Providers

General Responsibilities

Tufts Health Plan providers agree to comply with all state or federal laws and regulations applicable to Tufts Health Plan products in arranging or providing for services to any member.

Providers must also comply with Tufts Health Plan's contractual obligations, such as requests for information necessitated by government contracting requirements.

Contracted providers must accept the applicable financial arrangements set forth in the financial exhibits of their contracts as full compensation for such health services. Contracting providers may only collect applicable deductibles, coinsurance, or copayments from members, as specifically provided in the applicable product description, as well as fees for services that the provider provides on a fee-for-service basis that are not covered by the applicable product description where the member has specifically agreed in writing in advance to pay these noncovered services.

Note: Tufts Health Plan does not allow the use of a so-called "waiver" to circumvent or override the provider's obligations under the applicable participation agreement about services covered under the member's plan. By way of illustration and not limitation, the waiver is of no validity when applied to missed filing deadlines, provider's failure to comply with authorization requirements and/or attempts to collect payments other than applicable copayments, coinsurance or deductibles.

Use of noncontracting labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, Tufts Health Plan may hold the ordering provider accountable for any inappropriate behavior on the part of the noncontracting lab that has been selected.

Telehealth Responsibilities

Providers shall adhere to the following standards when delivering medically necessary care via telehealth:

- For an initial appointment with a new patient, review the patient's relevant medical history and any relevant medical records with the patient before initiating the delivery of any service
- For existing provider-patient relationships review the patient's medical history and any available medical records with the patient during the service
- Prior to each patient appointment, ensure the same services standards can be delivered as in-person care and in compliance with the provider's licensure regulations and requirements, programmatic regulations, and performance specifications related to the service (e.g., accessibility and communication access)
- If the appropriate standard of care or other requirements for providing requested care via telehealth cannot be met, make this determination prior to the delivery of treatment, notify the patient of this, and advise the patient to instead seek appropriate in-person care
- Ensure patients the same rights to confidentiality and security as provided in face-to-face services, to the extent feasible, and inform patients of any relevant privacy considerations prior to providing services via telehealth
- Follow consent and patient information protocols consistent with the protocols followed during in-person visits as well as any telehealth specific protocols
- Inform patients of the location of the provider rendering services via telehealth (i.e., distant site) and obtain the location of the patient (i.e., originating site)
- Inform the patient how to see a clinician in-person in the event of an emergency or otherwise

Uniformed Services Family Health Plan

US Family Health Plan is a health plan sponsored by the Department of Defense, serving eligible military families, for which Tufts Health Plan acts as a subcontractor in providing administrative services. US Family Health Plan members are

easily identified with the US Family Health Plan logo on the identification card. Providers rendering services to US Family Health Plan members are subject to TRICARE reimbursement policies and regulations. For information on TRICARE's reimbursement policies and regulations, refer to the TRICARE Reimbursement Manual. For more information on Tufts Health Plan's relationship with US Family Health Plan, refer to the Uniformed Services Family Health Plan overview page.

Provider Newsletter

Tufts Health Plan produces *Insights and Updates for Providers,* a monthly newsletter for providers, hospital administrators and ancillary providers in the Tufts Health Plan network. The newsletter is Tufts Health Plan's primary vehicle for providing 60-day notifications and other critical business-related information to providers.

Tufts Health Plan distributes the newsletter by email and via the News section of the Point32 Health Provider website. To receive the newsletter by email, providers must register by completing the online registration form.

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

Note: Providers who have registered to receive the newsletter by email but are still not receiving it must check their spam folder or check with their organization's system administrator to ensure the organization's firewall is adjusted to allow for receipt of the newsletter.

Fraud, Waste and Abuse

Providers must comply with federal and state laws and regulations designed to prevent, identify, and correct fraud, waste and abuse (FWA). Tufts Health reserves the right to audit claims for FWA. If a provider becomes aware of a questionable practice by a Tufts Health Plan provider or member that may indicate possible health care fraud, Tufts Health Plan has established a hotline to help Tufts Health Plan's members, providers and vendors who have questions, concerns and/or complaints related to possible fraudulent, wasteful, or abusive activity.

Providers may call the Tufts Health Plan Fraud Hotline to report concerns 24 hours a day, 7 days a week at 877-824-7123. Callers may self-identify or choose to remain anonymous. Information provided will be forwarded within one business day to the Tufts Health Plan Compliance Department.

Confidentiality of Member Medical Records

Tufts Health Plan requires that providers comply with all applicable laws relating to the confidentiality of member medical records, including, but not limited to, the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA).

To meet Tufts Health Plan confidentiality requirements, providers must do the following:

- Maintain medical records in a space staffed by office personnel
- Maintain medical records in a locked office and/or password-protected electronic file(s) when staff is not present
- Prohibit unauthorized review and/or removal of medical records
- Maintain and adhere to policies and procedures regarding patient confidentiality

Tufts Health Plan monitors providers' compliance with its confidentiality policies through clinical quality reviews and audits.

Tufts Health Plan may require providers, upon request, to provide member medical information and medical records for the following purposes:

- Administer Tufts Health Plan's health benefit plans, such as claims payment, coordination of benefits,

subrogation, enrollment, eligibility verification, reinsurance, and audit activities
- Manage care, including but not limited to utilization management (UM) and quality improvement (QI) activities
- Carrying out member satisfaction procedures described in member benefit documents
- Participate in reporting on quality and utilization indicators, such as Health Plan Employer Data and Information Set (HEDIS®)
- Comply with all applicable federal and state laws

Providers are responsible for obtaining any member consents or releases that are necessary beyond those that Tufts Health Plan has already acquired through the enrollment process or the member benefit documents. Tufts Health Plan maintains and uses member medical information in accordance with Tufts Health Plan's confidentiality policies and procedures.

Note: A member consent/authorization to release medical records to Tufts Health Plan for the purpose of an appeal is not necessary.

Medical Record Charges

Tufts Health Plan periodically requests medical records from providers for a variety of business reasons. Providers are responsible for producing copies of the requested medical record(s) within a timeline consistent with industry standards and within reasonable time frames to meet appeals and grievance, accreditation and/or government or regulatory timelines. Medical records will be provided at no additional cost to Tufts Health Plan.

The use of a third-party vendor to produce copies of medical records is the responsibility of the provider who has contracted with said vendor. The provider will intervene if a vendor withholds any medical records for payment.

Quality Improvement (QI) Activities

Providers/practitioners must cooperate with the Tufts Health Plan's QI activities to:

- Improve the quality of care and services and the members' experiences, including the collection and evaluation of data and participation in Tufts Health Plan's QI programs
- Allow Tufts Health Plan to collect and use performance measurement data
- Assist Tufts Health Plan in improving clinical and service measures

Directory Accuracy and Suppression of Unverified Provider Information

Introduction

Tufts Health Plan is committed to maintaining an accurate provider directory in order to provide our members with the information they need to choose and contact providers. This commitment supports requirements from the Centers for Medicare & Medicaid Services and other regulatory bodies that health plans maintain and update data in provider directories. Tufts Health Plan relies on providers to review their data and notify us of any changes as they happen to ensure that members have access to accurate information.

Notification Requirements

Notification of changes to practice locations, availability to see members, including whether there is a waitlist of 4 weeks or less, and other changes that affect the content or accuracy of the Tufts Health Plan Provider Directory should be submitted **at least 30 days** prior to the change. You may review all of your practice information via Tufts Health Plan's online Provider Directory. If you need to update any information, you may do so in one of several ways. If you are an

individual practitioner, you can update your information using the CAQH Provider Data Portal (formerly known as CAQH ProView), a tool offered through a partnership with HealthCare Administrative Solutions (HCAS), which offers a centralized process for providers to review and report changes to directory data. More information can be found on the HCAS website.

Alternatively, you may submit your change via a Medical or Behavioral Health Provider Information Form to Provider_Information_Dept@point32health.org

Enrollment of Practice Locations

Practice locations that should be submitted for enrollment and inclusion in the Tufts Health Plan provider directory are locations where the provider regularly provides patient care. Locations in which a provider may occasionally render care — such as interpretation of tests or inpatient-only care — should be specified as such on the Provider Information Form (Medical or Behavioral Health) and/or CAQH Provider Data Portal to ensure the location information is included in the provider's demographic profile, but not in the provider directory.

Practitioners who practice only in a hospital or urgent care setting should be identified as such on the Provider Information Form and/or in CAQH Provider Data Portal in order to be properly enrolled.

Suppression of Unverified Provider Information/Provider's Duty to Verify

Tufts Health Plan reserves the right to suppress provider information from the directory for a variety of reasons. If Tufts Health Plan becomes aware that any of the provider's information on the directory is inaccurate, we will conduct a review to validate and obtain accurate information. This review may include outreach to the provider's office. Because Tufts Health Plan is required to quickly resolve potential inaccuracies or suppress the information, it is important to respond to any inquiries in a timely manner to avoid suppression.

To assist with maintaining accurate and up-to-date data, every 90 days providers must verify and attest to the accuracy of their directory data, including practice location, practice phone, digital contact information (if applicable), etc. via the CAQH Provider Data Portal. Failure to re-attest to this directory data within this timeframe may result in your data being suppressed from our provider directory.

For any further questions, call Provider Services at 888-884-2404.

Provider Inactivity and Administrative Termination of Network Providers

Introduction

Up-to-date provider data, including but not limited to the information displayed in directories, is of vital importance for health care consumers, health plans, and other providers — and Tufts Health Plan relies on providers to support maintaining information that accurately reflects network availability. Tufts Health Plan is required by the Centers for Medicare and Medicaid Services, National Committee for Quality Assurance, and federal and state laws to maintain up-to-date and accurate provider network information and provider directories.

Administrative Termination of Providers

We view lack of services rendered to our members by participating providers as an indicator of a potential data inaccuracy.

As a result, Tufts Health Plan systematically reviews our provider network information on an annual basis, and may administratively terminate providers who have not provided services to our members for the immediate prior two years.

Prior to termination, Tufts Health Plan will use our best efforts to contact the provider and/or the provider organization the provider is affiliated with, to request confirmation of whether the provider would like to remain a participating provider despite their inactivity. If unable to verify the provider's network information, Tufts Health Plan may proceed with termination.

Ensuring Renewed or Continued Plan Participation

Please contact directory_inaccuracy_research@point32health.org if you receive a termination notice for inactivity but wish to remain a participating provider. A provider that is terminated through this process, but later would like to participate in the Tufts Health Plan network may reapply to become a participating provider through our standard credentialing and enrollment process.

Primary Care Providers (PCPs)

The PCP must be able to provide integrated, accessible, health care services and be accountable for addressing a large majority of personal health needs, developing a sustained partnership with patients, and practicing in the context of the family and the community.

The following encompasses a common set of proficiencies for all PCPs:

- Training in a primary care discipline or significant additional training in primary care after training in a nonprimary care discipline
- Periodic assessment of the asymptomatic patient
- Screening for early disease detection
- Evaluation and management of acute illness
- Ongoing management of patients with established chronic diseases
- Coordination of care among specialists, including acute hospital care and long-term care
- Assessment and either management or referral of patients with more complex problems needing the diagnostic and therapeutic tools of a medical specialist or other professional
- Any provider designated as a PCP must devote a significant percent of his or her clinical time to a practice that encompasses the above list of proficiencies.

Note: This definition was adapted from the *Report on Primary Care* from the Institute of Medicine, 1996. Individual consideration may be given for specialists to serve as PCPs under circumstances at the individual provider unit level.

Responsibilities

PCPs are responsible for monitoring the care of their Tufts Health Plan members to provide quality and cost-efficient medical management. Successful management and coordination of a member's medical services likely results in medical and financial success for the provider unit.

Responsibilities of the PCP include, but are not limited to, the following:

- **Routine preventive:** care includes physical examinations, immunizations, hypertension and cancer screening, and pap smears
- **Health education:** includes safety and nutrition counseling, family planning unless specifically excluded in the member's benefit booklet, and other counseling as needed
- **Specialty care:** The PCP arranges most specialty care for members. For medically necessary specialty care services outside of the Tufts Health Plan network, authorization by the provider reviewer is required. Refer to Our Plans for product-specific information.
- **Urgent and emergency care:** includes coordination of emergency services and inpatient and outpatient care. Report emergencies that occur out of the service area to Tufts Health Plan.

Membership Report

Providers may access their Membership Report through the secure Provider portal. The membership report includes the names of members who have chosen the provider as their PCP, and additions to and deletions from a PCP's panel.

Closing and Opening a Panel

PCPs may close their practices to new members for reasons such as maternity leave or other similar absences; however, the PCP cannot close a panel for only selected plans and payers.

The provider must notify the Tufts Health Plan Provider Information Department, in writing, within 90 days or within the timeframe outlined in the provider's agreement with Tufts Health Plan, if otherwise indicated. During the 90-day transition period, members are still allowed to select the provider as their PCP. For email instructions, refer to the Provider Information Change Form.

Even though a panel may be closed, members who have been appearing on a provider's monthly member list are still in the PCP's panel. These members must be treated or directed to appropriate specialists, even if the provider has not treated them prior to the panel closure.

To reopen the panel, the provider must notify the Provider Information Department in writing and include in the letter the date the panel will reopen.

Providers are also responsible for reviewing and verifying the accuracy of their demographic data (including, but not limited to, specialty information, practice location, phone number, hours of operation and availability to see members, including whether the provider has a waitlist of 4 weeks or less.) Providers may log into CAQH Provider Data Portal or fill out the Provider Information Change form and submit the completed form to the appropriate email, as noted on the form.

Temporary Transfer of Responsibility

Provider agreements obligate PCPs to establish and maintain coverage 24 hours a day, 7 days a week. However, personal illness, sabbatical or maternity leave are examples of times when brief withdrawal from a practice and temporary transfer of this responsibility may be necessary.

In the event the provider must withdraw from his or her practice for a planned period (e.g., maternity leave), Tufts Health Plan, at its discretion, may agree that a *locum tenens* practitioner may be engaged by the PCP to provide coverage for a limited period of time. The provider must arrange for this coverage and provide Tufts Health Plan with written notice of temporary transfer of responsibility to a *locum tenens* practitioner acceptable to Tufts Health Plan (see *Locum Tenens* Policy below).

The provider must include in the arrangement with the *locum tenens* practitioner the ability to terminate, without cause and effective upon notice, the *locum tenens* practitioner's provision of services with respect to Tufts Health Plan members.

If the intended interruption will exceed 60 days, Tufts Health Plan may close the provider's panel, since absence beyond two months may not allow for direct patient management. Sustained periods of unavailability also are not in the best interest of our members, as they are unable to access their chosen PCP.

If a PCP's temporary transfer of responsibility beyond 60 days involves unique circumstances, they must contact the Tufts Health Plan Credentialing Department directly.

Leave of Absence Policy

Tufts Health Plan requires a practitioner to notify Tufts Health Plan if they are taking a leave of absence (LOA) for longer than 60 calendar days. At a minimum, this notification must include the dates and the general reason for the LOA (sabbatical, medical reason, etc.). Practitioners must notify Tufts Health Plan regarding a pending LOA as soon as possible.

Practitioners who will be taking a LOA must arrange for coverage by another participating practitioner in the Tufts Health

Plan network. All covering arrangements must be acceptable to Tufts Health Plan.

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

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

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

Covering Provider

The covering provider is responsible for emergent or urgent care only. Follow-up treatment must always occur with the member's PCP or a Tufts Health Plan specialist.

All Tufts Health Plan participating providers have contractually agreed to be accessible to members 24 hours a day, 7 days a week. If a provider is not available, they are responsible for maintaining appropriate provider coverage. Tufts Health Plan requires that all covering providers be contracted and credentialed; exceptions may be granted based on geographic availability. A written notification of the termination or addition of providers for a covering doctor should be sent to the Provider Information Department in a timely manner.

Locum Tenens Policy

Tufts Health Plan requires that *locum tenens* providers with the potential to treat a Tufts Health Plan member be enrolled. Provider organizations wishing to enroll *locum tenens* providers should have the provider submit the following forms:

- HCAS enrollment form
- Release & attestation form
- IPA endorsement form
- W9 (for payment purposes)

If the *locum tenens* provider will be covering for Tufts Health Plan members, the provider should also include the Tufts Health Plan endorsement form. Enrollment will be valid for up to six months. If a *locum tenens* provider's services are required by the IPA/PHO for more than six months, the *locum tenens* provider may be required to execute an appropriate contract with the IPA/PHO and be fully credentialed.

Note: *Locum tenens* practitioners will not be listed in the Tufts Health Plan directory and are not permitted to have a panel.

Removing a Tufts Health Plan Member from a Panel

Provider Requests to Disengage from Member

Under rare circumstances, a provider may feel that it is no longer appropriate to act as a PCP for a Tufts Health Plan member. The provider must send a written notice to the member and a copy to Tufts Health Plan's Member and Provider Services Department, explaining the reason for the decision. The provider is required to provide urgent care for up to 30 days, so the member has time to select a new PCP.

The written notice may be sent to:

Tufts Health Plan Member and Provider Services

PO Box 9170
1 Wellness Way, Canton, MA 02021

When the member and Provider Services Department receives the letter, a letter will be sent to the member notifying them when the PCP will be removed from their plan and instructing them to select a new PCP.

If a provider has a member on their panel but believes they are not a patient and does not have contact information for the member, the provider should contact the Provider Services Department at 888-884-2404. A Provider Services representative will provide the member's contact information.

Member Inappropriately Selects Provider

A member may inadvertently select a PCP whose practice is closed to new members or who has agreed to accept only established patients. If a member selects a PCP who is only accepting established patients, Tufts Health Plan will assign the member to the requested PCP, even if the established patient indicator is not present on the enrollment transaction.

If a provider realizes they have been inappropriately selected as a member's PCP, the provider must immediately notify Provider Services at 888-884-2404 and assume the role of PCP for that member on an interim basis until the member selects a new PCP. If notification is not received, the member is deemed part of the provider's panel.

Medical Care Access Standards for Primary Care Offices

Access to medical care services is a key component of health care quality. Members must be able to access their providers, although in a life-threatening situation they are expected to obtain care at the nearest medical facility.

Tufts Health Plan recognizes the diversity with which providers handle member calls, arrange urgent care, and schedule routine care. Tufts Health Plan expects that members be heard, and their medical needs met in a manner that is reasonable and provides quality medical care.

Tufts Health Plan has developed medical care access standards that all provider offices are expected to adopt and review with their office staff. The standards include suggestions that PCPs may adopt to provide better service to their patients. Many providers may have already included these suggestions in their telephone triage system.

Members periodically contact Tufts Health Plan with concerns about office waiting times, appointment availability, and similar issues. Tufts Health Plan uses these standards to determine whether member concerns are reasonable and provides feedback to the members and providers as necessary.

Since the PCP is ultimately responsible for coordinating the member's care, these standards are not as directly pertinent to a specialist's office. They do, however, provide a sense of what is reasonable in terms of appointment dates, waiting times, telephone callback times, etc. As such, they are a good way to measure how well an office is functioning.

All medical care access standards are evaluated at least annually by Tufts Health Plan management and revised, as necessary, based on the results of access surveys and the input of plan providers.

Providing medical care is not a completely predictable experience. Emergencies and episodic increases in the demand for services, at times, overwhelm the ability of an individual office to meet each of these goals. However, in the normal course of providing medical care, primary care offices must regularly meet these standards.

Office Visit Appointments

- **Emergency care:** appointments scheduled on the same day as requested with an available clinician
- **Urgent care:** appointments scheduled to occur within 24 hours of request with an available clinician
- **Nonurgent symptomatic care:** appointments for non-urgent episodic illness are scheduled to occur within 10 calendar days of request with an available clinician
- **Preventive care:** for history and physical check-ups with no acute illness, the PCP or other appropriately licensed clinician sees the member within 45 days of the request

Office Waiting Time

In most situations, member should not have to wait more than 30 minutes past their appointment time to be seen. If a longer wait is anticipated, staff members must explain the reason for the delay and offer to book the member for another appointment, if desired. Office staff should return any copayment if the appointment is rescheduled.

Overflow Patients

If an office has more urgent cases than it can handle, the staff must arrange for urgent care at another site. Routine use of an emergency department in such overflow situations is not acceptable.

Telephone Callbacks during Office Hours

Members are expected to exercise good judgment about urgent needs for service when contacting their provider outside normal office hours.

An answering service or machine answers telephones after hours. For urgent problems, an answering service offers to contact the provider or a covering provider. An answering machine provides a number through which a provider can be contacted for urgent problems. Providers normally return urgent calls within one hour.

If a provider uses a nurse triage service for telephone screening after hours, the provider must instruct the nursing staff to identify himself or herself as a nurse who is covering for a provider. The nurse must also communicate to the member that if it is a life-threatening situation, the member must hang up and either call 911 or go to the nearest emergency department, as appropriate. At the completion of the call, the nurse must verify that the member is comfortable with the nurse's advice and tell the member of his or her right to speak to the covering provider. All practitioners or providers used for covering purposes must be licensed as required by law.

Note: Routine use of an emergency department to supply after-hours care is not an acceptable coverage arrangement.

Behavioral Health/Substance Use Disorder Treatment Access Standards

All contracted inpatient and outpatient behavioral health and substance use disorder (BH/SUD) providers are expected to meet the standards described below.

Temporal Access

Tufts Health Plan covers emergency BH/SUD care at any licensed facility when medically necessary. Emergency care is available at any Tufts Health Plan contracted facility with emergency services.

- A member with life-threatening and non-life-threatening needs must be seen immediately in the emergency room
- Urgent care must be available within 24 hours of a member's request. Any Tufts Health Plan BH/SUD provider may provide this care.
- Nonurgent care must be available within 10 calendar days of a member's request. Any Tufts Health Plan BH/SUD provider can provide this care.

Geographic Access

Outpatient BH/SUD care is available within 30 miles of the member's home or workplace. For certain areas of subspecialty care, a greater distance may be required.

Specialist Provider

The specialist provider within the Tufts Health Plan network is expected to provide quality, cost-efficient health care to Tufts Health Plan members. The specialist's primary responsibility is to provide authorized medical treatment to members who have an electronic or written referral from their PCP or as otherwise authorized by Tufts Health Plan.

If a specialist feels that additional treatment is required and they cannot provide these services, the specialist is responsible for contacting the member's PCP and suggesting that the PCP provide the member with an alternative referral, when applicable.

When POS members see a Tufts Health Plan or non-Tufts Health Plan specialist without a referral (i.e., they exercise their right to use their unauthorized level of benefits), the specialist may provide medical treatment without the PCP's authorization. In these instances, the member is responsible for an applicable copayment or deductible and coinsurance.

Specialists are required to provide 90 days prior notice of termination of their participation with Tufts Health Plan, both to Tufts Health Plan and to members who have been or are currently under the ongoing care of said specialist, unless a different time period or other arrangement has been agreed upon in the applicable health services agreement.

Physician Reviewer

Many provider units appoint a physician reviewer to oversee utilization management within the provider unit. Some provider units designate more than one reviewer for specialty consultations, such as pediatrics or obstetrics. Physician reviewers are available for clinical consultations and serve as a resource for availability of in-network services. Physician reviewers work cooperatively with Tufts Health Plan care managers to facilitate care management of members through the continuum of care.

With outpatient treatment, a physician reviewer's role will vary according to the member's plan. Depending on the site of care, both PCP and physician reviewer approval may be required. For care to be rendered at an out-of-plan facility, the physician reviewer's authorization is required. Refer to the Prior Authorization through the Behavioral Health Department section of the Referrals, Prior Authorizations and Notifications chapter for information on outpatient behavioral health services.

Note: If the member is on a select/limited network plan, services from an out-of-plan or out-of-network provider require Tufts Health Plan review and approval, even if both the PCP and physician reviewer have approved the request. Specialty care providers outside the select/limited network must fax the completed Out-of-Network Coverage at In-Network Level of Benefits and Continuity of Care Prior Authorization Form to Tufts Health Plan's Precertification Operations Department at 617-972-9409 prior to services being rendered.

Physician reviewers also are involved with inpatient cases. If elective services are to be performed at an out-of-plan facility, the PCP must contact the physician reviewer in advance for approval.

Members enrolled in a Tufts Health Plan Preferred Provider Organization (PPO) may access services without the direction of a PCP or physician reviewer. Refer to Our Plans for product-specific information.

Nurse Practitioners and Physician Assistants

Nurse practitioners (NPs) and physician assistants (PAs) may elect to either bill under a supervising or collaborating physician or contract directly with Tufts Health Plan. NPs and PAs may not do both (i.e., bill under a supervising/collaborating physician as well as contract independently). Independently credentialed and contracted NPs/PAs may be listed in provider directories and may hold a panel if they practice as a PCP.

As permitted by state law, NPs/PAs who work under the auspices of a licensed physician may bill for covered services under the supervising physician's identification number, provided that the supervising physician and/or facility (e.g., hospital) have met all applicable requirements.

It is the responsibility of the collaborating provider to educate the NP/PA on all Tufts Health Plan policies, procedures, and guidelines. The collaborating provider is responsible for maintaining appropriate state licensing information and proof of appropriate professional malpractice liability insurance coverage for all NPs/PAs under their supervision.

For billing and authorization information, refer to the Nurse Practitioner and Physician Assistant Payment Policy.

Practitioner Treatment of Self and Family Members

Practitioners may not receive compensation for any treatment of themselves or a family member. Family members include a spouse (or equivalent), parent, child, sibling, parent-in-law, son/daughter-in-law, stepparent, step-child, step-sibling, or other relative permanently residing in the same residence as the practitioner.

Note: The definition of a family member is adopted from the Board of Registration in Medicine Regulations, 243 CMR 2.07: "General Provisions Governing the Practice of Medicine."

Chaperones for Office Examinations

Tufts Health Plan practitioners should have an office policy regarding chaperones for examinations relating to the breast and genital area, including rectal exams. It is suggested that practitioners offer all patients the option of the presence of a chaperone during such exams.

The policy should address the following elements:

- **Documentation:** Will there be written documentation of the chaperone being offered and the patient's response?
- **Communication:** How is the policy communicated to patients and when in the visit is the chaperone offer made?
- **Types of exams:** For which exams will chaperones be offered? The chaperone policy applies to all practitioners, regardless of gender.

Summary of the Credentialing Process

Tufts Health Plan credentials affiliated practitioners when they join the Tufts Health Plan network and at a minimum every three years thereafter, in accordance with state, federal, regulatory, and accrediting agency requirements. Credentialing standards are applied uniformly for behavioral-health and non-behavioral health practitioners that are applying to the Tufts Health Plan Commercial network. Refer to the public Provider website for more information.

Provider Requirements

For initial credentialing and recredentialing, each practitioner is required to comply with the Tufts Health Plan Credentialing Program and submit the following information to Tufts Health Plan via email to Provider_Information_Dept@point32health.org or to the designated credentialing verification organization for review as indicated below:

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

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

Primary Hospital Requirements

Each MD and DO must indicate their primary hospital on the credentialing application when applicable. For initial credentialing, Tufts Health Plan queries that hospital for an assessment of the practitioner's performance, as mandated by state regulation. During recredentialing, the hospital is queried again. The practitioner must notify Tufts Health Plan in writing of changes in primary hospital affiliation.

Tufts Health Plan Requirements

Along with the credentialing information specified in CAQH ProView, Tufts Health Plan reviews the following information prior to the final assessment of each practitioner in states other than Rhode Island:

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

For Rhode Island practitioners, along with the credentialing information specified in CAQH ProView, Tufts Health Plan reviews the following information prior to the final assessment of each practitioner:

- Provider demographics including name and current mailing address
- Current valid license, registration or certificate in Rhode Island or other state as applicable
- History of any revocation, suspension, probationary status or other disciplinary action regarding provider's license, registration or certificate
- Clinical privileges at a hospital, as applicable
- Valid Drug Enforcement Agency and Controlled Substance certificate/registration and/or other state or federal verification to prescribe controlled substances (if applicable)
- Evidence of board certifications
- Evidence of malpractice/professional liability insurance
- Medicare/Medicaid sanctions
- Medicare opt-out
- System of Award Management (SAM) sanctions
- Medicare Preclusion sanction
- History of professional liability claims and description of any settlements or judgements paid to a claimant in connection with a professional liability claim

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

Practitioners cannot see Tufts Health Plan members without the following:

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

Note: For initial credentialing applicants, practitioners are deemed in-network based upon the credentialing effective date or the contract effective date, whichever is later. Per regulations, Tufts Health Plan is not allowed to backdate credentialing effective dates.

If the contract provides for credentialing activities by a first-tier or downstream entity, the first-tier or downstream entity must meet all applicable Tufts Health Plan credentialing requirements, including Tufts Health Plan's review of medical professionals' credentials or reviewing, preapproving and auditing the credentialing process.

Medicaid Participation: Screening and Mainstreaming

Providers seeking to participate in Tufts Health Plan's network should be aware of the following requirements related to Medicaid.

- Rhode Island providers seeking to participate in Tufts Health Plan's commercial network must also be enrolled as a participating provider in all our Rhode Island products, including our Medicaid product RITogether. Pursuant to Rhode Island Law Section 210-RICR-30-05-2.13, Rhode Island Medicaid Managed Care Organizations ("MCOs"), including Point32Health, that also offer and sell commercial health insurance products in the state of Rhode Island are required to align their commercial and Medicaid MCO provider networks.
- In accordance with federal regulations under the 21st Century Cures Act, Medicaid providers must be screened or enrolled with the local State Medicaid agency to render services to Medicaid beneficiaries. Visit the Medicaid agency website for your state for additional information on requirements. For Rhode Island, visit the Rhode Island Executive Office of Health and Human Services (EOHHS) provider portal; for Massachusetts, visit the MassHealth website.

Practitioners' Rights and Responsibilities

Practitioners have the right, upon written request, to:

- Review Tufts Health Plan's credentialing policies and procedures
- Be informed of the status of their credentialing or recredentialing application by contacting the Credentialing Department via the following:

  Phone: 617-972-9495
  Fax: 617-972-9591

  Email: Provider_Information_Dept@point32health.org

  Mail: Tufts Health Plan
  Attn: Credentialing Department
  1 Wellness Way, Canton, MA 02021
- Review information submitted to Tufts Health Plan for purposes of credentialing or recredentialing, including information obtained by Tufts Health Plan from any outside source, such as a malpractice carrier, state license board, or the National Practitioner Data Bank (NPDB).
  - Notwithstanding the foregoing, Tufts Health Plan is not required to reveal the information source if the information was not obtained for the purpose of meeting Tufts Health Plan's credentialing requirements.
  - Providers are not entitled to review references, recommendations or information that is peer-review privileged or any information which by law Tufts Health Plan is prohibited from disclosing.

- Receive notification if credentialing information obtained from sources other than the practitioner varies substantially from the credentialing information provided to Tufts Health Plan by the practitioner.
- Correct erroneous information submitted by other parties within 10 days of receipt.
  Note: If Tufts Health Plan obtains or receives information during the credentialing process that varies substantially from the information provided in the application, Tufts Health Plan will notify the provider of the discrepancy. Providers have the right to review any information submitted in support of the credentialing application and to correct erroneous information other parties provide (excluding peer-review information). To submit corrections to the Credentialing Department, email Provider_Information_Dept@point32health.org
- There is no right of appeal from an initial credentialing determination by the QOCC except when required by applicable state or federal law.

In the event the QOCC votes to take disciplinary action, the practitioner is entitled to notice consisting of a written statement of the reasons for the action and, if applicable, has the right to appeal such action by filing a written appeal within 30 calendar days of receipt of the statement of reasons.

The practitioner is entitled to be represented by an attorney or other representative of the practitioner's choice. If that new information becomes available, the practitioner may submit new information up until the Appeals Committee meeting.

Each committee member must engage in a fair and impartial review of the practitioner's appeal. No committee member may be an economic or geographic competitor of the reviewing practitioner. The committee member should not be employed by or act in the capacity of a Tufts Health Plan board member or otherwise be a representative of Tufts Health Plan.

The decision of the Appeals Committee is final. The practitioner will be provided with written notification of the appeal decision, which contains the specific reasons for the decision.

Hospital Credentialing

Tufts Health Plan credentials hospitals when they join the Plan and are recredentialed every three years in accordance with National Committee for Quality Assurance (NCQA) standards.

Requirements for Initial and Recredentialing

For initial and recredentialing, each hospital is assessed for quality. The hospital must be accredited by an applicable accrediting agency acceptable to Tufts Health Plan such as the Joint Commission, the American Osteopathic Association, or the National Integrated Accreditation for Health Care Organizations. The hospital must have a current state license. The hospital will be reviewed for Medicare and Medicaid sanctions, and, for recredentialing, quality events will be reviewed. Tufts Health Plan may review additional information reasonably deemed pertinent to credentialing, including a site visit.

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

Cell and Gene Therapy (CGT) Monitoring Requirement

To ensure efficacy and durability of response, high-cost therapies are subject to long-term monitoring. Providers must comply with long-term monitoring requirements including requests for follow-up clinical data and/or attestation of clinical outcome.

PUBLICATION HISTORY

02/02/24	Added “Directory Accuracy and Suppression of Unverified Provider Information”; administrative edits
03/01/24	Updated email addresses
04/19/24	Updated “Closing and Opening a Panel” section and “Directory Accuracy and Suppression of Unverified Provider Information” sections with text on availability to see members, including whether the provider has a waitlist of 4 weeks or less; administrative edits; links updated.
06/05/24	Added “Medicaid Participation: Screening and Mainstreaming” section
08/01/24	Added “Provider Inactivity and Administrative Termination of Network Providers” section.
09/05/24	Administrative edits, links updated
03/14/25	Administrative edits; links updated