Y <input type="checkbox"/> N <input type="checkbox"/>	Refuse disposal available	Y <input type="checkbox"/> N <input type="checkbox"/>
Doorways are at least 3.5 feet wide	Y <input type="checkbox"/> N <input type="checkbox"/>	Office hours posted	Y <input type="checkbox"/> N <input type="checkbox"/>
At least one bathroom has adequate space for a wheelchair or assistant	Y <input type="checkbox"/> N <input type="checkbox"/>	Exit signs readily visible	
Entrance is safely accessible (e.g., free of snow and ice)	Y <input type="checkbox"/> N <input type="checkbox"/>	Record/file area secure/confidential and locked when unattended; legible file markers; records easily located	Y <input type="checkbox"/> N <input type="checkbox"/>
Stairs have handrails	Y <input type="checkbox"/> N <input type="checkbox"/>	Policies/procedures for patient confidentiality available	Y <input type="checkbox"/> N <input type="checkbox"/>
At least one examining room has adequate space for a wheelchair	Y <input type="checkbox"/> N <input type="checkbox"/>	Adequate seating	Y <input type="checkbox"/> N <input type="checkbox"/>
		Smoke detectors present	Y <input type="checkbox"/> N <input type="checkbox"/>
<b>Adequacy of medical/treatment record keeping</b>		<b>Adequacy of appointments</b>	
Health information and data: staff has immediate access to key information, such as patients' diagnoses, allergies, test results, treatments and medications	Y <input type="checkbox"/> N <input type="checkbox"/>	Routine office visit within 1 week of request with an available clinician	Y <input type="checkbox"/> N <input type="checkbox"/>
File area locked when unattended	Y <input type="checkbox"/> N <input type="checkbox"/>	Urgent care within 24 hours with an available clinician	Y <input type="checkbox"/> N <input type="checkbox"/>
Office utilizes a reminder system(s) to prompt and alert the staff to ensure regular screenings and preventative practices	Y <input type="checkbox"/> N <input type="checkbox"/>	24-hour coverage	Y <input type="checkbox"/> N <input type="checkbox"/>
Office has a scheduling system(s) for booking appointments and record keeping is orderly	Y <input type="checkbox"/> N <input type="checkbox"/>		
Legible file markers			
Legible documentation	Y <input type="checkbox"/> N <input type="checkbox"/>		
	Y <input type="checkbox"/> N <input type="checkbox"/>		
<b>Adequacy of waiting and examining room space</b>			
Sharps disposal	Y <input type="checkbox"/> N <input type="checkbox"/>	<b>Score of 32 =</b>	<b>%</b>
Biohazard waste disposal	Y <input type="checkbox"/> N <input type="checkbox"/>	(Score of 85% or greater is passing)	
Provisions for universal precautions (wearing gloves, masks, hand washing)	Y <input type="checkbox"/> N <input type="checkbox"/>		
Medications and prescription pads locked or restricted access	Y <input type="checkbox"/> N <input type="checkbox"/>		
Use of clean linen and/or paper on exam tables	Y <input type="checkbox"/> N <input type="checkbox"/>		

## Medical Records

Tufts Health Plan requires medical records be maintained in a manner that is current, detailed, organized and that permits effective and confidential patient care and quality review.

The medical record, whether electronic or on paper, must contain the patient's past medical treatment, past and current health status, and treatment plans for future health care. Well-documented medical records facilitate communication, coordination, and continuity of care and promote the efficiency and effectiveness of treatment.

Tufts Health Plan considers all medical records to be confidential and requires that all providers:

- Maintain medical records in a space staffed by office personnel
- Maintain medical records in a locked office when staff is not present
- Not permit unauthorized review or removal of medical records without a patient's authorization
- Provide office staff periodic training in confidentiality of member information

In addition, as a CMS contractor, Tufts Health Plan participates in QI activities as directed by the contracting agency. This often involves medical record reviews. Tufts Health Plan requires that providers provide access to medical records when requested as part of these QI activities. Confidentiality is maintained during and after the review of these medical records.

## Behavioral Health/Substance Use Disorder Treatment Access Standards

All contracted inpatient and outpatient behavioral health and substance use disorder (BH/SUD) providers are expected to meet the standards described below.

### Temporal Access

Tufts Health Plan covers emergency BH/SUD care at any licensed facility when medically necessary. Emergency care is available at any Tufts Health Plan contracted facility with emergency services.

- Tufts Health Plan designated facilities (DFs) must have BH/SUD emergency and triage services available 24 hours a day.
- A member with life-threatening and non-life-threatening needs must be seen immediately in the emergency room
- Urgent care must be available within 48 hours of a member's request. Any Tufts Health Plan BH/SUD provider may provide this care.
- Nonurgent care must be available within 10 business days of a member's request. Any Tufts Health Plan BH/SUD provider can provide this care.

### Geographic Access

Outpatient BH/SUD care is available within 30 miles of the member's home or workplace. For certain areas of subspecialty care, a greater distance may be required.

## Preventive Health and Clinical Practice Guidelines

Tufts Health Plan uses evidence-based guidelines that are adopted from national sources or developed in collaboration with specialty organizations and/or regional collaborative groups. There are two types of guidelines:

- Preventive health guidelines, involving screening for disease
- Clinical practice guidelines, outlining a recommended treatment path or use of ancillary services

These guidelines are not intended to replace the practitioner's clinical judgment. Rather, they are standards designed to assist practitioners in making decisions about appropriate health care for specific clinical circumstances. When no such evidence-based guidelines are available from recognized sources, Tufts Health Plan will involve representative practitioners from appropriate specialties in the development or adoption of clinical practice guidelines.

Guidelines are reviewed at least every two years and revised as needed. Literature reviews occur quarterly to ensure that all Tufts Health Plan internally developed guidelines are current. When new guidelines are published, they are reviewed internally by Tufts Health Plan physicians and then posted for contracting Tufts Health Plan providers to review before adoption.

Tufts Health Plan's clinical practice and preventive health guidelines are designed to support preventive health, behavioral health, acute disease treatment protocols, and/or chronic disease management programs. Both medical and behavioral health clinical practice guidelines are available [online](#).

## HEDIS/Quality Improvement Programs: Heart failure and diabetes providers

### **Heart Failure:**

PCPs receive a list of their panel members identified as having HF along with pharmacy compliance data regarding ACE/ARB RX refills.

### **Diabetes:**

The diabetes program provides education and tools to improve the health of members with diabetes. The goal is to improve member's self-management of diabetes and to prevent diabetes-related complications and hospitalizations. Identified members receive an educational mailing that may include a diabetes care card for tracking preventive screening tests or other self-management tools.

PCPs receive annual preventive screening information for their panel of members in need of recommended screenings which include dilated eye exam, A1C screening and monitoring for nephropathy.

## Serious Reportable Events

**Never Events:** Serious reportable events (SREs), serious reportable adverse events (SRAEs), and provider preventable conditions (PPCs).

### Definitions

The National Quality Forum (NQF) defines "never events" as "errors in medical care that are of concern to both the public and health care professionals and providers, clearly identifiable and measurable, and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the health care organization". Tufts Health Plan considers the following types of events as never events:

- **SREs and SRAEs:** Unambiguous, serious, preventable adverse incidents involving death or serious harm to a patient resulting from a lapse or error in a healthcare facility. SREs are developed and endorsed by the NQF. SRAEs are defined by CMS.
- **PPCs:** Conditions that meet the definition of a "health care-acquired condition (HCAC)" or a "provider-preventable condition (PPC)" as defined by CMS in federal regulations at 42 CFR 447.26(b).

### Nonpayment for SREs, SRAEs and PPCs

Tufts Health Plan's longstanding policy and regulatory obligation has been to deny or retract payment for services related to care which meet the definition of SREs, SRAEs or PPCs once they have been identified. Tufts Health Plan will not compensate providers or permit providers to bill members for services related to the occurrence of SREs, SRAEs and/or PPCs.

Providers are required to notify Tufts Health Plan of SREs, SRAEs and PPCs that occur when providing services to Tufts Health Plan members.

### Reporting for SREs, SRAEs, and PPCs

To report a SRE, SRAE or PPC to Tufts Health Plan, providers should fax their report to Tufts Health Plan's QM Department at 617.673.0973. The QM Department works directly with the provider involved to review the event and identify opportunities for quality improvement.

Refer to the [Serious Reportable Events, Serious Reportable Adverse Events and Provider Preventable Conditions Payment Policy](#) for more information.

Reference Sources:

- Refer to the [National Quality Forum](#) for information on reporting SREs and SRAEs
- Refer to the following link for information on reporting Provider Preventable Conditions (PPCs):
- CMS: [Hospital-Acquired Conditions](#)

# UTILIZATION MANAGEMENT GUIDELINES

## Introduction

Tufts Health Plan's utilization management (UM) guidelines are intended to help providers plan and manage care in an efficient manner with high quality standards.

## Role of Plan Provider

Plan providers are expected to cooperate fully with reviewers and Tufts Health Plan staff when sharing clinical information concerning members under their care. This includes the following:

- Following authorization procedures for inpatient notification as outlined in the [Referral, Authorization and Notification Policy](#)
- Following policies for services subject to prior authorization
- Coordinating with hospital and Tufts Health Plan staff concerning care management and discharge planning activities
- Responding within the requested timeframe regarding questions that arise during the process of conducting utilization review (including the member appeals process) and care management
- Complying with confidentiality requirements as detailed in the [Providers](#) chapter

Refer to the [Providers](#) chapter for information regarding the provider payment dispute process and confidentiality of member medical records.

## Utilization Management Program

Tufts Health Plan's Utilization Management Program includes the evaluation of requests for coverage by determining the medical necessity, appropriateness and efficiency of the health care services under the applicable health benefit plan. UM services will be provided where licensed or permissible under state and federal law, or other regulatory authority.

The Senior Vice President/Chief Medical Officer (CMO) has senior level executive responsibility for UM and reports directly to the President and Chief Executive Officer (CEO). Plan providers supply input to the program through consultative and ad hoc provider groups brought together to help develop specific programs.

The staff within the Utilization Management Program reviews coverage requests for the following services including but not limited to:

- Inpatient and outpatient care
- Home care services
- Prescription drugs
- Assisted reproductive technologies (ART)
- Durable medical equipment (DME)
- Select elective surgical procedures
- Out-of-network referrals
- Transplants
- Behavioral health services, including both behavioral health and substance use disorder (BH/SUD) services

Tufts Health Plan adheres to the following guidelines when administering its UM Program:

- It is the responsibility of the attending provider to make clinical decisions regarding medical treatment. These decisions must be made consistently with generally accepted principles of professional medical practice and in consultation with the member.
- It is the responsibility of Tufts Health Plan to determine benefit coverage based on the member's benefit document. Tufts Health Plan uses medical necessity guidelines/utilization review criteria, if applicable, to evaluate requests for coverage.
- All utilization review decisions to deny coverage are made by qualified, licensed physicians, or when appropriate and when allowable by law, by licensed health care professionals with expertise in the

- specialty for which services are being requested.
- **Note:** Doctoral-level psychologists can render denial of coverage decisions for BH/SUD services unless the requesting provider is a licensed physician; in which case, a licensed physician must render the denial of coverage decision.
- Tufts Health Plan does not compensate individuals conducting utilization review for issuing denials of coverage, and it does not provide financial incentives for UM decision-makers to encourage denials of appropriate coverage. Financial incentives for utilization review do not encourage decisions that result in underutilization. UM decision-making is based on medical necessity, applicable coverage guidelines and appropriateness of care and service.

## Medical Necessity Guidelines

Tufts Health Plan determines benefit coverage for the benefits described in each member's product description by using [Medical Necessity Guidelines \(MNGs\)](#) to determine the medical necessity and appropriateness of health care services under the applicable health benefit plan. These utilization review MNGs are:

- Developed and reviewed with input from Tufts Health Plan specialty consultants, actively practicing physicians, and specialty physicians and other providers
- Developed in accordance with standards adopted by national accreditation organizations and regulatory and government entities
- Reviewed on an annual basis and updated as new treatments, applications and technologies are adopted as generally accepted professional medical practice
- Evidence-based, if such evidence is available
- Applied in a manner that considers the individual health care needs of the member and characteristics of the local delivery system
- Evaluated at least annually for the consistency with which those involved in utilization review apply the MNGs in the determination of coverage

Tufts Health Plan also utilizes some commercially purchased criteria. The use of these criteria is also reviewed in the manner described above.

MNGs are used by providers when making coverage determinations for Commercial members. [MNGs](#) are available on the public Provider [website](#) or by calling Provider Services at 888.884.2404 to request a printed copy.

**Note:** Providers may contact Cigna by calling 800.88CIGNA (800.882.4462) or refer to Cigna's [website](#) for questions about medical management policies.

## Medical Technology Assessment Process

The Tufts Health Plan Medical Technology Assessment Process evaluates emerging and new uses of existing technologies and medical interventions, including those for behavioral health services, to determine safety and effectiveness. Tufts Health Plan uses information gathered from the Hayes, Inc. Technology website and Hayes Reports, published/peer-reviewed scientific literature, national consensus guidelines, the FDA, other regulatory bodies, and internal and external expert consultative sources in its evaluation efforts.

The process involves the interrelated committees:

**Medical Technology Assessment Committee** consists of Medical Policy Department staff and Tufts Health Plan medical directors for Medical Policy and Medical Directors for the divisions who manage the process described above for review of new and emerging technologies or medical services. Recommendations are reviewed by the Integrated Medical Policy Advisory Committee (IMPAC).

**Medical Specialty Policy Advisory Committee (MSPAC)** consists of Tufts Health Plan Medical Affairs Department physicians, Medical Policy Department staff and external specialist physicians who evaluate new and emerging technologies and procedures, as well as new uses of existing technologies and procedures, related to the medical specialty, for safety and effectiveness. MSPAC members make a recommendation regarding the safety and efficacy of the new technologies and medical interventions, and also provide annual review of the existing MNGs. The recommendations of this committee are presented at the Tufts Health Plan Integrated



Medical Policy Advisory Committee (IMPAC) meeting for decision making.

**Integrated Medical Policy Advisory Committee (IMPAC)** is a decision-making body for medical and behavioral health services. This internal committee is chaired by the Senior Manager of Medical Policy and consists of representative from many departments within Health Care Service who are responsible for providing input on coverage recommendations, MNGs and utilization review (UR) activities for medical and behavioral health services. The Tufts Health Plan Chief Medical Officers (CMOs), including the Senior Vice President and CMO, and representatives from the Medical Policy, Precertification Operations, Appeals and Grievances, Behavioral Health, and Pharmacy departments and others make up this committee. Topics requiring review that cannot be addressed at the MSPAC meetings are brought to this committee.

Led by the Tufts Health Plan's Senior Vice President and CMO, the above referenced committees make the final determinations as to whether the procedure, service or supply will be covered and if so, whether coverage will be subject to prior authorization. The program managers for products in the Medical Policy Department are responsible for the development of the MNGs associated with these coverage decisions.

## Time Frames for Utilization Review Determinations of Coverage

Tufts Health Plan's UM decision and notice requirements are developed consistent with applicable state and federal laws and regulations and accreditation standards. Refer to the [Utilization Review Determinations Timeframes](#) chapter for information about decision and notification time frames.

**Written notice of authorization of coverage:** Authorization notices contain a reference number and the appropriate dates and/or number of days/units of services authorized. Notices for continuation of services indicate the number of days, units, or services approved.

**Written notice of denial of coverage determination requirements:** The written notification of a denial of coverage determination based upon medical necessity includes:

- The specific clinical rationale for the determination
- A description of the member's presenting symptoms or condition, diagnosis, and treatment interventions
- Alternative treatment options/services covered under the member's plan, if any
- Description of the member's appeal rights and how to initiate an appeal

**Written notice of denial of payment requirements:** The written notice includes but is not limited to:

- The specific clinical rationale for the denial
- A description of the member's presenting symptoms or condition, diagnosis, and treatment interventions
- Description of the provider appeal rights and how to initiate an appeal

## Reconsideration<sup>7</sup>

Providers have the opportunity to seek reconsideration of an initial or concurrent denial of coverage decision from a board-certified, actively practicing clinical peer reviewer in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review. This reconsideration process occurs within one working day of the receipt of the request and is conducted between the provider rendering the service and the clinical peer reviewer or clinical peer designated by the clinical peer reviewer if said reviewer cannot be available within one working day. If the denial of coverage determination is not reversed by the reconsideration process, the provider may pursue the appeals process on behalf of the member.

**Note:** The reconsideration process is not a prerequisite to the formal standard and expedited appeals processes.

If an adverse determination is made, Tufts Health Plan notifies the treating practitioner or their office staff by phone to inform them that a Medical Affairs, Utilization Management practitioner, or Pharmacy Utilization

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<sup>7</sup> Applies to Massachusetts Commercial plans only.

Management Department practitioner or their designee is available to discuss the decision.

For prospective and concurrent adverse determinations for members covered under a Massachusetts fully insured plan, if the peer-to-peer conversation does not resolve differences of opinion, the provider may request the opportunity to seek reconsideration of the initial adverse determination.

Tufts Health Plan will facilitate the reconsideration process with a Massachusetts board-certified, actively practicing physician or healthcare professional of the same or similar specialty that typically manages the medical condition, procedure, or treatment, who was not involved in the initial adverse determination. The reconsideration process will occur within one business day of the request. If the initial adverse determination is overturned upon reconsideration, written notice of the decision will be sent.

If the reconsideration process does not reverse the adverse determination, the provider or member may pursue the expedited or standard appeal process. The reconsideration process is not a prerequisite to the expedited or standard appeal process.

## Access and Coverage System for Medical Affairs Department Physicians

A Tufts Health Plan Medical Affairs Department physician will be available either in person or readily accessible by telephone to perform utilization review (UR) or other clinical consults for all Tufts Health Plan's UM staff. This coverage will be provided Monday through Friday from 8:30 a.m. to 5 p.m. in accordance with Tufts Health Plan's standard business hours (excluding holidays). Additional coverage is provided in accordance with individual account contracts.

Tufts Health Plan Medical Affairs Department physicians are available within one business day to discuss coverage determinations with the attending physician or ordering provider.

The Medical Affairs Department physicians will conduct all outbound communication within standard business hours and will identify themselves by name, title, and organization name when initiating or returning calls regarding UM issues.

## Role of Provider Unit Physician Reviewers (Massachusetts and New Hampshire)

Many provider units have a physician reviewer. The physician reviewer works collaboratively with Tufts Health Plan care managers and Medical Affairs Department physicians to facilitate care management of Tufts Health Plan members throughout the continuum of care.

Tufts Health Plan physician reviewers are expected to:

- Be health care professionals who are qualified, as determined by the Plan, to render a clinical opinion about clinical conditions and treatments under review; physician reviewers are also required to maintain an active unrestricted license as a medical or osteopathic doctor
- Receive training from Tufts Health Plan personnel regarding Tufts Health Plan policies and procedures
- Serve as a resource for primary care providers (PCPs) and specialty care physicians in the provider unit regarding resources that are available within Tufts Health Plan and the medical community
- Review and authorize/deny out of area service requests by Provider Units for members using Tufts Health Plan MNGs/approved commercially purchased criteria

## Outpatient Services Review

Outpatient service review is performed in a number of ways. For all Commercial products, except Preferred Provider Organization (PPO), the PCP directs and manages member access to most specialty care based on clinical need. Using electronic or written authorization to a specialist, the PCP specifies the maximum number of times that a member can be seen for evaluation, testing, and treatment. The specialist is expected to communicate findings to the PCP and seek authorization for further treatment and, if necessary, additional referrals.

In addition, Tufts Health Plan reviews and manages certain outpatient services. These include the following:

- All services included on the prior authorization list

- Assisted reproductive technology (ART)
- Home care
- Oral surgery
- Outpatient BH/SUD services
- Outpatient physical, occupational, and speech therapy
- Certain out-of-network requests
- Select durable medical equipment (DME)
- Select injectable drugs
- Select pharmacy medications
- Select surgical procedures

## Retrospective Code Review

Utilization reports are used to retrospectively review outpatient services. These reports identify aberrant patterns of care. Further analysis occurs and action steps are taken with the provider unit as indicated. Broad claims issues are also identified and administratively addressed by the Plan.

## Inpatient Notification

Inpatient notification is required for all elective, urgent and emergency admissions to acute care, extended care/long-term acute care, acute rehabilitation and skilled nursing facilities. All inpatient admissions require inpatient notification prior to services being rendered, except for urgent or emergency care. Admitting providers and facilities are responsible for notifying Tufts Health Plan, following the procedures outlined in the [Referrals, Authorizations and Notifications](#) chapter and in accordance with the following time frames:

- Elective admissions must be reported no later than five business days prior to admission
- Urgent or emergency admissions must be reported by 5 p.m. the next business day following admission.

For facilities under a diagnosis-related group (DRG) arrangement, authorization for coverage of DRG inpatient services is determined using Tufts Health Plan and nationally-recognized medical necessity guidelines. For facilities under a non-DRG arrangement, an authorized initial length of stay and an authorized end date will be assigned for inpatient admissions.

**Note:** An inpatient notification is a condition of payment and does not take the place of referral or prior authorization requirements for services; it is subject to eligibility<sup>8</sup> and benefit verification.

Prospective utilization review for coverage of inpatient services is conducted for selected procedures, diagnoses or facilities. These include, but are not limited to:

- Transplants
- Preoperative inpatient hospital days (for facilities with a non-DRG arrangement only)
- Selected procedures and diagnoses to determine appropriateness and/or place of service
- Admissions resulting in an initial length of stay of zero days
- All extended care inpatient admissions
- Readmissions within 14 days of a previous discharge. Refer to the [DRG Facility Payment Policy](#) for more information.

**Note:** Except as otherwise required by law, BH/SUD intermediate levels of care require authorization through the Behavioral Health Department. For additional information, refer to the [Referral, Authorization and Notification Policy](#) on the Tufts Health Plan website.

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<sup>8</sup> Eligibility may be subject to retroactive reporting of disenrollment.

## Prospective and Concurrent Utilization Review of Inpatient Services

Decision and notification time frames are described in detail in the [Utilization Review Determinations Time Frames](#). Late notifications from a non-DRG facility will be reviewed from the date of notification forward. Late notifications from a DRG facility will be subject to a penalty reduction of the DRG payment. For more information, refer to the Inpatient [DRG](#) and [Non-DRG](#) Payment Policies.

## Medical Care Management and Discharge Planning

Registered nurse inpatient managers and utilization management coordinators staff the Inpatient Services Department. Inpatient utilization management is performed for contracting facilities either by telephone, fax or by access to the facilities EMR. Using nationally recognized clinical criteria, the inpatient manager perform inpatient review and determines whether the case should be referred to a Tufts Health Plan Medical Affairs Department physician for review. Inpatient managers also coordinate coverage decisions for discharge planning and assist with transition to contracted providers for the most appropriate next level of care. Members with multiple comorbidities and/or complex care needs, or those who are likely to incur future hospitalizations or emergency department visits, are referred to the Tufts Health Priority Care triage for possible enrollment. Additional programs following discharge care management include Healthy Birthday and Transition to Home, detailed in the Commercial Care Management section of this chapter.

Medical necessity criteria are used to evaluate the following:

- Severity of the member's illness
- Type and intensity of the service provided
- Level of care

An example of an inpatient coverage determination that Tufts Health Plan performs is a "criteria-not-met." A "criteria-not-met" determination is a request for inpatient level of care that does not meet medical necessity criteria for the requested level of care. Such cases are referred to a Tufts Health Plan Medical Affairs Department physician for a coverage determination. This determination may result in a denial of coverage to the member and, consequently, a denial of payment to the hospital and/or physician.

Payment determinations, such as observation level of payment is made using THP Observation Payment Policy.

Coverage denial decisions do not preclude the member from obtaining a service or supply, or the provider from recommending them to the member. Clinical decisions regarding the member's care are solely the responsibility of the member and the attending provider. However, the provider will be held financially liable for the noncovered service/supply unless the member specifically agrees in writing, in advance, to pay for the service/supply. The provider's agreement with the member must meet the terms of the provider health agreement through which the provider participates with Tufts Health Plan.

**Note:** Documentation that the member has agreed in advance to pay for these noncovered services is subject to review by Tufts Health Plan. Refer to the sample member waiver language in the [Referrals, Authorizations and Notifications](#) chapter.

To effectively perform telephonic or faxed reviews, Tufts Health Plan needs to receive clinical information within the requested time frame to meet regulatory and accreditation requirements. Failure to provide the requested clinical information within the requested timeframe will result in a denial of payment to the provider (administrative denial). In such instances, the member cannot be billed for the denied claim. Access to the facility EMR removes this administrative requirement of the facility, but must be provided to THP by the facility.

To determine correct compensation levels, Tufts Health Plan may also conduct reviews of some inpatient services (e.g., requests for inpatient services upon review may be able to be provided at an outpatient level of care, such as observation or surgical day care). Tufts Health Plan also conducts reviews to determine whether the services are provided or arranged in an efficient manner. Refer to the [payment policies](#) on the public Provider website for information regarding these types of reviews. These policies are intended to provide Tufts Health Plan providers and facilities with information on benefits, billing, and compensation for services. To ensure accurate claims processing, providers must follow these policies and/or distribute to their office staff on a regular basis.

## Data Requirements: Clinical Information

- Clinical information to support the appropriateness and level of service proposed
- History of presenting problem
- A clinical exam
- Diagnostic testing results
- Treatment plans and progress notes
- Patient psychosocial history
- Information on consult with treating practitioner
- Evaluations from other health care practitioners and providers
- Photographs (if applicable)
- Operative pathological reports
- Rehabilitation evaluations
- Anticipated discharge plan
- Contact person for detailed clinical information

## Clinical Practice Guidelines

Tufts Health Plan offers a variety of clinical programs to support adult, pediatric and pregnant members with preventive health, chronic conditions and complex medical needs (refer to the Behavioral Health section below for a list of behavioral health-related programs). Eligible members are primarily identified for condition management through medical and pharmacy claims, physician referral or self-referral. Members can also be identified through their participation in the Complex Care Management program.

The care management programs are available to members of all Commercial products and based on program criteria for the populations serviced. Programs are provided at no cost to the member and participation has no impact on eligible member benefits.

Refer to the [Clinical Practice Guidelines](#) page for more information on medical and behavioral health programs available to members.

## Identification of Members

Tufts Health Plan identifies medically complex members at risk for future hospitalization or high health care costs through predictive software and/or direct referrals.

- Physicians, nurse practitioners, medical directors, BH staff, transition manager registered nurses (RNs) and UM RNs identify the majority of members who warrant complex care management.
- Members are identified following admission to an acute or rehabilitation hospital for a complex medical or behavioral health episode or a catastrophic medical event.
- Members who participate in the Population Health (condition management) program and have more complex care management needs are referred to Priority Care.
- Members with complex needs may be referred into Priority Care from employers, medical providers and other Tufts Health Plan programs, or may also self-refer.

Complex medical conditions include but are not limited to members with the following:

- Stroke
- Transplant
- Brain injury
- Spinal cord injuries
- Substance use disorders
- Cancer diagnoses
- Complex gastrointestinal conditions
- Chronic rare diseases such as multiple sclerosis and amyotrophic lateral sclerosis
- Pediatric complex illness
- Medical conditions complicated by significant behavioral health concerns
- Diabetes with complex complications
- Members whose diseases do not fall into these specific categories, but are likely to use a high level of

medical resources

### Referral for all Commercial Care Management programs

Refer members to Commercial care management programs by any of the following options:

- Call: 888.766.9818 ext. 53532
- Fax: 617.972.9470
- Email: [PriorityCareReferral@tufts-health.com](mailto:PriorityCareReferral@tufts-health.com)

Leave the member's name, Tufts Health Plan ID number, member phone number and/or email contact information, reason for referral, as well as your name and contact information.

### Behavioral Health and Substance Use Disorder Care Management Programs

Referrals for the following behavioral health and substance use disorder (BH/SUD) care management programs can be made by calling the Behavioral Health Department at 800.208.9565.

#### Transition to Home Program

The Transition to Home Program is a resource for patients who have been recently hospitalized with a psychiatric diagnosis and require additional help to get back on their feet, follow-through with aftercare plans, or someone to talk to about any questions they may have.

#### Behavioral Health and Medical Integration Program

BH care management services are provided for members with coexisting medical and BH conditions. Some medical conditions can be exacerbated by BH issues and can worsen if not addressed. The BH integration program works with members to address BH issues that may be impacting their physical health.

#### Emergency Department Aftercare Program

In collaboration with the Behavioral Health and Medical Integration Program, Tufts Health Plan offers the Emergency Department (ED) Aftercare Program. Many members make repeated visits to the ED with medical symptoms for which a medical cause cannot be identified; often there is a BH component that has not been addressed.

In an effort to reduce unnecessary ED use and assist members with obtaining appropriate care, the ED aftercare program will assign a medical or BH care manager, as appropriate, to work with members to follow ED discharge instructions. The care manager will direct members to appropriate services to address issues that may be contributing to ED visits, and also assist with crisis planning so they are better equipped in the future to address situations that do not require a visit to the ED.

#### Substance Use Transitions Program

The Substance Use Transitions Program provides support to members who are in early recovery from the use of opiates, alcohol or other substances.

The program typically includes members who have recently entered or completed acute treatment in a hospital or residential treatment center for a diagnosis of a SUD. Care managers work with members to understand and follow through with aftercare plans and begin to take charge of their recovery.

The program also works with members who have recently needed medical care for an illness related to substance use. This includes members who have gone through detoxification in a medical unit, have been hospitalized due to a medical condition during which substance use problems were identified, or for medical problems that were caused or worsened by substance use. Care managers help to coordinate the different programs, providers and facilities involved with the member's care and help to establish goals and a plan to move forward.

The Tufts Health Plan Substance Use Disorder Navigator assists members, their families and their providers to

find resources that will help them to keep moving forward on the road to recovery. The Navigator will provide information on treatment programs, and also community resources available to help support the member and their family. For additional information, contact the Substance Use Disorder Navigator at 617.972.9400, ex. 54013.

## Concurrent Adverse Determination of Inpatient Coverage (Termination of Benefits)

Tufts Health Plan care managers may refer questions regarding the concurrent inpatient (including acute care, extended care, and BH/SUD intermediate level of care services) treatment plan to Medical Affairs Department providers. The Medical Affairs Department provider may speak with the attending provider to clarify the treatment plan or discuss the need for care management services.

Upon case referral, the Medical Affairs Department provider may conduct a concurrent inpatient utilization review coverage determination, in accordance with applicable law and accreditation standards. Concurrent adverse determinations for payment to the provider and facility may be rendered by a Medical Affairs Department provider in instances where clinical review criteria are not met. In these instances, the member is generally not held responsible for payment due to the “member hold harmless” clause in Tufts Health Plan provider contracts.

## Emergency Services

### Definition

The following definition is generally used in connection with most Tufts Health Plan products; however, the specific Tufts Health Plan benefit document should always be consulted for the exact definitions used for a particular product or member:

An illness or medical condition, whether physical or mental, which manifests itself by symptoms of sufficient severity (including severe pain) for which the absence of prompt medical attention could reasonably be expected by a prudent layperson (who possesses an average knowledge of health and medicine) to result in:

- Serious jeopardy to the physical and/or mental health of a member or another person (or with respect to pregnant member, the member's or her unborn child's physical and/or mental health)
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Inadequate time for pregnant women experiencing contractions to effect a safe transfer to another hospital before delivery, or a threat to the safety of the member or unborn child in the event of transfer to another hospital before delivery

Some examples of illnesses or medical conditions requiring emergency care are severe pain, a broken leg, loss of consciousness, vomiting blood, chest pain, difficulty breathing, or any medical condition that is quickly worsening.

Refer to the [Emergency Department Services Payment Policy](#) for more information regarding ED services.

## Emergency Services “Prudent Layperson” Standards

In accordance with applicable laws and accreditation standards, Tufts Health Plan provides coverage for emergency medical conditions that meet the “prudent layperson” standard. Tufts Health Plan benefit documents, member handbooks, policy manuals, and other printed materials clearly state that members have the option of calling the emergency telephone access number 911, or the local equivalent, or proceeding to the nearest facility whenever faced with a medical condition they believe to be an emergency. Tufts Health Plan provides coverage for medical and transportation expenses incurred as a result of emergency medical conditions that meet the “prudent layperson” standard.

### In-Plan Treatment

If the member is in the Tufts Health Plan service area, Tufts Health Plan staff works with the provider as part of

our standard UM protocol to review requests for additional medically necessary treatment. Situation examples include the following:

- If the member is being admitted for inpatient care, the Tufts Health Plan standard inpatient notification processes must be followed. The member's PCP will be notified, if on file.
- If the member requires outpatient services (occupational or physical therapy, BH/SUD services, etc.), Tufts Health Plan standard outpatient processes must be followed. Where applicable, PCP referral and prior authorization procedures are followed. These procedures are outlined in the Tufts Health Plan Provider Manual.
- If the member requires home health care services, Tufts Health Plan will work with the requesting provider (with authorization from the member's PCP, where applicable) to put medically necessary skilled services in place.

### Out-of-Plan Treatment

If the member is hospitalized outside the Tufts Health Plan service area, a Tufts Health Plan care manager will work with the treating physician and the member's family to determine the most appropriate next level of medically necessary care and coordinate its delivery and reimbursement at a place and location that Tufts Health Plan deems to be most clinically and financially appropriate at that time.

Further, the care manager will continue to coordinate appropriate care delivery in consultation with the treating providers and the member, and at such a time as Tufts Health Plan determines it to be safe and in the best interest of the member, efforts will be made to transition the member's care to providers within the Tufts Health Plan network.



## UTILIZATION REVIEW DETERMINATION TIME FRAMES

The purpose of this chart is to reference utilization review (UR) determination time frames for Tufts Health Plan Commercial products. It is not meant to completely outline the UR determination process. Refer to the [Utilization Management Guidelines](#) chapter for more detailed instructions regarding UR determinations.

Written notice of authorization requirements are applicable to determinations for fully insured HMO, POS and PPO products<sup>9</sup>. Tufts Health Plan does not rescind coverage of previously approved services unless it is determined that intentional misrepresentation or fraudulent practices have occurred. With respect to self-insured groups, upon request, Tufts Health Plan will provide written notice of authorization. In all instances, Tufts Health Plan strives to conduct UR determinations and provide notice of these determinations within a reasonable period of time, appropriate to the medical circumstances.

**Note:** A provider is defined as a health care practitioner, facility or vendor.

The following information is specific to members covered under a fully insured Rhode Island plan:

- A peer-to-peer attempt to communicate must be made/documented prior to the first level appeal determination.
- For prospective reviews of non-urgent and non-emergent health care services, a response within one business day of the request for a peer-to-peer discussion
- For concurrent and prospective reviews of urgent/emergent health care services, a response within a reasonable period of time of the request for a peer to peer discussion
- For retrospective reviews, a response prior to the internal level appeal decision
- Denial letter must include 180 day filing limit in which to file an appeal and RI appeal information
- Members must receive copies of all denial letters, even when not at financial risk for payment.
- In the event the member or an authorized representative fails to follow Tufts Health Plan’s claims procedures for a prospective (preservice) claim of nonurgent services, Tufts Health Plan will notify the member or the authorized representative, as appropriate, of this failure as soon as possible and no later than five calendar days following the failure and this notification must also inform member of the proper procedures to file a preservice claim. If the prospective (preservice) claim relates to urgent or emergent health care services, Tufts Health Plan will notify and inform member or the authorized representative, as appropriate, of the failure and proper procedures within 24 hours following the failure. Notification may be oral, unless written notification is requested by the member or authorized representative.

**Note:** For the purposes of this document, verbal and written notices to providers and members must occur as expeditiously as the member’s health requires, but no longer than the time frames specified below.

### Review Types

The review scenarios below apply to Commercial products in Massachusetts, New Hampshire and Rhode Island.

**Note:** some time frames may be state-specific and are identified where applicable.

#### Prospective (Pre-Service) Review of Nonurgent Services

UR that is performed prior to an admission or other course of treatment

<b>Decision Timeframe</b>	<ul style="list-style-type: none"> <li>• <b>Two business days</b> of receipt of the necessary information</li> <li>• <b>Note:</b> For RI residents or members receiving services in RI, decision and notification must be completed within <b>15 business days</b> of receipt of all necessary information, or prior to the proposed date of service if more than seven days, but not to exceed 15 calendar days from the request.</li> </ul>
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<sup>9</sup> The time frames outlined in this document are also applicable to Tufts Health Direct. Refer to the [Tufts Health Public Plans Provider Manual](#) for more information on Tufts Health Direct.

<b>Extension Rules</b>	<p>Decision time frame may be extended (if necessary) due to reasons outside control of Tufts Health Plan.</p> <ul style="list-style-type: none"> <li>• If after 10 calendar days from receipt of the request, the information received is inadequate for review, written notice must be sent to the member and provider requesting additional information.</li> <li>• Written notice must specify information must be received within 45 calendar days of receipt of the written request by Tufts Health Plan.</li> <li>• Once the requested additional information is received, the determination must be completed within <b>two business days</b>.</li> <li>• If the information is not received within the timeframe afforded the member and provider, an administrative denial may be rendered, if reasonable under the circumstances</li> <li>• <b>Note:</b> for RI fully insured plans, if the Plan has any information on which to render a determination (beyond simply the request itself), a medical necessity determination will be rendered based on the information available.</li> </ul>
<b>Notice of Authorization Determination</b>	<p>Verbal notice must be given to the provider within 24 hours of the authorization determination</p> <p>Written notice for fully insured products must be sent to the provider and member within two business days of the verbal notice, but no later than 15 calendar days from receipt of the request</p>
<b>Notice of Denial Determination</b>	<ul style="list-style-type: none"> <li>• Verbal notice must be given to the provider within 24 hours of the denial determination</li> <li>• Written notice must be sent to the provider and member within one working day of verbal notice</li> </ul> <p><b>Note:</b> Any request for coverage received for which a decision, verbal notification or written notification is due on Friday or over the weekend must be completed by the close of business on Friday.</p>

#### Review Type: Prospective (Pre-Service) Review of Urgent Services

UR performed for requests for coverage of medical care or treatment with respect to which the application of the time periods for making nonurgent coverage determinations:

- Could seriously jeopardize the life or health of the member or others, due to the member's psychological state, or the ability of the member to regain maximum function, or
- In the opinion of a physician with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.
- The process of rendering the decision and completing the notice must not exceed 72 hours.

<b>Decision Timeframe</b>	<p>Decision and notification as soon as possible taking into account medical exigencies and always within two business days of receipt of all information but not later than 72 hours of receipt of the request.</p>
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<b>Extension Rules</b>	<p>The decision timeframe may be extended, if necessary, once for 48 hours if Tufts Health Plan is unable to render a determination based on lack of information required to complete review.</p> <ul style="list-style-type: none"> <li>• Within 24 hours after receipt of the coverage request, verbal notice must be provided to the provider, specifying information required to complete the determination. The verbal notice must specify that the additional information must be received by Tufts Health Plan within 48 hours of the verbal request from Tufts Health Plan.</li> <li>• Prospective review must be completed as soon as possible, taking into account the medical exigencies, but no later than 48 hours after the earlier of a) the receipt of information, or b) the end of the period afforded the member/provider to provide the information.</li> </ul> <p>*Please note that for RI fully insured Plans, if the Plan has any information on which to render a determination (beyond simply the request itself), a medical necessity determination will be rendered based on the information available.</p>
<b>Notice of Authorization Determination</b>	<p>Verbal notice to the requesting provider, must occur as soon as possible, taking into account the medical exigencies and always within 24 hours of the decision, but no later than 72 hours of the receipt of the request.</p> <ul style="list-style-type: none"> <li>• Verbal notice for authorizations must be completed by end of day Friday.</li> <li>• Written notice for fully insured commercial products must be sent to the requesting provider and the member within 2 working days of verbal notice</li> <li>• If the written authorization notice is requested by the member, provider or facility the written notice will be sent within 72 hours of the request.</li> </ul>
<b>Notice of Denial Determination</b>	<p>Verbal notice to the requesting provider must occur as soon as possible, taking into account the medical exigencies, and always within 24 hours of the decision but no later than 72 hours of receipt of the request.</p> <ul style="list-style-type: none"> <li>• The provider must be verbally informed of the process of initiating the expedited appeals.</li> <li>• Written Notice must be sent to the provider and member within one working day of verbal notice, but no later than 72 hours of receipt of the request.</li> </ul> <p>*Any request for coverage received for which a decision, verbal notification or written notification is due on Friday or over the weekend must be completed by the close of business on Friday.</p>

**Review Type: Concurrent Review of Urgent Services**

UR performed during a hospital stay or other course of treatment. It includes review of requests for extended stays or additional services.

UR performed for requests for coverage of medical care or treatment with respect to which the application of the time periods for making nonurgent coverage determinations:

- Could seriously jeopardize the life or health of the member or others, due to the member’s psychological state, or the ability of the member to regain maximum function, or
- In the opinion of a physician with knowledge of the member’s medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

**Note:** Must always consider request concurrent urgent if request made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments

\*The whole process of rendering the decision and completing the notice must not exceed 72 hours.

<b>Decision Timeframe</b>	<p>As soon as possible, taking into account the medical exigencies, and within 24 hours of the receipt of the request.</p>
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<b>Extension Rules</b>	N/A
<b>Notice of Authorization Determination</b>	<p>Verbal notice to the provider as soon as possible, taking into account the medical exigencies, but always within 24 hours of receipt of the request. Written notice for fully insured products must be sent to the provider and the member within 24 hours of the receipt of the request.</p> <p>If the written authorization notice is requested by the member, provider or facility, the written notice will be sent:</p> <ul style="list-style-type: none"> <li>• Within 24 hours of the request, if the request was received at least 24 hours before the expiration of the currently certified period or treatment; or</li> <li>• Within 72 hours of the request, if the request was received less than 24 hours before the expiration of the currently certified period or treatments.</li> </ul>
<b>Notice of Denial Determination</b>	<p>Verbal notice to the provider must occur as soon as possible, taking into account the medical exigencies and always within 24 hours of the receipt of the request.</p> <ul style="list-style-type: none"> <li>• Written notice must be sent to the provider and the member within 24 hours of receipt of request. For inpatient cases, written notice may be provided via facsimile.</li> </ul> <p><b>Note:</b> Any request for coverage received for which a decision, verbal notification or written notification is due on Friday or over the weekend must be completed by the close of business on Friday.</p>

#### Review Type: Retrospective (Post-Service)

UR of services after they have been provided to the member

<b>Decision Timeframe</b>	Decisions must occur within 30 calendar days of the receipt of the request for coverage.
<b>Extension Rules</b>	<p>The decision timeframe may be extended for 15 calendar days, if necessary due to reasons beyond control of plan/lack of information.</p> <p>Written notice must be sent to the member and provider within 30 calendar days if the information received is inadequate for review, specifying the information required to complete the review.</p> <ul style="list-style-type: none"> <li>• The written notice must specify that the additional information must be received by Tufts Health Plan within 45 calendar days of receipt of the written request for additional information.</li> <li>• The time period for making the retrospective review determination is suspended from the date of the written notification to the earlier of: <ul style="list-style-type: none"> <li>• The date on which Tufts Health Plan receives a response from the member, or</li> <li>• The date established for furnishing the requested information (at least 45 calendar days) has expired</li> </ul> </li> <li>• The extension period (15 calendar days) within which the review determination must be completed begins from the date Tufts Health Plan received additional information (without regard to whether all of the requested information is provided) or, if earlier, the due date established by Tufts Health Plan for furnishing the requested information (at least 45 calendar days).</li> <li>• If the requested information is received, the retrospective review determination, verbal and written notice must be completed within 15 calendar days.</li> <li>• If the requested information is not received, an administrative denial can be rendered within 15 calendar days. Verbal and written notice must also be completed within 15 calendar days.</li> </ul> <p>*Please note that for RI fully insured groups, if Tufts Health Plan has any information on which to render a determination (beyond simply the request itself), a medical necessity determination will be rendered based on the information available.</p>

<b>Notice of Authorization Determination</b>	Written notice may be sent to the provider and member within 30 calendar days (unless suspended; if suspended, complete within 15 calendar days) of the receipt of the request for coverage
<b>Notice of Denial Determination</b>	Written notice must be sent to the provider and member within 30 calendar days of receipt of the request for coverage (unless decision timeframe is suspended; if suspended, complete within 15 calendar days).

## IMAGING PRIVILEGING PROGRAM

### Imaging Privileges for Nonradiologists

Tufts Health Plan's Imaging Privileging Program addresses quality and utilization issues related to nonemergency, outpatient diagnostic imaging provided by nonradiologists. The program's goal is to enhance quality and patient safety, assure the appropriateness of tests, and improve cost-effectiveness while minimizing disruption of healthcare delivery. Privileging is a condition of payment; however, claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral and utilization management guidelines when applicable, adherence to plan policies and procedures, and claims editing logic.

Providers who are nonradiologists and provide imaging services within an office setting must be privileged. Services for which a provider is privileged are considered integral to the practice of the provider and are reimbursable. In most instances, privileging to perform specialty appropriate procedures is granted based on a provider's specialty designation.

**Note:** Tufts Health Plan does not backdate privileging requests.

Tufts Health Plan does not compensate MRI/MRA, CT/CTA, and PET services performed by a nonradiologist. This includes both the technical and professional component. MRI/MRA, CT/CTA, and PET procedures must be performed in a contracted designated freestanding imaging center or a contracting hospital.

**Note:** Refer to the [High-Tech Imaging Prior Authorization Program](#) for more information on specific procedures that may require prior authorization.

The Tufts Health Plan specialty- and service-specific privileging tables below list approved procedures by specialty and CPT code. Providers who do not have specialty- or service-specific training addressed in these tables do not have imaging privileges and will not be compensated for any imaging services performed in an office setting. Providers may not bill the member for such services unless the member has agreed in advance, in writing, to forego services by a privileged provider. In these cases, providers are expected to direct members back to their PCP to have the necessary diagnostic imaging study performed by the appropriate Tufts Health Plan participating radiologist or imaging facility.

The following is additional information about the Tufts Health Plan Imaging Privileging Program:

- Mammographies may be performed in an office setting, regardless of provider specialty. All facilities must comply with the Mammography Quality Standards Act (MQSA) regulations. American College of Radiology (ACR) accreditation is required.
- Mobile imaging services are subject to the same privileging restrictions established for the provider for whom they perform services, except for obstetrical (OB) ultrasound. If a mobile provider performs an OB ultrasound in an office setting, a Tufts Health Plan board-certified radiologist or American Institute of Ultrasound Medicine (AIUM) accredited provider must interpret the films.

### Specialty-Specific Privileging Tables

Board-certified or board-eligible providers in the specialties indicated in the following tables can only be reimbursed for the imaging procedures listed under that specialty. A Tufts Health Plan radiologist or imaging provider must perform all other imaging procedures. The description under each specialty indicates whether the provider will be privileged for reimbursement of the technical or global component of each procedure.

**Note:** Specialists who are privileged for the technical component must have a Tufts Health Plan network radiologist perform the final reading (professional component) of the study. Specialists who are privileged to perform the global component must comply with the ACR standards for communication and to generate a written report.

The specialty-specific tables address the privileges for the following specialties:

- [Anesthesiology](#) or physical medicine and rehabilitation
- [Cardiovascular disease](#)
- [Echocardiography](#)

- [Endocrinology](#)
- [General vascular surgery](#)
- [Hand surgery](#)
- [Nuclear cardiology](#)
- [Obstetrical ultrasound](#)
- [Ophthalmology](#)
- [Orthopedic surgery and rheumatology](#)
- [Podiatric medicine](#)
- [PCPs](#) (internal medicine, family practice, pediatrics)
- [Pulmonary disease](#)
- [Urology](#)

### Anesthesiology or Physical Medicine and Rehabilitation

Providers who specialize in anesthesiology or physical medicine and rehabilitation are privileged to perform the following services and are eligible for global compensation, if appropriate.

Procedure Code	Description
72275	Epidurography, radiological supervision and interpretation
77002	Fluoroscopic guidance for needle placement
77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)

### Cardiovascular Disease

Providers who specialize in cardiovascular disease are privileged to perform the following services and are eligible for technical compensation only. The professional component of these procedures must be performed by a radiologist.

Procedure Code	Description
71045	Chest, 1 view
71046	Chest, 2 views
71047	Chest, 3 views
71048	Chest, 4 or more views
76706	Ultrasound, abdominal aortic, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)
93880	Duplex scan, extracranial arteries, complete
93882	Duplex scan, extracranial arteries, limited (follow-up)
93886	Doppler, intracranial arteries, complete
93888	Doppler, intracranial arteries, limited (follow-up)
93922	Physiologic extremity study
93923	Physiologic extremity study
93924	Physiologic extremity study
93925	Lower extremity artery study, complete
93926	Lower extremity artery study, limited
93930	Upper extremity artery study, complete
93931	Upper extremity artery study, complete
93970	Extremity veins study, complete
93971	Extremity veins study, limited

Procedure Code	Description
93975	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete
93976	Limited study
93978	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete
93979	Unilateral or limited study
93980	Duplex scan of arterial inflow and venous outflow of penile vessels; complete
93981	Follow-up limited study
93990	Duplex scan, hemodialysis access

### Echocardiography (ECG)

Providers who specialize in cardiovascular disease, pulmonary disease, cardiac electrophysiology, or pediatric cardiology are privileged to perform the following services.

Procedure Code	Description
93303	Transthoracic ECG for congenital cardiac anomalies; complete
93304	Transthoracic ECG for congenital cardiac anomalies; complete follow-up or limited study
93306	ECG, transthoracic, real-time with image documentation (2D), includes M-mode recording
93307	ECG, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete
93308	ECG, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete follow-up or limited study
93312	ECG, transesophageal (TEE), real-time with image documentation (2D) with or without M-mode recording
93313	Placement of TEE probe only
93314	Image acquisition, interpretation and report only
93315	ECG, TEE, for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
93316	Placement of TEE probe only
93317	Image acquisition, interpretation and report only
93318	ECG, TEE, for monitoring purposes, including probe placement, real time 2D image acquisition and interpretation
93320*	Doppler ECG, pulsed wave and/or continuous wave with spectral display; complete
93321*	Follow-up or limited study
93325*	Doppler ECG color flow velocity mapping
93350	ECG, transthoracic, real-time with image documentation (2D), with or without M-mode recording
93351	ECG, transthoracic, real-time with image documentation (2D), includes M-mode recording
93352*	Use of ECG contrast agent during stress ECG

\* List separately in addition to codes for ECG imaging primary procedure

**Note:** Prior authorization is required for outpatient high-tech imaging services through National Imaging Associates (NIA). The procedure codes listed above require prior authorization, which can be obtained by logging into [RadMD](#) or calling NIA at 866.642.9703 prior to scheduling the test. For additional information, refer to the [High-Tech Imaging Prior Authorization Program](#).



## Endocrinology

Providers specializing in endocrinology are privileged to perform the following services.

Procedure Code	Description
76942	Ultrasonic guidance for needle placement, imaging supervision, and interpretation
76536	Ultrasound, soft tissues of head and neck, real-time with image documentation

## General Vascular Surgery

Providers with a specialty of general vascular surgery are privileged to perform the following services.

Procedure Code	Description
93880	Duplex scan, extracranial arteries, complete
93882	Duplex scan, extracranial arteries, limited (follow-up)
93886	Doppler, intracranial arteries, complete
93888	Doppler, intracranial arteries, limited (follow-up)
93922	Physiologic extremity study
93923	Physiologic extremity study
93924	Physiologic extremity study
93925	Lower extremity artery study, complete
93926	Lower extremity artery study, limited
93930	Upper extremity artery study, complete
93931	Upper extremity artery study, complete
93970	Extremity veins study, complete
93971	Extremity veins study, limited
93975	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study
93976	Limited study
93978	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study
93979	Unilateral or limited study
93980	Duplex scan of arterial inflow and venous outflow of penile vessels; complete study
93981	Follow-up limited study
93990	Duplex scan, hemodialysis access

## Hand Surgery

Providers who specialize in hand surgery are privileged to perform the following services.

Procedure Code	Description
73070	Radiology exam, elbow, anteroposterior and lateral views
73080	Radiology exam, elbow, anteroposterior and lateral views; complete, 3+ views
73090	Radiologic examination forearm; 2 views
73100	X-ray exam of wrist
73110	X-ray exam of wrist, complete
73120	X-ray exam of hand, 2 views

Procedure Code	Description
73130	X-ray exam of hand, 3+ views
73140	X-ray exam of finger(s), 2+ views

### Nuclear Cardiology

Providers who specialize in nuclear medicine, cardiovascular disease or cardiac electrophysiology are privileged to perform the following services:

Procedure Code	Description
78451	Myocardial perfusion imaging, tomographic (SPECT); single study
78452	Myocardial perfusion imaging, tomographic (SPECT); multiple studies
78453	Myocardial perfusion imaging; single study
78454	Myocardial perfusion imaging, planar; multiple studies
78466	Myocardial imaging
78468	With ejection fraction by first pass
78469	Tomographic SPECT
78472	Nuclear scan, cardiac blood pool, single, gated equilibrium
78473	Multiple studies
78481	Nuclear scan, cardiac blood pool
78483	Nuclear scan, multiple studies
78494	Cardiac blood pool imaging, SPECT at rest
78496	Cardiac blood pool imaging, single study
A4641	Supply of radiopharmaceutical diagnostic imaging agent, not otherwise classified

**Note:** Prior authorization is required for outpatient high-tech imaging services through National Imaging Associates (NIA). The procedure codes listed above require prior authorization, which can be obtained by logging into [RadMD](#) or calling NIA at 866.642.9703 prior to scheduling the test. For additional information, refer to the [High-Tech Imaging Prior Authorization Program](#).

### Obstetrical Ultrasound

Providers who specialize in obstetrics and gynecology are privileged to perform the following services:

Procedure Code	Description
76801	OB ultrasound, pregnant uterus, <14 weeks, single fetus
76802	Each additional gestation, <14 weeks
76805	OB ultrasound, complete
76810	OB ultrasound, complete multi gestate
76811	OB ultrasound, detailed fetal anatomic exam, single fetus
76812	OB ultrasound, detailed fetal anatomic exam, each additional fetus
76813	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation
76814	Each additional gestation (List separately in addition to code for primary procedure)
76815	OB ultrasound, limited
76816	OB ultrasound, follow-up (repeat)
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal

Procedure Code	Description
76818	Fetal biophysical profile
76819	Fetal biophysical profile; without non-stress testing
76820	Doppler velocimetry, fetal; umbilical artery
76821	Doppler velocimetry, fetal; middle cerebral artery
76825	Fetal echocardiography, real time with image documentation (2D) with or without M-mode recording
76826	Fetal echocardiography, follow-up (repeat)
76827	Fetal Doppler echocardiography
76828	Fetal Doppler echocardiography, follow-up (repeat)
76830	Transvaginal ultrasound
76831	Hysterosonography, with or without color flow Doppler
76856	Echography, pelvic B-scan/complete
76857	Echography, pelvic B-scan/limited
76941	Ultrasound guide for intrauterine fetal transfusion
76945	Ultrasound guide for Chorionic Villus sampling
76946	Ultrasound guide for amniocentesis and amnio guidance codes
76948	Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation

### Ophthalmology

Providers who specialize in ophthalmology are privileged to perform the following services:

Procedure Code	Description
76510	Ophthalmic ultrasound, diagnostic, B-scan and quantitative A-scan performed during same patient encounter
76511	Ophthalmic ultrasound, diagnostic, A-scan only
76512	Ophthalmic ultrasound, diagnostic, contact B-scan (w/ or w/o A-scan)
76513	Ophthalmic ultrasound, diagnostic, immersion (water bath) B-scan
76514	Ophthalmic ultrasound, corneal pachymetry
76516	Ophthalmic biometry by ultrasound, A-scan
76519	Ophthalmic biometry by ultrasound, A-scan, w/ intraocular lens power calculation
76529	Echo exam of eye for foreign body

### Orthopedic Surgery and Rheumatology

Providers who specialize in orthopedic surgery or rheumatology are privileged to perform the following services:

Procedure Code	Description
71100	Ribs, unilateral; 2 views
71101	Ribs, posteroanterior chest; 3+ views
71110	Ribs, bilateral; 3 views
71111	Ribs, posteroanterior chest; 4+ views
72010	Spine, complete survey
72020	Spine, 1 views, specific level
72040	Cervical spine, 2 views

Procedure Code	Description
72050	Cervical spine, 4+ views
72052	Cervical spine, w/oblique & flexion
72070	Thoracic spine, 2 views
72072	Thoracic spine, 2 views, w/swim view
72074	Thoracic spine, 4+ views, w/obliques
72080	Thoracolumbar spine, 2 views
72081	Spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (e.g., scoliosis evaluation); 1 view
72082	Spine, entire thoracic and lumbar; 2-3 views
72083	Spine, entire thoracic and lumbar; 4-5 views
72084	Spine, entire thoracic and lumbar; 6+ views
72100	Lumbosacral spine, AP & LAT
72110	Lumbosacral spine, complete w/obliques
72114	Lumbosacral spine, complete, bending
72120	Lumbosacral spine, 4+ views, bending
72170	Pelvis, AP only
72190	Pelvis, 3+VW
72200	X-ray exam of sacroiliac joints
72202	X-ray exam of sacroiliac joints
72220	X-ray exam of tailbone, 2+ views
73000	Clavicle, complete
73010	Scapula, complete
73020	Shoulder, 1 views
73030	Shoulder, complete, 2+ views
73050	Acromioclavicular joints, bilateral
73060	Humerus, 2+ views
73070	Elbow 2 views (AP & LAT)
73080	Elbow, complete, 3+ views
73090	Forearm 2 views (AP & LAT)
73092	Upper extremity, infant, 2+ views
73100	Wrist 2VW (AP & LAT)
73110	Wrist, complete, 3+VW
73120	Hand 2VW
73130	Hand 3+VW
73140	Finger(s), 2+VW
73501	Radiologic examination, hip, unilateral, with pelvis when performed; 1 view
73502	Radiologic examination, hip, unilateral; 2-3 views
73503	Radiologic examination, hip, unilateral; 4+ views
73521	Radiologic examination, hips, bilateral; 2 views
73522	Radiologic examination, hips, bilateral; 3-4 views
73523	Radiologic examination, hips, bilateral; 5+ views
73551	Radiologic examination, femur; 1 view
73552	Radiologic examination, femur; 2+ views
73560	Knee, 2 views (AP & LAT)

Procedure Code	Description
73562	Knee w/obliques 3+ views
73564	Knee w/obliques, tunnel, patellar, standing
73565	Knees, both, stand, AP
73590	Tibia and fibula AP & LAT
73592	Lower extremity infant 2+ views
73600	Ankle, 2 views (AP & LAT)
73610	Ankle, complete, 3+ views
73620	Foot, 2 views (AP & LAT)
73630	Foot, complete, 3+ views
73650	Heel, 2+ views
73660	Toe(s) 2+ views
77071	Manual application of stress performed by physician or other qualified health care professional for joint radiography, including contralateral joint if indicated

### Podiatric Medicine

Providers who specialize in podiatric medicine are privileged to perform the following services:

Procedure Code	Description
73600	Ankle, 2 views (AP & LAT)
73610	Ankle, complete
73620	Foot, 2 views (AP & LAT)
73630	Foot, complete, 3+ views
73650	Heel, 2+ views
73660	Toe(s) 2+ views

### PCPs (Internal Medicine, Family Practice, Pediatrics)

PCPs are able to perform the following services and are eligible for compensation of the technical component only, if appropriate. The professional component of these procedures must be performed by a radiologist.

Procedure Code	Description
71045	Chest, 1 view
71046	Chest, 2 views
73020	Shoulder, 1 views
73030	Shoulder, complete 2+ views
73050	Acromioclavicular joints, bilateral
73060	Humerus, 2+ views
73070	Elbow 2 views (AP & LAT)
73080	Elbow, complete, 3+ views
73090	Forearm 2 views (AP & LAT)
73092	Upper extremity, infant, 2+ views
73100	Wrist 2 views (AP & LAT)
73110	Wrist, complete, 3+ views
73120	Hand 2 views

Procedure Code	Description
73130	Hand 3+VW
73140	Finger(s), 2+VW
73501	Radiologic examination, hip, unilateral, with pelvis when performed; 1 view
73502	Radiologic examination, hip, unilateral; 2-3 views
73503	Radiologic examination, hip, unilateral; 4+ views
73521	Radiologic examination, hips, bilateral; 2 views
73522	Radiologic examination, hips, bilateral; 3-4 views
73523	Radiologic examination, hips, bilateral; 5+ views
73551	Radiologic examination, femur; 1 view
73552	Radiologic examination, femur; minimum 2 views
73560	Knee 2 views (AP & LAT)
73562	Knee w/obliques 3+ views
73564	Knee w/obliques, tunnel, patellar, standing
73565	Knee, both, stand, AP
73590	Tibia and fibula AP & LAT
73592	Lower extremity infant 2+ views
73600	Ankle, 2 views (AP & LAT)
73610	Ankle, complete, 3+ views
73620	Foot, 2 views (AP & LAT)
73630	Foot, complete 3+ views
73650	Heel, 2+ views
73660	Toe(s) 2+ views
74018	Radiologic examination, abdomen; 1 view
74022	Complete acute abdomen series

### Pulmonary Disease

Providers who specialize in pulmonary disease are privileged to perform the following services and are eligible for compensation of the technical component only, if appropriate. The professional component of these procedures must be performed by a radiologist.

Procedure Code	Description
71045	Chest, 1 view
71046	Chest, 2 views
71047	Chest, 3 views
71048	Chest, 4 or more views

### Urology

Providers who specialize in urology are privileged to perform the following services.

Procedure Code	Description
74420	Retrograde urography
74455	Urethrocystography, voiding
76770	Echography, retroperitoneal B-scan, complete

Procedure Code	Description
76775	Echo exam, retroperitoneal, limited
76856	Echo exam of pelvis, complete
76857	Echo exam of pelvis, limited
76870	Echo exam of scrotum
76872	Echo exam of prostate
76942	Ultrasound guide for needle biopsy

## Service-Specific Certifications

Tufts Health Plan requires service-specific certification or accreditation for providers to be compensated for the following imaging services. The certifications and accreditations are required from the organizations listed within the category of service identified, and providers will only be reimbursed when Tufts Health Plan receives a copy of the certification or accreditation.

Providers may send a copy of the certificate or accreditation to:

705 Mount Auburn Street  
 Mail Stop 84  
 Watertown MA 02472  
 Attn: Tufts Health Plan Imaging Privileging Committee.

**Note:** Service-specific privileges are not granted retroactively.

The following service-specific privileges allow for global compensation (providers are required to comply with the ACR standards for communication and to generate a written report). The service-specific certifications are:

- [Bone densitometry](#)
- [Breast ultrasound](#)
- [Vascular ultrasound](#)

### Bone Densitometry

International Society for Clinical Densitometry (ISCD) certification is required for providers who wish to perform and/or interpret the bone densitometry studies listed below. To perform these services, providers must submit a copy of the ISCD certification and a completed [Bone Density Equipment Information Form](#) to Tufts Health Plan.

For information about the individual certification programs and course availability, contact ISCD at 860.259.1000 or access their [website](#).

Procedure Code	Description
76977	Quantitative ultrasound
77078	Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (e.g., hips, pelvis, spine)
77080	DEXA (dual energy x-ray absorptiometry), bone density study
77081	DEXA, peripheral
77085	Axial skeleton (e.g., hips, pelvis, spine), including vertebral fracture assessment
77086	Vertebral fracture assessment via dual-energy x-ray absorptiometry (DXA)
G0130	SEXA

### Breast Ultrasound

Accreditation by the American Institute of Ultrasound in Medicine (AIUM) or certification by the American Society

of Breast Surgeons (ASBS) is required for all providers who wish to perform and/or interpret the breast ultrasounds listed below. To contact AIUM for more information on becoming an accredited facility, call 800.638.5352 or visit their [website](#).

Providers who have been initially privileged with an ASBS certification must be re-privileged (at the expiration of the ASBS certification) with an AIUM accreditation.

Procedure Code	Description
76641	Ultrasound, breast, unilateral; complete
76642	Ultrasound, breast, unilateral; limited
76942	Ultrasonic guidance for needle placement, imaging supervision and interpretation

### Vascular Ultrasound

Accreditation by the Intersocietal Accreditation Commission (IAC) is required for providers who are not board-certified or eligible in general vascular surgery or cardiovascular disease. For more information about this accreditation, contact IAC at 800.838.2110 or visit their [website](#).

Procedure Code	Description
93880	Duplex scan, extracranial arteries, complete
93882	Duplex scan, extracranial arteries, limited (follow-up)
93886	Doppler, intracranial arteries, complete
93888	Doppler, intracranial arteries, limited (follow-up)
93922	Physiologic extremity study
93923	Physiologic extremity study
93924	Physiologic extremity study
93925	Lower extremity artery study, complete
93926	Lower extremity artery study, limited
93930	Upper extremity artery study, complete
93931	Upper extremity artery study, complete
93970	Extremity veins study, complete
93971	Extremity veins study, limited
93975	Duplex scan of arterial inflow & venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study
93976	Limited study
93978	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study
93979	Unilateral or limited study
93980	Duplex scan of arterial inflow & venous outflow of penile vessels; complete study
93981	Follow-up limited study
93990	Duplex scan, hemodialysis access