

The following payment policy applies to Tufts Health Plan[®] commercial contracted providers.

This policy applies to commercial¹ products. For information on Tufts Medicare Preferred HMO's policies and procedures, [click here](#).

Note: Audit and disclaimer information is located at the end of this document.

Policy

Tufts Health Plan covers medically necessary chiropractic services in accordance with the member's benefit.

General Benefit Information²

Services and subsequent payment are based on the member's benefit plan document. Providers and their office staff are required to use self-service channels to verify effective dates and copayments for commercial members prior to initiating services.

Reference the [Electronic Services](#) section of our [website](#) for our self-service channel options. Benefit specifics should be verified prior to initiating services by logging on to our [website](#) or by contacting [Provider Services](#).

Note: Effective January 1, 2008, spinal manipulation for children age 12 and under is not covered.

Member Responsibility

Copayments, deductible and/or coinsurance will apply pursuant to the terms of the member's benefit plan document.

Providers are encouraged to advise members before treatment that they are responsible for payment for any services requested by the member that are excluded under the member's benefit plan, and to confirm the member's understanding in writing.

Tufts Health Plan recommends not billing the member for the coinsurance and/or deductible amount until the claim has processed so that the appropriate member responsibility can be determined. Both the provider's Statement of Account (SOA) and the Electronic Remittance Advice (ERA) will reflect the member's responsibility amount.

Authorization Requirements

Reference the [Authorization Policy](#) for specific referral and authorization requirements.

Services Requiring Prior Authorization

Depending upon the service, while you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

Some procedures require prior authorization with the Tufts Health Plan Precertification Department. Reference the [Clinical Resources](#) section of our website for a list of procedures, services and items that require prior authorization. Reference the [CareLinkSM Prior Authorization List](#) for a list of procedures, services and items requiring prior authorization for CareLink members.

¹ Commercial products include [HMO, POS, PPO & CareLinkSM when Tufts Health Plan is Primary Administrator](#)

² Eligibility is subject to retroactive reporting of disenrollment.

For a complete description of Tufts Health Plan's commercial authorization requirements, reference the Authorization section within the [Tufts Health Plan Commercial Provider Manual](#).

Billing Information

- Submit the most updated industry-standard codes.
- Submit the appropriate ICD-9 diagnosis code(s) carried out to the highest level of specificity.
- Submit standard CPT and HCPCS modifiers in accordance with the appropriate CPT or HCPCS procedure code(s).
- For more information regarding modifiers refer to the [Modifier Payment Policy](#).

Note: Annually and quarterly, HIPAA medical code sets³ undergo revision by CMS, AMA and CCI. Revisions typically include adding, deleting or redefining the description or nomenclature of new HCPCS, CPT procedure and ICD-9 diagnosis codes. As these revisions are made public, Tufts Health Plan will update its system to reflect these changes.

EDI Claim Submitter Information

- Submit claims in HIPAA compliant 837P format for professional services. Claims billed with non-standard codes will reject if billed electronically.

Paper Claim Submitter Information

- Submit claims on a CMS-1500 form for professional services. Claim line(s) billed with non-standard codes will deny.

Services Rendered by Tufts Health Plan Contracted Chiropractors

Chiropractors should bill the CPT procedure code(s) listed in their Provider Agreement. Billing for services other than those identified will deny as non-contracted services. **The member is not responsible for payment.** The absence or presence of a CPT procedure code is not an indication and/or guarantee of coverage and/or reimbursement.

New Patient Encounters

Procedure Codes	Description
99202-99205	Office visit for initial evaluation and management of a new patient

Established Patient Encounters

Procedure Codes	Description
99212-99215	Office visit for evaluation and management of an established patient

Chiropractic Manipulative Treatment (CMT)

During the course of a single visit, submit the following procedure codes with manipulation treatment, an initial evaluation or an established patient visit, when appropriate

Procedure Codes	Description
98940	CMT, spinal, one to two regions
98941	CMT, spinal, three to four regions
98942	CMT, spinal, five regions

³ HIPAA medical code sets include HCPCS, CPT Procedure and ICD-9 diagnosis codes.

Modalities

During the course of a single visit, submit the following procedure codes with manipulation treatment, an initial evaluation or an established patient visit, when appropriate. The absence or presence of a CPT procedure code is not an indication and/or guarantee of coverage and/or reimbursement.

Procedure Codes	Description
97012	Mechanical Traction
97014	Electrical Stimulation (unattended)
97016	Vasopneumatic Devices
97024	Diathermy (e.g. microwave)
97026	Infrared
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97033	Iontophoresis, each 15 minutes
97035	Ultrasound
97110	Therapeutic procedure, one or more areas, each 15 minutes, to develop strength and endurance
97124	Massage
97140	Myofascial release

Compensation/Reimbursement Information

Chiropractors may be eligible for compensation of medically necessary x-rays taken in their office. Prior to initiating x-ray services, verify the member's benefit specifics and refer to your Allied Health Service Agreement – Exhibit A-2A for contracted radiology codes.

Providers are compensated according to the Tufts Health Plan network physician compensation or contracted rates regardless of where the service is rendered. Claims are subject to payment edits that are updated at regular intervals and generally based on CMS, specialty society guidelines, drug manufactures' package label inserts, and National Correct Coding Initiative (CCI).

Chiropractic Manipulation and Evaluation and Management Services

- Most evaluation and management (E&M) services are included in chiropractic manipulation services. Tufts Health Plan will consider compensation for the E&M service if the appropriate [modifier](#) is appended to the procedure code to indicate that the service is distinct and separately identifiable.

Modalities

- Tufts Health Plan will not compensate for hot and cold packs as they are considered incidental to other payable services performed by the same provider on the same day or within the previous twelve months. Reference CMS' Bundled Services policy for additional information.

Statement of Account (SOA)

The SOA is sent to all providers to provide information on the status of the claim(s) submitted to Tufts Health Plan. The SOA indicates status of claims payments, denials and pending claims.

If the procedure code(s) submitted is not used in processing, the SOA will reflect the actual procedure code(s) utilized by Tufts Health Plan to process the claim.

Effective January 1, 2012, paper Statements of Account and the Summary of Account on Tufts Health Plan's secure Provider website will no longer display embedded procedure code modifiers or any Tufts Health Plan unique characters.

Electronic Remittance Advice (ERA)

The HIPAA compliant 835 ERA is an EDI transaction that providers may request to electronically post paid and denied claims information to their accounts receivable system.

When an industry-standard code(s) is submitted and accepted by Tufts Health Plan, the electronic remittance advice will reflect the code(s) submitted and the actual procedure code(s) utilized by Tufts Health Plan for claims processing.

Document History

October 2007: Removed Liberty by Tufts Health Plan information.

February 2008: Revised general benefit information with self-service channels information.

December 2008: Added note that effective 1/1/08, upon employer group's renewal, spinal manipulation for children age 12 and under is not covered.

April 2010: Removed CPT procedure code 97010 and added CPT procedure code 97110.

July 2010: Reviewed document, minor changes made for clarity.

October 2011: Reviewed document, template updates and minor changes made for clarity.

Audit and Disclaimer Information

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, Tufts Health Plan will expect your office/facility to refund all payments related to non-compliance.

This policy provides information on Tufts Health Plan claims adjudication processing guidelines. As every claim is unique, the use of this policy is not a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, adherence to plan policies and procedures and claims editing logic.

This policy does not apply to Tufts Medicare Preferred HMO or Private Health Care Systems (PHCS) network also known as Multiplan members. This policy applies to CareLink when CIGNA HealthCare is Primary Administrator for providers in Massachusetts and Rhode Island service areas for pricing purposes only. Providers in the New Hampshire service area are subject to CIGNA HealthCare's provider arrangement for the purpose of CareLink members.