**Gastroenterology Payment Policy**

The following payment policy applies to Tufts Health Plan contracting facilities and providers who render services in an outpatient or office setting. This policy applies to Commercial¹ (including Tufts Health Freedom Plan), Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options (SCO) products.

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 gastroenterology 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.

**Note:** There is no member responsibility for Tufts Health Plan SCO members.

Colonoscopies accompanied by treatment/surgery (e.g., polyp removal) may be subject to a day surgery copayment.

**AUTHORIZATION REQUIREMENTS**

**Commercial Products Only**

**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, refer to the Designated Provider Network for Bariatric Surgery List.

**Capsule Endoscopy**

Prior authorization is required for capsule endoscopy procedures. Refer to the Video Capsule Endoscopy Medical Necessity Guidelines for additional information.

**Note:** Tufts Health Plan does not cover the SmartPill GI Monitoring System® (91299) as this is considered experimental/investigational. Refer to the Noncovered Investigational Services for a list of additional procedures Tufts Health Plan does not cover.

**Upper GI Endoscopy**

Prior authorization is required for upper GI endoscopy. Refer to the Upper GI Endoscopy: Certain Elective Procedures Medical Necessity Guidelines for additional information.

**BILLING INSTRUCTIONS**

**Commercial Products Only**

**Anesthesia Assistance with Elective Gastrointestinal Endoscopic Procedures**

Tufts Health Plan may cover anesthesia assistance for gastrointestinal endoscopic procedures when documentation in the medical record indicates that certain risk factors and/or a significant medical condition exists. Refer to the Anesthesia Assistance with Elective Gastrointestinal Endoscopic Procedures Medical Necessity Guidelines for more information.

As defined in the AMA CPT Manual, “all anesthesia services are reported by use of the anesthesia five-digit procedure code (00100-01999), plus the addition of a physical status modifier. The use of other optional modifiers may be appropriate.” Refer to the Anesthesia Professional Payment Policy or the Modifier Payment Policy.

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¹ Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is the primary administrator.
COMPENSATION/REIMBURSEMENT INFORMATION

Frequency Policies and Descriptions
Tufts Health Plan sets frequency limits on certain procedures based on medical necessity. The following are policies that fall within frequency limitations:

<table>
<thead>
<tr>
<th>Policy</th>
<th>Description</th>
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<tbody>
<tr>
<td>Colorectal Screening</td>
<td>In accordance with CMS, Tufts Health Plan does not compensate for:</td>
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<tr>
<td></td>
<td>• Fecal occult blood tests (82270, 82274) more than once every 12 months for patients over the age of 50.</td>
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<td>• A sigmoidoscopy or barium enema more than once within 48 months.</td>
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<td>• A colonoscopy or a barium enema on individuals at high risk more than once within 23 months.</td>
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<td></td>
<td>• A diagnostic, non-high risk colonoscopy more than once within a 10-year period unless a colorectal cancer screening (sigmoidoscopy) has been billed in the previous four years.</td>
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<tr>
<td>Tufts Health Plan limits coverage of colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (e.g., KRAS, NDRG4 AND BMP3) to one visit within three years, consistent with clinical guidelines.</td>
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</tbody>
</table>

Multiple Surgical Procedures (Commercial only)
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. In most cases, ancillary services billed with the surgical procedure code(s) are included in the compensation of the primary surgical procedure code(s). These services will not be compensated separately.

Payment Dispute Process
A provider has the right to file a payment dispute if s/he disagrees with a claim decision regarding the denial or compensation of a claim. Refer to the Provider Payment Dispute Overview for more information.

DOCUMENT HISTORY
- January 2017: Template updates
- August 2016: Policy reviewed for clarity; 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
- December 2014: Added Revenue Codes 0681-0684, 0689, 1000-1002 accepted when submitted electronically without a corresponding CPT and/or HCPCS procedure code, template updates
- January 2014: Added information regarding anesthesia assistance for Endoscopic Gastrointestinal procedures, physical status modifiers, added a link to the associated medical necessity guideline, template updates
- November 2013: Template updates
- September 2013: Template conversion
- April 2012: Template updates
- March 2012: Updated CareLink disclaimer language
- September 2011: Reviewed policy, minor content changes made, template updates
- December 2009: Newly documented policy

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’saudit 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, and adherence to plan policies and procedures and claims editing logic.

This policy does not apply to Tufts Health Public Plans or the Private Health Care Systems (PHCS) network (also known as Multiplan). This policy applies to CareLink for providers in the 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.