Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Payment Policy:
General Coding and Claims Editing

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products
☒ Tufts Health Plan Commercial products

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☒ Tufts Health Together – MassHealth Accountable Care Partnership Plans
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan
☒ Tufts Health One Care – A dual-eligible product

Senior Products

☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)
☒ Tufts Medicare Preferred HMO/PPO (Medicare Advantage products)

Policy

This policy serves as a reference guide for general coding and claims editing information for all Point32Health products.

General Benefit Information

Services are pursuant to the member's benefit plan documents and are subject to applicable member out-of-pocket cost (e.g., copayment, coinsurance, deductible). Member eligibility and benefit specifics should be verified prior to initiating services.

Refer to the Point32Health provider page for online resources and provider portals.

General Coding and HIPAA Compliance

Point32Health will accept only standard diagnosis and procedure codes that comply with HIPAA (Health Information Portability and Accountability Act) transaction code set standards. Refer to current industry standard coding guidelines for a complete list of CPT/ HCPCS, ICD-10 codes, revenue codes, modifiers and their usage, as well as specific payment policies for additional information. Point32Health complies with all applicable state and federal laws regarding coverage of healthcare services, including mental health parity requirements.

Specific types of standard coding include:

- CPT Level I codes: 5-digit numeric codes maintained by the American Medical Association (AMA). These codes have descriptors that correspond to a procedure or service. Codes range from 00100–99499 and are generally ordered into sub-categories based on procedure/service type and anatomy.
- HCPCS Level II codes: Alpha-numeric (1 letter followed by 4 numbers) codes, which are used to identify products, supplies and services not included in Level I CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.
- C codes are temporary HCPCS codes established by the Centers for Medicare and Medicaid Services (CMS) for use under the Hospital Outpatient Prospective Payment System (OPPS). Point32Health will reimburse some C codes to outpatient facilities and ambulatory surgery centers only. They will not be reimbursed to professional providers.
- HCPCS Temporary National "S" codes are temporary codes for private payor use. Providers may only bill procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules
- Current Dental Terminology (CDT) Codes: Dental codes maintained by the American Dental Association (ADA)
- International Classification of Diseases (ICD) 10-CM codes: Used to indicate diagnosis or condition. ICD-10 codes are required on all claims. Point32Health follows ICD-10-CM Official Guidelines for Coding and Reporting and may deny claims when billed inappropriately.

- NDC (National Drug Code) codes- A universal number that identified a drug. The NDC number consists of 11 digits in a 5-4-2 format (Do not bill with hyphens, only the 11-digit NDC).
- Revenue codes- 4-digit numeric codes used by institutional providers. CPT/HCPCS codes may be required in addition to specific revenue codes to describe services rendered.

Quarterly and annual revisions are made to CPT, HCPCS, and ICD-10-CM codes by CMS and AMA. This can include adding, deleting, or redefining the description of applicable codes. As these revisions are released, Point32Health will update its systems and any related payment policies.

Tufts Health Plan

Refer to Medicare or Medicaid guidelines for coverage and claims submission guidelines for applicable plans.

Claims Editing Overview

Point32Health uses claims editing software for automated claims coding verification and to ensure that Point32Health is processing claims in compliance with general industry standards. The policies and procedures included in the claims editing software are incorporated herein by reference as policies and procedures of Point32Health.

Claims Editing Software Application

Using a comprehensive set of rules, claims editing provides consistent and objective claims review by:

- Accurately applying coding criteria for the clinical areas of medicine, surgery, laboratory, pathology, radiology, and anesthesiology as outlined by the American Medical Association's (AMA) Current Procedural Terminology (CPT) manual.
- Evaluating the CPT and HCPCS codes submitted by detecting, correcting, and documenting coding inaccuracies including, but not limited to, unbundling, up-coding, fragmentation, duplicate coding, invalid codes, and mutually exclusive procedures.
- Reviewing ICD-10 codes to ensure ICD-10-CM manual guidelines are followed by detecting incorrect or inaccurate coding (e.g., ICD-10 code not coded to the highest level of specificity). This may also be in conjunction with CPT or HCPCS codes and modifiers (e.g., Claim lines where a diagnosis code indicates right side but a left side modifier is billed).
- Incorporating historical claims auditing functionality, which links multiple claims found in patient's claims history to current claims to ensure consistent review across all dates of service.

Claims Editing Determination

Claims editing does not affect claims submission or Explanation of Payment (EOP) statements.

- A claim edit determination may be appealed or disputed due to unusual clinical circumstances; separate reimbursement may be considered upon medical record review.
- Claim appeals or disputes resulting from the claim-editing determinations are treated the same as any other provider claim appeal or dispute.

Claims Editing Updates

Claims editing software is updated regularly to incorporate the most recent medical practices, coding practices, annual changes to the AMA's CPT manual and other industry standards.

Claims Editing Principles

Conflicts with Other Common Core Data

Providers are expected to adhere to correct coding guidelines. Claims are screened for patient and/or provider information conflicts. Reimbursement will not be made for claims where procedure or diagnosis codes conflict with common core data, including but not limited to:

- Place of service with procedure
- Patient age with procedure
- Patient age with diagnosis
- Diagnosis with procedure
- Provider with procedure

Incidental Procedures

Procedures that are performed at the same time as a primary procedure are considered incidental if clinical practice standards indicate they are normally included as part of the primary procedure. Incidental procedures are not reimbursed separately.

Mutually Exclusive Procedures

Two or more procedures are considered mutually exclusive if they cannot reasonably be performed at the same anatomic site or patient encounter. These coding combinations are deemed submitted in error and only the primary service is considered for reimbursement.

Separate Procedures

Procedure codes that include the term “separate procedure” should not be reported with a related procedure. Separate procedure codes are eligible for separate reimbursement when they are performed on the same day but at a different session, or at an anatomically unrelated site. If appropriate and supported by the medical documentation, report the separate procedure by appending either of the following modifiers when applicable;

- XE- Separate encounter
- XS- Separate organ/structure

Unbundling

Unbundling occurs when two or more procedures are reported separately when a single, comprehensive code exists that accurately describes the service performed.

- Services should not be unbundled into multiple procedure codes but should be reported as a single comprehensive code.
- Unbundled procedure codes may be denied or re-bundled and processed as the more accurate, single, comprehensive procedure code.

Professional/Technical Component

Point32Health uses CMS Professional Component/Technical Component (PC/TC) Indicators in the National Physician Fee Schedule (NPFS) Relative Value File to determine whether a procedure (CPT/HCPCS) is eligible for separate professional and technical service reimbursement.

Code Auditing Reference Tool (Professional Claims)

Harvard Pilgrim Health Care

For CMS 1500 claims, Harvard Pilgrim offers the Code Auditing Reference Tool, a Web-based software application designed to enable providers to gain a better understanding of code auditing rules including, but not limited to, incidental procedures, mutually exclusive procedures, bundling/unbundling procedures and codes in conflict with age. The Code Auditing Reference Tool can increase your administrative efficiency by reducing manual inquiries, claim appeals, and misunderstandings regarding claim edits. Providers and their office staff registered with HPHConnect can review the claim payment methodology and reimbursement policies behind coding edits. To access Harvard Pilgrim's Code Auditing Reference Tool, please login into HPHConnect.

Professional/Technical Component

Point32Health uses CMS Professional Component/Technical Component (PC/TC) Indicators in the National Physician Fee Schedule (NPFS) Relative Value File to determine whether a procedure (CPT/HCPCS) is eligible for separate professional and technical service reimbursement.

- Per CMS, the reporting of CPT code 85060 (PC/TC 8) by a physician or other qualified health care professional must be accompanied by place of service (POS) code 21 (inpatient hospital).

Other Coding Guidance

Add-on Codes

- Add-on codes are only those codes designated by CPT and identified by a specified descriptor that includes the phrase “each additional” or “list separately in addition to the primary procedure.”
- Add-on codes are reimbursable only when billed with their primary procedure.

Ambulatory Blood Pressure Monitoring

Harvard Pilgrim Health Care Commercial

Effective for DOS beginning Jan. 1, 2026, CPT codes 93784-93790 (ambulatory BP monitoring; recording; analysis or review/report BP recording) will deny if billed for a reason other than elevated blood pressure reading without a diagnosis of hypertension.

Bilateral Services

Bilateral services are procedures performed on both sides of the body during the same session or on the same day. As defined

in the CPT manual, modifier 50 is used to identify a “bilateral procedure. Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5-digit code”.

- Modifier 50 is used to report diagnostic, radiological, and surgical procedures.
- HCPCS modifiers LT and RT are used when the procedure is valid for a modifier 50 procedure but was only performed on one side.
- Do not use modifiers RT and LT when modifier 50 applies. A bilateral procedure is reported on one line, using modifier 50.
- Modifier 50 is not applicable to:
  - Procedures that are bilateral by definition
  - Procedures with descriptions including “bilateral” or “unilateral”

Bilateral services performed on both sides of the body during the same session or on the same day, when billed with modifier 50, are reimbursed at 150% of the fee schedule allowed amount.

- Modifiers that reduce the fee schedule/ allowed amount must be billed in the primary modifier position, and modifier 50 in the secondary position (e.g., for professional component of a bilateral procedure, bill modifier 26 in the primary modifier position and modifier 50 in the secondary position).

Refer to the Medicare Physician Fee Schedule (MPFS) database to determine when modifier 50, RT, or LT is applicable for a procedure code.

Multiple Surgical Procedures

When applicable multiple procedures are performed at the same session, the procedure with the highest allowable rate will be reimbursed at 100% of the allowable rate. Subsequent reimbursable procedures will be paid at 50% of the allowable rate.

Unlisted Codes

Unlisted CPT codes are reimbursed after individual consideration and review of the operative notes. When submitting supporting documentation, underline the portion of the report that identifies the test or procedure associated with the unlisted procedure code. Required information must be legible and clearly marked.

Medical Record Documentation and Physician Queries

Point32Health will not accept retrospectively amended medical records or physician queries beyond 30 days from the date of service. Point32Health considers medical record documentation and/or physician queries upon review as the official record to support services provided for the basis of coverage or reimbursement determination. Clinical documentation or physician queries amended over 30 days from the date of service will not be accepted to defend reimbursement, increase reimbursement, or for consideration of a previously denied claim.

Self-Treatment or Treatment of Immediate Family Members

Point32Health does not reimburse contracted providers for treatment or service rendered to immediate family members or for self-treatment.

The following degrees of relationship are included within the definition of immediate family member:

- Husband or wife
- Natural or adoptive parent, child, or sibling
- Stepparent, stepchild, stepbrother, or stepsister
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law
- Any other relative(s) residing in the same residence as the licensee

Provider Billing Guidelines and Documentation

- Services should only be billed once they have been provided to the member
- Refer to the applicable Provider Manual for claims submission guidance

Publication History

10/01/2026: Annual policy review; added multiple surgical procedures reimbursement; removed edits; administrative edits
01/01/2026: Added existing reporting requirement for CPT code 85060
10/01/2025: Added edits for ambulatory blood pressure monitoring and neurostimulator procedures on the peripheral nerves for Harvard Pilgrim Health Care members, effective for DOS beginning Jan. 1, 2026

10/01/2024:	Annual review; no changes
08/01/2024:	Added edits effective on or after dates of service 10/1/2024
09/29/2023:	Moved to new template, includes all lines of business; archived Harvard Pilgrim Health Care Bilateral Services and CPT Modifier 50 Payment Policy, merged with this policy; Archived Tufts Health Plan Bilateral and Multiple Surgical Procedures Payment Policy, merged bilateral services with this policy

Background and Disclaimer Information

This policy applies to the products of Harvard Pilgrim Health Care and Tufts Health Plan and their affiliates, as identified in the check boxes on the first page for services performed by contracted providers.

Payment is based on member benefits and eligibility on the date of service, medical necessity review, where applicable, and the provider's network participation agreement with the Plan. 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.

Point32Health reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated as applicable; please adhere to the most recent CPT and HCPCS coding guidelines.

We reserve the right to conduct audits on any provider and/or facility to ensure accuracy and 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, Harvard Pilgrim Health Care and Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance.