Referrals, Prior Authorizations and Notifications

To help ensure the quality of member care, Tufts Health Public Plans is responsible for monitoring authorization, medical appropriateness, and cost efficiency of services rendered. Refer to this chapter for information about:

Referrals (Tufts Health Together ACPPs only)

Members in Tufts Health Together with UMass Memorial Health and Tufts Health Together with Cambridge Health Alliance may require a referral to see a contracted specialist outside of their ACO network. A referral verifies that the PCP has authorized the member's care.

The member's PCP must submit a referral to Tufts Health Public Plans. The PCP is responsible for indicating the number of visits and type of specialty care required. Tufts Health Public Plans will then issue a referral number to the PCP. In most cases, a referral is valid in the Tufts Health Public Plans system for one year or until the approved number of visits is exhausted.

Before providing care, specialists should check which members require a referral, or the status of an existing referral request, via the secure Provider portal. Specialists can also determine whether to request a referral by calling Provider Services at **888-257-1985**. Tufts Health Public Plans will not pay for specialist visits that do not have a PCP referral when a referral is required. Members cannot be billed for these services.

Referral Inquiry

Providers may check the status of an existing referral by using the Referrals & Authorizations function via the secure Provider portal. Once submitted, it can take up to 24 hours for referral status to display.

Referral Adjustments

To request an adjustment to a referral that is already in the Tufts Health Public Plans system, the PCP must contact Provider Services at **888-257-1985**. Tufts Health Public Plans cannot adjust referrals based on the specialist's request. If the specialist would like to request an adjustment to a referral, the specialist should follow up directly with the member's PCP.

Exclusions

Tufts Health Together members belonging to an ACO plan do not require a PCP referral for the following services when provided inside the ACO network:

- Ancillary care:
  - Laboratory services
  - Radiology services **Note:** Some radiology services require prior authorization. Refer to the Radiology Imaging Services Payment Policy for more information.

  - Anesthesia services **Note:** Some anesthesia services require prior authorization. Refer to the Anesthesia Services Payment Policy for more information.
- Obstetric and gynecological care rendered by a contracting obstetrician, gynecologist, certified nurse midwife, or family practitioner:
  - Annual preventive gynecologic health examinations, including care deemed medically necessary by the practitioners listed above
  - Maternity care
  - Medically necessary evaluations and resultant health care services for acute or emergency gynecologic conditions
- Covered practitioner services provided in an inpatient setting (place-of-service 21)
- Behavioral health services rendered by licensed, in-network behavioral health providers
- Services rendered in emergency department (ED), qualified urgent care center, or limited-service clinic (e.g., MinuteClinics), including independent laboratory services ordered by these facilities
- Chiropractic services. Please refer to the Chiropractic Services Payment Policy for more information.

For other services, or for services outside of the ACO network, a referral may be required.

Referrals are not required for Tufts Health Direct, Tufts Health RITogether, Tufts Health Together MCO or Tufts Health One Care members.

Prior Authorizations

Authorization for certain services, drugs, devices and equipment is based on Tufts Health Public Plans medical necessity guidelines (MNGs) or InterQual® criteria. Any request for services provided by out-of-network (OON) providers requires prior authorization. Any additional criteria used are referenced in the appropriate MNGs. Refer to the Evolent (formerly National Imaging Associates, Inc./NIA) section for high-tech imaging, spinal conditions management and joint surgery utilization management programs. Providers rendering services to members may not have claims paid if they fail to obtain prior authorization. Additionally, for Tufts Health One Care, Medicare National Coverage Determination (NCD) and Local Coverage Determination (LCD) criteria may also be used for Medicare-covered services. NCD and LCD criteria are available on the CMS website at cms.gov.

MNGs are based on current literature review, consultation with practicing physicians in the Tufts Health Public Plans service area, the policies of federal and state government agencies such as the FDA, MassHealth and Rhode Island Executive Office of Health and Human Services (EOHHS), and standards adopted by applicable national accreditation organizations. The guidelines are revised and updated annually, or more frequently as new evidence becomes available that suggests needed revisions. MNGs and InterQual criteria are used in conjunction with the member's benefit plan document and in coordination with the provider recommending the service, drug, device or supply.

MNGs are available on the Tufts Health Plan public Provider website; printed copies are available upon request to providers by contacting Provider Services at **888-257-1985** (Massachusetts) or **844-301-4093** (Rhode Island).

Refer to the appropriate MNGs for prior authorization requirements. Submit a prior authorization request at least **five** business days in advance of the scheduled procedure, service or planned admission through one of the following channels:

- MHK Portal via the secure Provider portal
- Fax the appropriate completed form as outlined below:
  - Massachusetts Standardized Prior Authorization Request Form for Tufts Health Direct and Tufts Health Together to 888-415-9055 or Tufts Health One Care to 857-304-6304
  - Rhode Island Medicaid Prior Authorization Form for Tufts Health RITogether to 857-304-6404

Providers are responsible for verifying the member's eligibility on the date of service. Approval is dependent on eligibility and other determining factors. Tufts Health Public Plans will not pay for services rendered to patients who were not members on the date of service.

Providers can check the status of a prior authorization request through the MHK Portal via the secure Provider portal. Incomplete request forms will be returned to the provider for completion and will delay the processing of the request.

Note: The ordering provider is responsible for obtaining prior authorization. Because prior authorization is a condition of payment, the rendering and/or interpreting provider should confirm that prior authorization has been obtained before the service is provided.

Refer to the Behavioral Health chapter and the Tufts Health Together and Tufts Health Direct Behavior Health Prior Authorization (PA) and Notification Grid or Tufts Health One Care Behavioral Health Prior Authorization (PA) and Notification Grid for Massachusetts members or the Tufts Health Rhode Island Together Behavioral Health Prior Authorization (PA) and Notification Grid for information specific to behavioral health services.

Prior Authorization through the Precertification Operations Department

To obtain authorization for a service, device or equipment requiring prior authorization through the Precertification Operations Department, the provider must submit the appropriate clinical documentation for review. As a condition of payment, the **treating** provider is required to obtain approval for authorization requests. Authorization requests must include documentation of medical necessity for services requiring authorization. Documentation should detail:

- The member's diagnosis
- Planned treatment, including medical rationale for the service requested
- All pertinent medical information available for review

Prior authorization requests should be faxed to the Precertification Operations Department at 888-415-9055 (Tufts Health Together, Tufts Health Direct), 857-304-6304 (Tufts Health One Care) or 857-304-6404 (Tufts Health RITogether). When the use of an InterQual SmartSheet is required, it may be submitted without additional supporting documentation unless specifically indicated. Printed copies of InterQual SmartSheets (criteria) are available upon request to providers by contacting Provider Services at **888-257-1985** (Massachusetts) or **844-301-4093** (Rhode Island).

For a more comprehensive list of services that require prior authorization, refer to the MNGs section of the Resource Center or the Utilization Management Guidelines chapter.

Contact Provider Services at **888-257-1985** (Massachusetts) or **844-301-4093** (Rhode Island) with urgent requests or questions.

Prior Authorizations through Approved Vendors

Evolent (formerly National Imaging Associates, Inc./NIA)

Tufts Health Public Plans requires providers to obtain prior authorization through Evolent for high-tech imaging, spinal conditions management (interventional pain management and spine surgeries) and joint surgery utilization management programs.

For a list of procedure codes subject to prior authorization by Evolent, refer to the High-Tech Imaging/Cardiac Program Prior Authorization Code Matrix and Spinal Conditions Management and Joint Surgery Code Matrix. To obtain and verify authorizations or access MNGs, log into RadMD or call Evolent at **800-207-4209**.

It is the **ordering** provider's responsibility to obtain prior authorization before scheduling appointments for members. **Rendering** providers will need to ensure that all tests have the required authorization number before the service is performed.

Note: For the High-Tech Imaging program, both professional and technical claims for which there is no authorization number will be denied and the member may not be billed for the service associated with the denied claim. Diagnostic imaging services performed in the emergency room, observation, and inpatient settings do not require prior authorization. Urgent/emergent CT/CTA, MRI/MRA, PET scan or nuclear cardiology procedures rendered at a site other than a hospital emergency department require notification to Evolent within **two business days** of the service.

Refer to the Radiology Imaging Services Payment Policy or the Imaging and Cardiac Program Prior Authorization Management Guide for additional information.

eviCore (Sleep Studies)

Tufts Health Plan requires providers to obtain prior authorization through eviCore for sleep studies, sleep therapy and/or resupplies. Refer to the Sleep Studies and PAP Therapy Prior Authorization Program and Sleep Studies Payment Policy for more information.

Carelon Medical Benefits Management (formerly AIM Specialty Health)

Tufts Health Plan requires providers to obtain authorization through Carelon for genetic/genomic or molecular tests. Refer to the Prior Authorization Program for Genetic Testing section of the Tufts Health Plan Vendor Information page for additional information.

Inpatient Notification

Inpatient notification is a process that notifies Tufts Health Public Plans of all inpatient admissions. Tufts Health Public Plans covers medically necessary inpatient services when inpatient notification is given in accordance with the time frame established by Tufts Health Public Plans or when applicable, the time frame as specified by applicable law. Outpatient procedures, including surgical day care and observation services, do not require inpatient notification.

As a condition of payment, Tufts Health Public Plans requires notification for any member who is being admitted for inpatient care, regardless of whether or not Tufts Health Public Plans is the primary or secondary insurer. Inpatient notification does not guarantee payment by Tufts Health Public Plans.

Notification Requirements

Admitting practitioners and facilities are responsible for notifying Tufts Health Public Plans and submitting the clinical information supporting the medical necessity of the inpatient admission and/or inpatient elective procedure that is scheduled in accordance with the following timelines:

- Elective admissions must be reported no later than five business days prior to admission
- Urgent or emergency admissions must be reported within two business day
- Urgent/emergent acute behavioral health admissions must be reported within 72 hours for Tufts Health Direct, Tufts Health Together and Tufts Health One Care
- For partial hospital programs (PHP), all in-network providers are required to provide notification to Tufts Health Plan after the first day/visit of treatment.

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

Submissions Channels

Providers should submit non-behavioral health inpatient notifications through the following channels:

- MHK portal via the secure Provider portal. For more information refer to the Tufts Health Public Plans MHK Portal User Guide.
- Emergent and urgent admissions: fax a completed Inpatient Notification form to the following:
  - Tufts Health Direct and Tufts Health Together: 888-415-9055
  - Tufts Health One Care: 857-304-6304
  - Tufts Health RITogether: 857-304-6404

  Note: No other forms will be accepted.

- Elective (scheduled) admissions: fax the appropriate completed form as outlined below:
  - Massachusetts Standardized Prior Authorization Request Form for Tufts Health Direct and Tufts Health Together to 888-415-9055 or Tufts Health One Care to 857-304-6304
  - Tufts Health RITogether Prior Authorization Request Form 857-304-6404

Incomplete forms will be returned to the submitting provider for completion and resubmission. Processing the request will be delayed until all information is returned to Tufts Health Public Plans.

If the date for an elective admission/procedure changes, but an inpatient notification has already been submitted, use the submission channels above to report the new date of admission to ensure accurate claims processing.

Telehealth/Telemedicine Requirements

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

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

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

PUBLICATION HISTORY

01/01/24	Updated plan name to Tufts Health One Care; revised phone number
05/17/24	Replaced “National Imaging Associates, Inc./NIA” with “Evolent”; administrative edits
07/12/24	Updated link to Tufts Health One Care Behavioral Health Prior Authorization (PA) and Notification Grid