Referrals, Prior Authorizations and Notifications

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Referrals

A referral verifies that the member's PCP has approved the member's request to receive services from a specialist provider. It is the responsibility of the PCP to ensure that the member is directed to the appropriate specialist. Referrals should be coordinated prior to services being rendered.

Referrals are not required for Tufts Medicare Preferred PPO members. To ensure that appropriate specialty care is provided for Tufts Medicare Preferred HMO and/or Tufts Health Plan SCO members, the PCP must initiate and coordinate the referral management process according to the following list:

- The PCP may approve a referral to a specialist in or out of the Tufts Medicare Preferred HMO or Tufts Health Plan SCO networks, indicating the specific services and number of visits to be provided to the member, when:
  - The PCP decides that such a referral is medically necessary
  - The specialist agrees to a treatment plan and provides the PCP with all necessary clinical and administrative information on a regular basis
  - The health care services to be provided are consistent with the terms of the member's plan benefits
- Specialists must submit a summary report on a timely basis to the medical group following the member's appointment.
- Any questions or problems regarding referrals should be directed to Senior Products Member Services.

- PCPs should not generate referrals for urgent/emergent services and should instead contact the Tufts Medicare Preferred HMO or Tufts Health Plan SCO care manager to notify of urgent/emergency care. Providers should contact Senior Products Provider Services at 800-279-9022 to identify the care manager assigned to the member. All PCP urgent/emergent admissions are reported to the group care manager on a daily basis on the Day of Admission report.
- Tufts Health Plan is financially responsible for any nonurgent/nonemergent outpatient care authorized by Tufts Health Plan that is provided outside the network; if authorized by the medical group that provides services (rather than Tufts Health Plan), the care is the financial responsibility of the medical group.

Referral Exclusions

Tufts Health Plan does not require a PCP referral for the following services, including, but not limited to:

- Ancillary care:
  - Laboratory services
  - Radiology services **Note:** Some radiology services require prior authorization. Please refer to the Imaging Services Payment Policy for more information.
  - Anesthesia services **Note:** Some anesthesia services require prior authorization. Please 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
  - Maternity care
- Covered practitioner services provided in an inpatient setting (place-of-service 21)
- Services rendered in emergency department (ED), qualified urgent care center, or limited services clinic (e.g., MinuteClinics), including independent laboratory services ordered by these facilities

Completing the Paper Referral Form

The paper referral form requires information about the PCP, the member, and the consulting provider. To order paper referral forms, providers may fill out the W.B. Mason Provider Forms Requisition and fax it to W.B. Mason at 800-738-3272 or email it to tuftshealthplan@wbmason.com.

The PCP must complete the referral form. If any required fields are left blank, the referral form will be returned to the PCP requesting additional information. Upon receipt, the Tufts Health Plan Claims Department enters the referral in the system.

Claim reviewers verify the date range on the referral matches the date of service on the claim. If no matching referral is found, the claim will pend for *AUREQ* (authorization/referral expired).

Member name, ID number, and date of birth are required for claim payment. Member information may be obtained from the following sources:

- Member ID card
- Individual Election Form
- Monthly Eligibility Listing Report
- Eligibility Inquiry on the secure Provider portal

- Change Healthcare™
- Integrated voice response (IVR) system at 800-279-9022

Electronic Referral Exclusions

Tufts Health Plan referral policies apply to electronic referrals. However, certain services and/or coverage for certain specialties do not require referrals or may have alternative prior authorization or inpatient notification requirements, as applicable. Refer to the Senior Products payment policies for specific authorization requirements, as applicable. Refer to the Tufts Medicare Preferred HMO and PPO Prior Authorization, Notification, and No Prior Authorization List or the Tufts Health Plan Senior Care Options Prior Authorization, Notification, and No Prior Authorization list for specific procedures, items, and/or services that fall under these requirements.

Out-of-Area Services

Tufts Medicare Preferred HMO/Tufts Health Plan SCO may provide coverage outside the service area to members in certain circumstances, including but not limited to the following:

- Urgently needed or emergency care (including post-stabilization services provided after an emergency)
- Kidney dialysis services provided by a Medicare-certified dialysis facility
- Medically necessary care that cannot be obtained from an in-network provider (e.g., a provider whose specialty is not contracted with Tufts Health Plan)

Providers may contact Senior Products Provider Services at 800-279-9022 to verify benefit coverage when the member is outside the service area.

Referral Inquiry

Providers may check the status of an existing referral by using **Referral Status Inquiry** on the Tufts Health Plan secure Provider portal. The referral status inquiry tool provides the status of referrals submitted to Tufts Health Plan, regardless of how the referral was initially submitted.

Referral Adjustments

To request an adjustment to a referral that is already in the Tufts Health Plan system, the PCP must contact Senior Products Provider Services at 800-279-9022 for assistance. Tufts Health Plan cannot adjust referrals based on the specialist's request.
If the specialist would like to request an adjustment to a referral, the specialist should follow up directly with the member's PCP.

Prior Authorizations

A prior authorization (PA) may be required to determine medical necessity and appropriateness of certain health care services. Services that may require prior authorization include surgical services, durable medical equipment (DME), and/or prescription drugs. Additional prior authorization information may be found on the Prior authorization resources page. Providers rendering services to members may not have claims paid if they fail to obtain required prior authorization, and claims for any related ancillary and supporting services may also deny.

Medical & Behavioral Health Coverage Prior Authorization Requests

To obtain authorization for a medical 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/ordering 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.

We encourage the use of the Tufts Health Plan secure provider portal for submitting prior authorization requests. For Tufts Medicare Preferred members, please utilize the MHK portal (which is accessed via the Tufts Health Plan secure portal) to submit your prior authorization request; for more information please refer to the MHK Portal User Guide.

Alternatively, you may fax requests to the Precertification Operations Department at 617-972-9409.

When the use of an InterQual® SmartSheet is required, it may be submitted without additional supporting documentation, unless otherwise indicated.

Please submit authorization requests in a timely manner to meet patient care timelines and avoid delays in care.

Refer to the Tufts Medicare Preferred HMO and PPO Prior Authorization, Notification, and No Prior Authorization List or the Tufts Health Plan Senior Care Options Prior Authorization, Notification, and No Prior Authorization list for specific nonpharmacy services, items and supplies that require PA.

Please be aware that Tufts Medicare Preferred PPO members do not require prior authorization for out-of-network services. However, members are encouraged to ask for a pre-visit coverage decision to confirm that the out-of-network services are covered and are medically necessary. Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and the member will be responsible for the entire cost.

Sleep Studies

The following applies to sleep studies for Tufts Senior Products:

- Tufts Medicare Preferred HMO members require prior authorization through eviCore healthcare, Tufts Health Plan's sleep benefits manager. For details on the current program — including services, requirements, criteria and information on how to request prior authorization — please refer to the Vendor prior authorization program page on our provider website.
- For Tufts Health Plan SCO members, notification is required to the Tufts Health Plan SCO care manager for sleep studies and sleep equipment (e.g., PAP therapy equipment and related supplies). Refer to the Tufts Health Plan SCO Notification List to identify specific items and services that require notification. Contact Senior Products Provider Services at 800-279-9022 to identify the appropriate Tufts Health Plan SCO care manager.

Prescription Drugs Prior Authorization Requests

Certain prescription medications require prior authorization through Tufts Health Plan. Providers may submit an electronic prior authorization (ePA) through electronic medical record (EMR) system, through a third party ePA vendor or directly from Tufts Health Plan public or secured Provider portal via PromptPA.

For Part D drugs covered under the pharmacy benefit, providers must submit the Request for Medicare Prescription Drug Coverage Determination. For certain drugs requiring Part B versus a Part D determination the Centers for Medicare and Medicaid Services (CMS), providers must submit the Coverage Determination and Prior Authorization Request for Medicare Part B versus Part D form.

Requests for Part B and Part D drug authorizations may be submitted to the Pharmacy Utilization Management Department via the following:

Fax: 617-673-0956
Mail: Tufts Health Plan
Attn: Pharmacy Utilization Management Department
1 Wellness Way
Canton, MA 02021

Exception Requests

All formulary exception requests require a supporting statement from the prescribing provider. The provider may submit the request using the Request for Medicare Prescription Drug Coverage Determination Form. This form requests information regarding diagnoses, what other drugs (if any) have been prescribed for the diagnoses and why they have not worked. The provider may submit via ePA, fax, mail or PromptPA options listed above. Providers may also provide an oral supporting statement by calling Senior Products Member Services.

All **standard** coverage determination and exception requests will be made within **72 hours** after receipt of the request but may be up to 14 calendar days if supporting information is needed from the requesting provider.

All **expedited** coverage determination and exception requests will be made within **24 hours** after receipt of the request but may be up to 14 calendar days if supporting information is needed from the requesting provider.

Formulary

A formulary is a list of covered drugs selected for Tufts Health Plan in consultation with a team of health care providers. This list represents the prescription therapies believed to be a necessary part of a quality treatment program. Tufts Health Plan will cover drugs listed in the Tufts Medicare Preferred HMO, Tufts Medicare Preferred PPO, and Tufts Health Plan SCO formularies as long as the drug is medically necessary, the prescription is filled at a network pharmacy, and all other plan rules are followed. If approved, the member will be covered for the drug. If denied, members and providers may follow the appeal process outlined in the Member Appeals and Grievances chapter.

Note: Some Part D drugs obtained at out-of-network pharmacies are covered by Tufts Medicare Preferred HMO and Tufts Health Plan SCO, as required by CMS and federal regulations (Medicare Prescription Drug Benefit Manual, Chapter 6, Section 10.2: "Part D Drugs and Formulary Requirements," in accordance with 42CFR §423.124)

Note: The Tufts Health Plan comprehensive formulary includes the Part D formulary approved by CMS.

Medicare Part D Transition

Tufts Health Plan may offer a temporary 30-day supply of prescription drugs that were either not on the previous year's formulary or that may have been restricted in some way. Members may receive this "transition fill" during the first 90 calendar days of new membership or the first 90 calendar days of the calendar year for existing members. If the member receives a transition fill, Tufts Health Plan will send a letter to the practitioner and the member detailing the nature of the temporary supply.

Medications Covered by Original Medicare Part B

Tufts Health Plan provides coverage for most drugs and biologicals that are covered by Original Medicare Part B.

Note: Medications covered by Original Medicare Part B are not part of the member's Part D prescription drug benefit. Refer to the Coverage Determination and Prior Authorization Request Form: Medicare "Part B versus Part D" Drugs for more information.

Original Medicare-covered Part B medications include the following:

- Drugs billed by providers and typically provided in an office setting
- Drugs billed by pharmacy suppliers and administered through DME (e.g., respiratory drugs given through a nebulizer)
- Some drugs filled by the pharmacy (e.g., some immunosuppressant drugs depending upon use and some oral chemotherapy drugs)
- Some end-stage renal disease (ESRD) drugs

Vaccines

Some vaccines are covered under the member's medical benefit (Part B) while others are covered under the pharmacy benefit (Part D). When vaccines are covered under Part D, the administration costs will be reimbursed under Medicare Part D. Refer to the Vaccines and Immunization Payment Policy for more information.

Pharmacy Plan Management Programs

Prior Authorization (PA)

The PA process encourages rational prescribing of drug products with significant safety and/or financial concerns. A provider can submit a request for coverage based on a member's medical need for a particular drug.

Quantity Limit (QL)

Because of potential safety and utilization concerns, Tufts Health Plan has placed dispensing limitations on certain prescription drugs. Pharmacies may only dispense a certain quantity of these drugs within a given time period. These quantities are based on recognized standards of care, such as FDA recommendations for use. If a member needs a quantity greater than the program limitation, their prescribing provider may submit a formulary exception request for coverage under the medical review process.

Step Therapy Prior Authorization (STPA)

Step therapy is an automated form of PA that uses claims history for approval of a drug at the point of sale. STPA programs help encourage the clinically proven use of first-line therapies and are designed to ensure the utilization of the most therapeutically appropriate and cost-effective agents first, before other treatments may be covered. Members who are currently on drugs that meet the initial STPA criteria will automatically be able to fill their prescriptions for a stepped medication. If the member does not meet the initial STPA criteria, the prescription will deny at the point of sale with a message indicating that PA is required.

Medication Therapy Management (MTM) Program

Tufts Medicare Preferred and Tufts Health Plan SCO 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, 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 MTM Program page.

Appeals and Grievances for Pharmacy Benefits

Timelines for appeals and/or grievances for pharmacy benefits may differ from those surrounding preservice coverage determinations (also known as organization determinations). For more information regarding appeals and grievances, refer to the Member Appeals and Grievances chapter.

Organization Determinations

The term "organization determination[1]" is a CMS term used to describe pre- and post-service coverage decisions made by Tufts Health Plan. Tufts Health Plan's processes may include prior authorization requests for services addressed in this chapter and other coverage decisions, such as benefit exhaustions.

Preservice organization determinations may be requested for any Medicare procedure, service, or supply, regardless of whether or not that service requires prior authorization. If the member disagrees with a treatment decision or plan of care, an organization determination may be initiated by the member, the member's authorized representative, or the provider on the member's behalf.

Once an organization determination is requested, Tufts Health Plan will:

- Validate that the requestor is approved to make a request
- Determine whether the request is expedited or standard, as defined by CMS
- Collect and review the applicable coverage documents (e.g., Medicare regulations, member evidence of coverage [EOC], or supporting medical necessity documentation)
- Ensure that the member and provider are notified of coverage decisions within the required time frames

Organization Determination Time Frames

Requests may be expedited if either the member or provider believes that waiting for a decision under the standard timeframe could place the member's life, health or ability to regain maximum function in serious jeopardy.

Tufts Health Plan follows CMS and EOHHS regulations regarding decision and notification time frames for organization determinations and expects contracting providers to be in compliance with these regulations. Providers may contact Member Services with additional questions regarding the organization determination process.

Tufts Health Plan must notify the member of the determination as expeditiously as the member's condition requires but not later than the expiration of the time frames below:

- For standard requests, the member must be notified of the decision no later than 7 calendar days from the time of the request
- For expedited requests, the member must be notified of the decision no later than 72 hours from the time of the request

An extension to the above time frames may be requested under certain limited circumstances, as defined by CMS. Refer to the Tufts Health Plan Utilization Review Determination Time Frames for more information. Part B drugs cannot be extended.

For Part B drug requests, Tufts Health Plan must notify the member of the determination as expeditiously as the member's condition requires but not later than the expiration of the time frames below:

- For standard Part B drug requests, the member must be notified of the decision no later than 72 hours from the time of the request
- For expedited Part B drug requests, the member must be notified of the decision no later than 24 hours from the time of the request

[1] Tufts Health Plan SCO refers to pre- and post-service coverage decisions as integrated organization determinations.

Organization Determination Process

Providers play a vital role in submitting Organization Determination (OD) requests to health plans, ensuring patients receive the services they need. Provider responsibilities include:

Assessing Medical Necessity: Providers should evaluate the patient's condition and determine whether the requested service or treatment meets medical necessity criteria based on clinical guidelines and evidence-based practices.

Compliance with Policies: Providers must adhere to the specific policies and requirements of the health plan, including filing deadlines, documentation standards, and communication protocols. In doing so, providers advocate for their patients, help streamline the OD process, and ensure the delivery of necessary care. It is expected that all Medicare-certified providers be familiar with the coverage regulations related to the services that they order and/or provide.

In order to process an organization determination, Tufts Health Plan must collect and review all necessary supporting documentation to make a decision. Documentation may include, but not be limited to, the member's EOC, Medicare regulations (including LCD/NCDs), medical necessity guidelines and clinical documentation submitted by the provider.

Tufts Medicare Preferred and Tufts Health Plan SCO providers are expected to submit all organization determination requests with sufficient clinical documentation for Tufts Health Plan to make a timely decision. Providers must accurately complete the required forms and provide detailed documentation, including patient demographics; procedure and diagnosis codes; requesting and servicing provider Name, ID, NPI and TIN; requesting and servicing provider fax and phone numbers; and all supporting medical records, test results, or treatment history.

Ensuring that the information provided is complete and accurate is crucial to avoiding delays or denials.

If a request is received with insufficient clinical information to make a decision, Tufts Health Plan will fax a request for more information (RFMI) letter to the provider (or call the provider in expedited cases). The RFMI letter includes the specific clinical information being requested, submission options, and a due date by which the information must be received by Tufts Health Plan in order to process the request within regulatory requirements.

In general, providers are asked to respond to these requests by the end of the next business day. RFMI letters will be directed to the treating provider, except for out-of-plan and/or out-of-referral circle services that require a referral. These requests will be directed to the centralized contact specified by each medical group for such requests instead of the PCP. If there is no timely response from the provider to the RFMI request, follow-up outreach calls to the provider office and group medical director or integrated delivery networks (IDN) leader will be made.

Providers must participate in discussions with Tufts Health Plan medical directors and clinicians as needed to discuss coverage requests.

Once all the necessary documentation is on hand, Tufts Health Plan will make an organization determination. The member and provider will be notified verbally and in writing of the decision, according to regulations.

In the event of an adverse determination (denial), the decision may be appealed (reconsideration). Medicare does not allow for a peer-to-peer discussion of the decision in lieu of filing an appeal. Refer to the Member Appeals and Grievances chapter for additional information about the appeal process.

Refer to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for complete information about the organization determination requirements under Medicare. For additional guidance pertinent to Tufts Health Plan SCO, an applicable integrated plan, refer to the Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans.

Member-Initiated Requests for Organization Determinations

If there is a disagreement between the member and provider where a provider declines to provide a service or course of treatment, in whole or part, the provider must inform the member of the right to contact Tufts Health Plan and request an

organization determination. The same organization determination timeframe, notice and process requirements are in effect for all member-initiated requests as those described above.

Although it is encouraged, members are not required to discuss their request with their provider before contacting Tufts Health Plan. Members who have not discussed the requested coverage with their provider will be educated about the member's plan design and the benefit of discussing treatment options with their PCP who is familiar with their health condition.

Once a member requests an organization determination, the appropriate clinical department will fax an RFMI letter to the group medical director or IDN leader explaining the member's request, the specific information being requested to complete the review, and the deadline by which the information must be returned to Tufts Health Plan, unless sufficient information can be provided directly by the member at the time of the request. Responding by the deadline is expected so Tufts Health Plan can make a timely decision in compliance with CMS regulations. Phone calls will also be made in expedited cases.

Benefit Exhaustions (Tufts Medicare Preferred members)

Certain services, such as skilled nursing facility, inpatient rehabilitation and long-term acute care hospital may have benefit limitations for Tufts Health Plan Tufts Medicare Preferred members. Members receiving these services must be notified in writing that their benefit will be exhausted as of a certain date prior to the exhaustion of their benefit.

Tufts Health Plan must be notified by the provider in advance of the benefit exhaustion so a letter can be generated, and the member may be notified, in accordance with CMS requirements. In order for the member to receive timely notice, the letter will be written by Tufts Health Plan and must be delivered to the member in the facility, or to their authorized representative.

If a member is exhausting their SNF, acute inpatient rehabilitation, or long-term acute care hospital benefit, the care manager must notify the member/member's authorized representative and the facility of the impending benefit exhaustion **15 calendar days prior** to the date the coverage will end. The care manager is also required to complete and fax an Extended Care Exhaustion of Benefit Notification Form to the Precertification Operations Department at 617-673-0955. Instructions and additional information regarding this process may be found here.

After receiving the form, the Precertification Operations Department uses the information to generate the Notice of Denial of Medical Coverage and Payment (NDMCP) (also known as the Integrated Denial Notice) for Tufts Health Medicare Preferred members or the Coverage Decision Letter for Tufts Health Plan SCO members and then faxes it to the facility to be delivered to the member. In addition to serving as Tufts Health Plan's formal notification of benefit exhaustion to the member, the NDMCP also provides the member with their appeal rights and the process to request an organization determination if the member disagrees with the benefit exhaustion.

Refer to the Member Appeals and Grievances chapter for additional information on appeals and grievances.

Prior Authorization Lists

For a complete listing of services requiring prior authorization, refer to the Tufts Medicare Preferred HMO and PPO Prior Authorization and Notification List and Tufts Health Plan SCO Prior Authorization List.

Notifications

Inpatient notifications are a process that makes Tufts Health Plan aware of all inpatient admissions and/or transfers to another facility. Inpatient notifications should be completed by the facility (where the member is admitted or scheduled to be admitted) or may be completed by the specialist.

Inpatient notification is required for the following services, in accordance with the notification lists for Tufts Medicare Preferred and Tufts Health Plan SCO found on our Prior Authorization Resources page.

- Inpatient acute hospital admissions, including acute rehabilitation and long-term acute care
- Inpatient BH/SUD admissions[2] **Note:** In addition to inpatient notification, providers are required to perform the Emergency Psychiatric Inpatient Admission (EPIA) Protocol Escalation Steps as outlined in the EPIA Protocol.
- Behavioral Health Partial Hospital Programs (PHPs) Skilled nursing facility (SNF) admissions
- Institutional long-term care and other services provided to members while at a custodial level of care

Note: For behavioral health and substance use disorder admissions, a concurrent review is required after the initial notification.

Inpatient Notification Process

Inpatient notification is a notification to Tufts Health Plan of utilization of inpatient services. Inpatient notification is required for all elective, urgent, and emergent hospital admissions, as well as acute rehabilitation and skilled nursing facility (SNF) admissions.

When an admission is reported, the inpatient notification process does the following:

- Verifies member eligibility (subject to retroactive reporting of disenrollment)
- Screens for coverage/benefit exclusions
- Identifies the facility as an in-network facility
- Verifies authorization for inpatient services outside of the Medicare Preferred HMO network.
- Identifies the facility as Medicare-approved, for services that must be performed in a Medicare-approved facility.

Tufts Health Plan verifies that covered services are directed by the PCP and/or the care manager. The Tufts Medicare Preferred or Tufts Health Plan SCO clinical team will also be notified so they can identify and intervene in any potential transition planning and/or discharge needs for the member. When the inpatient notification process is completed, an inpatient notification reference number is assigned and is used as a reference for adjudication of claims associated with a particular episode.

Inpatient Notification Requirements

Notification verifies that covered services are directed by the PCP and have appropriate approvals by the medical group. The Utilization Review Clinician is also notified so they can initiate concurrent review using Medicare coverage guidelines and InterQual criteria and can identify and intervene in any potential discharge needs for the member.

Admitting providers and hospital admitting departments share the responsibility of notifying Tufts Health Plan in accordance with the following timelines:

- Elective admissions requests must be submitted to the Precertification Operations Department or the UM Intake Department must be reported no later than **five business days prior** to admission to submit an authorization request (**Note:** SNF and LTAC admissions are not subject to this time frame)
- Urgent or emergent admissions must be reported within one business day following admission. This includes admissions that occur after hours, on weekends, or on holidays.

[2] There is a 190-day lifetime limit under Medicare for inpatient BH/SUD services provided in a private psychiatric hospital. This limit does not apply to inpatient BH/SUD services provided in a general hospital.

If a previously submitted inpatient notification of admission is cancelled, the Precertification Operations Department must be notified of that cancellation and the reschedule date, if applicable. If an admission changes from outpatient or emergency to inpatient, the provider must notify the Precertification Operations Department within one business day.

Submission Channels

Registered providers may submit inpatient notification 24 hours a day, 7 days a week using the Tufts Health Plan secure Provider portal or New England Healthcare EDI Network (NEHEN), and will receive a notification number upon submission in most cases.

Providers may also fax a completed Inpatient Notification Form to the Precertification Operations Department at the appropriate number listed on the form, 24 hours a day, 7 days a week. No other forms will be accepted. Incomplete forms will be returned to the submitting provider for completion and resubmission. Processing of the request will be delayed until all required information is submitted.

Confirmation of Inpatient Notification

Notifications submitted via the web will be confirmed on entry. Notifications submitted via fax are confirmed via the Provider Inquiry screen on the secure Provider portal.

If a provider wants to obtain an inpatient notification number after submitting a notification request via fax, they may access this information via the Provider Inquiry screen or contact Senior Product Provider Services at 800-279-9022.

Payment

Inpatient admissions for which an inpatient notification has been submitted according to the foregoing requirements are eligible for claim adjudication by Tufts Health Plan, as long as all other requirements have been met.

An inpatient notification number or the report of an admission does not guarantee payment. Denial of payment for late inpatient notification or lack of notification applies to the hospital claims. Tufts Medicare Preferred or Tufts Health Plan SCO network providers who are denied payment for late notification or lack of notification may not bill the member. To dispute a denial or request a claim review in writing, refer to the instructions outlined in the Claims Requirements, Coordination of Benefits and Payment Disputes chapter. Confirmation of inpatient notification, or receipt of an inpatient notification number, does not constitute authorization of the service or a guarantee of payment. Confirmation of inpatient notification, or receipt of an inpatient notification number may be used to appeal a denial of service for lack of notification or late notification.

Medicare-Approved Facility Requirement

Medicare has issued several National Coverage Determinations (NCDs) providing coverage for services and procedures of a complex nature, with the stipulation that the facilities providing these services meet certain criteria. These criteria usually require, in part, that the facilities meet minimum standards to ensure the safety of beneficiaries receiving these services. Certification as a Medicare-approved facility is required for performing the following procedures. For coverage criteria, refer to the Medicare National Coverage Determination Manual (NCD manual):

- Lung volume reduction surgery (LVRS): NCD manual, Section 240.1
- Carotid artery stenting (CAS): NCD manual, Section 20.7

Note: This requirement does not apply to CAS performed in a Medicare-covered Category B IDE study or post approval study.

- Ventricular assist device (VAD) destination therapy: NCD manual, Section 20.9
- Certain oncologic positron emission tomography (PET) scans in Medicare-specified studies: NCD Manual, Section 220.6.17

In addition to these procedures, there is also a long-standing requirement that all heart, heart-lung, liver, intestinal/ multivisceral, kidney, and pancreas transplants be performed at a Medicare-approved facility. The transplant work-up evaluation must also be performed in a Medicare-approved transplant facility. For more information regarding transplants, refer to the Transplant Facility Payment Policy.

To determine if a facility is Medicare-approved to perform a particular service, refer to the List of CMS-Approved Organ Transplant Programs available on the Quality, Certification and Oversight Reports (QCOR) website.

Not all in-network providers who perform these services are Medicare-approved. Tufts Health Plan will not compensate for services rendered at a non-Medicare-approved facility and network providers cannot hold the member liable for these services.

In addition to the Medicare-approved facility requirement, all plan inpatient notification, prior authorization, and in-network and out-of-network plan rules apply. Providers must be sure members are referred only to Medicare-approved facilities for these services. To the extent a medical group/PCP is involved in referring a member to a non-Medicare-approved facility, the provider will be financially liable for the associated costs. Because these services must be provided in a Medicare-approved facility to be covered, the costs of services in a non-Medicare-approved facility cannot be paid using Medicare funds.

PUBLICATION HISTORY

01/01/25	Updated “Inpatient Notification Requirements” section; updated “Payment section”; administrative edits
02/01/25	Added Referral Exclusions section; administrative edits
04/01/25	Updated “Inpatient Notification Requirements” section, updated language to note urgent or emergent admissions must be reported within one business day following admission; updated “Organization Determination Process” section; updated “Medical & Behavioral Health Coverage Prior Authorization Requests” section; administrative edits
05/20/25	Updated Sleep Studies section
01/01/26	Updated organization determination time frame for standard requests.
04/01/26	administrative edits
07/01/26	Updated Medical & Behavioral Health Coverage Prior Authorization Requests section to document scope of claim payment denial for services rendered without required prior authorization; updated URLs.