Gastroenterology 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 gastroenterology 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 gastroenterology services, in accordance with the member's benefits. Anesthesia assistance for gastrointestinal endoscopic procedures may also be covered when medical necessity criteria is met, as outlined in the Anesthesia Assistance with Elective Gastrointestinal Endoscopic Procedures Medical Necessity Guidelines.

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.

Gastrointestinal procedures that are not considered preventive in nature may be subject to outpatient hospital or ambulatory surgical center cost-share amounts.

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

Commercial and Tufts Health Public Plans Products

Bariatric Surgery

Prior authorization is required for bariatric surgery and bariatric reoperation. Refer to the Bariatric Surgery and Bariatric Reoperation for Complications medical necessity guidelines. For a list of facilities approved to perform bariatric surgeries for Commercial members in Massachusetts and Rhode Island, refer to the Designated Provider Network for Bariatric Surgery List.

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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.

Endoscopies
Prior authorization is required for the following procedures:

- Video Capsule Endoscopy
- Upper GI Endoscopy: Certain Elective Procedures[3]

Tufts Medicare Preferred HMO and Tufts Health Plan SCO
A specialist referral is required for gastroenterology services.

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.

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.

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.

All Products
Tufts Health Plan does not routinely compensate for the following:

- 82270, 82274 (fecal occult blood tests) more than once every 12 months for patients over the age of 50
- A sigmoidoscopy or barium enema more than once within 48 months
- A colonoscopy or a barium enema on individuals at high risk more than once within 23 months
- A diagnostic, nonhigh risk colonoscopy more than once within a 10-year period unless a colorectal cancer screening (sigmoidoscopy) has been billed in the previous four years
- Colorectal cancer screenings (stool-based DNA and fecal occult hemoglobin [e.g., KRAS, NDRG4 AND BMP3]) are limited to one visit within three years
- 45300, 45330, 45378, 46600 (endoscopic colorectal cancer screenings) for members less than 45 years of age on the date of service if the only diagnosis on the claim is screening for malignant neoplasm of colon.
- 45330 or 45378 (endoscopic colorectal cancer screening) for members less than 45 years of age on the date of service if the only diagnosis on the claim is constipation
- 81528 (oncology colorectal screening) for members less than 45 years of age on the date of service.
- 45381 (colonoscopy, flexible; with injection[s]) if billed with 45383-45385, 45388 or G6024 (colonoscopy)

Multiple Surgical Procedures
Tufts Health Plan compensates for multiple surgical procedure code(s) by paying the surgical procedure code(s) with the highest allowable compensation at 100 percent. Subsequent surgical procedure code(s) that are subject to reduction logic are compensated at 50 percent of the allowed amount. Refer to the Bilateral and Multiple Surgical Procedures Payment Policy for more information.

Senior Products
Tufts Health Plan does not routinely compensate G0102-G0103 (prostate cancer screening tests) for members under 50 years of age on the date of service.

Tufts Health Public Plans
Tufts Health Plan does not routinely compensate 45378 (colonoscopy, flexible, proximal to splenic flexure; diagnostic) if billed more than once within one year.

[3] Prior authorization is not required for members under the age of 18 on the date of service.

ADDITIONAL RESOURCES

- Noncovered Investigational Services List
- Anesthesia Services Professional Payment Policy
- Surgery Professional Payment Policy

DOCUMENT HISTORY

- September 2020: Policy reviewed by committee; added existing Tufts Health Public Plans gastroenterology content; clarified nonpreventive gastrointestinal procedures may be subject to member cost-share
- October 2019: Added existing edit for colonoscopy compensation
- August 2018: Added claim edits for prostate cancer screening tests, DNA-based colorectal cancer screening tests, and colonoscopy effective for dates of service on or after October 1, 2018.
- May 2018: Policy reviewed by committee; added link to Bilateral and Multiple Surgical Procedures Payment Policy
- January 2017: Template updates
- August 2016: Policy reviewed by committee; modified Cigna travel network language; removed table of rev codes accepted without corresponding HCPCS/CPT code; template updates
- September 2015: Template conversion
- July 2015: Added coverage limitation for colorectal cancer screening, stool-based DNA and fecal occult hemoglobin for commercial claims effective for dates of service on or after October 1, 2015, template updates
- April 2015: Added Tufts Medicare Preferred HMO and Tufts Health Plan SCO, template updates
- March 2015:Defined diagnostic colonoscopy in policy, template updates
- January 2015: Removed 45383 as it is end-dated 1/1/2015

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.