

Provider UPDATE



SPRING ■ 2008

NEWS FOR THE NETWORK

NOTIFICATION FOR FEBRUARY 1, 2008

Tufts Health Plan 60-Day Notification

Effective April 1, 2008

Coverage Updates for Commercial Products

Tufts Health Plan implements changes to its commercial coverage status throughout the year. Please review these changes, which will go into effect April 1, 2008.

The following codes will be added to existing prior authorization programs as of April 1, 2008:

- **Deep brain stimulation** (61863, 61864, 61867, 61868, 61880)
- **Spinal cord/dorsal column stimulation** (95972, 95973)

The following commercial procedures and services will not be covered by Tufts Health Plan as of April 1, 2008:

- **Cryoablation for the treatment of breast adenomas** (19105)
- **Laser-assisted uvulopalatoplasty (LAUP)** (S2080)
- **Private-duty nursing** (No codes available)

The following change will be effective April 1, 2008:

- Tufts Health Plan will cover **electrical and hospital breast pump** (E0603, E0604) **rentals for one month** in the following situations only:

1. Premature, hospitalized newborn*
 2. Newborn with congenital anomalies, such as a cleft palate
 3. Mother is hospitalized and separated from her newborn
- Newborns:** Newborn may have either an inpatient preregistration or one of the following diagnosis codes:
- **Cleft palate and lip** (749.00 – 749.04, 749.10 – 749.14, 749.20 – 749.25)
 - **Other anomalies of the tongue** (750.10 – 750.19)
 - **Other specific anomalies of the mouth and pharynx** (750.21 – 750.29)
- Mothers:** Mothers must have an inpatient preregistration and the following diagnosis code:
- **Lactating mother** (V24.1)

For more information, visit the Clinical Resources section of www.tuftshealthplan.com/providers.

*Tufts Health Plan may cover an electric or hospital breast pump for a second month if the newborn is still hospitalized after the initial, covered month.

CLINICAL NOTIFICATIONS

Important Note Regarding Drug Coverage Changes

Tufts Health Plan members who are currently taking a covered medication that is moved to our List of Non-Covered Drugs or a medication that is added to the Prior Authorization–Step Therapy program do not require authorization to continue taking that medication.

Prescribing physicians are not required to submit an authorization request to continue coverage for medications affected by those specific coverage changes unless the member was taking the medication prior to enrolling with Tufts Health Plan.

Tufts Health Plan Medicare Preferred Medicare Determinations Issued

As a Medicare Advantage organization, Tufts Health Plan Medicare Preferred must follow Medicare coverage guidelines.

Network providers should be aware of the following recent Medicare National Coverage Determinations (NCDs). To access the NCD manual, visit the Centers for Medicare & Medicaid Services (CMS) Web site, www.cms.hhs.gov.

■ **Lumbar artificial disc replacement (LADR) NCD**

150.10: Effective for services performed on or after August 14, 2007, CMS has determined that LADR is not reasonable and necessary and, therefore, is non-covered for the Medicare population over 60 years of age. **This decision reflects a change from non-coverage for a specific LADR implant (Charite™) to non-coverage for the LADR procedure for the Medicare population over 60 years of age.**

- **Ultrasound diagnostic procedures NCD 220.5:** Effective for claims with dates of service on and after May 22, 2007, CMS has determined that esophageal Doppler monitoring of cardiac output for ventilated patients in the ICU and for operative patients with a need for intra-operative fluid optimization is reasonable and necessary, and, therefore, removes the current national non-coverage of cardiac output Doppler monitoring.

- **Routine costs in clinical trials NCD 310.1:** Medicare covers routine costs associated with qualified clinical trials. Effective July 9, 2007, CMS clarifies that the item or service under investigation in a clinical trial, if covered outside the trial, is covered as a routine cost. Otherwise, the investigational item or service is excluded from coverage.

Reminder: Managed Care Organization authorization and in- and out-of-network requirements do not apply to services rendered in these CMS-approved clinical trials. Members are required to pay Medicare coinsurance for the clinical trial services and providers must bill fee-for-service directly for the covered routine services.

In addition, effective July 9, 2007, CMS may determine through the NCD process that certain items and services—for which there is some evidence of significant medical benefit, but for which there is insufficient evidence to support a “reasonable and necessary” determination—are only reasonable and necessary when provided in a clinical trial. CMS calls this “coverage with evidence in development (CED).” Coverage determined under CED will be implemented through subsequent NCDs issued regarding specific coverage topics.

Effective January 1, 2008

Changes to Tufts Health Plan Pharmacy Benefit

To offer a pharmacy benefit that is clinically appropriate and cost-effective, Tufts Health Plan reviews coverage for prescription medications on an ongoing basis, and makes periodic adjustments to meet these goals.

The following changes were made to our pharmacy benefit, effective January 1, 2008, and are reflected in our online drug list.

Medications moved from Tier-3 to Tier-2 of the 3-Tier Pharmacy Copayment program

- Tricor

Medications moved from Tier-2 to Tier-3 of the 3-Tier Pharmacy Copayment program

- Altace ■ Caduet
- Antara ■ Myfortic

Medications moved from the Non-Covered Drugs with Suggested Alternatives list to Tier-3 of the 3-Tier Pharmacy Copayment program

- Prosed/DS ■ Rozerem

Medications added to the Prior Authorization Step Therapy program

- Lunesta ■ Sonata
- Rozerem

Medications moved from covered status to the List of Non-Covered Drugs with Suggested Alternates

- Accupril ■ Monopril HCT
- Accuretic ■ Pravachol
- Altoprev ■ Uniretic
- Ambien ■ Univasc
- Capozide ■ Vasercic
- Lotensin ■ Zestoretic
- Lotensin HCT ■ Zestril
- Mavik ■ Zocor
- Monopril

Medications added to Dispensing Limitations program

To view medications that have been added to this program, go to our online formulary at www.tuftshealthplan.com/providers. Medications with dispensing limitations have a DL designation.

Find Current Pharmacy Information on the Web

For the most current information about the Tufts Health Plan pharmacy benefit—including tier changes, our online formulary, and descriptions of our pharmacy management programs—visit the Pharmacy section of www.tuftshealthplan.com/providers. The Tufts Health Plan Web site is a useful tool in your work with Tufts Health Plan patients.

Tufts Health Plan 60-Day Notification

CodeReview Edits: An Update

Tufts Health Plan uses CodeReview, a claims editing software issued by McKesson, and we are now reviewing 2008 CodeReview edit updates.

Beginning in the second calendar quarter of 2008, the most current edits will be applied to claims.

As is normal business practice, claims are subject to payment edits that are updated at regular intervals and generally based on Centers for Medicare &

Medicaid Services (CMS), specialty society guidelines, and the National Correct Coding Initiative (CCI).

Procedure and diagnosis codes undergo annual and quarterly revision by CMS, the American Medical Association, and CCI.

As these revisions are made public, Tufts Health Plan will update its system to reflect these changes. Payment policies will be updated to reflect the

addition and replacement of procedure codes, where applicable.

Continue to use the Clear Claim Connection tool on www.tuftshealthplan.com/providers to obtain clinical explanations of how your claim is processed. Clear Claim Connection provides detail that supports CodeReview edits, including bundling denials.

Tufts Health Plan 60-Day Notification

Effective April 1, 2008

Billing Changes Implemented for Bilateral Procedures

Please note that effective April 1, 2008, Tufts Health Plan will no longer accept claims billed with bilateral procedures on two claim lines/service lines.

To align with industry standards, we ask providers to submit claims billed with bilateral procedures on one claim line/service line and append modifier 50 (bilateral procedure).

For more information, please review the Bilateral and Multiple Surgical Procedures Facility or Professional payment policies, which can be found at www.tuftshealthplan.com/providers.

Tufts Health Plan 60-Day Notification

2008 CPT and HCPCS Additions and Revisions

Tufts Health Plan will update fee schedules to accommodate any new 2008 additions or revisions to CPT and HCPCS codes or reimbursable status.

- **Hospital outpatient ancillary fee schedule:** Changes will be effective for claims with 2008 dates of services, effective April 1, 2008.
- **Physician and hospital outpatient surgical fee schedules:** Changes will be effective for claims with 2008 dates of services as they are received.
 - Physician fees for vaccine codes will be updated on a quarterly basis and based on the most current information available from the Centers for Medicare & Medicaid Services. These changes will be effective beginning with April 1, 2008, dates of service. Amendments to existing fee schedules and non-reimbursable codes will be distributed to your provider organization and hospital leadership.

ADMINISTRATIVE NOTIFICATIONS

Results Are In

2007 Medical Record Review Audit

As part of our continuing commitment to clinical quality measurement and improvement, we examine the documentation practices of primary care physicians (PCPs) in the Tufts Health Plan network by reviewing a sample of medical records each year.

During 2007, we reviewed medical records of 202 network PCPs with panels of 50 or more Tufts Health Plan members. We have reported our findings to participating practitioners.

You can read a full article reviewing our findings at www.tuftshealthplan.com/providers.

You may also review the policies and procedures related to medical record review documentation—including confidentiality, organizational availability, and performance goals—in the Tufts Health Plan Provider Manual at www.tuftshealthplan.com/providers.

Coming Soon

Online Claims Adjustment—Register or Update Your Profile on Our Web Site

We are pleased to announce that coming soon in 2008 providers will be able to submit and track their commercial claim adjustments online using the claims status inquiry tools in Tufts Health e-Access for providers.

Providers will have to be registered Web users at www.tuftshealthplan.com to use this new functionality.

If you are not currently registered on our Web site, go to www.tuftshealthplan.com/providers to register. Just select

Provider Login and follow the instructions for provider registration.

Current access administrators who would like to grant access to this functionality to additional users in their office can use the Access Administration function on login.

More information on the benefits of this tool will be available in the months to come.

PLANS/PRODUCTS/BENEFITS

EyeMed Vision Care Now Provides Eye Care Services

Beginning January 1, 2008, providers participating in the EyeMed Vision Care network provide preventive eye and medical optometry services for Tufts Health Plan commercial and Tufts Medicare Preferred members.

Please note the following:

- **Optometrists** must be contracted with EyeMed Vision Care to provide covered preventive and medical optometry services to plan members and should submit claims directly to EyeMed.
- **Ophthalmologists** must be contracted with EyeMed Vision Care to provide covered preventive eye care services to plan members and should submit claims for routine services to EyeMed.

However, eye exams for **members with medical conditions** such as diabetes and glaucoma are covered by the member's medical benefit.

Ophthalmologists must submit eye exam claims for those commercial members to Tufts Health Plan with the medical condition diagnosis code as the primary diagnosis.

Referrals for plan members

Plan members do not require referrals for covered preventive eye care services. When appropriate, PCPs can issue referrals for medical services to participating EyeMed or Tufts Health Plan providers. Referrals cannot be issued electronically to EyeMed-contracted

providers at this time. In instances where a PCP deems it appropriate to issue a referral to an EyeMed provider for medical services, a paper referral should be sent to Tufts Health Plan.

To find an EyeMed-participating provider, go to the Provider Search function at our Web site, www.tuftshealthplan.com/providers. Under Find a Provider by Type, select Routine Eye Care, then click on Accept to access the EyeMed Provider Locator. Or call EyeMed at 1-866-504-5908.

For more information, please review our Vision Services Professional Payment Policy, which can be found at www.tuftshealthplan.com/providers.

TUFTS Health Plan

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For More Information

Always go to

www.tuftshealthplan.com/providers.

Or call Tufts Health Plan's

Provider Services Department

at 1-888-884-2404.