Outpatient Payment Policy

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

**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.

Tufts Health Plan SCO members have no member copayment, coinsurance or deductible responsibility.

**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**

**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 new 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 Table. For Tufts Medicare Preferred HMO and Tufts Health Plan SCO claims, refer to CMS for more information.

**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 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. Refer to the CMS Internet Only Manual for additional information.

Only services that have a professional and technical component may be billed with modifiers 26 and TC, respectively. Refer to the AMA Principles of CPT Coding for additional information.

¹ Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is the primary administrator.
Use of noncontracting labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by you as the treating provider or other unreasonable financial exposure. In such circumstances, Tufts Health Plan may hold you accountable for any inappropriate behavior on the part of the non-participating lab that you selected.

**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. Refer to the Regional CMS Publication for additional information.

**Procedure Codes**

<table>
<thead>
<tr>
<th>Policy</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age/Gender</td>
<td>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.</td>
</tr>
<tr>
<td>Bundling</td>
<td>Edits may bundle procedures based on the appropriateness of the code selection.</td>
</tr>
<tr>
<td>Deleted Procedure Codes</td>
<td>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.</td>
</tr>
<tr>
<td>Separate Procedure</td>
<td>The description for many CPT codes includes a parenthetical statement that the procedure represents a “separate procedure.” The inclusion of this statement indicates that 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.</td>
</tr>
<tr>
<td>Add-on Codes</td>
<td>Add-on codes will not be compensated if the primary procedure code has not been 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. Refer to the AMA CPT Manual for additional information.</td>
</tr>
</tbody>
</table>

**COMPENSATION/REIMBURSEMENT INFORMATION**

Tufts Health Plan has adopted CMS’s differential compensation for office and facility-based services, replacing Tufts Health Plan’s standard facility fee reduction. Refer to your contract for details regarding outpatient compensation provisions.

**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 global delivery codes if the provider has billed antepartum care in the last 8 months.

Effective for dates of service on or after October 1, 2017, Tufts Health Plan will not routinely compensate 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. Refer to the CMS Outpatient Prospective Payment System for additional information.

**Distinct Service Modifiers**
Effective for dates of service on or after October 1, 2017, Tufts Health Plan will not routinely compensate for services that are billed with inappropriate modifiers.

**CMS Coverage Rules**
Tufts Health Plan does not compensate for certain services when billed prior to the effective date of FDA approval. Refer to the CMS Outpatient Prospective Payment System for additional information.

Tufts Health Plan does not compensate for wound care management services performed by a physical, occupational or speech therapist when billed by the outpatient facility. Refer to the CMS Outpatient Prospective Payment System for additional information.

Tufts Health Plan does not compensate for electrical stimulation for wound healing or ambulation training for a spinal injury when performed at home, assisted living facilities, or custodial care facilities. Refer to the CMS Transmittals/Memos/Publications for additional information.

**Column I and Column II Procedure Codes**
Tufts Health Plan does not routinely compensate for a Column I procedure code if the Column II procedure code has been previously paid.

**Device and Supply**
Tufts Health Plan aligns compensation with CMS. Tufts Health Plan does not compensate imaging agents when billed without the appropriate imaging procedures. Refer to the Regional CMS Policy (Local Coverage Determination) for additional information.

**Diagnosis**
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 a claim when the gender and/or age of the member do not match the definition of the diagnosis. Refer to the ICD-CM Diagnosis Manual for additional information.

**Drug and Biological Policies**
For information on drug and biological policies, refer to the Drugs and Biologicals Payment Policy.

**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:

<table>
<thead>
<tr>
<th>Policy</th>
<th>Description</th>
</tr>
</thead>
</table>
| Bone Density         | Commercial: Tufts Health Plan will compensate for bone density studies once within a 23-month period.  
Tufts Medicare Preferred HMO and Tufts Health Plan SCO: Bone density studies for members 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. Refer to the CMS Transmittals/Memos/Publications.  |
| Colorectal Screening | In accordance with CMS, Tufts Health Plan will not compensate for:  
• 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 colonoscopy more than once within a 10-year period.                                                                                       |
Policy | Description
--- | ---
Home Health | Tufts Health Plan compensates for physician recertification for Medicare-covered home health services under a home health plan once every 60 days. Refer to the CMS Transmittals/Memos/Publications.

Lipid Panel Testing | Tufts Health Plan will not compensate for a lipid panel test more than two times within a 365-day period. Refer to the 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 will not compensate for a 90-day pharmacy dispensing fee when billed more often than every 33 days.
Tufts Health Plan will not compensate for a 30-day pharmacy dispensing fee when 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.

**Intravenous**
Tufts Health Plan does not routinely compensate for IV infusion or injections when billed with neuromuscular studies, as they are considered to be included in the performance of neuromuscular studies.

Tufts Health Plan will not compensate for puncture aspiration of a hydrocele when billed with hernia, hydrocele, spermatic cord, and varicocele repairs as the puncture aspiration is considered part of hernia, hydrocele, spermatic cord and varicocele repairs.

Tufts Health Plan will not compensate for the introduction of an intravenous needle or catheter when billed with a venipuncture, as the introduction of an intravenous needle or catheter is included in a venipuncture.

**Modifiers Inappropriate for Professional Claims**
Effective for dates of service on or after October 1, 2017, Tufts Health Plan will not routinely compensate any procedure billed with modifier 27, 73, 74 or CA if billed by or on behalf of a professional provider.

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

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>71020</td>
<td>Radiologic examination, chest, two views, frontal and lateral</td>
</tr>
<tr>
<td>80051</td>
<td>Electrolyte panel</td>
</tr>
<tr>
<td>80053</td>
<td>Comprehensive metabolic panel</td>
</tr>
<tr>
<td>82565</td>
<td>Creatinine; blood</td>
</tr>
<tr>
<td>84520</td>
<td>Urea nitrogen; quantitative</td>
</tr>
<tr>
<td>86900, 86901</td>
<td>Blood typing; ABO, Rh (D)</td>
</tr>
<tr>
<td>85004</td>
<td>Blood count; automated differential WBC count</td>
</tr>
<tr>
<td>85014</td>
<td>Hematocrit (Hct)</td>
</tr>
<tr>
<td>85018</td>
<td>Hemoglobin (Hgb)</td>
</tr>
<tr>
<td>85025</td>
<td>Complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count</td>
</tr>
<tr>
<td>85027</td>
<td>Complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)</td>
</tr>
<tr>
<td>93000</td>
<td>Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report</td>
</tr>
<tr>
<td>93005</td>
<td>Tracing only, without interpretation and report</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>93010</td>
<td>Interpretation and report only</td>
</tr>
</tbody>
</table>

**Pressure Ulcer Stage Codes**

Effective for dates of service on or after October 1, 2017, Tufts Health Plan will not routinely compensate for pressure ulcer stages when billed without a pressure ulcer.

**Procedure-Age Consistency**

Effective for dates of service on or after October 1, 2017, Tufts Health Plan will 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. Refer to the AMA CPT Manual for additional information.

**Vascular Diagnostic Studies**

Tufts Health Plan does not routinely compensate for duplex scan of extracranial arteries, study when billed in the 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**

Effective for dates of service on or after October 1, 2017, Tufts Health Plan will not routinely compensate for 36410 (venipuncture, age 3 years or older) when 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. Refer to the CMS outpatient prospective payment system (OPPS) for additional information. Tufts Health Plan does not routinely compensate for E&M services when billed with cardiovascular services on the same day. Refer to the [CMS Internet Only Manual](https://www.cms.gov) for additional information.

Tufts Health Plan does not routinely compensate for E&M services when 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 Commercial [Evaluation and Management Professional Payment Policy](https://www.commercialclaims.com) 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 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. For a list of procedure codes considered by Tufts Health Plan as nonreimbursable for outpatient facilities, refer to the Nonreimbursable Code List for Outpatient Hospitals on our website. 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 require an anatomical modifier when billed without an 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
- July 2017: Added edits effective for dates of service on or after October 1, 2017 for the following: distinct service modifiers, antepartum care, 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 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’s audit policies, refer to our website.

This payment 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 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.