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
  - Subrogation
  - Recovery of overpayments
- Claims payment
  - Clean/complete claims
  - Explanation of Payment
  - Electronic Remittance Advice
  - Electronic Data Interchange (EDI) 277 CA
- Corrected claims
- Filing deadline for initial claims
- Claims appeals
- Payment adjustments
  - Returned funds
  - Retroactive denials
  - Member enrollment retroactivity
- Payment reduction
- Member responsibility
- Claims specifications
  - Completing the UB-04 form
  - Completing the CMS-1500 (02/12) 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, clean 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 section of this chapter for further information.

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.

Methods for claim submission

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

Electronic claims

Submit HIPAA-compliant Professional (837P) claims and Institutional (837I) claims directly to Tufts Health Public Plans 24 hours a day, seven days a week, using any of our e-channels — our secure portal and EDI options including NEHENNet, NEHEN or EDI-Direct, and others. Advantages of sending claims electronically include:

- Ability to submit claims attachments through our secure portal.
- No transaction fees (no cost per claim).
- The highest level of customer service support and response.
- Confirmation that your claim file has been received.
- Response reports within 24-72 hours (claim acceptance/rejection, including reject reason).
- Optional Electronic Remittance Advice (electronic version of an Explanation of Payment).
- Claim status availability using the 276/277 transaction, or online in our secure portal or NEHEN and NEHENNet.

Electronic data interchange (EDI) claims

Tufts Health Public Plans encourages direct electronic submission to the plan. 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, the claim will reject. If an electronic claim is rejected, resubmit a clean electronic claim no later than 60 calendar days from the date of service. For additional information, refer to Avoiding EDI Claim Rejections.

EDI submission commonly refers to claims transactions, but can be applied to other transaction types as well. Tufts Health Plan offers options for electronic referrals, online eligibility inquiries and claim status information.

For more information about electronic transactions or a setup request., visit the Electronic Services section of the Provider website or contact Tufts Health Plan's EDI Operations Department at EDI_operations@point32health.org.

Paper claims

Industry-standard paper claim forms should be submitted for the following instances:

- Corrected claims (e.g., bill type 135 [late charges] and bill type 137 [replacement claim])
- Claims requiring additional supporting documentation, such as operative or medical notes (e.g., COB/TPL documentation or invoices, etc.)
- Claims for provider payment appeals
- 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 provided by W.B. Mason. 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 calendar 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.
- Remove all staples from claims and supporting documentation.
- 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 and Rhode Island paper claim submissions
Tufts Health Public Plans – Paper Claims Submissions
P.O. Box 189
Canton, MA 02021-0189

Coordination of benefits (COB)

Tufts Health Public Plans 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. The Coordination of Benefits Payment Policy applies to all behavioral health services except for 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 Public Plans is payer of last resort for Tufts Health Together, Tufts Health RITogether and Tufts Health One Care. Providers must submit the claim(s) to all known available carriers as the primary insurer and receive an explanation of payment or equivalent, then submit the paper claim or electronic submission with the primary insurer's EOP to the secondary insurer (Tufts Health Public Plans). Do not take a cost-sharing amount up front.

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.
- 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 Public Plans to pay as a primary carrier.

For appropriate adjudication of COB claims, complete and accurate information from the primary payer claim is required. Claims submitted without the following information will be rejected.

Header/Line	Loop	Reference	Codes	Field
Header	2320	AMT		COB Payer Amount Paid (Total amount paid by the other insurer)
Header	2330B	NM1		Other Payer Name
Line	2430	SVD02	AMT	Monetary Amount (Line amount paid by the other insurer)
Secure Portal Online Adjustment Requests Line	2430	CAS01	CO 45 CO 96 CO 97	Claim Adjustment Group Code – Contractual Obligations (Amount not paid by the other insurer due to contractual obligations. If the Billed amount is not equal to the sum of the Paid, Deductible, Coinsurance and Copay, then CO 45, 96 or 97 and an amount must be provided.)
Line	2430	CAS01	PR	Claim Adjustment Group Code – Patient Responsibility (Patient responsibility after payment by the other insurer)
Header ***or*** Line	2330B ***or*** 2430	DTP		Claim Check or Remittance Date (Date that other insurer paid the claim/line.)

For additional information, please refer to the updated 837 Health Care Institutional & Professional Claims Transactions: Standard Companion Guide.

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.

When filing a paper claim, please also remember to:

- Submit the EOP from the primary insurer must be submitted with the claim when Tufts Health Public Plans is the secondary payer
- Submit the claim with the EOP from the primary insurer must be submitted to correct the initial claim submission address
- Carefully circle or asterisk the member's name on the EOP.
- Do not highlight the information. Highlighting causes the data to be blacked out in the scanning process.

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 Public Plans 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 Public Plans 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 Public Plans recovers its overpayments to providers.

Claims payment

Clean/complete claims

The Massachusetts Executive Office of Health and Human Services (MassHealth) defines 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. A claim is not clean if it comes from a provider who is under investigation for fraud or abuse, or if the claim under review for medical necessity. The Rhode Island Executive Office of Health and Human Services uses the term "complete claim" instead of "clean claim."

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) When applicable, Tufts Health Public Plans applies the appropriate PCP cost share based on the PCP specialty that the covering provider self-identifies for covering providers submitting claims for Tufts Health Direct members.
- 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 calendar 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
- "Clean claims" do not include a claim from a provider who is under investigation for fraud or abuse

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 non-capitated providers for both payment and tracking purposes.

Explanation of Payment (EOP)

The Tufts Health Public Plans explanation of payment (EOP) is a weekly report of all claims that have been paid or denied to the provider. EOPs may be viewed electronically by logging on to Payspan Health. If the explanation is unclear, contact Provider Services at **888-257-1985** (Massachusetts) or **844-301-4093** (Rhode Island).

Electronic Remittance Advice (ERA)

Tufts Health Public Plans offers the 835 health care claim payment advice through Payspan Health. This electronic remittance advice (ERA) includes paid and denied claims submitted either via Electronic Data Interchange (EDI) or on paper forms and uses HIPAA standard reason codes.

Registration and support questions for retrieving the ERAs from PaySpan Health and for ongoing support is handled by the Payspan Provider Services team who the provider may contact by email at providersupport@payspanhealth.com or by phone at 877-331-7154, option 1 (Mon-Fri, 8 a.m. – 8 p.m. ET).

EDI 277CA

For claims submitted via direct 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 calendar days from the date of the 277CA. If a claim is submitted within 60 calendar days from the date of the 277CA, but 90 calendar days or more past the date of service, resubmit on paper with a copy of the Tufts Health Public Plans 277CA. The claim may be denied if timely filing limits and these instructions are not followed.

For more information, refer to the Standard Companion Guide.

Corrected claims

Corrected claims are submitted when the original claim has missing, inaccurate or invalid data. Providers may submit corrected claims electronically or through paper claim forms, in accordance with applicable industry standard guidelines such as the National Uniform Claim Committee (NUCC) billing guidelines, HIPAA EDI standards, and/or state and federal requirements for providers.

Providers may submit corrected claims electronically through our secure portal, EDI submission process, or on paper, as outlined below.

Secure portal online submissions

Registered providers may submit corrected claims using our secure portal. Follow the instructions when submitting online claim adjustments. After the transaction has been completed, providers will receive a tracking number as confirmation that the adjustment has been received.

Please be aware that some claims may not be adjustable on the secure portal. If a claim cannot be adjusted via the portal, a message will appear indicating the claim is not adjustable. In this instance, claim adjustments may be submitted on paper.

EDI submissions

To submit a corrected claim via EDI:

- Enter the frequency code (third digit of the bill type for institutional claims; separate code for professional claims) in **Loop 2300, CLM05-3** as one of the following:
  - **7** (corrected claim)
  - **5** (late charges)
  - **8** (void or cancel a prior claim)
- Enter the last 8 digits of the original claim number in Loop 2300, REF segment with an F8 qualifier. For example, for claim #000123456789, enter **REF*F8*23456789**.

Please note that some claims may not be adjustable via EDI. If you receive a rejection report, please submit the claim adjustment on paper.

Paper submissions

A Request for Claim Review Form must be submitted with the corrected paper claim. To submit a paper corrected claim via paper:

- Print out 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 EOP remit advice from the original 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 for initial claims

The standard filing deadlines are as follows:

- 90 days from the date of service for professional (CMS-1500) claims
- 90 days from the claim end date when interim billing is allowed, for example for certain inpatient stays at a rehabilitation facility, long term acute care hospital or skilled nursing facility, and certain outpatient services with hospice or home health care agency
- 90 days from date of hospital discharge when interim billing is not allowed

The timely filing window begins on the date entered in the 'to' date in Box 24A for professional (CMS-1500) claims or in the 'through' date in Box 6 for institutional (UB-04) claims.

Tufts Health Public Plans will deny claims submitted after the filing deadline for failure to meet timely filing requirements. Members may not be billed for services that have been denied for exceeding the filing deadline. In addition, timely filing deadlines are as follows:

If the provider is…	Submission Timeline
Submitting a claim for a COB or TPL	Standard: 60 calendar days from the date on the original primary carrier’s EOP or third-party determination letter Exception — Tufts Health Direct mental health or substance use disorder claims: 365 days from the date of the primary insurer’s denial
Submitting a claim with a retraction statement	60 calendar days from the date of the other carrier’s retraction statement

The acceptable formats for filing proof of electronic submissions are either a rich text format (RTF) document or a 277CA 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.

Claims appeals

If the provider disagrees with Tufts Health Plan's decision regarding the denial or reimbursement of a claim, the provider has the right to file an appeal, in which the claim may be reviewed for reconsideration.

Types of appeals include, but are not limited to: duplicate claims, referral denial, notification or prior authorization denials, compensation or reimbursement, and unlisted procedure code denials.

Tufts Health Public Plans will consider payment appeals and any other adjustment requests for claims with dates of service within the current year, and the two previous calendar years from the EOP date. To be considered for review, appeals/requests for review must be submitted within 60 calendar days of the date of the Explanation of Payment on which the claim originally denied. Disputes received after that timeframe will not be considered.

Tufts Health Public Plans will enforce a maximum limit of two levels of appeals.

Appeals related to timely filing limit

Tufts Health Public Plans will not review or consider appeals submitted for claims denied for exceeding the timely filing limit — unless they meet one of the following exception criteria outlined by MassHealth in accordance with G.L. c. 118E, § 38:

- a medical service was provided to a person who was not a member on the date of service, but was later enrolled as a member for a period that includes the date of service
- a medical service was provided to a member who failed to inform the provider in a timely fashion of the member's eligibility for MassHealth
- other exceptions that are expressly authorized by the MassHealth agency pursuant to a MassHealth transmittal letter or provider bulletin

Please submit documented proof of one of the applicable exceptions with any request for review related to claims denied for lack of timely filing.

Late charges

Claims for services submitted after initial submission of the claim are considered late charges. Late charges applied to Tufts Health Public Plans claims must be submitted within 90 calendar days of the date of service (for outpatient claims) or date of discharge (for inpatient or institutional claims.)

Submitting proof of timely filing for other types of appeals

For other types of appeals, please submit documented proof that the claim was filed within the timely submission deadlines:

- For **EDI claim submissions**, the following are considered acceptable proof of timely submission:
  - For claims submitted though a clearinghouse, 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

Submitting your appeal

Tufts Health Public Plans providers can submit a claims appeal using the claims adjustment tool on the secure portal or on paper.

Paper payment appeals should be submitted to:

Tufts Health Public Plans
Attn: Provider Payment Disputes
P.O. Box 524, Canton, MA 02021

Appeals must include the following:

- a copy of the EOP
- appropriate documentation
- a completed Request for Claim Review Form
- only one claim number per form. Multiple claim numbers on one form are not accepted.

To expedite the review process, when submitting hospital records, please include the page numbers for the history, physical and discharge summaries.

Please include the following documentation in addition to the documentation noted above, based on appeal type:

- **Claims denied for no referral:** For all claims paid at the unauthorized benefit level or denied for no referral, attach a copy of the referral or the referral number to the EOP and circle the claim number to be adjusted.
- **Claims denied for lack of prior authorization or inpatient notification**
  - Submit a typed, case-specific letter of appeal with the necessary supporting clinical documentation.
  - Attach a copy of the claim
  - Include pertinent information in your appeal: an explanation as to why the proper procedure to obtain inpatient notification or prior authorization was not followed or an explanation and evidence of how the proper procedure was followed. Tufts Health Public Plans considers relevant supporting documentation to be a copy of the provider's original information faxed/submitted to Tufts Health Public Plans and relevant medical records. If authorization is applicable, please include the authorization number received verbally or in writing from Tufts Health Public Plans.
- **Compensation/reimbursement appeals**
  - Submit a typed letter of medical necessity (LOMN) explaining why the service was necessary.
  - Attach the EOP and circle the claim to be reviewed.
  - Submit all supporting documentation in the form of invoices, operative notes, office notes, radiology/pathology report(s) or any necessary medical record information for a fee adjustment request.
- **Appeals for unlisted procedure code denials**
  - Appeals for denials resulting from the billing of an unlisted procedure code must include operative notes that identify the service(s) performed associated with the unlisted code.
  - Providers submitting unlisted or miscellaneous drug codes not currently covered by a HCPCS code must include an invoice with the claim that includes the drug name, appropriate National Drug Code (NDC) number and dosage.

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 EOP. 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.

Tufts Health Public Plans does not initiate adjustments more than 24 months from the original Tufts Health Public Plans EOP date for medical benefit claims. For mental health or substance use disorder claims, retroactive denial or retraction of payment is not allowed after 12 months from the original submission date. Exceptions to the time limits include the following:

- Fraud
- Adjustment with another insurer/administrator/payer
- The claim payment was incorrect because the provider or the insured was already paid for the services identified in the claim
- The health care services identified in the claim were not delivered by the provider
- The claim payment is the subject of legal action
- Payment for services covered by Title XVIII, XIX or XXI of the Social Security Act

Returned funds and disclosure for overpayments and/or improper payments

In the event of overpayments and/or improper payments, providers must complete and submit the Returned Funds Form and include any pertinent supporting documentation. Submitting funds without this information may delay the reallocation process.

In accordance with MassHealth requirements, overpayments for Tufts Health Together claims must be returned within 60 calendar days of the overpayment identification and the provider must notify Tufts Health Public Plans in writing of the overpayment reason. Tufts Health Public Plans will report the notification to EOHHS in the Self-Reported Disclosures report.

Retroactive denials (Tufts Health Direct, Tufts Health Together and Tufts Health One Care)

Tufts Health Public Plans 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 Public Plans sends notification to behavioral health providers in Massachusetts and allows 30 calendar 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 calendar days (15 calendar days for coordination of benefits or worker's compensation claims), the claim will be readjusted and processed.

Member enrollment retroactivity (Tufts Health Direct, Tufts Health Together and Tufts Health RITogether)

Tufts Health Public Plans makes retroactive changes to member enrollment data based solely on information received from an applicable governing agency and re-adjudicates claims affected by these changes.

Tufts Health Public Plans identifies and re-adjudicates claims processed during the retroactive period. If another insurer has denied a claim for services rendered during the retroactive period, providers must submit the claim to Tufts Health Public Plans along with a copy of the other insurer's explanation of payment. Tufts Health Public Plans only reimburses services covered under the member's plan. If prior authorization is required for services rendered during the retroactive period, providers must submit medical documentation to obtain authorization.

Payment reduction

Tufts Health Public Plans may reduce payment when two or more services are billed for the same member, on the same date of service, from the same family of codes.

Reductions may result due to:

- Absence of modifiers
- Multiple procedures
- Clinical guidelines
- Other incorrect coding issues

Billing instructions

Unless otherwise stated, Tufts Health Public Plans follows industry-standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers, and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules.

Payment reduction identification

Incorrect billing/payments are identified through multiple pre- and post-payment review methods, including proprietary web-based software and internal and external claims audits.

Tufts Health Public Plans processes claims according to applicable provider agreements, payment policies, and industry-standard coding guidelines.

Process for making reductions

Tufts Health Public Plans applies payment reductions when providers perform two or more related procedures for the same member on the same date of service. Providers are notified via an EOP or 835 file. The EOP identifies the adjusted amount, member name, member ID number, claim number, provider name, and correct payment amount.

Time-limit for payment reductions

Reductions are not initiated more than 24 months after the original Tufts Health Public Plans EOP date without agreement from the provider, unless the adjustment is related to fraud, waste, and/or abuse.

Compensation/reimbursement information

Providers are compensated according to the applicable network contracted rates and applicable fee schedules.

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.

Members may not be billed for services that have been 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. In accordance with the Consolidated Appropriations Act, 2021 Tufts Health Direct members cannot be balance billed and are only responsible for their in-network cost share for emergency services or services rendered by a non-participating provider at an in-network facility. Where a member has completed a consent form from a provider which satisfies the requirements of the Consolidated Appropriations Act, the member may be held financially liable for certain non-ancillary services rendered by a non-participating provider at an in-network facility.

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.

Providers agree to not seek or accept payment from any member of Tufts Health Together or Tufts Health RITogether for any covered service rendered, and providers agree to not make any claim against or seek payment from EOHHS for any covered service rendered to a member of Tufts Health Together or Tufts Health RITogether. Instead, providers agree to look solely to Tufts Health Public Plans for payment with respect to covered services rendered to members of Tufts Health Together 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, 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.

For Tufts Health One Care members, a provider may not charge members for any service that:

- is not a medically necessary covered service or non-covered service
- for which there may be other covered services or non-covered services that are available to meet the member's needs
- that the provider did not explain the items above

Members cannot be held liable to pay for of any such services in which the provider did not discuss the above. The provider must document compliance with this provision.

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.
- Provide medical records to review upon request, for payment accuracy.
- **RITogether member claims:** Submit the attending/rendering physician's name, NPI and Rhode Island license number on the claim form.

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.

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

Mandatory fields are marked with 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.

Box	Field Name	MA	RI	Instructions
1	Untitled	**M**	**M**	Enter the name and address of the hospital/provider.
2	Untitled	**M**	**M**	Enter the address of payee (if different from the address in box 1).
3a-b	Patient control number	**O**	**M**	3a: Enter member account number. 3b: Enter medical record number.
4	Type of bill	**M**	**M**	Enter the 3-digit code to indicate the type of bill. Claim will be returned if the type of bill is missing.
5	Federal tax number	**M**	**M**	Enter the hospital/provider federal tax ID. Claim will be returned if federal tax ID is not on the claim.
6	Statement covers period	**M**	**M**	Enter the beginning and ending service dates of the period covered by this bill (MMDDYY). These dates are necessary on all claims. • For services received on a single day, both the “from” and “through” dates will be the same. • If the “from” and “through” dates differ, these services must be itemized by date of service (see Box #45).
7	Untitled	**N/A**	**N/A**	Not applicable
8a	Patient ID and name	**M**	**M**	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.
9a-e	Patient address	**M**	**M**	Enter the member’s mailing address from the member record.
10	Birth date	**M**	**M**	Enter the member’s date of birth (MMDDYYYY).
11	Sex	**M**	**M**	Indicate Male (M) or Female (F).
12	Admission date	**M**	**M**	Enter date of admission/visit. This field is optional for outpatient services (except home health).
13	Admission hour	**M**	**M**	Enter the time (hour: 00–23) of admission/visit. This field is optional for outpatient services.
14	Admission type	**M**	**M**	Enter the code indicating the type of this admission/visit This field is optional for outpatient services.
15	Source of admission (SRC)	**M**	**M**	Enter the code indicating the source of this admission/visit.
16	Discharge hour	**M**	**M**	Enter the time (hour: 00–23) the member was discharged This field is optional for outpatient services.
17	STAT (Patient discharge status)	**M**	**M**	Enter the code to indicate the status of the member as of the through date on this billing. The member status cannot be member.
18-28	Condition codes	**O**	**O**	Enter the code used to identify conditions relating to this bill that can affect payer processing.

Box	Field Name	MA	RI	Instructions
29	Accident state	**M**	**M**	Enter the state in which accident occurred.
30	Accident Date	**N/A**	**N/A**	Date the accident occurred, if applicable (MMDDYY)
31-34	Occurrence codes and dates	**M***	**M***	Enter the code and associated date defining a significant event relating to this bill that can affect payer processing. Tufts Health Public Plans requires all accident-related occurrence codes to be reported.
35-36	Occurrence span code and dates	**O**	**M**	Enter a code and the related dates that identify an event that relates to the payment of the claim.
37	Untitled	**N/A**	**N/A**	Not applicable
38	Untitled	**N/A**	**N/A**	Not applicable
39-41	Value codes and amounts	**N/A**	**M***	• Enter up to three value codes to identify circumstances that may affect processing of this claim, if applicable. • In the amount box, enter the number, amount, or UCR value associated with that code.
42	Revenue code	**M**	**M**	Enter the most current uniform billing revenue codes.
43	Revenue description	**M**	**M**	Enter a narrative description that describes the services/procedures rendered. Use CPT-4/HCPCS definitions whenever possible.
44	HCPCS/rates	**M**	**M**	For outpatient services, use CPT/HCPCS codes for procedures, services and supplies. • Do not use unlisted codes. If an unlisted code is used, then supporting documentation must accompany the claim. • Do not indicate rates.
45	Service date	**O**	**O**	Enter all of the dates of service with each date of service reported separately using MMDDCCYY. Please note that this is required for all outpatient claims
46	Units of service	**M**	**M**	Enter the units of service rendered per procedure.
47	Total charges	**M**	**M**	Enter the charge amount for each reported line item. A negative amount will not be accepted.
48	Noncovered charges	**O**	**M**	Enter any noncovered charges for the primary payer pertaining to the revenue code.
49	Untitled	**N/A**	**N/A**	Not applicable
50a-c	Payer	**M**	**M**	List all other health insurance carriers on file. If applicable, attach an EOB from another carrier.
51	Health plan ID	**O**	**O**	List provider number assigned by health insurance carrier.
52	Rel. info (release of information)	**N/A**	**M**	Enter “Y” for yes or “N” for no.
53	Asg ben (assignment of benefits)	**N/A**	**M**	Enter “Y” for yes.

Box	Field Name	MA	RI	Instructions
54	Prior payments (payer and patient)	**M**	**M**	Report all prior payment for claim. Attach EOB from another carrier, if applicable. A negative amount will not be accepted.
55	Est. amount due	**N/A**	**N/A**	Not applicable
56	NPI	**M**	**M**	Enter valid NPI number of the servicing/rendering provider.
57a-c	Other Prv ID (another provider ID)	**N/A**	**N/A**	Not applicable
58a-c	Insured's name	**M**	**M**	Enter the name of the individual who is carrying the insurance.
59	P. Rel (patient's relationship to insured)	**M**	**M**	Enter the code indicating the relationship of the member to the identified insured/subscriber.
60a-c	Insured's Unique ID (health insurance claim/ID #)	**M**	**M**	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.
61a-c	Group name	**M**	**O**	Enter the name of the group or plan through which the insurance is proved to the insured.
62a-c	Insurance group number	**M**	**O**	Enter the ID number, control number or code assigned by the carrier or administrator to identify the group under which the individual is covered.
63a-c	Treatment authorization code	**O**	**M**	Enter the Tufts Health Public Plans referral/authorization number for outpatient surgical day care services.
64a-c	Document control number	**N/A**	**N/A**	Not applicable
65a-c	Employer name	**M***	**M***	Enter the name of the employer for the individual identified in box 58.
66	DX version qualifier	**N/A**	**N/A**	Not applicable
67a-q	Principal diagnosis code	**M**	**M**	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.
68	Other diagnosis codes	**M***	**M***	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.
69	Admit Dx	**M**	**M**	Enter the ICD-CM diagnosis code provided at the time of admission as stated by the provider.
70	Patient reason Dx	**O**	**M**	Enter the ICD diagnosis code that describes the patient's reason for visit.
71	PPS code (prospective payment system)	**O**	**O**	Optional
72	ECI (external cause of injury code)	**M***	**M***	Enter the ICD-CM code for the external cause of an injury, poisoning or adverse effect.
73	Untitled	**N/A**	**N/A**	Not applicable

Box	Field Name	MA	RI	Instructions
74a-e	Principal procedure code (code and date)	**M**	**M**	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).
75	Unlisted	**N/A**	**N/A**	Not applicable
76	Attending physician	**M**	**M**	Enter the ordering practitioner's NPI, last name, first name and middle initial.
77	Operating physician	**M***	**M***	Enter the name and NPI number of the practitioner who performed the principal procedure.
78-79	Other provider types	**O**	**O**	Optional
80	Remarks	**O**	**O**	Examples: "COB-related" or "billing for denial purposes only"
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: – 76a – 81CCa – 77b – 81CCb – 78c – 81CCc – 79d – 81CCd

Figure 2: CMS-1500 (02/12) claim form specifications

Mandatory fields are marked with 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.

Box	Field Name	MA	RI	Instructions
1	Type of insurance coverage	**O**	**O**	• Check the appropriate box to show health insurance coverage applicable to this claim. This field is optional. • If the *Other* box is checked, complete Box #9.
1a	Insured's ID number	**M**	**M**	• 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. • Inaccurate or incomplete ID numbers will delay processing the claim and can result in a denial.
2	Patient's name	**M**	**M**	Enter member's last name, first name and middle initial, if any, as shown on the member's Tufts Health Public Plans ID card.
3	Patient's birth date and sex	**M**	**M**	Enter member's date of birth and sex.
4	Insured's name	**M**	**M**	• If the insured and the member are the same person, enter SAME. • If the insured and the member are not the same person, enter the name of the insured (last name, first name and middle initial).

Box	Field Name	MA	RI	Instructions
5	Patient's address	**M**	**M**	Enter the member's permanent mailing address and telephone number: • On the first line, enter the street address. • On the second line, enter the city and state. • On the third line, enter the zip code and telephone number.
6	Patient relationship to insured	**M**	**M**	Check the appropriate box for the member's relationship to the insured (self, spouse, child, other).
7	Insured's address	**M**	**M**	If the insured's address is the same as the member's address, enter SAME. 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.
8	Reserved for NUCC use	**O**	**O**	No entry required
9	Other insured's name	**M**	**M**	• If the insured is the same as the person in Box #4, enter SAME. • 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).
9a	Other insured's policy or group number	**M**	**M**	If the other insured is covered under another health benefit plan, enter the other insured's policy or group number.
9b	Reserved for NUCC use	**O**	**O**	No entry required
9c	Reserved for NUCC use	**O**	**O**	No entry required
9d	Insurance plan name or program name	**M**	**M**	Enter the other insured's insurance plan name or program name and attach the other insurer's EOB to the claim.
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. 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.

Box	Field Name	MA	RI	Instructions
11b	Other claim ID	**M**	**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.
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.

Box	Field Name	MA	RI	Instructions
17	Name of referring provider or other source	**O**	**M**	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
17a-b	ID number of referring physician	**O**	**M**	• 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
18	Hospitalization dates related to current services	**M**	**O**	Enter the admission and discharge dates when a medical service was furnished as a result of, or subsequent to, a related hospitalization.
19	Additional claim information (designated by NUCC)	**O**	**O**	Enter additional claim information.
20	Outside lab	**O**	**O**	Check YES or NO to indicate if laboratory work was performed outside the practitioner's office.
21	Diagnoses	**M**	**M**	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.
22	Resubmission code	**O**	**M***	This item identifies a resubmission code.
23	Prior authorization number	**O**	**M***	If applicable, enter the inpatient notification number.
24a	Date(s) of service	**M**	**M**	• Enter the dates for each procedure in MMDDYY format, omitting any punctuation. • Itemize each date of service. • Do not use a date range.
24b	Place of service	**M**	**M**	Enter the appropriate place of service code.
24c	EMG	**N/A**	**M***	Check this item if the service was rendered in a hospital or emergency room.
24d	Procedures, services or supplies	**M**	**M**	Enter valid CPT/HCPCS procedure codes and any modifiers.

Box	Field Name	MA	RI	Instructions
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. 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. 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.

Box	Field Name	MA	RI	Instructions
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.

PUBLICATION HISTORY

01/01/24	Updated plan name to Tufts Health One Care
03/01/24	Updated box 45 in the UB-04 Claim Form section to optional in Massachusetts
04/01/24	Updated Corrected Claims section; administrative edits
04/04/24	Administrative edits to Corrected Claims section
08/14/24	Added table in Coordination of Benefits section; updated Coordination of Benefits section regarding electronic submission of attachments; and updated Note in Submitting Electronic Claims section
08/26/24	Administrative edits to Provider Portal links
09/01/24	Updated Instructions column for Boxes 12, 13,14, and 16 in the UB-04 Claim Form Specifications table to include outpatient services.
11/14/24	Updated links; administrative edits
01/01/25	Updated Filing Deadline Adjustments section; updated Provider Payment Disputes section to note a maximum limit of two levels of appeals.
02/01/25	Updated the chapter with information in the archived Provider Payment Dispute Policy, including the following sections: “Coordination of Benefits,” “Filing Deadline,” “Provider Payment Appeals” and “Payment Adjustments”; added a “Payment Reduction” section with information from an archived “Payment Reduction” Payment Policy”; administrative edits
03/07/25	Updated links; administrative edits
04/02/25	Administrative updates to “Corrected Claims,” “Filing Deadline for Initial Claims,” and “Claims Appeals”
01/01/26	Updated row 17 in the Figure 1: UB-04 Claim Form Specifications table regarding interim billing; product references; administrative edits.
11/01/26	Updated Filing Deadline for Initial Claims section to add specificity by claim type and plan rules; added time limits and exceptions for retraction of claims
11/15/26	Updated links to online resources; administrative edits