Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Payment Policy:
Provider Payment Disputes

Applies to:

Commercial Products

☐ Harvard Pilgrim Health Care Commercial products
☐ Tufts Health Plan Commercial products

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan
☒ Tufts Health One Care – A dual-eligible product

Senior Products

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product)
☐ Tufts Medicare Preferred HMO/PPO (Medicare Advantage products)

The following payment policy applies to Tufts Health Plan contracting providers.

Note: Audit and disclaimer information is located at the end of this document.

Policy

Providers have the right to file a payment dispute if they disagree with a claim decision regarding the denial or compensation of a claim. Providers may submit disputes and corrected claims via mail.

Provider Payment Disputes

Limitation of Dispute Process

Tufts Health Plan will consider payment disputes and adjustment requests for claims with dates of service within the current year, and the two previous calendar years from EOP date, for the following disputes, which include, but are not limited to:

- The level of compensation
- Claims denied for no referral when a referral was obtained
- Claims denied for lack of prior authorization or inpatient notification

Corrected Claims and Disputes of Duplicate Claim Denials

Corrected claims and provider payment disputes of duplicate claim denials must be received no later than 60 days from the date of the original adjudication. Any payment disputes received after that time will not be considered.

Late Charges

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

Submitting a Payment Dispute

Claim Adjustments Submitted via the Secure Provider Portal

Registered providers may submit claim adjustments using the secure Provider website. Providers who are not registered users of the website may register via the Provider login page. For additional information refer to the Online Claim Adjustments Quick Reference Guide.

Claim Adjustments Submitted via Mail

Refer to the Request for Claim Review Mailing Information document for the correct mailing address to submit disputes to Tufts Health Plan. The Request for Claim Review Form (v1.1) is required for provider payment disputes.

- All required information must be included on the form. Any supporting documentation must be single sided.
- Disputes submitted without the official Request for Claim Review Form (v1.1) will be rejected and returned to the submitter.

Adjustments can be requested when submitting a dispute for the following reasons:

- **Corrected Claim Adjustments**
  - When submitting a corrected claim adjustment, attach a written explanation (single sided only) of the requested changes or a corrected claim to the Explanation of Payment (EOP) and the Request for Claim Review Form (v1.1). The claim number to be adjusted should be circled and sent to the correct address.
- **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 and the EOP.
- 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 Plan considers relevant supporting documentation to be a copy of the provider's original information faxed/submitted to Tufts Health Plan and relevant medical records. If authorization is applicable, please include the authorization number received verbally or in writing from Tufts Health Plan.

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.

Proof of Timely Filing

The filing deadline is 90 days from the date of service (for professional or outpatient claims) and 90 days from the date of hospital discharge (for inpatient or institutional claims). To be considered for review, payment disputes received after the filing deadline must be submitted within 60 days of the EOP on which the claim originally denied. A request for reconsideration received more than 60 days past the deadline will not be considered.

Coordination of Benefits

When a member has multiple insurance plans, the filing deadline for claims submission is 60 days from the date of the primary insurer's EOP.

If submitting on paper, the EOP from the primary insurer must be submitted with the claim when Tufts Health Plan is the secondary payer.

- For paper claim submissions, 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.
- Submit the claim with the EOP from the primary insurer to the correct initial claim submission address.

Funds Retracted by Another Carrier

To ensure timely payment, submit the claim with the other carrier's retraction statement within 60 days of date on retraction statement.

Submitting Proof of Timely Filing

Attach documented proof of timely submission to the EOP and circle the claim to be adjusted. The following are considered acceptable proof of timely submission:

- Copy of EOP from the primary insurer that shows timely submission from the date that carrier processed the claim

- 277 transaction report to direct submitters or clearinghouse
- Copy of EOP from another carrier— if the member did not identify him/herself as a Tufts Health Plan member at the time of service
- Copy of a personal injury protection (PIP) letter received by Tufts Health Plan within 60 days of the date on the letter
- Copy of a Workers' Compensation denial received by Tufts Health Plan within 60 days of the date of the denial

Note: Refer to the Claim Requirements chapter of the Tufts Health Public Plans Provider Manual for information on paper claim submission requirements.

If acceptable proof of timely submission is received, the claim will be reprocessed. When the disputed claim is reprocessed, a subsequent denial may be generated. In this instance, a new dispute must be submitted with the appropriate documentation since each denial is based on the current message code on the claim.

Submitting Proof of Timely Filing for an EDI Submission

Providers who submit their claims electronically directly to Tufts Health Plan must send their EDI acceptance report, which indicates proof of timely submission.

Acceptance of an EDI claim as evidenced by a Tufts Health Plan claim number will be required as proof of timely submission. Reports must show receipt at Tufts Health Plan, through direct submission.

Submitting Returned Funds

In the event of an overpayment, 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.

Note: 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 Plan in writing of the overpayment reason. Tufts Health Plan will report the notification to EOHHS in the Self-Reported Disclosures report.

Related Policies and Resources

- Tufts Health Public Plans Provider Manual: Claim Requirements, Coordination of Benefits and Dispute Guidelines
- Fraud, Waste, and Abuse Policy

Publication History

- September 2023: Added return timeframe requirements for Tufts Health Together claim overpayments
- March 2021: Added information on submission of claim adjustments via the secure Provider portal
- December 2018: Clarified paper submission instructions
- June 2018: Document created

Background and disclaimer information

This policy applies to the products of Tufts Health Plan and their affiliates, as identified in the check boxes on the first page for services performed by contracted providers.

Payment is based on member benefits and eligibility on the date of service, medical necessity review, where applicable, and the provider's network participation agreement with the Plan. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to Plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment.

Point32Health reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated as applicable; please adhere to the most recent CPT and HCPCS coding guidelines.

We reserve the right to conduct audits on any provider and/or facility to ensure accuracy and compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance.