



HEADLINES

Tufts Health Plan 60-Day Notification

Effective January 1, 2010

Coverage Updates for Commercial Products

Tufts Health Plan implements changes to its commercial coverage throughout the year. The following changes are **effective for dates of service on or after January 1, 2010**.

Prior Authorization

Effective for dates of service on or after January 1, 2010, the following procedures and services will **require prior authorization**:

- Shoulder Arthroscopy: Diagnostic/Therapeutic (29805, 29806, 29807, 29819, 29822, 29823, 29824, 29826, 29827, 29828)
- Shoulder Arthroscopy: Arthroscopically Assisted Surgery (23130, 23412, 23415, 23420, 23450, 23455, 23460, 23462, 23466)
- Total Joint Replacement (23332, 23472, 27130, 27132, 27134, 27137, 27138, 27447, 27486, 27487, 27488)

The following codes will be **added** to existing prior authorization programs:

- Genetic Testing: General Policy: SignatureChip® (S3870) (All genetic tests require prior authorization unless noted as not covered in the Statements of Non-Coverage Medical Necessity Guidelines.)
- Temporomandibular Joint (TMJ) Disorder Treatment (21010, 29800, 29804)
- Vagus Nerve Stimulation (64553)

Non-Covered Services

Effective for dates of service on or after January 1, 2010, the following procedures **will not be covered** by Tufts Health Plan, as they are considered experimental/investigational, and will be **added to the Statements of Non-Coverage** Medical Necessity Guidelines:

- Cranialsacral Therapy
- Endoscopic Laser-Assisted Discectomy for Cervical Disc Herniation
- Intravascular Ultrasound (IVUS) for Assessment of Peripheral Artery Disease (PAD) of the Lower Extremities (37250, 37251 with a diagnosis of 440.20 – 440.29, 443.9)
- Laparoscopic Sleeve Gastrectomy for Super Obesity
- Laparoscopic Ileal Interposition and Sleeve Gastrectomy for Treatment of Type 2 Diabetes
- Multichannel Intraluminal Impedance Testing for GERD (91037, 91038)
- Percutaneous Mechanical Thrombectomy for Acute Limb Ischemia with the AngioJet® Rheolytic Thrombectomy System (Possis Medical, Inc.)
- Platelet-Rich Plasma (PRP) for Bone Healing and Fusion
- Pathwork® Tissue of Origin Test Gene Expression-Based Test
- Urinary Microsatellite Analysis
- Wireless Capsule for Measuring Gastric Emptying (SmartPill GI Monitoring System®) (91299)

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2009 InterQual® Criteria

Effective December 14, 2009, Tufts Health Plan will adopt 2009 InterQual® criteria in making clinical coverage determinations.

Tufts Health Plan requires submission of an InterQual® SmartSheet™ for prior authorization of some procedures, services and items. For dates of service on or after December 14, 2009, providers should submit the 2009 version when requesting prior authorization for any procedure for which an InterQual® SmartSheet™ is required.

Submitting the previous version will delay processing of the authorization request.

A list of procedures for which Tufts Health Plan requires an InterQual® SmartSheet™ is available in the Clinical Resources section of tuftshealthplan.com/providers, and the InterQual® SmartSheets™ for those procedures can be found on our secure Provider Web site. Providers can also request a copy of any of those documents by calling Provider Services.

Effective January 1, 2010

Coverage Updates for Commercial Products (continued from page 1)

Other Coverage Updates

- **Hysterectomy:** Effective January 1, 2010, the Medical Necessity Guidelines for Elective Hysterectomy have been updated regarding dysfunctional uterine bleeding. An Organizational Policy Note (OPN) has been added requiring endometrial ablation.
- **Upper GI Endoscopy: Celiac Sprue Diagnosis:** Effective January 1, 2010, Celiac Sprue Diagnosis has been added to the current Upper GI Endoscopy prior authorization program. Beginning January 1, 2010, providers should submit a letter of medical necessity instead of an InterQual® SmartSheet™ to request prior authorization for upper GI endoscopy for that diagnosis. Coverage criteria for those procedures are in the Medical Necessity Guidelines for Upper GI Endoscopy: Celiac Sprue Diagnosis.
- **Spinal Procedures: Certain Elective:** Effective January 1, 2010, the following additional diagnoses and procedures have been added to the current prior authorization program for Spinal Procedures: Certain Elective.

- Lumbar Fusion for the following diagnoses:
 - Isthmic Spondylolisthesis (any grade)
 - Degenerative Spondylolisthesis with or without Spinal Stenosis
 - Internal Lumbar Disc Disruption including Anterior Lumbar Interbody Fusion (ALIF)
 - Re-do Lumbar Fusion
 - Posterior Lumbar Decompression with Lumbar Spinal Fusion for Lumbar Spinal Stenosis
 - Posterior Decompression without Spinal Fusion for Spinal Stenosis
 - Hemilaminectomy, lumbar with or without discectomy/foraminotomy
- Tufts Health Plan's Medical Necessity Guidelines are in the Clinical Resources section of tuftshealthplan.com/providers. Copies of these guidelines are also available upon request by calling Provider Services at 888-884-2404.

CLINICAL NOTIFICATIONS

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 Centers for Medicare & Medicaid Services (CMS) Web site, cms.hhs.gov.

Erroneous Surgery

Retroactive to an effective date of January 15, 2009, CMS does not cover a surgical or other invasive procedure to treat a medical condition when the practitioner performs 1) a different procedure altogether; 2) the correct procedure on the wrong body part; or 3) the correct procedure on the wrong patient. CMS released detailed coding instructions available in Transmittal R1778CP.

For further information, refer to NCDs 140.6, 140.7 and 140.8 and Transmittal R1778CP.

Pharmacogenomic Testing for Warfarin Response

On August 3, 2009, CMS stated in a final decision memo that pharmacogenomic testing to predict warfarin responsiveness is not reasonable and necessary. Additional information is available in Decision Memo for Pharmacogenomic Testing for Warfarin Response (CAG-00400N).

Wheelchair Seating

Effective December 1, 2009, CMS has added several diagnoses that are indicated for types of wheelchair seating. For details, refer to LCD for Wheelchair Seating (L15845).

KX, GA, GZ and GY Modifiers

CMS has made changes in the definitions of these modifiers required for accurate billing in several LCDs. Details are available in article A49303 regarding KX, GA, GZ and GY modifiers.

Effective January 1, 2010

Commercial Pharmacy Coverage Changes

Non-Covered Medications

Effective for fill dates on or after January 1, 2010, Tufts Health Plan will no longer cover the following medications, and will move these drugs to the List of Non-Covered Drugs with Suggested Alternatives in its commercial formularies:

- Fosamax®
- Fosamax Plus D™
- Nexium®
- Prevacid®
- Proscar®
- Protonix®

This coverage change applies to the **brand name drugs only**. Their generic equivalents will remain covered on Tier 1. For a patient to continue on a brand name agent, providers must request coverage through the Medical Review process subject to the Medical Necessity Guidelines for Non-Covered Drugs.

Step Therapy Changes: Bisphosphonates and PPIs

Effective for fill dates on and after January 1, 2010, Step Therapy Prior Authorization will be required for the bisphosphonates and proton pump inhibitors (PPIs).

- **Bisphosphonates:** Boniva® and Actonel® (Step 2) will require a trial of alendronate (Step 1) before being covered. Members currently filling for Boniva or Actonel will be allowed to continue on their current regimen. Any member having filled for brand name Fosamax or Fosamax Plus D can fill for a Step 1 or Step 2 drug.
- **PPIs:** Omeprazole will be covered on Step 1, and lansoprazole (generic Prevacid, when released) and pantoprazole will be covered on Step 2. No brand name PPIs will be covered. Members currently filling for lansoprazole, omeprazole or pantoprazole will be allowed to continue on their current regimen. Any member having filled for the brands Nexium, Prevacid or Protonix can fill for a Step 1 or Step 2 drug, provided it is within the Dispensing Limit (DL) of one (1) capsule or tablet per day. If the member was previously approved for an override of the DL, he or she will be allowed to fill for any one of the covered generics at the approved DL.

Coverage Change for Lidoderm®

Effective for fill dates on or after January 1, 2010, Tufts Health Plan will require prior authorization for coverage of Lidoderm (lidocaine patch 5%).

Approval will be based on the member's having a documented diagnosis of pain associated with post-herpetic neuralgia. The current dispensing limitation of 30 patches per 30 days will remain in effect.

Tufts Health Plan will not authorize the use of Lidoderm for any other condition without clinical justification.

Gonadotropin Dispensing Guidelines

Effective January 1, 2010, Tufts Health Plan will change the dispensing guidelines for gonadotropins used in conjunction with in vitro fertilization (IVF) from 4500 units per cycle to 3600 units per cycle. Justification for doses exceeding these limits must be submitted to the designated Infertility Specialty Pharmacy.

Covered Under Prescription Drug Benefit

Effective for claims adjudicated on and after January 1, 2010, the following drugs will only be covered under the member's prescription drug benefit and will not be covered under the medical benefit. These drugs must be obtained by the member at the appropriate designated specialty pharmacy.

- Apokyn® (J0364 – Injection, apomorphine hydrochloride, 1 mg)
- Fuzeon® (J1324 – Injection, enfuvirtide, 1 mg)
- Hycamtin® (J8705 – Topotecan, oral, 0.25 mg)
- Increlex® (J2170 – Injection, mecasermin, 1 mg)
- Infergen® (J9212 – Injection, interferon Alfacon-1, recombinant, 1 microgram)
- Temodar® (J8700 – Temozolomide, oral, 5 mg)
- Xeloda® (J8520 – Capecitabine, oral, 150 mg, J8521 – Capecitabine, oral, 500 mg)

Coverage Change for Flolan® and Generic Epoprostenol

Effective December 1, 2009, Tufts Health Plan members for whom treatment with Flolan® is indicated will be required, as a condition of treatment, to first utilize the generic version epoprostenol, provided that the member meets the coverage criteria in our Pharmacy Medical Necessity Guidelines for Pulmonary Hypertension.

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.

Copies of information regarding our pharmacy management programs also can be provided upon request by calling Provider Services at 888-880-2404.

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Effective January 1, 2010

Commercial Coding Edit: Incomplete Lab Panels

The following edit is effective for claims adjudicated on or after January 1, 2010:

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 more than two hepatic function panel procedure codes.

This change applies to commercial independent laboratories and facility providers and is reflected in the Laboratory and Outpatient payment policies, located in the Payment Policy section at tuftshealthplan.com/providers. A copy of those policies also is available on request by calling Provider Services.

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, evaluation of 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 NCCI. As these revisions are made public, Tufts Health Plan will update its system to reflect these changes during the fourth 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

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 2010 CodeReview edit updates.

Beginning in the first calendar quarter of 2010, the most current edits will be applied to claims.

Please continue to use the Clear Claim Connection™ tool on tuftshealthplan.com/providers to obtain clinical explana-

tions of how your claim was processed. Clear Claim Connection provides detail that supports CodeReview edits, including bundling denials.

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

ADMINISTRATIVE NOTIFICATIONS

2009 Quality Improvement Work Plan

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

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

To design our plan, we review members' concerns, medical and claims data, member and physician feedback, and information about our members' health. This helps us better understand what we're doing well, what we need to improve, and most important, what you need. Some of the initiatives the 2009 QI Work Plan focuses on are:

- Working with members to help them get preventive screenings to keep them healthy
- Improving member satisfaction with claims processing
- Working to help prevent falls in the Tufts Health Plan Medicare Preferred population
- Advocating for safety in patient care
- Increasing physician adoption and use of electronic prescribing to improve patient safety

If you would like more information about our 2009 Quality Improvement Work Plan and/or progress toward reaching goals, please call a provider specialist.

Effective January 1, 2010

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, 2010. Tufts Health Plan will continue to base fees on the Centers for Medicare & Medicaid Services (CMS) fee schedules, adjusted to achieve the contracted level of reimbursement.

For physicians, Tufts Health Plan will diverge from CMS again in 2010 by directing a higher proportion of funds to the fees for vaginal deliveries and a slightly lower proportion of funds to psychiatry visits. Drug pricing will remain at the same ASP levels as in 2009.

In Tufts Health Plan's ongoing efforts to more closely align reimbursement with industry standards, physicians also can expect two important changes to the structure of Tufts Health Plan fees for 2010:

- Tufts Health Plan will replace its non-standard facility fee reduction and office surgery programs by adopting CMS' differential reimbursement for office- and facility-based services. This change is reflected in the Evaluation and

Management, Surgery Professional, and Mental Health and Substance Abuse Outpatient payment policies.

- Also consistent with CMS physician reimbursement, Tufts Health Plan will adjudicate and reimburse separate technical fees for selected procedures.

The specifics for fee schedule changes, the applicable 2010 fee schedule, and all modifications to our non-reimbursable procedures list will be distributed to hospitals and IPA leadership in November 2009.

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

To ensure appropriate reimbursement levels, physicians are reminded not to bill, on the same claim, for services with dates that cross calendar years.

Please remember to consult tuftshealthplan.com/providers for information regarding changes to payment policies and edits that could also affect reimbursement.

Reminder: 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 an online FWA training for providers.

Providers are urged to take the training online through the HCAS Web site because the provider only needs to attest once for all HCAS-participating health plans that the training was completed. In addition, a provider who has taken the training at another location can complete the attestation screen to demonstrate completion of FWA training.

Providers who submit their attestations on paper can submit them to Tufts Health Plan Medicare Preferred by mail, e-mail or fax:

Tufts Health Plan Medicare Preferred
Customer Relations
P.O. Box 9181
Watertown, MA 02471-9181
E-mail: THPMP_Provider_Relations@tufts-health.com
Fax: 617-972-9487

Additional information and a link to the online FWA training are available on the HCAS Web site at hcasma.org and at tuftshealthplan.com/providers.

Commercial Provider Manual Updated

Tufts Health Plan reviews and revises its Commercial Provider Manual at regular intervals throughout the year. Please be sure you are familiar with information in the manual, including the following:

- A description of Tufts Health Plan's utilization management (UM) program
- How to obtain Tufts Health Plan's Medical Necessity Guidelines (UM criteria)
- How to discuss UM decisions with reviewers
- Tufts Health Plan's criteria for medical record-keeping documentation
- Plan members' rights and responsibilities
- A link to the recent Clinical Practice Guidelines for treating substance abuse
- Tufts Health Plan's policy on financial incentives for UM decision-makers

It is the responsibility of the attending physician to make all clinical decisions regarding medical treatment. Network physicians may obtain these guidelines in the Clinical Resources section of tuftshealthplan.com/providers.

Visit our Web site for additional information and online access to the commercial Provider Manual. Paper copies of Tufts Health Plan's Commercial Provider Manual and our Medical Necessity Guidelines are also available upon request by contacting Provider Services.

Tufts Health Plan Medicare Preferred Corrected Claims

Tufts Health Plan Medicare Preferred accepts both electronic and paper corrected claims, in accordance with guidelines of the National Uniform Claim Committee (NUCC), the Medicare Managed Care Manual, and HIPAA EDI standards.

Electronic submissions

To submit a corrected facility or professional claim electronically:

- Enter the frequency code (third digit of the bill type for institutional claims; separate code for professional claims) in Loop 2300, CLM05-3 as either “7” (corrected claim), “5” (late charges), or “8” (void or cancel a prior claim).
- Enter the last 8 digits of the original claim number in Loop 2300, REF segment with an F8 qualifier. For example, for claim #000123456789, enter REF*F8*23456789.

Note: Provider payment disputes that require additional documentation must be submitted on paper.

Paper submissions

Disputes (not corrected claims) must include a Provider Payment Dispute Form, available in the Forms section at tuftshealthplan.com/providers. Both corrected claims and disputes, however, should be mailed to the address on the form.

For a corrected **facility** claim:

- On the UB-04 (CMS 1450) Form, enter either “7” (corrected claim), “5” (late charges), or “8” (void or cancel a prior claim) as the third digit in Box 4 (Type of Bill), and enter the original claim number in Box 64 (Document Control Number).

For a corrected **professional** claim:

- In Box 22 (Medicaid Resubmission Code) on the CMS 1500 Form, enter the frequency code “7” under Code and the original claim number in the same box under “Original Ref No.”

Save Time with Tufts Health Plan’s Secure Web Site

Tufts Health Plan offers your office a wide range of convenient electronic solutions at tuftshealthplan.com/providers. Using our secure Web site can help streamline your practice, reduce your administrative costs and increase information security.

As a registered Web user, you have 24-hour access to the following:

- Member eligibility and benefits inquiry
- Referral and preregistration submission
- Referral and high-tech imaging authorization inquiry
- Claim status inquiry
- Online claim adjustments
- Authorization for mental health services

These Web-based tools can help you save paper and spend less time on the phone. Visit tuftshealthplan.com/providers and click on “Provider Login” to get started today.

Reminder: Obstetrical Risk Assessment and Postpartum Visits

Obstetrical Risk Assessment

Tufts Health Plan reminds providers who render obstetrical services to complete the Massachusetts Health Quality Partners (MHQP) Obstetrical Risk Assessment Form and to fax the completed form to the Tufts Health Plan’s Health Programs department.

Submitting the Obstetrical Risk Assessment Form notifies Tufts Health Plan of members who are receiving prenatal care. Upon receipt of that form, Tufts Health Plan sends the pregnant member our Prenatal Care Guidebook. The guidebook includes educational materials, benefit information, and resources, along with a depression self-assessment screening tool specific to this population.

The Obstetrical Risk Assessment Form also helps Tufts Health Plan identify women at risk for premature delivery or

complications related to their pregnancy. When appropriate, Tufts Health Plan will offer obstetrical case management services to work with the provider and member to support the member’s treatment plan throughout pregnancy and to maximize community and other resources that may be available.

Postpartum Visits

Tufts Health Plan has adopted the MHQP guidelines for perinatal care, which recommend a postpartum visit four to six weeks after delivery. A full postpartum visit is still needed by patients who visit early for a brief check.

Additional postpartum appointments may be scheduled if complications occurred during the member’s pregnancy, labor, or delivery.

Adult BMI Assessment

Adult Body Mass Index (BMI) Assessment is a new Healthcare Effectiveness Data and Information Set (HEDIS) measure, and Tufts Health Plan will be reviewing medical records for that indicator in 2010.

The HEDIS measure is based on the percentage of members 18 to 74 years of age who had an outpatient visit and who had their BMI documented during the measurement year or the year prior to the measurement year.

It is important for practitioners to record a patient's BMI result in the medical record. Whenever you record a patient's weight, remember to calculate the BMI and record it as well.

BMI assessment is also an opportunity to discuss weight management with your patient. Many electronic medical records have the function to calculate a BMI, and a number of online tools are available to calculate BMI.

Important Updates

Tufts Health Plan has delayed implementation of the following policy changes:

- Revised Speech Therapy Coverage Guidelines will be effective on or around November 1, 2009.
- Revised payment policies for Bilateral / Multiple Surgical Procedures and Imaging Procedures have been delayed until further notice.

Additional information regarding implementation of these changes is available on our Web site or by calling Provider Services.

Reminder: Reimbursement for Physical Therapy Services

Tufts Health Plan only reimburses physical therapists practicing in contracted sites that are credentialed by Tufts Health Plan's Allied Health Department. Tufts Health Plan does not reimburse medical doctors for physical therapy services.

PLANS / PRODUCTS / BENEFITS

Revised and Restated Paper Claim Submission Requirements

Revised guidelines for submitting paper claims to Tufts Health Plan will be effective November 16, 2009.

Under these revised guidelines, Tufts Health Plan will no longer waive requirements for completing mandatory fields on paper claim forms. Those fields are noted in the detailed specifications for submitting UB-04 and CMS-1500 claims in the Tufts Health Plan provider manuals.

Submitted forms deemed incomplete will be rejected and returned to the submitter. The rejected claim and a letter stating the reason for rejection will be returned to the submitter, and a new claim with the required information must be resubmitted for processing.

For all commercial and Tufts Health Plan Medicare Preferred paper claims:

- Diagnosis codes must be entered in priority order (primary, secondary condition) for proper adjudication. Up to 4 diagnosis codes will be accepted on the CMS-1500 form, but consistent with our current policy, only the first code will be used for claim processing.

- Providers should submit industry-standard codes on all paper claims.
- Paper claims will be rejected and returned to the submitter if required information is missing or invalid. Common omissions and errors include but are not limited to the following:
 - Illegible claim forms
 - Member ID number
 - Date of service or admission date
 - Physician's signature (CMS-1500 Box 31)

For specific information on claim submission requirements, refer to the Claim Requirements chapter of the Tufts Health Plan Commercial and Tufts Medicare Preferred provider manuals at tuftshealthplan.com. Copies also are available by calling Provider Services or Tufts Medicare Preferred Provider Relations.



For More Information

Go to 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.

PLANS / PRODUCTS / BENEFITS

Effective January 1, 2010

Tufts Medicare Preferred to Offer Prescription Drug Plan

Tufts Health Plan Medicare Preferred will offer a Part D Prescription Drug Plan (PDP), effective January 1, 2010.

This stand-alone prescription plan will be offered to those who have Medicare as their primary medical plan and need to obtain drug coverage (Part D) by joining a Medicare Prescription Drug Plan (PDP). Those covered under a Medicare Advantage HMO plan, such as the Tufts Medicare Preferred HMO, cannot elect the new PDP.

Members who elect the PDP as individuals, not through an employer group, will have a 4-tier plan. Tier 4 includes Specialty Drugs. Members who join through an employer group will have a 3-tier plan.

Members who join the PDP will be issued a Prescription Drug Plan card. To identify a Tufts Health Plan PDP member, the card will be clearly labeled with "PDP" displayed in the upper right corner.

Tufts Medicare Preferred to Offer Medicare Supplement Plans

Effective January 1, 2010, Tufts Health Plan Medicare Preferred will offer group Medicare Supplement plans.

Under these plans, providers should submit medical claims directly to Medicare. Those claims will then be sent to Tufts Medicare Preferred for processing as crossover claims. Claims will not need to be submitted directly to Tufts Medicare Preferred as secondary claims.

Claims for Tufts Medicare Complement (TMC) members should continue to be sent to Tufts Health Plan as secondary claims according to the current process.

Questions should be directed to the Tufts Medicare Preferred Customer Relations Department at 800-279-9022.

Plan Benefit Changes Effective January 1, 2010

The following benefit changes will be effective January 1, 2010, and will be rolled out as employer groups renew or join Tufts Health Plan during the year.

Some groups may choose to opt out of these changes. Always check the member's eligibility and benefits, available on Tufts Health Plan's secure Web site, NEHEN, NEHENNet, and our Interactive Voice Response (IVR) system.

- **High-tech imaging (MRI/MRA, CT/CTA Scan, PET Scan, Nuclear Cardiology)** will require a \$25 copayment per visit for all HMO Premium plans. Members will be exempt from paying the copayment when high-tech imaging is required as part of an active treatment plan for a cancer diagnosis.
- **Physical and Occupational Therapy** will be limited to 30 visits per plan year for physical therapy and 30 visits per plan year for occupational therapy for all fully insured plans. (Members of RI-based employer groups currently have this benefit limit.)
- **Hearing Aids** for children (members under age 19) will no longer be a covered benefit for Select Network plans. Select Network Plans are currently offered to Massachusetts residents only.
- **Pediatric Dental Benefit** will be eliminated for HMO Select 10.

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