Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Payment Policy:
Evaluation and Management (E&M)

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 MCO Plan and 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

Tufts Health Plan covers medically necessary E&M services, in accordance with the member's benefits. For more information on E&M telemedicine services, refer to the Telemedicine Services Payment Policy.

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 portal or by contacting Provider Services.

Referral/Prior Authorization/Notification Requirements

Certain procedures, items and/or services may require referral and/or prior authorization. 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.

Any E&M services related to an inpatient admission will be denied if an inpatient notification has not been obtained by the admitting facility.

For more information, refer to the Referral, Prior Authorization and Notification Policy.

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. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules.

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.

Providers may only bill one E&M service per date of service (DOS). Addressing a problem or abnormality is considered part of the global service when a preventive medicine service is performed, unless the problem or abnormality is significant enough to require additional work to meet the key components of a problem-oriented E&M service, which must be reported appropriately and separately.

Multiple E&M Services
Only one E&M service is allowed for a single DOS for the same provider group (same tax ID number) and specialty, regardless of the place of service. If multiple E&M procedure codes are submitted for a single DOS for the same provider group (same tax ID number) and specialty, the E&M procedure code with the highest allowable compensation will be processed and any additional E&M code(s) will be denied. Refer to the Compensation/Reimbursement Information section below for additional information.

Preventive Medicine Visits
If a preventive medicine procedure code (99381–99397, 99429) and a problem-focused E&M procedure code (99202–99380) are billed on the same DOS, modifier 25 should be appended to the problem-focused E&M procedure code. Refer to the Compensation/Reimbursement Information section below for additional information.

Interprofessional (Provider to Provider) E-Consults
Tufts Health Together, Tufts Health One Care, Tufts Health Plan SCO

In accordance with MassHealth APB 364, providers should submit claims using the following information:

- Initial e-consults should use 99452. This code will only be reimbursed once per member in a 14-day period, even if billed multiple times
  - Providers in a primary care setting or providing E/M services may use 99452 when seeking specialty guidance from a specialist with whom the member currently has no established relationship
- Use 99451, 99446, 99447, 99448 or 99449 to answer a provider-to-provider e-consult of at least five minutes of medical consult time
  - Codes will be reimbursed once per seven-day period, even if billed multiple times
  - Codes will not be reimbursed if a visit occurs with the provider type as that which was e-consulted within 14 days of the e-consult
- Specialty care providers should use 99451, 99446, 99447, 99448, 99449 when acting in a consultative function
  - Specialty guidance must be from a specialty type with whom the member currently has no established relationship
- All e-consult codes must be billed on a professional claim form
- Telehealth POS codes 02 and 10 and/or telehealth modifiers will **not** be accepted for these codes as they're not considered telehealth services
- E-consults may be billed for the same DOS as the member's office visit

Compensation/Reimbursement Information

Providers are compensated according to the applicable network contracted rates and applicable fee schedules.

Unless otherwise noted, the following reimbursement information applies to all Tufts Health Plans products. **Note:** Refer to the appropriate sections for additional E&M compensation information specific to Commercial, Senior Products or Tufts Health Public Plans.

Note: Tufts Health Plan's claims editing logic for E&M services are based on a provider's information with Tufts Health Plan.

All Products

Annual Wellness Visit
Tufts Health Plan does not routinely compensate for the following:

- G0439 (Annual wellness visit) if another annual wellness visit (G0438 or G0439) has been billed and paid in the current 11 months (Commercial and Tufts Health Public Plans) or current calendar year (Senior Products)
- G0438 (annual wellness visit; initial visit) if billed more than once in a member's lifetime.

Collaborative Care
Collaborative care services are reimbursed when provided under the direction of a treating physician or other qualified health care professional that identifies a member's behavioral health needs and integrates care management support and regular psychiatric inter-specialty consultation with the primary care team during a calendar month. When billing collaborative care services delivered during the calendar month, use the last date that the collaborative care service was performed in the month as the DOS on the claim form. Claims must be submitted after the services have been rendered in the entire month.

- **99492:** Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.

- **99493:** Follow up psychiatric collaborative care management, first 60 minutes in a following month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.
- **99494:** Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional directs. (use 99494 in conjunction with 99492,99493)
- **G2214:** Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional

Critical Care Services[1]
The following services are included in critical care services provided during inter-facility transport (99289–99290):

- Routine venous access
- Blood collection
- Arterial puncture
- Naso- or oro-gastric tube placement
- Chest x-ray interpretation
- Temporary transcutaneous pacing
- Ventilation assist and management
- CPAP or CNP
- Pulse oximetry
- Analysis of computer data

Tufts Health Plan does not routinely compensate for an E&M service under the following circumstances:

- When billed with a critical care service. Tufts Health Plan will consider compensation for the E&M service if the appropriate modifier is appended to the E&M procedure code
- 99291 (critical care E&M, first 30-74 minutes) when billed with more than one unit per day. Tufts Health Plan compensates providers for only one critical care or intensive care procedure code for a single DOS.

Diagnosis and Procedure Consistency
Tufts Health Plan does not routinely compensate 96150-96155 (health and behavior assessment/intervention) if all ICD-CM codes on the claim line are inappropriate diagnosis/procedure combinations as defined by Regional CMS Guidelines.

Tufts Health Plan does not routinely compensate E&M services (excluding normal newborn care) billed with preventive medicine services (99381-99429) when reported with an ICD-CM "Z" diagnosis code as the only diagnosis on the claim.

Discharge Services
Tufts Health Plan does not routinely compensate for hospital discharge services (99238-99239) when 99238 or 99239 has been billed and paid for the subsequent DOS.

Established E&M visits
Unless a significant, separately identifiable service was performed, Tufts Health Plan does not routinely separately compensate for an established patient E&M service if billed with cardiac stress tests, transthoracic echocardiography, and myocardial perfusion imaging, as the E&M service is included in those procedures.

Inpatient Neonatal and Pediatric Critical Care and Intensive Care Services
Tufts Health Plan does not routinely compensate the following:

- 99477 (initial neonatal intensive care) if reported subsequent to the date of admission **for Commercial products**
- Initial neonatal and pediatric critical care (99468, 99471, 99475) if the patient has had inpatient critical care services the previous day **for Tufts Health Public Plans products**

Tufts Health Plan limits the coverage of the following:

- Any combination of 99477-99480 (neonatal intensive care) and 99468-99476 (neonatal and pediatric critical care) to one unit per DOS by any provider for **Tufts Health Public Plans**

Modifiers
Tufts Health Plan does not routinely compensate for E&M services when bill with modifier 24 or modifier 57 as outlined in the Modifier Payment Policy.

[1] According to CMS, a critical care service includes an E&M service when reported on the same day. Refer to the CMS Internet Only Manual for additional information.

Refer to the Modifier Payment Policy for additional information on the compensation for E&M codes with modifier 25.

Multiple E&M Services on the Same Day
If an E&M service with a lower allowed amount has previously been processed for the same DOS, any subsequent E&M services will be denied, even if the allowable amount is higher than the first E&M service that was processed.

Tufts Health Plan does not routinely compensate for more than one E&M procedure code with modifier 25 appended, excluding a preventive E&M code billed with a problem-focused E&M code[2], when billed on the same DOS with the same provider group (same tax ID number) and specialty. If a rendering provider bills with two E&M procedure codes with modifier 25 appended to each E&M procedure code on the same claim or multiple claims on the same DOS, one of the E&M procedure codes will deny.

Tufts Health Plan does not routinely compensate for a new patient or initial care visit when billed in excess of one unit by the same provider tax ID number and same specialty.

Newborn Care Services
Tufts Health Plan does not routinely compensate for initial hospital or birthing center care services if the member received initial or subsequent newborn care services the previous day.

New Patient Visits[3]
When services are performed in an office or outpatient setting, Tufts Health Plan denies subsequent new patient visit(s) of the same service level if:

- A provider has submitted a claim with a new patient E&M procedure code for the same member within the previous three years
- A provider from the same provider group (same tax ID number) and specialty has submitted any other E&M procedure code within the previous three years. **Note:** Tufts Health Plan defines the same provider as one having the same provider group (same tax ID number) and same specialty.

Tufts Health Plan does not routinely compensate for a new patient visit when billed by a non-physician practitioner and any face-to-face service has previously been billed by the same group practice (same Tax ID, any specialty) within the last three years and the primary diagnosis on the new patient visit matches any diagnosis on the previous face-to-face service.

Observation Care Services
Tufts Health Plan does not routinely compensate for the following:

- 99238-99239 (hospital discharge day management) submitted with observation care services that include admission and discharge (99234–99236) will be denied, as they are included in the observation care services.
- Hospital discharge day management when billed and observation or inpatient hospital care, including admission and discharge on the same day, was billed the previous day.
- Observation services when billed for more than one unit per DOS in any combination by any provider and the place of service is 21 (inpatient hospital), 22 (outpatient hospital), 23 (ED), or 24 (ambulatory surgical center).[4]
- 99238-99239 (hospital discharge day management) if 99221-99223 (initial hospital care) or 99231-99233 (subsequent hospital care) has not been billed within the previous three days.

Practitioner Care Management (CM) Services
Tufts Health Plan compensates for the following services when a practitioner is responsible for direct care of a patient, and bills these services supplied for coordinating and controlling access to or initiating and/or supervising other health care services needed by the member:

- Team conference (99366–99368): Practitioner spends 30 to 60 minutes in conference coordinating member care with other medical or community professionals.
- Telephone calls (99441–99443): Simple, intermediate, or complex phone calls made by a practitioner to the member or other health care/allied professionals that are medically necessary to manage and coordinate care.

Note: Details of billed telephone calls must be documented in the member's medical record.

Practitioner CM services submitted by the same provider for the same DOS as an office visit or consult procedure code would result in the practitioner CM service being denied as included in the primary procedure.

Tufts Health Plan does not routinely compensate for CM services (99487 and 99489-99490) under the following circumstances:

- When billed more than once during the same calendar month by any practitioner

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[2] Refer to the E&M services with preventive medicine visits section in this table.
[3] Tufts Health Plan follows the AMA's definition of a new patient as one who has not received any professional services from the same provider or another provider of the same specialty who belongs to the same group practice (same tax ID number) within the past three years.
[4] Policy applies to professional claims only.

- Performed within 90 days of a surgery for **Senior Products**

Prolonged Services
Tufts Health Plan does not routinely compensate for prolonged service procedure codes 99358-99359, Prolonged procedure codes are used when a service involving direct (face-to-face) patient contact is beyond the usual services in either an outpatient or inpatient setting. Denied claims may be disputed with supporting clinical documentation. Refer to the AMA CPT Manual for additional information.

Smoking and Tobacco Use Cessation Counseling
Tufts Health Plan does not routinely compensate 99202-99397 or 99420-99499 (E&M service) when billed with 99406, 99407 or G0436, G0437 (Smoking and tobacco cessation counseling visit) on the same DOS.

Transitional Care Management Services
Tufts Health Plan does not routinely compensate for transitional care management (TCM) services (99495, 99496) under the following circumstances:

- Unless a facility E&M service was billed for the same DOS or in the previous 30 days by any provider.
- When billed within 29 days of another TCM service unless a discharge service has been billed by any provider in the previous 30 days
- When billed on the same DOS as a previously billed TCM service by any provider
- Performed within 90 days of a surgery when billed by any provider for **Senior Products**
- Another TCM service has been billed by any provider within the same Tax ID and specialty within 29 days for **Tufts Health Public Plans**

Peak Flow
Tufts Health Plan does not routinely separately compensate for a peak flow rate under the following circumstances:

- If billed with an E&M service, as it is an inherent part of the E&M examination for **Commercial products**
- As a component of the E&M or physician service, unless a distinct services modifier is appended to either code for **Tufts Health Public Plans**

Services Rendered on Weekends or Holidays for Commercial and Tufts Health RITogether
Providers who render services on Saturdays, Sundays or on the following holidays will receive additional compensation for services rendered.

- New Year's Day
- President's Day
- Memorial Day
- Independence Day
- Labor Day
- Columbus Day
- Thanksgiving Day
- Christmas Day

Tufts Health Plan only compensates for the additional fee for services rendered on the actual date of the legal holiday listed during the specified calendar year when procedure code 99050 (services requested on Saturdays, Sundays, and holidays in addition to basic service) is submitted in addition to the E&M procedure code. The added holiday fee will not be paid for services provided in instances where the actual holiday does not fall on the date of the legal holiday.

Telehealth Services

Interprofessional Telephone/Internet Consultations:
- 99446-99449, or 99451 (interprofessional telephone/internet consultation) are not compensated if any face-to-face service has been billed on the same date or within the previous 14 days.
- 99446-99449 or 99451 are limited in any combination to one unit in seven days.

Online Digital E&M Services
- 99421-99423, 98970-98972 (online digital E&M services) are limited to one combined unit within a seven-day period
- 99421-99423 (online digital E&M services) will be denied when billed within seven days of certain other E&M services:
  - 99091 (collection and interpretation of physiologic data)
  - 99487-99489 (complex chronic care management services)
  - 99495-99496 (transitional care management services)
  - 99339-99340 (individual physician supervision of a patient [patient not present] in home, domiciliary or rest home)
  - 99374-99380 (supervision of a patient under home health, hospice, or nursing care)

Remote Physiologic Monitoring
Tufts Health Plan does not routinely compensate for the following:

- 99474 (separate self-measurements of blood pressure twice daily over 30-day period) if billed more than once in the same month
- 99457 (remote physiologic monitoring treatment management services) unless 99473 or 99474 (self-measured blood pressure device services) has been billed in the previous 30 days

Venipuncture Services
Venipuncture services will not be compensated when billed on the same DOS as an E&M service under the same provider group/tax ID number. Blood collection is considered an integral component of the E&M service and should not be separately reimbursed.

Similarly, venipuncture services performed in a facility will not be separately compensated, as they are considered an integral component of all facility fees, regardless of which other services are billed.

Note: Venipuncture performed as the sole service (i.e., without an accompanying E&M or lab service) are compensated.

Commercial Products

The following reimbursement information applies to Commercial products only.

After Hours Care
Tufts Health Plan considers compensation for services rendered after normal posted business hours when procedure code 99056 (services typically provided in the office, provided out of the office at the request of patient, in addition to basic service) or 99058 (services provided on emergency basis in the office, which disrupts other scheduled office services, in addition to basic service) is submitted.

Note: This does not apply to ED services.

Counseling
Tufts Health Plan does not routinely separately compensate for counseling and/or risk factor reduction if billed with an E&M service, as it is considered to be part of the global services for either problem-oriented E&M codes or preventive medicine services.

Inpatient Admission or Consultation Services
Tufts Health Plan does not routinely compensate for hospital care services when an initial hospital care claim has been submitted in the previous three days with the same diagnosis by the same provider.

Online Practitioner Exams
Tufts Health Plan does not routinely compensate for online E&M services (99444).

Senior Products

Procedure Codes	Allowable Places of Service
99381-99397 (comprehensive preventive medicine services)	03, 04, 05, 06, 07, 08, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 22, 26, 33, 49, 50, 71, 72
99460, 99462-99465 (Newborn care)	21, 25

Tufts Health Public Plans Products

Multiple Inpatient Admission Services
Tufts Health Plan does not routinely compensate 99221-99223 (initial hospital care) under the following circumstances:

- If any type of inpatient visit has been billed in the previous week by the same provider group and specialty, and an 99238-99239 (hospital discharge) has not also been billed
- If an initial hospital care has been billed in the previous three days with the same diagnosis by the same Tax ID and subspecialty

Place of Service Restriction
Tufts Health Plan does not routinely compensate for procedure codes that are not billed in the appropriate places of service listed below:

Procedure Codes	Allowable Places of Service
99221-99223 (initial hospital inpatient or observation care) 99231-99233 (subsequent hospital inpatient or observation care) 99238-99239 (hospital inpatient or observation discharge)	02, 06, 08, 21, 22, 25, 26, 34, 51, 52, 61
99304-99310, 99315-99316 or 99318 (nursing facility E&M visits)	31, 32, 34, 54, 56

Related Policies and Resources

- Anesthesia Professional Payment Policy
- Home Health Care Payment Policy
- Outpatient Behavioral Health and Substance Use Disorder Professional Payment Policy
- Preventive Services
- Surgery Professional Payment Policy
- Telehealth/Telemedicine Payment Policy

Publication History

- November 2024: Annual policy review; updated Related Policies and Resources; administrative edits
- August 2024: Added collaborative care services definition and procedure codes
- November 2023: Annual policy review; administrative updates
- May 2023: Added billing information for provider-to-provider e-consults for Tufts Health Together, Tufts Health Unify, and Tufts Health Plan SCO, effective for DOS on or after April 1, 2023, in accordance with MassHealth APB 364
- February 2023: Annual code updates
- November 2022: Annual policy review; administrative updates
- April 2022: Added compensation information for venipuncture services, effective for dates of service on or after June 1, 2022 for all products
- September 2021: Added compensation information regarding consultation CPT codes, effective for dates of service on or after November 1, 2021
- May 2021: Added claim edits for annual wellness visit, new patient visits, and special services, procedures and reports, effective for dates of service on or after July 1, 2021; added previously communicated edit for annual wellness visit for Senior Products
- November 2020: Reviewed by committee; added boiler plate language; removed Preventive Services content; added telehealth edits for online digital E&M services, modifier G0, interprofessional telephone/internet consultations and remote physiologic monitoring, effective for dates of service on or after January 1, 2021
- October 2020: Reviewed by committee;
- June 2019: Clarified list of applicable holidays subject to additional compensation for services

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.