

The following payment policy applies to Tufts Health Plan[®] commercial contracted independent laboratory providers and physicians rendering laboratory services.

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

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

Policy

Tufts Health Plan reimburses medically necessary laboratory 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 Web site for our self-service channel options. Benefit specifics should be verified prior to initiating services by logging on to our [Web site](#) or by contacting [Provider Services](#).

Member Responsibility

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

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.

Referrals are not required for lab services, however a medical requisition form/prescription is required from the requesting physician to direct the Member to the appropriate lab, as well as perform medically necessary services.

Some procedures require prior authorization with the Tufts Health Plan Precertification Department. Reference the [Clinical Resources](#) section of our Web site 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, reference the Authorization section within the [Tufts Health Plan Commercial Provider Manual](#).

¹ Commercial products include [HMO, POS, PPO](#)

² Eligibility is subject to retroactive reporting of disenrollment by the member's employer group or Medicare.

Billing Information

- Submit the most updated industry-standard codes.
- Submit the appropriate laboratory CPT or HCPCS procedure code with a [modifier](#) if applicable, modifier 26 when billing for a professional component or modifier TC when billing for a technical component.
- Submit the modifier that impacts reimbursement in the first modifier field and the informational modifiers in the secondary fields.
- Submit the appropriate ICD-9 diagnosis code carried out to the highest level of specificity.
- 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.

Reimbursement Information

Physicians are expected to direct lab services to Tufts Health Plan contracted labs for the purposes of cost containment and quality control. Laboratory services are reimbursed based on the terms of the provider's contract. 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).

In-Office Tests

For PCPs and/or specialists who are affiliated with a Provider Organization (e.g., "IPA") of a commercial HMO member's PCP, the following applies:

- Physicians will be reimbursed a fee of \$5.62 per test subject to the following limits:
 - o Physicians will be reimbursed for one test for an adult member and up to three tests for a pediatric member per office visit.
 - o Physician reimbursement will be subject to withhold at the contractual rate.

Note: For PCPs and/or specialists who are not affiliated with a Provider Organization of a commercial HMO member's PCP, physicians will be reimbursed in accordance with contracted rates. Physicians will be reimbursed in accordance with their contracted rates for non-HMO products.

Capitation

Contracted laboratories may have a capitation agreement with the Plan for lab services to be performed for a specific Provider Unit.

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

Column I (Comprehensive) and Column II (Component) Codes

Correct Coding Initiative has identified comprehensive procedure codes and their associated component codes. Component codes are considered part of the more global comprehensive code and are not eligible for reimbursement when billed with the comprehensive code. Reference the [CCI Policy Manual](#) for additional information.

Tufts Health Plan will not reimburse a venipuncture or phlebotomy procedure when billed with an intravenous infusion or administration of chemotherapy as the venipuncture or phlebotomy is included as part of the intravenous infusion or administration of chemotherapy. Reference the [CCI Policy Manual](#) for additional information.

Frequency Policy and Description

Tufts Health Plan sets frequency limits on certain procedures based on medical necessity. The following policy falls within frequency limitations.

Policy	Description
Lipid Panel Testing	Effective for claims adjudicated on or after April 1, 2010 , Tufts Health Plan will not reimburse a lipid panel test more than two times within a 365-day period. Reference the CMS Internet Only Manual for additional information.

Incomplete Laboratory Panels

Policy	Description
Basic Metabolic Panel	Tufts Health Plan will not reimburse for more than two basic metabolic panel procedure codes when submitted on the same date of service, as additional laboratory components of a panel are included in the price of the laboratory panel code itself. Tufts Health Plan will not reimburse for more than one of the following procedure codes (82040, 82247, 84075, 84460, 84450) when billed with a basic metabolic panel procedure code on the same date of service, as additional procedure codes are included in the price of the basic metabolic panel code itself.
Comprehensive Metabolic Panel	Tufts Health Plan will not reimburse for more than three comprehensive metabolic panel procedure codes when submitted on the same date of service, as additional laboratory components of a panel are included in the price of the laboratory panel code itself.
Electrolyte Panel	Tufts Health Plan will not reimburse more than two electrolyte panel procedure codes when submitted on the same date of service, as additional laboratory components of a panel are included in the price of the laboratory panel code itself.
Hepatic Function Panel	Effective for claims adjudicated on or after January 1, 2010 , Tufts Health Plan will not reimburse more than two hepatic function panel procedure codes when submitted on the same date of service, as additional laboratory components of a panel are included in the price of the laboratory panel code itself.
Renal Function Panel	Tufts Health Plan will not reimburse for more than three renal function panel procedure codes when submitted on the same date of service, as additional laboratory components of a panel are included in the price of the laboratory panel code itself.

Recoding

Edits may recode procedures based on the appropriateness of the code selection. For example, if 80048 (basic metabolic panel), 84443 (TSH) and 85025 (CBC) are billed on the same date of service, the more appropriate code 80050 (General health panel) will be substituted for 84443.

Surgical Global Services

Tufts Health Plan will not reimburse the additional surgical service, procedure code 36415 (venipuncture), when billed with an office setting place of service as the venipuncture is included as part of the global surgical package of the initial surgical procedure. Reference [CMS's](#) list of 90-day surgeries for additional information.

Preventive Services

Tufts Health Plan will not reimburse a pap smear screening when billed with a preventive medicine service by the same physician on the same date of service. Reference [CMS](#) 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.

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

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

May 2009: Added laboratory-diagnosis code combination information effective for claims adjudicated on or after July 1, 2009.

August 2009: Added incomplete laboratory panel and recoding information effective for claims adjudicated on or after October 1, 2009.

November 2009: Added **Effective for claims adjudicated on or after January 1, 2010**, Tufts Health Plan will not reimburse more than **two hepatic function panel** procedure codes when submitted on the same date of service. Removed laboratory-diagnosis code combination information effective for claims adjudicated on or after July 1, 2009. These edits are no longer effective.

February 2010: Added effective for claims adjudicated on or after April 1, 2010, Tufts Health Plan will not reimburse a lipid panel test more than two times within a 365-day period.

Additional Resources

[Pathology Payment Policy](#)

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 Health Plan Medicare Preferred, CareLinkSM when CIGNA HealthCare is primary administrator, or Private Health Care Systems (PHCS) network also known as Multiplan members. Providers in the New Hampshire service area are subject to CIGNA HealthCare's provider arrangement for the purpose of CareLinkSM members.