Referrals, Prior 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 Tufts Health Public Plans
  - Prior Authorization through Approved Vendors
- Inpatient Notification
  - Notification Requirements
- How to Submit Notification and Prior Authorization Requests
  - Forms
- Honoring Prior Authorizations from Previous Insurers
- Telehealth/Telemedicine Requirements

Referrals (Tufts Health Together with Cambridge Health Alliance (CHA) only)

Specialty services rendered outside of the Cambridge Health Alliance (CHA) ACO network require that a valid referral be on file with Tufts Health Public Plans. A referral verifies that the member's primary care provider (PCP) has authorized the specialty care.

The member's PCP must specify the number of visits and the type of specialty care required and follow their organization's standard procedures to submit a referral. Upon approval, Tufts Health Public Plans issues a referral number which, in most cases, is valid in the Tufts Health Public Plans system for one year or until the approved number of visits is exhausted.

Before providing care, specialists should check which members require a referral, or the status of an existing referral request, via the secure Provider portal. Specialists can also determine whether to request a referral by calling Provider Services at **888-257-1985**. Tufts Health Public Plans will not pay for specialist visits 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 via the secure Provider portal. 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 Together members do not require a PCP referral for services designated by MassHealth as exceptions to referral requirements as communicated and/or referenced in All Provider Bulletin 409.

Prior Authorizations

Prior authorization (prior approval) is required for certain services, drugs, devices, and supplies based on Tufts Health Public Plans medical necessity guidelines (MNGs), InterQual® criteria, or as managed by an approved vendor. Any request for services provided by out-of-network (OON) providers requires prior authorization. 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.

Use the Prior authorizations page on our provider website to navigate to resources to support the prior authorization process, including MNGs. While MNGs are available on the website, you may also request printed copies by calling the Provider Service Center. Refer also to the Utilization Management Guidelines and the Behavioral Health chapters of this Provider Manual for additional information.

Prior Authorizations through Tufts Health Public Plans

As a condition of payment, the ordering and treating provider must obtain approval for authorization requests. Refer to the appropriate MNG or Medical Drug MNG for prior authorization requirements. Authorization requests must include 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

Submit a prior authorization request at least five business days in advance of the scheduled procedure, service, or planned admission. Because prior authorization is a condition of payment, the rendering and/or interpreting provider should confirm that prior authorization has been obtained before the service is provided. Providers can check the status of a prior authorization request through the MHK Portal via the secure Provider portal.

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 Authorizations through Approved Vendors

Tufts Health Plan has partnerships with approved vendors to conduct utilization management for certain services. For details on current programs — including services, requirements, criteria, and information on how to request prior authorization — please refer to the Vendor programs page on our provider website.

Inpatient Notification

Inpatient notification is a process that notifies Tufts Health Public Plans of all inpatient admissions. Inpatient notification does not take the place of referral or prior authorization requirements for a service or procedure. 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. Dependent on facility payment contract, an authorization status will be assigned which may or may not include an authorized initial length of stay and an authorized end date for admissions. A concurrent review is required after the initial inpatient notification period.

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 for Tufts Health Together, Tufts Health One Care and RITogether
- Urgent or emergency admissions must be reported within two business days for Tufts Health Direct
- Urgent/emergent acute behavioral health admissions must be reported within 72 hours for Tufts Health Direct, Tufts Health Together and Tufts Health One Care
- For partial hospital programs (PHP), all in-network providers are required to provide notification to Tufts Health Plan after the first day/visit of treatment.
- In the event a Tufts Health One Care member seeks care in the emergency room, the hospital is required to notify the member's PCP, and/or the Integrated Care Team within one business day.
- Observation stays are an alternative to an inpatient admission that allows reasonable and necessary time to evaluate, stabilize and treat a member whose diagnosis and treatment is not expected to exceed 24 hours but may extend up to 48 hours before a decision can be made to discharge or admit to inpatient. Plan notification is not required for observation stays. If the member stays beyond 48 hours because they are admitted to inpatient, the provider must notify us within the following timeframes:
  - Tufts Health Direct: notification must be provided within 2 business days.
  - Tufts Health Together, Tufts Health One Care and RITogether: notification must be provided within 1 business day.
- Administratively Necessary Days (AND)- When a member is initially admitted, the stay may be approved based on medical necessity. However, during concurrent review, if the continued stay no longer meets medical necessity criteria, the plan may determine that the stay qualifies for Administratively Necessary Days (AND) and offer AND days to the facility.
  - If the facility accepts the AND days, the authorization will be updated and approved at the designated AND rate.
  - If the facility declines AND days, the request is forwarded to a Medical Director for a medical necessity review. If denied, a denial letter will be issued to both the facility and the member. The facility then has up to two (2) days from the date of the denial to reconsider and request acceptance of AND days.
  - If the facility chooses to accept AND days within this timeframe, the previously denied authorization line can be updated to reflect approval for AND days at the AND rate.
- For MA Together NICU admissions, the provider must notify us within 25 calendar days from birth. This notification timeframe allows time for the enrollment of the newborn.

Timely notification of admission is a requirement for payment. Late notification may result in denial of some or all of the inpatient days being requested.

How to Submit Notification and Prior Authorization Requests

Tufts Health Plan recommends submitting notification and prior authorization requests through the MHK portal on the secure Provider portal for ease and efficiency. For more information refer to the Tufts Health Public Plans MHK Portal User Guide.

Otherwise, submit by fax (see linked list for fax numbers by product).

Refer to the Vendor programs page on our website for submission processes to approved utilization management vendors.

Forms

Use the Inpatient Notification form for emergent and urgent admissions. No other forms will be accepted. 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.

Use the Massachusetts Standardized Prior Authorization Request Form or Rhode Island Medicaid Prior Authorization Form for most services, noting some services use a form specific to the type care. Please refer to the Forms page on the provider website.

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.

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.

Honoring Prior Authorizations from Previous Insurers (for Tufts Health Direct only)

Tufts Health Plan honors existing prior authorizations from in-network providers for 90 days from the member's new plan start date when a patient switches to Tufts Health Direct from another insurer. This applies to benefit-equivalent medical and behavioral health services, as well as pharmacy drugs and items. (Please note that medical drugs are not in scope and will require a new prior authorization.) During this 90-day continuity of care period, no additional medical necessity review is required.

To continue medical and behavioral health services without interruption, providers must validate that the member had an active authorization on file with their previous insurer by submitting a copy of the authorization letter. Alternatively, providers can submit the following documentation:

- Previous provider information
- Dates of service
- CPT codes
- Number of units or visits authorized
- Authorization number from the previous plan

This information should be submitted by fax to 888-415-9055 for medical services or 888-977-0776 for behavioral health services.

For pharmacy drugs, if an active authorization existed under the member's previous plan, providers are not required to submit proof of prior authorization. To request a 30-day prescription extension, call the Provider Service Center at 888-257-1985.

Telehealth/Telemedicine Requirements

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment, you must confirm that prior authorization has been obtained.

The same referral requirements apply for telemedicine services as for in-person visits. For more information about telehealth/telemedicine, refer to the Telehealth/Telemedicine Payment Policy.

For OON services, refer to the Referring to Out-of-network Providers Policy.

PUBLICATION HISTORY

01/01/24	Updated plan name to Tufts Health One Care; revised phone number
05/17/24	Replaced “National Imaging Associates, Inc./NIA” with “Evolent”; administrative edits
07/12/24	Updated link to Tufts Health One Care Behavioral Health Prior Authorization (PA) and Notification Grid
02/01/25	Administrative updates
02/14/25	Administrative updates
04/01/25	Updated Notification Requirements section; administrative edits
01/01/26	Updated Notification Requirements section with information on notification for One Care members for emergency room visits. Added information on prior authorization continuity of care period for Tufts Health Direct.
05/01/26	Updated Inpatient Notification section to add content about authorization status and notification requirements for observation stays and NICU. Removed content covered in *Utilization Management Guidelines* chapter. Revised structure to improve clarity.
07/01/26	Updated Referral section to align with updates to business process; updated Prior Authorizations section to document scope of claim payment denial for services rendered without required prior authorization; updated Notification Requirements section to add Administratively Necessary Days policy; other administrative edits to improve clarity