TUFTS Health Plan

Provider UPDATE

JANUARY 1, 2009 NOTIFICATION

NEWS FOR THE NETWORK

HEADLINES

Tufts Health Plan 60-Day Notification

Effective January 1, 2009

Coverage Updates for Commercial Products

Tufts Health Plan implements changes to its coverage for commercial products throughout the year. The following changes are effective as of January 1, 2009:

Continuous Glucose Monitoring Systems: The following procedures will be **covered with prior authorization** when they meet the Medical Necessity Guidelines for Continuous Glucose Monitoring Systems:

- **A9276:** Sensor; invasive (e.g., subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, 1 unit = 1-day supply
- **A9277:** Transmitter; external, for use with interstitial continuous glucose monitoring system
- **A9278:** Receiver (monitor); external, for use with interstitial continuous glucose monitoring system
- **S1030:** Continuous noninvasive glucose monitoring device, purchase; and **S1031:** rental, including sensor, sensor replacement, and download to monitor

Cochlear Implants: The following procedures will be **added** to the current Medical Necessity Guidelines for Cochlear Implants for Adults and Children:

- **L8615:** Headset/headpiece for use with cochlear implant device, replacement
- **L8616:** Microphone for use with cochlear implant device, replacement
- **L8617:** Transmitting coil for use with cochlear implant device, replacement
- **L8618:** Transmitter cable for use with cochlear implant device, replacement
- **L8621:** Zinc air battery for use with cochlear implant device, replacement, each
- **L8622:** Alkaline battery for use with cochlear implant device, any size, replacement, each
- **L8623:** Lithium ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each
- **L8624:** Lithium ion battery for use with cochlear implant device speech processor, ear level, replacement, each

Intrathecal Pump for the Infusion of Baclofen: The following procedures will be **added** to the current Medical Necessity Guidelines for Intrathecal Pump for the Infusion of Baclofen:

- **62350:** Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump, without laminectomy; and **62351:** with laminectomy
- **62360:** Implantation or replacement of device for intrathecal or epidural drug infusion, subcutaneous reservoir; **62361:** Non-programmable pump; and **62362:** programmable pump, including preparation of pump, with or without programming
- **62367:** Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming; and **62368:** with reprogramming
- **E0785:** Implantable intraspinal (epidural/intrathecal) catheter used with implantable infusion pump, replacement

Statements of Non-Coverage: The following procedures **will not be covered** and will be added to the Statements of Non-Coverage Medical Necessity Guidelines:

- Transvaginal and Transurethral Radiofrequency Tissue Remodeling for Urinary Stress Incontinence (55873)
- Home Uterine Activity Monitoring (S9208, S9209)
- Genetic Testing for Narcolepsy (no CPT or HCPCS code available)

Tufts Health Plan 60-Day Notification

Effective January 1, 2009
Pharmacy Updates for Commercial Products

Coverage Change for Anti-Obesity Medications

Effective January 1, 2009, Tufts Health Plan will require members who utilize weight loss medications to enroll in a dietary/behavioral modification program and follow a fitness regimen (as documented on the authorization request) in order to obtain initial and continuing authorization of these medications. Physicians will document the member's adherence to a fitness regimen on the authorization request.

Medication therapy for weight loss is most effective when combined with both a dietary/behavioral support program and a fitness regimen. In the past, Tufts Health Plan has required that members utilizing anti-obesity medications enroll in an exercise, nutritional, or behavioral modification program for weight loss in order to continue therapy beyond an initial eight-week trial.

Exclusion of Prescription Drugs Co-packaged with OTC Products

Effective January 1, 2009, prescription medications co-packaged with non-prescription products will be excluded from coverage. At that time, formulary exceptions for those co-packaged medications will no longer be available.

Pharmaceutical companies are marketing more prescription medications co-packaged with non-prescription products, including over-the-counter (OTC) drugs. These co-packaged products, sometimes referred to as "convenience kits," also may include dietary supplements, non-medicated skin cleansers, sunscreen, dandruff shampoos, or other non-prescription products. Typically, the prescription medication is available as a generic or as a brand-name single-product item.

Exclusion of Non-sedating Antihistamines from Pharmacy Program

In recent years, the U.S. Food and Drug Administration (FDA) has approved over-the-counter sale of the non-sedating antihistamine drugs Claritin®, Claritin-D®, Zyrtec®, and Zyrtec-D®. Once prescription medications become available over the counter, Tufts Health Plan may not cover the specific medication(s) and the entire class of prescription medications.

Due to the over-the-counter availability of several non-sedating antihistamine formulations, Tufts Health Plan will exclude all non-sedating antihistamines from coverage effective July 1, 2009. At that time, formulary exceptions will no longer be available. Please begin to transition any of your patients who might be affected by this change.

Coverage Change for Allegra®, Allegra-D®, and Fexofenadine

In anticipation of the exclusion of the non-sedating antihistamine class, all forms of Allegra, Allegra-D, and fexofenadine will be moved to Tufts Health Plan's list of non-covered drugs with suggested alternatives, effective January 1, 2009.

Providers may submit a formulary exception request under the medical review process for non-covered drugs with suggested alternatives. Beginning July 1, 2009, formulary exceptions will no longer be available for all non-sedating antihistamines.

Kepivance and Prialt Removed from Prior Authorization List

Effective September 1, 2008, the drugs Kepivance and Prialt no longer require prior authorization and remain covered under the member's medical benefit.

Nasacort AQ and Rhinocort Aqua

Effective January 1, 2009, the nasal steroids Nasacort AQ and Rhinocort Aqua will not be covered. Nasonex will remain covered in Tier-2.

Quinolone Antibiotics: Levaquin Tablets

Effective January 1, 2009, Levaquin tablets will not be covered. Avelox tablets will continue to be covered.

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 drug recalls and alerts from the FDA or drug manufacturers.

Tufts Health Plan Medicare Preferred
Recent Medicare Determinations

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, www.cms.hhs.gov.

Computed Tomographic Angiography

On July 24, 2008, CMS established that a national coverage determination for CTA is not appropriate at this time and continues to leave coverage decisions to local contractors through LCDs or case-by-case adjudication. See NCD 220.1 and LCD 25907.

Continuous Positive Airway Pressure Therapy for Obstructive Sleep Apnea

Effective March 13, 2008, CMS limited initial coverage of CPAP for adult patients with OSA to a 12-week period and continues coverage only for those patients who demonstrate a benefit from use during the 12-week period. In addition, CMS no longer requires that the patient have moderate to severe OSA and that surgery is a likely alternative. Qualification for a diagnosis of OSA was expanded to include a clinical evaluation and a positive unattended Home Sleep Testing (HST) with a Type II, Type III, or Type IV home sleep monitoring device that measures at least three channels. See NCD 240.4.

PET for Infection and Inflammation

After consideration of FDG-PET imaging for three off-label uses, CMS decided on July 18, 2008, not to expand coverage to include these uses. CMS determined that coverage is not reasonable and necessary due to inadequate evidence that FDG-PET improves health outcomes for Medicare populations with the considered diagnoses. See NCD 220.6.16.

Colorectal Cancer Screening Tests

CMS decided on August 20, 2008, not to expand the colorectal cancer screening benefit to include Pre-Gen Plus™. See NCD 210.3.

Percutaneous Transluminal Angioplasty

On July 25, 2008, CMS denied a request for expansion of coverage of PTA. See NCD 20.7 for coverage limitations.

Microvolt T-Wave Alternans

CMS decided on July 28, 2008, not to expand coverage of MTWA to include the modified moving average (MMA) method of measurement. CMS continues to cover MTWA for evaluation of sudden cardiac death (SCD) only when the spectral analysis method is used for measurement. See NCD 20.30.

Commercial Provider Manual Updated

The Commercial Provider Manual is revised three times per year. The most recent updates include the following:

- **Claim Requirements chapter:** Added information on online adjustment requests and indicated effective October 1, 2008, providers and their office staff should use the online claim adjustment tool to process their claim adjustments.
- **Providers chapter:** Added credentialing information for Rhode Island providers.
- **Tufts Health Plan Quality Administrative Guidelines chapter:** Clarified information on site visits, indicated office site appraisal components, and updated the Credentialing Site Visit Checklist. Added information on serious reportable events (“never events”).
- **Utilization Management Guidelines chapter:** Clarified the medical technology assessment process.

The provider manuals were developed to supply our providers and their office staff with details on Tufts Health Plan’s products, policies, and procedures. We recommend that providers and their staff read this information and reference it on an ongoing basis for the most up-to-date information.

Tufts Health Plan 60-Day Notification

New Commercial Coding Edit: Subcutaneous and Intramuscular Injection Codes

Effective for dates of services on or after February 1, 2009, Tufts Health Plan will not reimburse the subcutaneous or intramuscular injection code when billed with the administration of vaccines and toxoids, as the subcutaneous or intramuscular injection code is inappropriate to use for the administration of vaccines and toxoids. Reference the AMA CPT Manual for additional information.

This change applies to commercial professional, facilities, and ambulatory surgical center providers, and is reflected in the Immunization Professional, Outpatient, and Ambulatory Surgical Center payment policies.

Tufts Health Plan 60-Day Notification

New Commercial Coding Edit: Diagnostic and Radiology Services

Effective for dates of services on or after February 1, 2009, Tufts Health Plan will not reimburse a diagnostic test or radiology service billed with modifier 26 (professional component) and modifier TC (technical component) if the technical and professional components of the service are performed by the same provider billed on the same or different claim on the same date of service. According to the AMA Principles of CPT Coding, it is not appropriate to report the components of the professional and technical service separately.

This change applies to commercial professional providers and is documented in the Imaging Professional Payment Policy.

Tufts Health Plan 60-Day Notification

Correct Coding Reminder and CodeReview® Edits

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, 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 during the first calendar quarter of 2009.

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

CodeReview Edits: An Update

Tufts Health Plan uses CodeReview®, a claims editing software issued by McKesson, and we are currently in the process of reviewing 2009 CodeReview edit updates.

Beginning in the first calendar quarter of 2009, the most current edits will be applied to claims.

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

HEDIS 2009 Improvement Interventions

CPT Category II Codes

The Centers for Medicare and Medicaid Services (CMS) uses CPT Category II codes for Medicare Fee-for-Service quality payments. Although Medicare Advantage and commercial plans are not included in the CMS quality payment program, the use of Category II codes can decrease the need for medical record review and thereby reduce the administrative burden on physician practices and hospital record departments.

Tufts Health Plan currently does not reimburse for these codes. However, reporting these codes will improve HEDIS scores.

The Category II codes are alphanumeric and consist of four digits followed by the alpha character "F." Use of these codes is optional, and they are not a substitute for Category I codes. CPT Category II codes are used to supplement the collection of information about the quality of care delivered by coding services or test results that support nationally established performance measures and have an evidence base as contributing to quality patient care.

Yearly Eye Exams for Diabetic Patients

For your diabetic patients, it is important for them to have a dilated eye exam each year. This eye exam must be provided by a participating EyeMed optometrist or a participating Tufts Health Plan ophthalmologist. Referrals are required for this eye exam when provided by a Tufts Health Plan ophthalmologist.

Please note: Some members are covered for one routine eye exam every 24 months. Because the dilated eye exam for diabetic members is not a routine eye exam, it is covered every year. For this eye exam to be covered, it is important for your patient to notify the optometrist or ophthalmologist that s/he has diabetes and for providers to submit diabetic eye exam claims to Tufts Health Plan with the diabetes diagnosis code as the primary diagnosis.

Attention: Physicians Who Care for Young Women

Every year, Chlamydia is one of the most frequently reported bacterial sexually transmitted diseases in the U.S. According to the Centers for Disease Control and Prevention, under-reporting is substantial because nearly three-quarters of infected women have no symptoms.

Tufts Health Plan encourages physicians to test women, particularly those between the ages of 16-24 years who are sexually active, for the presence of Chlamydia.

Clinical Quality Management reports, available to PCPs on Tufts Health Plan's secured Web site, list the PCP's members who are age-appropriate for Chlamydia screening and whether a screening has been performed within the past 12 months.

Non-Emergency Transportation – Prior Authorization Change

After comprehensive review of Tufts Health Plan's current prior authorization policy for non-emergency ambulance transportation, a decision has been made to streamline the prior authorization process for providers.

As previously communicated to ambulance transportation providers, effective October 1, 2008, the prior authorization process will be replaced by a retrospective review process focusing on medical necessity, in accordance with Medicare guidelines.

An appropriate medical necessity form will be required to be submitted with all non-emergency ambulance claims. This new process will apply only to transports with dates of service on or after October 1, 2008.

This change is documented in the Ambulance and Transportation Payment Policy.

Tufts Health Plan 60-Day Notification

Effective January 1, 2009
No Referral Required for Optometry Services

Effective January 1, 2009, medical services rendered by an optometrist (OD) will no longer require a PCP referral. This change applies to Tufts Health Plan's Commercial and Tufts Medicare Preferred products.

Medical services rendered by an ophthalmologist (MD) will continue to require a PCP referral.

This change will be reflected in the Vision Services Payment Policy and Authorization and Notification Policy.

Note: For members with an eye disease such as glaucoma or a condition such as diabetes, services including periodic follow-up eye exams are considered "non-preventive/ non-routine" instead of "routine."

Utilization Management Guidelines Support Quality Care

Our utilization management programs aim at helping Tufts Health Plan members receive quality health care in an appropriate treatment setting. To help ensure that our members receive quality health care in an appropriate treatment setting, Tufts Health Plan's utilization management program uses Medical Necessity Guidelines in evaluating requests for coverage. The following guidelines are used by Tufts Health Plan in the administration of its utilization management program:

- It is the responsibility of the attending physician to make all clinical decisions regarding medical treatment. These decisions should be made consistent with generally accepted principles of professional medical practice and in consultation with the member.
- It is the responsibility of Tufts Health Plan to determine benefit coverage. Tufts Health Plan uses Medical Necessity Guidelines to evaluate requests for coverage. Copies of our Medical Necessity Guidelines are available in the Clinical Resources section of our Web site.
- All utilization review decisions are made by qualified, licensed physicians. For mental health and substance abuse services, doctoral-level psychologists may render coverage decisions, unless the requesting provider is a licensed physician. In that event, a licensed physician must render the coverage decision.

A Tufts Health Plan medical director is available by phone to discuss coverage determinations based on medical necessity. Utilization management decision-making is based on medical necessity, applicable coverage guidelines, and appropriateness of care and service. Tufts Health Plan does not compensate 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.

How to discuss a utilization review determination

Treating physicians who would like to discuss a utilization review determination with the decision-making medical director at Tufts Health Plan may contact the Tufts Health Plan Clinical Services Department toll-free at 888-766-9818, ext. 4276, between 8:30 a.m. and 5:00 p.m. Mental health and substance abuse providers should call toll-free 800-208-9565.

Quality Improvement Work Plan Supports Patient Care

Tufts Health Plan appreciates the quality care that our network physicians provide our members.

To support the quality care you provide, each year we develop a set of priority quality initiatives which we believe will have the greatest impact on the health and well-being of the most members. We call this our Quality Improvement Work Plan.

In designing our work plan, we review members' concerns, physician and member feedback, medical and claims data, and other information about our members' health. This helps us understand what we're doing well, what we need to improve, and most important, what our members need. Some of the initiatives in the 2008 Quality Improvement Work Plan focus on:

- Working with members with chronic diseases, such as diabetes, to help them get the tests they need to stay healthy
- Improving member satisfaction with Member Services Department interactions
- Working with members and PCPs to ensure follow-up care after an inpatient psychiatric hospitalization
- Advocating for safety in patient care, including appropriate use of prescription medication
- Increasing preventive care women receive related to breast and cervical cancer

For more information or an update on our progress in meeting our quality improvement goals, please visit our Web site.

Tufts Health Plan Medicare Preferred

Financial Implications of POA Reporting

As directed in the Deficit Reduction Act (DRA) of 2005, the Centers for Medicare and Medicaid Services (CMS) requires many hospitals to report present on admission (POA) information on certain diagnoses on their Medicare claims. The purpose of the POA reporting is to identify hospital-acquired conditions (HACs) that develop during the patient's inpatient admission. The DRA also requires an adjustment in Medicare Diagnosis Related Group (DRG) assignment for certain HACs.

Beginning October 1, 2007, CMS required Inpatient Prospective Payment System (IPPS) hospitals to submit POA information. Beginning April 1, 2008, CMS returned claims submitted for payment that do not contain proper reporting of POA information.

Effective with discharges on or after October 1, 2008, CMS and Tufts Health Plan Medicare Preferred will process POA information in the assignment of the DRG. Hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission, and the case will be paid as if the secondary diagnosis were not present. Tufts Medicare Preferred also will not provide additional payment for a condition if POA information required by CMS is not reported.

For more information, visit our Web site and the HAC & POA Indicator Reporting Web page on the CMS Web site at www.cms.hhs.gov/HospitalAcqCond/.

Tufts Health Plan 60-Day Notification

Effective January 1, 2009
Annual Updates to Physician and Hospital Reimbursement

Consistent with past years, Tufts Health Plan will update its physician and hospital fee schedules effective January 1, 2009. Tufts Health Plan will continue to base fees on Centers for Medicare & Medicaid Services (CMS) fee schedules, inflated to achieve the contracted level of reimbursement, and will follow a methodology similar to that used for setting 2008 fees.

For physicians, Tufts Health Plan will diverge from CMS again in 2009 by directing a higher proportion of funds to the fees for vaginal deliveries, as well as preventive medicine office visit codes. Slightly moderated increases to psychiatry visit fees compared to CMS will be continued and drug pricing will remain at the same ASP levels as in 2008.

The specifics for fee schedule changes, the applicable 2009 fee schedule, and all modifications to our non-reimbursable procedure list will be distributed to hospitals, independent physicians, and IPA leadership in November 2008.

In addition, please remember to consult www.tuftshealthplan.com/providers for information regarding changes to non-reimbursable codes, payment policies, and edits that could affect reimbursement.

Reminder: Claim Adjustment Requests

As previously communicated, effective October 1, 2008, providers and offices should use the online adjustment tool to process their claim adjustments. After that date, providers who do not use the online claim adjustment tool must submit their adjustment requests by mail following the Provider Payment Dispute process.

Our call center staff will continue to be available to explain and interpret claim adjudication, to answer questions on how to submit claim adjustment requests, and to assist with Web site registration.

Visit our Web site for more information, including training on our online claim adjustment functionality and how to register on our secure Web site.

PLANS/PRODUCTS/BENEFITS

Tufts Health Plan 60-Day Notification

Plan Benefit Changes Effective January 1, 2009

The following benefit changes will be effective January 1, 2009, and will be rolled out as employer groups renew or join Tufts Health Plan during the year.

These changes will apply to fully insured commercial plans as described below. Self-insured groups may choose whether to adopt these changes.

- **High-tech imaging (MRI/MRA, CT/CTA Scan, PET Scan, Nuclear Cardiology)** will require a $50 copayment per visit for:
  - All HMO Value plans
  - POS Value and PPO Value small-group plans

  High-tech imaging copayment information will be available on Tufts Health Plan's secure Web site, NEHEN, NEHENNet, and our Interactive Voice Response (IVR) system.

  Please note: Members with a cancer diagnosis will be exempt from copayments for high-tech imaging related to that diagnosis.
- **Pediatric dental care** will not be a covered benefit. This change applies to HMO Premium plans.
- **Hearing aids** for children under age 19 will not be a covered benefit. This change applies to all fully insured products and plans, with the exception of Select Network and Tufts Medicare Complement (TMC) plans.
- **Emergency room observation services** Members who have observation services in an emergency room will be responsible for an emergency room copayment. This change will apply only to members of employer groups who elect this option.

Refer your Tufts Health Plan patients to their current Tufts Health Plan member benefit document if they have questions about their coverage.

Tufts Health Plan 60-Day Notification

Tufts Health Plan to Enter Rhode Island Market

Tufts Health Plan has formally announced its plan to enter the Rhode Island health plan market and currently is offering its PPO product to employers for a January 1, 2009, effective date. To support anticipated membership growth, we also are actively expanding our provider network in Rhode Island.

Providers should note that Rhode Island coverage mandates may differ from those of Massachusetts. Members generally will be subject to the coverage mandates of the state in which the member's employer group is based, regardless of the state in which the member resides or in which services are rendered.

Member identification cards for Rhode Island-based employer group members will include a distinctive "RI" logo.

Providers are reminded to confirm member benefits and coverage using any of the member inquiry options for benefit information: Tufts Health Plan's secure Web site, NEHEN, or NEHEN*Net*.

Contracting providers are required to adhere to Tufts Health Plan's utilization management (UM) requirements, including prior authorization requirements described in our medical and pharmacy coverage criteria, payment policies, and procedures. That information is available in the Clinical Resources, Payment Policies, and Pharmacy sections of our Web site at www.tuftshealthplan.com/providers.

Additional information, including Rhode Island-specific coverage provisions effective January 1, 2009, are available on our Web site.

If your office is not Web-enabled, please contact Tufts Health Plan Provider Services at 888-884-2404 to request copies.

Avoiding Over-Utilization of Antibiotics

Antibiotic resistance is a global public health concern.

Tufts Health Plan has adopted the Antibiotic Resistance and Usage Guidelines of the Alliance for the Prudent Use of Antibiotics (APUA). The APUA Web site at www.tufts.edu/med/apua includes resources for both patients and practitioners on avoiding over-utilization of antibiotics.

To support efforts in educating patients regarding over-utilization of antibiotics, Tufts Health Plan also is providing the following links to patient education materials:

- Get Smart: Know When Antibiotics Work

  These reproducible materials are written in lay terminology and are available in English and Spanish.

- Combating Antibiotic Resistance

Links to the APUA guidelines and to the patient education materials can be found on the Clinical Practice Guidelines page in the Clinical Resources section of our Web site.

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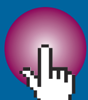

For More Information

Always go to www.tuftshealthplan.com/providers. Or call Tufts Health Plan's Provider Services Department at 1-888-884-2404, or Tufts Health Plan Medicare Preferred Provider Relations at 1-800-279-9022.