Authorizations

The Commercial Provider Manual applies to Commercial\(^1\) products (including Tufts Health Freedom Plan).

**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.

**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 (refer to the Behavioral Health and Substance Use Disorder payment policies), the PCP can authorize a standing referral to a specialist in the Tufts Health Plan network when: 1) he or she decides that such a referral is medically necessary, 2) the specialist agrees to a treatment plan and provides the PCP with all necessary clinical and administrative information on a regular basis, and 3) 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. Except for the following, all specialty services require a referral authorization when performed by a Tufts Health Plan provider:

- Annual gynecological exam and follow-up services
- Chiropractic services
- Durable medical equipment (DME)
- Emergency department (ED) services
- Home health care services
- Laboratory
- Imaging services
- Behavioral health/substance use disorder (BH/SUD) services
- Observation room services
- Obstetrical care
- Oral surgery
- Routine eye exam

**Note:** The above services may require notification or authorization from either Tufts Health Plan or another approved vendor.

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\(^1\) Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink\(^{SM}\) when Tufts Health Plan is the primary administrator.
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.

Tufts Health Plan uses W.B. Mason to print paper referral forms. To order referral forms, fill out the W.B. Mason Provider Forms Requisition, available in the Provider Resource Center, and fax it to W.B. Mason at 800.738.3272 or email at 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

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

<table>
<thead>
<tr>
<th>PRIMARY CARE PROVIDER INFORMATION</th>
<th>Special Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field Name</td>
<td>Special Instructions</td>
</tr>
<tr>
<td>Name</td>
<td>PCP's full name is required</td>
</tr>
<tr>
<td>Provider NPI</td>
<td>PCP's full NPI is required</td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SPECIALTY CARE PROVIDER INFORMATION</th>
<th>Special Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field Name</td>
<td>Special Instructions</td>
</tr>
<tr>
<td>Name</td>
<td>Provider’s full name is required</td>
</tr>
<tr>
<td>Provider NPI</td>
<td>Provider’s full NPI is required</td>
</tr>
<tr>
<td>Specialty</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td></td>
</tr>
<tr>
<td>Is above provider within the member’s network?</td>
<td>Search Select Network Plans in the Provider Directory.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TYPE OF REFERRAL</th>
<th></th>
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</thead>
</table>
Tufts Health Plan provider (in-plan) | Referral made by a PCP to a specialist within 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)
Provider outside member’s limited network plan | Referrals to out-of-plan or out-of-network providers required physician reviewer signature. *Before providing services to Spirit plan members, specialty care providers outside of the Spirit network must submit a letter of medical necessity by fax for approval.

**SERVICES REQUESTED (check one)**

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation (one visit only)</td>
<td>Authorizes one specialty visit</td>
</tr>
<tr>
<td>Consultation/second opinion only (one visit only)</td>
<td>Authorizes one second opinion visit</td>
</tr>
<tr>
<td>Consultation/diagnostic studies</td>
<td>Authorizes up to three visits, and includes diagnostics</td>
</tr>
<tr>
<td>Consultation/diagnostic studies and treatment</td>
<td>Enter the specific number of visits requested. If left blank, the default allowed is one visit</td>
</tr>
<tr>
<td>Number of visits: Physical therapy</td>
<td>Physical Therapy is not to exceed 1 evaluation and 8 treatment visits</td>
</tr>
<tr>
<td>Number of visits: Occupational therapy</td>
<td>Effective for dates of service on or after 1/1/2017, occupational therapy is not to exceed 1 evaluation and 8 treatment visits</td>
</tr>
<tr>
<td>Number of visits: Speech therapy</td>
<td>Provide number of visits</td>
</tr>
<tr>
<td>Diagnostic studies to be performed at</td>
<td>Location where diagnostic studies must be performed</td>
</tr>
</tbody>
</table>

**Signature of PCP**

**Authorization Date**

**Signature of Physician Reviewer (if applicable)**

**Authorization Date**

**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:** Patient
- **White:** Use a pre-addressed envelope (available at W.B. Mason, phone 508.436.8777) to mail to Tufts Health Plan

**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](#).

**Note:** A general type of acknowledgement (e.g., “I agree to pay for anything that my insurance does not pay for”) is not regarded as adequate to confirm the member's understanding and
acknowledgement to proceed without a required referral, or that he/she understands that it is not a covered service.

**Inpatient Admissions**

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. Tufts Health Plan requires prior authorization for certain services, medical drugs, devices, and equipment in order to be covered. Refer to the Clinical Resources section of our website to determine which services require prior authorization and the department that is responsible for review. Refer to the Authorization Policy on our website 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 Commercial admissions. Providers can log on to the Tufts Health Plan secure website to see these authorizations 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, he/she may request a faxed copy of the authorization.

**Note:** Inpatient notification does not take the place of a referral or prior authorization requirements for a service.

The following information is required when notifying Tufts Health Plan of an inpatient notification for a member for inpatient care:
- Member's name
- Member's Tufts Health Plan ID number
- Member's date of birth
- Hospital name
- Attending provider name
- Date of admission and/or service
- Complete diagnosis and procedure information (an inpatient diagnosis code is required.)

**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 Commercial acute inpatient non-DRG admission and extended care 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 Commercial 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 skilled nursing facility (SNF) level I to level II). Inpatient notification submitted via fax will also be available for viewing on the provider website. The Inpatient Admissions team within 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.

**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 inpatient level of care.

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 in the Authorization Policy. Providers can 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 our secure Provider website

• Access New England Healthcare EDI Network (NEHEN) (the provider must be a NEHEN member)

• Fax a completed inpatient notification form to the Inpatient Admissions team within the Precertification Operations Department at 617.972.9590 or 800.843.3553.

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), not through the Inpatient Admissions team. For additional information, contact American Health Holding.

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 Massachusetts Health Quality Partners (MHQP) Obstetrical Risk Assessment form and fax it to the Health Programs Department at 617.972.9417. This ensures that members receive all maternity benefits and are evaluated for participation in the Healthy Birthday (Tufts Health Plan’s preterm labor and delivery prevention program) and smoking-cessation for pregnant women programs.

For additional information, refer to our Obstetrics/Gynecology Payment Policy.

Rescheduled Elective Admissions
If an elective admission is rescheduled, fax the change to the Precertification Operations staff at 617.972.9590 or 800.843.3553 within the reporting time frame guidelines.

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.
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.

Concurrent Review
For all inpatient admissions regardless of type of service, the Tufts Health Plan care manager performs concurrent reviews using established screening criteria.

Payment and Denials
Only those hospital-based inpatient days of which Tufts Health Plan has been notified in accordance with this policy 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.

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 compensation dispute using the claim adjustments tool on the secure provider website. If you are not a registered user of our website, go to the secure Provider Login and follow the instructions. Providers may also submit a compensation dispute by mailing a Request for Claim Review Form to Tufts Health Plan. For more information, refer to the Provider Payment Dispute Policy.

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. The 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:

- Login 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:

- Login to the secure Provider website
- Call 800.208.9565 to use the IVR system
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 coinsurance and/or deductible 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 CareLinkSM. 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**

**Commercial Products**

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. 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.

**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 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.

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 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**
Certain services and procedures require prior authorization. Refer to the Clinical Resources section on the Resource Center for a list of procedures that require prior authorization. Benefits can vary by employer group. Direct members either to their benefit booklets or to call Member Services for clarification.

**Specialty Care Services**
Refer to the Provider Resource Center for authorization guidelines for specialty care services.

**Table 2: Specialty Care Services**

<table>
<thead>
<tr>
<th>Specialty Care Service</th>
<th>Description</th>
</tr>
</thead>
</table>
| Assisted Reproductive Technology (ART) | • The Massachusetts Infertility Mandate of 1988 requires all Commercial insurers and HMOs to cover non-experimental infertility or ART procedures for Massachusetts residents. As part of a member’s benefit package, Tufts Health Plan covers appropriately authorized, medically necessary ART treatment, such as IVF, GIFT, and ZIFT. ART must be provided by a Tufts Health Plan facility that is contracted specifically for ART. A member’s PCP refers the member to a specialist at an in-plan center. For more information, call an ART specialist at 888.880.8699 ext. 43405.  
• Due to variations by employer groups that are not subject to the mandate, ART benefits are not included in some PPO and POS benefit plans. Direct members to their benefit document or an ART specialist at 888.880.8699, ext. 43405 to determine individual coverage.  
• Refer to the ART Payment Policy and medical necessity guidelines for all infertility services. |
| Durable Medical Equipment (DME) | • Tufts Health Plan covers the purchase or rental of specified pieces of DME from designated vendors, selected based upon service, quality and cost. Tufts Health Plan decides whether to purchase or rent the equipment. Some items may require prior authorization through the Precertification Operations Department or Case Management. See the Clinical Resources section of the Resource Center for information about services and items that require prior authorization.  
• To arrange for DME, the ordering physician has three options:  
  − Directly contact a DME vendor listed in the Tufts Health Plan Provider Directory.  
  − Contact the appropriate care manager who will help to make the necessary arrangements.  
  − Fax a letter of medical necessity to the Precertification Operations Department at 617.972.9590 or 800.843.3553.  
• Refer to the DME Payment Policy for additional information. |
| Early Intervention Services | • Tufts Health Plan covers early intervention services for members until their third birthday. Services must be rendered at an early intervention site approved by the Massachusetts Department of Public Health or Rhode Island Department of Human Services.  
• The member’s PCP can authorize early intervention assessment services to the early intervention provider. Clinical review is not required. Members enrolled in Rhode Island plans can self-refer for early intervention services.  
• Refer to the Early Intervention Payment Policy for additional information. |
<table>
<thead>
<tr>
<th>Specialty Care Service</th>
<th>Description</th>
</tr>
</thead>
</table>
| Emergency Services     | • Tufts Health Plan covers services provided to a member for emergency medical conditions. An emergency is defined as an illness or medical condition, whether physical or mental, that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate 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 physical and/or mental health, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or in the case of pregnancy, a threat to the safety of the member and her unborn child.  
  • Members are not required to obtain prior authorization from their PCP before going to the ED. However, members are encouraged to contact their PCP within 48 hours after receiving care in an emergency facility so that the PCP can provide or arrange for follow-up care. In addition, if members are admitted as inpatient from the ED, the member (or someone acting for the member) should call the PCP or Tufts Health Plan within 48 hours after receiving care.  
  • Refer to the [emergency department services payment policies](#) for additional information. |
| Home Health Care       | • Tufts Health Plan covers the cost of medically necessary skilled nursing visits and short-term rehabilitative services for the homebound patient. Tufts Health Plan must authorize these services once the initial evaluation visit is completed, and a contracted home health care agency must provide the services.  
  • To receive authorization, providers can refer members to a contracting agency listed in the [Provider Directory](#). The agency must fax the authorization request to the Precertification Operations Department.  
  • Refer to the [Home Health and In-Home Palliative Care Payment Policy](#) for additional information. |
| Injectables            | Some injectables may require prior authorization through the [Pharmacy Management Program](#) and/or may require that members obtain it through a Tufts Health Plan designated specialty pharmacy. |
| Lactation Consultants  | Tufts Health Plan provides coverage for lactation consultants up to $75 per visit for up to a total of three visits per pregnancy. The member must pay up front for services and apply for reimbursement through Provider Services. |
| Nutritional Counseling | When applicable, Tufts Health Plan covers the cost of nutritional counseling when authorized by the PCP. Services must be rendered by a Tufts Health Plan provider who is a registered dietitian, and are subject to certain benefit limits. Members must obtain referral authorization from their PCP. For exclusions to this benefit, contact Provider Services. |
| OB/GYN Services        | • Tufts Health Plan members are not required to obtain referrals or prior authorization from their PCP for the following OB/GYN services provided by participating obstetricians, gynecologists, certified nurse midwives, or family practitioners:  
  – Maternity care  
  – Medically necessary evaluations and related health care services for an acute or emergency gynecology condition  
  – Routine annual gynecological exam, including any follow-up obstetrics and/or gynecology (including certified nurse midwives and family practitioners)  
  • Once a member has self-referred to a participating provider who specializes in obstetrics and/or gynecology (including certified nurse midwives and family practitioners), any further referrals to other providers must be obtained through the PCP. [Inpatient notification](#) is required for inpatient services.  
  • Refer to the [Obstetrics/Gynecology Professional Payment Policy](#). |
### Authorizations

<table>
<thead>
<tr>
<th>Specialty Care Service</th>
<th>Description</th>
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</table>
| Oral Health            | - Tufts Health Plan offers a limited oral surgery benefit. Members can obtain care for covered procedures in a Tufts Health Plan oral surgeon’s office on an ambulatory or inpatient basis.  
- No referral is needed for outpatient services. Inpatient notification is required for inpatient admissions.  
- Refer to the Oral Surgery Payment Policy for additional information. |

<table>
<thead>
<tr>
<th>Outpatient Rehabilitation</th>
<th>Physical Therapy (PT)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>A PCP referral may be required in accordance with the member’s benefit plan for one initial therapy evaluation in addition to a maximum of eight medically necessary physical therapy visits for diagnoses that are appropriate for physical therapy services. To obtain prior authorization for continuation of treatment beyond eight physical therapy treatment visits, physical therapy providers must complete the Rehabilitative Services: Physical Therapy Authorization Form and submit it to the Precertification Operations Department.</td>
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| Occupational Therapy (OT) | Effective for dates of service on or after January 1, 2017, a PCP referral may be required in accordance with the member’s benefit plan for the initial OT evaluation and up to eight treatment visits per plan year. The referral authorizes OT treatment to be rendered in accordance with the Tufts Health Plan short-term rehabilitation benefit. OT providers must complete the Rehabilitative Services: Occupational Therapy Authorization Form and submit it to the Precertification Operations Department to obtain prior authorization for continuation of treatment beyond the initial eight occupational treatment visits. |

| Speech Therapy (ST) | ST is covered with a PCP referral for up to 30 visits for medically based conditions, when applicable. If the condition is not classified as medically based, the treating therapist may submit a Tufts Health Plan Rehabilitative Services: Speech Therapy Authorization form prior to initiation of treatment. The Precertification Operations Department determines if ST is covered for the member’s condition, and if so, authorizes up to 30 visits. The treating therapist must submit requests for visits exceeding 30. Both a PCP referral and prior authorization through the Precertification Operations Department are needed for all visits beyond the initial 30. For additional information on PT, OT and ST services, refer to the Habilitative and Rehabilitative: PT, OT and ST Payment Policy. |

| Vision Care Program | - Eligible Tufts Health Plan members can go to a contracting EyeMed Vision Care ophthalmologist or optometrist for routine eye exams and optometry medical services. Routine eye exams do not require a referral.  
- For additional information regarding contracting vision care providers, refer members to either Tufts Health Plan’s Provider Directory or Member Services.  
- Refer to the Vision Services Professional Payment Policy for additional information. |

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`Last updated 01/2017. Chapter revision dates may not be reflective of actual policy changes.`