

The following payment policy applies to Tufts Health Plan[®] contracted outpatient facilities and professional providers who render services in an outpatient setting. This policy applies to commercial¹ products.

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

Policy

Tufts Health Plan reimburses medically necessary services performed in an outpatient setting.

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 be applied depending upon the member's benefit plan specifics.

Tufts Health Plan recommends not billing the member for the deductible and/or coinsurance 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

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

Note: [Prior authorization](#) is required for certain high-tech imaging services. Reference the [Imaging Services Professional Payment Policy](#) for additional information.

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

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

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

Billing Information

- Submit the appropriate and updated industry standard CPT procedure codes.
- Submit the appropriate ICD-9 diagnosis code carried out to the highest level of specificity.
- Submit claims within 90 days from the date of service. Reference the [Claims Submission Policy](#) 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 appropriate HIPAA compliant format. Claims billed with non-standard codes will reject if billed electronically.
- Submit a corresponding CPT and/or HCPCS code for every Revenue Code submitted. Tufts Health Plan acknowledges that certain Revenue Codes may not have a corresponding CPT and/or HCPCS code; however, in all cases the provider is encouraged to find a procedure code for every Revenue Code.

Note: Tufts Health Plan has identified that the following Revenue Codes will not be rejected when submitted electronically without a corresponding CPT and/or HCPCS procedure code if one can not be found (*EDI acceptance does not guarantee reimbursement*):

250 - Pharmacy	276 - Intraocular Lens	527- Visit Nurse to Home HH short area
251 - Generic	278 - Other Implants	528- RHC/FQHC visit to other (not 4,5)
252 - Non-Generic	279 - M&S Supplies - Other	621 - Incident to Radiology
258 - IV Solutions	370 - Anesthesia	622 - Incident to other Diagnostics
259 - Pharmacy - Other	371 - Incident to Radiology	656 - Hospice-Inpatient General Care
270 - M&S Supplies	372 - Incident to Other Diagnostic	659 - Hospice - Other
271 - Non-sterile Supplies	379 - Anesthesia – Other	663- Daily Respite Care
272 - Sterile Supplies	392- Processing and Storage	710 - Recovery Room
274 - Prosthetic/Orthopedic Devices	524- RHC/FQHC visit to SNF (Part A)	719 - Recovery Room - Other
275 - Pacemaker Supplies	525- RHC/FQHC visit to Facility (not 4)	

Paper Claim Submitter Information

- Submit claims on appropriate paper claim form. Claims billed with non-standard codes will deny.
- Submit a corresponding CPT and/or HCPCS procedure code for every date of service submitted when a date range is indicated in box 6 of the UB-04.

CMS Coverage Rules Adopted by Tufts Health Plan

Preadministrative-related services for IV infusion of immunoglobulin need to be reported with the appropriate immunoglobulin injection code for the same encounter. Reference the [CMS Transmittals/Memos/Publications](#) for additional information.

Corrected Claims and Late Charges

Tufts Health Plan defines “corrected claims” as adjustment requests made to an original claim submission. The adjustment requests correct or change information on the original submission. Adding new services to the original claim submission is not a corrected claim.

Tufts Health Plan defines “late charges” as charges for services associated with the original claim submission, but submitted after the initial submission of the claim. Late charges are identified by a type

³ HIPAA medical code sets include HCPCS, CPT Procedure and ICD-9/ICD-10 diagnosis codes.

of bill ending in “5” (for example, 115 for inpatient late charges, or 135 for outpatient late charges). Late charges can add additional lines and change the original amount billed on the original claim submission. Once the claim line(s) are added to the original claim, the claim that the late charges were submitted on is denied as a duplicate claim.

Corrected Claims

When submitting a corrected claim electronically, providers must submit the following:

- Include the original reference number, which is the Tufts Health Plan claim number, to expedite processing.
- Indicate type of bill 137 (Hospital, outpatient, replacement of prior claim)

When submitting a corrected claim on paper, providers must submit the following:

- Indicate the type of bill in box 4 when submitting a corrected claim.
- Include type of bill 137 for outpatient services.

Late Charges

When submitting a late charge electronically:

- Include the original reference number, which is the Tufts Health Plan claim number, to expedite processing. If the late charges are submitted without the original claim number, the claim may be processed as a new claim resulting in a duplicate submission.

Note: Effective April 1, 2010, providers submitting late charges **electronically** without the original reference number and the type of bill for late charges will be rejected.

When submitting a late charge as a paper claim:

- Indicate the type of bill in box 4 when billing for late charges.
- Include type of bill 135 for outpatient services.

Place of Service

When the application of a skin graft substitute is provided in a non-facility setting, the same provider should report both the application and the tissue substitute on the same claim. Reference the [Regional CMS Publication](#) for additional information.

Processing Information

Global Surgery

Global surgery includes all necessary services normally furnished by the surgeon before, during and after a surgical procedure. Global surgery applies only to surgical procedures that have post-operative global periods of 0, 10 and 90 days. The global surgery concept applies only to primary surgeons and co-surgeons. Global surgery includes preoperative and same day E&M visits after the decision is made to operate and all post-operative E&M visits and procedures for 10-day and 90-day global surgeries related to the primary procedure. Reference the AMA CPT Manual for additional information.

IV Infusion/Chemotherapy

Intravenous infusion services are included in intravenous chemotherapy services when administered at the same session unless a separately identifiable service is documented. Reference the National Correct Coding Initiative (CCI) and Policy Manual for additional information.

Once Per Lifetime

There are national and regional CMS policies, that indicate certain procedures or services that can only be done once in a patient's lifetime. In general, these procedures involve the removal of some organ in the body, such as the thyroid gland, the tonsils or the stomach or a service such as initial use of home INR monitoring. If one of these codes is billed more than once for a patient, the subsequent service will be denied. Reference the [Regional CMS Publication](#) for additional information.

Procedure Codes⁴

Policy	Description
Age/Gender	Edits have been developed that support correct coding based on the definition or nature of a procedure code, or combination of procedure codes and are limited to the treatment of a specific age, age group or gender. In order for a claim to be processed correctly, the procedure codes and the age and/or gender of the patient must agree.
Re-Coding	Edits may either bundle or re-code procedures based on the appropriateness of the code selection. For example, if 27705 (osteotomy, tibia) is reported with 27707 (osteotomy, fibula), the more appropriate code 27709 (osteotomy, tibia and fibula) will be substituted.
Modifiers	Most modifiers have descriptions indicating that the procedure applies to a specific anatomic site, that the services were performed distinctly from other services, or that special circumstances surrounded the performance of services. It is inappropriate for providers to bill certain modifiers with certain procedures. Procedures billed with inappropriate modifiers will be denied as inappropriately coded procedures.
Deleted Procedure Codes	Deleted procedure codes are defined as procedure codes that have been valid at some point in the past, but have since been deleted by a governing entity. All procedure codes are assigned an effective date and a termination date by their governing entities. If the procedure code is invalid for the date of service then the procedure will either be mapped to the updated procedure code, if there is one, or denied if one does not exist.
Separate Procedure	The description for many CPT codes includes a parenthetical statement that the procedure represents a "separate procedure". The inclusion of this statement indicates that the procedure should not be reported when it is performed in conjunction with, and related to, a major service. However, if the separate procedure is carried out independently from, or is unrelated to, the major procedure, then the separate procedure may be reported with the appropriate modifier.

Professional, Technical and Global

Outpatient facilities should only bill for the technical component of a procedure and not the global or professional component. Reference the CMS Internet Only Manual for additional information.

Only services that have a professional and technical component may be billed with [modifiers](#) 26 and TC respectively. Reference the AMA Principles of CPT Coding for additional information.

Procedures, which are defined as technical component only in nature, do not require a [modifier](#) and therefore should not be billed with modifier TC or 26. Reference the CMS National Physician Relative Value File for additional information.

Reimbursement

Providers are reimbursed according to the Tufts Health Plan physician reimbursement or contracted rates regardless of where the service is rendered. Reference your current contract for details regarding outpatient reimbursement provisions. 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 National Correct Coding Initiative (CCI).

⁴Reference the AMA CPT Manual for additional information.

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 reimbursement provisions.

Note: 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.

Add-on Codes

Tufts Health Plan will not reimburse add-on code(s) if the primary procedure code has not been submitted on the same date of service. Add-on codes are always performed in conjunction with a primary procedure and should never be reported as stand-alone services. If the primary procedure is not allowed, then the add-on code will also not be allowed. Reference the AMA CPT Manual for additional information

Bundled Services

Tufts Health Plan will not reimburse bundled services performed in an outpatient hospital setting, as they are included in the facility payment. Reference the CMS Outpatient Prospective Payment System for additional information.

CMS Coverage Rules Adopted by Tufts Health Plan

Tufts Health Plan will not reimburse certain services when billed prior to the effective date of FDA approval. Reference the CMS Outpatient Prospective Payment System for additional information.

Tufts Health Plan will not reimburse wound care management services performed by a physical, occupational or speech therapist when billed by the outpatient facility. Reference the CMS Outpatient Prospective Payment System for additional information.

Tufts Health Plan will not reimburse electrical stimulation for wound healing or ambulation training for a spinal injury when performed at home, assisted living facilities, or custodial care facilities. Reference the [CMS Transmittals/Memos/Publications](#) for additional information.

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

Correct Coding Initiative (CCI) 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.

Device and Supply

Tufts Health Plan aligns reimbursement with CMS. Imaging agents, when billed without the appropriate imaging procedures, will not be reimbursed. Reference the [Regional CMS Policy \(Local Coverage Determination\)](#) for additional information.

Diagnosis

Tufts Health Plan will reimburse ultrasound codes that involve multiple gestations when accompanied by one of the diagnoses for multiple gestations. Reference the ICD-9 Diagnosis Manual for additional information.

Certain diagnoses, by definition or nature of the diagnoses, are limited to the treatment of one gender and/or age. Tufts Health Plan will deny a claim when the gender and/or age of the Member do not match the definition of the diagnosis. Reference the ICD-9 Diagnosis Manual for additional information.

Evaluation and Management Services

Tufts Health Plan will only reimburse one E&M service on the same date of service by an outpatient hospital facility. Reference the CMS Outpatient Prospective Payment System for additional information.

Tufts Health Plan will not reimburse E&M services when billed with cardiovascular services on the same day. Reference the [CMS Internet Only Manual](#) for additional information.

Additional information on professional E&M services can be obtained by referencing the [Evaluation and Management Professional Payment Policy](#).

Frequency Policies and Descriptions

Tufts Health Plan sets frequency limits on certain outpatient procedures based on medical necessity. The following are policies that fall within frequency limitations.

Policy	Description
Bone Density	Tufts Health Plan will reimburse bone density studies once within a 23-month period. Reference the CMS Medicare Carriers Manual for additional information.
Care Plan Oversight	Tufts Health Plan will not reimburse Care Plan Oversight when reported separately under the ESRD benefit when ESRD services have been paid for the month. Reference the CMS Transmittals/Memos/Publications for additional information.
Colorectal Screening ⁵	In accordance with CMS, Tufts Health Plan will not reimburse fecal occult blood tests more than once every 12 months for patients over the age of 50. In accordance with CMS, Tufts Health Plan will not reimburse a sigmoidoscopy or barium enema more than once within 48 months. In accordance with CMS, Tufts Health Plan will not reimburse a colonoscopy or a barium enema on individuals at high risk more than once within 23 months. In accordance with CMS, Tufts Health Plan will not reimburse a colonoscopy more than once within a 10-year period.
Home Health	Tufts Health Plan will reimburse HCPCS code G0179 (Physician recertification for Medicare-covered home health services under a home health plan) once every 60 days. Reference the CMS Transmittals/Memos/Publications for additional information.
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.
Mammograms	Tufts Health Plan will reimburse screening mammographies once a year for all patients over age 39. If a breast condition were discovered at that time or during the year, then additional diagnostic mammographies would be reimbursed. Reference the CMS Internet Only Manual for additional information.
Nebulizers	For claims adjudicated on or after October 1, 2009, Tufts Health Plan will implement the following commercial coding methodologies: Tufts Health Plan will not reimburse 90-day pharmacy dispensing fee when billed more often than every 83 days. Reference CMS for additional information. Tufts Health Plan will not reimburse 30-day pharmacy dispensing fee when billed more often than every 23 days. Reference CMS for additional information.

Global Surgery

Tufts Health Plan will not reimburse E&M services performed by the facility, as they are included in the global fee for the procedure. Reference the CMS Outpatient Prospective Payment System for additional information.

⁵ Reference the [CMS Medicare Carriers Manual](#) for additional information.

Intravenous⁶

Tufts Health Plan will not reimburse IV infusion or injections when billed with neuromuscular studies as they are considered to be included in the performance of neuromuscular studies.

Tufts Health Plan will not reimburse puncture aspiration of a hydrocele when billed with hernia, hydrocele, spermatic cord, and varicocele repairs as the puncture aspiration is considered part of hernia, hydrocele, spermatic cord, and varicocele repairs.

Tufts Health Plan will not reimburse the introduction of an intravenous needle or catheter when billed with a venipuncture as the introduction of an intravenous needle or catheter is included in a venipuncture.

Mutually Exclusive⁷

National Correct Coding Initiative (CCI) has identified procedures that are considered mutually exclusive. Mutually exclusive procedures are those procedures that cannot be reasonably performed in the same operative session. When the same provider bills mutually exclusive procedures for the same date of service, then the procedure with the lowest allowed amount is reimbursed.

CCI 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.

Place of Service Policies and Descriptions⁸

Policy	Description
E&M Services	Tufts Health Plan will reimburse E&M services when billed with the appropriate place of service, e.g. 99431 or 99433-99440 (Newborn care) reported with POS 21 (Inpatient hospital) or 25 (Birthing center).
Emergency Room	Tufts Health Plan will reimburse emergency department visits when billed with place of service 23 (Emergency room).
Home Dialysis	Tufts Health Plan will reimburse home dialysis services when reported with place of service home (12), outpatient (22) or an end-stage renal disease treatment facility (65).
Home Health	Tufts Health Plan will reimburse home health and home infusion codes when services provided in a patient's place of residence.
Hyperbaric Oxygen Therapy	Tufts Health Plan will reimburse hyperbaric oxygen therapy when billed in place of service 21 (Inpatient hospital), 22 (Outpatient hospital) or 23 (Emergency room). Reference the CMS National Coverage Issues Manual for additional information.
Inpatient Services	Tufts Health Plan will reimburse certain procedures that are only appropriate for the inpatient setting. Reference the CMS Outpatient Prospective Payment System for additional information.

Non-Reimbursable Procedure Codes

CMS considers some procedure codes non-reimbursable. Tufts Health Plan may apply non-reimbursable logic to certain procedure codes based on CMS guidelines and/or Tufts Health Plan Policy. Reference your current contract for details regarding non-reimbursable logic.

Tufts Health Plan will not reimburse Ambulatory Continuous Glucose Monitoring Up to 72 Hours – 95251 (physician interpretation and report) for commercial professional and facility providers.

⁶ Tufts Health Plan Medical and Administrative Policies

⁷ Reference the National Correct Coding Initiative (CCI) and Policy Manual for additional information

⁸ Reference the AMA CPT Manual for additional information

Subcutaneous or Intramuscular Injection

Tufts Health Plan will not reimburse the subcutaneous or intramuscular injection code when billed with the administration of vaccines and toxoids as the subcutaneous or intramuscular injection code is inappropriate to use for the administration of vaccines and toxoids. Reference the AMA CPT Manual for additional information.

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.

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 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	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.

Drug and Biological Edits

The following edits are based on Tufts Health Plan's assessment of the drug manufacturer's packet label insert for each drug.

Policy	Description
Darbopoetin	Iron stored should be replete before beginning therapy with darbopoetin. Tufts Health Plan will not reimburse for darbopoetin if iron or iron binding capacity has not been billed within three months of administering darbopoetin.
Epoetin alfa	Chronic renal insufficiency should be documented before giving epoetin alfa. Tufts Health Plan will not reimburse for epoetin alfa if chronic renal insufficiency has not been billed within the past year. Iron stored should be replete before beginning therapy with epoetin alfa. Tufts Health Plan will not reimburse for epoetin alfa if iron or iron binding capacity has not been billed within three months of administering epoetin alfa

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.

Additional Resources

[Ambulatory Surgical Center Payment Policy](#)

[Inpatient Payment Policy](#)

[Laboratory Payment Policy](#)

[Observation Facility Payment Policy](#)

[Surgery Facility Payment Policy](#)

Document History

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

May 2008: Added effective July 1, 2008, Tufts Health Plan will not reimburse Ambulatory Continuous Glucose Monitoring Up to 72 Hours – 95251.

June 2008: Removed statement that Tufts Health Plan will not reimburse E&M services when billed with critical care services on the same day and added Tufts Health Plan will reimburse home dialysis services when reported with place of service outpatient (22).

November 2008: Added that effective for dates of services on or after February 1, 2009, Tufts Health Plan will not reimburse the subcutaneous or intramuscular injection code when billed with the administration of vaccines and toxoids as the subcutaneous or intramuscular injection code is inappropriate to use for the administration of vaccines and toxoids.

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

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

June 2009: Clarified add-on codes will not be reimbursed if the primary procedure code has not been submitted on the same date of service.

August 2009: Added information about new commercial coding methodologies for nebulizers, lab panels, recoding and drug and biological edits 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 for claims adjudicated on or after July 1, 2009. These edits are no longer effective.

Removed two drug and biological edits effective for claims adjudicated on or after October 1, 2009: **1.** Docetaxel should only be administered once every three weeks. Tufts Health Plan will not reimburse for docetaxel if submitted more than once in a three-week period. **2.** Serum creatine should be monitored prior to each dose of zoledronic acid. Tufts Health Plan will not reimburse for zoledronic acid if serum creatine has not been billed in the previous week. These edits are no longer effective.

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.

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. Also added effective April 1, 2010, providers submitting late charges **electronically** without the original reference number and the type of bill for late charges will be rejected.

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 payment 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 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, Uniformed Services Family Health Plan or 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.