Evaluation and Management Professional Payment Policy

Applies to the following Tufts Health Plan products:

- ☒ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)[1]
- ☒ Tufts Medicare Preferred HMO (a Medicare Advantage product)[2]
- ☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)[2]

Applies to the following Tufts Health Public Plans products:

- ☒ Tufts Health Direct (a Massachusetts Qualified Health Plan [QHP]; a commercial product)
- ☒ Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plans)
- ☒ Tufts Health RITogether (a Rhode Island Medicaid Plan)
- ☒ Tufts Health Unify (OneCare Plan; a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting providers who render evaluation and management (E&M) services.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the Professional Services and Facilities Payment Policy.

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

POLICY

Tufts Health Plan covers medically necessary E&M services, in accordance with the member's benefits. For more information on E&M telemedicine services for Commercial products, refer to the Telemedicine Services Payment Policy.

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 the secure Provider portal or by contacting Provider Services.

Note: There is no member responsibility for covered services for Tufts Health Plan SCO, Tufts Health Unify, Tufts Health Together or Tufts Health RITogether members.

REFERRAL/PRIOR AUTHORIZATION/NOTIFICATION REQUIREMENTS

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained.

Any E&M services related to an inpatient admission will be denied if an inpatient notification has not been obtained by the admitting facility.

For more information, refer to the Referral, Prior Authorization and Notification Policy.

BILLING INSTRUCTIONS

Unless otherwise stated, Tufts Health Plan follows industry-standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. For more information, refer to the Professional Services and Facilities Payment Policy.

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[1] Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink℠ when Tufts Health Plan is the primary administrator.

[2] Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

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

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 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.

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. Refer to the Compensation/Reimbursement Information section below for additional information.

Preventive Medicine Visits

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. Refer to the Compensation/Reimbursement Information section below for additional information.

COMPENSATION/REIMBURSEMENT INFORMATION

Providers are compensated according to the applicable network contracted rates and applicable fee schedules, regardless of the address where the service is rendered. For additional information, refer to the Professional Services and Facilities Payment Policy.

Unless otherwise noted, the following reimbursement information applies to all Tufts Health Plans products. **Note:** Refer to the appropriate sections for additional E&M compensation information specific to Commercial, Senior Products or Tufts Health Public Plans.

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

Annual Wellness Visit

Tufts Health Plan does not routinely compensate for the following:

- G0439 (Annual wellness visit) when billed and another annual wellness visit (G0438 or G0439) has been billed and paid in the previous 11 months by any provider.
- G0438 (annual wellness visit; initial visit) when billed more than once in a member's lifetime.

Critical Care Services[3]

The following services are included in critical care services during inter-facility transport (99289–99290):

- Routine venous access
- Blood collection
- Arterial puncture
- Naso- or oro-gastric tube placement
- Chest x-ray interpretation
- Temporary transcutaneous pacing
- Ventilation assist and management
- CPAP or CNP
- Pulse oximetry
- Analysis of computer data

Tufts Health Plan does not routinely compensate for an E&M service under the following circumstances:

[3] According to CMS, a critical care service includes an E&M service when reported on the same day. Refer to the CMS Internet Only Manual for additional information.

- When billed with a critical care service. Tufts Health Plan will consider compensation for the E&M service if the appropriate modifier is appended to the E&M procedure code
- Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate 99291 (critical care E&M, first 30-74 minutes) when billed with more than one unit per day.

Tufts Health Plan compensates providers for only one critical care or intensive care procedure code for a single date of service.

Diagnosis and Procedure Consistency
Tufts Health Plan does not routinely compensate 96150-96155 (health and behavior assessment/intervention) if all ICDs on the claim line are inappropriate diagnosis procedure combinations as defined by Regional CMS Guidelines.

Discharge Services
Tufts Health Plan does not routinely compensate for hospital discharge services (99238-99239) when 99238 or 99239 has been billed and paid for the subsequent date of service.

Established E&M visits
Unless a significant, separately identifiable service was performed, Tufts Health Plan does not routinely separately compensate for an established patient E&M service if billed with cardiac stress tests, transthoracic echocardiography, and myocardial perfusion imaging, as the E&M service is included in those procedures.

Factors Influencing Health Status and Contact with Health Services Diagnoses and Non-Routine Examinations
Tufts Health Plan does not routinely compensate E&M services (excluding normal newborn care) billed with preventive medicine services (99381-99429) when reported with an ICD-CM "Z" diagnosis code as the only diagnosis on the claim.

Gynecology exam/Pap smear
Tufts Health Plan does not routinely separately compensate for a gynecology exam and/or a pap smear if 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 CMS Internet Only Manual for additional information.

Inpatient Neonatal and Pediatric Critical Care and Intensive Care Services
Tufts Health Plan does not routinely compensate the following:

- Initial neonatal intensive care services (99477) if reported subsequent to the date of admission for **Commercial products**
- Initial (99468, 99471, 99475) or subsequent (99469, 99472, 99476) neonatal and pediatric critical care codes if the member has had inpatient critical care services the previous day for **Senior Products**
- Initial neonatal and pediatric critical care (99468, 99471, 99475) if the patient has had inpatient critical care services the previous day for **Tufts Health Public Plans**
- Tufts Health Plan limits the coverage of the following: Any combination of 99477-99480 (neonatal intensive care) to one unit per date of service by any provider for **Senior Products**
- Any combination of 99477-99480 (neonatal intensive care) and 99468-99476 (neonatal and pediatric critical care) to one unit per date of service by any provider for **Tufts Health Public Plans**

Modifiers
Tufts Health Plan does not routinely compensate for E&M services when bill with modifier 24 or modifier 57 as outlined in the Modifier Payment Policy.

Refer to the Modifier Payment Policy for additional information on the compensation for E&M codes with modifier 25.

Multiple Consultations
Tufts Health Plan does not routinely compensate outpatient E&M consultation procedure codes submitted in an office setting if the same provider group (same tax ID number) and specialty has also submitted any other E&M procedure code for the same member in any place of service in the previous 12 months.

Multiple E&M Services on the Same Day

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[4], 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.

Tufts Health Plan does 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.

Newborn Care Services

Tufts Health Plan does not routinely compensate for initial hospital or birthing center care services if the member received initial or subsequent newborn care services the previous day.

New Patient Visits[5]

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:

- A provider has submitted a claim with a new patient E&M procedure code for the same member within the previous three years
- A provider from the same provider group (same tax ID number) and specialty has submitted any other E&M procedure code within the previous three years. **Note**: Tufts Health Plan defines the same provider as one having the same provider group (same 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).[6]

Tufts Health Plan will not routinely compensate for observation care discharge services (99217) if a qualifying initial observation care admission service (99218-99220) or subsequent observation care (99224-99226) has not been billed within the previous three days.

Tufts Health Plan will not routinely compensate for observation care discharge services (99217) when an initial hospital care code (99221-99223) was billed the previous day.

Practitioner Care Management (CM) 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.

[4] Refer to the E&M services with preventive medicine visits section in this table.
[5] 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.
[6] Policy applies to professional claims only.

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

Practitioner CM 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 CM service being denied as included in the primary procedure.

Tufts Health Plan does not routinely compensate for CM services (99487 and 99489–99490) under the following circumstances:

- When billed more than once during the same calendar month by any practitioner
- Performed within 90 days of a surgery for **Senior Products**

Preventive Medicine Visits
Tufts Health Plan does not routinely compensate preventive medicine services when the problem-oriented E&M service has been previously processed for payment, unless modifier 25 is also reported.

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 following the appropriate Provider Payment Dispute Policy for Commercial, Senior Products or Tufts Health Public Plans. Refer to the AMA CPT Manual for additional information.

Smoking and Tobacco Use Cessation Counseling
Tufts Health Plan does not routinely compensate 99201-99397 or 99420-99499 (E&M service) when billed with 99406, 99407 or G0436, G0437 (Smoking and tobacco cessation counseling visit) on the same date of service.

Transitional Care Management Services
Tufts Health Plan does not routinely compensate for transitional care management (TCM) services (99495, 99496) 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 unless a discharge service has been billed by any provider in the previous 30 days
- When billed on the same date of service as a previously billed TCM service by any provider
- Performed within day days of a surgery when billed by any provider for **Senior Products**
- Another TCM service has been billed by any provider within the same Tax ID and specialty within 29 days for **Tufts Health Public Plans**

Peak Flow
Tufts Health Plan does not routinely separately compensate for a peak flow rate under the following circumstances:

- If billed with an E&M service, as it is an inherent part of the E&M examination for **Commercial products**
- As a component of the E&M or physician service, unless a distinct services modifier is appended to either code for **Tufts Health Public Plans**

Services Rendered on Weekends or Holidays for Commercial and Tufts Health RITogether
Commercial and Tufts Health RITogether providers who render services on Saturdays, Sundays or on the following holidays will receive additional compensation for services rendered:

- New Year's Day
- President's Day
- Memorial Day
- Independence Day
- Labor Day
- Columbus Day
- Thanksgiving Day
- Christmas Day

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.

Telehealth Services

Unless otherwise stated, the following apply to Senior Products and Tufts Health Public Plans products. Refer to the Telemedicine Services Professional Payment Policy for information on Commercial products.

Interprofessional Telephone/Internet Consultations

Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate 99446-99449, or 99451 (interprofessional telephone/internet consultation) if any face-to-face service has been billed on the same date or within the previous 14 days.

Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit 99446-99449 or 99451 (interprofessional telephone/internet consultation) in any combination to one unit in seven days.

Modifier G0

Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate for the following:

- **Professional claims:** services inappropriately billed with telehealth services modifier G0 (telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke)[7]
- **Facility claims:** services billed with revenue code(s) 0960-0989 (professional services) that are inappropriately billed with telehealth services modifier G0

Online Digital E&M Services

Effective for dates of service on or after January 1, 2021:

- Tufts Health Plan will limit 99421-99423, 98970-98972 (online digital E&M services) to one combined unit within a seven-day period
- Tufts Health Plan will not routinely compensate 99421-99423 (online digital E&M services) when billed within seven days of certain other E&M services:
  - 99091 (collection and interpretation of physiologic data)
  - 99487-99489 (complex chronic care management services)
  - 99495-99496 (transitional care management services)
  - 99339-99340 (individual physician supervision of a patient [patient not present] in home, domiciliary or rest home)
  - 99374-99380 (supervision of a patient under home health, hospice or nursing care)

Remote Physiologic Monitoring

Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate for the following:

- 99474 (separate self-measurements of blood pressure twice daily over 30-day period) if billed more than once in the same month
- 99457 (remote physiologic monitoring treatment management services) unless 99473 or 99474 (self-measured blood pressure device services) has been billed in the previous 30 days

Commercial Products

The following reimbursement information applies to Commercial products only.

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

[7] Also applies to Commercial products.

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.

Counseling
Tufts Health Plan does not routinely separately compensate for counseling and/or risk factor reduction if billed with an E&M service, as it is considered to be part of the global services for either problem-oriented E&M codes or preventive medicine services.

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.

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

Place of Service Restriction
Tufts Health Plan will not routinely compensate for consultation services (99241-99245) when billed with a place of service 21 (inpatient hospital).

Senior Products
The following reimbursement information applies to Senior Products only.

Antepartum Care by Same Provider Group
Tufts Health Plan will not routinely compensate for E&M services billed five months after a billing of 59425 or 59426 when the diagnosis is normal pregnancy and there is no intervening history of ectopic pregnancy (59100-59151) or abortion (59812-59857, S0199, S2260, S2265-S2267).

Consultation Procedure Codes
Tufts Health Plan does not routinely compensate consultation procedure codes, in accordance with Medicare guidelines.

Place of Service Restriction
Tufts Health Plan does not compensate comprehensive preventive medicine services (99381-99397) when billed in a place of service other than 03, 04, 05, 06, 07, 08, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 22, 26, 33, 49, 50, 71, or 72.

Tufts Health Plan does not routinely compensate newborn care (99460, 99462-99465) if billed in a place of service other than 21 or 25.

Tufts Health Public Plans Products
The following reimbursement information applies to Tufts Health Public Plans products only.

Auditory Screening with Preventive Medicine Visits
Tufts Health Plan does not routinely compensate for 92551, 92560, V5008 (auditory screening services) when billed by a provider at the time of a preventive medicine visit (99381-99397) or annual wellness visit (G0438-G0439).

Cardiovascular Services with E&M Services
Tufts Health Plan does not routinely compensate E&M services when billed the same date of service as cardiovascular services (93260-93261, 93282-93284, 93287, 93289, 93292).

Electrocardiogram (ECG)
Tufts Health Plan does not routinely compensate under the following circumstances:

- 93042 when billed with an E&M service in the hospital setting.
- 93010 when billed with an E&M service in an office setting unless 93005 (ECG tracing) is also billed.

Electromyography, Nerve Conduction Tests and Reflex Tests with E&M Services
Tufts Health Plan does not routinely compensate E&M service when billed the same date as electromyography, nerve conduction tests or reflex tests.

Multiple Inpatient Admission or Consultation Services
Tufts Health Plan does not routinely compensate:

- An initial inpatient hospital visit (99221-99223) if any type of inpatient visit has been billed in the previous week by the same provider group and specialty, and an inpatient discharge visit (99238-99239) has not also been billed
- An inpatient hospital consult (99251-99255) if any type of inpatient visit (initial inpatient admission, inpatient hospital consult, subsequent hospital care) has been billed in the previous week by the same provider group and specialty, and an inpatient discharge visit (99238-99239) has not also been billed
- An initial hospital care (99221-99223) if an initial hospital care has been billed in the previous three days with the same diagnosis by the same Tax ID and subspecialty

Place of Service Restriction
Tufts Health Plan does not routinely compensate for procedure codes that are not billed in the appropriate places of service listed below:

Procedure Codes	Allowable Places of Service
Initial hospital care services (99221-99223) Follow-up hospital care services (99231-99233) Hospital discharge services (99238-99239)	02, 06, 08, 21, 25, 26, 34, 51, 52, 61
Nursing facility E&M visits (99304-99310, 99315-99316 or 99318)	31, 32, 34, 54, 56
Outpatient consultation services (99241-99245)	01, 02, 03, 04, 05, 06, 07, 08, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 23, 24, 25, 26, 33, 49, 50, 53, 54, 57, 60, 62, 65, 71, 72, 99

ADDITIONAL RESOURCES

- Outpatient Behavioral Health and Substance Use Disorder Professional Payment Policy
- Preventive Services

DOCUMENT HISTORY

- November 2020: Reviewed by committee; added boiler plate language; removed Preventive Services content; added telehealth edits for online digital E&M services, modifier G0, interprofessional telephone/internet consultations and remote physiologic monitoring, effective for dates of service on or after January 1, 2021
- October 2020: Reviewed by committee;
- June 2019: Clarified list of applicable holidays subject to additional compensation for services
- November 2018: Added edit for E&M services billed with modifier 57, effective for dates of service on or after January 1, 2019
- June 2018: Template updates
- February 2018: Added claim edits for diagnosis and procedure consistency, effective for dates of service on or after April 1, 2018
- November 2017: Added edits for annual wellness visit (G0438, G0439), factors influencing health status and contact with health services diagnoses and nonroutine examinations, minor surgery 10 day procedures and modifier 24 with E/M services during the postoperative period of major procedures, inpatient neonatal and pediatric critical care and intensive care services, and smoking and tobacco-use cessation counseling, effective for dates of service on or after January 1, 2018
- 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

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 a provider/facility did not comply with this payment policy, Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan's audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication 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 requirements (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 applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and 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. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.