Authorizations

The Commercial Provider Manual applies to Commercial\textsuperscript{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.

\textbf{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

\textbf{Note:} The above services may require notification or authorization from either Tufts Health Plan or another approved vendor.

\textsuperscript{1} Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink\textsuperscript{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></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></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></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>
## TYPE OF REFERRAL

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

## SERVICES REQUESTED (check one)

<table>
<thead>
<tr>
<th>Consultation (one visit only)</th>
<th>Authorizes one specialty visit</th>
</tr>
</thead>
<tbody>
<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>

<table>
<thead>
<tr>
<th>Signature of PCP</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorization Date</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of Physician Reviewer (if applicable)</th>
<th>Required for referrals to non-Tufts Health Plan specialists and facilities, and to providers outside of the member’s limited-network plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorization Date</td>
<td></td>
</tr>
</tbody>
</table>

## 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](#).
**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.

Providers who are registered on Tufts Health Plan’s secure Provider website can request inpatient notification 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 notification of inpatient admissions directly to the Inpatient Admissions team within the Precertification Operations Department 24 hours a day, 7 days a week at 617.927.9590 or 800.843.3553.

For elective admissions, providers must contact Tufts Health Plan Inpatient Admissions team within the Precertification Operations Department at least five business days prior to an elective admission.

For after-hours urgent and emergency admissions, providers must report to the Tufts Health Plan Inpatient Admissions team within one business day (by 5 p.m.). 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.

The Precertification Department requires faxed inpatient notification to be submitted on Tufts Health Plan’s Inpatient Notification Form. No other forms are accepted by Tufts Health Plan. Prior to submitting a completed Inpatient Notification Form, providers must populate all form fields with the requested information. Forms submitted with missing or incomplete information will be returned to the submitting provider for completion and resubmission. Processing of the request will be delayed until all required information is returned to Tufts Health Plan.

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

**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 the 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.

**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.

**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. 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. Providers who are not registered users of the secure website may 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 (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. 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:

- 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. Upon submission of the notification, 8 visits will be available. If these visits are exhausted, the provider should submit a notification for another 8 visits.

To notify Tufts Health Plan of initiation or continuation of services, BH/SUD providers can:

- Log in 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 CareLink™. 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**

Tufts Health Plan requires prior authorization for certain specialty services, drugs, devices and equipment as a condition of payment. Authorization is based on InterQual® 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.

*Last updated 03/2018. Chapter revision dates may not be reflective of actual policy changes.*