

The following payment policy applies to Tufts Health Plan commercial contracted providers and products<sup>1</sup>.

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

## Policy

Tufts Health Plan excludes coverage for services related to a non-covered service (except for complications related to non-covered pregnancy terminations).

Tufts Health Plan **may cover** medical and hospital services required to treat a condition or complication that arises as a result of a prior non-covered service, when all of the following are met:

- The services are being provided after discharge from the level of care at which the non-covered service was provided (e.g., from hospital inpatient to Skilled Nursing Facility (SNF) from Surgical Day Care (SDC) to home, from doctor's office to home);
- The services being provided are not otherwise included in the global post procedural period as defined by Current Procedural Terminology (CPT®);
- The services being provided are deemed medically necessary per Tufts Health Plan guidelines and policies.

In addition, services provided that address other diseases or injuries unrelated to the non-covered service, when identified as separate and distinct procedures or services as defined by CPT and coded with appropriate CPT modifiers will be considered on a case-by-case basis to determine the medical necessity of the service and its potential relationship to the non-covered service.

## **Noncovered Services**

Tufts Health Plan **does not cover** the following:

- Facility charges and /or related services during the same hospitalization or treatment setting during which the non-covered service is provided. Related services include all follow up care and the treatment of complications directly associated with the non-covered procedure/service.
- Services that are part of any non-covered surgical package and follow-up care for therapeutic surgical procedures, as defined by CPT including:
  - Subsequent to the decision for surgery, one related evaluation and management encounter on the date immediately prior to or on the date of procedure (including history and physical)
  - Typical postoperative follow-up care, including dictating operative notes, talking with the family and other physicians
  - Services included in the Global post procedural period.

Refer to the [Noncovered Services Medical Necessity Guidelines](#) for more information.

## General Benefit Information<sup>2</sup>

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.

Refer to 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](#).

<sup>1</sup> Commercial products include [HMO, POS, PPO & CareLink<sup>SM</sup>](#) when Tufts Health Plan is Primary Administrator

<sup>2</sup> Eligibility is subject to retroactive reporting of disenrollment.

## Member Responsibility

Copayments, deductible and/or coinsurance may be applied 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

### **Services Requiring Prior Authorization**

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.

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

Some procedures require prior authorization with the Tufts Health Plan Precertification Department. Refer to the [Clinical Resources](#) section of our Web site for a list of procedures, services and items that require prior authorization. Refer to the [CareLink<sup>SM</sup> 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 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 sets<sup>3</sup> 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.

## Compensation/Reimbursement Information

Providers are compensated according to the Tufts Health Plan network 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 Centers for Medicare & Medicaid Services (CMS), specialty society guidelines, drug manufacturers' package label inserts and National Correct Coding Initiative (CCI).

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

### **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, 2011, 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**

Current Procedural Terminology (CPT®) ©2008 American Medical Association: Chicago, IL

Centers for Medicare & Medicaid Services (CMS) [website]. Medicare Benefit Policy Manual. Chapter 1. Section 120. Available at: <http://www.cms.hhs.gov/manuals/Downloads/bp102c01.pdf>. Accessed December 10, 2007

### **Document History**

May 2010: Newly documented payment policy.

October 2011: Reviewed policy, template changes only.

### **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 neither 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, and 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.