Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Payment Policy:

Avoiding Administrative Claim Denials

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 is a list of administrative claim denials that Tufts Health Plan providers may receive when submitting claims, along with tips on how to correct/avoid them. Refer to the Claim Requirements, Coordination of Benefits and Payment Disputes chapter of the Commercial, Senior Products, and Tufts Health Public Plans Provider Manuals for more information on claims submission.

Denial Reason	Tips
No referral on file HMO, EPO, TMC, and Tufts Medicare Preferred HMO members are required to have electronic or paper referrals from their PCP for most specialty care services. The PCP is responsible for coordinating and submitting referrals to Tufts Health Plan prior to services being rendered. Referrals can be submitted via: • The secure Provider portal • NEHEN • NEHEN*Net* • POS device or Change Healthcare™ • Paper referral **Note:** Members who have PCPs in certain provider networks require referrals for specialty services.	• Confirm the referral was made prior to date of service (DOS) via the following resources: – Referral inquiry tool on the secure Provider portal – POS device or Change Healthcare™ – NEHEN or NEHEN*Net* – PCP's office – Contact Provider Services • Refer to the Referral, Prior Authorization, and Notification Policy for additional information. • Ask members to sign a waiver if they have not obtained a referral. • Refer to the referral waiver form for Commercial members or the Providers Chapter of the Senior Products Provider Manual for Tufts Medicare Preferred HMO members.
No supporting documentation provided Claims requiring supporting documentation (e.g., invoices, medical records, primary carrier's EOP) deny if submitted electronically.	• Use industry-standard red paper claim forms • Mail the paper claim to the appropriate address outlined in the Commercial, Senior Products, and Tufts Health Public Plans (MA|RI) provider resource guides
Duplicate A claim might deny as duplicate if: • The same claim is submitted multiple times • A 'corrected claim' is submitted without the required corrections made • Late charges are submitted on a facility claim without the original claim number and/or correct bill type	• Refer to the applicable provider payment dispute policy for Commercial, Senior Products, and Tufts Health Public Plans • Submit a corrected claim using the Request for Claim Review Form. Corrected claims sent to Tufts Health Plan without the form will result in a duplicate denial. • To submit late charges electronically for facility claims, include the original reference number (Tufts Health Plan claim number) and the bill type. The third digit of the bill type should be '5' (late charges). • To check claim status: – Claim inquiry on the secure Provider portal – NEHEN or NEHEN*Net* – Contact Provider Services
Timely Filing of Claims • **Commercial claims** must be received by Tufts Health Plan within **90 days** from the DOS (for professional/outpatient claims) or the date of discharge (for inpatient/institutional claims). • **Senior Products claims** must be received by Tufts Health Plan within **60 days** from the DOS (for professional/ outpatient claims) or the date of discharge (for inpatient/institutional claims). • **Tufts Health Public Plans claims** must be received by Tufts Health Plan within **90 days** from the DOS (for professional/outpatient claims) or the date of discharge (for inpatient/institutional claims).	**EDI claim submissions** • Check the electronic summary reports to verify the claim was accepted by Tufts Health Plan. • For claims submitted through MD On-line, review acceptance and rejection reports in your LinkMail Box • Make all necessary corrections to the claim and re-submit within the filing deadline **Paper claim submissions** • Ensure all the information is correct prior to submission • Verify the correct address for paper claims submission • Check the claim status on the explanation of payment (EOP)
No Inpatient Admission Notification • Inpatient notification is required for all members who are admitted for inpatient care, regardless of whether Tufts Health Plan is the primary or secondary insurer. • Admitting providers and hospital admitting departments must notify Tufts Health Plan within the following timelines: – Elective admissions must be reported no later than 5 business days prior to admission. – Urgent or emergency admissions must be reported within 1 business day.	Use one of the following options to obtain an inpatient notification: • Inpatient notification inquiry on the secure Provider portal • Fax an Inpatient Notification Form to the Precertification Operations Department – **Note:** elective medical/surgical procedures for Tufts Health Public Plans members require an inpatient admission to be submitted via the Standardized Prior Authorization Form • 278 batch transactions: Contact EDI Operations at 888.880.8699 ext. 54649 or EDI_Operations@point32health.org for more information

No Prior Authorization on File Tufts Health Plan requires providers to obtain prior authorization for certain services, drugs, devices and/or equipment to be covered	Refer to the Referral, Prior Authorization, and Notification Policy to determine which services require prior authorization and the Utilization Management chapters of the Commercial, Senior Products, and Tufts Health Public Plans Provider Manuals to determine the review process. **Behavioral Health** *Commercial/Senior Products* Outpatient Services Requiring Prior Authorization/Notification *Tufts Health Public Plans* • Call 888.257.1985 by the next business day (required) • For more information refer to the Behavioral Health chapter of the Tufts Health Public Plans Provider Manual

Background and Disclaimer Information

This policy applies to the products of Harvard Pilgrim Health Care and 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, Harvard Pilgrim Health Care and Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance.