

Outpatient 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)
- Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting outpatient facilities and professional providers who render services in an outpatient setting.

In addition to the specific information contained here, providers must adhere to the policy 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 services performed in an outpatient setting, 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.

AUTHORIZATION REQUIREMENTS

Commercial only: Prior authorization is required for certain high-tech imaging services. Refer to the [Imaging Services Professional Payment Policy](#) for additional information.

BILLING INSTRUCTIONS

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.

Immunoglobulin

Pre-administrative-related services for the IV infusion of immunoglobulin need to be reported with the appropriate immunoglobulin injection code for the same encounter. Refer to the [CMS Transmittals/Memos/Publications](#) for additional information.

Modifier 59 Subsets

CMS has established four HCPCS modifiers to define subsets of modifier 59, used to define a "distinct procedural service." These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be utilized in lieu of modifier 59 whenever possible. For more information, refer to CMS.

Tufts Health Plan accepts either a modifier 59 or a more selective modifier as correct coding, and the compensation currently applied to modifier 59 will be applied to modifiers XE, XS, XP and XU. For more information on Commercial claims, refer to the [Modifier Policy](#). For Tufts Medicare Preferred HMO and Tufts Health Plan SCO claims, refer to CMS.

Global Surgery

Global surgery includes all necessary services normally furnished by the surgeon before, during and after a surgical procedure. Global surgery applies only to surgical procedures that have post-operative

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

global periods of 0, 10 and 90 days. The global surgery concept applies only to primary surgeons and co-surgeons. Global surgery includes preoperative and same day E&M visits after the decision is made to operate and all post-operative E&M visits and procedures for 10-day and 90-day global surgeries related to the primary procedure. Refer to the AMA CPT Manual for additional information.

Professional, Technical and Global

- Outpatient facilities should only bill for the technical component of a procedure and not the global or professional component.
- Only services that have a professional and technical component may be billed with [modifiers](#) 26 and TC, respectively.

Once Per Lifetime

National and regional CMS policies indicate certain procedures or services that can only be done once in a patient's lifetime. In general, these procedures involve the removal of some organ in the body, such as the thyroid gland, the tonsils or the stomach, or a service such as initial use of home INR monitoring. If one of these codes is billed more than once for a patient, the subsequent service will be denied.

Procedure Codes

Age/Gender

Edits have been developed that support correct coding based on the definition or nature of a procedure code, or combination of procedure codes and are limited to the treatment of a specific age, age group or gender. In order for a claim to be processed correctly, the procedure codes and the age and/or gender of the patient must agree.

Bundling

Edits may bundle procedures based on the appropriateness of the code selection.

Deleted codes

Deleted procedure codes are defined as procedure codes that have been valid at some point in the past, but have since been deleted by a governing entity. All procedure codes are assigned an effective date and a termination date by their governing entities. If the procedure code is invalid for the date of service then the procedure will either be mapped to the updated procedure code (if there is one) or denied if one does not exist. In this instance, providers may submit a [corrected claim](#) using the appropriate procedure code(s).

Separate procedures

The description for many CPT codes includes a parenthetical statement that the procedure represents a "separate procedure" (e.g., the procedure should not be reported when it is performed in conjunction with, and related to, a major service). However, if the separate procedure is carried out independently from, or is unrelated to, the major procedure, then the separate procedure may be reported with the appropriate modifier.

Add-on codes

Add-on codes are not compensated if the primary procedure code is not submitted on the same date of service. Add-on codes pertain to services performed in conjunction with a primary procedure and should never be reported as stand-alone services. If the primary procedure is not allowed, then the add-on code will also not be allowed.

COMPENSATION/REIMBURSEMENT INFORMATION

Tufts Health Plan uses CMS's differential compensation for office and facility-based services. Refer to the provider's current contract for details regarding outpatient compensation provisions.

All Products

Abrasion Arthroplasty

Tufts Health Plan does not separately compensate for procedure code 29879 (arthroscopy of knee with abrasion arthroplasty) when billed with procedure code 29880 or 29881 (arthroscopy of knee with meniscectomy).

Ambulatory EEG Monitoring

Tufts Health Plan does not compensate for ambulatory EEG when a resting EEG has not been billed on the same day or within the previous 12 months.

Antepartum Care

Effective for dates of service on or after October 1, 2017, Tufts Health Plan will not routinely compensate for the following:

- Global delivery codes if the provider has billed antepartum care in the last 8 months
- Antepartum services billed with a date of service up to one week following a delivery

Billing for Established Patients in a Facility

Tufts Health Plan does not compensate for a new patient visit when any service has previously been billed within the last three years.

Bundled Services

Tufts Health Plan does not compensate for bundled services performed in an outpatient hospital setting, as they are included in the facility payment.

Cervical Cancer Screening

Effective for dates of service on or after January 1, 2018, Tufts Health Plan does not routinely compensate for cervical or vaginal screening services for a female patient less than 21 years of age when the only diagnosis is a screening diagnosis code.

Effective for dates of service on or after October 1, 2018, Tufts Health Plan does not routinely compensate cervical or vaginal screening services for a female member 21 years of age or older when the only diagnosis is a screening diagnosis code and any of these screening services has been reported in the previous 13 months.

Effective for dates of service on or after October 1, 2018, Tufts Health Plan does not routinely compensate cervical or vaginal screening services for a female member 21 years of age or older on the date of service if the only diagnosis is a screening diagnosis code and any of these screening services has been reported in the previous three years.

Colonoscopy and Cologuard

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

- 45330 or 45378 for a member who is less than 50 years of age on the date of service and the only diagnosis on the claim is constipation
- 45300, 45330, 45378, 46600 (endoscopic colorectal cancer screening) for a member who is less than 45 years of age on the date of service and the only diagnosis on the claim is screening for malignant neoplasm of colon
- 81528 (oncology colorectal screening) if billed and the member is less than 50 years of age on the date of service

CMS Coverage Rules

Tufts Health Plan does not routinely compensate for the following:

- Services billed prior to the effective date of FDA approval
- Wound care management services performed by a physical, occupational or speech therapist if billed by the outpatient facility
- Electrical stimulation for wound healing or ambulation training for a spinal injury if performed at home or in an assisted living or custodial care facility
- Imaging agents billed without the appropriate imaging procedures

Drug and Biological Policies

For information on drug and biological policies, refer to the [Drugs and Biologicals Payment Policy](#).

Electroencephalogram (EEG)

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

- 95950, 95951, 95953, 95956 (24-Hour EEG monitoring) or 95957 (EEG for epileptic spike analysis) if billed in any combination greater than three days
- 95957 (EEG for epileptic spike analysis) if billed for the same date of service as 95951, 95953, or 95956 (monitoring for localization of cerebral seizure focus).

Endometrial Biopsy for Infertility (for Tufts Medicare Preferred HMO and Tufts Health Plan SCO)

Effective for dates of service on or after October 1, 2018, Tufts Health Plan does not routinely compensate 58100 or 58110 (endometrial biopsy) if the only diagnosis on the claim is infertility or infertility encounter.

Frequency Policies and Descriptions

Tufts Health Plan sets frequency limits on certain outpatient procedures based on medical necessity. The following are policies that fall within frequency limitations according to CMS:

Policy	Description
Bone Density	Commercial: Bone density studies are covered once within a 23-month period. Tufts Medicare Preferred HMO and Tufts Health Plan SCO: Bone density studies are covered once every 24 months.
Care Plan Oversight	Tufts Health Plan will not compensate for care plan oversight when reported separately under the end stage renal disease (ESRD) benefit when ESRD services have been paid for the month (CMS Transmittals/Memos/Publications)
Colorectal Screening	Tufts Health Plan does not compensate for: <ul style="list-style-type: none">• Fecal occult blood tests more than once every 12 months (365 days) for members over the age of 50• Sigmoidoscopy or barium enema more than once within 48 months• Colonoscopy or a barium enema on individuals at high risk more than once within 23 months• Colonoscopy more than once within a 10-year period
Home Health	Tufts Health Plan compensates for physician recertification for Medicare-covered home health services under a home health plan once every 60 days (CMS Transmittals/Memos/Publications)
Lipid Panel Testing	Tufts Health Plan does not compensate for a lipid panel test more than two times within a 365-day period (CMS Internet Only Manual)
Mammograms	Tufts Health Plan will compensate for screening mammography once a year for all patients over age 39. If a breast condition is discovered at that time or during the year, then additional diagnostic mammography would be covered.
Nebulizers	Tufts Health Plan does not compensate for the following: <ul style="list-style-type: none">• 90-day pharmacy dispensing fee if billed more often than every 83 days• 30-day pharmacy dispensing fee if billed more often than every 23 days

Global Surgery

Tufts Health Plan does not routinely compensate for E&M services performed by the facility, as they are included in the global fee for the procedure. Refer to the CMS Outpatient Prospective Payment System for additional information.

Home Prothrombin Time/INR Monitoring for Anticoagulation Management

Effective for dates of service on or after January 1, 2018, Tufts Health Plan does not routinely compensate additional units of INR monitoring (G0249) if more than three units have been billed within a three-month period.

Intravenous

Tufts Health Plan does not routinely compensate for the following:

- IV infusion or injections if billed with neuromuscular studies, as they are considered to be included in the performance of neuromuscular studies
- Puncture aspiration of a hydrocele if billed with hernia, hydrocele, spermatic cord, and varicocele repairs, as the puncture aspiration is considered part of hernia, hydrocele, spermatic cord and varicocele repairs
- Introduction of an intravenous needle or catheter if billed with a venipuncture, as the introduction of an intravenous needle or catheter is included in the venipuncture

Lung Cancer Screening with Low Dose Computed Tomography

Effective for dates of service on or after January 1, 2018, Tufts Health Plan does not routinely compensate G0296 (counseling visit to discuss need for lung cancer screening), or G0297 (low-dose CT scan (LDCT) for lung cancer screening) when billed and the diagnosis is not personal history of tobacco use/personal history or nicotine dependence, cigarettes.

Modifiers Inappropriate for Professional Claims

Tufts Health Plan does not routinely compensate any procedure billed with modifier 27, 73, 74 or CA if billed by or on behalf of a professional provider.

Nerve Conduction Studies and Electromyography for Radiculopathy

Effective for dates of service on or after January 1, 2018, Tufts Health Plan will not routinely compensate for the following if the only diagnosis on the claim is radiculopathy:

- Needle electromyography (95860-95864) if billed without a nerve conduction study (95905)
- Nerve conduction study (95907-95913) if billed without a needle electromyography (95885, 95886)

Observation Services

Tufts Health Plan will not routinely compensate for observation care discharge services (99217) in the following circumstances:

- 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; or
- If an initial hospital care code (99221-99223) was billed the previous day

Obstetrical Ultrasounds

Effective for dates of service on or after January 1, 2018, Tufts Health Plan does not routinely compensate pregnant uterus ultrasound services (76801, 76802) if either code has been billed in the past three months.

Tufts Health Plan compensates for ultrasound codes that involve multiple gestations when accompanied by one of the diagnoses for multiple gestations. Certain diagnoses, by definition or nature of the diagnoses, are limited to the treatment of one gender and/or age. Tufts Health Plan will deny claims when the gender and/or age of the member do not match the definition of the diagnosis.

Orthopedic Injections

Effective for dates of service on or after January 1, 2019, Tufts Health Plan will not routinely compensate the following orthopedic injections if billed without a required diagnosis, per CMS policy:

- 20526 (injection, therapeutic, carpal tunnel)
- 20527 (injection, enzyme, palmar fascial cord)
- 20550 (injection[s]; single tendon sheath, or ligament, aponeurosis)
- 20551 (injection[s]; single tendon origin/insertion)
- 20612 (aspiration and/or injection of ganglion cyst[s] any location)

Preadmission Testing

Tufts Health Plan does not separately compensate routine preadmission testing performed prior to an admission. The following procedure codes will be included as part of in the inpatient compensation:

Code	Description
71020	Radiologic examination, chest, two views, frontal and lateral
80051	Electrolyte panel
80053	Comprehensive metabolic panel
82565	Creatinine; blood
84520	Urea nitrogen; quantitative
86900, 86901	Blood typing; ABO, Rh (D)
85004	Blood count; automated differential WBC count
85014	Hematocrit (Hct)
85018	Hemoglobin (Hgb)
85025	Complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
85027	Complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)

Code	Description
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
93005	Tracing only, without interpretation and report
93010	Interpretation and report only

Pressure Ulcer Stage Codes

Tufts Health Plan does not routinely compensate for pressure ulcer stages if billed without a pressure ulcer.

Procedure-Age Consistency

Tufts Health Plan does not routinely compensate for procedures submitted that are inconsistent with the patient's age based on the nature or indication for the procedure.

Subcutaneous or Intramuscular Injection

Tufts Health Plan does not routinely compensate for the subcutaneous or intramuscular injection code when billed with the administration of vaccines and toxoids as the subcutaneous or intramuscular injection code is inappropriate to use for the administration of vaccines and toxoids.

Trigger Point Injections

Effective for dates of service on or after January 1, 2018, Tufts Health Plan does not routinely compensate any combination of trigger point injections (20552, 20553) if billed more than three times in a 90-day period day period at the same anatomic site.

Urinary Catheter for Incontinence

Effective for dates of service on or after October 1, 2018, Tufts Health Plan does not routinely compensate catheter insertion (51702, 51703) if the only diagnosis on the claim is urinary incontinence.

Vascular Diagnostic Studies

Tufts Health Plan does not routinely compensate for duplex scan of extracranial arteries, study if billed in an office setting unless the member is over 18 years of age and a carotid artery stenosis symptom diagnosis is also present on the claim.

Venipuncture

Tufts Health Plan does not routinely compensate for 36410 (venipuncture, age 3 years or older) if billed without a covered diagnosis.

Commercial Products Only

Ambulatory Continuous Glucose Monitoring

Tufts Health Plan does not routinely compensate ambulatory continuous glucose monitoring up to 72 hours (95251, physician interpretation and report) for Commercial professional and facility providers.

Ambulatory Blood Pressure Monitoring

Tufts Health Plan does not routinely compensate for procedure codes 93784–93790 (ambulatory blood pressure monitoring; recording analysis or review/report blood pressure recording) when billed without ICD-10 code R03.0 (diagnosis of elevated blood pressure reading without a diagnosis of hypertension).

Evaluation and Management Services

Tufts Health Plan only compensates for one E&M service on the same date of service by an outpatient hospital facility, per the CMS Outpatient Prospective Payment System (OPPS).

Tufts Health Plan does not routinely compensate for E&M services when billed with cardiovascular services on the same day.

Tufts Health Plan does not routinely compensate for E&M services if billed with a stress test, as compensation for the E&M service is included in the stress test. Tufts Health Plan will consider compensation if the appropriate [modifier](#) is appended to the E&M procedure code.

Refer to the [Evaluation and Management Professional Payment Policy](#) for additional information regarding professional E&M services.

Intensive Behavioral Therapy for Obesity

Tufts Health Plan does not routinely compensate for face-to-face behavioral counseling for obesity unless a diagnosis of Body Mass Index (BMI) of 30 or greater is also on the claim.

Modifier 25

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

Nonreimbursable Procedure Codes

Some procedure codes are either reimbursed as part of a more comprehensive procedure or are deemed nonreimbursable by Tufts Health Plan. Refer to the [Nonreimbursable Code List for Outpatient Hospitals](#) for a list of procedure codes considered by Tufts Health Plan as nonreimbursable for outpatient facilities. This list is updated quarterly. Tufts Health Plan members are not responsible for the payment for these services.

Tufts Medicare Preferred HMO and Tufts Health Plan SCO Products Only

Anatomical Modifiers

Tufts Health Plan does not routinely compensate for procedures that are billed without a required anatomical modifier.

ADDITIONAL RESOURCES

[Ambulatory Surgical Center Payment Policy](#)

[Drugs and Biologicals Payment Policy](#)

[Claims Submission Policy](#)

[Inpatient Facility Payment Policy](#)

[Laboratory Payment Policy](#)

[Observation Services Payment Policy](#)

DOCUMENT HISTORY

- November 2018: Added edits for orthopedic injections, effective for dates of service on or after January 1, 2019
- August 2018: Added claim edits for cervical cancer screening, endometrial biopsy for infertility, urinary catheter for incontinence, effective for dates of service on or after October 1, 2018
- June 2018: Template updates
- May 2018: Added claim edits for colonoscopies, effective for dates of service on or after July 1, 2018
- November 2017: Added edits for cervical cancer screening, electroencephalogram (EEG), home prothrombin time/international normalized ratio (PT/INR) monitoring for anticoagulation management, lung cancer screening with low dose computed tomography (LDCT), nerve conduction studies (NCS) and electromyography (EMG) for radiculopathy, obstetrical ultrasounds, and trigger point injections, effective for dates of service on or after January 1, 2018
- August 2017: Added edits effective for dates of service on or after October 1, 2017 for the following: distinct service modifiers, antepartum care, observation services, pressure ulcer stage codes, procedure-age consistency, and venipuncture
- January 2017: Template updates
- September 2016: Clarified NCCI Policy Manual Column I/Column II language
- July 2016: Added abrasion arthroplasty edit effective for dates of service on or after October 1, 2016
- May 2016: Moved Vitamin D; 25 hydroxy to laboratory payment policies
- January 2016: Template updates
- November 2015: Added changes to recoding policy, effective for dates of service on or after January 1, 2016, template updates
- September 2015: Template conversion, template updates
- July 2015: Added vascular diagnostic studies policy, effective for dates of service on or after October 1, 2015, template updates
- May 2015: Added Modifier 25 policy for commercial claims, effective for dates of service on or after July 1, 2015, template updates
- February 2015: Moved drug and biological policies to the Drugs & Biologicals payment policy
- December 2014: Added modifiers XE, XP, XS and XU, effective for dates of service on or after January 1, 2015, added Revenue Codes 0681-0684, 0689, 1000-1002 accepted when

submitted electronically without a corresponding CPT and/or HCPCS procedure code, template updates

- November 2014: Added policies regarding Column I and Column II procedure codes and anatomical modifiers, effective for dates of service on or after January 1, 2015, template updates
- August 2014: Added drug and biological edits effective for dates of service on or after October 1, 2014 for ferumoxytol, leuprolide acetate depot, 3.75 mg. and 7.5 mg., octreotide acetate and palonosetron,. Updated new patient facility billing policy for commercial products according to CMS policy, template updates
- July 2014: Added link to the outpatient facilities nonreimbursable list, template updates
- June 2014: Increased the coverage of iron dextran (J1750) to twenty (20) units when billed for any diagnosis other than antepartum anemia or chronic kidney disease diagnoses, template updates.
- May 2014: Policy reviewed. Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options information was incorporated. Added policies effective for dates of service on or after July 1, 2014, template updates
- February 2014: Template updates.
- November 2013: Add information about preadmission testing, effective for dates of services on or after January 1, 2014, template updates.
- August 2013: Added information about drug and biological edits effective for dates of service on or after October 1, 2013, template updates.
- May 2013: Added information about drug and biological edits effective for dates of service on or after July 1, 2013, added information about corrected claims and disputes of duplicate claims adjudicated on or after July 1, 2013, added information about submission of late charges, effective for dates of service on or after July 1, 2013, updated description and covered diagnoses for Zoledronic acid, moved some policies to the Oncology policy, template updates.
- April 2012: Template updates
- March 2012: Updated CareLink disclaimer language
- November 2011: Added information regarding paper Statements of Account and the Summary of Account on Tufts Health Plan's secure Provider website, effective January 1, 2012, additional template updates.
- August 2011: Template updates, clarified policy descriptions of Darbepoetin, Epoetin alfa and Zoledronic acid.
- May 2011: Added eight drug and biological claim edits for claims adjudicated on or after July 1, 2011.
- November 2010: Removed the following: **Note:** Effective April 1, 2010, providers submitting late charges electronically without the original refer to number and the type of bill for late charges will be rejected.
- August 2010: Added applicable procedure codes to colorectal screening and mammography sections of Frequency Policies and Descriptions.
- May 2010: Added the following: Effective for facility claims adjudicated on or after July 1, 2010, Tufts Health Plan will not reimburse E&M services when billed with a stress test, as reimbursement for the E&M service is included in the stress test. Tufts Health Plan will consider reimbursement if the appropriate [modifier](#) is appended to the E&M procedure code.
- February 2010: Added effective for claims adjudicated on or after April 1, 2010, Tufts Health Plan will not reimburse a lipid panel test more than two times within a 365-day period. Also added effective April 1, 2010, providers submitting late charges electronically without the original refer to number and the type of bill for late charges will be rejected.
- November 2009: Added Effective for claims adjudicated on or after January 1, 2010, Tufts Health Plan will not reimburse more than two hepatic function panel procedure codes when submitted on the same date of service. Removed laboratory-diagnosis code combination information for claims adjudicated on or after July 1, 2009. Removed two drug and biological edits effective for claims adjudicated on or after October 1, 2009. Added a note: 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.
- August 2009: Added information about new commercial coding methodologies for nebulizers, lab panels, recoding and drug and biological edits effective for claims adjudicated on or after October 1, 2009.

- June 2009: Clarified add-on codes will not be reimbursed if the primary procedure code has not been submitted on the same date of service.
- May 2009: Added laboratory-diagnosis code combination information for claims adjudicated on or after July 1, 2009.
- April 2009: Removed smoking and tobacco-use counseling with E&M services edit as this is no longer effective.
- November 2008: Added that effective for dates of services on or after February 1, 2009, Tufts Health Plan will not reimburse the subcutaneous or intramuscular injection code when billed with the administration of vaccines and toxoids as the subcutaneous or intramuscular injection code is inappropriate to use for the administration of vaccines and toxoids.
- June 2008: Removed statement that Tufts Health Plan will not reimburse E&M services when billed with critical care services on the same day and added Tufts Health Plan will reimburse home dialysis services when reported with place of service outpatient (22).
- May 2008: Added effective July 1, 2008, Tufts Health Plan will not reimburse Ambulatory Continuous Glucose Monitoring Up to 72 Hours – 95251.
- February 2008: Revised general benefit information with self-service channels information.
- December 2006: Policy created

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 CareLinkSM 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.