

Provider UPDATE



AUGUST 1, 2009

NEWS FOR THE NETWORK

HEADLINES

Tufts Health Plan 60-Day Notification

Effective October 1, 2009

Coverage Updates for Commercial Products

Tufts Health Plan implements changes to its commercial coverage status throughout the year. The following changes are **effective for dates of service on or after October 1, 2009**.

Prior Authorization

The following procedures and services will **require prior authorization** as of October 1, 2009:

- Selective Internal Radiation Therapy (SIRT) for Intrahepatic Radioembolization (S2095)
- Pediatric Pain Rehabilitation Centers

Non-Covered Services

The following procedures **will not be covered** by Tufts Health Plan, as they are considered experimental or investigational, and will be **added to the Statements of Non-Coverage** Medical Necessity Guidelines as of October 1, 2009:

- Hip Arthroscopy for Femoroacetabular Impingement (FAI) (29999)
- Nasal Function Studies (92512)
- Nebulized Antibiotic Therapy Except for the Treatment of Cystic Fibrosis
- Sublingual Immunotherapy for the Treatment of Allergies and Asthma
- Tissue/Tumor Chemosensitivity Assays (such as ChemoFX® Assay from Precision Therapeutics, Inc.)
- Triple Nerve Decompression/Release (28035, 64704, 64708, 64712, 64722)
- Urine-Based Ancillary Tests Designed to Detect Molecular Changes (Tests may include, but are not limited to, survivin and telomerase.)

Other Coverage Updates

- As previously communicated, effective August 1, 2009, Tufts Health Plan will no longer cover preimplantation genetic diagnosis to test for aneuploidy. In addition, the Medical Necessity Guidelines for Preimplantation Genetic Determination have been updated to clarify that Tufts Health Plan does not cover PGD for the purpose of human leukocyte antigen (HLA) tissue typing, as it is not considered to be medically necessary.
- Continuous passive motion (CPM) exercise device for use on knee only (E0935) will **no longer require prior authorization** as of August 31, 2009.
- Effective October 1, 2009, the Medical Necessity Guidelines for Oral Formula will be changed. Hydrosylate formula for use beyond age 1 year will be authorized only for six months if approved. Authorization requires a letter of medical necessity documenting a failed trial of soy formula at 1 year of age. Each subsequent authorization will require a letter of medical necessity documenting a recent failed trial of soy formula.
- Effective October 1, 2009, all prior authorization requests for a Continuous Glucose Monitoring System must be submitted on a Tufts Health Plan authorization form completed by an endocrinologist.

Tufts Health Plan Medical Necessity Guidelines are available in the Clinical Resources section of tuftshealthplan.com. If your office is not Web-enabled, copies of those guidelines are available upon request by calling Provider Services at 888-884-2404.

Tufts Health Plan 60-Day Notification

Effective October 1, 2009

Pharmacy Coverage Change: Viscosupplements for Osteoarthritis

Effective for fill dates on or after October 1, 2009, Tufts Health Plan will not cover the following viscosupplements for osteoarthritis:

- Synvisc® (J7322) and Synvisc One™
- Orthovisc® (J7324)
- Hyalgan® (J7321)
- Supartz® (J7321)

Tufts Health Plan will cover the preferred product, Euflexxa® (J7323). Also effective October 1, 2009, Euflexxa must be obtained through our designated specialty pharmacy, Curascript, at 866-297-0933.

This change applies to Tufts Health Plan commercial and Tufts Health Plan Medicare Preferred products.

Other coverage changes

Effective July 1, 2009, Sonata® has been removed from the Pharmacy Medical Necessity Guidelines for Insomnia Treatments under the Prior Authorization Program, and will be added to the list of Non-Covered Drugs with Suggested Alternatives. This change applies to Tufts Health Plan's commercial products only.

Find Current Pharmacy Information on the Web

For the most current information regarding the Tufts Health Plan pharmacy benefit – including tier changes, the online formularies and descriptions of pharmacy management programs – go to the Pharmacy section of our Web site.

Our Web site is updated regularly and is a useful resource in your work with Tufts Health Plan patients. Check Pharmacy Updates for postings of formulary changes, notification of new pharmacy programs and important information about drug recalls and alerts from the FDA or drug manufacturers.

If your office is not Web-enabled, copies of information regarding our pharmacy management programs can be provided upon request by calling Provider Services at 888-880-2404.

Tufts Health Plan 60-Day Notification

Effective October 1, 2009

Updated Coverage Guidelines for Speech Therapy

Tufts Health Plan has updated the diagnosis codes listed in the Medical Necessity Guidelines for Speech Therapy to align with current correct coding guidelines as published in the ICD-9 manual.

Effective October 1, 2009, claims for speech therapy submitted with a diagnosis code listed in Attachment A will deny. The member will be responsible for payment for those services, as stated in the member's handbook.

Contracting providers should note that members can be held liable for non-covered services only if the member agreed to pay for those services after being informed that the services are non-covered and signed a valid waiver of liability. The waiver must clearly demonstrate that the member agreed in advance in writing to pay for those services after being so informed. A general statement agreeing to pay for services not paid by the insurer is not sufficient.

For more information, refer to the Medical Necessity Guidelines for Speech Therapy in the Clinical Resources section of our Web site. Copies of those guidelines are available upon request by calling Provider Services at 888-884-2404.

Reminder: Preregistration for Elective Admissions

Admitting physicians and hospital admitting departments are responsible for notifying Tufts Health Plan no later than five business days prior to an elective admission.

Physicians who admit to more than one hospital should be sure to designate the facility at which the surgery will be performed.

If the date of a previously preregistered elective admission changes, contact the Precertification Department by phone (800-672-1515 or 617-972-9550) or fax (617-972-9590) to report the new date of admission to ensure accurate claims processing.

For more information on preregistration timelines and procedures, please refer to our Authorization Policy, available in the Payment Policies section of our Web site. Paper copies of that policy are available upon request by calling Provider Services at 888-884-2404.

Tufts Health Plan 60-Day Notification

Effective October 1, 2009

Commercial Drug and Biological Edits

The following edits are based on Tufts Health Plan's assessment of the drug manufacturer's packet label insert for each drug and are effective for claims adjudicated on or after October 1, 2009.

Tufts Health Plan will not reimburse for the following:

- **Docetaxel** if submitted more than once in a three-week period
- **Darbopoetin** if iron or iron-binding capacity has not been billed within three months of administering darbopoetin
- **Zoledronic acid** if serum creatine has not been billed in the previous week
- **Epoetin alfa** if chronic renal insufficiency has not been billed within the past year, or if iron or iron-binding capacity has not been billed within three months of administering epoetin alfa

These changes apply to commercial professional, facility and ambulatory surgical center providers and are reflected in the Ambulatory Surgical Center and Outpatient payment policies.

New Commercial DME, Orthotics and Prosthetics Edits

For commercial claims submitted by non-DME providers and adjudicated on or after October 1, 2009, Tufts Health Plan will implement coding methodologies to claims for durable medical equipment (DME), orthotics and prosthetics to more closely align with nationally and regionally accepted standards for correct coding, including:

- DME Regional Medicare Administrative Contractors (DME MAC)
- National Coverage Determinations (NCD)
- HCPCS definitions

For DME providers, this change is effective August 31, 2009, as stated in the notification dated June 30, 2009.

For additional information, refer to the Durable Medical Equipment, Home Infusion and Outpatient payment policies for commercial providers on our Web site.

Tufts Health Plan 60-Day Notification

Effective November 15, 2009

Bilateral/Multiple Surgical Procedures and Imaging Payment Policies Revised

Tufts Health Plan has revised its payment policies for bilateral and multiple surgical procedures and imaging services. The revised policies are effective for claims processed on or after November 15, 2009.

Bilateral and Multiple Surgical Procedures

Tufts Health Plan has revised its Bilateral and Multiple Surgical Procedures Facility and Professional payment policies to more closely align with CMS's code groups. In addition, we have also revised the current policy regarding multiple procedure reduction when two or more surgical procedures, including bilateral procedures, are performed by the same provider within the same operative session.

Multiple Imaging Procedures

Tufts Health Plan has revised its Multiple Imaging Procedures List to more closely align with CMS's code groups subject to multiple imaging procedure reduction.

For more information, refer to the section on Reimbursement for Multiple Imaging Procedures in the Imaging Services Facility, Freestanding and Mobile Imaging, and Imaging Professional payment policies.

These and other payment policies are available in the Payment Policies section at tuftsheathplan.com/providers. If your office is not Web-enabled, copies of those documents are available upon request by calling Provider Services at 888-884-2404.

Correct Coding Reminder

Tufts Health Plan would like to remind you that, 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) guidelines, specialty society guidelines, drug manufacturers' package label inserts and the National Correct Coding Initiative (NCCI).

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 during the third calendar quarter of 2009.

Payment policies will be updated to reflect the addition and replacement of procedure codes, where applicable.

Tufts Health Plan 60-Day Notification

Effective October 1, 2009

Commercial Coding Edits: Incomplete Lab Panels

The following edits are effective for claims adjudicated on or after October 1, 2009:

When submitted on the same date of service, laboratory components of a panel are included in the laboratory panel code itself. Providers will not be separately reimbursed for the following:

- More than **three renal function panel** procedure codes
- More than **two electrolyte panel** procedure codes
- More than **two basic metabolic panel** procedure codes
- More than **three comprehensive metabolic panel** procedure codes
- More than **one** of the following procedure codes when billed with a basic metabolic panel procedure code: 82040, 82247, 84075, 84155, 84460, 84450

Recoding

Edits may either bundle or recode procedures based on the appropriateness of the code selection. For example, if 80048 (basic metabolic panel), 84443 (TSH) and 85025 (CBC) are billed on the same date of service, the more appropriate code 80050 (General health panel) will be substituted for 84443.

These changes apply to commercial independent laboratories and facility providers and are reflected in the Laboratory and Outpatient payment policies located in the Payment Policy section at tuftshealthplan.com/providers.

ADMINISTRATIVE NOTIFICATIONS

Tufts Health Plan 60-Day Notification

Physician, Outpatient Hospital Fee Schedules to be Updated October 1

Tufts Health Plan reviews its commercial physician and outpatient hospital fee schedules quarterly to help ensure they are current, comprehensive and consistent with industry standards to the extent supported by our systems.

The next update will occur on October 1, 2009, and changes may involve both new and existing CPT and HCPCS codes. In most instances, updates involve the addition of new codes and fees and not changes to existing fees. Physician fees for vaccine and toxoid codes will be updated based on the most current information available from CMS.

Detailed information about changes to existing fee schedules and non-reimbursable logic is distributed to your Provider Organization and hospital leadership in advance of effective dates.

Independent physicians who have questions about fee schedule changes should contact Tufts Health Plan's Network Contracting Department at 888-880-8699, ext 2169.

Fraud, Waste and Abuse Training for Providers

The Centers for Medicare & Medicaid Services (CMS) requires all Medicare Advantage-Prescription Drug health plans to ensure that their participating providers complete Fraud, Waste and Abuse (FWA) training no later than December 31, 2009, and annually thereafter.

To assist in streamlining the training process for providers, HealthCare Administrative Solutions (HCAS) and its member health plans have created a Web site that includes an online FWA training program to be completed by providers. In addition to Tufts Health Plan, other HCAS-participating plans that have Medicare Advantage-Prescription Drug programs are Blue Cross Blue Shield of Massachusetts, Fallon Community Health Plan, Harvard Pilgrim Health Care, and Health New England.

Providers are urged to take the training online through the HCAS Web site because the provider needs to attest only once for all five HCAS-participating health plans that the training has been completed. Otherwise, the provider will need to contact each health plan separately to attest to having taken the training.

In addition, a provider who has already taken the training at another location can complete the attestation screen to demonstrate completion of FWA training.

Additional information and a link to the online FWA training is available on the HCAS Web site at hcasma.org and at tuftshealthplan.com/providers. If you need assistance or have questions about this training, please call Tufts Health Plan Medicare Preferred Provider Relations at 800-279-9022.

Tufts Health Plan Medicare Preferred Updates

As a Medicare Advantage Organization, Tufts Medicare Preferred must follow Medicare coverage guidelines. Network providers should be aware of the following recent Medicare National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), which can be accessed online at the CMS Web site, cms.hhs.gov

CT Colonography (CTC) for Colorectal Cancer

On May 12, 2009, CMS issued a final decision memo that CT colonography (also known as Virtual Colonoscopy) for colorectal cancer screening remains noncovered. Per LCD L17259, virtual colonoscopy is only indicated for those patients in whom an instrument colonoscopy of the entire colon is incomplete.

Pharmacogenomic Testing for Warfarin Response

In a proposed decision memo, CMS stated that pharmacogenomic testing to predict warfarin responsiveness is not reasonable and necessary and proposes that testing be covered only when provided to Medicare beneficiaries who are candidates for anticoagulation therapy with warfarin, and only then in the context of a prospective, randomized, controlled Medicare qualifying clinical study.

PET (FDG) for Solid Tumors

CMS posted a final decision memo replacing the current four-part treatment framework with a two-part framework that will differentiate PET (FDG) imaging used to inform the initial anti-tumor strategy from other uses related to guiding subsequent treatment strategies post initial treatment. For more information, see the Decision Memo for Positron Emission Tomography (FDG) for Solid Tumors (CAG-00181R).

Travel Oxygen

NHIC, Corp. has provided clarification on CMS coverage of oxygen equipment, contents and all related items and services during short-term travel or temporary relocation outside the supplier's service area.

Oxygen Non-Coverage

CMS does not cover oxygen services provided by an airline. Payment for oxygen furnished by an airline is the responsibility of the beneficiary and not the responsibility of the supplier.

For more detail on these determinations and links to related CMS resources, visit tuftshealthplan.com/providers.

2008 Medical Record Review Audit Results

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

During 2008, we reviewed medical records of 202 network PCPs with panels of 50 or more Tufts Health Plan members. We have reported our findings to these participating practitioners.

You can read the full article detailing our findings at 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 Commercial Provider Manual, also available at our Web site.

Nurse Practitioners Added to Network

In 2008, the Massachusetts General Laws were amended to include Chapter 176R “Consumer Choice in Nurse Practitioner Services.” Effective January 1, 2009, this law allows enrollees of benefit plans that require the selection of a primary care provider (PCP) to select nurse practitioners as a PCP.

As the result of a new Massachusetts mandate, beginning May 15, 2009, Tufts Health Plan members are allowed to choose a Massachusetts or New Hampshire contracted and credentialed nurse practitioner as their primary care or specialty care provider.

These contracted and credentialed nurse practitioners will, at their request, be included in both the print version of the Tufts Health Plan Provider Directory and the Provider Search tool on the Tufts Health Plan Web site.

Members who wish to select a nurse practitioner as their PCP will need to confirm that the nurse practitioner is part of the Tufts Health Plan network. Members are able to check online using the Provider Search function on our Web site.

Utilization Management Reviews

Utilization management decision-making is based on appropriateness of care and service, applicable coverage guidelines and medical necessity.

Tufts Health Plan does not specifically reward practitioners or other individuals who conduct utilization review for issuing denials of coverage, nor does it provide financial incentives for utilization management decision-makers to encourage denials of appropriate coverage.

Financial incentives for utilization review do not encourage decisions that result in underutilization.

Self-Service Tool Enhancements

Tufts Health Plan is pleased to announce enhancements to our self-service tools for providers.

Online Claim Adjustments

More than 20 message codes have been added to those that can be submitted for adjustment through our Online Claim Adjustment Tool. In addition, you no longer need to submit an attachment to adjust claims denied for no referral—you can now simply enter the referral number in the Comments field.

Interactive Voice Response

Our interactive voice response (IVR) system now allows providers to check claim status and offers the option to request line-item detail on their claims. Providers can also request a Statement of Account through our IVR. The member's identification number, date of birth, and the date of service are required to access these functions. To access the IVR, call 888-884-2404.

Radiation Safety Awareness Initiative

In March 2009, Tufts Health Plan began a Radiation Safety Awareness Initiative, in conjunction with National Imaging Associates (NIA), to improve patient safety and raise awareness regarding radiation exposure.

NIA has developed a white paper on Radiation Exposure and other resources regarding their radiation awareness program. To view that document and other information on radiation exposure, visit tuftshealthplan.com/providers, or the NIA Web site at radmd.com.

Update: Paper Claim Submission Requirements

Revised guidelines for paper claims submitted to Tufts Health Plan, previously announced as effective September 21, 2009, will instead be effective October 19, 2009.

For all commercial and Tufts Medicare Preferred paper claims submitted on or after October 19, 2009, up to four diagnosis codes will be accepted on the CMS-1500 form. Paper claims will be returned to the submitter if the date of service, the physician's signature or the federal tax ID is missing.

In addition, paper claims submitted to Tufts Medicare Preferred will be returned to the submitter if:

- the procedure code field is blank or the submitted code is invalid
- the place of service field is blank (box 24b on the CMS-1500 form)
- the diagnosis code field is blank or the submitted code is invalid

In addition, providers should submit industry-standard codes on all paper claims.

If a claim is returned to the submitter, the provider must resubmit the claim no later than 90 days from the date of service for all commercial products and no later than 60 days from the date of service for Tufts Medicare Preferred products.

To ensure accurate and timely processing of claims, refer to the specifications for completing each field of the UB-04 and CMS-1500 claim forms in the Claim Requirements chapter of the Tufts Health Plan Commercial and Tufts Medicare Preferred provider manuals. Those documents are available on our Web site. If your office is not Web-enabled, copies are available upon request by contacting Provider Services at 888-884-2404.

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