Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Payment Policy:
Outpatient Facility

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 services performed in an outpatient facility setting, in accordance with the member's benefits.

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).

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

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 Manual

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 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

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.

Compensation/Reimbursement Information

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

For services rendered to Tufts Health Together members, 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.

If a member receives multiple levels of service within the same episode of care, compensation for the lower-intensity services will be bundled into the payment for the highest intensity services rendered:

1. Hospital inpatient services
2. Hospital surgical day care services
3. Hospital ambulatory/minor surgical services
4. Hospital observation bed services
5. Hospital emergency department (ED) services
6. Hospital urgent care clinic services
7. Hospital clinic services

Place of Service

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 CMS for more information.

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

AAOS Intraoperatve Services

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

Arthrocentesis

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

Electroencephalogram (EEG)

- Tufts Health Plan does 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.
- Tufts Health Plan does 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.
- 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

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.

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

- 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.
- 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 is aged 21 and older on the date of service.

Trigger Point Injections

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.

Ulcer Debridement and Ulcer Stages

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

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)

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 and Provider Preventable Conditions Payment Policy for more information.

Additional Resources

- Ambulatory Surgical Center Payment Policy
- Drugs and Biologicals Payment Policy
- Emergency Department Services Payment Policy
- Inpatient Facility Payment Policy
- Laboratory and Pathology Payment Policy
- Modifier Payment Policy
- Observation Services Payment Policy
- Outpatient Rehabilitation Facility Payment Policy

Document History

- November 2023: Annual policy review; administrative updates
- February 2023: Annual code updates
- October 2022: Annual policy review; administrative updates
- May 2022: Added existing hospital hierarchy compensation information
- September 2018: Policy created

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.