Evaluation and Management Professional Payment Policy

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 (including Tufts Health Freedom Plan). For Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care options, click here.

In addition to the specific information contained here, providers must adhere to the policy information outlined in the professional payment policies for Commercial and Tufts Medicare Preferred HMO/Tufts Health Plan SCO products, located in the Provider Resource Center or on the Payment Policies page.

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

POLICY

Tufts Health Plan covers medically necessary evaluation and management (E&M) services.

GENERAL BENEFIT INFORMATION

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to our secure Provider website or by contacting Provider Services.

PREVENTIVE SERVICES

Due to the Patient Protection and Affordable Care Act (commonly referred to as federal health care reform), with the exception of groups maintaining "grandfathered" status, all plans offered by Tufts Health Plan are required to provide 100% coverage for preventive care services. Grandfathered groups are not subject to this requirement, but many of these groups have opted to cover preventive services with no cost sharing.

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 nonpreventive services received in conjunction with a preventive services visit. Refer to the Preventive Services List for a complete list of services that have been deemed preventive in nature.

BILLING INSTRUCTIONS

Submit the appropriate consultation procedure codes when billing for consultation services.

New Patient Visits

Tufts Health Plan follows the AMA’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 number) within the past three years.

Note: Tufts Health Plan defines the same provider as one having the same provider group (same tax ID number) and same specialty.

<table>
<thead>
<tr>
<th>Policy</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>New patient visits</td>
<td>When services are performed in an office or outpatient setting, Tufts Health Plan denies subsequent new patient visit(s) of the same service level if:</td>
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<tr>
<td></td>
<td>• A provider has submitted a claim with a new patient E&amp;M procedure code for the same member within the previous three years</td>
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<td></td>
<td>• A provider from the same provider group (same tax ID number) and specialty has submitted any other E&amp;M procedure code within the previous three years</td>
</tr>
<tr>
<td>Multiple consultations</td>
<td>Tufts Health Plan denies outpatient E&amp;M consultation procedure codes submitted in an office setting when the same provider group (same tax ID number) and specialty has also submitted any other E&amp;M procedure code for the same member</td>
</tr>
</tbody>
</table>

¹ Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is the primary administrator.
Suboxone and Subutex
A licensed and qualified provider must submit procedure code(s) 99201-99205 when rendering services for the treatment of an opiate addiction with Suboxone and Subutex in an office setting. Refer to the Outpatient Behavioral Health and Substance Use Disorder Professional Payment Policy for additional information.

COMPENSATION/REIMBURSEMENT INFORMATION
Use of noncontracting labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by you as the treating provider or other unreasonable financial exposure. In such circumstances, Tufts Health Plan may hold you accountable for any inappropriate behavior on the part of the nonparticipating lab that you selected.

Note: Tufts Health Plan’s claims editing logic for E&M services are based on a provider’s information with Tufts Health Plan.

Discharge Services
Effective for dates of service on or after October 1, 2017, Tufts Health Plan will not routinely compensate for hospital discharge services (99238-99239) when 99238 or 99239 has been billed and paid for the subsequent date of service.

Facility Fee Reduction
Providers 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 that Tufts Health Plan applies to medical office visits in these settings. Refer to the provider’s 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.

Inpatient Admission or Consultation Services
Tufts Health Plan does not routinely compensate for hospital care services when an initial hospital care claim has been submitted in the previous three days with the same diagnosis by the same provider. This policy is based on specialty review panel and Tufts Health Plan policy.

<table>
<thead>
<tr>
<th>Policy</th>
<th>Description</th>
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<tbody>
<tr>
<td>Critical care services</td>
<td>Tufts Health Plan compensates providers for only one critical care or intensive care procedure code for a single date of service. When a provider submits critical care services and emergency department (ED) services on the same date of service, only the critical care services will be compensated. Refer to the Emergency Department Professional Payment Policy for additional information. Tufts Health Plan does not routinely compensate for an E&amp;M service when billed with a critical care service. According to CMS, a critical care service includes an E&amp;M service when reported on the same day. Tufts Health Plan will consider compensation for the E&amp;M service if the appropriate modifier is appended to the E&amp;M procedure code.</td>
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<tr>
<td>Policy</td>
<td>Description</td>
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</tbody>
</table>
| Multiple E&M services          | 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. **Note:** If an E&M service with a lower 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. Tufts Health Plan does not routinely 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 code 

2, when billed on the same date of service with the same provider group (same tax ID number) and 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. |

| E&M services with preventive medicine visits | 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. If the appropriate modifier is not submitted, the problem-focused visit will be denied as included in the preventive medicine visit. If a preventive medicine procedure code (99381–99397, 99429) 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 | 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. 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. |

**Family Planning Services**
Effective for dates of service on or after October 1, 2016, Tufts Health Plan does not routinely separately compensate for E&M services when billed with a diagnosis of postpartum care, contraceptive management or family planning advice when a delivery care-only service has been billed in the past 42 days (six weeks) by the same provider or another provider of the same specialty who belongs to the same group (same tax ID number.)

**Modifier 24**
Tufts Health Plan does not separately compensate for E&M services billed with modifier 24 and either of the following:
- A minor surgical procedure with a 10-day postoperative period has been billed in the previous 10 days, and the E&M service has a primary diagnosis associated to the 10-day medical or surgical service.

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2 Refer to the E&M services with preventive medicine visits section in this table.
• A major surgical procedure with a 90-day postoperative period has been billed in the previous 90 days, and the E&M service has a primary diagnosis associated to the 90-day medical or surgical service.

**Modifier 25**
When an E&M code with modifier 25 and a procedure code having a 0-, 10- or 90-day postoperative period are billed by the same provider for the same date of service, Tufts Health Plan will compensate the E&M service at 50% of the otherwise allowed amount. This policy applies to professional and outpatient claims.
• This modifier may be appended to E&M codes 99201–99215 and 99241–99245 or to general ophthalmologic codes (92002-92014).

Refer to the [Modifier Payment Policy](#) for additional information.

**Multiple Evaluation and Management Services on the Same Day**
Effective for dates of service on or after October 1, 2017, Tufts Health Plan will not routinely compensate for a new patient or initial care visit when billed in excess of one unit by the same provider tax ID number and same specialty.

**Observation Care Services**
Tufts Health Plan does not routinely compensate for the following:
• 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 they are included in the observation care services.
• Observation care discharge or hospital discharge day management when billed and observation or inpatient hospital care, including admission and discharge on the same day, was billed the previous day.
• Observation services when billed for more than one unit per date of service in any combination by any provider and the place of service is 21 (inpatient hospital), 22 (outpatient hospital), 23 (ED), or 24 (ambulatory surgical center).

**Online Practitioner Exams**
Tufts Health Plan does not routinely compensate for online E&M services (99444).

**Place of Service Restriction**
Effective for dates of service on or after October 1, 2017, Tufts Health Plan will not routinely compensate for consultation services (99241-99245) when billed with a place of service 21 (inpatient hospital).

**Practitioner Care Management Services**
Tufts Health Plan compensates for the following services when a practitioner 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 member:
• Team conference (99366–99368): Practitioner spends 30 to 60 minutes in conference coordinating member care with other medical or community professionals.
• Telephone calls (99441–99443): Simple, intermediate or complex phone calls made by a practitioner to the member or other health care/allied professionals that are medically necessary to manage and coordinate care.

**Note:** Details of billed telephone calls must be documented in the member’s medical record.

Practitioner care management services submitted by the same provider for the same date of service as an office visit or consult procedure code would result in the practitioner care management service being denied as included in the primary procedure.

Effective for dates of service on or after October 1, 2016, Tufts Health Plan does not routinely compensate for care management services (99487 and 99489–99490) when billed more than once during the same calendar month by any practitioner.

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3 Policy applies to professional claims only.
**Prolonged Services**
Tufts Health Plan does not routinely 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. Refer to the AMA CPT Manual for additional information.

**Transitional Care Management Services**
Tufts Health Plan does not routinely compensate for transitional care management (TCM) services under the following circumstances:

- Unless a facility E&M service was billed for the same date of service or in the previous 30 days by any provider.
- When billed within 29 days of another TCM service.
- When billed on the same date of service as a previously billed TCM service by any provider.

**Professional E&M Services in an Outpatient Setting**
The following policies apply to professionals who render E&M services in an outpatient setting:

<table>
<thead>
<tr>
<th>Policy</th>
<th>Description</th>
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<tbody>
<tr>
<td>Counseling</td>
<td>Tufts Health Plan does not routinely separately compensate for counseling and/or risk factor reduction when billed with an E&amp;M service, as it is considered to be part of the global services for either problem-oriented E&amp;M codes or preventive medicine services.</td>
</tr>
<tr>
<td>Critical care</td>
<td>The following services are included in critical care services during inter-facility transport (99289–99290):</td>
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<tr>
<td></td>
<td>- Routine venous access</td>
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<td>- Blood collection</td>
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<td>- Arterial puncture</td>
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<td>- Naso- or oro-gastric tube placement</td>
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<td>- Chest x-ray interpretation</td>
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<td>- Temporary transcutaneous pacing</td>
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<td>- Ventilation assist and management</td>
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<td>- CPAP or CNP</td>
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<td>- Pulse oximetry</td>
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<td></td>
<td>- Analysis of computer data</td>
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<tr>
<td></td>
<td>Refer to the <a href="https://www.cms.gov">CMS Internet Only Manual</a> for additional information.</td>
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<tr>
<td>Established E&amp;M visits</td>
<td>Unless a significant, separately identifiable service was performed, Tufts Health Plan does not routinely separately compensate for an established patient E&amp;M service when billed with cardiac stress tests, transthoracic echocardiography, and myocardial perfusion imaging, as the E&amp;M service is included in those procedures.</td>
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<tr>
<td>Gynecology exam/Pap smear</td>
<td>Tufts Health Plan does not routinely 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. Refer to the <a href="https://www.cms.gov">CMS Internet Only Manual</a> for additional information.</td>
</tr>
<tr>
<td>Peak flow</td>
<td>Tufts Health Plan does not routinely separately compensate for a peak flow rate when billed with an E&amp;M service, as it is an inherent part of the E&amp;M examination.</td>
</tr>
<tr>
<td>Vision</td>
<td>Tufts Health Plan does not routinely separately compensate for a vision screening when billed with a routine <a href="https://www.cms.gov">ophthalmologic</a> exam. An E&amp;M service for an eye-related condition would regularly include a quantitative screening test of visual acuity. Visual screening is included in the E&amp;M service or general ophthalmologic service.</td>
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</tbody>
</table>

Providers may only bill one E&M service per date of service. Addressing a problem or abnormality is considered part of the global service when a preventive medicine service is performed, unless the

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4 Refer to the AMA CPT Manual for additional information.
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.

**After-Hours Care**

Tufts Health Plan considers 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 does not apply to ED services.

**Services Rendered on Weekends or Holidays**

Providers who render services on Saturdays, Sundays or on the following holidays will receive additional compensation for services rendered.

Tufts Health Plan only compensates for the additional 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.

<table>
<thead>
<tr>
<th>Holiday</th>
<th>Date</th>
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<tbody>
<tr>
<td>New Year’s Day</td>
<td>January 1, 2017</td>
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<tr>
<td>President’s Day</td>
<td>February 15, 2017</td>
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<tr>
<td>Memorial Day</td>
<td>May 29, 2017</td>
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<td>Independence Day</td>
<td>July 4, 2017</td>
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<td>Labor Day</td>
<td>September 4, 2017</td>
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<tr>
<td>Columbus Day</td>
<td>October 9, 2017</td>
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<tr>
<td>Thanksgiving Day</td>
<td>November 23, 2017</td>
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<tr>
<td>Christmas Day</td>
<td>December 25, 2017</td>
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</tbody>
</table>

**DOCUMENT HISTORY**

- July 2017: Added edits for discharge services, multiple E&M services on the same day, and place of service restrictions, effective for dates of service on or after October 1, 2017
- March 2017: Policy reviewed; minor formatting changes
- January 2017: Template updates
- July 2016: Added family planning and care management edits effective for dates of service on or after October 1, 2016.
- September 2015: Added information regarding prior authorization to Suboxone section, template conversion, template updates
- July 2015: Added transitional care services policies effective for dates of service on or after October 1, 2015, moved Inpatient Admission/Consultation Services policy from the Inpatient Payment Policy, template updates
- May 2015: Added changes to Modifier 25 policy, effective for dates of service on or after July 1, 2015, template updates
- January 2015: Added 2015 holidays
- November 2014: Added policies regarding Modifier 24, observation care or hospital discharge day management and observation services when billed for more than one unit per date of service, effective for dates of service on or after January 1, 2015, template updates
- May 2014: Added Modifier 25 policy effective for dates of service on or after July 1, 2014, template updates
- February 2014: Added information regarding recoding, effective for dates of service on or after April 1, 2014, template updates
- January 2014: Added 2014 holidays, template updates
- September 2013: Template conversion
- January 2013: Template updates.
- April 2012: Template updates.
• January 2012: Added 2012 holidays, template updates
• July 2011: Clarified guidelines regarding multiple E&M services rendered on same date of service.
• 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®.
• September 2010: Added information regarding preventive services
• 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.
• 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.
• December 2009: Added that Tufts Health Plan will continue to accept consultation codes for its commercial members and 2010 holidays.
• 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. Refer to your contract for details regarding outpatient reimbursement provisions.
• October 2009: Added Suboxone® and Subutex® information.
• April 2009: Removed smoking and tobacco-use counseling with evaluation and management services edit as this is no longer effective.
• January 2009: Added 2009 holidays. Clarified that CPT procedure code 99050 includes Saturdays.
• 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
• 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
• May 2008: Added a new E&M and critical care edit that will be effective for claims adjudicated on or after August 1, 2008
• February 2008: Revised general benefit information with self-service channels information
• January 2008: Added 2008 holidays and revised team conference, telephone calls and online physician exams with 2008 CPT procedure codes
• October 2007: Added E&M services billed with smoking and tobacco use counseling information
• March 2007: Added online physician exam and facility fee reduction information

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. For more information about Tufts Health Plan’s audit policies, refer to our website.

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, adherence to plan policies and procedures and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy does not apply to Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options, Tufts Health Public Plans or the Private Health Care Systems (PHCS) network (also known as Multiplan). This policy applies to CareLink for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna’s provider agreements with respect to CareLink members.