

Tufts Health Plan® wants to help you avoid administrative claim denials. To prevent denials from occurring, a list of administrative claim denials that providers may receive has been created, along with tips on how to avoid them. The table below has been created as a tool to help you avoid administrative claim denials.

Administrative Claim Denials and Tips to Avoid Them	
Denials	Tips
<p>No Referral HMO, EPO, TMC, & Tufts Health Plan Medicare Preferred HMO members are required to have electronic or paper referrals from their PCP for most specialty care services.</p> <p>The PCP is responsible for coordinating and submitting referrals to Tufts Health Plan prior to services being rendered.</p> <p>Referrals can be submitted via:</p> <ul style="list-style-type: none"> o Tufts Health Plan Web site o NEHEN o NEHEN/Net o POS device or Emdeon Office o Paper referral 	<ul style="list-style-type: none"> • Confirm that the referral was made prior to services being rendered by referencing <ul style="list-style-type: none"> o the referral inquiry on the Tufts Health Plan Web site o POS device or Emdeon Office o NEHEN o NEHEN/Net o calling the PCP's office o calling the Provider Services Call Center or the Tufts Health Plan Medicare Preferred Provider Relations Department • Reference the Authorization Policy for additional information. • Ask members to sign a waiver if they have not obtained a referral. • Reference the referral waiver form for commercial members or the referral waiver requirements for Tufts Medicare Preferred members.
<p>Duplicate Below are reasons why a claim may deny as a duplicate:</p> <ul style="list-style-type: none"> • The same claim is submitted multiple times. • A corrected claim is submitted, but the corrections are not made. • Late charges are submitted on a new claim, but the facility claim does not indicate the original claim number and the correct type of bill number. 	<ul style="list-style-type: none"> • Reference the Provider Payment Dispute Policy and the Provider Payment Dispute Form to submit a corrected claim and mail to the appropriate PO Box. Corrected claims sent to Tufts Health Plan without a provider payment dispute coversheet will result in a duplicate denial. • To submit late charges electronically for facility claims, include the original reference number, which is the Tufts Health Plan claim number and the type of bill number. The type of bill number should indicate a third digit frequency ending in five. • Providers can check claim status via: <ul style="list-style-type: none"> o Tufts Health Plan Web site o NEHEN o NEHEN/Net o by calling the Provider Services call center or Tufts Medicare Preferred Provider Relations • Reference the Claims Requirements Chapter within the Commercial Provider Manual for more information or the Claim Requirements and Dispute Guidelines Chapter within the Tufts Medicare Preferred Provider Manual.

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Denials	Tips
<p>Filing Limit Tufts Health Plan must receive claims within 90 days from the date of service for all commercial products.</p> <p>Tufts Health Plan must receive claims within 60 days from the date of service for Tufts Health Plan Medicare Preferred products.</p>	<ul style="list-style-type: none"> • EDI Claim Submitters: <ul style="list-style-type: none"> ○ Check the electronic summary reports to make sure the claim was accepted by Tufts Health Plan ○ Review the rejection, correct the claim, and re-submit the claim within the filing limit • Paper Claim Submitters: <ul style="list-style-type: none"> ○ Ensure all of the information is correct on the paper claim form ○ Verify the correct address for paper claims submission ○ Call the Provider Services Call Center or Tufts Medicare Preferred Provider Relations if you have not received status on the claim via the Statement of Account (SOA) • Reference the Claims Submission Policy for additional information.
<p>No Preregistration Tufts Health Plan requires a preregistration for all members who are admitted for inpatient care, regardless of whether Tufts Health Plan is the primary or secondary insurer.</p> <p>Admitting physicians and hospital admitting departments are responsible for notifying Tufts Health Plan within the following timelines:</p> <ul style="list-style-type: none"> • Elective admissions must be reported no later than five business days prior to admission • Urgent or Emergency admissions must be reported within one business day 	<p>To obtain an authorized preregistration use one of the following options:</p> <ul style="list-style-type: none"> ○ The secure Tufts Health Plan Web site ○ NEHEN ○ NEHEN/Net ○ Fax a Preregistration Form to the Precertification Department ○ Contact the Preregistration Department at (800) 672-1515 <ul style="list-style-type: none"> • Reference the Authorization Policy for additional information.
<p>No Authorization Tufts Health Plan requires providers to obtain prior authorization through for certain services, drugs, devices and equipment in order to be covered.</p>	<ul style="list-style-type: none"> • Reference the Clinical Resources section of the Tufts Health Plan Web site to determine which services require prior authorization and the process for review. • Submit requests for a Mental Health authorization via the Tufts Health Plan Web site, or by calling the Mental Health department (800)-208-9565. • Submit requests for high-tech imaging authorizations via the National Imaging Associates (NIA) Web site or by calling NIA directly (866)-642-9703.

Register to use the Tufts Health Plan Web site by logging into the [Provider login](#) section of the [Tufts Health Plan Web Site](#), or by calling the Provider Services Web Queue at 888-884-2404 option #1.