

The following payment policy applies to Tufts Health Plan[®] commercial contracted providers who render professional services in an outpatient or office setting.

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 evaluation and management services.

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](#).

Suboxone[®] and Subutex[®]

Tufts Health Plan requires prior authorization for coverage of Suboxone[®] and Subutex[®]. Coverage criteria for Suboxone and Subutex can be found in [Tufts Health Plan's Pharmacy Medical Necessity Guidelines](#). Tufts Health Plan covers medically necessary services for the treatment of an opiate addiction with Suboxone and Subutex when rendered in an office setting by an appropriately licensed and qualified provider. Suboxone and Subutex are covered in accordance with the member's prescription drug benefit. Evaluation and management services related to the treatment of an opiate addiction with Suboxone and Subutex are covered based on the member's benefit plan document. For claims submission information for Suboxone and Subutex, refer to page 2.

Preventive Services

Effective for new groups and existing groups when they renew **on or after September 23, 2010**, most Tufts Health Plan employer groups will be required to provide all insured members 100% coverage for preventive care services. A minority of employers who have elected to maintain "grandfathered" status under the Patient Protection and Affordable Care Act (commonly referred to as "healthcare reform") are not subject to this requirement. However, many of these groups have opted to cover preventive services with no cost sharing, and their "grandfathered" status may change over time.

This means that most members will have no cost-sharing responsibility when preventive services are rendered by an in-network provider. Members may still be required to pay a copayment, deductible or coinsurance for preventive services received from out-of-network providers (PPO and POS plans), or for non-preventive services received in conjunction with a preventive services visit. Please reference the [Preventive Services](#) list for a complete list of services that have been deemed preventive in nature.

Member Responsibility

Copayments, deductible and/or coinsurance may apply depending upon the member's benefit plan specifics.

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

² Eligibility is subject to retroactive reporting of disenrollment.

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

Refer to the [Authorization Policy](#) for specific preregistration, 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.

All inpatient admissions require preregistration prior to services being rendered. Professional claims will be denied if the preregistration to the hospital has not been obtained.

Some procedures require prior authorization with the Tufts Health Plan Precertification Department. Refer to 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.

For a complete description of Tufts Health Plan's commercial authorization requirements, refer to 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 carried out to the highest level of specificity.
- Submit a modifier, when appropriate, with the corresponding CPT and/or HCPCS procedure code.
- For more information regarding modifiers refer to the [Modifier Payment Policy](#).
- Submit original claims only once; additional submissions of the same claim will result in a duplicate denial. Reference [Avoiding Administrative Claim Denials](#) for additional information.

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.

Consultation Procedure Codes

Unlike Medicare, Tufts Health Plan will continue to accept consultation procedure codes for its commercial members. Submit appropriate consultation procedure codes when billing for consultation services.

Note: Medicare restriction does not allow Tufts Health Plan to accept consultative procedure codes for Tufts Health Plan Medicare Preferred members.

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

Suboxone® and Subutex®

A licensed and qualified provider must submit the applicable procedure code(s) below when rendering services for the treatment of an opiate addiction with Suboxone® and Subutex® in an office setting.

Procedure Code	Description
99201	Office or other outpatient visit for the evaluation and management of a new patient, 10 minutes face-to-face
99202	Office or other outpatient visit for the evaluation and management of a new patient, 20 minutes face-to-face
99203	Office or other outpatient visit for the evaluation and management of a new patient, 30 minutes face-to-face
99204	Office or other outpatient visit for the evaluation and management of a new patient, 45 minutes face-to-face
99205	Office or other outpatient visit for the evaluation and management of a new patient, 60 minutes face-to-face

Processing Information

New Patient Visit Definition

Tufts Health Plan follows the American Medical Association's definition of a new patient as one who has not received any professional services from the same provider, or another provider of the same specialty who belongs to the same group practice (same tax ID), within the past three years.

Policy	Description
New Patient Visits and Recoding	<p>When services are performed in an office or outpatient setting, Tufts Health Plan will deny subsequent new patient visit(s) of the same service level if a provider has submitted a claim with a new patient E&M procedure code for the same member within the previous three years or recode to an established visit(s) of the same service level.</p> <p>Tufts Health Plan will also deny subsequent new patient visit(s) of the same service level if a provider from the same group practice (same tax ID number), same specialty has submitted any other E&M procedure code within the previous three years or recode the subsequent new patient visit(s) to an established visit(s) of the same service level.</p>
Multiple Consultations and Recoding	<p>Tufts Health Plan will deny outpatient E&M consultation procedure codes submitted in an office setting when the same provider (same tax ID number), same specialty has also submitted any other E&M procedure code for the same member in any place of service in the previous 12 months or recode the outpatient E&M consultation procedure code to an equivalent level office visit procedure code.</p>

Note: Consultations submitted with primary diagnosis of V72.8–V72.85 that are performed for the purpose of post-operative evaluations will not be recoded to an established E&M procedure code.

Compensation/Reimbursement Information

Providers are compensated according to the Tufts Health Plan network physician 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 manufacturers' package label inserts and the National Correct Coding Initiative (CCI).

Tufts Health Plan's claims editing logic for E&M services are based on a provider's information with Tufts Health Plan. Tufts Health Plan defines the same provider as those with the same provider specialty and same provider group (same tax ID number).

Facility Fee Reduction

Physicians who perform office visits in a hospital or outpatient clinic may be subject to a facility fee reduction. This reduction is consistent with Medicare's site of service differentiation built into Medicare fees, and parallels the facility fee reduction Tufts Health Plan applies to medical office visits in these settings. Reference your current contract for details regarding outpatient compensation provisions.

Note: Tufts Health Plan adopts CMS's differential compensation for office and facility-based services, replacing Tufts Health Plan's standard facility fee reduction. Reference your contract for details regarding outpatient compensation provisions.

Policy	Description
Critical Care Services	<p>Tufts Health Plan will compensate providers for only one critical care or intensive care procedure code for a single date of service.</p> <p>When a provider submits critical care services and emergency department services on the same date of service, only the critical care services will be compensated. Reference the Emergency Services Professional Payment Policy for additional information.</p> <p>Tufts Health Plan will not compensate for an evaluation and management (E&M) service when billed with a critical care service. According to CMS, a critical care service includes an E&M service when reported on the same day. Tufts Health Plan will consider compensation for the E&M service if the appropriate modifier is appended to the E&M procedure code.</p>
Multiple E&M Services	<p>Only one E&M service is allowed for a single date of service for the same provider group (same tax ID number) and specialty regardless of the place of service. If multiple E&M procedure codes are submitted for a single date of service for the same provider group (same tax ID number) and specialty, the E&M procedure code with the highest allowable compensation will be processed and any additional E&M code(s) will be denied.</p> <p>Note: If an E&M service with a lesser-allowed amount has previously been processed, for the same date of service, any subsequent E&M services will be denied, even if the allowable amount is higher than the first E&M service that was processed.</p> <p>Tufts Health Plan will not compensate for more than one E&M procedure code with modifier 25 appended, excluding a preventive E&M code billed with a problem-focused E&M code⁴, when billed on the same date of service with the same provider identification number and within the same specialty. If a rendering provider bills with two E&M procedure codes with modifier 25 appended to each E&M procedure code on the same claim or multiple claims on the same date of service, one of the E&M procedure codes will deny.</p>
E&M Services with Preventive Medicine Visits	<p>Tufts Health Plan will consider compensation for two different E&M services on the same day when a provider submits a problem-focused office visit procedure code with a preventive medicine procedure code and the appropriate modifier is appended to the problem-focused procedure code to indicate that the service is distinct and separately identifiable.</p> <p>If the appropriate modifier is not submitted, the problem-focused visit will be denied as included in the preventive medicine visit.</p>

⁴ Refer to the E&M Services with Preventive Medicine Visits section in this table.

	If a preventive medicine procedure code (99381–99397, 99429) ⁵ and a problem-focused E&M procedure code (99201–99380) are billed on the same date of service, modifier 25 should be appended to the problem-focused E&M procedure code. The E&M procedure code will be compensated at 50% of the allowed amount for that service.
E&M Services within Global Period	<p>Surgical procedures are assigned a global day period of 0, 10 or 90 day(s) by CMS based on the complexity of the procedure. Services rendered within the assigned specified numbers of global days, including E&M services are considered inclusive to the primary procedure and are not eligible for separate compensation.</p> <p>Tufts Health Plan will consider compensation for services rendered during the global day period if the appropriate modifier is appended to the E&M procedure code to indicate that the service rendered is distinct from the primary procedure.</p>

Prolonged Services

Tufts Health Plan does not compensate for prolonged service procedure codes (99354–99359). Prolonged procedure codes are used when a service involving direct (face-to-face) patient contact is beyond the usual services in either an outpatient or inpatient setting. Denied claims may be [disputed](#) with supporting clinical documentation. Reference the AMA CPT Manual for additional information.

Observation Services

Policy	Description
Initial Observation Care and Recoding	<p>An observation discharge service (99217) submitted for the same date of service as the initial observation care service (99218–99220) will result in the initial observation service (99218–99220) being recoded to the appropriate procedure code for observation care with an admission and discharge procedure code (99234–99236).</p> <p>Initial hospital care services (99221–99223) submitted for the same date of service as hospital discharge services (99238–99239) in an outpatient hospital place of service will result in the initial hospital care services (99221–99223) being recoded to the appropriate procedure code for observation care with admission and discharge (99234–99236).</p>
Observation Care Services	Hospital discharge services (99238–99239) or observation discharge services (99217) submitted with observation care services that include admission and discharge (99234–99236) will be denied as included in the observation care services.

Services Rendered Saturdays, Sundays or Holidays

Providers who render services on Saturdays, Sundays or on the following dates will be paid an added fee for services rendered.

Tufts Health Plan will only pay the added fee for services rendered on the actual date of the legal holiday listed during the specified calendar year when procedure code 99050 (services requested on Saturdays, Sundays and holidays in addition to basic service) is submitted in addition to the E&M procedure code. The added holiday fee will not be paid for services provided in instances where the actual holiday does not fall on the date of the legal holiday.

Holiday	Date
New Year's Day	January 1, 2012
President's Day	February 20, 2012
Memorial Day	May 28, 2012

⁵ Code set effective for dates of service on or after July 1, 2011

Independence Day	July 4, 2012
Labor Day	September 3, 2012
Columbus Day	October 8, 2012
Thanksgiving Day	November 22, 2012
Christmas Day	December 25, 2012

After-Hours

Tufts Health Plan will consider compensation for services rendered after normal posted business hours when procedure code 99056 (services typically provided in the office, provided out of the office at the request of patient, in addition to basic service) or 99058 (services provided on emergency basis in the office, which disrupts other scheduled office services, in addition to basic service) is submitted.

Note: This after-hours policy does not apply to emergency room services.

Physician Case Management Services

Tufts Health Plan compensates for the following services when a physician is responsible for direct care of a patient, and bills these services supplied for coordinating and controlling access to or initiating and/or supervising other health care services needed by the patient.

- Team Conference (99366–99368): Physician spends 30–60 minutes in conference coordinating patient care with other medical or community professionals.
- Telephone Calls (99441–99443): Simple, intermediate or complex phone calls made by a physician to the patient or other health care/allied professionals that are medically necessary to manage and coordinate patient care.

Note: Details of billed telephone calls must be documented in the patient's medical record.

Physician Case Management Services submitted for the same date of service by the same provider as an office visit or consult procedure code would result in the Physician Case Management Service being denied as included in the primary procedure.

Online Physician Exams

Tufts Health Plan does not compensate for online evaluation and management services (99444).

Professional E&M Services in an Outpatient Setting⁶

The following policies apply to professionals who render E&M services within an outpatient setting.

Policy	Description
Counseling	Tufts Health Plan will not separately compensate for counseling and/or risk factor reduction when billed with an E&M service, as it is considered to be part of the global services for either problem-oriented E&M codes or preventive medicine services.
Critical Care	The following services are included in critical care services during interfacility transport (99289–99290): routine venous access, blood collection, arterial puncture, naso- or oro-gastric tube placement, chest x-ray interpretation, temporary transcutaneous pacing, ventilation assist and management, CPAP or CNP, pulse oximetry, and analysis of computer data. Reference the CMS Internet Only Manual for additional information.
Established E&M Visits	Unless a significant, separately identifiable service was performed, Tufts Health Plan will not separately compensate for an established patient E&M service when billed with cardiac stress tests, transthoracic echocardiography, and myocardial perfusion imaging, as the E&M service is included in those procedures.

⁶ Reference the AMA CPT Manual for additional information.

Gynecology Exam/Pap Smear	Tufts Health Plan will not separately compensate for a gynecology exam and/or a pap smear when billed with a preventive medicine visit, as the gynecology exam and/or the pap smear is a component of the preventive medicine visit. Reference the CMS Internet Only Manual for additional information.
Peak Flow	Tufts Health Plan will not separately compensate for a peak flow rate when billed with an E&M, as it is an inherent part of the E&M examination.
Vision	Tufts Health Plan will not separately compensate for a vision screening when billed with a routine ophthalmologic exam. An E&M service for an eye-related condition would regularly include a quantitative screening test of visual acuity. Visual screening is included in the E&M service or general ophthalmologic service.

Note: Providers may only bill one E&M service on the same day. Taking care of a problem or abnormality is considered part of the global service when a preventive medicine service is performed unless the problem or abnormality is significant enough to require additional work to meet the key components of a problem-oriented E&M service, which must be reported appropriately and separately.

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.

Additional Resources

[Emergency Services Professional Payment Policy](#)

[Modifier Table](#)

[Outpatient Payment Policy](#)

Document History

March 2007: Added online physician exam and facility fee reduction information.

October 2007: Added E&M services billed with smoking and tobacco use counseling information.

January 2008: Added 2008 holidays and revised team conference, telephone calls and online physician exams with 2008 CPT procedure codes.

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

May 2008: Added a new E&M and critical care edit that will be effective for claims adjudicated on or after August 1, 2008.

October 2008: Removed Tufts Health Plan will not reimburse more than three inpatient follow-up consultation services within seven days as this edit is no longer effective.

November 2008: Added preventive medicine procedure code and problem-focused E&M procedure code reimbursement change effective for claims adjudicated on or after January 1, 2009.

January 2009: Added 2009 holidays. Clarified that CPT procedure code 99050 includes Saturdays.

April 2009: Removed smoking and tobacco-use counseling with evaluation and management services edit as this is no longer effective.

October 2009: Added Suboxone[®] and Subutex[®] information.

November 2009: Added a note that explains: Effective January 1, 2010, Tufts Health Plan will adopt CMS's differential reimbursement for office and facility-based services, replacing Tufts Health Plan's standard facility fee reduction. Reference your contract for details regarding outpatient reimbursement provisions.

December 2009: Added that Tufts Health Plan will continue to accept consultation codes for its commercial members and 2010 holidays.

February 2010: Added **effective for claims adjudicated on or after April 1, 2010**, Tufts Health Plan will not reimburse more than one E&M procedure code with modifier 25 appended, when billed on the same date of service with the same provider identification number and within the same specialty.

March 2010: Clarified the E&M edit changes effective for claims adjudicated on or after April 1, 2010, with the following information: If a rendering provider bills with two E&M procedure codes with modifier 25 appended to each E&M procedure code on the same claim or multiple claims on the same date of service, one of the E&M procedure codes will deny.

September 2010: Added information regarding preventive services

May 2011: Provided additional instruction regarding the use of modifier 25 when billing E&M services with preventive services. Added that effective for fill dates on or after July 1, 2010, prior authorization is required for coverage of Suboxone[®] and Subutex[®].

July 2011: Clarified guidelines regarding multiple E&M services rendered on same date of service.

January 2012: Added 2012 holidays, template updates.

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. 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 servicing CareLink members.