TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>2</td>
</tr>
<tr>
<td>Tufts Health Unify</td>
<td>4</td>
</tr>
<tr>
<td>Providers</td>
<td>14</td>
</tr>
<tr>
<td>Referrals, Authorizations, Notifications</td>
<td>25</td>
</tr>
<tr>
<td>Claim Requirements, Coordination of Benefits, and Dispute Guidelines</td>
<td>29</td>
</tr>
<tr>
<td>Utilization Management Guidelines</td>
<td>46</td>
</tr>
<tr>
<td>Care Management</td>
<td>54</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>62</td>
</tr>
<tr>
<td>Quality</td>
<td>72</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>77</td>
</tr>
<tr>
<td>Rights and Responsibilities</td>
<td>83</td>
</tr>
</tbody>
</table>
INTRODUCTION

About the Tufts Health Public Plans Provider Manual

Tufts Health Public Plans developed the Public Plans Provider Manual to supply providers and their office staff with details on certain products, policies and procedures of Tufts Health Public Plans. The Public Plans Provider Manual applies to Tufts Health Public Plans products. Refer to the Tufts Health Public Plan Provider Resource Center to find information such as:

- Forms
- Medical and behavioral health benefit summary grids
- Pharmacy medical necessity guidelines
- Payment policies
- Clinical practice guidelines

Additionally, utilize Tufts Health Provider Connect, a secure 24/7 portal that allows providers to file a claim, check member eligibility, check the status of referrals and more.

For more information on Tufts Health Plan Commercial Products (including Tufts Health Freedom Plan) or Tufts Health Plan Senior Products policies and procedures, refer to the 2020 Commercial or Senior Products provider manuals.

Overview of Tufts Health Public Plans

Tufts Health Public Plans offers the following products:

**Tufts Health Together** provides high-quality, low cost MassHealth coverage to individuals and low-income families enrolled in the state’s Medicaid plan. Tufts Health Public Plans offers four Accountable Care Partnership Plans (ACPPs) Accountable Care Organizations (ACOs):

- Tufts Health Together with Atrius Health
- Tufts Health Together with Boston Children’s
- Tufts Health Together with BIDCO
- Tufts Health Together with CHA

As well as a Managed Care Organization (MCO) plan:

- Tufts Health Together

**ACOs** are groups of doctors, hospitals and other health care providers who work together to coordinate a member’s care. In an ACPP, a group of PCPs work with one Managed Care Organization (MCO) to form a network of PCPs, specialists, behavioral health providers, and hospitals. The member’s PCP plans and coordinates the care to meet health care needs. Members enrolled in an ACPP must live in the ACO service area and use the plan’s provider network. A PCP must be chosen or one will be assigned.

**MCO for MassHealth** members provides care through the Tufts Health Public Plans network. The MCO network includes PCPs, hospitals, behavioral health providers, and specialists. Members enrolled in an MCO must live in the MCO service area and use the MCO network of providers. A PCP must be chosen, or one will be assigned. The PCP cannot be part of an ACO.

**Tufts Health RITogether** is the Tufts Health Public Plans Rhode Island Medicaid plan providing low-cost Medicaid coverage for individuals and families.

**Tufts Health Direct** is a Massachusetts Qualified Health Plan (a commercial product) for individuals and small groups.

**Tufts Health Unify** is a dual-eligible Medicare-Medicaid One Care plan. One Care is a MassHealth and CMS

---

1. Tufts Health Public Plans products include Tufts Health Together ACPPs and MCO, Tufts Health RITogether, Tufts Health Direct and Tufts Health Unify.
2. Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink℠ when Tufts Health Plan is the primary administrator.
initiative to integrate the delivery and financing of Medicare and Medicaid services for those who are eligible for both Medicare and Medicaid. Individuals are eligible for Tufts Health Unify if they are Massachusetts Medicaid beneficiaries between the ages of 21 and 64 who are also eligible for Medicare due to a disability. CMS and MassHealth jointly determine eligibility.
TUFTS HEALTH UNIFY

Medicare-Medicaid plan

Tufts Health Unify, Tufts Health Public Plans’ One Care plan for people ages 21 – 64, integrates care for people who are eligible for both Medicare and Medicaid services. One Care was established by MassHealth and the Centers for Medicare & Medicaid Services (CMS) to streamline delivery and financing of care for patients who typically receive services from both agencies (dually eligible).

As a Medicare-Medicaid One Care plan, Tufts Health Unify focuses on the effective integration of services and is designed to:

- Establish and enhance care coordination with care providers
- Streamline care among providers
- Improve health and functional outcomes
- Recognize and address care needs holistically, keeping members central to their own care plan
- Improve quality of care by addressing member needs across the care continuum
- Promote independence within the community

Refer to this chapter for more information about:

- **Model of care (MOC) overview**
  - Interdisciplinary Care Team (ICT)
- **Enrollment and Member transition**
- **Care management**
  - Assessment
  - Regular Member Outreach and Engagement
  - The Individualized Care Plan (ICP)
  - Centralized Enrollee Records (CER)
- **Coordination of care**
  - Community Supports
- **Provider training**
- **Tufts Health Unify provider responsibilities**
- **Tufts Health Unify Member rights and responsibilities**
  - Member Rights
  - Member Responsibilities
- **Tufts Health Unify coverage decisions, grievances and appeals**
  - Tufts Health Unify Coverage Decisions
  - Tufts Health Unify Grievances
  - Tufts Health Unify Appeals
- **Tufts Health Unify pharmacy program**
  - Pharmacy Advisor Support Vendor: CVS Health
  - Medication Therapy Management Program Vendor: Mirixa

Refer to other chapters of this Provider Manual for information not covered in this chapter.

Model of care (MOC) overview

Tufts Health Public Plans collaborates with primary care providers (PCPs), specialists, and community organizations to strengthen member care coordination across medical, pharmacy, and behavioral health (BH) services; community-based long-term services and supports (LTSS); and wellness services. This method of care coordination is the foundation of the Tufts Health Unify MOC. Tufts Health Public Plans facilitates data and information sharing among community providers. Tufts Health Public Plans’ distinct model of care features:

- A person-centered, integrated care strategy organized around a flexible interdisciplinary care team (ICT) that focuses on engaging the member in all care planning efforts
- Close collaboration with providers to holistically coordinate medical, behavioral, social, and community needs
- Flexibility based on the infrastructure of the primary care site, including BH services, as appropriate
• member-focused ICT composition based on member needs and practice capacity
• A secure online tool to maintain member records and ensure that the authorized member, family advocates, and ICT providers can access and share updated information quickly

Interdisciplinary Care Team (ICT)
The member-specific ICT includes the member and their family, friends or advocates, the member’s assigned clinical care coordinator and the Member’s PCP. The ICT can encompass all providers involved in a member’s care, including BH and LTSS providers, state agencies, the member’s Long-Term Services Coordinator (LTS-C), care coordinators, community health workers, peer specialists and anyone else the member delegates. Each ICT participant has a defined role appropriate to their licensure and relationship to the participant. However, the team collectively shares responsibility for delivering coordinated care and providing services that best meet the member’s needs. This includes assisting the member in developing a member-approved care plan. As needed, the ICT may also include additional organizations across the continuum of care and support. (Refer to the Additional ICT participants section in this chapter for additional background.)

Primary point of contact
Tufts Health Public Plans works with ICTs to designate a care team member to serve as the member’s primary contact and be responsible for leading care coordination or clinical care management services. ICT lead designation depends upon the level of care complexity and capacity of the PCP practice or health home. The primary point of contact will be one of the following:

• **Relationship Lead** – The Relationship Lead serves as the member’s primary point of contact. The ICT member who serves as the Relationship Lead may be the Care Coordinator, Community Health Worker, Behavioral Health Care Manager, or Accountable Care Manager depending on the member’s risk level.

• **Care Coordinator** – the Care Coordinator works under the direction of the licensed Accountable Care Manager and serves as the Relationship Lead for low risk members to ensure timely care coordination across the continuum of care. The Care Coordinator will collaborate with all members of the care team to execute the member-driven care plan within their scope of practice, including completing member outreach, pre- and post-visit follow up, completing key administrative functions, and escalating any change in member status to appropriate members of the care team.

• **Community Health Worker** – the Community Health Worker (CHW) works under the direction of the licensed Accountable Care Manager and serves as the Relationship Lead for moderate risk members to ensure they receive timely and coordinated care. The CHW will work with the Accountable Care Manager and other members of the care team to create a member-approved care plan and execute on the identified problems, goals and interventions. CHWs help identify and address a member’s social and environmental needs in a culturally sensitive manner with the goal of keeping the member in the community. The CHW specializes in face-to-face engagement and will support members in the community by delivering health and wellness interventions, disease management services, and managing member’s care across the continuum.

• **Behavioral Health Care Manager** – the Behavioral Health Care Manager is a licensed clinician who provides intensive care management services and serves as the Relationship Lead for members with primary behavioral health diagnoses, in close collaboration with the PCP and ICT. The Behavioral Health Care Manager will also serve as a consultative resource to all other care team members to ensure that all members have access to coordinated and appropriate behavioral health services.

• **Accountable Care Manager** – the Accountable Care Manager is a licensed clinician who provides intensive care coordination and clinical management services in close collaboration with the PCP and the rest of the ICT. The Accountable Care Manager is the Relationship Lead for the highest complexity members and is responsible for leading the entire care team. The Accountable Care Manager coordinates across providers to create member-driven care plans and is responsible for supporting the care team to drive positive outcomes for all members.

The member may request a new primary point of contact at any time to allow for flexibility and to address changes in wellness.
Additional ICT participants
The Tufts Health Unify medical director and/or behavioral health medical director are available to all ICTs to provide consultative assistance. As appropriate and at the discretion of the member, the ICT also may include:

- **Behavioral Health (BH) clinicians:** for members primarily with BH needs, Tufts Health Public Plans will encourage and support PCPs to offer and deliver care coordination services by a BH clinician at the point of service. Where insufficient capacity exists within the PCP site, Tufts Health Public Plans will support the PCP to deliver these services with a Tufts Health Public Plans-employed or contracted BH clinician. Tufts Health Public Plans will also work with the PCP to enhance care coordination efforts with BH clinicians during the course of the program. For some members, the BH clinician may serve as the primary provider on the Integrated Care Team.

- **Long-term services (LTS) coordinator:** Each Tufts Health Unify member has access to an LTS Coordinator who may help identify and coordinate the delivery of LTSS services that support a Member’s independent living goals. Members with LTS Coordinators may choose to have their LTS Coordinators participate in the ICT.

- **Family caregivers/peers or member-appointed representatives:** with the member’s permission, caregivers, peers, and/or other appointed representatives may be ICT participants. These individuals often provide critical support and care and can provide valuable insights into the member’s needs.

- **State and other agency representatives or case managers:** state and other agency (e.g., independent learning center [ILC] or recovery learning center [RLC]) representatives or case managers may be included on a member’s ICT with the member’s permission. In addition, as part of the ICT, the agency representatives would be able to access member information on the centralized enrollee record (CER), if the member gives permission.

- **Clinical Pharmacists:** Clinical Pharmacists are available to provide the ICT with support for members with complex medical management needs.

- **Other identified professionals as appropriate:** a member’s ICT may incorporate other professionals as the member allows, including:
  - A specialist with knowledge and experience who can support the ICT
  - A home health nurse
  - A health educator
  - Advocates

Enrollment and member transition

- **Enrollment:** Tufts Health Unify members may enroll in the plan without an established PCP relationship. Tufts Health Public Plans works with new members to identify and establish a PCP relationship within 14 days of enrollment. Providers are notified when selected to be a Tufts Health Unify member’s PCP.

- **Continuity of care:** If an out-of-network provider is actively treating a newly enrolled Tufts Health Unify member, the member may continue to receive services through that provider for up to 90 days or until a Tufts Health Unify Care Management team completes an initial comprehensive assessment. At that time, a member must transition their care to an in-network provider.

Care management

Assessment
Tufts Health Public Plans will schedule an in-person comprehensive assessment with new members within 90 days of enrollment and will perform additional assessments as necessary for members requiring more intensive behavioral health services or community-based LTSS. Reassessments are based on member risk level and any change in member status, and will occur annually, at a minimum.

Providers who are active members of Tufts Health Unify’s ICT may view member assessments in the member’s record through Tufts Health Provider Connect.

Regular Member Outreach and Engagement
Tufts Health Unify members will receive frequent contact in person, by telephone, and by electronic forms of
communication from the ICT. These outreach efforts aim to direct members to manage their own care and wellness interventions by:

- Helping them understand their current status (health, social, issues of daily living)
- Coordinating their care and services
- Addressing their concerns and barriers to care
- Proactively monitoring progress toward agreed-upon goals
- Identifying their needs
- Assisting them in obtaining appropriate services to meet their needs and maintain independence

**The Individualized Care Plan (ICP)**

Each member or their appointed representative will be integrally involved in collaborating with the ICT to develop a person-centered ICP that is based on their own beliefs and desires, and addresses all of the member’s medical, behavioral, functional, environmental, and social needs. The Relationship Lead will actively manage the ICP in collaboration with other members of the care team, for example, by updating a member’s health status or care transitions, as the member’s situation requires. Members, their families, and their caregivers are all critical to the case management process, and Tufts Health Public Plans will engage them all to the greatest extent possible. Through the ICT, Tufts Health Public Plans will also educate members about their conditions, strategies to improve or maintain their health and functioning, and community or other resources available to them.

**Centralized Enrollee Records (CER)**

Tufts Health Public Plans’ CER is CCMS, the application that houses the member’s clinical record, including assessment, care plan, care team and other important information. Tufts Health Unify members and providers have the ability to access the member’s record in the CER through Tufts Health Provider Connect secure portal or the secure member portal. In addition to being able to view member assessments and ICPs, the Tufts Health Provider Connect secure portal also allows for the submission of notes to be appended to the member’s record in the CER. This information can then be communicated to members and their ICT. To comply with the Health Insurance Portability and Accountability Act (HIPAA), members determine the level of access to their protected health information they want to give to a particular provider or caregiver. Members and the ICT will have access to the web-based tool, 24 hours a day, seven days a week.

**Coordination of care**

Tufts Health Public Plans places great importance on continuity of care between health care and community-based settings to reduce inefficiencies and duplication of services and to ensure that the member receives care in the most appropriate setting to meet their needs effectively. Tufts Health Public Plans will actively engage appropriate ICT members and providers, including care coordinators, peer specialists, or CHWs, to support members during these challenging transitions.

**Community Supports**

Community supports are services provided in a home or other community setting that promote disease management, wellness, and independent living, and that help avert unnecessary medical interventions (e.g., avoidable or preventable emergency department visits and facility admissions).

Community-based long-term services and supports (LTSS) programs are essential to supporting Tufts Health Public Plans members’ independence and well-being. Tufts Health Unify includes coverage for services such as:

- Community health workers
- Community support services (CSP)
- Day habilitation
- Group adult foster care
- Home care/Homemaker services
- Home health care services
- Home modifications
- Nurse midwife services
- Peer support/Counseling/Navigation
- Personal care assistance
• Program of assertive community treatment (PACT)
• Respite care

Refer to the Tufts Health Unify medical and behavioral health benefit summary grids for coverage details and prior authorization requirements.

LTSS include a wide variety of services and supports that help people with disabilities meet their daily need for assistance and improve the quality of their lives. Examples include, but are not limited to, durable medical equipment; home health; therapies; assistance with bathing, dressing, and other basic activities of daily life and self-care; as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

Provider training

The Executive Office of Health and Human Services (EOHHS) and the Centers for Medicare and Medicaid Services (CMS) require ICT members to complete comprehensive training on the One Care program.

This training program has two tracks:
• **Track One:** A general training series developed, coordinated, and delivered by MassHealth via UMass Medical School. Providers can access Track One trainings through the One Care Shared Learning website at: [https://onecarelearning.ehs.state.ma.us/](https://onecarelearning.ehs.state.ma.us/)
• **Track Two:** A plan-specific training for Tufts Health Unify. Providers can access Track Two trainings by visiting [tuftshealthplan.com/onecaretraining](http://tuftshealthplan.com/onecaretraining)

**Tufts Health Unify provider responsibilities**

As a member of the ICT, Tufts Health Unify providers are responsible for the following:
• Coordinate care with a member’s other health care providers to ensure appropriate access to care, including BH, LTSS, and community supports providers
• Utilize waiting room and exam room furniture that meet the needs of all members, including those with physical and nonphysical disabilities
• Provide accessibility along public transportation routes and/or provide enough parking
• Use clear signage and way finding (e.g., color and symbol signage) throughout facilities
• Provide secure access for staff-only areas
• Not discriminate based on race, ethnicity, national origin, religion, sex, age, sexual orientation, medical or claims history, mental or physical disability, genetic information, or source of payment
• Provide covered services listed in the Tufts Health Unify contract
• Complete an ADA accessibility survey
• Accept and treat all Tufts Health Public Plans members regardless of English proficiency and health status and to assists members with interpreter services, if necessary

**Tufts Health Unify member rights and responsibilities**

As part of Tufts Health Public Plans’ strong commitment to quality care and customer service, it is important that Tufts Health Unify members remain informed about their rights and responsibilities. Members are allowed to exercise these rights without having their treatment adversely affected. The following list is included to inform providers of member’s rights and responsibilities in order to assist members in getting the most of their memberships.

**Member Rights**

Members have the right to:
• Be treated and accepted with respect, privacy and dignity regardless of race, ethnicity, creed, religious belief, sexual orientation, privacy, health status, gender, age, language needs, disability or source of payment for care
• Reasonable accommodation
• The delivery of services in a prompt, courteous, responsible, and culturally competent manner
• Obtain medically necessary treatment, including emergency care
• Make decisions concerning their medical care
• Obtain information about Tufts Health Public Plans and our services, limitations on services, or services not covered, as well as PCPs, specialists, and other health care providers. Tufts Health Public Plans will provide the information in a manner that is easily understood, by alternative technologies if necessary, including, but not limited to, TDD/TTY, Video Relay Service (VRS), written format, large print (at least 16-point font), and language lines with qualified interpreters that include ASL. All notices can be read to members upon request, and assistance can be given to members to complete forms.
• Be told by a provider about all medical and treatment information in words they understand
• Have their provider ask them for permission for all treatment, except in emergencies wherein an individual’s health is in serious danger and they cannot sign a consent form
• Discuss any illness they have and the recommended treatment options, regardless of cost or benefit coverage
• Choose a PCP from the list of contracted providers
• Work with their PCP, specialists, and other health care providers to make decisions about their health care, and do so without interference from Tufts Health Public Plans
• Accept or refuse medical, surgical, or trial treatment and be informed of the possible outcomes of that choice
• Contact their PCP and/or BH provider’s office by phone, 24 hours a day, seven days a week
• Expect that all records regarding their health care are private, and that Tufts Health Public Plans abides by all laws regarding confidentiality of patient records and personal information, in recognition of the member’s right to privacy
• Seek a second opinion for proposed treatments and care, including in such instances where the member does not agree to a treatment for moral or religious reasons
• File a grievance to express dissatisfaction with their providers and the quality of care or services they have received and receive a timely response
• Appeal a denial made by Tufts Health Public Plans for care or services and receive a timely response
• Be free from any form of restraint or seclusion used as a means of coercion, discipline, or retaliation
• Request more information or explanation on anything, either verbally or in writing
• Obtain written notice of any significant and final changes to the Tufts Health Public Plans provider network, including, but not limited to, PCP, specialist, hospital, and facility terminations that affect the member
• Request and receive a copy of their medical records in a timely manner and request that the records be amended or corrected as necessary
• Get services as described in the One Care program covered services list
• Have their provider advocate on their behalf without restriction
• Certain rights that relate to an advance directive
• Not be balance billed by a provider for any covered service
• Make suggestions about member rights and responsibilities
• Exercise their rights without having their treatment adversely affected

Member Responsibilities

Members have a responsibility to:
• Treat all health care providers with respect and dignity
• Keep appointments, be on time, or call if they will be late or need to cancel an appointment
• Present a Tufts Health Public Plans member ID card prior to receiving services
• Protect their Tufts Health Public Plans member ID card from being used by another person
• Give Tufts Health Public Plans, their PCP, specialists, and other health care providers complete and correct information about their medical history, medicines they take, and other matters about their health
• Ensure they get services from providers who are part of the Tufts Health Public Plans provider network
• Ask for more information from their PCP and other health care providers if they do not understand what they have been told
- Participate with their PCP, specialists, and other health care providers to understand and help develop plans and goals to improve their health
- Follow plans and instructions for care that they have agreed to with their providers
- Know and confirm benefits before getting treatment
- Understand that refusing treatment may have serious effects on their health
- Contact their PCP or mental health and/or substance abuse provider within 48 hours after a visit to the emergency room so they can provide follow-up care
- Use emergency room services only for an injury or illness that they believe may be a serious threat to their life or health
- Change their PCP or mental health and/or substance abuse provider if they are not happy with their current care
- Communicate their concerns and complaints as clearly as possible to their provider and to Tufts Health Public Plans
- Report to Tufts Health Public Plans if they have access to any other insurance
- Report to Tufts Health Public Plans if they suspect potential fraud and/or abuse
- Inform Tufts Health Public Plans and the state of any address, phone, or PCP changes

Tufts Health Unify coverage decisions, grievances and appeals

Grievances and appeals may be submitted by the member or the provider by telephone, mail, email, fax, or in person. Members are notified of grievance and appeal rights upon enrollment, and on an annual basis thereafter. Members must complete an Authorized Representative Form to document that a provider is authorized to file a grievance on their behalf.

Tufts Health Unify Coverage Decisions

Tufts Health Unify members may request a coverage decision on any service or benefit that they think should be covered. All coverage decision requests must be made through Tufts Health Public Plans. Tufts Health Public Plans does not retaliate or take any punitive action against a provider who requests an expedited resolution or supports an enrollee’s appeal or grievance.

There are two kinds of coverage decisions:

1. **Standard coverage decision** — Tufts Health Public Plans must notify the member of a nondrug standard coverage decision within 14 days after it’s received. If Tufts Health Public Plans does not provide a decision within 14 days, the member can file an appeal. Tufts Health Public Plans will inform the member if additional time is needed and explain the reasoning for extra time. For a standard coverage decision regarding Part D drug coverage, Tufts Health Public Plans must notify the member within 72 hours after receipt, but no more than 14 calendar days if supporting statement is needed from the provider.

2. **Fast coverage decision** — Tufts Health Public Plans must notify the member of a nondrug fast coverage decision within 72 hours after receipt but can take up to 14 additional days if it is determined that more time is needed. If Tufts Health Public Plans does not provide a decision within 14 days, then the member can file an appeal. For a fast coverage decision regarding Part D drug coverage, Tufts Health Public Plans must notify the member within 24 hours after receipt, but no more than 14 calendar days if supporting statement is needed from the provider. The member can ask for a fast coverage decision if they or their health care provider believe the member’s health, life, or ability to regain maximum function may be put at risk by waiting up to 30 days for a decision.

Tufts Health Public Plans will automatically give a member a fast coverage decision when a provider asks for one or supports the member’s request. If a member asks for a fast coverage decision without support from their health care provider, Tufts Health Public Plans will decide if the member’s health requires a fast coverage decision. If Tufts Health Public Plans does not grant a fast coverage decision, a decision will be provided to the member within 14 days for a nondrug coverage and 72 hours regarding Part D drug coverage.

**Medicare Part B Prescription Drug Requests**

**Expedited (urgent) prospective and concurrent requests** — Tufts Health Public Plans will make a determination and notify the member as expeditiously as the member’s health condition requires, but not
exceeding 24 hours from the receipt of the request. This time frame cannot be extended.

**Standard (nonurgent) prospective and concurrent requests:** Tufts Health Public Plans will make a determination and notify the member as expeditiously as the member’s health condition requires, but no later than 72 hours after receipt of request. This time frame cannot be extended.

**Tufts Health Unify Grievances**

Tufts Health Unify members may file a complaint or grievance to address concerns such as quality of care or services provided, aspects of interpersonal relationships, such as rudeness, on the part of a provider or employee of Tufts Health Public Plans, a failure to respect certain rights, a disagreement with Tufts Health Public Plans’ decision not to approve a request that an internal appeal be expedited, and/or a disagreement with Tufts Health Public Plans’ request to extend the time frame for resolving an authorization decision or an internal appeal. Tufts Health Public Plans will respond to all clinical grievances in writing. Tufts Health Public Plans will undertake an investigation of all grievances, including those that relate to potential provider violation of enrollee rights. Tufts Health Public Plans will resolve grievances within 30 calendar days of receiving them. Tufts Health Public Plans can take up to 14 additional days if it determined that more time is needed to resolve the grievance. An extension may be taken in instances where a member requests an extension, or if we determine there is a need for additional information and can demonstrate how the delay is in the best interest of the member. Tufts Health Public Plans will give the member prompt oral notice of the day and, within two business days, provide written notice for rationale with the day. Members will be informed of their right to file an expedited grievance if the member disagrees with the decision to extend the grievance resolution timeframe.

**Tufts Health Unify Appeals**

Tufts Health Unify members have the right to appeal decisions through a two-level process. Because Tufts Health Unify combines the benefits of two programs (Medicare and Medicaid), the appeal process varies based on the program that provides the benefit. All appeals must begin at Level 1 Appeal, which is a plan-level appeal, and then, based on outcome, may be escalated further to the correct program entity in a Level 2 Appeal.

**Level 1 Appeals**

Members have the right to ask Tufts Health Public Plans to review the decision by requesting a Level 1 Appeal (sometimes called an internal appeal or plan appeal). Members can ask to see the medical records and other documents used to make the decision any time before or during the appeal. Members may also request a free copy of the guidelines used to make the decision.

Members must ask for a Level 1 Appeal within 60 days after receiving notice of the decision. Tufts Health Public Plans may provide members more time if there is a good reason for missing the deadline.

If a member appeals because Tufts Health Public Plans intends to reduce or stop a service a member is already receiving, the member has a right to keep receiving that service during the appeal when the appeal is received 10 calendar days from the date of the denial.

Providers can request the appeal on a member’s behalf. If members want a relative, friend, attorney, or someone besides the provider to make the appeal for them, an Appointment of Representative Form must be completed first. The form gives the other person permission to act for the member. Providers do not need to complete this form to appeal on a member’s behalf.

There are two kinds of Level 1 Appeals:

1. **Standard appeal** — Tufts Health Public Plans must give members a written decision on a nondrug standard appeal within 30 days after receipt. For an appeal regarding a preservice Part D drug coverage, Tufts Health Public Plans must give members a written decision within 7 days of appeal receipt. For an appeal regarding a post service Part D drug coverage, Tufts Health Public Plans must give members a written decision within 14 days of appeal receipt. If the request is for a Medicare Part B prescription drug, Tufts Health Public Plans must give members a written decision, as expeditiously as the member’s health condition requires, but not exceeding 7 days (for preservice requests) of appeal receipt. Post service requests will be resolved within 60 calendar days of appeal receipt. The decision might take longer if members ask for an extension, or if Tufts Health Public Plans needs more information about the appeal. Members will be informed if extra time is needed and an explanation for the additional time
will be provided. The review time frame for Part B drug requests will not be extended.

2. **Fast (expedited) appeal** — Tufts Health Public Plans must give a decision on a fast (expedited) appeal within 72 hours after receipt. Members can ask for a fast appeal if they or their health care provider believe the member’s health, life, or ability to regain maximum function may be put at risk by waiting up to 30 days for a decision.

Tufts Health Public Plans will automatically give members a fast appeal when a provider asks for one or supports the request. If a member asks for a fast appeal without support from their health care provider, we will decide if the member’s health requires a fast appeal. If we don’t grant a fast appeal, we will give the member a decision within 30 days.

**Level 2 Appeals**

Members have the right to have Medicare, MassHealth, or both review Tufts Health Public Plans’ decision by making a Level 2 Appeal (sometimes called an external appeal). A Level 2 Appeal is done by an independent organization that is not connected to the plan. Medicare’s Level 2 Appeal organization is called the Independent Review Entity (IRE). MassHealth’s Level 2 Appeal organization is called the MassHealth Board of Hearings. Members can ask Tufts Health Public Plans for the opportunity to see the medical records and other documents used to make the Level 1 Appeal decision any time before or during the Level 2 Appeal. Members may also ask for a free copy of the guidelines used to make the decision.

Members can ask the MassHealth Board of Hearings to review Tufts Health Public Plans’ decision to deny the Level 1 Appeal. Members must ask for this within 120 days of the notice date.

If a member is making an appeal because Tufts Health Public Plans intends to reduce or stop a service they are already receiving, the member has a right to receive the service while appealing to the Board of Hearings. In order to receive a previously approved service while appealing, a member must ask for a Level 2 Appeal from the Board of Hearings within 10 days of the notice date.

Also, the Medicare IRE will automatically review Tufts Health Public Plans’ decision to deny a Level 1 part C Appeal for Medicare covered services requested. A member does not have to do anything to make a Level 2 Appeal to the Medicare IRE. Tufts Health Public Plans will send the case to the Medicare IRE to get its review. However, the member will not get the service while appealing unless they also make a Level 2 Appeal to the MassHealth Board of Hearings.

There are two kinds of Level 2 Appeals:

1. **Standard appeal** — the IRE and Board of Hearings must give written decisions on a standard appeal within 30 days of appeal receipt. For an appeal regarding Part D drug coverage, the IRE and Board of Hearings must give members a written decision within 7 days of appeal receipt.

2. **Fast (expedited) appeal** — A member can ask for a fast appeal if they or their health care provider believe the member’s health, life, or ability to regain maximum function may be put at risk by waiting a standard appeal decision.

The IRE will give the member a Level 2 fast appeal if the health care provider asks for one or supports the request. If a member asks for a fast appeal from the IRE without support from their health care provider, the IRE will decide if the member’s health requires a fast appeal. If a fast appeal is not granted, the member will receive a decision within 30 days.

If a member disagrees with a decision to stop coverage for home health care, skilled nursing care, or comprehensive outpatient rehabilitation facility (CORF) services, a Level 1 “fast track” appeal may be filed directly with a quality improvement organization (QIO). Level 1 “fast track” appeals require the QIO to notify the member of a decision within 24 hours of receiving all required information. A member must file the Level 1 appeal no later than noon of the day after receiving written notice of the initial decision. If the QIO approves the service, Tufts Health Public Plans must continue to cover the service. If the QIO does not approve the service, the member can file a Level 2 “fast track” appeal with the same QIO, and the QIO must notify the member of a final decision within 14 days of receiving all required information. The member must file the Level 2 Appeal within 60 days of the original QIO decision.

Members may contact Unify Member Services at 855.393.3154 Monday – Friday 8am – 8pm.
Tufts Health Unify pharmacy program

Pharmacy benefit information for Tufts Health Unify members is available on the public Provider website. Use the Tufts Health Unify List of Covered Drugs in English or Spanish, updated on a monthly basis, to find out if a specific drug is covered.

Pharmacies should bill Tufts Health Public Plans’ pharmacy benefit manager, CVS/caremark, for pharmacy services for Tufts Health Unify members. Contact CVS/caremark directly with billing questions:

**CVS/caremark**
Tufts Health Unify Customer Care: **800.768.1796**
Medicare Part D Pharmacy Help Desk: **866.693.4620**

Providers should submit pharmacy coverage determination requests through electronic prior authorization (ePA) or submit the medication request form to Tufts Health Public Plans:

**Mail:** Tufts Health Plan
Attn: Pharmacy Utilization Management Department
705 Mount Auburn Street
Watertown, MA 02472

**Fax:** 617.673.0956

 Expedited coverage decisions are made within 24 hours after receipt but can be up to 4 days if a supporting statement is needed. Standard coverage determinations are made within 72 hours after receipt but can be up to 6 days if supporting statements are needed. Notification of the decisions to approve or deny the request will be made via electronic prior authorization (ePA), mail or fax.

**Pharmacy Advisor Support Vendor: CVS Health**

The Pharmacy Advisor Support program analyzes pharmacy claims to identify potential nonadherence for specific conditions and educate members on the importance of taking medications as prescribed.

Providers are notified of potential member non-adherence for specific conditions by fax approximately 10-15 days after the refill due date.

**Medication Therapy Management Program Vendor: Mirixa**

Tufts Health Unify members may be eligible for the Medication Therapy Management (MTM) Program. Eligible members are automatically enrolled in the program and are offered a one-to-one telephone consultation with a clinical pharmacist. Information gathered during this process, along with pharmacy claims and clinical notes from the provider (when made available), are used to develop clinical recommendations where appropriate. Pharmacist recommendations are faxed to the provider for consideration. Members will receive an individualized written summary of the consultation and comprehensive medication review (CMR) by mail. CMRs are offered at least once a year.

In addition, targeted medication reviews (TMRs) are done to assess medication use, monitor unresolved issues, and identify new drug therapy problems. These TMRs are performed on a quarterly basis with any recommendations sent to the provider via fax. Participation in the program is voluntary and a member can disenroll at any time.

For additional information on program eligibility criteria, refer to the 2020 Medication Therapy Management Program.
PROVIDERS

Provider resources and responsibilities for Tufts Health Public Plans providers are outlined in the following sections:

- Clinical Responsibilities
- Provider Update
- PCP Responsibilities
  - Rhode Island Provider Responsibilities
  - Covering Provider
  - Leave of Absence Policy
  - Providers who can serve as PCPs
- Provider Access Standards
- Other Administrative Responsibilities
- Covered Services Lists
- Summary of the Credentialing Process
  - Provider Requirements
  - Primary Hospital Requirements
  - Tufts Health Public Plans Requirements
  - Board-Certified Policy
  - Provider Suspension, Termination or Sanction
  - Practitioners’ Rights and Responsibilities
  - Facility Credentialing
  - Hospital Credentialing
  - Laboratory Credentialing
  - Behavioral Health Facility Credentialing
- Fraud and Abuse Policy
  - Key Definitions

Refer to the Tufts Health Unify chapter for specific provider responsibilities regarding Tufts Health Unify.

Clinical responsibilities

Tufts Health Public Plans providers agree to comply with all state and federal laws and regulations applicable to arranging or providing services to any member. Responsibilities of Tufts Health Public Plans providers include, but are not limited to, the following:

- Use the Provider Resource Guide: MA version | RI version, as a quick reference for doing business with Tufts Health Public Plans
- Make covered health services available to all members
- Accept and treat members in an identical manner to all other patients in the practice
- Accept and treat all members regardless of age, race/ethnicity, English proficiency, sexual orientation, health status or disability
- Make Tufts Health Public Plans patients aware of clinical management options and all care options
- Participate in discharge planning and follow-up
- Respond to members’ linguistic, cultural and other unique needs (including communicating with patients in their primary language)
  
  **Note:** Help non-English-speaking patients receive interpreter services, if necessary. Members can call Tufts Health Public Plans for translation assistance:
  - Tufts Health Together and Tufts Health Direct: 888.257.1985
  - Tufts Health Unify: 855.393.3154
  - Tufts Health RITogether: 844.301.4093
- Have systems in place for accurately documenting:
  - Member information
  - Clinical information
  - Clinical assessments
  - Treatment plans
- Treatment or services provided and outcomes
- Contacts with a member’s family, legal guardian or other authorized representative
- Discharge plans
- Members’ consent for their medical and/or behavioral health providers to exchange information with each other and with us
  - Notify a member’s primary care provider (PCP) about any services and/or treatment provided if you are not the member’s PCP
  - Agree to follow requirements and limitations in applicable federal and state regulations, government contracts, and the contract with Tufts Health Public Plans when attempting to disenroll a member from the practice.
  - Complete an Americans with Disabilities Act (ADA) accessibility survey
  - Ensure office hours of operations for Tufts Health Together ACPP members, Tufts Health Together MCO members, and Tufts Health RITogether members are no more restrictive than those for your Tufts Health Direct members, Tufts Health Plan commercial members, MassHealth/Medicaid or Rhode Island Medicaid fee-for-service patients.

**Note:** Tufts Health Public Plans members cannot be charged any fee for cancelling or missing an appointment. If a member misses an appointment because of transportation or any other nonmedical need, Tufts Health Public Plans’ social care managers can help. Call the social care management team at **888.257.1985** (Massachusetts) or **844.301.4093** (Rhode Island). For more information about social care management, refer to the Care Management chapter.

In addition, do not charge Tufts Health Public Plans members for any service that is not medically necessary or not a covered service without providing documentation to the member communicating that they would have to pay for the service or discussing alternative services could meet their needs and obtain the member’s written acknowledgement of this notice.

**Provider Update**

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

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

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

Individuals who register to receive **Provider Update** by email are responsible for keeping their email addresses and contact information updated. To update information that was previously submitted through the online registration form, providers should resubmit the form with updated information.

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

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

---

3 Providers who do not register to receive **Provider Update** by email can be mailed copies of the full issue upon request by calling **888.257.1985** (Massachusetts) or **844.301.4093** (Rhode Island).
PCP Responsibilities

Members must have a PCP from whom to get regular services. Responsibilities of the PCP include, but are not limited to, the following:

- Offer coverage 24 hours a day, seven days a week, as well as back-up, on-call, after-hours, short-term and long-term leave-of-absence coverage
- Refer members to in-network specialists, if needed
  - Use our Find a Doctor, Hospital or Pharmacy tool or log into Tufts Health Provider Connect
  - See our Specialty Services Payment Policy for more information
- Discuss all treatment options with members, regardless of cost or benefit coverage
- Allow members to exercise their rights without having to worry about adversely affecting their treatment
- Encourage members to let you share information with their behavioral health provider, if they have one, and with us
- Verify members are in the practice’s panel before seeing them through Tufts Health Provider Connect, by calling us at 888.257.1985 (Massachusetts) or 844.301.4093 (Rhode Island), or New England Healthcare Exchange Network (NEHEN), NEHENNet, the Committee on Operating Rules for Information Exchange (CORE) web service for Massachusetts.

Rhode Island Provider Responsibilities

In addition to complying with provider requirements, Rhode Island providers must do the following:

- Enroll as a user of CurrentCare, including hospital alerts, and to assist your high-utilizing member in enrolling with CurrentCare
- Participate in Electronic Visit Verification (EVV)
- Ensure that family planning counseling is provided and, if appropriate, the extended family planning benefit explained during the last trimester of pregnancy and at the six-week postpartum visit.

Covering Provider

All Tufts Health Public Plan providers have contractually agreed to be accessible to members 24 hours a day, seven days a week. Providers who are unavailable are responsible for maintaining appropriate coverage that is acceptable to Tufts Health Public Plans. Covering providers must be contracted and credentialed by Tufts Health Public Plans.

Information regarding on-call activities must be relayed by the covering provider or the PCP to the Utilization Management (UM) Committee, for logging and tracking purposes and for continuity of care. This information includes:

- All admissions
- Member’s name, date of birth and ID number
- Instructions to members regarding follow-up care
- Instructions given or authorized services

Leave of Absence Policy

Tufts Health Public Plans requires a practitioner to notify Tufts Health Public Plans when he or she is taking a leave of absence (LOA) for longer than 60 calendar days. At a minimum, this notification must include the dates and the general reason for the LOA (sabbatical, medical reason, etc.). Practitioners must notify Tufts Health Public Plans regarding a pending LOA as quickly as possible.

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

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

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

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

Providers who can serve as PCPs

The following types of providers can serve as a member’s PCP:

- Providers with a general practice or internal medicine, pediatric, adolescent medicine or family practice specialties
- Providers credentialed in more than one specialty area
- Credentialed nurse practitioners whom we recognize as fully participating PCPs as detailed in the [Nurse Practitioner as Primary Care and Specialist Payment Policy](#)
- Credentialed physician assistants whom we recognize as fully participating PCPs
- OB/GYNs who serve as PCPs and who maintain member panels

Provider Access Standards

Providers agree to make services available to members as set forth in the requirements below:

<table>
<thead>
<tr>
<th>Appointment</th>
<th>Massachusetts Plans</th>
<th>RITogether Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>After-hours Care Telephone</td>
<td>Available 24 hours, 7 days a week</td>
<td>Available 24 hours, 7 days a week</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Specialists must have an answering service available 24 hours a day, 7 days a week</td>
<td>Immediately or referred to an emergency facility</td>
</tr>
<tr>
<td>Urgent Care Appointment</td>
<td>Within 48 hours of a request</td>
<td>Within 24 hours of a request</td>
</tr>
</tbody>
</table>
| Non-urgent Care Appointment (such as headache or fatigue) | • Within 10 calendar days of a request for PCPs  
  • Within 30 calendar days of a request for Specialists  
  [Note: PCPs and Specialists must see Tufts Health Unify members within 48 hours of a request.](#) | Within 10 calendar days of a request |
| Routine/Non-Symptomatic Care Appointment | • Within 45 calendar days of a request for PCPs  
  • Within 60 calendar days of a request for Specialists  
  [Note: PCPs and Specialists must see Tufts Health Unify members within 30 days.](#) | Within 30 calendar days of a request |
| Physical Exam             | Within 45 days of request  
  [Note: PCPs must see Tufts Health Unify members within 30 days.](#) | 180 calendar days                                   |
| EPSDT Appointment         | In accordance with the schedule established by EPSDT  
  [Note: PCPs and Specialists must see Tufts Health Unify members within 30 days.](#) | Within 6 weeks of a request                         |
### Appointment Requirements

<table>
<thead>
<tr>
<th>Appointment</th>
<th>Massachusetts Plans</th>
<th>RITogether Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Member Appointment</td>
<td>Within 45 days of request</td>
<td>Within 30 calendar days</td>
</tr>
<tr>
<td><strong>Note:</strong> PCPs must see Tufts Health Unify members within 30 days.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Emergent or Non-Urgent Mental Health or Substance Use Services</td>
<td>Refer to the Behavioral Health Provider’s Responsibilities section.</td>
<td>Within 10 calendar days of request</td>
</tr>
<tr>
<td>Initial Prenatal Appointment</td>
<td>Within 21 calendar days of a request</td>
<td>Within 21 days of request</td>
</tr>
<tr>
<td>Family-planning Appointment</td>
<td>Within 14 calendar days of a request</td>
<td>Within 14 days of a request</td>
</tr>
<tr>
<td>Postpartum Visit</td>
<td>N/A</td>
<td>No more than six (6) weeks after delivery</td>
</tr>
<tr>
<td>Department of Children and Families (MA) or Department of Youth and Families (RI) initial screening for patients in DCF/DCYF care</td>
<td>Within seven calendar days of a request, and comprehensive medical screening within 30 calendar days of a request</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*If an appointment is required more quickly to ensure the provision of screenings in accordance with the schedule established by the EPSDT Periodicity Schedule this must be met.*

### Other Administrative Responsibilities

Providers are responsible for managing the following administrative responsibilities:

- Ensure Tufts Health Public Plans has current and correct provider information. Submit a completed [Medical Provider Information Form](#) or [Behavioral Health Provider Information Change Form](#) as soon as possible when changes occur using one of the following submission channels:
  - Fax: 857.304.6311
  - Email: Provider_Data_Request@tufts-health.com
  - Phone: [888.257.1985](#) (Massachusetts) or [844.301.4093](#) (Rhode Island)
- Meet the appropriate credentialing and recredentialing requirements as outlined in this chapter.
- Have the National Provider Identifier (NPI) and Tax ID number available when contacting Provider Services.
- Verify member eligibility the day services are rendered using one of the following sources:
  - Tufts Health Provider Connect, the online secure provider portal or by calling the Tufts Health Public Plans Interactive Voice Response (IVR) system at [888.257.1985](#) (Massachusetts) or [844.301.4093](#) (Rhode Island). **Note:** If the member’s plan ID is not available, use the member’s name, gender and date of birth when checking eligibility.
  - Committee on Operating Rules for Information Exchange (CORE) web service
  - [Massachusetts Members](#) eligibility can be checked using the following sources:
    - New England Healthcare Exchange Network (NEHEN) or NEHENNet
    - MassHealth’s Provider Online Service Center or customer service center at [800.841.2900](#), option 2 for Tufts Health Together ACPPs and Tufts Health Together MCO plans. **Note:** A MassHealth provider number or NPI and password are required.
  - [Rhode Island Members](#) eligibility can be checked using the Rhode Island Medicaid’s online portal or the help desk at [401.784.8100](#) (local) or [800.964.6211](#) (toll free). **Note:** A Rhode Island Medicaid provider number or NPI number and password are required.

### Covered Services Lists

Visit the public Provider [website](#) for information about covered services:

- Tufts Health Together MCO covered services list
- Tufts Health Together ACPPs covered services list:
  - Tufts Health Together with Atrius Health
Summary of the Credentialing Process

Tufts Health Public Plans 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 Public Plans Credentialing Program and submit the following information to Tufts Health Public Plans via email to Tufts_Health_Plan_Credentialing_Department@tuftshealth.com or to the designated credentialing verification organization for review as indicated below:

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

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

Primary Hospital Requirements

Each MD and DO must indicate their primary hospital on the credentialing application when applicable. For initial credentialing, Tufts Health Public Plans 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 Public Plans in writing of changes in primary hospital affiliation.

Tufts Health Public Plans Requirements

Along with the credentialing information specified in CAQH ProView, Tufts Health Public Plans reviews the following information prior to the final assessment of each practitioner:

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

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

Providers cannot see Tufts Health Public Plans members without the following:

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

Board-Certified Policy

Physicians seeking credentialing must be board-certified or in the process of receiving certification after completing requisite board education and training within a time frame set by the applicable specialty.

Board-certified physicians must maintain certification in accordance with their applicable specialty board guidelines. If physicians do not maintain board certification in at least one clinical specialty, Tufts Health Public Plans may terminate their network participation.

New physicians who are eligible but not yet certified, such as physicians who have finished the applicable training and education but have not yet obtained board certification, are exempt from the board-certification requirement. Tufts Health Public Plans will only excuse the board certification requirement provided that no more than six years or two exam cycles, whichever is greatest, have elapsed since the physician completed residency in the applicable medical specialty.

Additionally, Tufts Health Public Plans may contract with physicians who have training consistent with board eligibility but who are not board-certified. In such circumstances, on a case-by-case basis, Tufts Health Public Plans will submit documentation describing the business need that is trying to be addressed by adding a non-board-certified physician to the network for review and approval by the Executive Office of Health and Human Services.

Provider suspension, termination or sanction

If MassHealth, Medicare, the Massachusetts Health Connector, Rhode Island Medicaid program, and/or another state’s Medicaid program or other state or federal agency suspends, terminates or sanctions a provider, the Tufts Health Public Plans participating provider status will be updated to reflect the same status. When the provider resolves any outstanding issues to the satisfaction of the agency and they have changed the provider’s status, the provider must notify Tufts Health Public Plans of the change in status. If the provider had been terminated, the provider will need to be initially credentialed.

The provider must notify Tufts Health Public Plans immediately of any disciplinary actions a governmental agency or licensing board takes against them or if they know of any such confirmed or pending disciplinary actions. Tufts Health Public Plans monitors the Board of Registration in Medicine (BORIM), Department of Health (DoH) licensing board, Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), the Medicare Exclusion Database and the Service Agreement Management System (SAM).

In the event there is a disciplinary action or evidence of serious quality issues, the credentialing committee will determine if there will be a change to the provider’s credentialing status or suspend or terminate the contract. Quality issues that could cause Tufts Health Public Plans to suspend or terminate may include:

• Refusing to comply with any Tufts Health Public Plans provider contract provisions
• Failing to comply with federal, state or local clinical or administrative practice requirements or regulations
• Failing to maintain full and unrestricted licensure
• Failing to obtain or maintain board-certified status (if board certified, the provider must maintain that status)
• Failing to maintain active hospital privileges
• Failing to comply with acceptable ethical and professional standards of behavior
• Significant quality concerns

The provider must notify Tufts Health Public Plans immediately if another health plan or institution terminates for:

• Refusing to comply with any contract element that also appears in our provider contract
• Failing to comply with federal, state or local clinical or administrative practice requirements or regulations
• Failing to maintain full and unrestricted licensure
• Failing to obtain or maintain board-certified status (if board certified, the provider must maintain that status)
• Failing to maintain active hospital privileges, as applicable
• Failing to comply with acceptable ethical and professional standards of behavior
• Significant quality concerns

The provider must also notify Tufts Health Public Plans immediately about the following:

• Suspension, termination or sanctions from MassHealth, Medicare, the Massachusetts Health Connector, Rhode Island Medicaid program or another state’s Medicaid program
• Any state or federal licensure action of which you are the subject
• Suspension from the Massachusetts BORIM, Rhode Island Department of health licensing board or other applicable board

If the credentialing committee decides to terminate or suspend a provider, the provider will be notified of the decision within three business days.

Practitioners’ Rights and Responsibilities

Practitioners have the right, upon written request, to:

• Review Tufts Health Public Plans’ credentialing policies and procedures
• Be informed of the status of their credentialing or recredentialing application by contacting the Credentialing Department via the following:
  - **Phone:** 617.972.9495
  - **Fax:** 617.972.9591
  - **Email:** Tufts Health Plan Credentialing Department@tufts-health.com
  - **Mail:** Tufts Health Plan
    Attn: Credentialing Department
    705 Mount Auburn Street
    Watertown, MA 02472
• Review information submitted to Tufts Health Public Plans for purposes of credentialing or recredentialing, including information obtained by Tufts Health Public Plans from any outside source, such as a malpractice carrier, state license board, or the National Practitioner Data Bank (NPDB).
  - Notwithstanding the foregoing, Tufts Health Public Plans is not required to reveal the information source if the information was not obtained for the purpose of meeting Tufts Health Public Plans’ credentialing requirements.
  - Providers are not entitled to review references, recommendations or information that is peer-review privileged or any information which by law Tufts Health Plan is prohibited from disclosing.
• Correct erroneous information submitted by another party, and Tufts Health Public Plans hereby notifies practitioners of their right to correct erroneous information. Tufts Health Public Plans will inform the provider how and where to submit corrections.
• Receive notification if credentialing information obtained from sources other than the practitioner varies substantially from the credentialing information provided to Tufts Health Public Plans by the provider.

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 Public Plans board member or otherwise be a representative of Tufts Health Public Plans.
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.

Facility credentialing

At the time of contracting, facilities are asked to complete and return the contracting package to Tufts Health Public Plans. Tufts Health Public Plans’ credentialing team will review the documentation for completeness and current, valid licensure and then submit the package to the credentialing committee for review.

Tufts Health Public Plans credentials the following types of facilities:

- Acute-care and rehabilitation hospitals
- Ambulatory care centers
- Skilled nursing facilities
- Home care agencies
- Hospice agencies
- Free-standing imaging centers
- Facilities the Department of Mental Health licenses as mental health or substance-use clinics

Tufts Health Public Plans requires the following from facilities before we begin the (re)credentialing process:

- Current and valid license
- Current and valid accreditation, as applicable
- Tufts Health Public Plans Medical or Behavioral Health Provider Information Form (PIF) (initial credentialing only)
- Form W-9 (initial credentialing only)
- Completed Federally Required Disclosures Form
- Confirmation of an acceptable and timely site visit, if not accredited; if there is no recent site visit, Tufts Health Public Plans may perform one

After the credentialing committee reviews the credentialing application, facilities are contacted by Tufts Health Public Plans to inform them whether or not their credentials are approved.

There is no right of appeal from adverse credentialing decisions for facilities.

Facilities will be recredentialed at least every three years or more frequently as required by state, federal or accrediting agency requirements.

Hospital Credentialing

Tufts Health Public Plans 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 Public Plans 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 Public Plans may review additional information reasonably deemed pertinent to credentialing, including a site visit.

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

Laboratory credentialing

Tufts Health Public Plans credentials clinical laboratories in accordance with the federal Clinical Laboratory Improvement Amendments (CLIA). Credentialed laboratories are required to:

- Have a current, unrevoked or unsuspended certificate of waiver, registration certificate, certificate of compliance, certificate for provider-performed microscopy (PPM) procedures or certificate of
accreditation issued by the U.S. Department of Health and Human Services applicable to the category of examinations or procedures performed by the laboratory, or

- Be CLIA-exempt, as defined in 42 CFR 493.2, or satisfy an exception set forth in 42 CFR 493.3(b)

There is no right of appeal from adverse credentialing decisions for laboratories.

Laboratories will be recredentialled at least every three years or more frequently as required by state, federal or accrediting agency requirements.

**Behavioral health facility credentialing**

In addition to the requirements outlined in this chapter, behavioral health providers must meet state and federal regulatory requirements, including but not limited to the Department of Mental Health (DMH) regulations for licensing of mental health facilities, as described in 104 CMR 27, for network inclusion. For more information about the behavioral health program, refer to the Behavioral Health chapter.

Tufts Health Public Plans uses the following criteria to credential any behavioral health facility or clinic provider:

- The provider must be licensed by the applicable state licensing agency.
- The facility may be accredited by the Joint Commission (formerly the Joint Commission on the Accreditation of Healthcare Organizations) or another Tufts Health Public Plans-recognized accreditation organization. If not accredited, other requirements apply (e.g., a recent site visit by Department of Public Health or Tufts Health Public Plans).
- The provider must have an organized and fully implemented quality management plan.
- The provider must not discriminate or restrict access on the basis of sex, race, creed, physical disability, national origin, sexual orientation or ability to pay, and must make services available to any person in the state.

Additionally, per contract requirements hospitals that provide behavioral health inpatient services must:

- Follow a human rights protocol that is consistent with DMH requirements and includes training of staff and education of patients regarding human rights
- Have a human rights officer, overseen by a human rights committee, and provide written materials to patients regarding their human rights, in accordance with DMH requirements

There is no right of appeal from adverse credentialing decisions for behavioral health facilities.

Behavioral health facilities will be recredentialled at least every three years or more frequently as required by state, federal or accrediting agency requirements.

**Fraud and abuse policy**

**Key definitions**

- **Fraud** means knowingly and intentionally misrepresenting facts to obtain or attempt to obtain payment or another benefit.
- **Waste** means overutilization of services and other actions that result in unnecessary costs to a health plan.
- **Abuse** means actions that may, directly or indirectly, result in unnecessary costs to a health plan, improper payment, and payment for services that fail to meet professionally recognized standards of care or services that are medically unnecessary.

Providers must comply with federal and state laws and regulations designed to prevent, identify and correct fraud, waste and abuse (FWA). FWA includes any act that constitutes fraud under applicable state or federal health care fraud laws. Examples include:

- Members lending their ID cards to someone else to obtain health care or pharmacy services
- Members providing false information when applying for programs, services, enrollment and benefits
- Providers performing unnecessary tests or procedures
- Providers billing for services they are not licensed to perform
- Providers billing for services or supplies they did not deliver, or reporting incorrect diagnoses or procedures to maximize payment
• Providers charging separately for services that were part of a single procedure
• Providers prescribing medications improperly
• Providers accepting or giving either money or services for member referrals
• Violations of Tufts Health Public Plans’ Payment Policies

Please note that your patients may receive a letter from us to verify that they received the services for which you billed. If you have questions, suspicions, concerns, or would like to report potential fraud and abuse involving a Tufts Health Public Plans member or provider, please call us at 888.257.1985 (Massachusetts) or 844.301.4093 (Rhode Island) or email us at fraudandabuse@tufts-health.com. You do not need to identify yourself. You may also call our confidential compliance hotline at 877.824.7123, or send an anonymous letter to us at:

Tufts Health Plan
Attn: Fraud & Abuse
705 Mount Auburn Street
Watertown, MA 02472

Rhode Island providers may report concerns directly to the state of Rhode Island, by contacting the Department of Human Services at 401.574.8175 or through their fraud website.
REFERRALS, AUTHORIZATIONS AND NOTIFICATIONS

To help ensure the quality of member care, Tufts Health Public Plans is responsible for monitoring authorization, medical appropriateness, and cost efficiency of services rendered. Refer to this chapter for information about:

- **Referrals**
  - Referral Inquiry
  - Referral Adjustments
  - Exclusions
- **Prior Authorizations**
  - Prior Authorization through the Precertification Department
  - Prior Authorization through Approved Vendors
- **Inpatient Notification**
  - Notification Requirements

Referrals

Certain services for members enrolled in certain Massachusetts plans requires a referral to confirm that member’s primary care providers (PCPs) and Tufts Health Public Plans has approved the member’s specialty care services. A referral verifies that the PCP has authorized the member’s care.

The member’s PCP must submit a referral to Tufts Health Public Plans when specialty care is needed from a contracted specialist. Tufts Health Public Plans will then issue a referral number to the PCP. 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 Public Plans system for one year, or until the approved number of visits or member’s benefit is exhausted.

Before providing care, specialists should check which members require a referral, or the status of an existing referral request, via Tufts Health Provider Connect. Specialists can also determine whether to request a referral by checking for "PCP referral required" on the member’s ID card or by calling Provider Services at 888.257.1985. Tufts Health Public Plans will not pay for specialty services that do not have a PCP referral when a referral is required. Members cannot be billed for these services.

Referral Inquiry

Providers may check the status of an existing referral by using the Referrals & Authorizations function on Tufts Health Provider Connect. Once submitted, it can take up to 24 hours for referral status to display.

Referral Adjustments

To request an adjustment to a referral that is already in the Tufts Health Public Plans system, the PCP must contact Provider Services at 888.257.1985. Tufts Health Public Plans cannot adjust referrals based on the specialist’s request. If the specialist would like to request an adjustment to a referral, the specialist should follow up directly with the member’s PCP.

Exclusions

Tufts Health Direct, Tufts Health Together and Tufts Health Unify does not require a PCP referral for the following services:

- Ancillary care:
  - Laboratory services
  - Radiology services **Note:** Some radiology services require prior authorization. Refer to the Radiology Imaging Services Payment Policy for more information.
  - Anesthesia services **Note:** Some anesthesia services require prior authorization. Refer to the Anesthesia Services Payment Policy for more information.
- Obstetric and gynecological care rendered by a contracting obstetrician, gynecologist, certified nurse midwife, or family practitioner:
  - Annual preventive gynecologic health examinations, including care deemed medically necessary by the practitioners listed above
Prior Authorizations

Authorization for certain services, drugs, devices and equipment is based on Tufts Health Public Plans Medical Necessity Guidelines (MNGs) or InterQual® criteria. Providers rendering services to members may not have claims paid if they fail to obtain prior authorization. Additionally, for Tufts Health Unify, Medicare National Coverage Determination (NCD) and Local Coverage Determination (LCD) criteria may also be used for Medicare-covered services. NCD and LCD criteria are available on the CMS website at cms.gov.

Medical Necessity Guidelines are based on current literature review, consultation with practicing physicians in the Tufts Health Public Plans service area, the policies of government agencies such as the FDA, and standards adopted by applicable national accreditation organizations. The guidelines are revised and updated annually, or more frequently as new evidence becomes available that suggests needed revisions. Medical Necessity Guidelines and InterQual criteria are used in conjunction with the member’s benefit plan document and in coordination with the provider recommending the service, drug, device or supply.

MNGs are available on the Tufts Health Public Plans public website (via the link above); printed copies are available upon request to providers by contacting Provider Services at 888.257.1985 (Massachusetts) or 844.301.4093 (Rhode Island).

Refer to the appropriate Medical Necessity Guidelines for prior authorization requirements. Submit a prior authorization request through the MHK Portal via Tufts Health Provider Connect or by faxing a completed Massachusetts Standardized Prior Authorization Request Form to 888.415.9055 or Rhode Island Standardized Prior Request Authorization Request Form to 857.304.6404 at least five business days in advance of the scheduled procedure, service or planned admission.

Providers are responsible for verifying the member’s eligibility on the date of service. Approval is dependent on eligibility and other determining factors. Tufts Health Public Plans will not pay for services rendered to patients who were not members on the date of service.

Prior Authorization through the Precertification Operations Department

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

- The member’s diagnosis
- Planned treatment, including medical rationale for the service requested
- All pertinent medical information available for review
Prior authorization requests should be faxed to the Precertification Operations Department at 888.415.9055 (Massachusetts) or 857.304.6404 (Rhode Island). When the use of an InterQual SmartSheet is required, it may be submitted without additional supporting documentation unless specifically indicated. Printed copies of InterQual SmartSheets (criteria) are available upon request to providers by contacting Provider Services at 888.257.1985 (Massachusetts) or 844.301.4093 (Rhode Island).

For a more comprehensive list of services that require prior authorization, refer to the Medical Necessity Guidelines section of the Resource Center, medical benefit summary grids or the Utilization Management Guidelines chapter.

Contact Provider Services at 888.257.1985 (Massachusetts) or 844.301.4093 (Rhode Island) with urgent requests or questions.

Prior Authorizations through Approved Vendors

**National Imaging Associates (NIA)**

Tufts Health Public Plans requires providers to obtain prior authorization through NIA for high-tech imaging, spinal conditions management and joint surgery utilization management programs.

For a list of procedure codes subject to prior authorization by NIA, refer to the High-Tech Imaging/Cardiac Program Prior Authorization Code Matrix and Spinal Conditions Management and Joint Surgery Code Matrix. To obtain and verify authorizations or access medical necessity guidelines, log into RadMD or call NIA at 800.207.4209.

It is the ordering provider’s responsibility to obtain prior authorization before scheduling appointments for members. Rendering providers will need to ensure that all tests have the required authorization number before the service is performed.

**Note:** For the High-Tech Imaging program, both professional and technical claims for which there is no authorization number will be denied and the member may not be billed for the service associated with the denied claim. Diagnostic imaging services performed in the emergency room, observation, and inpatient settings do not require prior authorization. Emergency CT/CTA, MRI/MRA, PET scan or nuclear cardiology procedures rendered at a site other than a hospital ED require notification to NIA within two business days of the service.

Refer to the Radiology Imaging Services Payment Policy or the High-Tech Imaging Program Prior Authorization Management Guide for additional information.

**Inpatient Notification**

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

As a condition of payment, Tufts Health Public Plans requires notification for any member who is being admitted for inpatient care, regardless of whether or not Tufts Health Public Plans is the primary or secondary insurer. Inpatient notification does not guarantee payment by Tufts Health Public Plans.

**Notification Requirements**

Admitting practitioners and facilities are responsible for notifying Tufts Health Public Plans and submitting the clinical information supporting the medical necessity of the inpatient admission and/or inpatient elective procedure that is scheduled in accordance with the following timelines:

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

Timely notification of admission is a requirement for payment. Late notification will result in denial of all inpatient days prior to when the notification is received.
Submission Channels

Providers should submit non-behavioral health inpatient notifications through the following channels:

- MHK portal through [Tufts Health Provider Connect](#). For more information refer to the [MHK User Guide](#).
- Emergent and urgent admissions: fax a completed [Inpatient Notification form](#) to the following:
  - Tufts Health Direct and Tufts Health Together: 888.415.9055
  - Tufts Health Unify: 857.304.0304
  - Tufts Health RITogether: 857.304.6404
  **Note:** No other forms will be accepted.
- Elective (scheduled) admissions: fax the appropriate completed form as outlined below:
  - [Massachusetts Standardized Prior Authorization Request Form](#) for Tufts Health Direct and Tufts Health Together to 888.415.9055 or Tufts Health Unify to 857.304.0304
  - [Rhode Island Standardized Prior Request Authorization Request Form](#) for Tufts Health RITogether to 857.304.6404

Incomplete forms will be returned to the submitting provider for completion and resubmission. Processing the request will be delayed until all information is returned to Tufts Health Public Plans.

If the date for an elective admission/procedure changes, but an inpatient notification has already been submitted, use the submission channels above to report the new date of admission to ensure accurate claims processing.
CLAIM REQUIREMENTS, COORDINATION OF BENEFITS AND DISPUTE GUIDELINES

The following topics are covered in this chapter:

- **General Guidelines**
- **Methods for Claim Submission**
  - Electronic Claims
  - Paper Claims
- **Coordination of Benefits**
  - Filing Deadline for Coordination of Benefits Claims
  - Coordination of Benefits Adjustments
  - Third-Party Liability
  - Subrogation
  - Motor Vehicle Accidents (No-Fault or PIP Coverage)
- **Claims Payment**
  - Clean Claims
  - Explanation of Payment
  - Electronic Remittance Advice
  - Electronic Data Interchange (EDI) 277 CA
- **Requests for Claim Review**
- **Corrected Claims**
- **Filing Deadline**
- **Filing Deadline Adjustments**
- **Provider Payment Disputes**
- **Payment Adjustments**
  - Retroactive Denials
- **Member Responsibility**
- **Claims Specifications**
  - Completing the UB-04 Form
  - Completing the CMS-1500 (02/12) Claim Form
  - Figure 1: UB-04 Claim Form Specifications
  - Figure 2: CMS-1500 (02-12) Claim Form Specifications

**General guidelines**

Tufts Health Public Plans processes completed claims that meet the conditions of payment and that are submitted within the time frame identified in provider agreements with Tufts Health Public Plans. Completed claims are claims submitted in industry-standard electronic format or on industry-standard forms with all fields completed accurately, refer to the Claims specifications.

Claims must be submitted within the contracted filing deadline according to the date of service, date of discharge or date of the primary insurance carrier’s explanation of benefits (EOB). Tufts Health Public Plans will deny claims submitted after the filing deadline, and the member is not responsible for payment. Refer to the Filing Deadline section of this chapter for more information.

**Payment policies** and clinical coverage criteria for specific services are available on the provider website. To ensure accurate claims processing, providers and their office staff must follow these documented policies.

Refer to Avoiding Administrative Claim Denials for tips to how to correct/avoid claim denials.

**Methods for claim submission**

Providers may submit claim electronically or on paper, as outlined below:
Electronic claims

Providers may submit claims electronically via the following methods:

- **Tufts Health Provider Connect** — an online self-service tool that allows providers to check member eligibility, submit individual CMS-1500 and UB-04 claims, and check claim and prior authorization status. Providers may also check claim status and view claim details. For more details, see the Tufts Health Provider Connect User Guide.

- **Direct electronic data interchange (EDI) submission** — this method is ideal for submitting a large volume of claims. Submit electronic claims files through secure file transfers. Direct claims submission is free and offers customized reporting and increased control over testing and processing. For more information, email EDI_Operations@tufts-health.com or call 888.880.8699 x54042 to speak with an EDI specialist.

- **New England Healthcare Exchange Network (NEHEN)** — NEHEN is a consortium of regional payers and providers that offers a secure and innovative e-commerce solution for claims submission and other health care transactions. Visit NEHEN online for information on how to join or call 781.907.7210.

- **NEHEN Net** — the NEHEN consortium collaborated on a single website called NEHEN Net, which allows smaller practices and providers with less IT support to manage the most popular and essential transactions for a fixed monthly fee. For more information, visit NEHEN Net, request an invitation to a weekly webinar via email at nehen-tech@nehen.org or call 781.907.7210.

- **Clearinghouse submission** — we accept professional and institutional EDI claims via the MD Online clearinghouses. Update the clearinghouse with the Tufts Health Public Plans payer ID number: 04298.

- **ABILITY®** — for questions about setup and connectivity, visit ABILITY’s website or call 888.499.5465.

- **Other clearinghouses** — for questions about setup and connectivity to another clearinghouse, or how to appropriately configure the clearinghouse’s software, email EDI_Operations@tufts-health.com or call 888.880.8699 x54042 to speak with an EDI specialist.

**Submitting electronic claims**

To submit claims electronically, providers must include the following:

- NPI number
- Tax ID number
- Payment address

**Note:** Claims with attachments (e.g. COB/TPL documentation, invoices, medical records) must be submitted as paper claims. Attachments are not accepted electronically.

**Electronic data interchange claims**

Tufts Health Public Plans encourages direct electronic submission to the plan but also accepts claims submitted via a clearinghouse or ABILITY. To be accepted, claims submitted directly to Tufts Health Public Plans must be in HIPAA-compliant standard 837 format and include all required information. Refer to the 837 Companion Guide for additional information. All methods of electronic data interchange (EDI) claim submission produce claim reports that can be accessed electronically. These reports are used to confirm the receipt of claims as well as follow up on rejected claims.

When required information is missing, Tufts Health Public Plans or the clearinghouse will reject the claim. If an electronic claim is rejected, resubmit a clean electronic claim no later than 60 days from the date of service. For additional information, refer to Avoiding EDI Claim Rejections.

Refer to the Electronic Services section of the provider website to download a set-up form and companion documents for submitting claims electronically directly to Tufts Health Public Plans or contact Tufts Health Public Plans’ EDI Operations Department by email at EDI_operations@tufts-health.com or by phone at 888.880.8699, ext. 54042 for additional information about submitting electric transactions or a setup request. For quality assurance purposes, providers must complete testing procedures. An EDI analyst will assist with coordinating...
the testing and implementation with the provider’s organization.

**EDI referrals, eligibility and claim status inquiry**

Tufts Health Public Plans offers options for electronic referrals, online eligibility inquiries and claim status information, as follows:

<table>
<thead>
<tr>
<th>Referral</th>
<th>Web-based referral inquiry via Tufts Health Provider Connect</th>
</tr>
</thead>
</table>
| Eligibility       | Web-based eligibility status via Tufts Health Provider Connect  
| Claim Inquiry Status | Web-based claims inquiry via Tufts Health Provider Connect  
|                   | NEHEN for Massachusetts providers only |

**Multiple payees**

For providers billing through EDI, Tufts Health Public Plans cannot accommodate payment to multiple payees at multiple payment addresses. Payment will be sent to the address listed as the primary provider’s office location in the Tufts Health Public Plans provider database. Any address changes or primary vendor/payee changes should be submitted to the Provider Information Department by emailing provider_data_request@tufts-health.com or faxing a completed Provider Information Change Form to 857.304.6311.

**Paper claims**

Some claims cannot be submitted electronically. Industry-standard paper claim forms should be submitted for the following instances:

- Claims requiring additional supporting documentation, such as operative or medical notes (e.g. COB/TPL documentation or invoices, etc.)
- Claims for provider payment disputes
- Unlisted CPT procedures that require explanations or descriptions

**Paper Claim Submission Requirements**

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

To avoid a filing deadline denial, rejected paper claims must be submitted within 90 calendar days from the date of service for professional or outpatient services or within 90 calendar days from the date of discharge. Claims submitted by paper display on Explanation of Payment (EOP) Reports within 30 days.

Submitted paper claim forms should include all mandatory fields as noted in the Claims specifications section of this chapter. Paper claim forms deemed incomplete will be rejected and a new claim with the required information must be resubmitted for processing.

**Tips:**

- Industry-standard codes should be submitted on all paper claims.
- Diagnosis codes must be entered in priority order (primary, secondary condition) for proper adjudication. Up to 12 diagnosis codes will be accepted on the CMS-1500 form.
- Paper claims will be rejected and returned to the submitter if required information is missing or invalid. Common omissions and errors include but are not limited to the following: Illegible claim forms, member ID number, date of service or admission date, and practitioner’s signature (CMS-1500 box #31)
Initial paper claims should be mailed to the following address:

**Massachusetts Paper Claim Submissions**
Tufts Health Public Plans  
P.O. Box 8115  
Park Ridge, IL 60068-8115

**Rhode Island Paper Claim Submissions**
Tufts Health Public Plans  
P.O. Box 859  
Park Ridge, IL 60068-0859

**Coordination of benefits**

Tufts Health Plan coordinates benefits when a member has additional insurance coverage (e.g., other primary insurance, third-party liability coverage).

Refer to the [Coordination of Benefits Payment Policy](#) for information on coordinating benefits for Tufts Health Direct members. **Note:** The Coordination of Benefits Payment Policy is applied to all behavioral health services with the exception of intensive care coordination (ICC) and family support and training (FS&T).

Federal and state regulations mandate that as a Medicaid managed care organization, Tufts Health Plan is payer of last resort for Tufts Health Together, Tufts Health RITogether and Tufts Health Unify. Providers must submit the claim(s) to the all known available carriers as the primary insurer and receive an explanation of payment or equivalent, then submit the paper claim with the primary insurer’s EOP to the secondary insurer (Tufts Health Public Plans). Do not take a cost-sharing amount up front.

If an attorney or insurance company other than Tufts Health Public Plans requests copies of a Member’s medical records or bills, notify the Tufts Health Public Plans TPL recoveries team via fax at 857.304.6336.

When filing a claim for a Member with third-party resources:

- Attach documentation to the paper CMS-1500 or UB-04 form showing claims processing results from the primary payer. Claims with attachments must be submitted as paper claims. Attachments are not accepted electronically.
- Attach a copy of the TPL carrier’s EOP, denial notice and benefits-exhausted statement to include both personal injury protection (PIP) and MedPay (auto insurance covering medical and funeral expenses resulting from an accident for the policyholder and any passengers riding with the policyholder) for claim payment.
- The primary insurance carrier’s EOP must contain the date the claim was processed or the check date. Also, a description of any remark codes indicated on the EOP must be submitted. An administrative denial (claim preparation error or because sufficient information to process the claim was not received) from the primary carrier is not accepted as a reason for Tufts Health Plan to pay as a primary carrier.

When submitting a claims retraction request for a claim that a motor vehicle, workers’ compensation, health, or other third-party insurer has paid, providers must include a copy of the primary carrier’s EOP and, when applicable, a check.

**Subrogation**

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

Tufts Health Plan has outsourced subrogation recovery services to The Rawlings Company in Louisville, Kentucky. As a result, providers could receive correspondence from Rawlings related to duplicate claim payments (e.g., Tufts Health Plan and a motor vehicle carrier). Inquiries related to such claims should be directed to the Rawlings Company representative at the number indicated on the correspondence. All other subrogation questions must be directed to Provider Services at 888.257.1985 (Massachusetts) or 844.301.4093 (Rhode Island).

**Recovery of overpayments**

In accordance with federal and state laws, Tufts Health Plan recovers its overpayments to providers.
Claims Payment

Clean Claims

MassHealth and Rhode Island define a clean claim as a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It may include a claim with errors originating from a contractor’s claims system. It may not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Clean claims must be filed within the timely filing period with the appropriate CPT/HCPCS codes and any applicable modifiers. For information about the forms to use for submitting claims, refer to the Claims specifications section in this chapter. To qualify for payment, clean claims must also meet the following conditions of payment:

The billed services must be:

- Covered in accordance with the applicable benefit document provided to members who meet eligibility criteria and are members on the date of service
- Furnished by a provider eligible for payment under Medicare and/or Medicaid
- Provided or authorized by the member’s PCP or the PCP’s covering practitioner in accordance with the applicable benefit document, or as identified elsewhere the provider’s contract with Tufts Health Public Plans (if applicable)
- Provided in the member’s evidence of coverage document
- Medically necessary as defined in the Medicare and/or Medicaid coverage guidelines
- Tufts Health Public Plans received the claim within 90 days from the date of service or the date of discharge if the member was inpatient, or date of the primary insurance carrier’s EOB
- Appropriately authorized in accordance with Tufts Health Public Plans’ inpatient notification, precertification and prior authorization procedures
- Billed electronically according to HIPAA standards or on CMS-1500 and/or UB-04 forms with a valid CPT/HCPCS code for professional services billed by a hospital

All services rendered to members must be reported to Tufts Health Public Plans as encounter or claims data. An encounter is a billing form submitted by capitated providers for tracking purposes. Claim forms are submitted by noncapitated providers for both payment and tracking purposes.

Explanation of Payment

The Tufts Health Public Plans explanation of payment (EOP) is a weekly report of all claims that have been paid or denied to that provider. EOPs may be viewed electronically by logging on to Change Healthcare. Electronic versions of EOPs are available for download and printing on the Change Healthcare website. If the explanation is unclear, contact Provider Services at 888.257.1985 (Massachusetts) or 844.301.4093 (Rhode Island).

Electronic Remittance Advice

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

All registration and support questions for retrieving the 835 from PaySpan Health and for ongoing support is handled by Change Healthcare via their website or by calling 866.506.2830.

Electronic Data Interchange (EDI) 277 CA

For claims submitted via direct Electronic Data Interchange (EDI), providers will receive an electronic 277CA Health Care Claim Acknowledgment Report that will indicate if claims were accepted for processing or denied.

Claims that appear on the 277CA as rejected are not active for processing in Tufts Health Public Plans’ claims system. Providers must correct and resubmit these claims within the timely filing limits or within 60 days from the date of the 277CA. If a claim is submitted within 60 days from the date of the 277CA, but 90 days or more past the date of service, resubmit on paper with a copy of the Tufts Health Public Plans 277 CA. The claim may
be denied if timely filing limits and these instructions are not followed.

For more information, refer to the Standard Companion Guide available through the Provider Resource Center.

Requests for claim review

If a provider has provided services to a member and disagrees with a claim denial or needs to provide additional or corrected information, submit a request for claim review. Refer to Avoiding Administrative Claim Denials for tips to correct/avoid claim denials.

Corrected claims

Tufts Health Public Plans accepts paper corrected claims, in accordance with guidelines of the National Uniform Claim Committee (NUCC), the Medicare Managed Care Manual, the MassHealth Provider Manuals and HIPAA EDI standards.

Corrected claims are submitted when the original claim had missing, inaccurate or invalid data. A Request for Claim Review Form must be submitted with the corrected paper claim. To submit a paper corrected claim:

- Print out or hand-write a new claim with corrected information
- Write “Corrected Claim” and the original claim number at the top of the claim
- Circle all corrected claim information
- Attach the Explanation of Payer (EOP) remit advice from the original claim
- Indicate the item(s) needing correction
- Highlight new or updated data elements on the claim
- **For Corrected Facility Claims:**
  - On the UB-04 (UB-04) form, enter either 7 (corrected claim), 5 (late charges) or 8 (void or cancel a prior claim) as the third digit in Box 4 (Type of Bill).
  - Enter the original claim number in Box 64 (Document Control Number).
- **For Corrected Professional Claims:**
  - In Box 22 (Medicaid Resubmission Code) on the CMS-1500 form, enter the frequency code 7 under “Code.”
  - In Box 22, enter the original claim number under “Original Ref No.”
  - Refer to the Request for Claim Review Form and Mailing Information for the appropriate address to submit the claim in the time frame specified by the terms in the provider’s contract.

Filing deadline

The timely filing deadline for first time claims submissions is as follows:

<table>
<thead>
<tr>
<th>If the provider is...</th>
<th>Submission Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>In state, in-network</td>
<td>90 days.</td>
</tr>
<tr>
<td>Submitting a claim for a COB or TPL</td>
<td>60 days from the date on the original primary carrier’s EOP or third-party determination letter.</td>
</tr>
</tbody>
</table>

The acceptable formats for filing proof of electronic submissions are either a rich text format (RTF) document or a 277 transaction report to the direct submitter or clearinghouse that indicates the claim was submitted and accepted by Tufts Health Public Plans within timely filing limits.

Filing Deadline Adjustments

To be considered for review, requests for review and adjustment for a claim received over the filing deadline must be submitted within 60 calendar days of the EOP date on which the claim originally denied. Disputes received after 60 calendar days will not be considered.

If the initial claim submission is after the filing limit and the circumstances for the late submission are beyond the provider’s control, the provider can submit a payment dispute for reconsideration. To do this, send a letter documenting the reasons why the claim could not be submitted within the contracted filing deadline, and include any supporting documentation and send a Request for Claim Review Form.
Note: Submit documented proof of timely submission with any request for review and payment of a claim previously denied due to the filing deadline.

For EDI claim submissions, the following are considered acceptable proof of timely submission:

- For claims submitted though a clearinghouse or ABILITY, a copy of the transmission report and rejection report showing that the claim did not reject at the clearinghouse or at Tufts Health Public Plans (two separate reports)
- For claims submitted directly to Tufts Health Public Plans, the corresponding report showing that the claim did not reject at Tufts Health Public Plans
- Copy of EOB from the primary insurer that shows timely submission from the date that carrier processed the claim
- Copy of EOB as proof that the member or another carrier had been billed, if the member did not identify himself or herself as a Tufts Health Public Plans member at the time of service

For paper claim submissions, the following are considered acceptable proof of timely submission:

- Copy of patient ledger that shows the date the claim was submitted to Tufts Health Public Plans
- Copy of EOB from the primary insurer that shows timely submission from the date that carrier processed the claim
- Copy of EOB as proof that the member or another carrier had been billed, if the member did not identify himself or herself as a Tufts Health Public Plans member at the time of service

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

- Copy of original claim form
- Copy of transmission report without matching rejection/error reports (EDI)
- Verbal requests

Requests for filing deadline adjustments for claims should be sent to the following address:

Tufts Health Public Plans
P.O. Box 9194
Watertown, MA 02471-9194
Attn: Provider Payment Disputes

Provider payment disputes

Providers have the right to file a payment dispute with a claim decision regarding the denial or compensation of a claim as outlined in the Provider Payment Dispute Policy. Tufts Health Public Plans providers can submit a claim payment dispute to:

Tufts Health Public Plans
P.O. Box 9194
Watertown, MA 02471-9194
Attn: Provider Payment Disputes

Payment disputes must include a copy of the EOP, appropriate documentation and a completed Request for Claim Review Form.

Note: Payment disputes and corrected claims cannot be submitted via EDI. Paper claims must be submitted.

Payment adjustments

Tufts Health Public Plans adjusts claims when providers receive incorrect payments as a result of various issues including, but not limited to:

- Billing errors
- Duplicate payments
- Coordination of benefits
- Payments inconsistent with contractually allowed amounts
- Member disenrollment

Tufts Health Public Plans applies adjustments to future claims payments or requests refund checks from
providers when appropriate. When the adjustment is applied to future payments(s), providers are notified via an explanation of payment. If an overpayment causes the adjustment and the retraction results in a negative balance, a provider does not receive additional payments until additional claims are received to offset the negative balance. With the exception of claims under investigation for fraud, waste and abuse, Tufts Health Public Plans does not initiate adjustments more than 24 months from the original Tufts Health Public Plans EOP date.

**Retroactive Denials (for Tufts Health Direct, Tufts Health Together and Tufts Health Unify)**

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

**Member responsibility**

Tufts Health Public Plans in-network providers agree to accept payment in accordance with applicable fees, rates and amounts established under their provider agreements and applicable compensation regulations.

Providers agree to not seek or accept payment from any member of Tufts Health Together ACPPs, Tufts Health Together MCO or Tufts Health RITogether for any MCO/ACPP covered service rendered, and providers agree to not make any claim against or seek payment from EOHHs for any MCO/ACPP covered service rendered to a member of Tufts Health Together ACPPs, Tufts Health Together MCO or Tufts Health RITogether. Instead, providers agree to look solely to Tufts Health Public Plans for payment with respect to MCO/ACPP covered services rendered to members of Tufts Health Together ACPPs, Tufts Health Together MCO or Tufts Health RITogether. Furthermore, providers agree they will not maintain any action at law or in equity against any member of Tufts Health Together ACPPs, Tufts Health Together MCO, Tufts Health RITogether or EOHHs to collect any sums that are owed by Tufts Health Public Plans under the contract for any reason, even in the event that Tufts Health Public Plans fails to pay for or becomes insolvent or otherwise breaches the terms and conditions of the agreement between the contractor and any network providers and non-network providers.

**Note:** Members may not be billed for services that have denied for exceeding the filing deadline or missed appointments.

Under the terms of providers’ contracts with Tufts Health Public Plans, balance billing of members (i.e., attempted collection of fees for services other than a member’s applicable cost share amount) is prohibited, and billing members for noncovered services is prohibited without an advance written agreement by a member to pay for the specific noncovered services.

**Note:** A general type of acknowledgement (e.g., ”I agree to pay for anything that my insurance does not pay for”) is not considered adequate to confirm the member's understanding and acknowledgement that it is not a covered service. Refer to the Forms section of our website for Tufts Health Plan’s [Agreement to Financial Liability form](#).

**Claim specifications**

**Completing the UB-04 Form**

Use the UB-04 form to complete a claim for institutional services. To complete this form, refer to the instructions in [UB-04 Claim Form Specifications](#) in this chapter. Field information is required unless otherwise noted. This form may be prepared according to Medicare guidelines as long as all required fields are completed. Follow these instructions to complete each hospital and facility claim accurately:

- Validate all procedure and diagnosis codes submitted for the date of service and bill to the fourth- and fifth-digit specification when appropriate.
- Include the prior authorization number on all inpatient submissions.
• Submit the attending physician’s name and Rhode Island license number of the claim form, for Tufts Health RITogether member claims.
• Provide medical records to review upon request, for payment accuracy.

Completing the CMS-1500 (02/12) Form

Use the CMS-1500 (02/12) form to submit a claim for noninstitutional services. All providers, including internal medicine, gynecology and psychiatry, should use ICD-CM diagnosis codes and HCPCS/CPT procedure codes. Oral surgeons may use CDT-3 codes, and dentists may use the ADA procedure codes and ADA form. To complete this form, refer to the instructions in the CMS-1500 (02/12) Claim Form Specifications section.

Note: If unlisted or miscellaneous codes are used, notes and/or a description of services rendered must accompany the claim. Using unlisted or miscellaneous codes will delay claims payment and should be avoided whenever possible. Claims received with unlisted or miscellaneous codes that have no supporting documentation may result in a claim denial and the member may not be held liable for payment.

Figure 1: UB-04 Claim Form Specifications

Note: Mandatory fields are marked with an M. Optional fields are marked with an O. The mandatory and optional fields may vary by state. Fields marked with an asterisk (*) are to be completed only if applicable.

<table>
<thead>
<tr>
<th>Box</th>
<th>Field Name</th>
<th>MA</th>
<th>RI</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Untitled</td>
<td>M</td>
<td>M</td>
<td>Enter the name and address of the hospital/provider.</td>
</tr>
<tr>
<td>2</td>
<td>Untitled</td>
<td>M</td>
<td>M</td>
<td>Enter the address of payee (if different from the address in box 1).</td>
</tr>
<tr>
<td>3a-b</td>
<td>Patient control number</td>
<td>O</td>
<td>M</td>
<td>3a: Enter member account number. 3b: Enter medical record number.</td>
</tr>
<tr>
<td>4</td>
<td>Type of bill</td>
<td>M</td>
<td>M</td>
<td>Enter the 3-digit code to indicate the type of bill.</td>
</tr>
<tr>
<td></td>
<td>Note: Claim will be returned if the type of bill is missing.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Federal tax number</td>
<td>M</td>
<td>M</td>
<td>Enter the hospital/provider federal tax ID. Claim will be returned if federal tax ID is not on the claim.</td>
</tr>
<tr>
<td>6</td>
<td>Statement covers period</td>
<td>M</td>
<td>M</td>
<td>Enter the beginning and ending service dates of the period covered by this bill (MMDDYY). These dates are necessary on all claims.</td>
</tr>
<tr>
<td></td>
<td>• For services received on a single day, both the “from” and “through” dates will be the same.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• If the “from” and “through” dates differ, these services must be itemized by date of service (see Box #45).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Untitled</td>
<td>N/A</td>
<td>N/A</td>
<td>Not applicable</td>
</tr>
<tr>
<td>8a</td>
<td>Patient ID and name</td>
<td>M</td>
<td>M</td>
<td>8a: Enter member ID number.  8b: Enter the member’s last name, first name and middle initial, if any, as shown on the member’s Tufts Health Public Plans member ID card.</td>
</tr>
<tr>
<td></td>
<td>Note: 8b is not a required field for RI.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9a-e</td>
<td>Patient address</td>
<td>M</td>
<td>M</td>
<td>Enter the member’s mailing address from the member record.  Note: 9a is required in Rhode Island. 9b-e are not required fields.</td>
</tr>
<tr>
<td>10</td>
<td>Birth date</td>
<td>M</td>
<td>M</td>
<td>Enter the member’s date of birth (MMDDYYYY).</td>
</tr>
<tr>
<td>11</td>
<td>Sex</td>
<td>M</td>
<td>M</td>
<td>Indicate Male (M) or Female (F).</td>
</tr>
<tr>
<td>Box</td>
<td>Field Name</td>
<td>MA</td>
<td>RI</td>
<td>Instructions</td>
</tr>
<tr>
<td>-----</td>
<td>---------------------------------</td>
<td>----</td>
<td>----</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>12</td>
<td>Admission date</td>
<td>M</td>
<td>M</td>
<td>Enter date of admission/visit.</td>
</tr>
<tr>
<td>13</td>
<td>Admission hour</td>
<td>M</td>
<td>M</td>
<td>Enter the time (hour: 00–23) of admission/visit.</td>
</tr>
<tr>
<td>14</td>
<td>Admission type</td>
<td>M</td>
<td>M</td>
<td>Enter the code indicating the type of this admission/visit.</td>
</tr>
<tr>
<td>15</td>
<td>Source of admission (SRC)</td>
<td>M</td>
<td>M</td>
<td>Enter the code indicating the source of this admission/visit.</td>
</tr>
<tr>
<td>16</td>
<td>Discharge hour</td>
<td>M</td>
<td>M</td>
<td>Enter the time (hour: 00–23) the member was discharged.</td>
</tr>
<tr>
<td>17</td>
<td>STAT (Patient discharge status)</td>
<td>M</td>
<td>M</td>
<td>Enter the code to indicate the status of the member as of the through date on this billing. Interim billing is not allowed, and the member status cannot be member.</td>
</tr>
<tr>
<td>18-28</td>
<td>Condition codes</td>
<td>O</td>
<td>M</td>
<td>Enter the code used to identify conditions relating to this bill that can affect payer processing.</td>
</tr>
<tr>
<td>29</td>
<td>Accident state</td>
<td>M</td>
<td>M</td>
<td>Enter the state in which accident occurred.</td>
</tr>
<tr>
<td>30</td>
<td>Accident Date</td>
<td>N/A</td>
<td>M*</td>
<td>Date the accident occurred, if applicable (MMDDYY)</td>
</tr>
<tr>
<td>31-34</td>
<td>Occurrence codes and dates</td>
<td>M*</td>
<td>M*</td>
<td>Enter the code and associated date defining a significant event relating to this bill that can affect payer processing.</td>
</tr>
<tr>
<td>35-36</td>
<td>Occurrence span code and dates</td>
<td>O</td>
<td>M</td>
<td>Enter a code and the related dates that identify an event that relates to the payment of the claim.</td>
</tr>
<tr>
<td>37</td>
<td>Untitled</td>
<td>N/A</td>
<td>N/A</td>
<td>Not applicable</td>
</tr>
<tr>
<td>38</td>
<td>Untitled</td>
<td>N/A</td>
<td>N/A</td>
<td>Not applicable</td>
</tr>
<tr>
<td>39-41</td>
<td>Value codes and amounts</td>
<td>N/A</td>
<td>M*</td>
<td>• Enter up to three value codes to identify circumstances that may affect processing of this claim, if applicable.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• In the amount box, enter the number, amount, or UCR value associated with that code.</td>
</tr>
<tr>
<td>42</td>
<td>Revenue code</td>
<td>M</td>
<td>M</td>
<td>Enter the most current uniform billing revenue codes.</td>
</tr>
<tr>
<td>43</td>
<td>Revenue description</td>
<td>M</td>
<td>M</td>
<td>Enter a narrative description that describes the services/procedures rendered. Use CPT-4/HCPCS definitions whenever possible.</td>
</tr>
<tr>
<td>44</td>
<td>HCPCS/rates</td>
<td>M</td>
<td>M</td>
<td>For outpatient services, use CPT/HCPCS codes for procedures, services and supplies. Do not indicate rates.</td>
</tr>
<tr>
<td>45</td>
<td>Service date</td>
<td>M</td>
<td>M</td>
<td>Enter the date the indicated service was provided.</td>
</tr>
<tr>
<td>46</td>
<td>Units of service</td>
<td>M</td>
<td>M</td>
<td>Enter the units of service rendered per procedure.</td>
</tr>
<tr>
<td>47</td>
<td>Total charges</td>
<td>M</td>
<td>M</td>
<td>Enter the charge amount for each reported line item. A negative amount will not be accepted.</td>
</tr>
<tr>
<td>Box</td>
<td>Field Name</td>
<td>MA</td>
<td>RI</td>
<td>Instructions</td>
</tr>
<tr>
<td>-----</td>
<td>------------------------------------------------</td>
<td>----</td>
<td>----</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>48</td>
<td>Noncovered charges</td>
<td>O</td>
<td>M</td>
<td>Enter any noncovered charges for the primary payer pertaining to the revenue code.</td>
</tr>
<tr>
<td>49</td>
<td>Untitled</td>
<td>N/A</td>
<td>N/A</td>
<td>Not applicable</td>
</tr>
<tr>
<td>50a-c</td>
<td>Payer</td>
<td>M</td>
<td>M</td>
<td>List all other health insurance carriers on file. If applicable, attach an EOB from another carrier.</td>
</tr>
<tr>
<td>51</td>
<td>Health plan ID</td>
<td>O</td>
<td>O</td>
<td>List provider number assigned by health insurance carrier.</td>
</tr>
<tr>
<td>52</td>
<td>Rel. info (release of information)</td>
<td>N/A</td>
<td>M</td>
<td>Enter &quot;Y&quot; for yes or &quot;N&quot; for no.</td>
</tr>
<tr>
<td>53</td>
<td>Asg ben (assignment of benefits)</td>
<td>N/A</td>
<td>M</td>
<td>Enter &quot;Y&quot; for yes.</td>
</tr>
<tr>
<td>54</td>
<td>Prior payments (payer and patient)</td>
<td>M</td>
<td>M</td>
<td>Report all prior payment for claim. Attach EOB from another carrier, if applicable. A negative amount will not be accepted.</td>
</tr>
<tr>
<td>55</td>
<td>Est. amount due</td>
<td>N/A</td>
<td>N/A</td>
<td>Not applicable</td>
</tr>
<tr>
<td>56</td>
<td>NPI</td>
<td>M</td>
<td>M</td>
<td>Enter valid NPI number of the servicing provider.</td>
</tr>
<tr>
<td>57a-c</td>
<td>Other Prv ID (another provider ID)</td>
<td>N/A</td>
<td>N/A</td>
<td>Not applicable</td>
</tr>
<tr>
<td>58a-c</td>
<td>Insured’s name</td>
<td>M</td>
<td>M</td>
<td>Enter the name of the individual who is carrying the insurance.</td>
</tr>
<tr>
<td>59</td>
<td>P. Rel (patient’s relationship to insured)</td>
<td>M</td>
<td>M</td>
<td>Enter the code indicating the relationship of the member to the identified insured/subscriber.</td>
</tr>
<tr>
<td>60a-c</td>
<td>Insured’s Unique ID (health insurance claim/ID #)</td>
<td>M</td>
<td>M</td>
<td>Enter the member’s Tufts Health Public Plans ID number, including the suffix, as shown on the member’s Tufts Health Public Plans ID card.</td>
</tr>
<tr>
<td>61a-c</td>
<td>Group name</td>
<td>M</td>
<td>O</td>
<td>Enter the name of the group or plan through which the insurance is proved to the insured.</td>
</tr>
<tr>
<td>62a-c</td>
<td>Insurance group number</td>
<td>M</td>
<td>O</td>
<td>Enter the ID number, control number or code assigned by the carrier or administrator to identify the group under which the individual is covered.</td>
</tr>
<tr>
<td>63 a-c</td>
<td>Treatment authorization code</td>
<td>O</td>
<td>M</td>
<td>Enter the Tufts Health Public Plans referral/authorization number for outpatient surgical day care services.</td>
</tr>
<tr>
<td>64 a-c</td>
<td>Document control number</td>
<td>N/A</td>
<td>N/A</td>
<td>Not applicable</td>
</tr>
<tr>
<td>65 a-c</td>
<td>Employer name</td>
<td>M*</td>
<td>M*</td>
<td>Enter the name of the employer for the individual identified in box 58.</td>
</tr>
<tr>
<td>66</td>
<td>DX version qualifier</td>
<td>N/A</td>
<td>N/A</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Box</td>
<td>Field Name</td>
<td>MA</td>
<td>RI</td>
<td>Instructions</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------</td>
<td>----</td>
<td>----</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>67a-q</td>
<td>Principal diagnosis code</td>
<td>M</td>
<td>M</td>
<td>Enter the most current ICD-CM code describing the principal diagnosis chiefly responsible for the admission/visit. Codes must be to the appropriate digit specification, if applicable. If the diagnosis is accident-related, then an occurrence code and accident date is also required. Present on admission (POA) indicator should be entered as the 8th character.</td>
</tr>
<tr>
<td>68</td>
<td>Other diagnosis codes</td>
<td>M*</td>
<td>M*</td>
<td>Enter the ICD-CM diagnosis codes corresponding to additional conditions that co-exist at the time of admission or develop subsequently. Code must be to the appropriate digit specification, if applicable.</td>
</tr>
<tr>
<td>69</td>
<td>Admit Dx</td>
<td>M</td>
<td>M</td>
<td>Enter the ICD-CM diagnosis code provided at the time of admission as stated by the provider.</td>
</tr>
<tr>
<td>70</td>
<td>Patient reason Dx</td>
<td>O</td>
<td>M</td>
<td>Enter the ICD diagnosis code that describes the patient’s reason for visit.</td>
</tr>
<tr>
<td>71</td>
<td>PPS code (prospective payment system)</td>
<td>O</td>
<td>O</td>
<td>Optional</td>
</tr>
<tr>
<td>72</td>
<td>ECI (external cause of injury code)</td>
<td>M*</td>
<td>M*</td>
<td>Enter the ICD code for the external cause of an injury, poisoning or adverse effect.</td>
</tr>
<tr>
<td>73</td>
<td>Untitled</td>
<td>N/A</td>
<td>N/A</td>
<td>Not applicable</td>
</tr>
<tr>
<td>74a-e</td>
<td>Principal procedure code (code and date)</td>
<td>M</td>
<td>M</td>
<td>Enter the most current ICD-CM code to the appropriate digit specification, if applicable, to describe the principal procedure performed for this service billed. Also, enter the date the procedure was performed. Date must be recorded as month and day (MMDD). <strong>Note:</strong> 74 is required in Rhode Island. 74a-e are not required fields.</td>
</tr>
<tr>
<td>75</td>
<td>Unlisted</td>
<td>N/A</td>
<td>N/A</td>
<td>Not applicable</td>
</tr>
<tr>
<td>76</td>
<td>Attending physician</td>
<td>M</td>
<td>M</td>
<td>Enter the ordering practitioner’s NPI, last name, first name and middle initial.</td>
</tr>
<tr>
<td>77</td>
<td>Operating physician</td>
<td>M*</td>
<td>M*</td>
<td>Enter the name and NPI number of the practitioner who performed the principal procedure.</td>
</tr>
<tr>
<td>78-79</td>
<td>Other provider types</td>
<td>O</td>
<td>O</td>
<td>Optional</td>
</tr>
<tr>
<td>80</td>
<td>Remarks</td>
<td>O</td>
<td>O</td>
<td>Examples: “COB-related” or “billing for denial purposes only”</td>
</tr>
</tbody>
</table>
| 81a-d | ICC                                     | O  | M  | • Enter B3 in the qualifier if fields 76-79 contain an NPI.  
• Enter the corresponding provider taxonomy of provider NPI’s entered in locations:  
  o 76a – 81CCa  
  o 77b – 81CCb  
  o 78c – 81CCc  
  o 79d – 81CCd |

**Figure 2: CMS-1500 (02/12) Claim Form Specifications**

**Note:** Mandatory fields are marked with an M. Optional fields are marked with an O. The mandatory and optional fields may vary by state. Fields marked with an asterisk (*) are to be completed only if applicable.
<table>
<thead>
<tr>
<th>Box</th>
<th>Field Name</th>
<th>MA</th>
<th>RI</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Type of insurance coverage</td>
<td>O</td>
<td>O</td>
<td>• Check the appropriate box to show health insurance coverage applicable to this claim. This field is optional.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• If the Other box is checked, complete Box #9.</td>
</tr>
<tr>
<td>1a</td>
<td>Insured's ID number</td>
<td>M</td>
<td>M</td>
<td>• Enter the member’s current identification number exactly as it appears on the member’s Tufts Health Public Plans ID card, including the alpha prefix and number suffix.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Inaccurate or incomplete ID numbers will delay processing the claim and can result in a denial.</td>
</tr>
<tr>
<td>2</td>
<td>Patient's name</td>
<td>M</td>
<td>M</td>
<td>Enter member’s last name, first name and middle initial, if any, as shown on the member’s Tufts Health Public Plans ID card.</td>
</tr>
<tr>
<td>3</td>
<td>Patient’s birth date and sex</td>
<td>M</td>
<td>M</td>
<td>Enter member’s date of birth and sex.</td>
</tr>
<tr>
<td>4</td>
<td>Insured’s name</td>
<td>M</td>
<td>M</td>
<td>• If the insured and the member are the same person, enter SAME.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• If the insured and the member are not the same person, enter the name of the insured (last name, first name and middle initial).</td>
</tr>
<tr>
<td>5</td>
<td>Patient’s address</td>
<td>M</td>
<td>M</td>
<td>Enter the member’s permanent mailing address and telephone number:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• On the first line, enter the street address.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• On the second line, enter the city and state.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• On the third line, enter the zip code and telephone number.</td>
</tr>
<tr>
<td>6</td>
<td>Patient relationship to insured</td>
<td>M</td>
<td>M</td>
<td>Check the appropriate box for the member’s relationship to the insured (self, spouse, child, other).</td>
</tr>
<tr>
<td>7</td>
<td>Insured’s address</td>
<td>M</td>
<td>M</td>
<td>- If the insured’s address is the same as the member’s address, enter SAME.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- If the insured’s address is different than the member’s address, enter the insured’s permanent mailing address (street number and name, city, state, zip code) and telephone number, if available.</td>
</tr>
<tr>
<td>8</td>
<td>Reserved for NUCC use</td>
<td>O</td>
<td>O</td>
<td>No entry required</td>
</tr>
<tr>
<td>9</td>
<td>Other insured’s name</td>
<td>M</td>
<td>M</td>
<td>• If the insured is the same as the person in Box #4, enter SAME.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• If the insured is not the same as the person in Box #4, enter the name of the other insured (last name, first name and middle initial).</td>
</tr>
<tr>
<td>9a</td>
<td>Other insured’s policy or group number</td>
<td>M</td>
<td>M</td>
<td>If the other insured is covered under another health benefit plan, enter the other insured's policy or group number.</td>
</tr>
<tr>
<td>9b</td>
<td>Reserved for NUCC use</td>
<td>O</td>
<td>O</td>
<td>No entry required</td>
</tr>
<tr>
<td>9c</td>
<td>Reserved for NUCC use</td>
<td>O</td>
<td>O</td>
<td>No entry required</td>
</tr>
<tr>
<td>9d</td>
<td>Insurance plan name or program name</td>
<td>M</td>
<td>M</td>
<td>Enter the other insured’s insurance plan name or program name and attach the other insurer’s EOB to the claim.</td>
</tr>
<tr>
<td>Box</td>
<td>Field Name</td>
<td>MA</td>
<td>RI</td>
<td>Instructions</td>
</tr>
<tr>
<td>-----</td>
<td>---------------------------------------------------------</td>
<td>----</td>
<td>----</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 10a-c | Is patient's condition related to:                      | M  | M  | • For each category (Employment, Auto Accident, Other Accident), check either YES or NO.  
• When applicable, attach an EOB or letter from the auto carrier indicating that personal injury protection (PIP) benefits have been exhausted. **Note:** Claims with attachments cannot be submitted electronically.  
• Enter the state postal code where the auto accident occurred. |
| 10d  | Claim codes                                             | O  | O  | Enter up to 4 claim condition codes                                                                                                          |
| 11   | Insured's policy group or FECA number                   | M  | O  | If the insured has other insurance, indicate the insured's policy or group number.                                                            |
| 11a  | Insured's date of birth and sex                         | M  | O  | Enter the insured’s date of birth and sex, if different from the information in Box #3.                                                        |
| 11b  | Other claim ID                                          | O  | M  | • Enter 2-character qualifier found in 837 electronic claim to the left of the dotted line.  
• Enter claim number from other insured’s plan to the right of the dotted line                                                                  |
| 11c  | Insurance plan name or program name                     | M  | M  | • Enter the insurance plan or program name, if applicable.  
• This field is used to determine if supplemental or other insurance is involved. If the supplemental or other insurer is a Blue Cross Blue Shield plan, enter the name of the state or geographic area. E.g., Blue Shield of [name of state]. |
| 11d  | Is there another health benefit plan?                   | M  | M  | Check either YES or NO to indicate if there is another primary health benefit plan. For example, a member may be covered under insurance held by a spouse, parent or other person. |
| 12   | Patient's or authorized person's signature              | M  | M  | • If the signature is not on file, the member or authorized representative must sign and date this box.  
• If the signature is on file, enter Signature on File.  
• If an authorized representative signs, indicate this person’s relationship to the member.                                                                 |
| 13   | Insured's or authorized person's signature              | M  | M  | • If the signature is not on file, the insured or authorized representative must sign this block to authorize payment of benefits to the participating practitioner or supplier.  
• If the signature is on file, enter Signature on File.                                                                                          |
| 14   | Date of current illness, injury or pregnancy (LMP)      | O  | M  | • Enter date of current illness, injury or pregnancy in the designated MMDDYY space.  
• Enter the qualifier found in the 837 electronic claim to the right of the QUAL dotted line.                                                  |
| 15   | Other date                                              | O  | O  | • Enter the qualifier found in the 837 electronic claim between the dotted lines to the right of QUAL.  
• Enter the date in the designated MMDDYY space.                                                                                                |
<p>| 16   | Dates patient unable to work in current occupation      | O  | O  | If the member is unable to work in his or her current occupation, enter the dates. An entry in this box could indicate employment-related insurance coverage. |</p>
<table>
<thead>
<tr>
<th>Box</th>
<th>Field Name</th>
<th>MA</th>
<th>RI</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Name of referring provider or other source</td>
<td>O</td>
<td>M</td>
<td>Enter 2-character qualifier found in 837 electronic claim to the left of the dotted line. Enter the name of the referring and/or ordering practitioner or other source if the member: • Was referred to the performing practitioner for consultation or treatment • Was referred to an entity, such as clinical laboratory, for a service • Obtained a practitioner’s order for an item or service from an entity, such as a DME supplier</td>
</tr>
<tr>
<td>17a-b</td>
<td>ID number of referring physician</td>
<td>O</td>
<td>M</td>
<td>• Enter the NPI-assigned practitioner ID number of the referring or ordering practitioner. • Referring practitioner information is required if another practitioner referred the member to the performing practitioner for consultation or treatment. • Ordering practitioner information is required if a physician ordered the diagnostic services, test or equipment</td>
</tr>
<tr>
<td>18</td>
<td>Hospitalization dates related to current services</td>
<td>M</td>
<td>O</td>
<td>Enter the admission and discharge dates when a medical service was furnished as a result of, or subsequent to, a related hospitalization.</td>
</tr>
<tr>
<td>19</td>
<td>Additional claim information (designated by NUCC)</td>
<td>O</td>
<td>O</td>
<td>Enter additional claim information.</td>
</tr>
<tr>
<td>20</td>
<td>Outside lab</td>
<td>O</td>
<td>O</td>
<td>Check YES or NO to indicate if laboratory work was performed outside the practitioner’s office.</td>
</tr>
<tr>
<td>21</td>
<td>Diagnoses</td>
<td>M</td>
<td>M</td>
<td>Enter the diagnosis/condition of the member indicated by ICD-CM code number. Enter up to 12 codes in priority order (primary, secondary condition). Codes are arrayed across the box.</td>
</tr>
<tr>
<td>22</td>
<td>Resubmission code</td>
<td>O</td>
<td>M</td>
<td>This item identifies a resubmission code.</td>
</tr>
<tr>
<td>23</td>
<td>Prior authorization number</td>
<td>O</td>
<td>M</td>
<td>If applicable, enter the inpatient notification number.</td>
</tr>
<tr>
<td>24a</td>
<td>Date(s) of service</td>
<td>M</td>
<td>M</td>
<td>• Enter the dates for each procedure in MMDDYY format, omitting any punctuation. • Itemize each date of service. • Do not use a date range.</td>
</tr>
<tr>
<td>24b</td>
<td>Place of service</td>
<td>M</td>
<td>M</td>
<td>Enter the appropriate place of service code.</td>
</tr>
<tr>
<td>24c</td>
<td>EMG</td>
<td>N/A</td>
<td>M</td>
<td>Check this item if the service was rendered in a hospital or emergency room.</td>
</tr>
<tr>
<td>24d</td>
<td>Procedures, services or supplies</td>
<td>M</td>
<td>M</td>
<td>Enter valid CPT/HCPCS procedure codes and any modifiers.</td>
</tr>
<tr>
<td>Box</td>
<td>Field Name</td>
<td>MA</td>
<td>RI</td>
<td>Instructions</td>
</tr>
<tr>
<td>-----</td>
<td>------------------------------------------------</td>
<td>----</td>
<td>----</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 24e | Diagnosis pointer                             | M  | M  | • Enter the diagnosis reference letter for up to 4 ICD-CM codes, as shown in box #21, to relate the date of service and the procedures performed to the appropriate diagnosis.  
• Enter a maximum of four letters that refer to four diagnosis codes. If multiple services are being performed, enter the diagnosis codes warranting each service. |
| 24f | $ Charges                                      | M  | M  | Enter the charge for each listed service.                                                                                                                                                             |
| 24g | Days or units                                  | M  | M  | Enter the days or units of service rendered for the procedures reported in Box 24d.                                                                                                                  |
| 24h | EPSDT family plan                              | O  | M  | Check this box if early and periodic screening, diagnosis and treatment, or family planning services were used.                                                                                         |
| 24i | ID QUAL                                        | O  | O  | Check this box if the service was rendered in a hospital emergency room. Note: If this box is checked, the place of service code in Field #24b should match.                                              |
| 24j | Rendering provider ID #                        | M  | M  | If the rendering practitioner is not the billing practitioner, enter the rendering practitioner’s NPI number.                                                                                         |
| 25  | Federal Tax ID number                          | M  | M  | Enter the practitioner/supplier’s federal tax ID, employer ID number or Social Security number.                                                                                                        |
| 26  | Patient’s account number                       | O  | O  | Enter the member’s account number assigned by the physician’s/supplier’s accounting system. Note: This is an optional field to enhance member identification by the practitioner or supplier.                      |
| 27  | Accept assignment?                             | M  | M  | Check YES or NO to indicate whether the practitioner accepts assignment for the claim. By accepting assignment, the practitioner agrees to accept the amount paid by Medicare or CHAMPUS as payment in full for the encounter. |
| 28  | Total charge                                   | M  | M  | Enter the total charges for the services (i.e., the total of all charges in Box 24f).                                                                                                                  |
| 29  | Amount paid                                    | M  | M  | • Enter the total amount paid by any other carrier/entity for the submitted charges in Box 28.  
• Attach supporting documentation of any payments (e.g., EOB, EOP or a copy of a cancelled check).                                                                                           |
| 30  | Reserved for NUCC use                          | O  | O  | No entry required                                                                                                                                                                                    |
| 31  | Signature of physician or supplier, including degrees or credentials | M  | M  | • If the signature is not on file, have the physician/supplier or authorized representative sign and date this block.  
• If the signature is on file, enter Signature on File.                                                                                                                                       |
<table>
<thead>
<tr>
<th>Box</th>
<th>Field Name</th>
<th>MA</th>
<th>RI</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 32, 32a-b | Service facility location information | M  | M  | If other than home or office, enter the name and address of the facility where services were rendered to the member:  
- Enter the NPI number for the facility  
- Enter other ID number, if applicable |
| 33, 33a  | Billing provider info and phone     | M  | M  | • 33: Enter the name and payment address of the entity receiving payment. This must match the Tax ID and name on file with the IRS.  
• 33a: Enter the NPI number for the entity receiving payment. |
Utilization Management Guidelines

Tufts Health Public Plans’ utilization management (UM) guidelines are intended to help providers plan and manage care in an efficient manner with high quality standards. Refer to this chapter for information about:

- Utilization Management Program
- Medical Necessity Guidelines
- Outpatient Services Review
- Appealing a Denied Request for Coverage
- Inpatient Hospital Review Process
- Initial Determinations
- Concurrent Review and Expedited Coverage Authorizations
- Provider Inquiry
- Retrospective Review Policy
- Continuity of Care – Massachusetts (for members of Tufts Health Together MCO and Tufts Health Together ACPPs only)
  - Provider Termination
  - New Enrollee Transition
- Continuity of Care and Transitioning Between Out-of-Network and In-Network Providers (for members of Tufts Health RITogether)
  - Existing Members
  - New Members
  - Members Transitioning from a Qualified Health Plan

Refer to the Tufts Health Unify chapter for specific utilization management guidelines for Tufts Health Unify.

Utilization Management Program

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

The UM Program consists of the following functions:

- Prospective, concurrent and retrospective utilization review (UR) of requests for coverage for inpatient admissions, inpatient and some outpatient behavioral health services, skilled nursing facility (SNF) services, long-term acute care services, acute hospital services, rehabilitation services, home care services, surgical procedures, medical technology, pharmaceuticals, some durable medical equipment, and targeted outpatient services
- The UM team may also perform discharge planning and quality measurement and improvement.

Medical Necessity Guidelines

The Tufts Health Public Plans Medical Necessity Guidelines, developed by the Medical Policy Department, adhere to standards adopted by national accreditation organizations and include input and instructions for applying the MNG from practicing specialty providers and PCPs, actively practicing practitioners in the community and Tufts Health Public Plans physicians. MNGs are the written guidelines used by Tufts Health Public Plans to determine medical necessity and appropriateness of health care services for the purpose of determining coverage under the applicable health benefit plan.

Tufts Health Public Plans’ MNGs are developed to facilitate consistent medical necessity determinations for coverage. These MNGs are used for requests for coverage of select medical and behavioral health services and supplies, such as assisted reproductive technologies (ART), durable medical equipment (DME), select elective surgical procedures, pharmaceuticals, oral surgery, transplants and other services determined by Tufts Health Public Plans to require a medical necessity determination for coverage.

MNGs are:

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

MNGs are available on the Tufts Health Public Plans public website (via the link above); printed copies are available upon request to providers by contacting Provider Services at 888.257.1985 (Massachusetts) or 844.301.4093 (Rhode Island).

Outpatient Services Review

Authorization for services, medical drugs, devices and equipment is based on Medical Necessity Guidelines (MNGs) or InterQual® criteria. Providers rendering services to members may not have claims paid if they fail to obtain prior authorization (PA). Refer to the appropriate Medical Necessity Guidelines for prior authorization requirements. Additionally, for Tufts Health Unify, Medicare National Coverage Determination (NCD) and Local Coverage Determination (LCD) criteria are used for Medicare-covered services. NCD and LCD criteria are available on the CMS website at www.cms.gov.

Note: All out-of-network services require prior authorization and must be initiated by the member’s PCP for coverage.

Refer to the Behavioral Health chapter and the product-appropriate grid for information specific to behavioral health services:

• Tufts Health Together and Tufts Health Direct Behavior Health Prior Authorization and Notification Grid
• Tufts Health Rhode Island Together Behavioral Health Prior Authorization and Notification Grid
• Tufts Health Unify Behavioral Health Prior Authorization and Notification Grid

Services not requiring prior authorization

Prior authorization is not required for coverage of:

• Emergency room and post-stabilization services
• Electric breast pumps (non-hospital grade) Note: Electric breast pumps are not covered for Tufts Health Unify.
• Skilled home health care services less than six months in duration, unless the request is for daily visits
• Office-based UV light therapy
• Pulmonary rehab
• Wigs

Services requiring prior authorization

Prior authorization is required for the following services including but not limited to:

• Any services from out-of-network providers
• Certain covered services (e.g., elective inpatient admission, some types of surgery)
• Out-of-network facilities, specialists and providers as identified by the Tufts Health Plan Find a Doctor, Hospital or Pharmacy search
• Daily home health care (HHC) services or for HHC extending beyond six months in duration
• Adult day care
• Inpatient rehabilitation and skilled nursing facility (SNF) services
• Certain DME with a combined rental or purchase price greater than $1,000. See the Durable Medical Equipment and Medical Supplies Payment Policy for detailed authorization requirements. Use the MassHealth Durable Medical Equipment and Medical Supplies General Prescription and Medical Necessity Review Form or the Tufts Health RITogether Durable Medical Equipment + Medical Supplies General Prescription and Medical Necessity Review Form to obtain authorization; the durable medical equipment vendor will verify the information on the form.
• Enteral nutrition formula for Tufts Health Together MCO or Tufts Health Together ACPP members; submit the Combined MassHealth MCO Medical Necessity Review Form for Enteral Nutrition Products (Special Formula) with the request for prior authorization.
• Enteral nutrition formula for Tufts Health RITogether: log onto Tufts Health Provider Connect and complete the request or submit the Standardized Prior Authorization Request form with the request for prior authorization.
• Hearing aids (as indicated per the member’s specific benefit).
• Outpatient therapy services (occupational therapy, physical therapy, and speech and language therapy). Refer to the Outpatient Therapy Services Payment Policy for specific authorization requirements.
• Certain behavioral health services — Refer to the Behavioral Health chapter.
• Certain drug authorizations — Refer to the Pharmacy chapter.
• High-tech imaging services, interventional pain management, spinal surgeries and management of joint surgeries (through National Imaging Associates, NIA). Refer to the Radiology Imaging Services Payment Policy, high-tech imaging and cardiac code matrix, spinal conditions management and joint surgery program matrix, as well as program landing pages for high-tech imaging, spinal conditions management and joint surgery for more information.

Refer to the medical and behavioral health benefit summary grids to verify whether or not a service is covered and requires prior authorization.

Appealing a denied request for coverage

Members can appeal a denied coverage request requiring prior authorization. If a member’s health or welfare could potentially be adversely affected by the adverse determination, Tufts Health Public Plans will expedite the appeal process upon request. Members may also designate the provider as their authorized representative to exercise the standard grievance and appeal rights on their behalf. For more information about Tufts Health Public Plans’ grievance and appeals processes, refer to the Rights and Responsibilities chapter.

Inpatient hospital review process

Tufts Health Public Plans conducts an initial review of the clinical information of all members admitted to an inpatient facility, as well as concurrent and discharge reviews. Tufts Health Public Plans notifies the facility of approved coverage determinations within one business day of receiving the necessary clinical information. The facility and admitting provider is notified within one business day of making a determination when denying coverage of the service.

A Tufts Health Public Plans UM physician reviews all cases that do not meet the clinical InterQual criteria used as the basis for the review. Providers are notified when a case under clinical review requires additional information and request additional relevant clinical documentation to substantiate a continued stay. All concurrent or continued stay reviews require clinical updates from the facility. Tufts Health Public Plans outreaches to the facility if clinical information is not received. If clinical information is not received in a timely manner, an administrative denial may be issued. Tufts Health Public Plans will discuss alternatives with the Provider and assess the member’s continued care, discharge planning and/or care management needs. For members of Tufts Health Together ACPPs, Tufts Health Public Plans notifies the member’s PCP at the applicable Accountable Care Organization of any proposed or urgent/emergent inpatient admission.

Note: Members of Tufts Health Together ACPPs and Tufts Health RITogether should contact their PCP and, if applicable, their behavioral health provider within 48 hours of receiving emergency services to arrange for any necessary follow-up care.

Tufts Health Public Plans will continue to cover medically necessary services throughout the duration of the hospital stay. Should a provider receive notification of an adverse determination; the member will not be
responsible for the cost of those services. When Tufts Health Public Plans sends providers a denial-of-service letter (adverse action or adverse determination) for inpatient services, a plan-specific member grievances and appeals enclosure will also be included. The letter and enclosure must be given directly to the member if they are not discharged so they can decide whether to exercise their right to appeal or file a grievance. For more information on member grievances and appeals, refer to the Rights and Responsibilities chapter.

Initial Determinations

Tufts Health Public Plans makes every effort to review an initial determination regarding a proposed admission, procedure or service requiring prior authorization. Prospective non-urgent requests will be completed within 14 calendar days for members of Tufts Health Together MCO, Tufts Health Together ACPPs or Tufts Health RITogether. Tufts Health Direct member determinations will be completed within two business days of obtaining all of the necessary information, but no later than 15 calendar days.

Prospective urgent requests for members of Tufts Health Together MCO, Tufts Health Together ACPPs or Tufts Health RITogether will be completed as soon as possible, taking into account medical exigencies, but not later than 72 hours of receipt of the request. Tufts Health Direct members’ urgent requests will be completed as soon as possible taking into account medical exigencies and always within 2 working days of receipt of all information but not later than 72 hours of receipt of the request.

For members of Tufts Health Together MCO, Tufts Health Together ACPPs or Tufts Health RITogether, the timeframe can be extended an additional 14 calendar days if further information is needed to make an initial determination.

If coverage of an admission, procedure, facility or service is approved, the provider is notified within 24 hours and written or electronic confirmation is sent within two business days thereafter stating the service(s) being covered. The provider must have this authorization letter before providing any service(s) requiring an authorization.

If a determination to deny, reduce, modify or terminate coverage of an admission, continued inpatient stay or any other health care service is made, Tufts Health Public Plans will notify the provider within 24 hours and send written or electronic confirmation to the provider and the Tufts Health Direct, Tufts Health Together MCO, Tufts Health Together ACPP or Tufts Health RITogether member within one business day thereafter.

Tufts Health Public Plans will not pay claims received from out-of-network specialists or facilities for any unauthorized services.

All UM decisions are based on appropriateness of care, availability of services and the members’ coverage. Tufts Health Public Plans does not reward providers, UM clinical staff, or consultants for denying care and does not offer network providers, clinical staff, or consultants money or financial incentives to encourage less use of services.

For information on authorizations for Tufts Health Unify members, refer to the Tufts Health Unify chapter.

Concurrent Review and Expedited Coverage Authorizations

Concurrent review is utilization review conducted during a member’s inpatient hospital stay or course of treatment. Concurrent reviews are typically associated with the extension of previously approved inpatient care, residential behavioral health care, intensive outpatient behavioral health care and ongoing ambulatory care.

If the inpatient stay extends beyond the initial authorization end date, the facility or attending physician must submit additional clinical information to substantiate the member’s continued stay. Concurrent urgent requests for members of Tufts Health Together MCO, Tufts Health Together ACPPs or Tufts Health RITogether will be completed as soon as possible, taking into account medical exigencies, but no later than 72 hours of receipt of the request. Tufts Health Direct members’ concurrent urgent requests will be completed as soon as possible taking into account medical exigencies and always within 24 hours of the request. Failure to submit clinical information, or the submission of clinical information that is not sufficient to support the extension request, may lead to the issuing of an adverse action/determination.

For additional information, refer to the Rights and Responsibilities chapter.
Provider Inquiry

If Tufts Health Public Plans has denied authorization for coverage of an inpatient admission while the member is still confined, outpatient services or an elective procedure after an initial determination or a concurrent review determination, providers may ask Tufts Health Public Plans to reconsider the decision. This involves a one-on-one discussion between the provider and a clinical peer reviewer about the details of your Tufts Health Together MCO, Tufts Health Together ACPP, Tufts Health RITogether or Tufts Health Direct member’s case. A clinical peer reviewer will contact the provider within one business day of the request. If Tufts Health Public Plans upholds the denial, the member may appeal the decision or may designate the provider to appeal on their behalf. Provider inquiry is not required before the member can appeal the denial. For more information on member appeals, refer to the Rights and Responsibilities chapter.

Retrospective Review Policy

To assist providers with ongoing efforts to provide Tufts Health Together MCO, Tufts Health Together ACPP, Tufts Health RITogether or Tufts Health Direct members with high quality care and ensure such care is managed appropriately, Tufts Health Public Plans reserves the right to retrospectively review all services provided to members.

Continuity of Care - Massachusetts
(For members of Tufts Health Together MCO and Tufts Health Together ACPPs only “Enrollees”)

Tufts Health Public Plans continues to support the care of Enrollees by applying the continuity of care principles as well as any regulatory requirements regarding continued care by a practitioner in order to minimize disruption of an ongoing episode of care and to ensure uninterrupted access to medically necessary services. Continuity of Care refers to the presence of an existing clinical relationship pertaining to the treatment of an ongoing clinical episode of acute care between the Enrollee and Practitioner under certain specific conditions.

Provider Termination

Provided the practitioner has not terminated for quality or fraud, Tufts Health Public Plans will continue to authorize coverage of services for continued treatment of Enrollees with a terminated practitioner in the following circumstances:

- Specialty care:
  - Enrollees who are receiving active treatment for a chronic illness or acute medical condition will be covered for continued treatment with the terminated practitioner through the current period of active treatment or up to 90 days, whichever is shorter.
  - During the period where a denial or termination of services has occurred and the Enrollee has filed an Internal Appeal (Qualified Health Plan) or a First-Level, Second-Level or Expedited Internal Appeal (MassHealth/CarePlus) on that decision
  - Enrollees who are pregnant may continue with coverage for a period up to and including the first postpartum visit.
  - Enrollees who are terminally ill and in the last 6 months of treatment for that terminal illness may continue treatment with the terminated provider until the Enrollee’s death.
- Primary care provider:
  - Provide the Enrollee with written notice at least 30 days prior to the termination or disenrollment of the primary care provider, including a description of the procedure for choosing a new primary care provider;
  - Allow the Enrollee to be covered for services consistent with Tufts Health Public Plans’ evidence of coverage and/or Member Handbook for at least 30 days following the primary care provider’s termination or disenrollment.
  - Follow the Enrollee’s condition and services for continued coverage as outlined above if the practitioner agrees to the following:
    ▪ The practitioner cannot balance bill the Enrollee; and
▪ The practitioner must adhere to the quality assurance standards and policies and procedures of Tufts Health Public Plans and is subject to the same oversight and requirements for clinical information had the practitioner not disenrolled.

New Enrollee Transition

Tufts Health Public Plans will continue to authorize coverage of services for continued treatment of new Enrollees in the following circumstances:

Primary care

Services provided by a provider who is an Enrollee’s previous primary care provider will be covered for up to 30 calendar days from date of enrollment with Tufts Health Public Plans.

Tufts Health Public Plans follows the Enrollee’s condition and services for continued coverage as outlined above if the practitioner agrees to the following:

- The practitioner cannot balance bill the Enrollee; and
- The practitioner provider must adhere to the quality assurance standards and policies and procedures of Tufts Health Public Plans and is subject to the same oversight and requirements for clinical information.

Non-primary care

- Tufts Health Public Plans will help ensure that Enrollees currently receiving inpatient care (medical or behavioral health) from a hospital, including non-Network hospitals, may continue to receive care from such hospital as long as services delivered are medically necessary. Upon notification, Tufts Health Public Plans will make outreach efforts to contact the facility to ensure continuity of care and discharge planning;
- Tufts Health Public Plans will ensure that, for at least 30 days after the Enrollee’s Effective Date of Enrollment, new Enrollees receiving outpatient medical, behavioral health or substance use disorder care may continue to seek and receive services from these providers. This includes Enrollees with upcoming appointments, ongoing treatments or services, or prior authorizations. New Enrollees may continue to seek and receive care from providers (including non-Network) with whom they have an existing relationship.
- For Enrollees who have an existing prescription, Tufts Health Public Plans will provide coverage for any prescribed refills of such prescription, unless Tufts Health Public Plans has a prior authorization policy and such policy requires a prior authorization for coverage of such prescription. If a prior authorization is required for an existing prescription, Tufts Health Public Plans will provide a minimum 72-hour supply of such medication.
- Tufts Health Public Plans will ensure that, for at least 30 days after the Effective Date of Enrollment, new Enrollees with any of the following listed below may have continued access. Tufts Health Public Plans will ensure continuity by providing new authorizations or extending existing authorization, if necessary, without regard to Medical Necessity criteria, for at least the required 30-day period. Tufts Health Public Plans will make sure that providers will be able to confirm or obtain any authorization, if needed, to continue such access.
  - Durable medical equipment (DME) that was previously authorized by MassHealth, a MassHealth-contracted MCO or a MassHealth Accountable Care Partnership Plan (ACPP);
  - Prosthetics, orthotics and supplies (POS) that were previously authorized by MassHealth, a MassHealth-contracted MCO or a MassHealth ACPP; and
  - Physical therapy (PT), occupational therapy (OT), or speech therapy (ST) that was previously authorized by MassHealth, a MassHealth-contracted MCO or a MassHealth ACPP.

Tufts Health Public Plans will honor all prior authorizations and prior approvals for above services for the duration of such prior authorizations and prior approvals. If Tufts Health Public Plans elects to modify or terminate a prior authorization and prior approval, these modifications will be administered as an Adverse Action and will follow the appeal rights policy and procedures (refer to the Rights and Responsibilities chapter), including notification to the Enrollee and the Enrollee's provider in question.
Special Consideration

- A pregnant Enrollee who enrolls during a transition period may choose to remain with her current provider of obstetrical and gynecological services, even if such provider is not part of the ACPP or MCO network. Tufts Health Public Plans will cover all medically necessary obstetrical and gynecological services through delivery of the child, as well as immediate post-partum care and the follow-up appointments within the first six weeks of delivery. A pregnant Enrollee will be permitted to select a new provider of obstetrician and gynecological services within the applicable Tufts Health Together (MCO) or Tufts Health Together (ACPP) Tufts Health Public Plans ACPP or MCO networks if she so chooses to do so.

- Enrollees with autism spectrum disorder (ASD) who are actively receiving ABA Services, either through MassHealth, another Accountable Care Partnership Plan, a MassHealth-contracted MCO or a commercial carrier and have a current prior authorization for ABA Services in place will be entitled to continuity of these services for a minimum of 90 days after such Enrollees are enrolled with Tufts Health Public Plans. Tufts Health Public Plans protocol will include the use of single-case agreements, full acceptance and implementation of existing prior authorizations for ABA Services and individual transition plans.

- Enrollees who are receiving ongoing services such as dialysis, home health, chemotherapy and/or radiation therapy
- Enrollees who have significant health care needs or complex medical conditions
- Enrollees who are hospitalized or are receiving treatment for behavioral health or substance abuse
- Enrollees who have received prior authorization for services including but not limited to:
  - Scheduled surgeries;
  - Out-of-area specialty services;
  - Durable medical equipment or prosthetics, orthotics, and supplies;
  - Physical therapy, occupational therapy or speech therapy; or Nursing home admission.
  - All Enrollees may access Emergency Services at any emergency room, including services from out-of-Network Providers and such Services will be provided at no cost to the member.

Continuity of care and transitioning between out-of-network and in-network providers – Rhode Island

Under the conditions below, Tufts Health Public Plans allows members to continue treatment with an out-of-network provider only if the provider agrees to the Tufts Health RITogether terms related to reimbursement, member co-payments (which cannot be higher than those listed in the RITogether medical and behavioral health benefit summary grids), quality, oversight, referrals, and additional Tufts Health RITogether policies and procedures, including the terms and conditions set forth in the Tufts Health RI Together Member Handbook.

Existing members

With prior authorization, an existing member may continue to see providers who are no longer in the Tufts Health Public Plans network (providing that the provider’s disenrollment has not been for reasons related to quality of care or fraud) when the member:

- Is receiving active medical or behavioral health treatment for a chronic illness or acute condition. The member will be covered for continued treatment with the terminated provider through the current period of active treatment or for up to ninety (90) days, whichever is shorter.
- Is in the second or third trimester of pregnancy; the member may continue with coverage of a period up to and including the first postpartum visit.
- Is terminally ill and in the last six months of anticipated treatment for a terminal illness; the member may continue treatment with the terminated provider until the member’s death.

---

5 Tufts Health RITogether follows the members’ condition and services for continued coverage as outlined herein if the out of network practitioner agrees to the following:

- To accept reimbursement at the rates applicable to participating providers as payment in full;
- The practitioner cannot balance bill the member; and
- The practitioner adheres to the quality assurance standards and policies and procedures of Tufts Health Public Plans and is subject to the same oversight and requirements for clinical information.
Refer to the Out-of-Network Coverage at the In-Network Level of Benefits MNG for additional information.

When a primary care provider is terminated for reasons other than those related to quality or fraud, Tufts Health RITogether will:

- Provide the member with written notice at least 30 days prior to the termination or disenrollment of the primary care provider, including a description of the procedure for choosing a new primary care provider
- Allow the member to be covered for services consistent with the *Tufts Health RITogether Member Handbook* for at least thirty (30) days following the primary care provider’s termination or disenrollment.

**New members**

A new member to Tufts Health RITogether, with a pre-existing relationship, may continue to see that non-contracted provider when there is an existing prior authorization with the provider for whom the authorization was granted for up to six (6) months or for a longer duration, if specified in the existing prior authorization.

**Specialty care**

Continuity of care for transitioning members between out-of-network and in-network providers exists when a new member:

- Is in the second or third trimester of pregnancy; the member may continue with coverage for a period up to and including the first postpartum visit.
- Is terminally ill and in the last six (6) months of treatment for that terminal illness; the member may continue treatment with the terminated provider until the member’s death.
- Is receiving active medical or behavioral health treatment for a chronic illness or acute condition; the member will be covered for continued treatment with the existing out-of-network practitioner for up to six (6) months from the date of enrollment, or for a longer duration, if specified in the existing prior authorization.
- At the end of the transition period, the member is required to transition to an in-network provider.

**Primary Care**

Services provided by a member’s previous out-of-network primary care provider are covered for up to thirty (30) calendar days from the enrollment effective date with Tufts Health RITogether.

**Members Transitioning from a Qualified Health Plan**

Tufts Health RITogether allows a transitional period of at least ninety (90) days following a member’s effective date of enrollment with Tufts Health RITogether, when the member can demonstrate that they were covered by a Qualified Health Plan (QHP) for at least one day during the 90 days preceding enrollment.

- Tufts Health RITogether will honor all existing prior authorizations authorized by the member’s former QHP and for which the provider shows evidence of the prior authorization and which would still be in effect if the member was still covered by his or her former QHP
- Tufts Health RITogether will make formulary exceptions to all eligible former QHP members to honor existing pharmacy prior authorizations by allowing the member to refill or renew any prescription which the member had received through their former QHP.
- Tufts Health RITogether will allow the member to continue seeing out-of-network providers on an in-network basis if:
  - The provider was a part of the member’s QHP network, and
  - The member had been in the care of that provider for a period of at least six (6) months.
CARE MANAGEMENT

Tufts Health Public Plans’ integrated care management services are intended to support the delivery of person-centered, coordinated activities to support Members’ goals and better health outcomes. Here is a list of the topics in this chapter:

- **Overview of Integrated Care Management Services**
- **Complex Care Management Services**
- **Disease Management Program**
- **Health Needs Assessment**
- **Maternal and Child Health Program**
  - Prenatal Registration
  - Doula by My Side Program
  - Prenatal and Postpartum Extra Benefits and Services
  - Notification of Birth
- **Massachusetts-Specific Care Management Services and Programs**
  - Social Care Management Services
  - Transition of Care Program (for members of Tufts Health Together MCO, Tufts Health Together ACPPs and Tufts Health Direct)
- **Rhode Island-Specific Care Management Services and Programs**
  - Transition of Care Program
  - Short-Term Care Coordination
  - Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Assistance
  - Emergency Room (ER) Visits 3-day Follow-up Services

**Overview of Integrated Care Management Services**

Tufts Health Public Plans’ Integrated Care Management programs are based on best practices and evidence-based guidelines employed across the case management industry and are aligned with the Case Management Society of America’s Standards of Practice. The program offers a multidisciplinary and team-based approach to provide Members with access to appropriate care and services. This approach allows the team to assist providers, Members, and, when authorized, Members’ families and caregivers to successfully navigate the continuum of care.

A Tufts Health Public Plans Care Manager is available to work with each Member and their caregivers (when authorized) to design individualized care plans outlining Members’ personal goals and health care preferences, and to engage them in their treatment and recovery. Tufts Health Public Plans works with primary care offices and other health care and social service providers to coordinate access to care and avoid duplication of services. This integrative method is based on what may be Members’ most critical needs.

The Integrated Care Management team has varied professional training and experiences in behavioral health, nursing, nutritional counseling, respiratory therapies, community health work and more. The team is diverse and represents a wide range of cultural and linguistic backgrounds, which enables Tufts Health Public Plans to effectively interact with Members, address cultural barriers, adapt to unforeseen challenges and coordinate access to high-quality health care services. Tufts Health Public Plans leverages translation services per Members’ preferences in order to effectively communicate with them and their caregivers.

Contact Provider Services at **888.257.1985** (Massachusetts) or **844.301.4093** (Rhode Island) to refer Members who may benefit from one of the Integrated Care Management programs.

**Complex Care Management Services**

Tufts Health Public Plans’ NCQA-accredited Complex Care Management program serves Members with hard-to-manage, unstable, or long-term medical and/or behavioral health conditions. Members in this program receive support from a licensed health care professional and clinical support staff that can assist with navigating the health care delivery system to facilitate appropriate care and access to services. This program strives to help members attain optimal and functional well-being, initiate early interventions to avoid complications and minimize the onset of secondary disabling conditions.
The Behavioral Health and Medical Care Management clinicians provide a range of services to help members achieve better health outcomes, including:

- Performing comprehensive behavioral, physical and social need assessments
- Developing and implementing a Member-centric, comprehensive care plan
- Coordinating care with caregivers, social service providers, and community partners
- Providing targeted health education for Members and their authorized representatives
- Enabling a link between clinical services and available community resources
- Collaborating with site-based care managers at outpatient primary care offices and community mental health organizations as well as inpatient treatment facilities and other provider locations
- Educating and empowering Members to take an active role in managing their health
- Working to decrease Emergency Room (ER) visits and acute inpatient lengths of stay
- Encouraging the use of health care resources as appropriate and in line with clinical guidelines

Tufts Health Public Plans identifies Members with complex medical and/or behavioral health conditions that are at risk for future hospitalization, significant health care needs or high health care costs through sources such as:

- Predictive modeling tools
- Utilization data, including facility admissions and pharmacy claims
- External referrals from Member, caregiver, or health care or social service providers
- Internal referrals from Behavioral Health Utilization Management, Medical Utilization Management and Integrated Care Management staff

Additionally, Complex Care Management may be beneficial for:

- Members with multiple health conditions or intensive medical and/or behavioral health needs
- All Members being considered for or being worked up for a transplant (either solid organ or BMT/SCT)
- Pregnancy
- Poor immunization record
- Current inpatient stay in a level 3 or 4 nursery (NICU) or special care nursery
- Co-existing diseases and/or co-morbidities affecting the recovery process Members with any of the following conditions:
  - Catastrophic event (e.g., overdose, suicide attempt, victim of physical assault and multiple traumatic injuries)
  - Medical admission related to alcohol and/or drug use
  - Supportive Service Needs (i.e., inpatient or recently discharged Members who require supportive services beyond the discharge planning period)
  - Conditions requiring episodic but extensive use of resources
  - Complex diagnosis, such as (but not limited to):
    - Traumatic brain injury
    - Progressive debilitating musculoskeletal or neurological disorders
    - Shaken infant syndrome
    - Severe and persistent mental illness
    - Adult or childhood obesity
    - Cancer
    - HIV/AIDS
    - Serious emotional disturbances
    - Congenital abnormalities of the nervous system
    - Encephalopathy
    - Central nervous system tumors or other mass lesions
    - Spinal cord injury
    - Degenerative neurological, metabolic or genetic diseases
    - Cerebral vascular accident
    - Terminal diagnosis
  - Functional impairments impacting personal skills and/or clinical needs

**Disease Management Program**

The Disease Management Program provides Members diagnosed with diabetes, asthma, chronic obstructive
pulmonary disease and/or heart failure with tools to increase their ability to self-manage their disease and any associated co-morbidities. Using an evidence-based comprehensive clinical assessment, coupled with motivational interviewing techniques, Disease Managers assist Members in developing Member-centric care plans with disease-specific interventions, such as education, coaching, advocacy, and care coordination of health care and social services.

The program interventions are established using the guidelines for the National Heart Lung and Blood Institute, American Diabetes Association, American Lung Association, Global Initiative for Obstructive Lung Disease and American College of Cardiology Foundation/American Heart Association.

Disease Managers are licensed as a Registered Nurses, Registered Respiratory Therapists or Registered Dietitians with Certification in Diabetes Education.

Tufts Health Public Plans also offers Members online educational resources and community supports, texting programs and digital coaching programs.

Goals of the Disease Management Program include:

- Increasing quality of care and reducing utilization of medical services
- Collaborating with Members and providers on Member-centered goals and care plan based on evidence-based condition-specific clinical assessment
- Assessing education gaps and increasing treatment plan adherence, such as medication regimens and doctor visits
- Reduce unnecessary hospital admissions and emergency room visits
- Decrease HEDIS gaps-in-care rates by working with Members to collaborate with their providers to schedule and review tests, as well as their medication regimen

High-risk Members are identified monthly for this program through medical and pharmacy claims data, medical utilization, HEDIS-like criteria and known risk factors. Once identified, Members will automatically be enrolled into the Disease Management Program with the ability to “opt-out” if they choose. Members can also self-refer or be referred by a member of Tufts Health Public Plans’ staff inpatient facility providers, outpatient providers, community service agency staff, vendors and authorized representative(s). Member outreach methods include phone outreach, text-messaging with opt-out available and gaps in care outreach letters. Providers also receive trigger letters identifying Members with gaps in care. Members can be referred without prior authorization or precertification.

Health Needs Assessment

Tufts Health Public Plans utilizes the Eliza Corporations IVR program to assess the needs of our Together pediatric (under 18-years-old) and adult populations in Massachusetts and Rhode Island, as needed. This program is available as an IVR call as well as a paper assessment. Members are called via the IVR system, and if not reached are provided a callback number. Paper surveys are mailed to members who do not complete the Health Assessment by phone.

The assessments are based on validated evidence-based tools and address mind, body, lifestyle, biometrics and social determinants of health. They are designed to solicit responses to risk factors that indicate potential need for Care Management interventions due to specific needs for immediate access to services due to potential or confirmed significant health and social issues. Providers are encouraged to assist Members with obtaining and completing the assessment tools. Health Assessments can be accessed by calling Provider Services at 888.257.1985 (Massachusetts) or 844.301.4093 (Rhode Island) or through the Integrated Care Management Department at Tufts Health Public Plans.

Maternal & Child Health Program

The maternal and child health services are designed to support all pregnant Members and complement the care provided. Tufts Health Public Plans works closely with providers to coordinate prenatal and postpartum care for new mothers and newborns.

Tufts Health Public Plans’ trained staff will perform further screening for the purpose of care management stratification and outreach based on the level of support the Member is identified as needing. This program includes:
• High-risk pregnancy care management and low-risk care coordination
• Congratulations and introductory educational materials
• A pregnancy calendar with information related to prenatal care; nutrition and exercise during pregnancy; labor and birth; postpartum care; breastfeeding; and newborn care for members of Tufts Health Together MCO or Tufts Health Together ACPPs
• Information regarding Tufts Health Public Plans wellness incentives (the EXTRAS program)
• Information and links to Healthy Baby Essentials, our preferred breast pump provider
• Information on the Doula by My Side program, which allows members to work with a doula during and after pregnancy

Prenatal Registration

Notify Tufts Health Public Plans of a member’s pregnancy using the Prenatal Registration Form and the member will become eligible for a variety of prenatal services and counseling. In addition, Massachusetts providers can receive $40 if the member’s pregnancy is reported within the member’s first trimester or $20 if the pregnancy is reported within the member’s second trimester. There is no reimbursement for notifications received within the patient’s third trimester. To receive the one-time payment per member, complete the Prenatal Registration Form using CPT code 0501F and diagnosis code Z34.90, then fax it to 857.304.6305 (Massachusetts) or 857.304.6404 (Rhode Island).

When the completed form is received, a precertification number is generated and a letter of acknowledgment is sent for Tufts Health Public Plans’ global obstetrical package that covers the member’s routine obstetrical ultrasound, prenatal nutritional counseling, care management, and other routine prenatal and postpartum services. Tufts Health Public Plans will also notify the member about childbirth and/or breastfeeding classes, and the importance of having a postpartum visit.

Doula By My Side 2x2 Program (for Tufts Health Together MCO, Tufts Health Together ACPPs and Tufts Health RITogether members)

Through the Doula by My Side program, a member has the option to engage with a specially trained doula for antepartum, birth and postpartum support. Members will receive outreach from a doula beginning at 28 weeks gestation. The program typically provides two antepartum visits and two postpartum visits. The member may also opt for a birth visit as part of the program.

Participating doulas may provide the following services:

• Education for mother and family about the pregnancy, labor and delivery, and postpartum expectations
• Breastfeeding education and support
• Instruction and support for newborn care

The outcome goals of the Doula by My Side Program include:

• Decreasing the risk of adverse birth outcomes and their consequences
• Decreasing NICU and Special Care Nursery admissions
• Decreasing preterm births
• Increasing postpartum visits between 21 and 56 days after delivery
• Improving member satisfaction
• Decreasing overall maternity costs

Members are identified for referral to the Doula by My Side program by a High-Risk Pregnancy Nurse Care Manager or Care Coordinator. Referrals can also come from: screening by Tufts Health Public Plans Low-Risk OB Coordinators; internal referrals from member Services, Medical Utilization Management and Integrated Care Management staff; provider referrals; and member self-referral. Members must meet certain eligibility criteria. For example, members must be:

• Families with limited resources
• Mothers with a limited support system
• Mothers with a history of depression
• Mothers with a high-risk pregnancy
• Mothers who have had a cesarean section
• Mothers who are dealing with chronic health conditions, such as hypertension, diabetes, substance use disorder and other behavioral health diagnoses

Prenatal and Postpartum Extra Benefits and Services

As part of the care provided to pregnant members, encourage them to take advantage of these services that Tufts Health Public Plans offers:

• Assistance with choosing an OB/GYN, certified nurse midwife or other pregnancy care provider, as well as a pediatrician or primary care provider for their baby
• Coordination of services for medically and socially high-risk pregnancies through the Complex Care Management Program, High-Risk Maternity care management services, the Early Intervention Partnership Program or other available community resources
• Prenatal and postpartum home visits from a visiting nurse at no additional cost to the member
• Breast pumps, and special and prescription formulas
• Education about text4baby, which sends text messages on postpartum care, baby health, parenting and more
• A “Grow Healthy Together” calendar for members of Tufts Health Together MCO or Tufts Health Together ACPPs, which includes information about pre- and postpartum infant development with PCP visit reminders

Notification of Birth

To help ensure continuity of care for mothers and newborns, and to facilitate the enrollment of newborns into MassHealth (for Massachusetts members), the admitting or delivering hospital must notify Tufts Health Public Plans of each delivery by phone at 888.257.1985 (Massachusetts) or 844.301.4093 (Rhode Island) or by fax at 888.415.9055 (Massachusetts) or 857.304.6404 (Rhode Island).

Massachusetts facilities must also submit a Notification of Birth form (NOB-1) to MassHealth within 30 days after the birth for members of the following plans:

• Tufts Health Together (MCO)
• Tufts Health Together with Atrius Health
• Tufts Health Together with Boston Children’s ACO
• Tufts Health Together with BIDCO
• Tufts Health Together with CHA
• Tufts Health Unify

Record Tufts Health Public Plans for the mother’s plan in “Section I: Mother’s Information” on the NOB-1 form.

Rhode Island facilities must fax a RIT Notification of Birth form to 857.304.6404 within 30 days after the birth.

Massachusetts-Specific Care Management Services and Programs

The following Care Management services and programs are for members with a Massachusetts plan:

Social Care Management Services

Tufts Health Public Plans Social Care Management services are provided by community health workers who support members and their families by coordinating access to services that address social determinants of health. The community health workers provide members both telephonic and on-site support to assist with:

• Applying for food stamps and locating food pantries and community meals
• Applying for benefits such as Supplemental Security Income (SSI) and Social Security and Disability Insurance (SSDI)
• Connecting with utility assistance programs
• Coordinating transportation to medically necessary appointments, when appropriate and applicable
• Finding support groups
• Identifying and scheduling appointments with in-network medical and behavioral health providers and specialists
• Locating emergency shelter and completing housing applications
• Understanding and accessing health plan benefits and community services

Transition of Care Program (for Tufts Health Together MCO, Tufts Health Together ACPPs and Tufts Health Direct members)

Members’ post-discharge outcomes are often complicated by concurrent medical and behavioral health co-morbidities as well as social determinants of health. The Tufts Health Public Plans Transition of Care (TOC) Program utilizes a case management approach to help ensure care continuity for Tufts Health Together MCO, Tufts Health Together ACPPs and Tufts Health Direct members transitioning between health care settings and home as their condition and care needs change. Tufts Health Public Plans leverages existing provider- and community-based case managers to preserve existing treatment relationships and avoid duplication of services. When members have case managers from provider sites and other community health teams, the case managers from these entities are typically considered the “lead” case managers. Tufts Health Public Plans care management staff work to inform providers of admission events and reconnect members to their treatment in the community with these providers.

Behavioral health TOC services aim to optimize the wellness of members being discharged from an inpatient psychiatric facility, dual diagnosis acute residential treatment program, community-based acute treatment program or emergency department. Physical health TOC services are provided to members identified at risk of readmission that are being discharged from acute, rehabilitative or skilled nursing facilities. Integrated Care Management Department staff will outreach members within 72 hours of discharge and conduct interventions such as:

• Completion of a TOC Assessment to assess type and priority of needs to be addressed for the primary goal of preventing avoidable readmissions
• Outreach calls and support in the form of referrals, appointment reminders, and education on health plan benefits and services, including Tufts Health Public Plan’s Clinical Community Outreach (CCO) Specialists providing assistance to address social determinants of health
• Review of discharge instructions and conducting medication review to assess whether the member has filled all of his or her prescriptions and understands the importance of medication adherence
• Efforts to ensure that the member has scheduled a follow-up appointment with the PCP or treating specialist within seven days of discharge, assisting with appointment scheduling and transportation as necessary
• Coordination of care across the medical and behavioral health continuum of care, including communication of event notification to providers and other community health teams as appropriate
• Education on, and referring member/designated caregiver to, resources available to aid in the navigation of the health care system, community services and publicly funded programs

Rhode Island Specific Care Management Services and Programs

The following Care Management services and programs are available to Tufts Health RITogether members:

Transition of Care Program

Behavioral Health and Medical Care Managers initiate care transition plans after members of Tufts Health RITogether leave an acute, subacute, or skilled nursing facility; transitional care unit; or rehabilitation setting. Through programs for behavioral health and medical transitions of care, Tufts Health Public Plans strives to:

• Identify and facilitate appropriate care and services for members who would benefit from interventions
• Ensure members know and understand their condition(s)
• Educate members about self-managing their condition(s)
• Reduce readmissions and ED utilization
• Provide individualized and integrated short-term care coordination to each member
• Identify incidences of, and develop interventions to improve, underused or overused services
• Improve members’ overall health

Tufts Health Public Plans’ Care Managers also work with ancillary providers (e.g., visiting nurse associations, durable medical equipment vendors) to assist members’ receipt of timely services. Transitional care can last
from 6 to 12 weeks.

Call Provider Services at **844.301.4093** to refer a member for behavioral health or medical Transition of Care Program.

**Short-Term Care Coordination**

Tufts Health Public Plans’ Behavioral Health, Medical, and Social Care Managers provide Short-Term Care Coordination services, that are designed to help members who may or may not have a chronic disease but have acute physical, behavioral health, or social care needs that impact health status, or are at risk of further exacerbation of their illness. When the members’ needs warrant immediate attention, short-term care coordination will ensure access to primary care and behavioral health services.

The goal of Short-Term Care Coordination is to reduce the impact of any adverse outcome. Services may include assistance with making or keeping needed medical or behavioral health appointments, and referrals related to the members’ immediate needs. Members are identified for Short-Term Care Coordination because their needs can be addressed in a time-limited fashion and do not meet the criteria for Complex Care Management programs.

Integrated Care Management staff provides both phone outreach and in-person support to assist members with such needs such as:

- Applying for food stamps
- Locating emergency shelter
- Coordinating transportation to medically necessary appointments, when appropriate and applicable
- Getting counseling or medical or behavioral health services
- Applying for benefits such as Supplemental Security Income (SSI) and Social Security and Disability Insurance (SSDI)
- Getting information about programs to help pay for utilities
- Finding disability support groups
- Accessing other community services in addition to services provided by Tufts Health Public Plans, including but not limited to:
  - Community Health Teams
  - Home Stabilization Program agencies
  - Rhode Island Department of Behavioral Health, Developmental Disabilities, and Hospitals (“BHDDH”) services
  - Rhode Island Department of Children, Youth, and Families (“DCYF”) services
  - Rhode Island Department of Health (“DOH”) services
  - Rhode Island Department of Human Services (“DHS”) services
  - Sobering Treatment Opportunity Program (“STOP”)
  - Special Education
  - Waiver Services

Call Provider Services at **844.301.4093** to refer a member for Short-Term Care Coordination services.

**Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Assistance**

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is the foundation for ensuring comprehensive and necessary medical care to all Medicaid recipients under the age of 21. Compliance with this program is essential for prompt identification of problems that, if left undiagnosed or untreated, could create greater disabilities or diminish one’s likelihood of achieving future life goals. Tufts Health Public Plans works to ensure that our members, especially those who are children, receive all services required to diagnose and treat potential and ongoing problems in a timely and culturally sensitive manner. Based on the EPSDT Periodicity Schedule, the Care Management team provides outreach calls and mailings to remind members about upcoming and past due wellness visits, offering assistance to address the barriers to attending appointments. Staff will also outreach to providers with members who have missed wellness visits.

**Emergency room (ER) visits 3-day follow-up services**

For members who are evaluated in Emergency Rooms (ERs) for behavioral health issues and not admitted to an inpatient level of care, Care Management staff will ensure that each member has a follow-up appointment
with a provider within three (3) business days of discharge from the ER. Care Management staff also ensures that the ER discharge plan is shared with the member’s primary care provider and any other care coordinating agency connected with the member.
BEHAVIORAL HEALTH

Tufts Health Public Plans’ behavioral health team assists with accessing varying levels of services for members based on their needs, intensity of utilization and/or coexisting medical conditions. Although many of the Behavioral Health Program and Services are similar for Massachusetts and Rhode Island, there are some significant differences. Be sure refer to the appropriate state-specific information in this chapter as outlined in the following sections:

- **Massachusetts and Rhode Island Behavioral Health Program**
- **Behavioral Health Provider Responsibilities**
- **Medical necessity and clinical criteria**
- **Payment policies**
- **Behavioral health services authorization**
- **Denials and appeals**
- **Patient care coordination**
- **Treatment and discharge planning**
- **Care management**
- **Medical records compliance**
- **Adverse incident reporting**
- **Massachusetts-Specific Behavioral Health Program**
  - Performance specifications
  - Community Partners (For Tufts Health Together ACOs)
- **Massachusetts-Specific Behavioral Health services**
  - Emergency Services Program
  - Children’s Behavioral Health Initiative Services (Tufts Health Together)
  - Child and adolescent needs and strengths (CANS) requirements
- **Rhode Island–Specific Behavioral Health services**
  - Criteria and procedures for all BH services
  - Continued-stay review procedure
  - Emergency Services Intervention (ESI)

Massachusetts and Rhode Island Behavioral Health Program

The following Behavioral Health Programs apply to both Massachusetts and Rhode Island.

**Behavioral Health Provider Responsibilities**

Responsibilities of the behavioral health service provider includes, but is not limited to:

- Comply with provider requirements
- Offer the following appointment availability:
  - Urgent care (services that are not emergency or routine) within 48 hours of a request
  - Routine behavioral health services intake within 10 calendar days of a request
  - Emergency Services Programs (ESPs) in Massachusetts and Emergency Service Intervention in Rhode Island immediately, 24 hours a day, seven days a week
  - Non-24-hour diversionary services within two calendar days of discharge
  - Medication management services within 30 calendar days of discharge
  - Post-hospital-intake services within 10 working days
  - Intensive Care Coordination Services within the time frame directed by EOHHS in Massachusetts
  - Other outpatient services within seven calendar days of discharge
- Encourage members to sign these forms, and then fax them to 888.977.0776 (Massachusetts) or 857.304.6400 (Rhode Island):
  - Authorization to Disclose Protected Health Information Form — allows Tufts Health Public Plans to release information about members to family members, state agencies or others. Submit this form with the Combined MCE (Managed Care Entity) Behavioral Health Provider/Primary Care Provider Communication Form below.
Medical Necessity and Clinical Criteria

Tufts Health Public Plans authorizes coverage of medically necessary behavioral health services that:

- Prevent, diagnose, alleviate, correct or cure the worsening of conditions that endanger a member’s life, cause suffering or pain, threaten to cause or aggravate a disability, or result in illness or infirmity;
- Cannot be replaced with a less intensive level of care;
- Are substantiated by clinical records;
- Meet professional health care standards; and
- Are covered benefits as set forth in the member’s plan document

Tufts Health Public Plans uses the following medical necessity guidelines and criteria for covered benefits and services:

- InterQual® is the primary source to determine medical necessity and appropriateness of treatment
- The ASAM Criteria are used in Rhode Island for substance-related conditions, and in Massachusetts for Residential Rehabilitation Services (ASAM Level 3.1). The ASAM Criteria were developed by the American Society of Addiction Medicine.
  - Please refer to What is the ASAM Criteria?
  - ASAM provides a guide for patients, families and friends: Opioid Addiction Treatment
- For Tufts Health Unify, Medicare National Coverage Determination (NCD) and Local Coverage Determination (LCD) criteria are also used for Medicare-covered services. NCD and LCD criteria are available on the CMS website at www.cms.gov.

When criteria are not available either in InterQual®, ASAM or CMS, determination is based on medical necessity guidelines developed for Tufts Health Public Plans.

Tufts Health Public Plans will only approve requests that meet guidelines and applicable criteria for a particular service. The provider is responsible for determining if a member meets criteria for services that are delivered. Tufts Health Public Plans’ medical necessity guidelines are available on the public Provider website or by calling Provider Services at **888.257.1985** to request a printed copy.

Payment Policies

For information on Tufts Health Public Plans Payment Policies for different levels of care, refer to the Provider Resource Center.

Behavioral Health Services Authorization

In order to receive an authorization for coverage of services for members, most services or levels of care require a prior authorization (PA) or notification. Refer to the following resources to access authorization or notification procedures for particular behavioral health services:

- **Tufts Health Together and Tufts Health Direct Behavior Health Prior Authorization (PA) and Notification Grid**
- **Tufts Health Rhode Island Together Behavioral Health Prior Authorization (PA) and Notification Grid**
- **Tufts Health Unify Behavioral Health Prior Authorization (PA) and Notification Grid**
- **Phone:** 888.257.1985
When an admission, procedure or service is approved, the provider is notified within 24 hours and/or written or electronic confirmation is sent within two business days. The authorization letter will indicate the services covered.

Providers requesting coverage authorization for outpatient psychotherapy services are urged to use the secure Tufts Health Provider Connect portal to complete online outpatient therapy requests. In most cases, providers receive an immediate response to the authorization request. Refer to the Behavioral Health Outpatient Prior Authorization Request Self Service User Guide for additional information. Providers may also fax the BH-Level of Care Request form (Standard Form) to 888.977.0776 if they prefer not to use the Tufts Health Provider Connect portal.

Always verify the eligibility of members at the time services are rendered. For more information about checking eligibility, refer to the Provider Resource Guide: MA version | RI version.

Inpatient authorization and notification procedure

Providers must have the following information available about members when requesting additional inpatient authorization from Tufts Health Public Plans and when requesting prior authorization for a step-down from 24-hour care:

- Tufts Health Public Plans member ID number
- Name, gender, date of birth, and city or town or residence
- Designated Emergency Services Program (ESP) provider name, and time and date of evaluation, if involved Note: This only applies to Tufts Health Together MCO and ACPP members.
- DSM-IV diagnosis
- Precipitating event and current symptoms indicating clinical need for this level of care
- Description of the recommended treatment plan relating to the admitting symptoms and presenting problem, and progress made to date
- Medication history
- Substance use history
- Prior treatment history
- General medical and psychosocial history (including family)
- PCP information

Note: Prior authorization is not required for an urgent inpatient admission, and no clinical review is required until the first business day following admission. However, notification must be provided in order to bill for the days for which no clinical review is required.

Additional authorization procedures

For information on authorization procedures for additional services, refer to the following resources:

- Tufts Health Together and Tufts Health Direct Behavior Health Prior Authorization (PA) and Notification Grid
- Tufts Health Rhode Island Together Behavioral Health Prior Authorization (PA) and Notification Grid
- Tufts Health Unify Behavioral Health Prior Authorization (PA) and Notification Grid
- Phone: 888.257.1985

In some cases, notification, initial authorization and/or additional authorization can be completed via fax or online, depending on the service. Tufts Health Public Plans will not reimburse for any interval between the last covered day and the date additional authorization is requested by the servicing provider.

The following information is generally requested for clinical review:

- Current diagnosis and treatment plan, including provider's orders, special procedure and medications
- Clinical rationale for continued care
- Description of the member's response to treatment since the initial authorization or last continued stay review
- Current mental status, discharge plan and discharge criteria, including actions taken to implement the discharge plan
- Proposed course of treatment during the continuation period
- Any medical conditions needing treatment (routine medical care is included in the per diem rate)
• Any potential barriers to discharge and plans to address such barriers
• Coordination with PCP, state agencies and other treatment providers, as well as involvement of family and/or other supports

Denials and Appeals
Tufts Health Public Plans will not pay for any unauthorized services. When an admission, continued inpatient stay or the availability of any other behavioral health service is denied, reduced, modified or terminated, providers are notified within 24 hours and written or electronic confirmation is sent to the provider and member within one business day. The notice will include information on the appeals process and an Authorized Representative Form (for Tufts Health Together MCO and Tufts Health Together ACPPs members) or a Tufts Health RITogether Authorized Representative Form (for Tufts Health RITogether members) for the member to sign if they would like their provider to appeal the denial on their behalf. Refer to the Rights and Responsibilities chapter for more information.

ADMINISTRATIVE APPEALS
Tufts Health Public Plans will administratively deny payment for care if providers do not follow authorization procedures. Also, failing to notify Tufts Health Public Plans of a member's admission, will result in a denied payment when Tufts Health Public Plans has not given authorization for those days. Approval for subsequent authorization is subject to clinical review.

Patient Care Coordination
Tufts Health Public Plans’ behavioral health clinicians and care managers, along with providers, work together to ensure members receive optimal health and:

• Continue improving the health of members
• Ensure members have timely and easy access to appropriate behavioral health care
• Involve members in their treatment planning and recovery
• Provide effective behavioral health care
• Enhance continuity and coordination of care among behavioral health providers

Tufts Health Public Plans’ services include:

• Monitoring treatment compliance
• Reviewing members’ ongoing service needs
• Assist with planning members’ discharge
• Providing members and their providers with information on community-based services

Tufts Health Public Plans recognizes more than one provider may contribute to the care of members. Providers, particularly primary care and behavioral health providers, who are caring for members are to explain to members the benefits of care coordination and integration and make their best efforts to secure member consent to share relevant information regarding diagnoses, medication and/or treatment to help improve health outcomes. If consent is not granted, this should be recorded in the member’s record.

Treatment and Discharge Planning
BH treatment and discharge planning are important components of our overall Utilization Management (UM) program.

Treatment planning
BH treatment planning focuses on identifying barriers to members’ ability to follow through with the treatment and discharge plan. Tufts Health Public Plans requires providers to complete an initial BH treatment plan within 24 hours of a member's admission to an acute care or 24-hour intermediate services, and to complete a multidisciplinary treatment plan within 24 hours of the member’s admission.

For members under the age of 21, Tufts Health Public Plans expects a parent or guardian to be involved with the treatment planning, with appropriate member consent. If an adult member has a guardian, that guardian must be included in treatment planning. As appropriate, we suggest treatment planning meetings include the
member, other providers, the member’s family, and/or guardian as well as representatives from other state agencies (e.g., Department of Children, Youth and Families). If BH care management from Tufts Health Public Plans is involved in the member’s care, please coordinate as appropriate. Contact Provider Services at 888.257.1985 to reach Tufts Health Public Plans’ care managers with any questions.

**Discharge planning**

Discharge planning is an integral component of BH treatment planning that begins upon the start of treatment and continues throughout the member’s treatment. For members under the age of 21, a parent or guardian is expected to be involved with the treatment planning after discharge, with appropriate member consent. Whenever possible, schedule a discharge meeting so that the member and the member’s family, and/or guardian are aware of the discharge plan. If the member’s care is being coordinated with Tufts Health Public Plans’ BH care management, include the care manager in the discharge planning meeting. As a key part of inpatient discharge planning, BH providers are urged to schedule two outpatient therapy appointments within seven days of discharge from an inpatient setting and, if appropriate, a medication appointment within 14 days of discharge. Tufts Health Public Plans recommends using step-down services, such as partial hospitalization, to help members successfully transition back into the community.

**Inpatient Transfers**

Members must meet the receiving facility’s inpatient admission criteria to be transferred, and the current provider should request prior authorization for the receiving facility from Tufts Health Public Plans prior to the transfer.

**Care Management**

Tufts Health Public Plans’ social care managers can assist with addressing members’ non-medical and social issues that may be barriers to care. Refer to the Care Management chapter for more information or call Provider Services at 888.257.1985 to reach the care managers.

**Note:** Refer to the Tufts Health Unify chapter for comprehensive information on the Unify model of care.

**Medical Records Compliance**

Providers are required to complete an individualized written assessment and treatment plan for all members treated within the following time frames:

- Acute inpatient treatment: within 24 hours of admission
- Diversionary/Intermediate treatment: within 48 hours of admission
- Outpatient treatment: before the third outpatient visit

Please see the Medical Inpatient Chart Documentation Tool that identify the required components. Refer to the performance specifications for more detailed medical record requirements in Massachusetts.

**Adverse Incident Reporting**

Tufts Health Public Plans requires that BH providers immediately report adverse incidents to us, including but not limited to:

- Unattended or unexpected death
- Occurrence that represents actual or potential serious harm to the well-being of a member receiving services managed by a Tufts Health Public Plans provider
- Serious injury resulting in hospitalization
- Injury requiring acute-care hospital admission
- Injury requiring medical attention but does not result in an acute-care hospital admission
- Sustained injury while in a 24-hour program
Any absence without authorization (AWA), or any AWA involving a member under the age of 18 or a member admitted or a member who has been committed to a facility who is also at risk of harm to self or others

- Unscheduled event(s) resulting in a member temporarily evacuating a program or facility (e.g., a fire to which a fire department responds)
- Sexual assault or alleged sexual assault
- Physical assault or alleged physical assault on or by a member
- Restraint and seclusion regulation violations or alleged violations

If any situation occurs at a BH provider site that fits the criteria for an adverse incident, providers must report the incident to a Tufts Health Public Plans care manager by calling Provider Services at 888.257.1985 the same day the incident occurs. If there are any questions on what would be considered an adverse incident, call to address the event or incident.

Fax a completed Adverse Incident Report Form to 617.972.9474 after reporting the incident on the same day the incident is reported. Present all information related to the nature of the incident, including the parties involved (names and telephone numbers) and the member’s current condition.

Massachusetts-Specific Behavioral Health Program

Performance Specifications

Tufts Health Public Plans has developed Performance Specifications for behavioral health services and require that behavioral health providers comply with all aspects of these specifications. There is a general performance specification that applies to all contracted Massachusetts Tufts Health Public Plans providers and additional performance specifications for individual levels of care. Refer to the Performance Specifications online in the Provider Resource Center.

Community Partner Program (For all Tufts Health Together members)

Designated Community Partner (CPs) are community-based health care and human services organizations that collaborate with Tufts Health Public Plans and Tufts Health Public Plans Accountable Care Organizations (ACOs) to integrate member care and improve health outcomes for members with complex long-term medical and/or behavioral health needs.

There are two types of CPs, Long-Term Services and Supports CPs (LTSS CPs) and Behavioral Health CPs (BH CPs). They work collaboratively with THP and ACO clinicians to provide care coordination. BH CPs provide care management and coordination to members with significant behavioral health needs. LTSS CPs provide care coordination and navigation to members with complex LTSS needs. Tufts Health Public Plans will communicate needed information about the programs and procedures as they continue to be implemented through Provider Update.

Massachusetts-Specific Behavioral Health services

Tufts Health Public Plans covers a range of behavioral health benefits and services for members. Take psychosocial, occupational, and cultural and linguistic factors into consideration when providing care to members. These factors may influence the risk assessment and service decisions.

The following resources outline the comprehensive continuum of behavioral health services available as covered services for members, along with a brief description of the level of care, the medical necessity guidelines used, and prior authorization or notification procedures:

- Tufts Health Together and Tufts Health Direct Behavior Health Prior Authorization (PA) and Notification Grid
- Tufts Health Unify Behavioral Health Prior Authorization (PA) and Notification Grid

Emergency Services Program (For all Tufts Health Together MCO and ACPP members)

Tufts Health Together ACPP and Tufts Health Together MCO members can access contracted specialized ESP providers 24 hours a day, seven days a week, and 365 days a year. ESP providers offer crisis assessment, crisis
intervention, short-term crisis counseling, crisis stabilization and mobile crisis intervention services for members.

Members who require acute treatment must be evaluated by an ESP provider to determine the most appropriate, least restrictive level of care to treat the member.

ESP providers are required to rapidly respond within one hour, assess and deliver a course of treatment intended to promote recovery, ensure safety and stabilize members’ crises in a manner that allows them to receive medically necessary services in the community or in an inpatient or 24-hour diversionary level of care. In all encounters, an ESP provider will conduct a behavioral health crisis assessment and offer short-term crisis counseling that includes active listening and support while also providing solution-focused and strengths-oriented crisis intervention. The crisis intervention is aimed at working with members and their families and/or other natural supports to understand the current crisis, identify solutions, and access resources and services for comfort, support, assistance and treatment.

An ESP provider will coordinate with other involved service providers and/or newly referred providers to share information (with appropriate consent) and make recommendations for the treatment plan. An ESP provider also provides members and their families with resources and referrals for additional services and supports, such as recovery-oriented and consumer-operated resources in their community. All ESP provider encounters should minimally include the three basic components of crisis assessment, intervention and stabilization. We believe that crisis services also require flexibility in the focus and duration of the initial intervention, as well as the member’s participation in the treatment, and that the provider should always consider the number and type of follow-up services members will require.

ESP providers accept requests and/or referrals for ESP services directly from members who seek them on their own and/or from any other individual or resource, such as:

- Family members and guardians
- Community-based agency staff
- Service providers
- PCPs
- Residential program staff
- School representatives
- State agency personnel
- Law enforcement representatives
- Court representatives

After considering all available input, an ESP provider will determine the most appropriate level of care or service for members and, when appropriate, will call a Tufts Health Public Plans behavioral health care manager at 888.257.1985 for service, coverage authorization, and/or to facilitate access and referral to the service. We will base our level-of-care determination on medical necessity criteria.

For a list of ESP providers, please see the ESP Statewide Directory.

If a Tufts Health Public Plans patient with a BH condition develops or has an emergency condition, refer them to the nearest emergency room and ensure that transportation is available and provided as needed. Examples of such situations include:

- Drug and/or alcohol overdose
- Chest pain
- Neurological functioning, consciousness level, or motor impairment changes
- Premature labor or bleeding in the case of pregnancy
- Malignant hypertension
- Self-mutilation requiring immediate medical attention

**ESP initial assessment and notification required for urgent admissions**

While a prior authorization is not required for an acute admission directly from an emergency department, Tufts Health Together ACPP and MCO Members should be seen by a designated ESP provider for an assessment prior to such an admission.

The ESP (and the admitting facility) is required to notify Tufts Health Public Plans of urgent behavioral health
admissions within one business day of admission. The ESP provider is required to fax the ESP Notification to 888.977.0776, and include relevant clinical information and disposition within one business day of the encounter.

**Mobile Crisis Intervention**

ESP providers deliver mobile crisis intervention services in the community 24 hours a day, seven days a week, and 365 days a year. Mobile crisis intervention services should be integrated into the ESP provider's infrastructure, services, policies and procedures, staff supervision and training, and community linkages.

An ESP provider's mobile crisis intervention services and staff provide all ESP services for Members. A best practice for delivering crisis services is via a discreet and minimally disruptive mobile response in a natural setting, such as in a Member's home or school, or a neutral community-based site. Delivering strengths-based and solution-focused intervention aims to resolve the crisis, mobilize natural supports and provide rapid linkage to the right level of care. Mobile crisis intervention services include consultative and collaborative services, placing a high value on achieving a least restrictive consensus disposition while ensuring access to medically necessary services.

Mobile crisis intervention services provide a short-term, on-site, face-to-face therapeutic response to Members experiencing a behavioral health crisis. These services help Members to identify, assess, treat, and stabilize the situation and reduce immediate risk of danger to themselves or others, consistent with their risk management/safety plan, if any.

**Youth Mobile Crisis Intervention**

Youth Mobile Crisis Intervention includes services from an ESP provider for Members under the age of 21. Youth Mobile Crisis Intervention services are short-term services. They are a mobile, on-site, face-to-face therapeutic response to a patient's behavioral health crisis. Goals of these services include identifying, assessing, treating and stabilizing the situation, and reducing immediate risk of danger to the patient or others by following the patient's risk management/safety plan, if any. This service is provided 24 hours a day, seven days a week.

Youth Mobile Crisis Intervention includes:

- A crisis assessment
- Development of a risk management/safety plan if the patient/family does not already have one
- Crisis intervention and stabilization services for up to seven days, including, as needed:
  - On-site, face-to-face therapeutic response intervention
  - Psychiatric consultation
  - Urgent psychopharmacology intervention
  - Referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care

For Members under the age of 21 who are receiving Intensive Care Coordination (ICC), Youth Mobile Crisis intervention staff will coordinate with the Member's ICC care coordinator throughout the delivery of the service. Staff will also coordinate with the Member's primary care physician, any other care management program, or any other behavioral health providers offering services to the Member throughout the delivery of the service.

**Children's Behavioral Health Initiative Services**

**For all Tufts Health Together MCO AND ACPP members**

The Executive Office of Health and Human Services (EOHHS) and MassHealth created the Children's Behavioral Health Initiative (CBHI). CBHI requires, among other things:

- Education and outreach to Providers, Tufts Health Together (MassHealth) MCO and ACPP Members, the public, and private and state agency staff who come into contact with MassHealth Members about Early Periodic Screening, Diagnosis and Treatment (EPSDT) services
- Implementation of standardized behavioral health screening, including use of standardized EPSDT behavioral health screening tools, as a part of EPSDT well-child visits
- Standardized behavioral health assessments for eligible patients who use behavioral health services
- An information-technology system to track assessments, treatment planning and treatment delivery
- Child and Adolescent Needs and Strengths (CANS) assessments
• Providers are responsible for providing or coordinating all age-specific Early Periodic Screening, Diagnosis and Treatment (EPSDT) services for members younger than 21 during all well-child visits, according to MassHealth requirements. Refer to Tufts Health Public Plans’ Massachusetts EPSDT resources to learn more about EPSDT screening tools and reimbursement.

Refer to the public Provider website for information on all of these topics.

Child and Adolescent Needs and Strengths (CANS) requirements
As part of the CBHI, Tufts Health Public Plans requires outpatient providers to be CANS-tool-certified and to use the CANS tool as part of an initial behavioral health assessment when conducting outpatient therapy for our MassHealth Tufts Health Together MCO and ACPP Members under the age of 21. Outpatient providers must complete a CANS assessment for inpatient and outpatient visits and all other CBHI services. The state requires providers to update the CANS assessment through the Virtual Gateway Children’s Behavioral Health Initiative (CBHI) Application every 90 days.

Conduct a CANS assessment for the following services:
• Outpatient therapy (diagnostic evaluations and individual, family and group therapy)
• In-home therapy
• Intensive care coordination
• Discharge planning for the following 24-hour care services:
  – Psychiatric inpatient hospitalization
  – Community-based acute treatment (CBAT)
  – Intensive community-based acute treatment (ICBAT)

CBHI performance specifications are available on the public provider website.

Rhode Island-Specific Behavioral Health Services
Tufts Health Public Plans covers a range of BH (mental health and substance use) benefits and services for Members which are identified on the Benefit Grids. Coverage of some BH services require notification and others many require prior authorization which is noted on the Tufts Health Rhode Island Together Behavioral Health Prior Authorization (PA) and Notification Grid. Take psychosocial, occupational and cultural and linguistic factors into consideration when providing care to Members. These factors may influence the risk assessment and service decisions. Services include:

Levels of Care for Members under the Age of 21

Acute
  Emergency Services Intervention
  Observation/Crisis Stabilization/Holding Bed
  Inpatient Acute Hospitalization
  Acute Residential Treatment (ART) including dual diagnosis

Outpatient Services
  Traditional Outpatient Services
  Individual Therapy
  Family Therapy
  Group Therapy
  Specialty Group Therapy (Special populations)
  Diagnostic Evaluation
  Developmental evaluations
  Psychological and Neuropsychological Testing
  Medication Management

Intermediate Services
  Partial Hospitalization (PHP)
  Day/Evening Treatment
  Intensive Outpatient Treatment (IOP)
  Enhanced Outpatient Services (EOS)

Home and Community Based Services
  Home Based Therapeutic Services (HBTS)
  Evidence Based Practices (EBP)
  Personal Assistance Services and Supports (PASS)
Levels of Care for Members Age 18 years or older

**Acute**
- Emergency Service Intervention
- Observation/Crisis Stabilization/Holding Bed
- Inpatient Acute Hospitalization
- Acute Residential Treatment (ART), including dual diagnosis
- Inpatient (non-hospital) detoxification (ASAM Level 3.7)

**Substance Use Residential Services**
- ASAM Level 3.5 Clinically Managed – High Intensity Residential
- ASAM Level 3.3 Clinically Managed – High Intensity Residential Adults only
- ASAM Level 3.1 Clinically Managed – Low Intensity Residential Services

**Intermediate and Outpatient Services**
- Partial Hospitalization (PHP)
- Day/Evening Treatment
- Intensive Outpatient Treatment (IOP)
- Enhanced Outpatient Services (EOS) for member under Age 21 only
- General Outpatient
- Medication Assisted Treatment including Methadone Maintenance (including Opioid Rx Program), Buprenorphine, and Suboxone Treatment

**ACT – Assertive Community Treatment**
- Bundled Services for eligible Members Age 18 and older carried out by Rhode Island’s Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) designated Community Mental Health Organizations (CMHOs)

**IHH – Integrated Health Home**
- Services carried out by BHDDH designated CMHOs, for eligible Members Age 18 and older

**Emergency Services Intervention (ESI)**

Tufts Health Public Plans members can access Emergency Services 24 hours a day, 7 days a week, for face-to-face care management and intervention when experiencing a behavioral health crisis. Such crisis includes an imminent, real, and significant risk of serious harm to self or others that requires immediate treatment. The activities are conducted by a licensed behavioral health provider in a hospital emergency room, residential placement setting, the individual’s home, police station or other community setting that the family and the child-family competent clinician agree is safe and clinically suitable to resolve the behavioral health crisis.

Providers need to ensure that Members who are evaluated in Emergency Rooms for behavioral health issues, and not admitted to an inpatient level of care, has a follow-up appointment with the Member’s PCP within three (3) business days of discharge from emergency services.

If a Tufts Health Public Plans member with a BH condition develops or has an emergency condition, refer them to the nearest emergency room and ensure that transportation is available and provided as needed. Examples of such situations include:

- Drug and/or alcohol overdose
- Chest pain
- Neurological functioning, consciousness level, or motor impairment changes
- Premature labor or bleeding in the case of pregnancy
- Malignant hypertension
- Self-mutilation requiring immediate medical attention
QUALITY

Tufts Health Public Plans is committed to working with providers to continuously improve the quality of health care provided to members. Refer to this chapter for information about:

- **Quality Improvement (QI) Program**
  - National Committee for Quality Assurance (NCQA)
  - Healthcare Effectiveness Data and Information Set (HEDIS)
  - The Consumer Assessment of Healthcare Providers and Systems (CAHPS)
  - Medical and Treatment Records
  - Confidentiality of Member Medical and/or Behavioral Health Records
  - Reporting
  - Massachusetts Quality Improvement Program (QIP)
  - External Quality Review Organization (EQRO)

- **Clinical Practice Guidelines**
- **Pay for Performance**
- **Patient Safety**
- **Delegation**

Tufts Health Public Plans monitors the following areas to continually improve the access to, and quality and frequency of, the medical and behavioral health care and services that members receive:

- Preventive health services such as well-child visits
- Acute and chronic care
- Care provided to members with specific diagnoses (e.g., diabetes, asthma, depression and/or attention deficit/hyperactivity disorder)
- Continuity and coordination of behavioral health services and medical care
- Services and medication underuse and overuse
- Patient safety and risk management
- Patient complaints, appeals and grievances
- Member and provider satisfaction
- Medical record documentation

### Quality Improvement (QI) Program

Tufts Health Public Plans’ Quality Improvement Program (QI) is designed to facilitate member access to high-quality medical and behavioral health care, access to primary and specialty care, continuity and coordination of care across settings, and culturally competent care. With the QI, Tufts Health Public Plans measures and tracks key aspects of care and services, using data-driven monitoring to identify improvement opportunities, implement interventions and analyze data to determine overall intervention effectiveness in improving clinical care.

The primary components of the program are:

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

The goals of the program are to:

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

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

Providers cooperate with Tufts Health Public Plans’ QI activities to:

• Improve the quality of care, services and the member experience, including the collection and evaluation of data and participation in Tufts Health Public Plans’ QI programs
• Allow the organization to collect and use performance measurement data
• Assist the organization in improving clinical and service measures

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

Specific positions, committees, and organizational units play a significant role in QI activities, including:

• Quality Management Committee (QMC)
• Quality of Care Committee (QOCC)
• Quality Performance Improvement Team (QPIT)
• QI work groups
• QI project teams

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

National Committee for Quality Assurance (NCQA)

As an NCQA-accredited Medicaid and Exchange health plan, Tufts Health Public Plans adheres to NCQA standards and guidelines to measure, analyze and improve the health care services members receive.

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS measures are industry-standard indicators of the quality of care health plan members receive. Tufts Health Public Plans monitors HEDIS data annually, as well as on a monthly basis, to monitor trends and identify opportunities to improve member’s care. Interim and annual rates are also evaluated against national and regional HEDIS benchmarks to assess the performance of Tufts Health Public Plans’ network. Tufts Health Public Plans considers the provider network in an effort to best serve members. By responding to HEDIS-related requests, Tufts Health Public Plans is able to measure the quality care provided that is so important to members.

HEDIS data are incorporated into provider performance reports, which are tools intended to drive quality improvement. Tufts Health Public Plans shares performance reports with provider practices to help give members the best care possible. These reports include performance on several key HEDIS measures. For questions about the provider performance reports, call Provider Services at 888.257.1985 (Massachusetts) or 844.301.4093 (Rhode Island).

The Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a standardized survey that measures member experience with the services provided by their health plan and its provider network. This survey addresses members’ experience with accessing care, coordination of care, and the care received by providers, as well as aspects of the health plan’s services. Tufts Health Public Plans uses CAHPS survey responses annually to help develop action plans, performance goals, and improve strategies to ensure the highest quality of care and services is being offered to members.

Medical and Treatment Records

Network practitioners and providers are required to maintain member health records in a current, detailed and organized manner in order to facilitate appropriate communication and coordination of care. Network practitioner
and provider records are subject to chart audits to ensure adherence to these standards, including appropriate medical record content and organization, ease of retrieving medical records and appropriate maintenance of confidential information.

**Primary Care Provider Medical Records**

Primary care provider medical records are expected to include the following information:

- All services provided directly by a practitioner who provides primary care services
- All ancillary services and diagnostic tests ordered by a practitioner
- All diagnostic and therapeutic services for which a member was referred by a practitioner, which includes, but is not limited to:
  - Home health nursing reports
  - Specialty physician reports
  - Hospital discharge reports
  - Physical therapy reports

**Medical record documentation standards**

Medical records are required to include the following information:

- History and physical
- Allergies and adverse reactions
- Problem list
- Medications
- Documentation of clinical findings and evaluation for each visit
- Preventive services and risk screening

Providers are required to cooperate with chart audits. Chart audits are part of Tufts Health Public Plans contractual obligations with regulatory agencies to monitor appropriateness of care and the quality of record-keeping.

Site visits initiated in response to complaints or quality concerns always include a medical and/or behavioral health record-keeping practice review. Tufts Health Public Plans will set up a time in advance to review the records. For questions about the record review process, call Provider Services at **888.257.1985** (Massachusetts) or **844.301.4093** (Rhode Island).

**Confidentiality of Member Medical and/or Behavioral Health Records**

Tufts Health Public Plans requires that providers comply with all applicable federal and state 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). Tufts Health Public Plans monitors providers’ compliance with its confidentiality policies through clinical quality reviews and audits. Providers must:

- Maintain medical records in a space staffed by office personnel
- Maintain medical records in a locked office and/or password-protect electronic medical records when staff is not present
- Prohibit unauthorized review and/or removal of medical records
- Maintain and adhere to policies and procedures regarding patient confidentiality and record retention
- Train staff periodically in member information confidentiality

Tufts Health Public Plans requires providers, upon request, to provide member medical information and medical and/or behavioral health records for the following purposes:

- Administering Tufts Health Public Plans’ 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 QI activities
- Carrying out member satisfaction procedures described in the *Member Handbook*
- Participating in reporting on quality and utilization indicators, such as 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’s consent/authorization to release medical records to Tufts Health Public Plans for the purpose of an appeal is not necessary.

**Reporting**

Tufts Health Public Plans sends providers a monthly report listing the names of members with asthma, diabetes, and chronic obstructive pulmonary disease (COPD) who are overdue for important health-related screenings or who may benefit from a discussion about medication usage. Twice a year providers are notified for women’s health-related screenings, such as screenings for breast cancer, cervical cancer and chlamydia. For more information about the asthma and diabetes disease management programs or women’s health management programs, refer to the Care Management chapter. For more information about Tufts Health Public Plans’ asthma and diabetes reports, please call Provider Services at 888.257.1985 (Massachusetts) or 844.301.4093 (Rhode Island).

When applicable, Tufts Health Public Plans provide performance reporting mechanisms for certain PCPs to review clinical performance.

Tufts Health Public Plans is contractually obligated to provide information to state and federal governments about the quality of care that members receive. Occasionally, providers are asked for information that is not available in claims or administrative data, such as medical record data, in order to comply with both state and federal regulatory reporting requirements.

**Massachusetts Quality Improvement Program (QIP)**

MassHealth evaluates Tufts Health Public Plans’ performance annually on a set of predetermined quality measures and evaluates the initiatives that Tufts Health Public Plans implements to improve performance.

**External Quality Review Organization (EQRO)**

The Centers for Medicare and Medicaid Services (CMS) and MassHealth arrange for objective, external third parties to evaluate the quality of the managed care plans with which they contract. These third parties evaluate the design, implementation and performance of specific quality performance improvement programs, as well as the HEDIS program and information systems capabilities.

**Clinical practice guidelines**

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

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

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

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

Tufts Health Public Plans’ clinical practice and preventive health guidelines are designed to support preventive health, behavioral health, acute disease treatment protocols, and/or chronic disease management programs. The clinical practice and preventive health guidelines are available online.
Pay for performance

At times, Tufts Health Public Plans may offer providers in Massachusetts extra reimbursement to improve clinical processes to ensure members get the services needed. For more information about specific programs, refer to the Care Management chapter or call Provider Services at 888.257.1985.

Tufts Health Public Plans offers extra reimbursements for the following activities:

- Pregnancy notification — Refer to the Care Management chapter
- Early Periodic Screening, Diagnosis and Testing (EPSDT) completion — Refer to the Providers chapter
- Child and Adolescent Needs and Strengths (CANS) assessments — Refer to the Behavioral Health chapter

Tufts Health Public Plans also offers members a variety of rewards for successfully completing key health care activities.

Patient safety

Tufts Health Public Plans addresses patient safety by:

- Facilitating the identification of children with serious emotional disturbances (SED) and monitoring the delivery of behavioral health services to them
- Distributing information to members pertaining to optimal clinical practices, enhancing their ability to monitor the safety of their own care
- Monitoring adverse and unanticipated events, such as ones resulting in death or serious physical or psychological injury occurring in inpatient and residential settings and identifying trends that could indicate unsafe environments or practices in these contracted institutions. Providers are required to inform Tufts Health Public Plans of the events that occur when serving members by emailing Adverse_Events_Submission@tufts-health.com.
- Monitoring provider preventable conditions (PPCs), serious reportable events (SREs) and Serious Reportable Adverse Events (SRAEs). *
  - For the full list of PPCs, SREs, and SRAEs please refer to the SRE, SRAE, PPC Payment Policy, the Massachusetts Executive Office of Health and Human Services’ June 2015 Transmittal Letter ALL-195, or Rhode Island Executive Office of Health and Human Services. Providers are required to inform Tufts Health Public Plans of SREs, SRAEs and PPCs that occur when serving members.
  - Tufts Health Public Plans will not compensate providers or permit providers to bill members for services related to the occurrence of SREs, SRAEs and PPCs. Such nonpayment will not prevent patients’ access to healthcare services.
- Monitoring new clinical sites for safety practices
- Monitoring and managing controlled substances overuse through the controlled substances management program
- Working with the pharmacy benefit manager to stop a pharmacy from dispensing medications that are inappropriate in terms of drug interaction, drug dosage, ingredient duplication, age precaution, pregnancy precaution, gender conflict and/or therapeutic duplication, if the drug on the claim may interact with other drugs in a member’s claims history

Delegation

Selected aspects of Tufts Health Public Plans’ utilization management, pharmacy, disease management, care management and credentialing programs may be delegated to providers and service organizations. Tufts Health Public Plans reviews these programs prior to delegation, and at least annually thereafter. Contact Provider Services with questions or concerns about such delegations.
The following topics are outlined in this chapter:

- **Pharmacy Benefit**
  - Prescription Information
  - Voluntary 90-Day Supply Pharmacy Program (Tufts Health Together and Tufts Health RITogether)
  - Over-the-Counter Drug List
- **Pharmacy Prior Authorization**
  - Requests for Prior Authorization
  - Requests for Step Therapy Agents
  - Requests for Drugs Not Listed on the Preferred Drug List
- **Limitations**
  - Exclusions
  - Generic Substitutions (Massachusetts)
  - Generic Substitutions (Rhode Island)
  - New-to-Market Drugs (Massachusetts)
  - Quantity Limitations
- **Medicare Part D (Massachusetts)**
- **Specialty Pharmacy**
  - Pharmacy Advisor Support Vendor: CVS Health

Tufts Health Plan welcomes clinicians, pharmacists, and ancillary medical provider input on our pharmacy program. Please contact the pharmacy team with any suggestions or comments by calling Provider Services at **888.257.1985** (Massachusetts) or **844.301.4093** (Rhode Island).

Refer to the [Tufts Health Unify](#) chapter for specific pharmacy information regarding Tufts Health Unify.

**Pharmacy benefit**

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

Tufts Health Together ACPPs, Tufts Health Together MCO and Tufts Health RITogether uses a [Preferred Drug List](#) (PDL). Each PDL promotes appropriate and cost-effective prescription outpatient drug products. The PDLs apply to medications Members receive through retail and specialty pharmacies (if applicable) and do not apply to medications used in direct-care settings.

Tufts Health Direct and Tufts Health Unify uses formularies. Formularies are a listing of drugs that are considered preferred therapy for Members within the pharmacy benefit of a managed health plan. Tufts Health Plan formularies are developed by a panel of providers and clinical pharmacists. The formularies include key agents within selected therapeutic classes. These agents offer comparable safety and efficacy yet are more cost-effective than similar agents. Complete lists of covered drugs, including specialty drugs included in the SP program are available on Tufts Health Plan’s website.

PDL and formulary updates are communicated via [Provider Update](#). PDLs and formularies can be searched on the public Provider website by generic name or brand name to find information about coverage and limitations (prior authorization, quantity limits, and step therapy). Refer to the following PDLs or formularies listed on the [Pharmacy](#) page for the Member’s coverage information:

- Tufts Health Together Accountable Care Organization for:
  - Tufts Health Together with Atrius Health
  - Tufts Health Together with Boston Children’s ACO
- Tufts Health Together with BIDCO
- Tufts Health Together with CHA
- Tufts Health Together Managed Care Organization (MCO)
- Tufts Health RITogether
- Tufts Health Direct (Qualified Health Plan)

**Note:** PDF versions of Tufts Health Together and Tufts Health RITogether products Member PDLs and Tufts Health Direct formularies can be downloaded from the public Provider website.

**Prescription Information**

Providers may prescribe:

- Up to a 30-day supply of most medications when Tufts Health Together or Tufts Health RITogether Members fill their prescription at a retail pharmacy
- Up to a 60-day supply of dextroamphetamine or methylphenidate for the treatment of ADHD or narcolepsy for Tufts Health Direct and Tufts Health Together Members.
- Additionally, a 90-day supply of maintenance medications may be prescribed for Tufts Health Direct patients when prescriptions are filled through the mail-order pharmacy, CVS Caremark.

**Voluntary 90-Day Supply Pharmacy Program for Tufts Health Together and Tufts Health RITogether Members**

Tufts Health Together and Tufts Health RITogether has a voluntary 90-day supply pharmacy program. The program allows for select generic maintenance medications used to treat common chronic conditions to be filled at a retail pharmacy for a 90-day supply. Refer to the appropriate PDL to see if a medication can be filled for a 90-day supply.

**Over-the-counter Drug List**

Tufts Health Plan covers select over-the-counter (OTC) drugs for Tufts Health Together MCO, Tufts Health Together ACPP, Tufts Health Direct and Tufts Health RITogether Members. If a Member needs a covered OTC drug, write a prescription for the product for the Member to fill at a pharmacy and obtain the drug under the pharmacy benefit. Refer to the over-the-counter medication coverage information for more details. For additional select drugs covered for Tufts Health Unify Members, refer to the Unify formulary.

**Pharmacy prior authorization**

The P&T Committee approves pharmacy medical necessity guidelines for drugs that require prior authorization.

**Requests for Prior Authorization**

Some drug products listed in the PDL and formulary require prior authorization.

To request a pharmacy prior authorization, refer to the Pharmacy Medical Necessity Guidelines for the specific drug prior authorization requirements on the public Provider website. Requests may be submitted through electronic Prior Authorization (ePA), fax or by mail with the appropriate request form to the Pharmacy Utilization Management Department:

- Tufts Health Unify: Fax to 617.673.0956
- Tufts Health Together (MCO and ACPP plans), Tufts Health RITogether and Tufts Health Direct: Fax to 617.673.0988
- Mail:
  Tufts Health Plan
  Attn: Pharmacy Utilization Management Department
  705 Mount Auburn Street
  Watertown, MA 02472

Tufts Health Plan clinicians review requests and make determinations regarding prior authorizations within 24 hours for Tufts Health Together (MCO and ACPP plans). Tufts Health RITogether and Tufts Health Direct determinations are made within 72 hours after receipt but can be up to 15 days if additional information is needed.
needed. Notification of the decision to approve or deny the request will be made via ePA, mail or fax.

If the request is denied because it does not meet Tufts Health Plan’s pharmacy medical necessity guidelines, an alternate therapy may be recommended. Providers may appeal denied requests. Refer to the Rights and Responsibilities chapter for additional information on the appeals process.

Requests for Step Therapy Agents

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

Drugs are placed in a step therapy program when one or more of the following criteria are met:

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

For more information, including which drugs are currently included in a step therapy program, refer to the PDL or formulary. Members who are currently on drugs that meet the initial step therapy criteria will automatically be able to fill their prescriptions for a step therapy medication. If the Member does not meet the initial step therapy criteria, the prescription will deny at the point of sale with a message indicating that prior authorization is required. Providers may submit prior authorization requests to Tufts Health Plan using the medical review process for Members who do not meet the step therapy criteria at the point of sale or who do not have claims history in the system.

Requests for Drugs Not Listed on the Preferred Drug List

Tufts Health Plan considers any product not in the current PDL or formulary to be a new-to-market or non-covered drug. Non-covered drugs have safe, comparably effective, less expensive alternatives available. In most cases, alternatives are approved by the FDA for the treatment of the particular diagnosis and are widely used and accepted by the medical community to treat the same condition. If a provider believes there is a medical necessity for a Member to continue on a non-covered drug product, a prior authorization request can be submitted under the medical review process.

Limitations

Exclusions

Tufts Health Plan does not cover the following medications as part of the pharmacy benefit:

- Medications used for cosmetic purposes
- Medications used for male or female sexual dysfunction for Tufts Health Together MCO, Tufts Health Together ACPP, Tufts Health RITogether and Tufts Health Unify Members
- Medications used for weight loss for Tufts Health Together MCO, Tufts Health Together ACPP and Tufts Health Unify Members
- Contraceptive implants* (for Tufts Health Together MCO, Tufts Health Together ACPP, Tufts Health Direct, and Tufts Health RITogether)
- Experimental and/or investigational drugs
- New-to-market medications for Tufts Health RITogether Members
- Infertility agents for Tufts Health Together MCO, Tufts Health Together ACPP and Tufts Health RITogether, and Tufts Health Unify Members*
- Over-the-counter medications not listed on the Tufts Health Direct formulary or on the Plan’s OTC list for Tufts Health Together MCO, Tufts Health Together ACPP and Tufts Health RITogether Members
- For Tufts Health Together MCO and Tufts Health Together ACPPs, immunizations administered or dispensed at a pharmacy, except for:
  - Influenza virus vaccine for members, when administered by a pharmacist between August 1 and April 30 at a participating pharmacy, and
– Shingrix vaccine for Members 50 years of age and older when the prescription is filled, and the medication is administered at a participating pharmacy
  • For Tufts Health Direct, immunizations administered or dispensed at a pharmacy, except for:
    – Influenza virus vaccine for members, when administered by a pharmacist between August 1 and April 30 at a participating pharmacy
    – Oral typhoid with a valid prescription.
    – Oral cholera with a valid prescription.
  • For Tufts Health RITogether members in the Extended Family Planning Plan, immunizations administered or dispensed at a pharmacy
  • Medical supplies*
  • Mifepristone (Mifeprex)*
  • Drugs not approved by the United States Food and Drug Administration (FDA)

* May be covered as a medical benefit

Contact Provider Services at **888.257.1985** (Massachusetts) or **844.301.4093** (Rhode Island) with any questions about coverage.

Generic Substitutions **(Massachusetts)**

Consistent with Massachusetts law, which mandates that individuals receive the generic equivalent of a medication when one is available, Members who are prescribed a brand-name drug will receive the generic drug at the pharmacy and will pay the applicable tier co-payment for that generic.

However, when the prescriber writes a “no substitutions” prescription for a brand-name drug when generic drugs are available, Tufts Health Plan will not cover the brand-name drug without approving a provider-submitted request for the non-covered brand-name drug. If Members need a brand-name drug, submit a request for medical necessity.

**Note:** The brand name product is preferred over the interchangeable generic in some instances for Tufts Health Together MCO and Tufts Health Together ACPPs. Please refer to the PDL when prescribing.

Certain drugs where blood-level maintenance is crucial, or with complex pharmacokinetics, dosage forms, or narrow therapeutic efficacy, are not subject to substitution (unless the Member is enrolled in **Tufts Health Unify**).

These products are:

- Dilantin
- Neoral oral solution
- Premarin
- Prograf
- Synthroid

Generic Substitutions **(Rhode Island)**

Consistent with Rhode Island law, Members who are prescribed a brand-name drug will receive the generic at the pharmacy and will pay the applicable tier co-payment for that generic.

**Note:** when the prescriber writes “brand name necessary” on a prescription for a brand-name drug when a generic version is available, Tufts Health Plan will not cover the brand-name drug without approving a provider-submitted request for the non-covered brand name drug. If the Member needs a brand-name drug, submit a request for medical necessity.

Certain drugs where blood-level maintenance is crucial, or with complex pharmacokinetics, dosage forms or narrow therapeutic efficacy, are not subject to substitution.

These products are:

- Dilantin
- Neoral oral solution
- Premarin
- Prograf
- Synthroid
New-to-Market Drugs (Massachusetts)

Tufts Health Plan reviews new drugs for safety and efficacy before adding them to the PDL or formulary. The coverage determination of new-to-market (NTM) drugs is delayed until the P&T Committee has reviewed them. In the interim, if a provider believes a Tufts Health Together MCO, Tufts Health Together ACPP, Tufts Health Direct or Tufts Health Unify Member has a medical need for the drug, a request can be submitted under the medical review process. Contact Provider Services at 888.257.1985 (Massachusetts) with any questions regarding the coverage status of a drug.

Quantity Limits

The quantity limitations program restricts the quantity of a drug covered in a given time period. These quantities are based on recognized standards of care, such as FDA recommendations for use. If a provider believes a Member needs a quantity greater than the program limitation, a request can be submitted under the medical review process.

Medicare Part D (Massachusetts)

If Members have Medicare prescription drug coverage (Part D), the Part D plan will cover most of the prescription drugs. Even so, Tufts Health Plan will cover some drugs, such as select excluded drugs. Some co-payment amounts may still apply to these covered drugs. Contact Provider Services at 888.257.1985 for additional information. Members can also find out more about their Medicare prescription drug coverage by calling Medicare at 800.633.4227 (TTY: 711), visiting Medicare’s website or referring to their Medicare and You Handbook.

Specialty pharmacy

Tufts Health Plan’s designated specialty pharmacy program supplies a select number of drugs used to treat complex disease states. Specialty pharmacies specialize in providing these medications and are staffed with nurses, coordinators and pharmacists to provide support services for Members. Medications include, but are not limited to, those used to treat hepatitis C, growth hormone deficiency, multiple sclerosis, rheumatoid arthritis and cancers. When appropriate, additional medications are identified and added to this program.

Tufts Health Plan offers Members a specialty pharmacy program through CVS Specialty pharmacy. For most medications, providers may prescribe up to a 30-day supply of medication through CVS Specialty pharmacy. Use the CVS Specialty Enrollment Form to request specialty medications. Medications that CVS Specialty pharmacy provides for Members are not covered through retail pharmacies, other specialty pharmacies or mail-order pharmacies.

In addition to providing specific specialty medications, CVS Specialty pharmacy will:

- Deliver medications to a Member’s home, designated delivery address, or clinician’s office
- Provide pharmaceutical expertise and counseling to answer Members’ and/or clinicians’ questions and offer medication assistance
- Offer education and wellness programs that provide clinicians and Members with information, materials, and ongoing support to help Members manage their health conditions and improve medication compliance
- Provide access to staff pharmacists, available to support Members 24 hours a day, seven days a week

Please send prescriptions for specialty medications to CVS Specialty pharmacy. Members should contact CVS Specialty pharmacy to set up delivery of their specialty medications.

- CVS Specialty pharmacy phone: 800.237.2767
- CVS Specialty pharmacy fax: 800.323.2445

For specialty pharmacy medications that require prior authorization, refer to the Pharmacy Medical Necessity Guidelines for that drug on the public Provider website. Provider can submit the prior authorization request via ePA, fax or mailing to:

- Tufts Health Together (MCO and ACPP), Tufts Health RITogether and Tufts Health Direct: Fax to 617.673.0988
- Tufts Health Unify: Fax to 617.673.0956
• Mail:
  Tufts Health Plan
  Attn: Pharmacy Utilization Management Department
  705 Mount Auburn Street
  Watertown, MA 02472

**Note:** The specialty pharmacy program is optional for Tufts Health Unify and Tufts Health RITogether members.

Synagis requires prior authorization for Tufts Health Direct, Tufts Health Together MCO, Tufts Health Together ACPPs, and Tufts Health RITogether. Tufts Health Plan reviews requests for Synagis according to the most recent American Academy of Pediatrics Guidelines. The Synagis season is defined as November 1st through March 31st. CVS Specialty will supply Synagis for members of a Massachusetts Tufts Health Public Plan who meet the pharmacy medical necessity guidelines.

**Pharmacy Advisor Support Vendor: CVS Health**

The Pharmacy Advisor Support program analyzes pharmacy claims to identify potential non-adherence for specific conditions and educate members on the importance of taking medications as prescribed.

Providers are notified of potential member non-adherence for specific conditions by fax approximately 10-15 days after the refill due date.
RIGHTS AND RESPONSIBILITIES

This chapter outlines provider and member Rights and Responsibilities. Refer to this chapter for information about:

- **Provider Termination**
- **Member Grievances, Appeals, Rights and Responsibilities**
  - Definition of Terms
- **Member Grievances**
  - Request a Grievance Decision Review
- **Member Appeals**
  - Tufts Health Direct Appeals
  - Medicaid Appeals (for members of Tufts Health Together MCO, Tufts Health Together ACPPs and Tufts Health RITogether)
- **Member Rights and Responsibilities**
  - Member Responsibilities
  - Member Rights
  - Privacy Rights
  - Advanced Directives
- **Permissible Marketing Activities**
  - Massachusetts Marketing Activities
  - Rhode Island Marketing Activities

Refer to the [Tufts Health Unify](#) chapter for specific rights and responsibilities information regarding members of Tufts Health Unify.

**Provider termination**

In accordance with the provider’s contract advance notice must be provided in writing of intent not to renew consistent with the time frame specified in the contract. Once notified, Tufts Health Public Plans will notify members that the provider will no longer be affiliated with the Tufts Health Public Plans network. If a provider is not directly contracted with Tufts Health Public Plans and is contracted through a Provider Organization, the provider is responsible for contacting the Provider Organization regarding the process for termination.

To facilitate continuity of care, whenever possible, Tufts Health Public Plans permits members to continue ongoing courses of treatment with their current provider during a transitional period from the time the member is notified about the provider’s termination. Providers must make available, pursuant to the provider contract, a transitional period when a member asks for one. When appropriate, Tufts Health Public Plans will work with providers to reassign members to an in-network provider. For information about member continuity of care, refer to the [Utilization Management Guidelines](#) chapter.

For information about involuntary provider suspension or termination, which Tufts Health Public Plans addresses through credentialing, refer to the [Providers](#) chapter.

**Member grievances, appeals, rights and responsibilities**

Members may designate a provider to exercise rights on their behalf as an authorized representative. Providers are not required to be designated as an authorized representative for an inpatient appeal process to proceed. However, Tufts Health Public Plans does require that members of Tufts Health Together MCO, Tufts Health Together ACPPs and Tufts Health Direct complete an [Authorized Representative Form](#) or Tufts Health RITogether members complete a [Tufts Health RITogether Authorized Representative Form](#) as documentation that the member did authorize the provider to file an expedited appeal on their behalf.

Tufts Health Public Plans does not retaliate or take any punitive action against a provider who requests an expedited resolution or supports a member’s expedited appeal or grievance.
Definition of terms

For members of Tufts Health Together MCO, Tufts Health Together ACPPs, and Tufts Health RITogether

An authorized representative is a person authorized in writing or allowed by law to act on a member’s behalf regarding a specific grievance, grievance decision review, internal appeal or external review. If a member is not able to pick an authorized representative, in a case where one is needed, a guardian, conservator, holder of a power of attorney, or family member, in that order of priority, may be named the member’s authorized representative or may pick another person to be the member’s authorized representative. If the member is under the age of 18 and is able by law to consent to a medical procedure, they can also pick an authorized representative without the consent of a parent or guardian.

A grievance is when a member or a member’s authorized representative tells Tufts Health Public Plans they are dissatisfied with any action or inaction other than an adverse action (for Tufts Health Together MCO, Tufts Health Together ACPP or Tufts Health RITogether members) or adverse determination (for Tufts Health Direct members). A grievance for Tufts Heath RITogether members may also include a request for disenrollment. Grievances may relate to quality of care or services provided; aspects of interpersonal communication, such as a provider’s or a Tufts Health Public Plans employee’s unprofessional behavior; failure to respect a member’s rights; a disagreement a member may have with Tufts Health Public Plans’ decision not to approve a request that an internal appeal be expedited; or a disagreement with Tufts Health Public Plans’ request(s) to extend the time frames for resolving an authorization decision or an internal appeal.

An internal appeal is an oral or written request for Tufts Health Public Plans to review any adverse action/determination.

An external review is a request for an external review agency to review Tufts Health Public Plans’ final internal appeal decision. An external review may be with the state fair hearing agency of the external appeal medical review agency, including the Office of Medicaid’s Board of Hearings (BOH) in Massachusetts and the Rhode Island EOHHS in Rhode Island.

An expedited appeal is an oral or written request for an expedited review of an adverse action/determination when a member’s life, health or ability to attain, maintain or regain maximum function will be at risk if we follow our standard time frames when reviewing the member’s request.

Adverse actions (whether actions or inactions) are when:

- Tufts Health Public Plans denies payments for all or part of a requested service
- A provider fails to provide covered services within the time frames we describe in the applicable Member Handbook
- Tufts Health Public Plans denies or limits authorization for a requested service
- Tufts Health Public Plans reduces, suspends or ends a service previously authorized
- Tufts Health Public Plans does not act on a prior authorization request within the time frames described in the applicable Member Handbook
- Tufts Health Public Plans does not follow the internal appeal time frames described in the applicable Member Handbook
- Tufts Health Public Plans denies a RITogether member’s request to dispute financial liability

Internal appeals are oral or written requests for Tufts Health Public Plans to review an adverse action.

A grievance decision review is our process for reviewing one of our grievance decisions at the provider’s request as a Tufts Health Public Plans member’s authorized representative.

For Tufts Health Direct members

An adverse determination is a decision, based upon a review of information the member or the member’s authorized representative provides to Tufts Health Public Plans or the designated utilization review organization to deny, reduce, modify or end an admission, continued inpatient stay or the receipt of any other services for failing to meet the requirements for coverage based on medical necessity, appropriateness of health care setting, and level of care or effectiveness.
Member Grievances

As a member’s authorized representative, providers may file a grievance in the following ways:

- **Telephone:** call for members of Tufts Health Public Plans’ Massachusetts plans at 888.257.1985, Monday through Friday, from 8 a.m. to 5 p.m., and members of Tufts Health RITogether 866.738.4116, 8 a.m. to 6 p.m. Monday through Friday, excluding holidays
- **TTY/TTD:** people with hearing loss can call our TTY line at: 711, Monday through Friday, from 8 a.m. to 5 p.m. for Massachusetts members and 8 a.m. to 6 p.m. for Rhode Island members, excluding holidays
- **Mail:**
  
  Tufts Health Plan
  Appeals & Grievances Department
  705 Mt. Auburn Street
  Watertown, MA 02471
- **Fax:** fax a grievance to 857.304.6342 (Massachusetts) or 857.304.6406 (Rhode Island)
- **In person:** visit the Massachusetts office at 705 Mount Auburn Street, Watertown, MA 02472, Monday through Friday, from 8 a.m. to 5 p.m., or our Rhode Island Office at 75 Fountain Street, Floor 1, Providence, RI 02903, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays

Members may file a grievance at any time. Tufts Health Public Plans will offer assistance in the filing process as needed. Tufts Health Public Plans will not take action on a member’s grievance from anyone other than the member unless the member signs an Authorized Representative Form (for Massachusetts Members) or Tufts Health RITogether Authorized Representative Form (for RITogether Members) designating an authorized representative. Members can call Member Services at 888.257.1985 (Massachusetts) or 866.738.4116 (Rhode Island), Monday through Friday, from 8 a.m. to 5 p.m. to request the appropriate form. If the signed Authorized Representative Form is not received within 30 calendar days of the initial request, Tufts Health Public Plans will dismiss the grievance.

Once a grievance is filed by a member or authorized representative, Tufts Health Public Plans will:

- Inform the member or authorized representative that the grievance was received by sending a written notice within one business day (Massachusetts) or five calendar days (Rhode Island)
- Look into and resolve the grievance within 30 calendar days from when the grievance is received
- Tell the member or authorized representative in writing of the outcome of the grievance, which will include the information considered, and explain the decision
- Provide interpreter services and offer assistance upon request

Request a grievance decision review

For members of Tufts Health Together MCO, Tufts Health Together ACPPs or Tufts Health RITogether

If a member is dissatisfied with how Tufts Health Public Plans resolved a grievance, the member, or provider as an authorized representative, may request a grievance decision review from in the same ways that members can file a grievance, as described previously.

Once a grievance decision review request is filed by a member or an authorized representative, Tufts Health Public Plans will:

- Tell the authorized representative or the member that the grievance decision review request was received by sending a written notice within one business day (Massachusetts) or five calendar days (Rhode Island)
- Look into the substance of the request, including any aspect of clinical care involved
- Resolve the grievance decision review within 30 calendar days of getting the request and let the member or authorized representative know of the outcome in writing
- Document the substance of the grievance decision review request and the actions taken
- Provide interpreter services and offer assistance upon request
Member Appeals

The appeals process differs by plan. Refer to the appropriate section below depending on the Member’s plan. Refer to the Tufts Health Unify chapter for Tufts Health Unify member appeals information.

**Note:** Tufts Health Public Plans will not take action on a member’s appeal from anyone other than the member unless the member signs an Authorized Representative Form selecting the provider, a family member, friend, or legal guardian as an authorized representative. If the member does not complete the Authorized Representative Form in a timely fashion, the appeal will be dismissed. For expedited appeals, or when a member is inpatient, Tufts Health Public Plans will allow the appeal process to proceed without the Authorized Representative Form. However, we do require that an Authorized Representative Form is completed, for Tufts Health Together MCO, Tufts Health Together ACPP or Tufts Health RITogether as documentation that the member had, in fact, authorized the provider to file the expedited appeal on the member’s behalf.

**Tufts Health Direct appeals**

The following appeals information is for Tufts Health Direct Members.

**Request an internal appeal**

A member, an in-network provider on behalf of a member, or an authorized representative of the member may file an internal appeal within 180 calendar days of an adverse determination. To process an internal appeal request, Tufts Health Public Plans requires a copy of the notice of adverse determination and any additional information about the internal appeal. File an internal appeal in the following ways:

- **Telephone** — call us at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays
- **TTY/TTD** — people with hearing loss can call the TTY line at: 711, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays
- **Mail** — mail a request for an internal appeal, including all documentation, to:
  Tufts Health Plan
  Appeals & Grievances Department
  705 Mt. Auburn Street
  Watertown, MA 02471
- **Fax** — request an internal appeal by faxing at 857.304.6321
- **In person** — visit the Tufts Health Public Plans office at 705 Mount Auburn Street, Watertown, MA 02472, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays

A member, provider or authorized representative has 180 days to request an internal appeal, however, acting as soon as possible is encouraged.

Tufts Health Public Plans will let the member and the provider or authorized representative know that the internal appeal request was received by sending a written notice within one business day, or 48 hours, whichever is less.

**Service continuation during the internal appeal**

If a Tufts Health Direct member files an appeal concerning the termination of ongoing coverage or treatment, Tufts Health Public Plans will continue the disputed coverage at our expense through the end of the appeal process as long as the member or authorized representative requests the internal appeal in a timely manner, based on the course of treatment. Ongoing coverage or treatment includes only services that had previously been authorized, and does not include services that were terminated pursuant to a specific time- or episode-related exclusion from the member’s contract for benefits, unless:

- The treatment or proposed treatment that is the subject of the appeal is, in the opinion of the physician responsible, medically necessary
- A denial of coverage for such services would create substantial risk of serious harm to the patient
- Such risk of serious harm is so immediate that the provision of such services should not await the outcome of the appeal process
Standard internal appeal time frames
Tufts Health Public Plans will review and make a decision about internal appeal requests within 30 calendar days from the date the request is received. Any Tufts Health Direct member internal appeal not properly acted on by Tufts Health Public Plans within the time frames specified will be decided in the member’s favor. Time limits include any extensions made by mutual written agreement between the member, or the authorized representative, and Tufts Health Public Plans.

Reviewing medical records as part of the internal appeal
A Tufts Health Direct member or an authorized representative may send Tufts Health Public Plans written comments, documents or other information relating to a member’s internal appeal. If Tufts Health Public Plans needs to review additional medical records, the standard internal appeal period of 30 calendar days begins when the member or authorized representative sends a signed authorization for release of medical records and treatment information, as required. If Tufts Health Public Plans does not receive this authorization within 30 calendar days of receipt of the internal appeal request, a decision on the internal appeal may be issued without reviewing some or all of the medical records. The member has a right to review their case file, which includes information such as medical records and other documents and records considered during the appeal process.

Expedited appeals
If Tufts Health Public Plans’ standard time frame of 30 calendar days could seriously harm a Tufts Health Direct member’s life, health or ability to get back to maximum function, or if it will cause a member severe pain that cannot be adequately managed without the requested service, then the member, provider or authorized representative may request an expedited appeal. The member or authorized representative may request an expedited appeal orally, in writing or in person rather than requesting a standard internal appeal. The member or authorized representative may also request an expedited external review from the Massachusetts Office of Patient Protection (OPP) at the same time they request an expedited appeal.

There are three situations when Tufts Health Public Plans may review an internal appeal in an expedited manner, and each situation has a certain time requirement in which the internal appeal must be decided:

- If the member is a patient in a hospital, Tufts Health Public Plans must issue a decision before the member is discharged from the hospital.
- If the provider informs Tufts Health Public Plans in writing that a delay in providing the requested service or supply would result in risk of substantial harm to the member, Tufts Health Public Plans must issue a decision within 48 hours.
- If the member is terminally ill, Tufts Health Public Plans must issue a decision within five business days.

Tufts Health Public Plans will issue a decision within 48 hours, or in less time for durable medical equipment (DME), when the provider:

- Certifies that the use of the DME is medically necessary
- Certifies that a denial of coverage for such DME would create a substantial risk of serious harm to the member
- Certifies that such risk of serious harm is so immediate that the provision of such DME should not await the outcome of the normal appeal process
- Describes the specific, immediate and severe harm that will result to the member absent action within the 48-hour time period specified in 105 CMR 128.309(2)
- Specifies a reasonable time period in which we must provide a response

Any expedited appeal not properly acted on by Tufts Health Public Plans within the time limits specified will be decided in the Tufts Health Direct member’s favor. Time limits include any extensions mutually agreed upon between the member, or the authorized representative, and Tufts Health Public Plans.

If the expedited appeal upholds the denial of coverage of treatment regarding terminal illness, Tufts Health Public Plans will allow the member or the authorized representative to ask for a conference. Tufts Health Public Plans will schedule the conference within 10 business days of receiving a request. The conference will be held within five business days of the request if the treating provider determines, after consulting with a Tufts Health Public Plans medical director, that the effectiveness of the proposed treatment or supplies, or any alternative
treatment or supplies, would be greatly reduced if not provided at the earliest possible date. The member or the authorized representative can attend the conference.

Written notice of appeal decisions
Tufts Health Public Plans will notify the member and any authorized representative of the appeal decisions in writing. For adverse determinations, this notice will include a clinical explanation for the decision and will:

- Give specific information upon which Tufts Health Public Plans based the adverse determination
- Discuss the member’s symptoms or condition, diagnosis and the specific reasons why the evidence submitted does not meet the relevant medical review criteria
- Specify alternate treatment options Tufts Health Public Plans covers
- Reference and include applicable clinical practice guidelines and review criteria
- Let the member or authorized representative know about options to further appeal the decision, including procedures for requesting an external review and an expedited external review

External review process
Tufts Health Direct members who receive a final adverse determination for a medical necessity appeal have the opportunity to file a request for an external review from the Massachusetts Office of Patient Protection (OPP).

Members, providers or their authorized representatives are responsible for starting the external review process. Tufts Health Public Plans will enclose an External Review Form any time a final adverse determination is issued. To start the review, the member or authorized representative must complete and submit the required form to the OPP within four months of receiving the final adverse determination.

If a Tufts Health Direct member has been receiving a covered service and coverage of the service has ended, the disputed coverage will continue at our expense through the end of the appeal process, as long as the member or authorized representative files the external review request by the end of the second business day after receiving the final adverse determination. If the external review agency decides a member should keep getting the service because there could be substantial harm if the service ends, Tufts Health Public Plans will keep covering the service until the external review is decided, no matter what the final external review decision is.

The OPP will screen all requests for external reviews to see if they:

- Meet the requirements of the external review
- Do not involve a service or benefit we specify in the applicable Member Handbook as excluded from coverage
- Result from our issuing a final adverse determination

The member will not need a final adverse determination from if Tufts Health Public Plans fails to act within the timelines for the internal appeal, or if the member filed for an expedited external review from the OPP and an expedited appeal from Tufts Health Public Plans at the same time.

The OPP will screen the request for an external review within five business days of receiving the request. Once the case is deemed eligible for external review, the OPP will submit it to the external review agency. The external review agency will then send the member and the authorized representative a written decision within 45 calendar days.

Expedited external reviews
A member, provider or an authorized representative may request an expedited external review if a provider certifies in writing to the OPP that a delay in providing the care would result in a serious threat to the member’s health. The OPP will screen the request within 48 hours of receiving it. Expedited external reviews are resolved within four business days from when the external review agency gets the referral from the OPP. Providers may request an expedited external review at the same time an expedited appeal from Tufts Health Public Plans is requested.

When an external review involves the decision to end a previously authorized service
If the external review involves ending ongoing coverage of services, the member or the authorized
representative may apply to the OPP to keep getting the services during the external review. The member or the authorized representative needs to make the request before the end of the second business day after getting the final adverse determination. If the external review agency decides the member should keep getting the service because there could be substantial harm to the Member if the service ends, Tufts Health Public Plans will keep covering the service until the external review is decided, no matter what the final external review decision is.

How to contact the OPP
If providers or members of Tufts Health Direct have questions about member rights or the external review process, contact the OPP the following ways:

- **Phone:** 800.436.7757
- **Fax:** 617.624.5046
- **Email:** hpc.opp@state.ma.us
- **Mail:**
  
  Health Policy Commission  
  Office of Patient Protection  
  50 Milk Street, Eighth Floor  
  Boston, MA 02109

Medicaid Appeals  
**for members of Tufts Health Together MCO, Tufts Health Together ACPPs and Tufts Health RITogether**

A member or an authorized representative can request an internal appeal for Tufts Health Public Plans to review an adverse action. Tufts Health Public Plans will offer assistance in the filing process, as needed.

**Appeal rights**
All members of Tufts Health Together MCO, Tufts Health Together ACPPs and Tufts Health RITogether and their authorized representatives have specific rights during the internal appeals process, including the right to:

- Make an appointment to present information in person or in writing within the internal appeal time frames
- Send Tufts Health Public Plans written comments, documents or other information about the internal appeal
- Review the member’s case file, including such information as medical records and other documents considered during the internal appeal process
- File a grievance if Tufts Health Public Plans asks for more time to make an internal appeal decision, and the member or the authorized representative disagrees
- File a grievance if Tufts Health Public Plans denies a request for an expedited appeal, and the member or the authorized representative disagrees with that decision
- File directly with the BOH (Massachusetts) or Rhode Island EOHHS (Rhode Island) if Tufts Health Public Plans does not make an appeal decision within the required time frames (as outlined in the following sections)

**Requesting an internal appeal**
A member or an authorized representative can request an internal appeal to ask that Tufts Health Public Plans reviews any adverse action. To process the request, Tufts Health Public Plans requires a copy of the notice of adverse action, and any additional information about the internal appeal. File an internal appeal in the following ways:

- **Telephone:** For Tufts Health Public Plans Massachusetts plan members call **888.257.1985**, 8 a.m. to 5 p.m., and for members of Tufts Health RITogether at **844.301.4093**, 8 a.m. to 6 p.m. Monday through Friday, excluding holidays
• **TTY/TTD:** people with hearing loss can call the TTY line at: 711, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays

• **Mail:**
  - Tufts Health Plan
  - Appeals & Grievances Department
  - 705 Mt. Auburn Street
  - Watertown, MA 02471

• **Fax:** request an internal appeal by faxing 857.304.6321 (Massachusetts) or 857.304.6406 (Rhode Island)

• **In person:** visit Tufts Health Public Plans’ Massachusetts office at 705 Mount Auburn Street, Watertown, MA 02472, Monday through Friday, from 8 a.m. to 5 p.m., or the Rhode Island office at 75 Fountain Street, Floor 1, Providence, RI 02903, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays

**Note:** If an internal appeal is requested by a member or an authorized representative via telephone or in person, Tufts Health Public Plans will request follow-up with a written internal appeal request, unless requesting an expedited appeal.

If Tufts Health Public Plans does not have enough information to make a decision about the internal appeal, we will ask the member or the authorized representative for it. If the additional information is not received, the internal appeal may be denied.

The member or the authorized representative must request an internal appeal within 60 calendar days of the notification of adverse action (or, if the authorized representative or member does not get a notice, within 60 calendar days of learning of the adverse action). The member or the authorized representative may also send written comments, documents or any additional information about the internal appeal. Tufts Health Public Plans will inform the member or the authorized representative in writing within one business day (Massachusetts) or five calendar days (Rhode Island) that the internal appeal request was received.

If Tufts Health Public Plans does not receive the internal appeal request within 60 calendar days, the adverse action will be considered final. Tufts Health Public Plans will dismiss internal appeals the member or the authorized representative requests after 60 days. If the member or the authorized representative believes that the internal appeal was requested on time, the member or the authorized representative has the right to request that the dismissal be reversed and continue the internal appeal. To do so, the member or the authorized representative must send a written request within 10 calendar days of the dismissal. Tufts Health Public Plans will decide whether to reverse the dismissal and continue the internal appeal.

**Standard internal appeal**

After looking into an internal appeal, including any additional information, Tufts Health Public Plans will make a decision based on a review by a health care professional with the appropriate clinical expertise within 30 days of receiving the appeal. If additional information is needed, and we expect our review to take longer than 30 calendar days, we will inform the member or the authorized representative and ask for an extension of 14 calendar days. At that time, Tufts Health Public Plans will give the member and the authorized representative a new date for to resolve the issue. Tufts Health Public Plans may ask for an extension if more information is needed to make a decision, if it is believed the information would lead to approving the request and if Tufts Health Public Plans can reasonably expect to receive this information in 14 calendar days. If the member or the authorized representative disagrees with the decision to take an extension, the member or the authorized representative can file a grievance as described previously. Also, the member or the authorized representative has the right to ask for an extension of 14 calendar days to provide more information.

Unless the member or the authorized representative indicates that the member does not want to get continuing services, Tufts Health Public Plans will keep covering previously approved services until the internal appeal is decided, as long as the request for an internal appeal is received within 10 calendar days of the notice of adverse action (or, if the member or the authorized representative does not get any notice, within 10 calendar days of learning of the adverse action). Note, this does not include denied requests to extend treatment beyond a previously authorized period. If the internal appeal is denied, the member may have to pay for these services.

If Tufts Health Public Plans denies the internal appeal, the member or the authorized representative may request an external appeal/review (fair hearing), following the process described in the Requesting an External Appeal and Requesting an External Review sections.
**Requesting an expedited appeal**

The expedited appeal process exists for circumstances that involve acute medical and/or behavioral health services, and when taking the time for a standard internal appeal could seriously jeopardize the member’s life, health or ability to attain, maintain or regain maximum function.

A member or an authorized representative can request an expedited appeal in any of the ways previously described how to request an internal appeal. In addition, the member or the authorized representative may request an expedited appeal at night, on weekends or on holidays by calling 888.257.1985 (Massachusetts) or 866.738.4116 (Rhode Island). Hearing impaired dial 711. The Member or the authorized representative must request the expedited appeal within 60 calendar days of the notification of adverse action (or, if the Member did not receive any notice, within 60 calendar days of learning of the adverse action).

Unless a member of Tufts Health Together MCO, Tufts Health Together ACPPs or Tufts Health RITogether indicates they do not want to continue getting services, Tufts Health Public Plans will continue covering previously approved services until a decision is made about the expedited appeal or the appeal is withdrawn, as long as the request is received within 10 calendar days of the notice of adverse action (or, if the member did not receive any notice, within 10 calendar days of learning of the adverse action). Note, this does not include denied requests to extend treatment beyond a previously authorized period. If Tufts Health Public Plans denies the expedited appeal, the member may have to pay back the cost of these services.

If the provider, files the expedited appeal request, or if the provider supports the member’s expedited appeal request, then Tufts Health Public Plans will approve the request to speed up the appeal when the request has to do with the member’s health condition. Tufts Health Public Plans must have the Authorized Representative Form showing the provider has permission to act on the member’s behalf. Please note that although Tufts Health Public Plans requires an Authorized Representative Form giving the provider permission to act on the member’s behalf, processing the expedited appeal will not be delayed while waiting to receive the form.

If the request for an expedited appeal does not relate to a specific health condition, Tufts Health Public Plans may or may not decide to speed up the appeal. If Tufts Health Public Plans denies the expedited appeal request, the member and the authorized representative will be informed within one business day (Massachusetts) or five calendar days (Rhode Island) and treat the request as a standard internal appeal (as described earlier). The member or the authorized representative may file a grievance if they disagree with the decision to deny the request for an expedited appeal.

If Tufts Health Public Plans accepts the expedited appeal request, a decision will be made as quickly as the member’s condition requires, and in no more than 72 hours, and the member or the authorized representative will be informed of the decision by phone and in writing. If more information is required, if there is a reasonable likelihood that such information would lead to the approval of the request and Tufts Health Public Plans can reasonably expect to receive this information in 14 calendar days, the member or any authorized representative will be notified and take a 14-calendar-day extension. The member or any authorized representative may file a grievance if they disagree with the need for this extension. The member or the authorized representative also has the right to ask for an extension of up to 14 calendar days to provide more information.

If the appeal is denied, the member or the authorized representative may request an external review (fair hearing) from the Office of Medicaid’s Board of Hearings (BOH), following the process described in the Requesting an External Appeal and Requesting an External Review sections.

**Requesting an external appeal (for members of Tufts Health Together MCO and Tufts Health Together ACPPs)**

When requesting an external review (fair hearing) with the BOH, a member or an authorized representative may request an external review (fair hearing) directly from the BOH after Tufts Health Public Plans denies an internal appeal; denies an expedited appeal; or if any of these appeals were not resolved within the appropriate time frames.

Tufts Health Public Plans will send a notice of the decision and a copy of the How to Ask for a Fair Hearing form and instructions any time an internal appeal is denied. The provider or the Member can call 888.257.1985 to obtain a copy of the form.

The member or the authorized representative must file a request for an external review (fair hearing) within 120 calendar days from the date of the internal appeal decision.
If the external review involves a decision by Tufts Health Public Plans to reduce, suspend or terminate a member’s previously-approved services and a provider wishes for the member to continue receiving the services under dispute during the external review, the BOH must receive the completed form within 10 calendar days of the decision, and the member or the authorized representative must indicate on the BOH application form that the member wants to continue receiving these services. If the external review decision upholds the appeal decision, the member may be held responsible to pay for the cost of these services.

Tufts Health Public Plans will comply with and implement BOH decisions as required.

**Requesting an external review (fair hearing) with the Rhode Island EOHHS (for members of Tufts Health RITogether)**

If the member isn’t satisfied with the outcome of our internal appeal, the member can request a fair hearing with the Department of Human Services (DHS). This hearing is free-of-charge. Members must exhaust Tufts Health Public Plans’ internal appeal process before requesting a State Fair Hearing. To request a State Fair Hearing, call the Department of Human Services (DHS) Call Center at 1.855.MYRIDHS (1.855.697.4347) (TTY 711) (English and Español).

A State Fair Hearing must be asked for within 120 calendar days of the outcome date of Tufts Health Public Plans’ internal appeal decision.

Members may also ask for an external appeal through an External Review Agency chosen by the RI Department of Health. An external appeal must be filed with the External Review Agency (ERA) within 4 months of receiving the notice that the appeal was denied. There is no cost to a member for an external review associated with filing an external appeal with an ERA. However, for providers who request an independent external review on their own behalf, there is an upfront cost of $210.00.

If the external review involves a decision by Tufts Health Public Plans to reduce, suspend or terminate a member’s previously-approved services and a provider wishes for the member to continue receiving the services under dispute during the external review, the DHS must receive the completed form within 10 calendar days of the decision, and the member or the authorized representative must indicate on the DHS application form that the member wants to continue receiving these services. If the external review decision upholds the appeal decision, the member may be held responsible to pay for the cost of these services.

Members who are not satisfied with the outcome of their appeal also have the right to notify the Rhode Island Department of Health at:

Rhode Island Department of Health  
Office of Managed Care  
3 Capitol Hill  
Providence, RI 02908  
Telephone: 401.222.6015

For additional assistance, members may contact the Office of the Health Insurance Commissioner’s Consumer Assistance Program at 1.885.RIREACH (1.885.747.3224).

Tufts Health Public Plans will comply with the External Review decision or Fair Hearing Decision.

**Member Rights and Responsibilities**

As part of Tufts Health Public Plans’ strong commitment to quality care and customer service it is important that members remain informed about their rights and responsibilities. Members are allowed to exercise these rights without having their treatment adversely affected. The following list is included to inform providers of member’s rights and responsibilities in order to assist members in receiving the most of their memberships.

**Member responsibilities**

- Treat all health care providers with respect and dignity
- Keep scheduled appointments with healthcare providers or provide adequate cancellation or late notice
• Give Tufts Health Public Plans, their primary care provider (PCP), specialists and other health care providers complete and correct information about their medical history, current medications and other matters about their health
• Ask for more information from their PCP and other health care providers if they do not understand what they have been told
• Participate with their PCP, specialists and other health care providers to understand and help develop health improvement plans and goals
• Follow care plans and instructions agreed to with their providers. Understand their health problems and participate in mutually agreed-upon treatment goals, to the degree possible and that refusing treatment may have serious effects on their health
• Contact their PCP or behavioral health provider for follow-up care within 48 hours of visiting the emergency room
• Change their PCP or behavioral health provider if they are not happy with their current care
• Voice concerns and complaints clearly
• Inform Tufts Health Public Plans of the following:
  – If they have access to any other insurance
  – If potential fraud and/or abuse is suspected
  – Of any address, phone or PCP changes. Note: The member is responsible for reporting changes to the state as well.
  – If they are pregnant or any other family composition changes
• Supply, to the extent possible, information needed by their healthcare providers and Tufts Health Public Plans and to the providers who provide their care

Member Rights

• Be treated and accepted with respect, privacy and dignity regardless of race, ethnicity, creed, religious belief, sexual orientation, privacy, health status, gender, age, language needs, disability or source of payment for care
• Receive information on all available treatment options and alternatives, presented in a manner appropriate to the member’s condition and ability to understand
• Receive a second opinion on a medical procedure, and to have Tufts Health Public Plans cover a second opinion consultation for members of Massachusetts plans
• Receive a second opinion for proposed treatment and care for members of RITogether
• Obtain medically necessary treatment, including emergency care
• Receive information about our organization, services, PCPs, specialists, other providers and member rights and responsibilities
• Have a candid discussion of appropriate or medically necessary treatment options for condition(s) regardless of cost or benefit coverage
• Work with their PCP, specialists and other providers to make decisions about their health care
• Accept or refuse medical or surgical treatment
• Call their PCPs and/or behavioral health provider’s office 24 hours a day, seven days a week
• Expect that their health care records are private, and that Tufts Health Public Plans and their providers abide by all laws regarding confidentiality of patient records and personal information, in recognition of members’ rights to privacy
• File a grievance to express dissatisfaction with Tufts Health Public Plans, their providers or the quality of care or services received
• Appeal a denial or adverse action/determination Tufts Health Public Plans makes for their care or services
• Be free from any form of restraint or seclusion used as a means of coercion, discipline or retaliation
• Receive services in a culturally competent manner
• Obtain written notice of any significant and final changes to our provider network, including but not limited to PCP, specialist, hospital and facility terminations that affect them
• Ask for and get copies6 of their medical records, and ask that Tufts Health Public Plans amend or correct the records, if necessary

---

6 Massachusetts providers may charge a reasonable fee for the expense of providing copies, in compliance with 243 CMR 2.07(13)(b). The provider may not charge a fee to any member if the record is requested for the purpose of supporting a claim or appeal.
• Receive covered services
• Make recommendations about member rights and responsibilities
• Ask for more information or explanation on anything included in the Member Handbook, either orally or in writing
• Ask for a duplicate copy of the Member Handbook at any time
• Ask for and receive the Member Handbook and other Tufts Health Public Plans information translated into their preferred language or in their preferred format
• Exercise their rights without having treatment adversely affected
• Be furnished ACPP Covered Services when applicable
• Be furnished MCO Covered Services when applicable

Privacy rights
Tufts Health Public Plans is committed to protecting the rights and privacy of members. Our Notice of Privacy Practices describes how Tufts Health Public Plans may use and disclose protected health information (PHI), and how members can get this information.

Notice of Privacy Practices is available online, in the Member Handbooks or by calling Provider Services at 888.257.1985 (Massachusetts) or 866.738.4116 (Rhode Island). Tufts Health Public Plans and the member’s provider are required by state and federal law (including HIPAA) to maintain the privacy of members’ PHI and members’ other personal information across our organizations, including oral, written and electronic forms of member information. The provider’s obligation to maintain the confidentiality of member information is also included in the provider contract.

Advance directives
Members have certain rights relating to an advance directive. Advance directives are written instructions, sometimes called a living will, health care proxy or durable power of attorney for health care. If a member is no longer able to make decisions about their health care, having an advance directive in place can help. These written instructions tell providers what to do if the member cannot make health care decisions and may authorize a Tufts Health Public Plans designated individual, also known as a health care agent or proxy, to make decision on them behalf. Tufts Health Public Plans has the authority to audit member records for the presence of advance directives.

Members who execute an advance directive or health care proxy also have the right to:

• Make decisions about their medical care
• Get the same level of care as Members without an advance directive and be free from any form of discrimination
• Get written information about their health care provider’s advance directive policies
• Have their advance directive, if they have one, in their medical record

In Massachusetts, members at least 18 years old and who have sound mind can make decisions for themselves. Members may also choose someone else to be their health care agent or health care proxy. The health care agent or proxy is a person who can make health care decisions for them in the event that their health care providers determine that they are unable to make their own decisions.

To choose a health care agent or proxy, a member must fill out a Health Care Proxy Form, available from their provider, another provider or Contacting Member Services. Tufts Health Public Plans members can also request a Health Care Proxy Form from the Commonwealth of Massachusetts. Members can write to the address below and send a self-addressed stamped envelope to:

Commonwealth of Massachusetts
Executive Office of Elder Affairs
1 Ashburton Place, Fifth Floor
Boston, MA 02108

Rhode Island providers may charge a reasonable administrative fee for copying medical records; however, the transfer of medical records cannot be delayed due to non-payment of administrative fees. Records should be provided within 30 days.
Permissible marketing activities

As a state-contracted Managed Care Organization (MCO) and Accountable Care Partnership Plan (ACPP), Tufts Health Public Plans must meet, as appropriate, MassHealth, Health Connector, EOHHS and Centers for Medicare & Medicaid Services (CMS) requirements, and other applicable state and federal regulations related to Member marketing activities.

Massachusetts marketing activities

Our Massachusetts state contract includes the following definitions:

**Marketing** is any communication from Tufts Health Public Plans, its employees, providers, agents or subcontractors, to an eligible member who is not enrolled in Tufts Health Public Plans and that reasonably can be interpreted as intended to influence the eligible member to enroll in Tufts Health Public Plans, or either to not enroll in, or to disenroll from, another MCO or MassHealth Primary Care Clinician plan. This includes the production and dissemination by or on behalf of Tufts Health Public Plans of any marketing materials. Marketing shall not include any personal contact between a provider and a member who is a prospective, current or former patient of that provider regarding the provisions, terms or requirements of MassHealth, the Health Connector or CMS as they relate to the treatment needs of that particular member.

**Provider-site marketing** is any activity occurring at or originating from a provider site, whereby Tufts Health Public Plans staff or designees, including physicians and office staff, personally present Tufts Health Public Plans and/or MassHealth marketing materials or other provider-site marketing materials to eligible individuals to convince them to enroll in Tufts Health Public Plans. This type of marketing also includes direct mail campaigns you send to your patients eligible for MassHealth or qualified health plans.

**Marketing materials** are materials that are produced in any medium, by or on behalf of Tufts Health Public Plans, and can reasonably be interpreted as intended for marketing to eligible individuals. This includes the production and dissemination by or on behalf of Tufts Health Public Plans of any promotional material or activities by any medium including, but not limited to, oral presentations and statements, community events, print media, online, audiovisual tapes, radio, television, billboards, Yellow Pages, and advertisements that explicitly or implicitly refer to MassHealth, the Health Connector or CMS, and are targeted in any way toward eligible individuals.

Our contracts require Tufts Health Public Plans to inform providers of this and, as a contracted provider, you must comply as well. Tufts Health Public Plans regularly reviews these policies and will provide any changes in writing.

Tufts Health Public Plans and contracted Tufts Health Public Plans providers may engage in only the following marketing activities, in accordance with MassHealth, Health Connector and CMS requirements:

- Implementing state-approved targeted marketing campaigns and distributing and/or publishing approved marketing materials in our service area by:
  - Posting written marketing materials at provider sites and other service areas
  - Initiating mailing campaigns
  - Advertising via television, radio, newspaper, websites, online, and other audio or visual advertising
- Sponsoring a health fair or community activity. We may conduct or participate in health fair marketing and other community activities if:
  - Regulators preapprove any marketing materials we distribute
  - Any free samples and gifts we offer (which will be of only a nominal value) are made available to all event attendees, regardless of their intent to enroll in our plan
- Participating in state-sponsored health benefit fairs

Tufts Health Public Plans and contracted Tufts Health Public Plans providers may NOT engage in the following marketing activities, in accordance with MassHealth, Health Connector and CMS requirements:

- Distributing any marketing materials EOHHS or the Health Connector does not approve
- Distributing any inaccurate, false, misleading, confusing or fraudulent marketing materials, including but not limited to making any assertion or statement, whether written or oral, that:
  - The recipient of the material must enroll in our plan to obtain benefits or to not lose benefits
  - CMS, the federal or state government, or a similar entity endorses Tufts Health Public Plans
• Engaging in any misleading, confusing or fraudulent marketing activities that misrepresent MassHealth, EOHHS, the Health Connector, Tufts Health Public Plans or CMS
• Seeking to influence a member’s Tufts Health Public Plans enrollment in conjunction with the sale or offering of any non-health-insurance products (e.g., life insurance, which Tufts Health Public Plans does not offer)
• Seeking to influence a member’s Tufts Health Public Plans enrollment in conjunction with the sale or offering of cash, cash equivalents or in-kind gifts
• Engaging directly or indirectly in door-to-door, telephonic or any other cold-call marketing activities
• Conducting any provider-site marketing, except as previously discussed
• Engaging in marketing activities that target members on the basis of health status or future need for health care services, or which otherwise may discriminate against individuals eligible for health care services

Contact Provider Services at 888.257.1985 with any questions about marketing activities.

Rhode Island marketing activities
Marketing means any communication, to a Medicaid member that can reasonably be interpreted as intended to influence the recipient to enroll in Medicaid Managed Care (42 CFR 438.104).

Marketing materials means materials that are produced in any medium that can reasonably be interpreted as intended to market to Potential Enrollees or Enrollees to change Health Plans.

Providers contracted with Tufts Health Public Plans must comply with all marketing requirements as outlined by the Rhode Island Executive Office of Health and Human Services. Tufts Health Public Plans regularly reviews these policies and will provide any changes in writing.

Tufts Health Public Plans and contracted Tufts Health Public Plans providers may engage in only the following marketing activities in accordance with Rhode Island Executive Offices of Health and Human Services and CMS requirements:

• Implementing state-approved targeted marketing campaigns and distributing and/or publishing approved marketing materials in our services area by:
  • Posting written marketing materials at provider sites and other locations
    - Initiating mailing campaigns
    - Advertising via television, radio, newspaper, websites, online and other audio or visual advertising
    - Sponsoring a health fair or community activity. We may conduct or participate in health care marketing and other community activities if:
      ▪ Regulators pre-approve any marketing materials we distribute
      ▪ Any free samples and gifts we offer (which will be of only a nominal value) are made available to all event attendees, regardless of their intent to enroll in our plan
  • Participating in state-sponsored health benefit fairs

Tufts Health Public Plans and contracted Tufts Health Public Plans providers may NOT engage in the following marketing activities, in accordance with Rhode Island Executive Offices of Health and Human Services and CMS requirements:

• Distributing any marketing materials Rhode Island Executive Offices of Health and Human Services does not approve
• Distributing any inaccurate, false, misleading, confusing, or fraudulent marketing materials, including but not limited to making any assertion statement, whether written or oral that
• The recipient of the material must enroll in our plan to obtain benefits or to not lose benefits CMS, the federal or state government, or a similar entity endorses Tufts Health Public Plans
• Engaging in any misleading, confusing or fraudulent marketing activities that misrepresents Rhode Island Executive Offices of Health and Human Services, Tufts Health Public Plans, or CMS
• Seeking to influence a member’s Tufts Health Public Plans enrollment in conjunction with the sale or offering of any non-health insurance products (e.g., life insurance, which Tufts Health Public Plans does not offer)
• Seeking to influence a member’s Tufts Health Public Plans enrollment in conjunction with the sale or offering of cash, cash equivalents, or in-kind gifts
• Engaging directly or indirectly in door-to-door, telephonic, or any other cold-call marketing activities
• Conducting any provider-site marketing, except as previously discussed
• Engaging in marketing activities that target members on the basis of health status or future need for healthcare services, or which otherwise may discriminate against individuals eligible for health care services

Contact Provider Services at 844.301.4093 with any questions about marketing activities.