Dermatology Professional Payment Policy

The following payment policy applies to Tufts Health Plan contracted providers who render services in an outpatient or office setting. This policy applies to Commercial\(^1\), Tufts Health Freedom Plan, Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options (SCO) products.

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

### POLICY

Tufts Health Plan covers medically necessary dermatology services.

### GENERAL BENEFIT INFORMATION\(^2\)

#### All products

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 copayments members prior to initiating services.

Refer to the [Electronic Services](#) section of our website for our self-service channel options. Benefit specifics should be verified prior to initiating services for Commercial, Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options members by logging on to our [website](#) or by contacting [Provider Services](#).

**Commercial only**

Some services for Commercial members are not covered by the plan as they have been determined to be cosmetic, experimental or investigational as defined in the member's handbook. Refer to the [Noncovered Investigational Services Medical Necessity Guidelines](#) for more information.

**Tufts Medicare Preferred HMO**

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. Tufts Medicare Preferred HMO’s benefit plan currently covers a limited number of non-Medicare covered items as supplemental benefits.

**Note:** Supplemental benefits are subject to change each year.

**Tufts Health Plan Senior Care Options**

Tufts Health Plan Senior Care Options follows Medicare coverage guidelines for Medicare-covered benefits and Medicaid coverage guidelines for Medicaid-only covered benefits.

**Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options**

Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, procedures or services for cosmetic purposes, anti-aging and mental performance) are not covered, except when medically necessary.

### MEMBER RESPONSIBILITY

Copayments, deductible and/or coinsurance may apply for commercial and Tufts Medicare Preferred HMO members pursuant to the member's benefit plan specifics.

Tufts Health Plan Senior Care Options members have no member copayment, coinsurance or deductible responsibility.

Tufts Health Plan recommends not billing the member for the coinsurance and/or deductible 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.

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\(^1\) Commercial products include HMO, POS, PPO & CareLink\(^{SM}\) when Tufts Health Plan is the Primary Administrator.

\(^2\) Eligibility may be subject to retroactive reporting of disenrollment.
Note: Tufts Health Plan will 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 copayments, coinsurance or deductibles.

AUTHORIZED REQUIREMENTS

Some procedures may require prior authorization with the Tufts Health Plan Precertification Department. Refer to the Guidelines section of our website for additional information. Refer to the CareLink℠ Prior Authorization List for a list of procedures, services and items requiring prior authorization for CareLink members.

Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List for a list of procedures, services and items requiring prior authorization for Tufts Medicare Preferred HMO members.

For a list of procedures, services and items requiring prior authorization or notification for Tufts Plan Senior Care Options members, refer to the Tufts Plan Senior Care Options Prior Authorization List or Tufts Health Plan Senior Care Options Notification List.

For specific inpatient notification, referral and authorization requirements, refer to the authorization payment policies.

For authorization information and/or prior authorization requirements for members using the PHCS (also known as MultiPlan) network, contact American Health Holding.

Services Requiring Prior Authorization

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 has been obtained.

For information on reconstructive scar revision for Commercial members, refer to the Scar Revision section within the Reconstructive and Cosmetic Surgery Medical Necessity Guidelines. Refer to the UVB Home Units for Skin Disease Medical Necessity Guidelines for information on a home UVB phototherapy unit for Commercial members.

For a complete description of Tufts Health Plan’s Commercial authorization and notification requirements, refer to the Authorizations chapter within the Tufts Health Plan Commercial Provider Manual.

For a complete description of Tufts Medicare Preferred HMO’s authorization requirements, refer to the Prior Authorizations chapter within the Tufts Medicare Preferred HMO Provider Manual.

For a complete description of Tufts Plan Senior Care Options’ authorization requirements, refer to the Prior Authorizations chapter within the Tufts Health Plan Senior Care Options Provider Manual.

BILLING INSTRUCTIONS

- Submit the most updated industry-standard codes.
- Submit the appropriate ICD-CM diagnosis and/or CPT/HCPCS procedure codes.
- Submit a modifier, when applicable, with the corresponding CPT and/or HCPCS procedure code(s).
- For information regarding modifiers, refer to the Modifier Payment Policy or CMS guidelines.

Note: Annually and quarterly, HIPAA medical code sets undergo revision by CMS, AMA and CCI. 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 system to reflect these changes.

To view the status of submitted authorizations and claims, log on to our secure website.

EDI Claim Submitter Information

- Submit claims in HIPAA compliant 837P format for professional services. Claims billed electronically with non-standard codes will reject.

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3 HIPAA medical code sets include HCPCS, CPT Procedure and ICD-CM diagnosis codes.
**Paper Claim Submitter Information**

- Submit claims on the official claim form for professional services. Claim line(s) billed with non-standard codes will deny.
- All paper claims must be submitted on official, 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 proper claim form.
- Submitted forms deemed incomplete will be rejected and returned to the submitter. The rejected claim and a letter stating the reason for rejection will be returned to the submitter, and a new claim with the required information must be resubmitted for processing.

**COMPENSATION/REIMBURSEMENT INFORMATION**

Providers are compensated according to the applicable 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, specialty society guidelines, and the National Correct Coding Initiative (CCI).

Use of non-contracting labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by you as the treating provider or other unreasonable financial exposure. In such circumstances, Tufts Health Plan may hold you accountable for any inappropriate behavior on the part of the non-participating lab that you selected.

Tufts Health Plan Medicare Preferred HMO members cannot be held financially responsible for services rendered without a referral or prior authorization unless the member received prior notice that the item or service would only be covered if further action is taken by the member. Such prior notice is the issuance of an organizational determination. Refer to the Prior Authorizations chapter of the Tufts Medicare Preferred HMO Provider Manual for more information regarding organizational determinations.

**Add-on Codes**

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

**Column I (Comprehensive) and Column II (Component) Codes**

Correct Coding Initiative (CCI) has identified comprehensive procedure codes and their associated component codes. Component codes are considered part of the more global comprehensive code and are not eligible for reimbursement when billed with the comprehensive code. Refer to the CCI Policy Manual for additional information.

**Multiple Surgical Procedures**

Tufts Health Plan compensates for multiple surgical procedure code(s) by paying the surgical procedure code with the Tufts Health Plan highest allowable compensation at 100%. Subsequent surgical procedure code(s) that are subject to reduction logic are compensated at 50% of the allowed amount. Refer to the Multiple Surgical Procedures List for the list of surgical procedure code(s) that are subject to multiple surgical procedures reduction for Commercial claims.

For information on multiple surgical procedures for Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options claims, refer to CMS.

**Wound Repair**

If a simple repair procedure code (12001, 12002) or an intermediate repair procedure code (12031,12032) is billed with a complex repair procedure code (13101, 13121) for the same wound site, then the simple repair procedure code or repair intermediate procedure code will deny as these services are included in the complex repair procedure code. Refer to the AMA CPT Manual for additional information. Tufts Health Plan will consider compensation if the appropriate modifier is appended to the simple repair or intermediate repair procedure code.

**Explanation of Payment (EOP)**

The EOP provides information on the status of the claim(s) submitted to Tufts Health Plan. The EOP indicates status of claims payments, denials and pending claims.
Electronic Remittance Advice (ERA)
The HIPAA compliant 835 ERA is an EDI transaction that providers may request to electronically post paid and denied claims information to their accounts receivable system.

ADDITIONAL RESOURCES
Evaluation and Management Professional Payment Policy

DOCUMENT HISTORY
- September 2015: Template conversion, template updates
- April 2015: Added Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options, template updates
- December 2014: Moved information about unlisted procedure codes to the Claims Submission payment policy, template updates
- November 2013: Template updates
- September 2013: Template conversion
- April 2012: Template updates
- March 2012: Updated CareLink disclaimer language
- September 2011: Policy reviewed, no content changes, template updates
- March 2011: Reviewed document for clarity; no content changes made
- September 2009: Newly documented payment policy

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 your office/facility did not comply with this payment policy, Tufts Health Plan will expect your office/facility to refund all payments related to non-compliance. For more information about Tufts Health Plan’s audit policies, refer to our website.

This policy provides information on Tufts Health Plan claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction 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 guidelines when applicable, adherence to plan policies and procedures and claims editing logic.

This policy does not apply to Tufts Health Public Plans or the Private Health Care Systems (PHCS) network (also known as Multiplan). This policy applies to CareLink for providers in the 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.