Providers

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

**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 as full compensation for such health services. Contracted providers may only collect 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 will 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 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 you as the treating provider or other unreasonable financial exposure. In such circumstances, Tufts Health Plan may hold you accountable for any inappropriate behavior on the part of the noncontracting lab that you 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 Provider Manual.

**Provider Update**

The Provider Update is Tufts Health Plan’s quarterly newsletter for providers, hospital administrators, and allied health providers in the Tufts Health Plan network. The Provider Update is our primary vehicle for providing 60-day notifications and other critical information to providers. Each quarterly issue includes important clinical and administrative notifications, benefit and plan information, and other news providers need to interact effectively with Tufts Health Plan in providing services to plan members. To view the current and past issues of Provider Update, go to the News section of Tufts Health Plan’s public Provider website.

Beginning August 1, 2016, Tufts Health Plan began a transition to distribute its Provider Update newsletter by email. To have Provider Update delivered directly to your inbox, complete the online registration form, available in the News\(^2\) section of the public Provider website. This requirement

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\(^1\) Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink\(^3\) when Tufts Health Plan is the primary administrator.

\(^2\) If you do not register to receive Provider Update by email, copies of this information can also be mailed upon request by calling 888.884.2404 for Tufts Health Plan Commercial products (including Tufts Health Freedom Plan).
applies 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.

Providers are responsible for keeping their contact information up to date. To make updates to information you previously submitted through the online registration form, resubmit the form with your updated information.

Office staff, provider organizations and hospital leadership can also register to receive Provider Update by email. Office staff may register a provider on his or her behalf by using the provider’s name, email address and NPI, and indicating the divisions of Tufts Health Plan with which the provider contracts.

Past issues and articles featured in Provider Update will also be available in the News section of public Provider website.

**Fraud, Waste and Abuse**

Providers must comply with federal and state laws and regulations designed to prevent, identify and correct fraud, waste and abuse (FWA). If a provider becomes aware of a questionable practice by a Tufts Health Plan provider or member that may indicate possible health care fraud, Tufts Health Plan has a hotline for reporting concerns. The hotline was established 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 can 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.

**Fraud, Waste and Abuse Information**

Providers who care for Tufts Health Plan Medicare members are required to comply with CMS certification requirements. CMS has educational materials about FWA, including web-based training, on their website.

**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). Providers must:

- 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 requires providers, upon request, to provide member medical information and medical records for the following purposes:

- Administering Tufts Health Plan’s health benefit plans, such as claims payment, coordination of benefits, subrogation, enrollment eligibility verification, reinsurance, and audit activities
- Managing care, such as utilization management and quality improvement activities
- Carrying out member satisfaction procedures described in member benefit booklets
- Participating in reporting on quality and utilization indicators, such as Health Plan Employer Data and Information Set (HEDIS)
- Complying with the law

Providers are responsible for obtaining any member consents or releases that are necessary to comply with state and federal law. **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 government 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 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 Provider’s Role**

The primary care provider (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:

- Periodic assessment of the asymptomatic patient
- Screening for early disease detection
- Evaluation and management of acute illness
- 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
- Ongoing management of patients with established chronic diseases
- Coordination of care among specialists
- The provision of acute hospital care and long-term care for the large majority of medical conditions
- Training in a primary care discipline or significant additional training in primary care subsequent to training in a nonprimary care discipline.

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 ensures medical and financial success for the provider unit.

Responsibilities of the PCP include the following:

- **Routine preventive care:** includes physical examinations, immunizations, hypertension and cancer screening, and pap smears. For additional information, refer to the guidelines for Preventive Care – Adults and Preventive Care – Children.
- **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 the Plans section on our website 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. 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

The provider agreement obligates PCPs to establish and maintain coverage 24 hours a day, 7 days a week.

Temporary transfer of this responsibility for reasons of personal illness, sabbatical, or maternity leave are examples of times when brief withdrawal from a practice may be necessary.

In the event the provider must withdraw from his or her practice for more than 30 days, 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, he or she must contact the Tufts Health Plan Credentialing Department directly.

Leave of Absence Policy

Tufts Health Plan requires a practitioner to notify Tufts Health Plan when he or she is taking a leave of absence (LOA) for longer than 60 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 longer than six months, Tufts Health Plan reserves the right to terminate the practitioner from the network based upon continuity of care issues. In addition, if a practitioner’s recredentialing is due during the LOA and the practitioner does not complete his or her recredentialing materials, Tufts Health Plan reserves the right to terminate the practitioner from the network based upon contractual noncompliance.

If the LOA is scheduled for six months or less, Tufts Health Plan confirms the conclusion of the LOA. If the LOA is concluded within six months, the practitioner’s LOA status is removed and the practitioner is reinstated to his or her prior status. If the practitioner extends the LOA for more than six months, Tufts Health Plan reserves the right to terminate the practitioner from the network based upon continuity of care issues.
**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 can 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 his or her to select a new PCP.

If a provider has a member on his or her panel that he or she believes is not his or her 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 provider realizes he or she has 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.

**Accepting Established Patients Only**

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.

As with all provider assignments, if a provider determines that he or she has 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 he or she cannot provide these services, the specialist is responsible for contacting the member’s PCP, if applicable, and suggesting that the PCP provide the member with an alternative referral.

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 can 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.

Covering Provider
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, he or she is 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. If there is a situation that may allow for an exception, contact the Network Contracting Department at 800.442.0422 x52169. 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.

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.

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 can be required. For care to be rendered at an out-of-plan facility, the physician reviewer’s authorization is required.

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) access services without the direction of a PCP or physician reviewer.

For additional information, refer to the Plans section of our website 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 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. NPs and PAs may also 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, 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.

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 plan and again at least every three years in accordance with state, federal, regulatory, and accrediting agency requirements.

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 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.
- Send appropriate contract documents (initial credentialing only) to Tufts Health Plan.
- Sign and date the health services agreement (initial credentialing only) and send to Tufts Health Plan.
- Sign W-9 form (initial credentialing only) and send to Tufts Health Plan.

Practitioners are notified of their recredentialing request through CAQH ProView prior to the practitioner’s date of birth, allowing enough time for each practitioner to complete the information online by his or her recredentialing date.

Primary Hospital Requirements

Each MD and DO must indicate his or her 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 is required to review 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

The Quality of Care Committee (QOCC), a board-level quality committee chaired by a Tufts Health Plan Medical Affairs Department physician, or its designee 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 QOCC Medical Affairs Department physician 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
• 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.
  - Practitioners are not entitled to review references, recommendations, information that is peer-review privileged, or information that, 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.
• 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.

**Rhode Island Practitioners**

For Rhode Island practitioners the following applies:
• The practitioner or his/her designee will receive a response from Tufts Health Plan regarding his/her application within 180 days after receipt of the application. If a credentialing decision is made to deny credentials to a practitioner, the QOCC sends the practitioner written notification of all reasons for the denial within 60 days of receipt of the completed and verified application.
• If the QOCC votes to take disciplinary action against a practitioner, the practitioner shall have 30 days from the receipt of the letter from the QOCC to notify Tufts Health Plan in writing that he/she will appeal the QOCC decision. If the practitioner exercises his/her appeal right, the
chair of the QOCC will arrange a hearing before an Appeals Committee that shall review the
decision of the QOCC and issue a decision prior to implementation of the disciplinary action
against the practitioner.

- If requested in writing by the practitioner whose credentials have been revoked or adversely
modified, the due process outlined in this chapter and in the Tufts Health Plan appeal process
shall be waived.

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 recredentialied and may
request additional information pertinent to its credentialing of the hospital.

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