Professional Services and Facilities Payment Policy

Applies to the following Tufts Health Plan products:

☒ Tufts Health Plan Commercial[1]

☒ Tufts Medicare Preferred HMO (a Medicare Advantage product)

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

Applies to the following Tufts Health Public Plans products:

☒ Tufts Health Direct – Health Connector

☒ Tufts Health Together – a MassHealth MCO Plan and Accountable Care Partnership Plans

☒ Tufts Health RITogether – A RI Medicaid Plan

☒ Tufts Health Unify – OneCare Plan

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

POLICY

Tufts Health Plan covers medically necessary services, in accordance with the member's benefits.

GENERAL BENEFIT INFORMATION

Cost share for services may apply pursuant to the member's specific benefit coverage. Coverage of services and subsequent payment are based on the member's benefit plan document. Providers and their office staff should use self-service channels to verify effective dates and cost share for members prior to initiating services. Eligibility may be subject to retroactive reporting of disenrollment.

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

Refer to the Electronic Services section of Tuft Health Plan's public Provider website for self-service channel options. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to Tufts Health Plan's secure Provider portal or by contacting Provider Services.

- Tufts Medicare Preferred HMO follows Medicare coverage guidelines. Tufts Health Plan cannot cover items and services not covered under the CMS-approved Tufts Medicare Preferred HMO benefit plan. The Tufts Medicare Preferred HMO benefit plan currently covers a limited number of non-Medicare-covered items as supplemental benefits (subject to change each year).
- Tufts Health Plan SCO follows Medicare coverage guidelines for Medicare-covered benefits and Medicaid coverage guidelines for Medicaid-only covered benefits.
- Tufts Health Plan complies with all applicable state and federal laws regarding coverage of healthcare services, including mental health parity requirements.

REFERRAL/PRIOR AUTHORIZATION/NOTIFICATION REQUIREMENTS

Certain procedures, items and/or services may require prior authorization with the Tufts Health Plan Precertification Operations Department. Requirements for authorization include timely notification and submission of all required documentation. 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 on procedures, services and items requiring referral and/or prior authorization, refer to the following resources:

Commercial (including Tufts Health Freedom Plan)

- Authorization Policy
- Referrals, Authorizations and Notifications chapter of the Commercial Provider Manual

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[1] Commercial products include HMO, POS, PPO, and CareLink℠ when Tufts Health Plan is the primary administrator.

- CareLink℠ Prior Authorization List

For members using the PHCS Healthy Directions (also known as Multiplan Travel) network, contact American Health Holding.

For members using the Cigna PPO network, contact Tufts Health Plan Provider Services.

Tufts Medicare Preferred HMO and Tufts Health Plan SCO

- Referral, Authorization and Notification Policy
- Prior Authorization and Inpatient Notification List (Tufts Medicare Preferred HMO only)
- Prior Authorization and Notification lists (Tufts Health Plan SCO only)
- Referrals, Prior Authorizations and Notifications chapters of the Senior Products Provider Manual

Tufts Health Public Plans

- Medical necessity guidelines available in the Provider Resource Center
- Benefit summary grids available in the Provider Resource Center
- Tufts Health Public Plans Provider Manual

INPATIENT NOTIFICATION

Inpatient notification must be obtained via electronic submission on the secure Provider portal or by faxing a completed Inpatient Notification Form to the Precertification Operations Department. For fax numbers by product, refer to the Notifications chapter in the applicable Provider Manual for Commercial, Senior Products and Tufts Health Public Plans.

Note: No other forms will be accepted. Incomplete forms will be returned to the submitting provider for completion and resubmission. Processing the request will be delayed until all required information is returned to Tufts Health Plan.

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 as well as content-specific payment policies for additional information. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules.

- Submit the most updated industry-standard codes and modifiers, when applicable, with the corresponding CPT/HCPCS procedure code(s).
- Ancillary providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements.
- Submit original claims once; additional submissions of the same claim will result in duplicate denials. Refer to Avoiding Administrative Claim Denials for additional information.
- Refer to Medicare billing guidelines to submit claims for Medicare-only-covered services, and to Medicaid guidelines to submit claims for Medicaid-only-covered services.

To view the status of submitted authorizations and claims, log on to Tufts Health Plan's secure Provider portal.

Annually and quarterly, HIPAA medical code sets[2] and modifiers undergo revision by CMS (including NCCI) and AMA. Revisions typically include adding, deleting or redefining the description or nomenclature of new HCPCS, CPT procedure and ICD-CM diagnosis codes. As these revisions are made public, Tufts Health Plan will update its systems to reflect these changes.

Tufts Health Plan does not add, remove or replace modifiers or procedure codes on submitted claims. These changes are based on the coding guidelines defined by AMA and CMS and are to be utilized appropriately by the submitting provider. Inappropriately coded claims will deny, and providers will have the opportunity to submit a corrected claim.

Note: Tufts Health Plan encourages direct electronic claim submission.

EDI Claims Submission: Submit claims in HIPAA-compliant 837P format. Claims billed electronically with nonstandard codes will reject. Refer to the 837 Companion Guide for additional information.

[2] HIPAA medical code sets include HCPCS, CPT procedure and ICD-CM diagnosis codes.

Paper Claims Submission: All paper claims must be submitted on standard red claim forms. Black and white versions of these forms, including photocopied and faxed versions, will not be accepted and will be returned with a request to submit on the standard red claim form. Claim line(s) billed with nonstandard codes will deny.

Submitted forms deemed incomplete will be rejected and returned to the submitter with a letter stating the reason for the rejection, and instruction to resubmit a new claim with the required information for processing within the applicable filing limits.

For additional billing requirements and instructions, refer to the Claim Requirements, Coordination of Benefits and Payment Disputes chapters of the Commercial, Senior Products and Tufts Health Public Plans Provider Manuals.

COMPENSATION/REIMBURSEMENT INFORMATION

Providers are compensated according to the applicable network contracted rates, regardless of the address where the service is rendered. Claims are subject to payment edits that are updated at regular intervals and generally based on CMS (including NCCI), specialty society guidelines and drug manufacturers' package label inserts.

Tufts Health Plan does not allow the use of a so-called "waiver" to circumvent or override the provider's obligations under the applicable participation agreement with regard to services covered under the member's plan. By way of illustration and not limitation, the waiver is of no validity when applied to missed filing deadlines, provider's authorization requirements and attempts to collect payments other than applicable cost share.

Tufts Health Plan members may not be held financially accountable for services performed by a noncontracting lab ordered by or referred from a contracting provider. In such circumstances, Tufts Health Plan may hold the ordering provider accountable for any inappropriate billing and related actions on the part of the nonparticipating lab the provider has selected.

Note: Tufts Health Plan does not separately compensate providers for time and direct costs associated with procuring and maintaining inventories of drugs and supplies, as this expense is a component of the existing compensation schedule.

Add-On Codes

Tufts Health Plan does not compensate add-on code(s) if the primary procedure code has not been submitted on the same claim. Add-on codes are always performed in conjunction with a primary procedure and should never be reported as stand-alone services. If the primary procedure code has not been submitted and compensated on the same date of service, then that add-on code will also not be allowed. Refer to the AMA CPT Manual for additional information.

Diagnosis Specificity: Tufts Health Plan does not routinely compensate for services if the ICD codes are not coded to the highest level of specificity.

Manifestation Codes: Tufts Health Plan does not routinely compensate services billed with a manifestation code as the only diagnosis on the claim.

Procedure code guidelines: Tufts Health Plan does not compensate for inappropriately coded services, based on CPT/HCPCS procedure code guidelines.

Tufts Health Public Plans does not routinely compensate any procedure or service received with an ICD-CM sequela (7th character "S") code billed as the only diagnosis on the claim.

Effective for dates of service on or after July 1, 2021, Tufts Health Plan does not routinely compensate procedure codes that are billed with inappropriate diagnosis codes.

Tufts Health Plan does not routinely compensate the following, according to current ICD-CM guidelines:

- Claim lines reported with mutually exclusive code combinations
- Claim lines where lateral diagnosis codes do not match the modifier(s) associated to a claim line (e.g., a diagnosis code indicates right-side but a left-side modifier is billed)
- Claim lines where lateral diagnosis codes associated to a claim line are billed incorrectly (e.g., diagnosis billed states right side, another diagnosis billed states left side, and there is a diagnosis code for bilateral)

Tufts Health Plan does not routinely compensate claim lines if the revenue code is 0636 (drugs requiring detailed coding) and the HCPCS code does not match.[3]

Tufts Health Plan does not routinely compensate any service if an inpatient or outpatient claim exists with a discharge status of 20, 40, 41, or 42 (patient deceased/expired) prior to the date of service.[7]

Tufts Health Plan recommends not billing the member for any cost-share amount until the claim has processed so that the appropriate member responsibility can be determined. Both the provider's explanation of payment (EOP) and the electronic remittance advice (ERA) will reflect the member's responsibility amount.

Explanation of Payment: The EOP provides information on the status of the claim(s) submitted to Tufts Health Plan, including claims payments, denials and pending claims.

Electronic Remittance Advice: The HIPAA-compliant 835 ERA is an EDI transaction that providers may request to electronically post both paid and denied claims information to their accounts receivable system.

For more information on how to obtain an EOP and/or ERA, refer to the Claim Requirements, Coordination of Benefits and Payment Disputes chapters of the Commercial, Senior Products and Tufts Health Public Plans Provider Manuals.

Place of Service Coding for Physician Services
Tufts Health Plan does not routinely compensate for the following:

- Physician service codes billed in place of service 11 (office) by a professional provider if the same code was billed by any outpatient provider or facility (including ambulatory surgical centers) for the same date of service.
- Physician service codes billed in a non-facility place of service by a professional provider if the same code was billed by any facility (on a CMS-1500) for the same date of service.

Senior Products Only
Duplicate/Multiple Professional Components for the Same Service
Tufts Health Plan only compensates for one professional or technical component for the same service if billed by different providers.

DOCUMENT HISTORY

- September 2021: Minor administrative edit
- May 2021: Added edit for procedure code guidelines effective for dates of service on or after July 1, 2021
- December 2020: Added general coding edits for diagnosis specificity and manifestation codes; removed from THPP claim edits grid
- July 2020: Updated references to secure Provider portal and chapters of the Tufts Health Public Plans Provider Manual; revised billing instructions boiler plate langauge
- October 2019: Added section on Inpatient Notification; updated chapter names and links to provider manuals
- May 2019: Added claim edits for discharge status and revenue/HCPCS code consistency, effective for dates of service on or after July 1, 2019; removed reference to Claims Submission Policy (retired)
- November 2018: Added edits for place of service and ICD-CM coding, effective for dates of service on or after January 1, 2019
- August 2018: Added claim edits for place of service coding for physician services and duplicate/multiple professional components for the same service effective for dates of service on or after October 1, 2018
- June 2018: Template updates
- May 2018: Added claim edit for inappropriately coded claims, effective for dates of service on or after July 1, 2018
- February 2018**:** Created one document for Tufts Health Plan

[3] Applies to Tufts Medicare Preferred HMO, Tufts Health Plan SCO, and Tufts Health Public Plans products.

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.