

The following payment policy applies to Tufts Health Plan commercial contracted physicians rendering professional surgical services in a physician office, inpatient or outpatient facility.

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 professional surgical 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.

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](#).

Reconstructive and Cosmetic Surgery

Services including surgery, procedures, supplies, medications or appliances used to change body structures in order to improve appearance and/or self-esteem are considered cosmetic and are not covered. Surgical services to improve the function of a body part or organ that has been adversely affected by illness, injury or congenital defect are covered with appropriate authorization.

Investigational Procedures

Surgical CPT codes and procedures that are classified as investigational in nature are not covered.

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

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.

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

² Eligibility is subject to retroactive reporting of disenrollment.

Reconstructive and Cosmetic Procedures

[Prior Authorization](#) will be required for procedures which have both a cosmetic and functional component, or when the issue of whether the procedure meets Tufts Health Plan's definition of cosmetic and/or reconstruction is in question.

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 [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 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.

Unlisted Surgical Procedure Codes

- Submit the most appropriate unlisted surgical procedure code(s) available on an appropriate paper claim form.
- Submit supporting clinical documentation to accurately describe the unlisted surgical procedure code(s). Unlisted procedure codes submitted without documentation will be denied. Electronic claims for unlisted procedure codes will be denied, as attachments are not accepted electronically at this time.

Note: Unlisted surgical procedure code(s) are subject to Medical Director Review. Refer to the [Provider Payment Dispute Policy](#) for additional information on the dispute process.

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).

Add-On Codes

Tufts Health Plan will not compensate for add-on code(s) if the primary procedure code has not been submitted on the same date of service. Add-on codes pertain to services performed in conjunction with a

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

primary procedure and should never be reported as stand-alone services. Add-on codes found in the CPT Manual are exempt from the multiple surgical procedure reduction.

Assistant Surgeons/Co-Surgeons and Team Surgery

In alignment with CMS and the American College of Surgeons, Tufts Health Plan will consider compensation for services requiring multiple physicians when the procedure warrants. The appropriate [modifier](#) must be appended to reimburse the claim according to the services rendered.

Bilateral and Multiple Surgical Procedures

Tufts Health Plan applies multiple surgical procedures reduction when the same provider performs two or more surgical procedures, including procedures performed bilaterally and/or different procedures in multiple compartments of the same joint, on the same member within the same operative session. Refer to the [Bilateral and Multiple Surgical Procedures Professional Payment Policy](#) for additional information regarding multiple surgical procedures reduction.

Office Surgery Program

Tufts Health Plan reimburses additional compensation for certain surgical procedures when performed in an office setting. The Office Surgery Program provides further compensation to cover the additional costs incurred by network physicians who perform certain surgical procedures that are routinely done in a hospital outpatient surgical setting, but can be done safely in a properly equipped physician office, without compromising quality of care.

For additional information regarding the Office Surgery Program, including a list of eligible procedure codes, refer to the [Office Surgery Program Guidelines](#).

Note: Tufts Health Plan applies CMS's differential compensation for office and facility-based services.. Refer to your current contract for details regarding outpatient compensation provisions.

Place of Service

Procedures or services that are not appropriate to be performed in an office setting will deny. For a list of procedure codes that are not appropriate to be billed in office setting, refer to the [CMS National Physician Relative Value File](#).

Robotic Surgical System

Tufts Health Plan does not compensate separately for the use of a robotic surgical system (S2900).

Surgical Global Day Period

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 evaluation and management services (E&M), are considered inclusive to the primary procedure.

Surgical Package Reimbursement

The following services are included in the global surgical package and are **not** considered separately reimbursable when billed by the same physician or another physician within the same provider group (same tax ID number):

- Pre-operative E&M services after the decision to perform surgery is made, one day prior to major surgery and on the same day a major or minor surgery is performed.
- Intra-operative services that are a usual and necessary part of the surgical procedure.
- Supplies, including surgical trays.
- All additional medical or surgical post-operative services required of the surgeon during the post-operative period because of complications that do not require additional trips to the operating room (OR).
- Post-operative E&M services that are related to the surgery.
- Post-operative pain management by the surgeon.
- Dressing changes, local incisional care, removal of operative packs, removal of cutaneous sutures, staples, lines, wires, tubes, drains, and splints; insertion, irrigation, and removal of urinary catheters,

routine peripheral intravenous lines, nasogastric and rectal tubes; and change and removal of tracheostomy tubes.

- Anesthesia provided by the surgeon.

Exceptions for Surgical Procedures

The following services will be considered for separate compensation when the appropriate [modifier](#) is appended:

- E&M service(s) for surgical procedure(s) that is unrelated or significant and separately identifiable from the surgical procedure performed on the same day.
- E&M service unrelated to the surgery within the post-operative period.
- E&M service(s) performed the day prior to or the same day of major surgery resulting in the decision for surgery.
- E&M service unrelated to the surgery.
- Complications requiring a return trip to the OR.

Note: The appropriate modifier must be appended in order for services to be considered for compensation.

Split Surgical Services

Physicians rendering a portion of the surgical service (pre-operative, intra-operative, post-operative) should indicate so by appending the appropriate [modifier](#) to indicate the portion of services rendered. Physicians will be compensated accordingly for the specific portion of services rendered.

If a surgical claim is submitted without a modifier appended, it is assumed that the same provider performed the pre-operative, intra-operative and post-operative services. Claims that do not have an appended modifier will be processed and compensated at the surgical rate.

Peripheral and Central Venous Access

Tufts Health Plan will not compensate a peripheral and central venous access when billed with a tunneled or non-tunneled central venous access procedure. According to the National Correct Coding Policy Manual, peripheral and central venous access is considered to be an integral part of performing a tunneled or non-tunneled central venous access procedure.

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 Room Professional Payment Policy](#)

Document History

February 2008: Added place of service reimbursement. Revised general benefit information with self-service channels information.

May 2008: Added new peripheral and central venous access edit that will be effective for claims adjudicated on or after August 1, 2008.

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

November 2009: Added the following: Effective January 1, 2010, Tufts Health Plan will adopt CMS's differential reimbursement for office and facility-based services, replacing Tufts Health Plan's office surgery program. Refer to your contract for details regarding outpatient reimbursement provisions.

May 2010: Added the following: **Robotic Surgical System:** Tufts Health Plan does not reimburse separately for the use of a robotic surgical system (S2900).

September 2011: Template updates, added information regarding paper Statements of Account and the Summary of Account on Tufts Health Plan's secure Provider website, effective January 1, 2012.

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 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.

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