Outpatient Facility Payment Policy

Applies to the following Tufts Health Public Plans products:

☒Tufts Health Direct – Health Connector

☒Tufts Health RITogether – A RI Medicaid Plan

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

☒Tufts Health Unify – OneCare Plan

The following payment policy applies to Tufts Health Plan contracting outpatient facilities.

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 contracting outpatient facilities that perform medically necessary services, as described below. Tufts Health Plan utilizes InterQual® criteria and Tufts Health Plan Medical Necessity Guidelines to determine the appropriateness of the requested level or setting (e.g., inpatient vs. SDC).

For information regarding physical, occupational and speech therapies, refer to the Outpatient Therapy Services Payment Policy.

For information regarding outpatient behavioral health, refer to the Provider Manuals for Massachusetts and Rhode Island.

DEFINITION

Outpatient facilities are defined as outpatient hospital departments, ambulatory surgical centers or freestanding facilities that perform medically necessary services for Tufts Health Plan members. These services may include up to a 24 hour stay but do not require an inpatient level hospital stay

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 Tufts Health Public Plans Provider Services.

Note: There is no member responsibility for covered services for Tufts Health Unify, Tufts Health Together or Tufts Health RITogether members.

AUTHORIZATION REQUIREMENTS

While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization for outpatient services has been obtained when applicable.

For information on procedures, services and items requiring referral and/or prior authorization, refer to the following resources:

- Medical necessity guidelines available in the Provider Resource Center
- Benefit summary grids available in the Provider Resource Center
- Tufts Health Public Plans Provider Manuals for Massachusetts and Rhode Island

Inpatient notification is required for outpatient services that result in an inpatient admission. The admitting provider or facility should submit an inpatient notification for the member at the time of admission. Refer to the Diagnosis Related Group (DRG) Inpatient Facility Payment Policy or Non-Diagnosis Related Group (DRG) Inpatient Facility Payment Policy for more information.

Note: Facility claims will be denied if the referral to the specialist/surgeon has not been obtained, if applicable.

BILLING INSTRUCTIONS

Tufts Health Plan follows AMA CPT/HCPCS coding guidelines and accepts all standard modifiers, CPT/HCPCS procedure codes, and revenue codes.

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.

COMPENSATION/REIMBURSEMENT INFORMATION

Procedures or services that are appropriate to be performed in an office setting may deny if billed in an outpatient facility.

Tufts Health Direct, Tufts Health RITogether and Tufts Health Unify

Outpatient facilities are compensated according to applicable network contracted rates, regardless of the address where the services is rendered. For additional information, refer to the Professional Services and Facilities Payment Policy.

Tufts Health Together

Outpatient hospitals are reimbursed based on the Massachusetts Executive Office of Health and Human Services (EOHHS) Adjudicated Payment per Episode of Care (APEC) payment methodology or according to their applicable network contracted rates.

The following apply to all products:

Services Inappropriate to Be Performed in an Outpatient Setting

Procedures that are inappropriate to be performed in an outpatient setting due to the complexity involved will be denied. Tufts Health Plan follows Medicare coverage guidelines. Refer to the CMS website for additional information.

AAOS Intraoperatve Services

Tufts Health Plan will not routinely compensate intraoperative services when billed with an orthopedic procedure.

Arthrocentesis

Effective for dates of service on or after April 1, 2018, Tufts Health Plan will not routinely compensate 20610 or 20611 (arthrocentesis, aspiration and/or injection; major joint or bursa [e.g., shoulder, hip, knee joint, subacromial bursa]) when submitted without an appropriate diagnosis code, as defined by CMS guidelines.

Cystourethroscopy

Tufts Health Plan will not routinely compensate 52353 or 52356 (cystourethroscopy with lithotripsy) when another cystourethroscopy with lithotripsy for the same side has been billed in the previous month.

Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds

Tufts Health Plan will limit coverage of G0281 (electrical stimulation, unattended, for chronic ulcers) or G0329 (electromagnetic therapy, for chronic ulcers) to appropriate ulcer diagnoses.

Electroencephalogram (EEG)

- Effective for dates of service on or after January 1, 2018, Tufts Health Plan will not routinely compensate 95950, 95951, 95953, 95956 (24-Hour EEG monitoring) or 95957 (EEG for epileptic spike analysis) when billed in any combination greater than three days.
- Effective for dates of service on or after January 1, 2018, Tufts Health Plan will not routinely compensate 95957 (EEG for epileptic spike analysis) when billed on same date of service as 95951, 95953, or 95956 (monitoring for localization of cerebral seizure focus).

Erectile Dysfunction

Tufts Health Plan will not routinely compensate inject corpora cavernosa with pharmacologic agents (54235) if billed more than one unique date of service within a year by any provider.

Home PT/INR Monitoring for Anticoagulation Management

- Tufts Health Plan does not routinely compensate G0248-G0250 (home prothrombin time [INR] monitoring) when billed without a covered diagnosis.

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

Implantable Neurostimulator Electrode
Effective for dates of service on or after January 1, 2018, Tufts Health Plan does not routinely compensate L8680 (Implantable neurostimulator electrode, each) when billed with 63650 (Percutaneous implantation of neurostimulator electrode array, epidural).

Intravenous and Venous Services
Tufts Health Plan does not routinely compensate 36470-36471 (injection of sclerosing solution; single vein; multiple veins, same leg) when billed in any combination greater than 4 unique visits within a three-month time frame by any provider.

Lung Cancer Screening with Low Dose Computed Tomography (LDCT)
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.

Nasal Endoscopy
Tufts Health Plan does not routinely compensate nasal endoscopy with debridement (31237) when it has been billed more than three times in the 3-month period following a surgical sinus endoscopy (31240-31297, 0406T-0407T).

Needle EMG
Tufts Health Plan does not routinely compensate needle EMG; 1-4 extremities with or without related paraspinal areas when billed and the only diagnosis code is carpal tunnel syndrome.

Nerve Conduction Studies (NCS) and Electromyography (EMG) for Radiculopathy
- Effective for dates of service on or after January 1, 2018, Tufts Health Plan does not routinely compensate needle electromyography (95860-95864) when billed without a nerve conduction study (95905) and the only diagnosis on the claim is radiculopathy.
- Effective for dates of service on or after January 1, 2018, Tufts Health Plan does not routinely compensate nerve conduction study (95907-95913) when billed without a needle electromyography (95885, 95886) and the only diagnosis on the claim is radiculopathy.

Procedures of the Knee
Tufts Health Plan does not routinely compensate 29879 (arthroscopy of knee with abrasion arthroplasty) when billed with 29880-29881 (arthroscopy of knee with meniscectomy).

Psychological or Neuropsychological Testing
Tufts Health Plan does not routinely compensate additional units of 96101, 96102, 96116, 96118, or 96119 when billed more than eight units in any combination.

Surgical Global Day Period
Surgical procedures are assigned a global day period of 0, 10 or 90 day(s) by CMS based on the complexity of the procedure. Services rendered within the assigned specified numbers of global days, including evaluation and management services (E&M), are considered inclusive to the primary procedure.

Note: Tufts Health RITogether has an assigned global day period of 30 days, based on RI Medicaid guidelines.

Surgical Dressings
Tufts Health Plan does not routinely compensate surgical dressings billed in the provider's office (POS 11).

Suture Removal
Tufts Health Plan does not routinely compensate 15850 or 15851 (removal of sutures under anesthesia [other than local]) when the patient's age 21 and older.

Therapy Services Modifiers GN, GO and GP
Tufts Health Plan does not routinely compensate non-therapy services when billed with therapy services modifiers GN, GO or GP.

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) when billed more than three times in a 90-day period day period at the same anatomic site.

Tympanometry
Tufts Health Plan does not routinely compensate additional billings of tympanometry (92567), when billed more than twice within a year without the appropriate diagnosis.

Ulcer Debridement and Ulcer Stages
Effective for dates of service on or after April 1, 2018, Tufts Health Plan does not routinely compensate 11042-11047 (debridement) when billed with a pressure ulcer stage 1 or stage 2 diagnosis and another pressure ulcer stage (3 or 4) or a non-pressure chronic ulcer diagnosis is not reported on the claim.

Unleveled Procedure Codes
Surgical procedure codes that do not have an assigned payment level (e.g., new procedure codes) will pend for medical director review. Upon review, a level is assigned, and the claim is paid at that payment level.

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

Urodynamics
Tufts Health Plan does not routinely compensate 51798 (measurement of post-voiding residual urine) or 76857 (pelvic ultrasound) when billed on the same date of service as 51725-51729 (simple or complex cystometrogram).

Vagus Nerve Stimulation (VNS)
Effective for dates of service on or after January 1, 2018, Tufts Health Plan does not routinely compensate neurostimulator procedure (insertion, replacement, revision, removal or analysis) when billed with a diagnosis of depressive disorders.

Serious Reportable Events ("Never Events")
The National Quality Forum defines "never events" as errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility. Tufts Health Plan will deny or retract payment for care related to procedures that meet the definition of a "never event" once they have been identified. Refer to the Serious Reportable Events, Serious Reportable Adverse Events and Provider Preventable Conditions Payment Policy for more information.

ADDITIONAL RESOURCES

- Emergency Department Services Payment Policy
- Observation Services
- Diagnosis Related Group (DRG) Inpatient Facility Payment Policy
- Non-Diagnosis Related Group (DRG) Inpatient Facility Payment Policy
- Outpatient Therapy Services Payment Policy
- Acute Hospital RY18 MassHealth EAPG Weights Chart D

DOCUMENT HISTORY

- September 2018: 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 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.