

## Gastroenterology Payment Policy

Applies to the following Tufts Health Plan products:

- Tufts Health Plan Commercial (including Tufts Health Freedom Plan)<sup>1</sup>
- Tufts Medicare Preferred HMO (a Medicare Advantage product)
- Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

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The following payment policy applies to Tufts Health Plan contracted providers who render services in an outpatient or office setting.

In addition to the specific information contained here, providers must adhere to the policy information outlined in the [Professional and Facility Services Payment Policy](#).

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

### **POLICY**

Tufts Health Plan covers medically necessary gastroenterology services, as described below.

### **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 [website](#) or by contacting [Commercial Provider Services](#) or [Senior Products Provider Relations](#).

**Note:** There is no member responsibility for covered services 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**

##### **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 List](#) for 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.

#### **Tufts Medicare Preferred HMO and Tufts Health Plan SCO**

A specialist referral is required for gastroenterology services.

### **BILLING INSTRUCTIONS**

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

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<sup>1</sup> Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink<sup>SM</sup> when Tufts Health Plan is the primary administrator.

optional modifiers may be appropriate.” Refer to the [Anesthesia Professional Payment Policy](#) or the [Modifier Payment Policy](#).

### **Anesthesia Assistance with Elective Gastrointestinal Endoscopic Procedures (Commercial Products Only)**

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.

## **COMPENSATION/REIMBURSEMENT INFORMATION**

### **Colonoscopy**

Effective for dates of service on or after October 1, 2018, Tufts Health Plan will not routinely compensate for the following:

- Endoscopic colorectal cancer screening (45300, 45330, 45378, 46600) for a member who is less than 45 years of age and the only diagnosis on the claim is screening for malignant neoplasm of colon.
- 45330 or 45378 for a member who is less than 50 years of age on the date of service if the only diagnosis on the claim is constipation.

The following procedures have frequency limitations based on medical necessity.

### **Colorectal Screenings**

In accordance with CMS, Tufts Health Plan does not compensate for:

- Fecal occult blood tests (82270, 82274) 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 screening; stool-based DNA and fecal occult hemoglobin (e.g., KRAS, NDRG4 AND BMP3) to one visit within three years

### **DNA-Based Colorectal Cancer Screenings**

Effective for dates of service on or after October 1, 2018, Tufts Health Plan will not routinely compensate 81528 (oncology colorectal screening) if the member's age is less than 49 years of age on the date of service.

### **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.

### **Prostate Cancer Screening Tests (Tufts Medicare Preferred HMO and Tufts Health Plan SCO members only)**

Effective for dates of service on or after October 1, 2018, Tufts Health Plan will not routinely compensate G0102-G0103 (prostate cancer screening tests) for a member under 50 years of age on the date of service.

## **ADDITIONAL RESOURCES**

[Surgery Professional Payment Policy](#)

## **DOCUMENT HISTORY**

- 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
- 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 an office/facility did not comply with this payment policy, Tufts Health Plan will expect the office/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<sup>SM</sup> 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.