motivhealth®

Payor Reimbursement Policy

Contents

Definitions

Appeal: A request from a provider or Member for the Plan to review an adverse determination of either a preauthorization or claim denial, where the Member may have some financial responsibility.

Benefit Exclusion: A service or supply that is not covered by the Plan regardless of Medical Necessity. A service or supply could be medically necessary and not covered by the Plan because it is a Benefit Exclusion.

Clean Claim: A clean claim is defined as a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

Computed Tomography (CT): Diagnostic imaging test in which a marrow bean of x-rays is aimed at the body and quickly rotated around it. This rotation produces signals that are computer processed. The result is crossed-sectional images or "slices" of the body. These slices are called tomographic images and provide more information about a person's condition than conventional x-rays.

Comorbidities/Complications (CC) and Major Comorbidities/Complications: Conditions or diseases that are present within a person at the same time. These are often chronic or long-term conditions.

Current Procedural Terminology (CPT®): A medical code set maintained by the American Medical Association (AMA) that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations. CPT is included in Level I Healthcare Common Procedure Coding System (HCPCS).

Discharge Planning: Medicare describes discharge planning as the process involving the transition of a patient's care from one level of care to the next. It involves:

- ñ Determining the appropriate post-hospital discharge destination for a patient
- ñ Identifying what the patient requires for a smooth and safe transition from the acute care hospital/post-acute care facility to his or her discharge destination
- ñ Beginning the process of meeting the patient's identified pre-and post-discharge needs. The discharge process must be thorough, clear, and comprehensive and understood by acute care hospital/post-acute care facility staff as well as the patient and/or the patient's representative.

Evaluation and Management (E/M) Services: Evaluation and management (E/M) are services in which a physician or other qualified health care professional diagnoses and treats illness or injury. Services usually include patient history, examination and medical decision making. .

Fluoroscopic Guidance: Type of imaging technique that shows a continuous x-ray image on a member to obtain real-time images of the internal parts of the body. These images are used to accurately place a needle into the target area of the body.

HCPCS Level II: A standardized coding system that is used primarily to identify medical supplies, durable medical equipment, non-physician services, and services not represented in the Level I code set CPT

Hospital Acquired Condition (HAC): A condition that is not present with the patient is admitted to or arrived at the hospital or other facility but occurs during or after the stay. HAC's include infections and medical errors.

Iatrogenic Complications: An adverse condition that is a direct result of treatment by a physician or other health care professional.

International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM, ICD-10): A morbidity classification system for classifying diagnoses and reason for visits in all health care settings for the purpose of coding and reporting.

Interventional Radiology (IR): Subspecialty of radiology where a range of techniques are performed for diagnostic or treatment purposes and which rely on radiologic guidance.

Intensive Care: Setting where the specialized care needs of patients are met whose conditions are either potentially life-threatening and/or who require continuous and comprehensive monitoring and care. Some examples of such settings are the intensive care unit (ICU), neonatal intensive care units (NICU), coronary care unit (CCU).

Intraoperative Autologous Transfusion (IAT): A medical procedure involving recovering blood lost during surgery and re-infusing it into the patient

Magnetic Resonance Imaging (MRI): An imaging procedure that produces three dimensional detailed anatomical images by emitting high frequency radio waves into tissues that subjected to magnetic fields. MRI produces the best soft tissue images of all the imaging modalities. A disadvantage of this technique is that patients must remain still for long periods of time in a noisy, confined space while the imaging is performed.

Massive Transfusion Protocol (MTP): A multidisciplinary process whereby blood and blood products are prepared and obtained rapidly for use in the patient with known or suspected exsanguinating or massive hemorrhage.

Medical Necessity: Any health care services, supplies or treatment provided for an illness or injury which is consistent with the Member's symptoms or diagnosis provided in the most appropriate setting that can be used safely, without regard for the convenience of a Member or Provider. However, such health care services must be appropriate with regard to standards of good medical practice in the state of Utah and could not have been omitted without adversely affecting the Member's condition or the quality of medical care the Member received as determined by established medical review mechanisms, within the scope of the Provider's licensure, and/or consistent with and included in policies established and recognized by MotivHealth. Any medical condition, treatment, service, equipment, etc. specifically excluded in the Master Policy is not an "Eligible Benefit" regardless of Medical Necessity.

Medically Unlikely Edits (MUE): An MUE for a HCPCS/CPT code is the maximum Units of Service (UOS) that a provider would report under most circumstances for the same beneficiary on the same date of service.

Medicare Severity Diagnosis Related Group (MS-DRG or DRG): A classification system statistically designed to calculate inpatient hospital claim pricing. DRG's are defined by a specific set of patient attributes which include principal diagnosis, specific secondary diagnoses, procedures, sex, and discharge status, and the present of complications or comorbidities.

Mutually Exclusive: Services that cannot reasonably be performed at the same anatomic site or during the same patient encounter.

National Correct Coding Initiative (NCCI or CCI): The Centers for Medicare & Medicaid Services (CMS) developed these edits to promote consistent, correct coding and appropriate payment. These coding edits are developed based on the AMA CPT code set and the HCPCS code set, as well as analysis of standard medical and surgical practice and input from various groups, including specialty societies, other national health care organizations, Medicare contractors, providers, and consultants.

National Uniform Billing Committee (NUBC): Committees responsible for the revenue code definitions and requirements for use.

Never Events/Serious Reportable Events (SRE): Errors in medical care that are of concern to both the public and health care professionals and providers and of a nature that the risk of occurrence is significantly influenced by the policies and procedure of the health care organization.

Present on Admission (POA) Indicator: A designation on the claim that identifies conditions that were present at the time the order for inpatient admission was written. Conditions that occurred in the emergency department, during outpatient surgery or observation stays that resulted in an inpatient admission are considered present on admission.

Procedure to Procedure Code Pair Edits (PTP): Automated prepayment edits that prevent improper payment when certain CPT/HCPCS codes are submitted together on a claim form.

Provider Reconsideration: A request from the provider to the Plan to review an adverse determination without a preauthorization or claim denial where the Member or patient has no financial responsibility.

Radiologic Guidance: The use of imaging procedures to allow visualization of the best past for needle placement in procedures such as aspiration, injection, biopsy or device placement. Imaging procedures include computed tomography (CT), fluoroscopic guidance, magnetic resonance imaging (MRI) and Ultrasound.

Radiologic Supervision and Interpretation (S&I): Personal supervision of the performance of the radiologic procedure by one or more physicians and the interpretation of the findings. The interpretation of the findings may be performed after the procedure and at a later time by another physician.

Revenue Codes (Rev Codes): Revenue codes are 4-digit numbers that are used on hospital bills to identify where a Member was located in a facility when they received treatment or services, or what service a Member received as a patient.

Room and Board: Daily charge for the use of hospital facilities and equipment. This includes but is not limited to a regular or special care hospital room and their related furnishings.

Routine Services/Supplies: All nursing services appropriate for the setting whether provided in regular or special care units and all routine supplies and items including dietary services, minor medical and surgical supplies, routine disposable and/or reusable equipment, and services related to discharge planning including coordinating transfer to another inpatient facility, post-acute care facility, and home health services.

State Uniform Billing Committees (SUBC): Committees responsible for the revenue code definitions and requirements for use.

Ultrasound: An imaging technique that uses high frequency sound waves to visualize soft tissues within the body in real time. Ionizing radiation is not involved. The quality of the images obtained using ultrasound is dependent on the patient's body size and the technician (ultra-sonographer) performing the procedures.

Unbundling: The use of multiple CPT/HCPCS codes to report a procedure when a single code adequately describes the service or supply.

Uniform Billing Editor (UBE): A reference tool utilized by facilities to manage the constant changes to Medicare billing and reimbursement processes. The UBE provides detailed, accurate, and timely information about Medicare and UB-04 billing rules and requirements.

Claims - General Information

All claims submitted to MotivHealth are subject to the Member's eligibility and benefits at the time of service. Verification of eligibility and benefits prior to the date of service is recommended. Contact MotivHealth's Personal Health Assistants at (844) 234-4472.

MotivHealth will process clean claims and issue an Explanation of Benefits and check, if applicable, within thirty (30) days of day the claim is received.

We accept electronically submitted claims using the following:

- EDI 837 transaction applying MotivHealth's Payor ID U7632.

A Clean claim is any claim submitted by a Provider that:

- Is received timely by MotivHealth Insurance Company
- If submitted on paper, must be on industry standard claim forms, UB-04 or CMS-1500
- If submitted electronically, must be compliant applicable federal and state regulatory authority and uses only permitted standard code sets; Current Procedural Terminology (CPT), Revenue Code (Rev Code) and/or Healthcare Common Procedure Coding Systems (HCPCS), and a valid Internal Classification of Disease 10th revision, Clinical Modification (ICD-10-CM) diagnosis code.
- Includes all relevant information to determine other carrier liability or to investigate possible fraud
- Complies with billing guidelines
- Includes all substantiating documentation

All submitted claims must include correct patient information including but not limited to:

- Name
- Date of Birth
- Address
- Member ID

For complete information on electronic claim submission, refer to the standard guides below.

Professional:
https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/downloads/5010a1837bcg.pdf

Facility:
https://www.cms.gov/medicare/billing/electronicbillingeditrans/downloads/5010a2837acg.pdf

Provider understands MotivHealth Insurance Company has the right to review Provider's claims prior to payment for compliance with Payor Reimbursement Policy and industry standard billing rules. MotivHealth shall audit and review claims on a line by line basis, or other such basis as deemed appropriate. If substantiating documentation is not submitted with the claim, MotivHealth will request any medical records or itemized bill as needed to verify accurate billing practices. Claims will be rejected until all requested records are received and reviewed.

Claims Timely Filing Limits

New claims must be submitted by a participating provider no later than:

- One Hundred Twenty (120) days from the date of service.
- 120 days from the date of receipt of the primary payer's explanation of benefits.

Claims submitted after the expiration of the 120-day period will be denied for timely filing and cannot be billed to or collected from the Member.

Adjustments and Corrected Claims

Adjustment requests in the form of corrected claims must be submitted within one hundred eighty (180) days from the date of original payment or denial. All adjusted or corrected claims must be notated as a corrected claim.

Overpayments- Refunds of overpayments are to be returned to MotivHealth within sixty (60) days of identification of overpayment.

Underpayments- If a claims has been underpaid, additional payment will be made to the provider within sixty (60) days of identification of underpayment

Appeals, Complaints or Grievances

MotivHealth has established a complaint or grievance process to address and resolve Member issues that are not related to adverse benefit determinations. Members may file a complaint or grievance by:

Phone: MotivHealth at (844)234-4472
Email: correspondence@motivhealth.com
Mail: MotivHealth Appeals Department,
PO Box 709718
Sandy, UT 84070-9718

MotivHealth will notify Members who submit a complaint or grievance by email in one (1) business day; or mail in five (5) business days upon receipt of their complaint or grievance. Complaints and grievances are reviewed by the appropriate delegate and a written response is provided to the Member within thirty (30) days of receiving the Member's concern.

If the Member's concern is related to an adverse benefit determination, MotivHealth is required to treat the concern as an Appeal, following the Appeal process.

Claim Disputes

Timely filing disputes must be submitted within one hundred eighty (180) days of receipt of timely filing denial. Supporting documentation should be included with the dispute. Supporting documentation can include the original claim number and/or a copy of the computerized printout of the patient account ledger, with the submission date identified.

If the denial is upheld, a letter will be sent advising the provider of the outcome within thirty (30) days. If the denial is reversed, the claim will be processed accordingly.

Claims denied for timely filing (120-day period) cannot be billed to the Member, this denial indicates the provider did not submit a claim in a timely manner and will not be the Member/patient's responsibility.

Payment for Covered Health Services Received by Non-Network or Non-Contracted Providers:

When a Member receives a service or supply from a non-network or non-contracted provider and submits a claim to MotivHealth, the claim will be reviewed to determine if it is eligible for coverage and processed following the procedures outlined in our policies. Any benefits owed will be paid directly to the Member unless the non-network provider notifies MotivHealth that the Member's signature is on file, assigning benefits payable directly to the non-network provider; or when a Member submits a request directing MotivHealth to pay the non-network provider directly.

Determining if a Service, Supply, Device or Medication is eligible for coverage by MotivHealth:

MotivHealth will determine if a service or supply is eligible for coverage based on the following (in order):

1. Is the Member eligible for coverage by MotivHealth on the date the service or supply was provided to the Member?
2. Is the request of a service, supply device or medication eligible for coverage and not a Benefit Exclusion in the MotivHealth Master Policy?
3. Does the request meet the MotivHealth definition of medically necessary and not considered experimental or investigational as defined in the MotivHealth Master Policy?

Post Service Review Process

Post service reviews are performed when a claim is submitted after a service or supply has been received by a Member. Members and providers will receive an Explanation of Benefits (EOB) within thirty (30) days from the date MotivHealth receives the clean claim detailing how the claim was processed.

If additional information is necessary to process a post service review request, MotivHealth will:

- ñ Notify Members and providers within the thirty (30) day timeframe that a one-time extension of up to fifteen (15) days is required with a description of additional information requested. If a Member or provider is notified that an extension is necessary, they will have forty-five (45) days to provide the necessary information.
- ñ Provide a claim determination within twenty (20) days upon receipt of the additional information. If the necessary information is not received within forty-five (45) days, the request will be denied, with an EOB sent to both the Member and provider explaining the reason(s) for the denial and the Appeal rights. (Please refer to the Appeal and Provider Reconsideration process.)

Pre-Service Review Processes (Precertification, Prenotification and Preauthorization)

Precertification, Prenotification and Preauthorization are requests for coverage of services, supplies, devices, and medications that require Members and providers to receive a coverage

determination prior to the services being rendered. In the event a provider or Member do not receive a coverage determination prior to the service, it may not be eligible for coverage.

Precertification is the process where a Member or provider contacts MotivHealth by phone to request certification for coverage of a specific service. In most cases, precertification determinations can be made during the initial phone call. The list of services that require a precertification can be found on the MotivHealth knowledge base under “preauthorization.”

Prenotification is the process where a provider or Member notify MotivHealth of an admission to an inpatient facility. Notification ensures MotivHealth’s clinical team reviews the reason for admission and determines if the inpatient stay is eligible for coverage, indicating the length of stay that will be covered and provide ongoing concurrent review. Notification of inpatient admissions shall be made to MotivHealth via phone at (844)234-4472. Failure to notify MotivHealth of an inpatient admission may result in the service not being eligible for coverage.

Pre-Service Claims

Pre-Service claims review (i.e. preauthorization) is the process where a provider or Member submits a request for a service that MotivHealth requires a medical review to determine if the service is a covered service, medically necessary and not experimental or investigational.

Preauthorization requests must be submitted in writing to MotivHealth containing the following information:

- ñ Patient Name and Member ID.
- ñ Procedure code.
- ñ Diagnosis code.
- ñ Ordering physician.
- ñ When and where the procedure will be conducted.
- ñ Medical records.

MotivHealth will reply to a correctly submitted preauthorization request in writing within fifteen (15) days of receipt of the request; unless:

- ñ The request if urgent in nature (member in severe pain or a condition that could jeopardize the life or health of the member), MotivHealth will notify member and provider within seventy-two (72) hours from receipt of request of the determination. If additional information is required for a decision to be made, a request will be sent within twenty-four (24) hours of receipt of request.

- ñ The required information is not submitted then a notification will be made within five (5) days from receipt of request of the failure to submit required documents to the member and provider.

- ñ Additional information is necessary, a request for a fifteen (15) day extension will be sent before the expiration of the original fifteen (15) days has expired describing the required information and the member and provider will have forty-five (45) days from receipt of the notice to provide the specified information. The preauthorization request will be processed once the additional information is submitted. However, if the requested information is not submitted within the allotted timeframe, the preauthorization will be denied. The Member and requesting provider will receive a written determination

indicating the reason(s) for the denial, and the right to file an Appeal. Please see the Appeal process for details.

Urgent Requests

When a Member or provider requests that a review be considered urgent, the request must demonstrate that a delay in treatment could jeopardize the Member's life, health, or the ability to regain maximum function, in the opinion of a physician with knowledge of the Member's medical condition. Requests for urgent reviews can be made by calling (844)234-4472.

When a request is determined urgent, MotivHealth will:

- ñ respond (in writing and by phone) within seventy-two (72) hours of receiving the information needed to make a determination.
- ñ If additional information is needed, MotivHealth will notify the provider within twenty-four (24) hours of receiving the urgent request, the provider will have forty-eight (48) hours to submit the needed information.
- ñ MotivHealth will make its determination no later than forty-eight (48) hours after receipt of the requested information; or at the end of the forty-eight (48) hour period the provider was given to submit the additional information. If the information is not received within that time, the request for coverage will be denied. The written notice of the denial will explain the reason(s) for the denial, and the right to file an Appeal. (Please refer to the Appeal and Provider Reconsideration process.)

Concurrent Care Requests

When a request is received for an extension of an ongoing course of treatment, that was previously approved for a specific period of time or number of treatments, MotivHealth will:

- ñ make a determination within twenty-four (24) hours of receipt of the request, if the request is made at least twenty-four (24) hours prior to the end of the approved treatment.
- ñ If the request for extension is not made at least twenty-four (24) hours prior to end of the approved treatment, the request will be treated as an urgent request following the Urgent Request process (refer to Urgent Requests).
- ñ When a request is received for an extension of an ongoing course of treatment that was previously approved for a specific period of time or number of treatments, but is not considered urgent, the request will be considered new and decided according to the preservice or post service process, whichever applies.

Retrospective Requests

MotivHealth may deny coverage when a preservice coverage determination is required, but the provider or Member did not request a preservice review, regardless of whether the service is eligible for coverage or medically necessary. Network or contracted providers have agreed to follow MotivHealth's payment policies, including those related to preservice requests and cannot bill the Member for services denied for coverage by MotivHealth for failure of the network provider to request a preservice review.

First Level Appeals

Appeals are requests for reviews of adverse benefit determinations either pre-service or post service, that may impact a Member. If the Member has no impact or risk of impact, regardless of who requests the Appeal, it will be treated and processed as Provider Reconsideration. An Appeal will be considered First Level when it is the first request to review an adverse determination and Second Level when MotivHealth has already reviewed the adverse determination (First Level appeal).

If a Member or Member representative disagrees with an adverse determination made by MotivHealth the Member has the right to have the determination reviewed. Members may request an Appeal by:

Phone: MotivHealth at (844)234-4472
Email: correspondence@motivhealth.com
Mail: MotivHealth Appeals Department,
PO Box 709718
Sandy, UT 84070-9718

Member's or their representatives have one hundred eighty (180) days from notification of the initial adverse benefit determination to request an Appeal. The following information is required for an Appeal to be reviewed:

- The patient's name and the identification number from their ID card;
- The date(s) of medical service(s);
- The provider's name;
- The reason the claim should be eligible for coverage;
- Any documentation or other written information to support your request.

Appeals will be reviewed by a qualified individual(s) who was not involved in the previous determination. If Medical Necessity, experimental treatment or similar exclusion or limit, or investigational was factor in the adverse determination, the review will be conducted by a health care professional that has the appropriate expertise and was not involved in any prior determinations. MotivHealth may consult with or seek the participation of medical experts as part of the appeal resolution process. When appropriate, a Member will be asked to provide MotivHealth with consent to share pertinent medical information to review their Appeal. In the event the Member declines to provide consent, MotivHealth may be forced to deny the appeal request.

Members or their representatives may request, at no cost, to have access to and copies of all documents, records, and other information relevant to the adverse determination.

Second Level Appeal

If the First Level Appeal is denied, Members or their representative may request a Second Level Appeal within sixty (60) days of receiving the determination of the First Level Appeal, following the same process. All Second Level Appeals are reviewed and determined by the MotivHealth's Appeals committee, consisting of a Medical Director, President and SVP of Operations or their delegates and other pertinent experts, who did not participate in the First Level Appeal decision.

MotivHealth follows the Appeal timeframes described below:

1. For Pre-service Appeal requests, MotivHealth will conduct the review and notify the Member or representative of the determination within fifteen (15) days of receipt of the preservice Appeal request.
2. For Post-service claim Appeals, MotivHealth will conduct the review and notify the Member or representative of the determination within thirty (30) days of receipt of the Appeal request.
3. For Urgent Appeals, MotivHealth will conduct the review and notify the Member or Member's representative of the determination within seventy-two (72) hours. An Appeal is considered urgent, when a physician with knowledge of the Member's medical condition indicates that a delay in treatment could jeopardize the Member's life, health, or the ability to regain maximum function.

The determination as to whether a service, supply, device or medication is necessary or appropriate is between the Member and their physician. MotivHealth's decisions are determinations based solely on whether the Member and the service, supply, device or prescription are eligible for coverage as described in the MotivHealth Master Policy.

Urgent Claim Appeals that Require Immediate Action

An Appeal may require immediate action if a delay in treatment could significantly increase the risk to a Member's health or the ability to regain maximum function or cause severe pain. In these urgent situations:

The Appeal does not need to be submitted in writing. The provider should call MotivHealth and request an urgent review. MotivHealth will review and provide a verbal and written determination within seventy-two (72) hours of the request, considering the seriousness of the Member's medical condition.

Independent Review Organization (IRO)

If a Member is dissatisfied with the outcome of a Second Level Appeal determination, the Member or Member representative may request an external review by an IRO within one hundred eighty (180) days of receiving the Second Level Appeal determination. Requests for an Independent Review must be submitted to the Utah Insurance Commissioner at Suite 3110 State Office Building, Salt Lake City, UT, 84114.

When received by the Utah Insurance Commissioner, the request will be forwarded to MotivHealth to process with an IRO. The request, including all documentation, will be delivered to the IRO by MotivHealth, within five (5) business days. There is no cost to a Member for an IRO external review. The IRO will provide their determination and rationale in writing to the Member, their representative and MotivHealth within seventy-two (72) hours of receiving the request. The IRO's decision is final and binding.

An IRO is an independent organization employing physicians and other medically qualified individuals or experts with the appropriate clinical expertise, which acts as the decision maker for external Appeal requests. The IRO practitioner rendering the decision will not have been involved in the original determinations. The IRO does not have any direct financial interest in MotivHealth or outcome of the independent review.

Voluntary External Review

If a Member is not satisfied with the final determination, they may have the right to civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"). Before a Member can take civil action, they must go through both levels of Appeal provided by MotivHealth. The Member and MotivHealth may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available to the Member is to contact their local US Department of Labor office or Utah's insurance regulatory agency.

Provider Reconsiderations

Provider Reconsideration is a request from a participating provider to review an adverse determination where the member or patient has no financial responsibility. Examples of this are timely filing denials, claims edit denials, pricing reconsiderations, etc.

An acknowledgement letter stating the reconsideration has been received will be sent to the provider within five (5) days of receipt. MotivHealth has thirty (30) days to provide the response to the reconsideration request. Participating providers have the right to request a claim reconsideration once, if the reconsideration is denied, the decision is final. A second level Provider Reconsideration is not offered. For further information regarding provider dispute resolution, providers can refer to their contractual agreement with the appropriate entity with whom the provider is contracted.

Correct Coding Guidelines

Correct Coding Guidelines apply to all physicians, other health care professionals, hospitals and other facilities.

Providers are required to submit accurate and complete claims for all medical and surgical services, supplies and items rendered to Members using industry standard coding guidelines. Coding guidelines include, but are not limited to, AMA, CPT, HCPCS, CMS Coding Initiatives, UBE, and ICD-10.

Any medical or surgical service, supply or item, either inpatient or outpatient, reported by any code, must be clearly documented in an appropriate medical record. Reimbursement is not allowed for undocumented professional, inpatient or outpatient medical and surgical services, supplies and items.

Hospitals and facilities must report all services, supplies and items using accurate Revenue Codes.

Reimbursement will not be allowed for incorrectly reported codes, including Revenue Codes, for medical and surgical services and supplies and items, for professional, inpatient or outpatient facility claims.

NCCI

The Medicare National Correct Coding Initiative (NCCI) (also known as CCI) was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. NCCI Procedure-to-Procedure (PTP) code pair edits are automated prepayment edits that prevent improper payment when certain codes are submitted together for services.

In addition to PTP code pair edits, the NCCI includes a set of edits known as Medically Unlikely Edits (MUEs). An MUE is a maximum number of Units of Service (UOS) allowable under most circumstances for a single Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code billed by a provider on a date of service for a single beneficiary.

MotivHealth follows CMS NCCI edits and guidelines. NCCI edits are applicable to the time period for which the edits are effective. For complete information regarding NCCI, refer to the CMS website.

NCCI edits will be denied automatically, therefore the denial may be appealed.

Procedure to Procedure (PTP) Code Pair Edits

PTP Edits- Practitioners:

These PTP code pair edits are applied to claims submitted by physicians, non-physician practitioners, and Ambulatory Surgery Centers (ASC's).

PTP Edits- Hospital:

PTP edits are applied to Types of Bills (TOBs) subject to the Outpatient Code Editor (OCE) for OPPS. These edits are applied to outpatient hospital services and other facility services including, but not limited to, therapy providers (Part B Skilled Nursing Facilities (SNFs)), comprehensive outpatient rehabilitation facilities (CORFs), outpatient physical therapy and speech-language pathology providers (OPTs), and certain claims for home health agencies (HHAs) billing under TOBs 22X, 23X, 75X, 74X, 34X.

Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the Modifier. A Modifier should not be appended to a HCPCS/CPT code solely to bypass a PTP code pair edit if the clinical circumstances do not justify its use. If the Medicare Program imposes restrictions on the use of a Modifier, the Modifier may only be used to bypass a PTP code pair edit if the Medicare restrictions are fulfilled.

In the Modifier indicator column, the indicator 0, 1, or 9 shows whether a PTP-associated Modifier allows the PTP code pair to bypass the edit. The following Modifier Identifier Table provides a definition of each of these indicators.

Modification Indicator	Definition
0 (Not Allowed)	There are no Modifiers associated with NCCI that are allowed to be used with this PTP code pair; there are no circumstances in which both procedures of the PTP code pair should be paid for the same beneficiary on the same day by the same provider.
1 (Allowed)	The Modifiers associated with NCCI are allowed with this PTP code pair when appropriate.

9 (Not Applicable)	This indicator means that an NCCI edit does not apply to this PTP code pair. The edit for this PTP code pair was deleted retroactively

The NCCI-associated Modifier must be appended to the code that would be the denied code in the code pair for the code to be considered for payment.

The following are NCCI-associated Modifiers:

24 - Unrelated E/M by Same Physician during Postoperative Period

25 - Separate E/M on Same Day

27 - Multiple outpatient hospital E/M encounters on the same day

57 - Decision for Surgery

58 - Staged Procedure

59 - Distinct Procedure

78 - Return to OR

79 - Unrelated Proc in Post-op

91 - Repeat Lab

E1-E4 - Eyelids

F1-F9 - Digits, Fingers

FA - Digits, Fingers

LC - Coronary Arteries

LD - Coronary Arteries

LM - Left main coronary artery

LT - Left

RC - Right Coronary Arteries

RI - Ramus intermedius coronary artery

RT - Right

T1-T9 - Digits, Toes

TA - Digits, Toes

XE - Separate Encounter

XP - Separate Practitioner

XS - Separate Structure

XU - Unusual Non-Overlapping Service

Medically Unlikely Edits (MUE)

A MUE for a HCPCS/CPT code is the maximum units of service allowable by the same provider for the same patient on the same date of service.

Not all HCPCS/CPT codes have a MUE. MUEs are developed based on HCPCS/CPT code descriptors, CPT coding instructions, anatomic considerations, established CMS policies, nature of service/procedure, nature of analyte, nature of equipment, prescribing information, and clinical judgment.

There are 3 NCCI indicators applied to CPT/HCPCS codes for MUE edits, 1, 2 or 3.

- ñ Indicator 1 is a claim line MUE. The CPT billed exceeded the maximum units for that line item.
- ñ Indicator 2 is a per day MUE based on anatomical or coding limitations. The code billed exceeded the maximum units per code description, 30-minute initial evaluation with 2 units billed.
- ñ Indicator 3 is a per day MUE based on clinical benchmarks. The CPT code reported is usually performed once a day, e.g. colonoscopy.

Claims are automatically denied based on the current NCCI edits. Appeals may be submitted.

*Status B Codes

Codes published on the NPFS Relative Value File assigned a status B codes are considered bundled into the payment for another service. We follow the CMS guidelines and do not reimburse for status B codes regardless of whether they are billed alone or in conjunction with other services.

*Status T Codes

Codes that are only paid if there are no other services payable under the physician fee schedule (PFS) billed on the same date by the same provider. If any other services payable under the PFS are billed on the same date by the same provider, these services are bundled into the services(s) for which payment is made.

Procedures should be reported with the CPT/HCPCS code that describes the services performed to the greatest specificity possible and only if all services described by that code are performed. Unbundling occurs when multiple codes are used to report a procedure covered by a single comprehensive CPT/HCPCS code.

*Refer to Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files for a list of B and T codes.

Unbundling

Providers must report services correctly and with the CPT code that describes the services performed. MotivHealth will not reimburse for charges related to unbundled procedures/services, see examples listed below (this is not a complete list of Unbundling situations):

- ñ Billing multiple CPT codes when one a single code describes the services;
- ñ Unbundling bilateral CPT codes into two unilateral procedure codes;
- ñ Reporting fragments a procedure into component parts;
- ñ Unbundling services that are integral to a more comprehensive procedure.

Global Surgical Periods

Global Periods are a period of time starting with the pre-operative period of a surgical procedure and ending some period of time after the procedure was performed.

Centers for Medicare & Medicaid (CMS) global surgery indicators are found in the CMS National Physician Fee Schedule Relative Value Files.

000 - Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount, evaluation and management services on the day of the procedure generally not payable.

010 - Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during the 10-day postoperative period generally not payable.

090 - Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule amount.
MMM - Maternity codes; usual global period does not apply.

XXX - The global concept does not apply to the code.

YYY - The carrier is to determine whether the global concept applies and establishes postoperative period, if appropriate, at time of pricing.

ZZZ - The code is related to another service and is always included in the global period of the other service.

Preoperative Evaluation and Management (E/M) Denial- E/M codes when provided on the day of or the day before a surgical procedure which has a 90-day global period.

Same Day E/M Denial- E/M codes when provided on the same day as a procedure or service with:

- A CMS assigned global period of 0, 10, 90 or ZZZ days.
- A global period (YYY) established by our health plan for codes for which CMS has not established a global period and has not indicated that a global period is inappropriate, e.g. codes with a CMS status indicator of C – Carrier priced codes.

Postoperative E/M Denial- E/M codes when provided during the global period of the surgical procedure.

Major Procedure- Surgical procedures with a 1-day preoperative period and 90-day postoperative period.

Minor Procedure- Surgical procedures with a 0 or 10-day postoperative period.

Components of a Global Surgical Package:

Reimbursement for surgical procedures includes payment for all related services and supplies that are necessary and/or related to that procedure. Appending a Modifier will not bypass these denials. These components of the surgical package are not eligible for separate reimbursement when provided within the global period and applies to services performed in all places of services including, but not limited to, physician office, hospital, ASC, etc.

Providers within the same provider group with the same or similar specialty are subject to the same global period rules when covering for another provider.

Preoperative Services:

The reimbursement for a surgical procedure includes payment for all E/M services that are related to that procedure:

A minor procedure includes the day of surgery unless that E/M service was for a significant, unrelated and separately identifiable E/M service than the surgical procedure performed. In this case, the E/M code may be eligible for separate reimbursement if Modifier 25 is appended to the E/M code.

A major procedure includes the day before and the day of surgery unless that E/M service resulted in the initial decision to perform that surgical procedure. In this case, the E/M code may be eligible for separate reimbursement if Modifier 57 is appended to the E/M code

EXCEPTIONS to major procedure requirement:
Anesthesia codes (00100-01999): Preoperative denials will apply to anesthesia services.
Global maternity package codes: Preoperative denials will apply two hundred seventy (270) days prior to delivery.

Intra-Operative Services:

The reimbursement for a surgical procedure includes payment for all intraoperative services that are a normal, usual and necessary part of that surgical procedure.

Postoperative Services:
The reimbursement for a surgical procedure includes payment for all professional services that

are related to that procedure and are provided during the postoperative period. This includes but is not limited to:

- Dressing changes.
- E/M services related to the original surgery, all settings (including home postpartum visits).
- Incisional care.
- Postoperative pain management by the surgeon.
- Removal of staples, tubes, drains, casts, splints and cutaneous sutures.
- Postoperative care or treatment (including complications) that are related to the original surgery but do not require a return trip to the operating room.
- Insertion, irrigation and removal of catheters.
- A procedure or service performed within the global period solely to confirm the success of the initial procedure
- Anesthesia codes one (1) day after the anesthetic was provided.
- Global maternity delivery codes for services within forty-five (45) days after delivery.

The reimbursement for a surgical procedure with '0' postoperative days as assigned by CMS, includes a global period of the first postoperative day.

If an E/M service is provided during the global period of a surgical procedure that is unrelated to that surgical procedure, the E/M code may be eligible for separate reimbursement if Modifier 24 is appended to the E/M code.

Reimbursable Services within the Global Period:

Some professional services are not included in the reimbursement for a surgical procedure and may be eligible for separate reimbursement. It may be necessary to append an appropriate Modifier to the code for the service to identify the circumstances which make the code eligible for separate reimbursement.

These services include but are not limited to:

- Evaluation of the problem by the surgeon to determine the need for surgery.
- An E/M service the day before or the day of a major surgical procedure only if the initial decision to perform the surgery was made during that visit. Modifier 57 must be appended to the E/M code to indicate decision for surgery.
- An E/M service provided on the same day as a minor procedure only if the E/M service is unrelated to the procedure performed. Modifier 25 must be appended to the E/M code to indicate the E/M is significant and separately identifiable.
- An E/M service during the surgical postoperative period only if the visit is unrelated to the surgical procedure. Modifier 24 must be attached to the E/M code to indicate the E/M is unrelated to the procedure performed.
- A repeat surgical procedure by the same surgeon performed on the same day as the original surgery, requiring a return trip to the operating room (OR), provided that the repeated surgical procedure was not related to a hospital acquired condition or iatrogenic event. (See policies related to these situations.) Modifier 76 must be attached to the procedure code to indicate a repeat surgical procedure.

- A repeat surgical procedure by a different surgeon, on the same day as the original surgery, requiring a return trip to the OR, provided that the repeated surgical procedure was not related to a hospital acquired condition or iatrogenic event. (See policies related to these situations.) Modifier 77 must be attached to the procedure code to indicate a repeat surgical procedure by a different surgeon.
- A procedure or treatment that is related to the original surgery that requires an unplanned return to the operating room. Modifier 78 must be attached to the surgical code to indicate unplanned return to the OR.
- A procedure or service that is unrelated to the original surgery. Modifier 79 must be attached to the procedure code to indicate the surgery is unrelated to the original procedure.
- A staged surgical procedure (one that was planned at the time of the original surgery) performed during the postoperative period of the original surgery. Modifier 58 must be attached to the procedure code to indicate a staged procedure.

Non-Surgical Procedures:

Separate reimbursement for E/M services will not be allowed for non-surgical services (e.g., Chemotherapy Administration) that already include E/M as part of the planned procedure or service. If the E/M service is documented to be unrelated and separately identifiable, Modifier 25 appended to the E/M code may allow separate reimbursement for the E/M service.

Procedure codes with a CMS "XXX" global period have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed, therefore separate reimbursement for E/M service will not be made. However, if the E/M service was for an unrelated and separately identifiable service Modifier 25 should be appended to the E/M code for reimbursement consideration.

Reimbursement for medical procedures (i.e., Chiropractic and Osteopathic Manipulative Treatment) includes payment for E/M services, all related supplies that are necessary and/or related to that procedure. Appending a Modifier will not bypass these denials.

One or More Sessions Codes:

Codes in CPT with descriptors that include the phrase 'one or more sessions' are eligible for reimbursement only once within their own global period, regardless of the number of sessions necessary to complete the treatment and regardless of the Modifier attached.

Facility DRG Validation

This policy applies to inpatient hospitals that are reimbursed using a DRG payment methodology. This policy does not pertain to Critical Access Hospitals.

Medicare Severity Diagnosis Related Group (MS-DRG or DRG) is a classification system statistically designed to calculate inpatient hospital claim pricing. DRG’s are defined by a specific set of patient attributes which include principal diagnosis, specific secondary diagnoses, procedures, sex, and discharge status, and the presence of complications or comorbidities.

The DRG and principal diagnosis are confirmed upon discharge, not based on the clinical suspicion at the time of admission. While specific diagnosis codes should be reported when

they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the health care encounter.

Clinical findings and physician documentation in the medical record must support all diagnoses and procedures billed including the Major Complication or Comorbidity (MCC) and Complication or Comorbidity (CC) that would affect the billing.

MotivHealth will not allow reimbursement for diagnoses, procedures, MCC's or CC that are not clearly documented in the medical record.

MotivHealth will review the medical record documentation to determine correct coding on a claim in accordance with industry coding standards as outlined by the Official Coding Guidelines, ICD-10 Coding Manual, Uniform Hospital Discharge Data Set (UHDDS), and/or Coding Clinics. DRG Validation Audits shall be conducted to confirm DRG assignment and accuracy of payment according to the information on the claim and medical record(s) when submitted.

DRG Validation Audits include, but are not limited to the following:

- Verification of the diagnostic code assignments.
- Verification of the procedural code assignments.
- Verification of present on admission indicator assignments.
- Verification of the sequencing of codes.
- Verification of DRG grouping assignment and associated payment.
- Verification of the MCC and CC when reported.

DRG Validation Audits may result in revisions to the diagnosis codes and/or procedural codes. If the DRG code is found to be inaccurate, MotivHealth will recalculate the payment and send a letter detailing the change to the DRG.

There are services and fees that are not separately payable from the inpatient hospital admission. If these items are billed separately from the inpatient claim or billed within the claim, they will be packaged into the DRG reimbursement:

- ñ Emergency department, if the member is admitted
- ñ Fees related to admission, late discharge or technical support
- ñ Observation stays
- ñ Discharge prescription drugs (take home)
- ñ Diagnostic laboratory services
- ñ Room and board including incremental nursing services, specialty services and all supplies
- ñ Medical transport of member, equipment or supplies when transport is performed by the facility.

References

ICD-10-CM Official Guidelines for Coding and Reporting

Medicare Claims Processing Manual - Chapter 23

Emergent and Other Non-elective Inpatient Admissions

Emergent and other non-elective inpatient admissions require notification as specified in the Utilization Management section of this policy.

MotivHealth will reimburse for medically necessary inpatient admissions. Decisions for admission are based on the medical judgment of physicians and other qualified health practitioners. The documentation in the medical record must support the decision-making process and the medical necessity of the inpatient admission.

In the absence of contract stipulations addressing inpatient admission determinations, MotivHealth will use evidence-based criteria provided by MCG to determine medical necessity and to ensure that consistent and clinically valid decision making was used to determine the reasonableness of an inpatient admission. MotivHealth does not use time as the deciding factor when making a determination of the appropriateness of admission or the place of service (inpatient vs. outpatient status). All claims for reimbursement for an inpatient admission are subject to medical review.

Our determination of the appropriateness of an inpatient admission will be based on the information available at the time of discharge from the emergency setting. MotivHealth recognizes that some events may eclipse standard MCG guidelines, and, in such cases, inpatient admission may be considered justified. These events may include patient death during the inpatient stay, transfer from another inpatient facility for services not performed by the admitting facility, decision to transfer to hospice during the inpatient stay, and the self-discharge of a patient from a healthcare facility against medical advice (AMA).

Every inpatient admission must have an order stipulating an inpatient admission and orders must meet MotivHealth's requirements for medical orders. Inpatient claims submitted without an inpatient order as specified in the Medical Order section of this policy will be denied.

Rebilling Denied Inpatient Claims:

Claims denied for inpatient admission and where an observation setting would have been more appropriate may be rebilled. Claims denied for lack of a valid inpatient order may not be rebilled.

Utilization Management

MotivHealth will need the following information to be included in a preauthorization request:

- ñ Patient Name and Member ID.
- ñ Procedure code.
- ñ Diagnosis code.
- ñ Ordering physician.
- ñ Rendering physician
- ñ When and where the procedure will be conducted.
- ñ Medical records that indicate the reason for the procedure/service.

Providers and Member's must call MotivHealth at (844)234-4472 to initiate a preauthorization. Medical records can be mailed to P.O, Box 709718 Sandy UT 84070-9718 or faxed to (844)533-1289 to the attention of our Utilization Management team.

MotivHealth's Utilization Management team will review the request and determine if we can approve the service for coverage based on the following (in order):

1. Is the Member covered by MotivHealth (the Plan) on the requested service date?
2. Is the service requested covered by the Member's plan and not a Benefit Exclusion?
3. Is the service requested experimental or investigational and therefore a Benefit Exclusion and not covered by the Plan?
4. Is the service requested medically necessary based on current Milliman Care Guidelines (MCG)?

The following services require Preauthorization which can be received by calling our Personal Health Assistants: add link to "living list" so we can update as necessary.

- ñ Any inpatient maternity stay that exceeds forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following delivery by Cesarean section.
- ñ Occupational Therapy.
- ñ Speech Therapy.
- ñ Miscarriage/D&C.
- ñ CT/MRI without contrast.
- ñ CT/MRI with contrast.

The following services require a written request, the following is a list of the most common services requiring written Preauthorization, it is no way inclusive of all services where preauthorization is necessary:

- ñ Air Ambulance.
- ñ All inpatient admissions (except inpatient maternity/newborn nursery services less than forty-eight (48) hours following a vaginal delivery or 96 hours following delivery by Cesarean section.
- ñ All Tertiary Care including inpatient stays at a Skilled Nursing Facility (SNF), Long Term Acute Care Hospital (LTAC), Rehabilitation Facility, Residential treatment (RTC), Partial Hospitalization (PHP), and all Intensive Outpatient Services.
- ñ Coronary CT angiography.
- ñ Organ or tissue transplants.

- ñ Cochlear implants.
- ñ Durable Medical Equipment with a purchase price over $750 or any rental of more than 60 days.
- ñ Wound care, except for the diagnosis of burns.
- ñ Home Health and Hospice Care.
- ñ Hyperbaric oxygen treatment.
- ñ Intrathecal pumps.
- ñ Spinal cord stimulators.
- ñ Implantable medications, excluding contraception.
- ñ Certain prescription and Specialty Drugs.
- ñ Continuous glucose monitoring devices and supplies.
- ñ Dialysis.
- ñ Stereotactic radiosurgery.
- ñ Breast reconstruction surgery.
- ñ Transnasal endoscopic microsurgery.
- ñ Anesthesia during standard colonoscopy or EGD surgery, other than moderate sedation (conscious sedation).
- ñ Sleep Studies (except at-home sleep studies).
- ñ Chemotherapy.
- ñ Enteral Nutrition Therapy.
- ñ Transesophageal echocardiography (TEE).

All preauthorization requests determined to be not eligible for coverage are reviewed and denied by a licensed physician.

If a preauthorization is denied, refer to the “Pre-Service Review Process” under the MotivHealth Payor Reimbursement Policy, “Claim Disputes”.

Site Visits and Monitoring

MotivHealth may make office site visits to network providers for a variety of oversight reasons. MotivHealth may evaluate a site for: physical accessibility, physical appearance, adequacy of waiting and examine room space. MotivHealth may also review the medical record-keeping practices, the methods used for keeping and maintaining the confidentiality of Member information, and the methods for keeping information in a consistent, organized manner for ready accessibility.

Notification of Status Changes

Network providers are required to notify MotivHealth in writing within fourteen (14) days of any changes related to the following circumstances:

- ñ Change in professional liability insurance.
- ñ Change of practice location, billing location, telephone number or fax number.
- ñ Status change of professional licensure, such as suspension, restriction, revocation, probation, termination, reprimand, inactive status or any other adverse situation.
- ñ Change in tax ID number used for claims filing.

- ñ Malpractice event, as described in the “Compliance with Policies” section of the Provider Service Agreement or Hospital Service Agreement.

Note: Providers who previously practiced only under a group and are now starting a solo practice require an individual contract.

Claim Specific Guidelines

Ambulance

Guidelines on Reimbursement of Ground and Air Ambulance Services:

An Ambulance Trip Sheet is required with ALL ground and air ambulance claim submissions. All Ambulance Trip Sheets will be reviewed for Medical Necessity prior to reimbursement.

Ambulance shall transport to the nearest facility that provides the appropriate care the patient needs in the shortest amount of time.

Reimbursement is allowed when the ambulance service date is the same as the admission or discharge date. Ambulance services billed while the patient is admitted to the hospital are not eligible for reimbursement.

Reimbursement is allowed for transportation, including transportation by ambulance, to and from another hospital or freestanding facility to receive specialized diagnostic or therapeutic services not available at the facility where the patient is an inpatient. Charges for any facility owned transportation are not separately reimbursable.

When the beneficiary is an inpatient of a long term care facility (LTCH), inpatient psychiatric facility (IPF) or inpatient rehabilitation facility (IRF) and is transported via ambulance to an acute care hospital to receive specialized services, reimbursement will be allowed if the presence of occurrence span code 74 (non-covered level of care) and the associated occurrence span code from and through dates is plus one day. The claim will be denied if the ambulance line item service date falls outside the occurrence span code 74 from and through dates plus one day. Services including, but not limited to oxygen, drugs, extra attendants, supplies, EKG, and night differential are not paid separately when reported as part of an ambulance transportation service.

Air Ambulance is reimbursable when the use of either basic or advanced life support ground ambulance is not appropriate because the patient's condition requires rapid transport to the nearest appropriate facility to treat the patient’s current medical condition. Air transport may also be reimbursable if the patient is inaccessible for a ground or water ambulance vehicle.

We follow state administration transport code for the state where the service is rendered.

Ambulance Modifiers:

Reimbursement will only be made when billed with the two-digit ambulance Modifier*. Any claim billed without the two-digit ambulance Modifier will be denied as a billing error. The provider may resubmit a corrected claim with applicable modifiers. Below is a list of the Modifiers eligible for reimbursement.

*Exception: A0998 (Ambulance response and treatment, no transport) - Ambulance service Modifiers are not required and should not be submitted on the claim since transport services are not rendered. The submission of an ambulance Modifier may result in a denial.
Each ambulance Modifier consists of two digits as follows:

1. A single digit alpha character identifying the origin of the transport in the first position.
2. A single digit alpha character identifying the destination of the transport in the second position. (e.g. SH = scene of accident or acute event to hospital)

Ambulance Modifier	Modifier Description
D	Diagnostic or therapeutic site other than P or H when these are used as origin codes
E	Residential, domiciliary, custodial facility (other than 1819 facility)
G	Hospital-based ESRD facility
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J	Free standing ESRD facility
N	SNF
P	Physician's office
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at physician's office on way to hospital (destination code only)

The following Modifiers are considered secondary Modifiers – do not bill them in the first position:

Ambulance Modifier	Modifier Description
GM	Multiple patients on one ambulance trip. Note: Providers need to submit the appropriate origin and destination Modifiers in the first Modifier position and Healthcare Common Procedure Coding System (HCPCS) Modifier GM in the second Modifier position.
QL	Patient pronounced dead after ambulance called
QM	Ambulance service provided under arrangement by a provider of services
QN	Ambulance service furnished directly by a provider of services

Transportation Indicators:

Transportation indicators below may be included on the claim to indicate the necessity of transport. The transportation indicator should be placed in the "narrative" field on the claim.

Transportation Indicators Transportation Indicator Description

Air and Ground:

C1 an inter-facility transport (to a higher level of care) determined necessary by the originating facility based upon The Emergency Medical Treatment and Labor Act (EMTALA) regulations and guidelines.
C2 a patient is being transported from one facility to another because a service or therapy required to treat the patient's condition is not available at the originating facility.
C3 Secondary code where a response was made to a major incident or mechanism of injury. All such responses are appropriately Advanced Level Service responses. A code that describes the patient's condition found on scene should also be included on the

claim but use of this Modifier is intended to indicate that the highest level of service available response was medically justified.

C4 Indicates that an ambulance provided a medically necessary transport, but the number of miles on the claim form appears to be excessive. This should be used only if the facility is on divert status or a particular service is not available at the time of transport only. The provider or supplier must have documentation on file clearly showing why the beneficiary was not transported to the nearest facility and may include this information in the narrative field.

Ground Only:

C5 Indicates situations where a patient with an ALS-level condition is encountered, treated and transported by a BLS-level ambulance with no ALS level involvement whatsoever. This situation would occur when ALS resources are not available to respond to the patient encounter.

C6 Indicates situations when an ALS-level ambulance would always be the appropriate resource chosen based upon medical dispatch protocols to respond to a request for service. Claims including this transportation indicator should contain two primary codes. The first condition will indicate the BLS-level condition corresponding to the patient's condition found on- scene and during the transport. The second condition will indicate the ALS-level condition corresponding to the information at the time of dispatch that indicated the need for an ALS- level response based upon medically appropriate dispatch protocols.

C7 Indicates circumstances where IV medications were required en route. The patient's condition should also be reported on the claim with a code selected from the list.

Air Only:

D1 Long Distance: patient's condition requires rapid transportation over a long distance.

D2 Under rare and exceptional circumstances, traffic patterns preclude ground transport at the time the response is required.

D3 Time to get to the closest appropriate hospital due to the patient's condition precludes transport by ground ambulance. Unstable patient with need to minimize out of hospital time to maximize clinical benefits to the patient.

D4 Pick up point not accessible by ground transportation

Ambulance Pricing:

Licensed ground ambulance shall not charge more than the rates described by Utah Administration Code Rule R426-8.

Air Ambulance pricing is set forth in the provider agreement.

Anesthesia

Reimbursement may be allowed for anesthesia services performed by an anesthesiologist or Certified Registered Nurse Anesthetist (CRNA).

Anesthesia services must be billed with CPT codes 00100-01999 and are reimbursed as time-based using the Standard Anesthesia Formula.

Modifiers

All services reported for anesthesia management must be submitted with the appropriate HCPCS Modifiers. These Modifiers identify monitored anesthesia and whether a procedure was personally performed, medically directed, or medically supervised. We will follow CMS Modifier percentage indicated in the table below.

Required Anesthesia Modifiers	**Descriptions**	**Percentage of Allowed Amount**
AA	Anesthesia services performed personally by an anesthesiologist.	100%
AD	Medical supervision by a physician; more than four concurrent anesthesia procedures.	100% (*AD Modifier Reimbursement Formula)
G8	Monitored anesthesia care (MAC) for deep complex, complicated or markedly invasive surgical procedure.	Informational Only
G9	Monitored anesthesia care (MAC) for a patient who has a history of severe cardiopulmonary condition.	Informational Only
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals.	50%
QS	Monitored anesthesia care service.	Informational Only
QX	CRNA service; with medical direction by a physician.	50%
QY	Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist.	50%
QZ	CRNA service; without medical direction by a physician.	100%
Informational Modifiers		

23	Unusual anesthesia - Used to report a procedure which usually requires either no anesthesia or local anesthesia; however, because of unusual circumstances must be done under general anesthesia. Coverage/payment will be determined on a "by-report" basis.	Information Modifier only
47	Anesthesia by surgeon – Used to report regional or general anesthesia provided by the surgeon (Not covered by Medicare).	Information Modifier only
GC	This service has been performed in part by a resident under the direction of a teaching physician.	Information Modifier only
QS	Monitored anesthesiology care services (can be billed by a qualified non-physician anesthetist or a physician).	Informational only, should be billed with a required anesthesia Modifier and not in the first Modifier position
XP	Separate practitioner: a service that is distinct because it was performed by a different practitioner.	
XS	Separate Structure: a service that is distinct because it was performed on a separate organ/structure.	

Modifier PT only allowed with code 00811

Modifier 33 recognized with Advance Care Planning (ACP) codes 99497-99498

Time Units:

The time is billed in minutes increments. The minutes are then divided into increments used in calculating anesthesia reimbursement. Our health plan uses 15-minute increments; 4 units per hour. Increments of 1-7 minutes will round down and increments of 8-14 minutes will round up.

Example: Anesthesia time is billed as 80 minutes. Time units are 5 units (5 units *15 minutes = 75 minutes. The remaining 5 minutes are not given extra units, the five minutes is included in the last 15-minute increment.)

Calculating Time Units for Anesthesia Services and Rounding

Submit 1 unit for every 15-minute interval, rounding up to the next unit for 8 to 14 minutes, rounding down for 1 to 7 minutes.

7 minutes or Less Do not Bill
8 minutes to < 23 minutes 1 unit

23 minutes to < 38 minutes 2 units
38 minutes to < 53 minutes 3 units
53 minutes to < 68 minutes 4 units
68 minutes to < 83 minutes 5 units
83 minutes to < 98 minutes 6 units
98 minutes to < 113 minutes 7 units
113 minutes to < 128 minutes 8 units

Claims must be reported with actual anesthesia time in one-minute increments. Example- if anesthesia time is one hour, 60 minutes should be submitted. Time begins when anesthesiologist or CRNA begins to prepare the patient for anesthesia care and ends when the patient is placed under post-anesthesia supervision.

For electronic claims: Per HIPAA guidelines, electronic claims submitted via the 837 Professional transaction set, should have the anesthesia minutes reported in loop 2400 SV 104 with an MJ qualifier in loop 2400 SV 103 per the 837 Implementation Guide.

For paper claims (CMS Paper Format 01-12): Anesthesia time (duration in minutes with start and end times) should be entered in shaded area of field 24 A-K and the total minutes in field 24G for each applicable service line. On line 24A, enter Qualifier 7 (anesthesia information). Qualifier 7 is to be used when reporting Anesthesia Time services.
Example: Begin 1415 End 1615 Time 120 minutes.

Anesthesia Rate Formula

Standard Anesthesia Formula:

Standard Anesthesia Formula = ([Base Unit Value + Time Units + Modifying Units] x Conversion Factor) x Modifier percentage.
AD Modifier Anesthesia Formula:

Standard Anesthesia Formula with Modifier AD* = ([Base Unit Value of 3 + 1 additional Unit if anesthesia notes indicate the physician was present during induction] x conversion factor) x Modifier Percentage.

Anesthesia and Procedural Bundled Services:

Procedural or Pain Management Codes Bundled into Anesthesia – NCCI Policy
Procedural or Pain Management Codes Allowed with Modifiers – NCCI Policy

Preoperative/Postoperative Visits:

- Not separately reimbursed E/M visits excluding critical care codes.
- Critical Care CPT codes 99291-99292 are not considered included in anesthesia services and will be separately reimbursed.

Not Eligible for Separate Reimbursement:

Services performed in conjunction with a surgical anesthetic are considered an integral part of that anesthesia service and therefore not eligible for separate reimbursement. These services include but are not limited to:

- Arterial blood gas analysis/monitoring.
- Blood pressure monitoring.
- Carbon dioxide monitoring.
- Moderate conscious sedation.
- EEG/EKG monitoring.
- Evaluation & management services.
- Field avoidance.
- Heparin analysis.
- Intraoperative monitoring.
- Esophageal doppler hemodynamic management.
- Intubation.
- Local anesthesia (for regional or field block).
- Nerve block (except as noted in this policy).
- Oximetry/pulse oximetry.
- Patient controlled analgesia.
- Patient positioning.
- Regional IV of local anesthetic.
- Supplies and equipment.
- Ventilator set-up and/or management.

Daily Hospital Management

Obstetric Anesthesia Services:

- Neuraxial Labor Analgesia Reimbursement Calculations – CPT Code 01967
- Obstetric Add-On Codes – 01968, 01969, 01967 – allow extra reimbursement due to extensive hours and possible anesthesia management to a second physician.

Maternity anesthesia reimbursement varies slightly due to the nature of the neuraxial labor analgesia where personal attendance by the anesthesiologist or CRNA is not required throughout the procedure. Time units for labor management (CPT code 01967) are calculated at 15-minute increments for the first hour, 30-minute increments for the second hour; 60-minute increments for subsequent hours.

Intraperitoneal procedures in the lower abdomen including laparoscopy, tubal ligation- CPT 00851 in conjunction with Neuraxial Labor Analgesia needs to be billed with appropriate Modifier 59, 76, 77, 78, 79, or XE to indicate separate and subsequent to original anesthesia management.

Moderate Sedation:

- 99151-99153 – same provider.
- Performed in facility – Surgeon/endoscopist – 99152 - one unit allowed
- 99153 – technical only- billed by facility only.
- 99155-99157 – different provider.
- G0500 GI Endoscopic initial 15 minutes, no longer bundled, used with endoscopy codes (43xxx, 453xx, and G0105/G0121).

Moderate sedation is eligible for separate reimbursement to the surgeon if:

1. Medicare's National Correct Coding Initiative (NCCI) does not deny the moderate sedation code as included in the primary procedure.
2. MotivHealth's health plan Correct Code Editor (CCE) does not deny the moderate sedation code as included in the primary procedure.
3. The primary procedure is not listed in CPT Appendix G (Summary of CPT Codes that Include Moderate (Conscious) Sedation).

Modifier 53 - Discontinued Anesthesia – Surgery cancelled by surgeon – Only base time for the billed anesthesia code will be considered for reimbursement.

Anesthesia Coding for Colonoscopy:

00811-PT- Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified

00812- Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy

00731- Anesthesia for upper intestinal endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified

00732- Anesthesia for upper intestinal endoscopic procedures, endoscope introduced proximal to duodenum; endoscopic retrograde cholangiopancreatography (ERCP)

00813- Anesthesia for combined upper and lower gastrointestinal endoscopic procedures, endoscope introduced both proximal to and distal to the duodenum

Modifiers P1 through P6:

Modifiers used with anesthesia codes that reflect the physical status of the patient receiving anesthesia.

Modifier and Physical Status Units:

- P1 — A normal healthy patient
  - Physical Status Units — 0
- P2 — A patient with mild systemic disease
  - Physical Status Units — 0
- P3 — A patient with severe systemic disease
  - Physical Status Units — 1
- P4 — A patient with severe systemic disease that is a constant threat to life
  - Physical Status Units — 2
- P5 — A moribund patient who is not expected to survive without the operation
  - Physical Status Units — 3
- P6 — A declared brain-dead patient whose organs are being removed for donor purposes
  - Physical Status Units — 0

Modifiers GC and QK:

Modifiers used by physicians when supervising residents or student nurse anesthetists.

- GC — Service performed by resident under direction of a teaching physician
- QK — Medical direction of 3 or 4 concurrent anesthesia procedures

Modifiers QX and QY:

Modifiers used with anesthesia codes that identify services provided by a licensed CRNA with medical direction by a physician.

- QX — CRNA service: with medical direction by a physician
- QY — Medical direction of one CRNA by an anesthesiologist

CRNA Supervision:

Supervision of a CRNA by an anesthesiologist must be submitted with Modifier QX or QY attached to the anesthesia codes. Reimbursement will be split evenly, 50% for the CRNA and 50% for the supervising anesthesiologist.

Supervision of a CRNA by the surgeon is not eligible for reimbursement.

Teaching Physicians:

Claims for supervision of residents and student nurse anesthetist should be submitted with proper Modifiers attached to the anesthesia codes. Reimbursement of the teaching physician must be submitted with Modifier QK when supervising three or four residents or student nurse anesthetists. Reimbursement will be reduced 50%. No payment is made to residents or student nurse anesthetists.

Multiple Anesthesia Services:

When multiple anesthesia services are performed during a single anesthetic administration, only the anesthesia code with the highest base unit value should be reported. The time reported is the combined total for all procedures.

The only exception to this rule is the anesthesia add-on codes used with burn excision/debridement and for deliveries. Anesthesia add-on codes must be billed with the appropriate primary code.

The total anesthesia time should be billed to the primary code, 01952, Anesthesia for second- and third-degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; between 4% and 9% of total body surface area. The Add-on code is 01953 - Anesthesia for second- and third-degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery. Each additional 9% total body surface area. This add-on code is reimbursed to a fee, not using the standard anesthesia reimbursement formula.

The add on codes listed below should be billed with the primary CPT code of 01967, neuraxial labor analgesia/anesthesia for planned vaginal delivery. The formula for anesthesia

reimbursement is applied to both the primary and add-on code. Actual anesthesia time for each service should be reported with each CPT code.

00851 - Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transaction
01968 - Anesthesia for cesarean delivery following neuraxial labor anesthetic
01969 - Anesthesia for cesarean hysterectomy following neuraxial labor anesthetic.

Qualifying Circumstances:

Qualifying circumstances CPT codes 99100 – 99140 are CMS status B codes and not eligible for reimbursement.

Epidural Management:

01996 - Daily hospital management of epidural or subarachnoid continuous drug administration, is reimbursed using a per day rate This code should be billed only in the hospital inpatient setting (place of service code 21) and is eligible for reimbursement once per date of service for up to three (3) postoperative days beginning the day after the surgery. Charges for four (4) or more days of this service may be reviewed for possible reimbursement. Code 01996 is not eligible for reimbursement on the day the epidural catheter was placed.

The pre-operative placement of an epidural catheter for postoperative pain relief is eligible for separate reimbursement to a provider other than the attending surgeon when:

1. the epidural catheter is not used as the primary surgical anesthetic, and
2. the appropriate epidural catheter code is submitted as a distinct procedural service, appended with Modifier 59.

The reimbursement made for the placement of an epidural catheter includes payment for all related professional service on that same date of service, including but not limited to: writing orders for medication, services related to the maintenance of the epidural catheter, services related to care of patient's pain and any injections of an anesthetic substance.

Nerve Blocks:

An epidural or peripheral nerve block injection for postoperative pain management in patients receiving general anesthesia, spinal (subarachnoid injection) anesthesia, or regional anesthesia by epidural injection may be administered preoperatively, intraoperatively, or postoperatively.

Nerve blocks administered by an anesthesiologist or CRNA as a component of the anesthesia are not eligible for separate reimbursement as they are considered a component of the anesthesia. Nerve blocks administered by an anesthesiologist or CRNA specifically for postoperative pain management are eligible for separate reimbursement. Modifier 59, XE or XU should be appended to the nerve block code.

When eligible for separate reimbursement, the nerve block code should be billed consistent with other non-anesthesia CPT codes and not billed using ASA units (base + time).

Anesthesia by Surgeon:

All methods of delivering anesthesia are not eligible for reimbursement, including but not limited to, nerve blocks, local, topical and regional anesthesia services, when provided by the same physician performing the medical or surgical service.

Stand-by Anesthesia:

Stand-by anesthesia (CPT Code 99360) or trauma team stand-by anesthesia do not provide direct patient care and therefore are not eligible for separate reimbursement.

Brief Emotional/Behavioral Assessment CPT 96127

Brief emotional or Behavioral assessments may be reimbursed. These services include assessments for depression, attention deficit/hyperactivity disorder (ADHD) with scoring and documentation per standardized instrument. This is used to identify behavioral health issues that may need to be addressed.

CPT 96127 can be billed on the same date of service as other common services such as psychiatry or therapy appointments and is appropriate when used as part of a standard clinical intake. Primary care and other specialists may use CPT code 96127 when screening and assessing their patients, up to four times per year per patient.

As appropriate, Modifier 59 (indicating that a procedure or service was distinct or independent from other services performed on the same day) should be billed in conjunction to the screening code. If multiple screenings are performed on a date of service CPT 96127 should be reported with the number of tests as the number of Units.

NOTE: Modifier 25 should be appended to the E/M and Modifier 59 should be appended to the 96127 CPT code.

Clinical Laboratory Improvement Amendment (CLIA)

This policy describes the information that is required on certain claims reported for laboratory services under the Clinical Laboratory Improvement Amendment (CLIA) 1988 statue and regulations. A valid CLIA Certificate Identification number will be required for reimbursement of clinical laboratory services reported on a CMS-1500 claim form or its electronic equivalent.

For electronic submissions:

Laboratory service providers must ensure the required CLIA information is submitted using the correct loops, segments, and associated line level qualifiers (X4 and F4). Refer to the ANSI X 12N 837 Professional Claim guidelines and the Medicare Claims Processing Manual Chapters 1, 16, 26, and 35 for further information.

All services in this policy may be subject to additional reimbursement policies, including but not limited to, CCI Editing Policy, the Laboratory Services Policy, and the Professional/Technical Component Policy.

Modifier QW:

Modifier QW – States the test performed are simple laboratory examinations and procedures that have an insignificant risk of error. They are considered CLIA waived tests/procedures.

Modifier QW should be reported when applicable laboratory service(s) is reported on a CMS 1500 claim form to evaluate the claim to determine eligibility for benefit coverage of the laboratory services based upon the CLIA certification.

Drug Testing

Presumptive Testing: A test used to detect the presence of a drug or drug class; they do not typically indicate a specific level of drug but rather give a positive or negative result.

Definitive Testing: A test, usually following a presumptive test, used to identify specific drugs or metabolites. Definitive drug tests are qualitative or quantitative tested used to identify specific drugs, specific drug concentrates, and associated metabolites. The test is usually performed in a laboratory or by a qualified health care provider.

Presumptive drug tests must be reported using procedure codes 80305-80307. Reimbursement for procedure codes 80305-80307 is limited to one unit per day. Only one of the four codes may be billed per day.

Definitive drug tests must be reported using procedure codes G0480, G0481 or G0659. Reimbursement for procedure codes G0480, G0481 or G0659 is limited to one unit per day. The units used to determine the appropriate code to bill is "drug class." The number of drug classes tested determines the appropriate code to use. Each drug class may only be used once per day. Only one of the three codes may be billed per day.

Modifiers:

Modifiers 59, XE, XP, XS, XU and 91 should not be reported with procedure codes 80305-80307, G0480, G0481 and G0659. These Modifiers will not bypass the edit.

Guidelines:

When covered by Health Plan, presumptive codes are eligible for reimbursement when testing is performed in an office, laboratory or facility setting. These codes are not eligible for reimbursement for chemical dependency facilities.

MotivHealth covers medically necessary presumptive drug tests for the following clinical indications:

- Suspected drug overdose, unreliable medical history, and an acute medically necessary situation. Medically necessary situations include, but are not limited to, unexplained coma, unexplained altered mental status, severe or unexplained cardiovascular instability, undefined toxic syndrome, and seizures with an undetermined history.

- Monitoring of a Member receiving COT (chronic opioid therapy) by a physician or other qualified health care professional (not related to substance abuse treatment). Decisions about which substances to screen for should be well documented and should be based on the following:
    - The Member's history of past drug use or abuse, the results of any physical examinations, and any of the Member's previous laboratory findings.
    - The Member's current treatment plan.
    - The Member's prescribed medication(s).
    - The Member's risk assessment plan.

- ñ Therapeutic drug monitoring (up to 12 units per calendar/plan year) used to evaluate compliance with long-term therapy for chronic conditions requiring medications with therapeutic levels (i.e., Lamictal for seizure control). Blood and/or urine testing may be ordered based on the drug therapy and the diagnosis. Test results are used to evaluate compliance with drug therapy and misuse or abuse of a prescribed medication. It is also used to adjust the prescribed medication dosage to achieve desired therapeutic results.

Testing performed as described below is not eligible for reimbursement:

- ñ Testing as required for, or in conjunction with, participation in substance abuse facilities, at higher levels of treatment, (e.g., residential, inpatient, partial hospitalization). Urine drug presumptive or definitive testing is considered included in the facility reimbursement.

- ñ Unbundled tests when using a multi-test kit screening (e.g. strip, dip card, or cassette).

- ñ Definitive testing as a routine supplement to drug screens, or in lieu of drug screens except when immunoassay testing is not commercially available.

- ñ Presumptive testing performed in conjunction with definitive immunoassay testing.

- ñ Standing orders for definitive testing also known as "custom profile."

- ñ Testing ordered by or for third parties (such as courts, schools, military or employers) or ordered for the sole purpose of meeting the requirements of a third party.

- ñ Specimen collection and preparation (included in reimbursement for the testing).

- ñ Routine billing of specimen validation is not eligible for reimbursement. (e.g. 81000, 81001, 81002, 81003, 81005, 81099, 82570, 83986 or any other code) This is because for all CPT codes in range 80305-80307 and G0480-G0483, G0659 the code description indicates that this testing is included if it is performed.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

MotivHealth will allow the cost of standard durable medical equipment (DME) or supplies as necessary to treat a medical condition. Additional charges for more elaborate or precision equipment or supplies shall be the responsibility of the Member.

**Preauthorization is required for equipment over $750.00.

DME/Medical Supplies general policy:

1. Used only to benefit in the care and treatment of an Illness or injury;
2. Durable and useful over an extended period of time;
3. Used only for a medical purpose rather than convenience or contentment;
4. Is prescribed by a Provider; and
5. Not used by other family Members for nontherapeutic purposes.

Limitations relating to DME/Medical Supplies:

1. One lens for the affected eye following eligible corneal transplant surgery. Contact lenses for documented Keratoconus may be approved as Medically Necessary.
2. One pair of ear plugs within sixty (60) days following eligible ear surgery.
3. Continuous Passive Motion (CPM) machine rentals may be approved for up to twenty-one (21) days rental only for total knee or shoulder arthroplasty.
4. All prosthetics must be prior authorized. Artificial eye prosthetic, when made necessary by loss from an injury or illness, the maximum prosthetic benefit available is one in a five (5) year period. The maximum breast prosthetic benefit available is one (1) per affected breast in a two (2) year period.
5. Wheelchairs require Preauthorization through Medical Case Management and are limited to one (1) power wheelchair in any five (5) year period.
6. Knee braces are limited to one (1) per knee in a three (3) year period.
7. Oxygen is for rental use only and Preauthorization is required.

DME Rental vs Purchase

Claims must indicate whether the DME item(s) is rented or purchased. Purchased equipment must specify whether it is new or used. If the claim does not indicate whether the item is new or used, the item will be denied for the appropriate Modifier.

A DME item that has been categorized by Centers for Medicare & Medicaid Services (CMS) on the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule as a capped rental (CR) item will be considered purchased and owned by the Member after ten (10) continuous rental months have been paid for the item. Rental charges received for the item after the 10th continuous month will be denied.

The following table indicates the Healthcare Common Procedure Coding System (HCPCS) Modifiers used to indicate rental or purchase status. Other Modifiers may be used in addition to those listed below to increase specificity.

Modifier Definition

LL	Lease/rental (use when DME equipment rental is to be applied against the purchase price)
NR	New when rented (use when an item that was new at the time of rental is subsequently purchased)
NU	New equipment
RR	Rental (use when DME is to be rented)
UE	Used durable medical equipment

In addition to this policy, claims payments are subject to other plan requirements, including, but not limited to, requirements of Medical Necessity and benefits coverage.

Emergency Department (ED)

Emergency department evaluation and management levels of service are based on the complexity of the visit including patient complaint, patient history, exam performed, diagnostic testing, and medical decision. The levels of service are level 1 through level 5 as listed below:

- ñ 99281 Level 1- Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor.

- ñ 99282 Level 2- Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.

- ñ 99283 Level 3- Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.

- ñ 99284 Level 4- Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.

- ñ 99285 Level 5- Emergency department visit 99285 is used for the evaluation and management of a patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

In view of the multi-tasking performed by emergency physicians, the ED code set does not have typical times assigned.

Modifier-25 always be appended to the ED E/M code (99281-99285) when provided on the same date as a diagnostic medical/surgical and/or therapeutic medical/surgical procedure(s).

Genetic Testing

Preauthorization is required prior to testing**.** Genetic counseling and BRCA 1 and BRCA2 mutation testing are covered preventive service for women who have not already been diagnosed with a cancer related to a mutation in BRCA1 or BRAC2 and who meet the USPSTF recommendations for testing.

Counseling services - 96040, 99401, 99402, 99403, 99404, or S0265
Genetic testing - 81211, 81212, 81213, 81214, 81215, 81216, 81217 or 81162

Also see Preventive Care Guidelines for more information on BRCA1/BRCA2 testing.

All other genetic testing is not reimbursable by MotivHealth.

Home Health, Home Infusion and Hospice

Coverage for Home Health, Home Infusion and Hospice are subject to contract benefits, Members coverage, and other limitations. Preauthorization is required.

See the list of codes for Home Health, Home Infusion and Hospice claim submission, it is not all inclusive. Claims must be submitted subject to the services rendered to the patient.

Home Health:

Home Health care is care provider in a patient's home by qualified personnel.

Home Health revenue code categories are:

- 055X Home Health - Skilled Nursing.
- 056X Home Health - Medical Social Services.
- 057X Home Health – Aide.
- 058X Home Health - Other Visits.
- 059X Home Health - Units of Service.
- 060X Home Health – Oxygen.

Physical and/or occupational therapy performed in the home is subject to the outpatient physical therapy or occupational plan limits. Refer to Rehabilitation Therapy for further information. Physical and occupational therapy revenue code categories are:

- 042X Physical Therapy
- 043X Occupational Therapy

Home Infusion:

Home infusion is the administration of medications or nutrition intravenously or through a feeding tube in a patient's home or a home infusion site.

Home Infusion CPT Codes are:

- S5497-S5523, S9325-S9379 (home infusion per diem codes);
- 99601 - Home infusion/specialty drug administration, per visit (up to 2 hours);
- 99602 - Home infusion/specialty drug administration, per visit (up to 2 hours); each additional hour (List separately in addition to code for primary procedure);
- 99199 - Unlisted special service, procedure or report;
- SH - Second concurrently administered infusion therapy;
- SJ - Third or more concurrently administered infusion therapy.

Hospice:

Hospice care (palliative care) is care provided to a terminally ill patient.

Hospice Revenue codes are:

- 0650 Hospice; General Classification.

- ñ 0651 Hospice; Routine Home Care.
- ñ 0652 Hospice Continuous Home Care.
- ñ 0655 Hospice Respite Care.
- ñ 0656 Hospice General Inpatient Care Non-Respite.
- ñ 0657 Hospice; Physician Services.
- ñ 0658 Hospice Room & Board – Nursing Facility.
- ñ 0659 Other Hospice Service.

Hospice care is eligible for reimbursement when the patient is no longer receiving any curative treatment, and is only receiving palliative care for pain relief, symptom control and comfort. Hospice claims must be submitted with a terminal ICD-10 diagnosis code.

Below is a list of services (including but not limited to) not eligible for reimbursement under Home Health, Home Infusion or Hospice care:

- ñ 24-hour a day care at home.
- ñ Meals delivered to home.
- ñ Homemaker services.
- ñ Custodial or Personal care.
- ñ Respite Care.
- ñ Home Health Aides.
- ñ Total Parenteral Nutrition through hospice care.
- ñ Private Duty Nursing.

Implants and Implant Components

Implant: An object, device or material that is inserted surgically, or embedded via surgical or nonsurgical means, or grafted into the body and remains in the body either indefinitely for prosthetic and/or therapeutic purposes or remains in the body for a period of time for diagnostic and/or therapeutic purposes.

Implant Components: Implant integral parts (i.e. screws, plates, rods) remaining in the body used in conjunction with the primary implant.
Implant Supplies: Elements (i.e., supplies and/or tools) of implant kits or implant systems used to place or remove implants, but do not remain in the body.

For claims with case reimbursement payment methodology at the time of service, implants and implant components implanted or remaining in the patient will not be considered for separate reimbursement.

For claims paid to any other reimbursement methodology, implants and implant components implanted or remaining in the patient will be paid according to the stipulations of the contract our health plan has with the provider at the time of service.

Notwithstanding the above, implants and implant components are not eligible for separate reimbursement when:

- Implants, implant components are opened and then found to be incorrect and not used.
- Implants, implant components that are inadvertently dropped from the sterile field and cannot be used again.
- Implants or implant components that are implanted then removed (i.e., implant screw removed and replaced when the wrong length of screw is used on a plate).
- Implants or implant components that malfunction and are replaced during implantation.

Implant supplies are not eligible for separate reimbursement.

Examples of non-reimbursable implant supplies include, but are not limited to:

- Specialized implant placement instruments (i.e. forceps, scissors, needle holder or other instruments).
- Specialized drill bits saw blades and others.

Notwithstanding the above, medical/surgical supplies that are used as part of the surgical procedure or are not separately reimbursable.

Examples of non-reimbursable medical/surgical supplies include, but are not limited to:

- ñ Anesthesia supplies.
- ñ Monitoring supplies (i.e. temperature, EKG leads, BP cuffs, O2 saturation monitors), catheters and stethoscopes.
- ñ Casting and splinting supplies.
- ñ Gowns (surgical and patient), surgical gloves.
- ñ Heparin, saline flushes and any type of IV flush or diluent to administer substances or drugs.

- ñ Intravenous supplies.
- ñ Leg compression system.
- ñ Needles (sterile), syringes, dressings, gauze, tape.
- ñ OR packs, procedural trays.
- ñ Skin prep, towels, drapes.
- ñ Staplers (surgical), sutures and skin glue.
- ñ Suction/irrigation supplies and additives.
- ñ Surgical instruments, including forceps, scissors, needle holder or other instruments whether reusable or not.
- ñ Vascular clips, hemostatis agents (i.e., Flowseal).
- ñ Programming of medical device or supply.

Invoice submission is required for reimbursement on all implants and implant components.

Laboratory Services

This policy describes the reimbursement methodology for laboratory panels, Component Codes, venipuncture services, laboratory services performed in a facility setting, laboratory handling, surgical pathology, clinical pathology consultants, and drug assay codes. This policy addresses the place of service and date of service as related to laboratory services.

Not all laboratory codes will be addressed. Codes not addressed in this policy may be subject to additional reimbursement policies, including but not limited to, CCI Editing Policy, the Clinical Laboratory Improvement Amendment Policy, and the Professional/Technical Component Policy.

Laboratory Modifiers:

Modifier 90- Reference or Outside Laboratory: When laboratory procedures are performed by a party other than the treating or reporting physician or other qualified health care professional, the procedure may be identified by adding Modifier 90 to the usual procedure code.

Modifier 91- Repeat clinical diagnostic laboratory test as used to report the same lab test when performed on the same patient, on the same day, to obtain subsequent test results. (Not to be confused with Modifier 59 -distinct procedural service- which states service is performed at a different anatomic site or at a different session but on the same date).

Place of Service:

Place of service (POS) designation identifies the location where the laboratory services were rendered.

Maternity Care

Maternity care includes antepartum care, delivery services and postpartum care. This policy describes reimbursement for global obstetrical (OB) codes and itemization of maternity care services. This policy also indicates what services are and are not separately reimbursable to other maternity care services.

Global OB Care:

The total obstetric care package includes the provision of antepartum care, delivery services and postpartum care. When the same group physician and/or other health care professional provides all components of the OB package, report the Global OB package code.
The CPT's for Global OB codes are:

59400 – Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care

59510 – Routine obstetric care including antepartum care, cesarean delivery, and postpartum care

59610 – Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery

59618 – Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

Billing Guidelines:

The global maternity allowance is a complete, one-time billing which includes all professional services for routine antepartum care, delivery services, and postpartum care.

The fee is reimbursed for all the Member's obstetric care to one provider.
If the Member is seen four or more times prior to delivery for prenatal care and the provider performs the delivery and performs the postpartum care, then the provider must bill the Global OB code.

Global maternity billing ends with release of care during the six (6) week follow up appointment after delivery. Global OB care should be billed after the delivery date/on delivery date.

Services included in global obstetrical package:

- Routine prenatal visits until delivery, after the first three antepartum visits.
- Recording of weight, blood pressures and fetal heart tones.
- Admission to the hospital including history and physical.
- Inpatient Evaluation and Management (E/M) service provided within twenty-four (24) hours of delivery.
- Management of uncomplicated labor.
- Vaginal or cesarean section delivery.
- Delivery of placenta (CPT code 59414).
- Administration/induction of intravenous oxytocin (CPT code 96365-96367).

- Insertion of cervical dilator on same date as delivery (CPT code 59200).
- Repair of first- or second-degree lacerations.
- Simple removal of cerclage (not under anesthesia).
- Uncomplicated inpatient visits following delivery.
- Routine outpatient E/M services provided within forty-two (42) days following delivery.
- Postpartum care after vaginal or cesarean section delivery (CPT code 59430).

The above-mentioned services are not separately reimbursed when reported separately from the global OB code.

As per ACOG (American College of Obstetricians and Gynecologists) coding guidelines, reporting of third- and fourth-degree lacerations should be identified by appending Modifier 22 to the global OB code (CPT codes 59400 and 59610) or delivery only code (CPT codes 59409, 59410, 59612 and 59614). Claims submitted with Modifier 22 must include medical record documentation that supports the use of Modifier.

Services Excluded from the Global Obstetrical Package:

The following services are excluded from the global OB package (CPT codes 59400, 59510, 59610, 59618) and may be billed separately.

- ñ First three antepartum E/M visits.
- ñ Laboratory tests (other than urinalysis CPT codes 81000 and 81002).
- ñ Maternal or fetal echography procedures (CPT codes 76801, 76802, 76805, 76810, 76811, 76812, 76813, 76814, 76815, 76816, 76817, 76820, 76821, 76825, 76826, 76827 and 76828).
- ñ Amniocentesis, any method (CPT codes 59000 or 59001).
- ñ Amniofusion (CPT code 59070).
- ñ Chorionic villus sampling (CPT code 59015).
- ñ Fetal contraction stress test (CPT code 59020).
- ñ Fetal non-stress test (CPT code 59025).
- ñ External cephalic version (CPT code 59412).
- ñ Insertion of cervical dilator (CPT code 59200) more than twenty-four (24) hours before delivery.
- ñ E/M services which are unrelated to the pregnancy (e.g. UTI, Asthma) during antepartum or postpartum care.
- ñ Additional E/M visits for complications or high-risk monitoring resulting in greater than the typical 13 antepartum visits. However, these E/M services should not be reported until after the patient delivers. Append Modifier 25 to identify these visits as separately identifiable from routine antepartum visits.
- ñ Inpatient E/M services provided more than twenty-four (24) hours before delivery
- ñ Management of surgical problems arising during pregnancy (e.g. Cholecystectomy, appendicitis, ruptured uterus).
- ñ Cerclage removal under anesthesia (CPT code 59871)

Non-global OB care, or partial services:

Non-global OB care, or partial services, refers to maternity care not managed by a single provider or group practice. Billing for non-global OB or partial care may occur if:

- A patient transfer into or out of a physician or group practice.

- A patient is referred to another physician during her pregnancy.
- A patient has the delivery performed by another physician or other health care. professional not associated with her physician or group practice.
- A patient terminates or miscarries her pregnancy.
- A patient changes insurer during her pregnancy.

The physician provides only partial services instead of global OB care may bill for that portion of maternity care only. Use the codes below for billing antepartum-only, postpartum-only, delivery-only, or delivery and postpartum only services.

Only one of the following options should be used, not a combination.

A. Antepartum care only:

- For 1 to 3 visits: Use E/M office visit codes.
- For 4 to 6 visits: Use CPT 59425, This code must not be billed by the same provider in conjunction with one to three office visits, or in conjunction with code 59426.
- For 7 or more visits: Use CPT 59426 – Complete antepartum care is limited to one beneficiary pregnancy per provider.

Billing Guidelines:

As per ACOG and AMA guidelines, the antepartum care only codes 59425 or 59426 should be reported as described below,

- A single claim submission of CPT code 59425 or 59426 for the antepartum care only, excluding the confirmatory visit that may be reported and separately reimbursed when the antepartum record has not been initiated.
- The units reported should be one.
- The dates reported should be the range of time covered, e.g. If the patient had a total of 4-6 antepartum visits, then the physician should report CPT code 59425 with the “from” and “to” dates for which the services occurred.
- CPT 59425 and 59426 – These codes must not be billed together by the same provider for the same beneficiary, during the same pregnancy.
- Pregnancy related E/M office visits must not be billed in conjunction with code 59425 or 59426 by the same provider for the same beneficiary, during the same pregnancy.

B. Delivery services only:

The following are the CPT codes for delivery services only-

59409 – Vaginal delivery only (with or without episiotomy and/or forceps).

59514 – Cesarean delivery only.

59612 – Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps).

59620 – Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery.

The delivery only codes should be billed by the same group physician for a single gestation when:

- The total OB package is not provided to the patient by the same physician or group practice.
- Only the delivery component of the maternity care is provided, and the postpartum care is performed by another physician or group of physicians.

The following services are included in the delivery only service and are not separately reimbursable:

As CPT and ACOG guidelines the following services are included in the delivery services codes and should not be billed separately.

- Admission to the hospital.
- The admission history and physical examination.
- Management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery, external and internal fetal monitoring provided by the attending physician.
- Intravenous induction of labor via oxytocin (CPT code 96365-96367).
- Delivery of the placenta, any method.
- Repair of first- or second-degree lacerations.
- Insertion of cervical dilator (CPT 59200) to be included if performed on the same date of delivery.

Reporting of third- and fourth-degree lacerations should be identified by appending Modifier 22 to the global OB code (CPT codes 59400 and 59610) or delivery only code (CPT codes 59409, 59410, 59612 and 59614).

Claims submitted with Modifier 22 must include medical record documentation which supports the use of Modifier.

C. Delivery only including postpartum care:

If the same physician or same physician group performs the delivery and postpartum care, the physician should bill one of the following CPT codes defined below:

59410 – Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care

59515 – Cesarean delivery only; including postpartum care

59614 – Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care

59622 – Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care

The following services are included in the delivery only, including postpartum care services and are not separately reimbursable:

- Hospital visits related to the delivery during the delivery confinement.

- Uncomplicated outpatient visits related to the pregnancy.
- Discussion of contraception.

D. Postpartum Care Only:

59430 – Postpartum care only (separate procedure)

The following services are included in the postpartum care services and are not separately reimbursable:

- Uncomplicated outpatient visits related to the pregnancy.
- Discussion of contraception.

The following services are excluded in the postpartum care services and are not separately reimbursable:

- E/M of problems or complications related to the pregnancy.

Billing Guidelines:

The postpartum care only should be reported by the same group physician provides the patient with services of postpartum care only.

If a physician provides any component of antepartum along with postpartum care, but does not perform the delivery, then the services should be itemized by using the appropriate counterpart care code and postpartum care code.

Twin Deliveries:

Reimbursement for twin deliveries follow ACOG's coding guidelines for vaginal, cesarean section, or a combination of vaginal and cesarean section deliveries. See below for the appropriate billing of twin births.

Vaginal	Baby 1	59400
	Baby 2	59409-59
VBAC*	Baby 1	59610
	Baby 2	59612-59
Cesarean Delivery	Baby 1 and Baby 2	59510
Repeat Cesarean Delivery	Baby 1 and Baby 2	59618
Vaginal + Cesarean Delivery	Baby 2	59510
	Baby 1	59409-51
VBAC* + Repeat Cesarean Delivery	Baby 2	59618
	Baby 1	59612-51

*VBAC - Vaginal birth after cesarean

If increased physician work involvement for delivery of the second baby, Modifier 22 is added to the global cesarean code (59510 or 59618). Claims submitted with Modifier 22 must include medical records to support the use of Modifier.

Fetal Non-Stress Test on Twin Gestations

:

Per coding guidelines, multiple non stress tests performed on twin gestations should be reported as indicated below:

- ñ Initial test for the first fetus is reported using CPT code 59025. If a subsequent test is performed on the same fetus, report CPT code 59025 a second time with Modifier 76, to identify the repeated procedure by the same physician; or with Modifier 77, to identify that the non-stress test was repeated by another physician.
- ñ The initial test for the second fetus is reported using CPT code 59025 with Modifier 59 added, to identify that a separate fetus is being evaluated. If subsequent testing is performed on the second fetus, CPT 59025 with Modifier 59 is reported a second time with Modifier 76, to identify the repeated procedure by the same physician; or with Modifier 77, to identify that the non-stress test was repeated by another physician.

Laboratory Tests:

Per ACOG coding guidelines, both laboratory tests below are included in the global antepartum or global OB service when submitted with an OB diagnosis code in an office setting.

- ñ 81000 Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy.
- ñ 81002 Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy.

Assistant Surgeon and Cesarean Sections:

Only a non-global cesarean section delivery code (CPT 59514 or 59620) is a reimbursable service when submitted with an appropriate assistant surgeon Modifier. See “Assistant Surgeon Policy” for Modifiers and reimbursement.

Prolonged Physician Services:

Prolonged physician services for labor and delivery services are not reimbursable services. CPT codes 99354, 99355, 99356, 99357, 99358, 99359, 99415, and 99416, are add-on codes used in conjunction with E/M codes. As described in ACOG coding guidelines, prolonged services are not reported for services involving indefinite periods of time such as labor and delivery management.

Multiple Procedure Reductions:

Multiple Procedure Reductions will be applied to OB codes having a delivery component for both vaginal and cesarean sections. Refer to Multiple Procedure Policy.

Preauthorization for Inpatient Maternity Services:

Any inpatient maternity stay that exceeds forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following delivery by cesarean section requires preauthorization. See Preauthorization & Care Management Policy for further information.

Medical Orders

Every treatment, procedure or admission requires a medical orders meet the requirements below.

Criteria for an Order

- Justification for the treatment, procedure, or admission,
- Expected length of stay for inpatient admissions,
- Signed by practitioner with authorization to sign and sufficient knowledge of the patient's condition at the time of treatment, procedure, or admission,
- Date order was signed,
- Documented in the medical record prior to hospital discharge or initiation of treatment or procedure.
- Orders may not be retrospective,
- Orders for inpatient admission may not be a standing order.

Authorization to Sign

The order must be signed by any one of the following practitioners:

- Doctor of medicine or osteopathy licensed by the state to perform services or admit inpatients and have been granted privileges by the facility to admit in the case of inpatient admissions,
- Dentist or dental surgeon as functioning as admitting physician of record for major dental procedure performed at an inpatient facility,
- Doctor of podiatric medicine (if authorized under state law) and must be responsible for the patient or have sufficient knowledge of the case and be authorized to certify.
- Medical residents, physician assistants, nurse practitioners, other non-physician practitioners or practitioners without admitting privileges may act as a proxy if authorized under state law and ordering physician approves and accepts the decision and countersigns prior to initiation of the treatment/procedure or prior to discharge in the event of an inpatient admission.

Defining Sufficient Knowledge

MotivHealth considers the following hospital staff to have sufficient knowledge to write an order for an inpatient admission:

- Admitting physician of record
- Surgeon or physician on-call
- Surgeon responsible for major procedure
- Dentist functioning as admitting physician of record or surgeon for major dental procedure
- Non-physician/non-dentist admitting practitioner licensed by state/ privileged by facility and on call for primary care practitioner
- ED physician

- ñ Primary or covering hospitalist

Any of the above practitioners whose knowledge of the patient is solely derived from a medical record review does not suffice as a practitioner with sufficient knowledge. Claims with orders for inpatient admissions signed by such practitioners will be denied.

Verbal Orders

Practitioners without admitting authority such as nurses may be permitted to accept and record verbal orders at their facility. The ordering practitioner must directly communicate the order and must countersign the order as written to authenticate it prior initiation of the treatment or procedure and, in the case of an inpatient admission, prior to discharge. MotivHealth will comply with state laws, hospital policies and bylaws if its policies contravene any statutes or regulations.

References

42 CFR § 424.13 - Requirements for inpatient services of hospitals other than inpatient psychiatric facilities.

Observation Care Evaluation and Management Codes

Observation Care- Evaluation and management services provided to patients designated as “observation status” in a hospital. This refers to the initiation of observation status, supervision of the care plan for observation and performance of periodic reassessments.

Observation evaluation and management (E/M) CPT codes are used to report observation services provided to patients under observation. CPT Codes 99224-99226.

Initial Observation Care:
CPT Codes 99218-99220

To report observation care codes, the physician must:

- ñ Indicate in the patient’s medical record that the patient is designated or admitted as observation status;
- ñ Clearly document the reason for the patient to be admitted to observation status; and
- ñ Initiate the observation status, assess, establish, and supervise the care plan for observation and perform periodic reassessments.

The CPT codebook states that "When ‘observation status’ is initiated in the course of an encounter in another site of service (e.g., hospital emergency department, office, nursing facility) all evaluation and management services provided by the supervising physician or other qualified health care professional in conjunction with initiating ‘observation status’ are considered part of the initial observation care when performed on the same date and should not be bill separately. The observation care level of service reported by the supervising physician or other qualified health care professional should include the services related to initiating ‘observation status’ provided in the other sites of services as well as in the observation setting.”

We follow the Centers for Medicare and Medicaid Services (CMS) Claims Processing Manual which provides the instructions to “pay for initial observation care billed by only the physician who ordered hospital outpatient observation services and was responsible for the patient during his/her observation care. A physician who does not have inpatient admitting privileges but who is authorized to furnish hospital outpatient observation services may bill these codes.

For a physician to bill observation care codes, there must be a medical observation record for the patient which contains dated and timed physician’s orders regarding the observation services the patient is to receive, nursing notes, and progress notes prepared by the physician while the patient received observation services. This record must be in addition to any record prepared as a result of an emergency department or outpatient clinic encounter."

Consistent with CMS guidelines, we require that an initial Observation Care CPT code, 99218-99220, should be reported for a patient admitted to Observation Care for less than eight (8) hours on the same calendar date.

Subsequent Observation Care:
CPT Codes 99224-99226

In the instance that a patient is held in observation status for more than two (2) calendar dates, the supervising physician should utilize a subsequent Observation Care CPT code, 99224 -

99226. Physicians other than the supervising physician providing care to a patient designated as “observation status” should report subsequent Observation Care.

According to the CPT codebook, “All levels of subsequent observation care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient’s status (i.e., changes in history, physical condition, and response to management) since the last assessment.

Observation Care Discharge Services:
CPT Code 99217

This code is to be reported for all services provided to a patient on discharge from outpatient hospital observation status if the discharge date is other than the initial date of observation status.

Observation Care Admission and Discharge on Same Date:
CPT Code 99234-99236

Report CPT codes 99234-99236 for same-date admission and discharge of observation care. The patient must be in observation status at least eight (8) hours (but less than twenty-four (24) hours since it must be on the same date) for a physician to bill same date admission and discharge code. If the patient is discharged after fewer than eight hours in observation status, bill only an initial observation care code, 99218-99220.

According to the CPT Code book, “Hospital observation or inpatient care service in cases where the patient is admitted and discharged on the same date of service by the supervising or qualified clinician is reported with 99234-99236. Observation status includes the supervision of the care plan for observation as well as the periodic reassessments. The patient is not required to be physically located in a designated observation area within a hospital; however, if such an area is utilized, these codes should be reported. When a patient is admitted to the hospital from observation status on the same date of service, the clinician should only report the appropriate level of initial hospital care code. The level of care reported should reflect all of the other services from the observation status services the clinician rendered to the patient on the same date of service as well as those provided in the actual inpatient setting. Codes do not differentiate between new or established patients. Under this care category, there are three levels represented by 99234, 99235, and 99236. All of these levels require all three key components-history, exam, and medical decision making-to be documented.”

99234 - The lowest level of care required. A detailed or comprehensive history and exam as well as straightforward medical decision making or that of low complexity with approximately 40 minutes time being spent at the patient's bedside and on the patient's floor or unit.

99235 - Moderate level of care required. A comprehensive history; a comprehensive examination; and Moderate complexity medical decision making with approximately 50 minutes time being spent at the patient's bedside and on the patient's floor or unit.

99236 - Highest-level of care. A comprehensive history; a comprehensive examination; and High complexity medical decision making with approximately 55 minutes time being spent at the patient's bedside and on the patient's floor or unit.

Observation care does not require preauthorization if less than 24 hours. Any observation care 24 hours and over requires preauthorization.

Observation admission is appropriate if the patient's condition can be evaluated or treated within 24 hours and/or rapid improvement of the patient's condition is anticipated within 24 hours.

Example of correct coding- A patient is admitted to observation status on one date and then admitted as an inpatient for two additional days

An initial observation care CPT Code 99218-99220 for the first day of observation status. Any E/M services in another setting, either office or emergency department, that are related to the admission to observation status cannot be billed separately, they are considered part of the initial observation care service.

An initial inpatient/ hospital care code, 99221-99223, on the second day when the patient is admitted to the hospital inpatient status. Observation discharge service code, CPT 99217, cannot be reported in conjunction with a hospital admission.

A hospital discharge service code, CPT 99238-99239, for the third day.

Positive Airway Pressure (PAP) and Supplies

The positive airway pressure (PAP) devices used for respiratory ventilation primarily in the treatment of sleep apnea are listed below. The appropriate Modifier(s) need(s) to be billed in conjunction with HCPCS code.

E0601 - Continuous airway pressure (CPAP/APAP) device.

E0470- Respiratory assist bi-level pressure (BiPAP) capability without backup rate feature used with noninvasive interface.

E0471- Respiratory assist bi-level pressure (BiPAP) capability with backup rate feature used with noninvasive interface.
E0472- Respiratory assist bi-level pressure (BiPAP) capability with backup rate feature used with invasive interface.

Modifiers must be used to denote rental of equipment:

Modifier	Definition
LL	Lease/rental (use when DME equipment rental is to be applied against the purchase price)
RR	Rental (use when DME is to be rented)

Preauthorization is required for new device. CPAP and BiPAP devices will be reimbursed on a ten (10) month rental, allowed amount not to exceed purchase price. Claims submitted with future dates of service will not be considered for processing. The devices may be eligible for replacement every five (5) years.

Accessories used with PAP devices may be covered if the device is medically necessary. We follow the Centers for Medicare & Medicaid Services (CMS) Local Coverage Determinations (LCD) to determine the quantities and frequencies for PAP accessory purchases.

Preventive Services

MotivHealth covers certain recommended preventive services identified by United States Preventive Services Task Force (USPSTF), Women's Preventive Services Initiative (WPSI) and Health and Human Resources (HHS). Below is a detailed list of services covered under the Preventive Care Benefit. Please check the Member specific benefit policy for coverage prior to adhering to this guideline.

Preventive Service	Description	Diagnosis Code - ICD 10	CPT®/HCPCS Code
Infants & Children			
Pediatric Preventive Visits	11 visits from birth through 35 months Annual visit after 36 months.	Z00.110-Z00.111 Z00.121-Z00.3	99381-99397 Laboratory tests including but not limited to urinalysis tests 81099-81050, 80050, 80053, 85025,
Vision Screening	1 per calendar year through age 21.	Z00.121-Z00.129 Z01.00-Z01.01	99173
Hearing Screening	1 per calendar year through age 21.	Z01.10, Z01.118, Z00.110-Z00.129	92551, 92552
Developmental/ Autism Screening	1 per calendar year through age 2.	Z00.110-Z00.129, Z13.41, Z13.42, Z13.31	96110, 96127
Depression Screening	USPSTF recommends screening for children and adolescents Ages 12-18.	Z13.31, Z13.32	96127, G0444
Counseling, Risk Factor Reduction, and Behavior Change Intervention		Z28.3, Z71.3, Z71.82, Z71.89, Z71.9	99401-99404
Intensive Behavioral Interventions for Obesity	Available for intensive behavioral interventions for obesity beginning at age 6-19.	Z00.00-Z00.01 E66.01-E66.2, E66.8-E66.9	Screening included in preventive visit, 99201-99215, 99401-99404, 99411-99412, 97802, 97803, 97804 G0447 (limited to once per year), G0473, S9470
Hematocrit or Hemoglobin	Up to 24 months (age 2).	Z13.0	85013 or 85014 or 85018
Lead Screening Assessment	Up to Member's 7th birthday	Z00.121, Z00.129, Z77.011, Z13.88	83655

Tuberculin Test	Recommended by USPSTF up to age 21.	Z00.129, Z20.1, Z00.121, Diagnosis code requirements for 99211- Z11.1, R76.11, R76.12	86580, Follow up Visit 99211.
Cholesterol Screening (Dyslipidemia Screening)	1 every 5 years.	Z00.121, Z00.129, Z13.220	80061 82465, 83718, 83719, 83721, 83722, 84478
Newborn Screening	Age 0-90 days USPSTF recommends hearing screening, hypothyroidism screening, phenylketonuria (PKU) screening, and sickle cell screening for all newborns. Includes facility, office, and laboratory claims.	No diagnosis code requirements	Hearing Screening: 92551, 92558, 92585, 92586, 92587, 92588, V5008 Hypothyroidism Screening 84437, 84443, PKU Screening 84030, S3620, Sickle Cell Screening 83020, 83021, 83030, 83033, 83051, S3850
Metabolic Screening Panel (Newborn)	Age 0-90 days Includes facility, office, and laboratory claims.	No diagnosis code requirements	82017, 82136, 82261, 82775, 83020, 83498, 83516,84030, 84437, 84443, S3620
Oral Health	Oral health screenings by a primary care provider and referral to a dentist at the appropriate age.	Assessment Included in Well Child Care preventive visit	
Prevention of Dental Caries in Children	Primary care clinicians may prescribe oral fluoride supplementation starting at age 6 months through age 16 for children whose water supply is deficient in fluoride. Over-the-counter fluoride tablets will be non-covered. Primary Care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption through age 5.	Prescription required for oral fluoride supplementation. Handled through the pharmacy benefit. D1206 99188	

Adult/Adolescent Preventive Services			
Annual Visit	Includes an age and gender appropriate history; physical examination; counseling, anticipatory guidance, or risk factor reduction interventions; and the ordering of laboratory or diagnostic procedures.	Z00.00, Z00.01	99381-99397 Laboratory tests including but not limited to urinalysis tests 81099-81050, 80050, 80053, 85025
Screening for Diabetes	Screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.	Z00.00, Z00.01, Z13.1	82947, 82948, 82950, 82951 or 83036
Counseling for sexually transmitted infections (STI)		Z00.00-Z00.01, Z71.7, Z71.89, Z72.51-Z72.53	Included in Preventive office visit or 99401-99404 if sole service
Counseling and screening for human immune deficiency virus (HIV)	Screening for HIV recommended for all pregnant women, adolescents and adults at increased risk for HIV infection.	Z00.00, Z00.01, Z00.121, Z00.129, Z11.3, Z11.4, Z11.59, Z11.9, Z20.6, Z22.6, Z22.8, Z22.9, O09.00-O9A.53 Z36.89, Z34.00-Z34.93	86701 or 86703 or 86689 or 87389 or 87390 or 87534 or 87535 or G0432 or G0433 or G0435 Counseling included in preventive office visit or 99401-99404 if sole service
Alcohol and Drug Use Assessment	Annual Screening in primary care settings.	Z13.89	99408, 99409, G2011, G0396, G0397, G0442, G0443 if sole service or included in preventive office visit
Sexually Transmitted Disease Testing Chlamydial Infection	USPSTF recommends screening for sexually active women age 24 years and younger and in older women who are at increased risk for infection.	Z00.00, Z00.01, Z00.121, Z00.129, Z11.3, Z11.8, Z11.9, Z20.2, O09.00-O9A.53 Z34.00-Z34.93 Z36.89	86631, 86632, 87110, 87270, 87490, 87491, 87492, 87810, 87320
Gonorrhea	The USPSTF recommends screening for gonorrhea in sexually active women age 24 years and younger and in older women who are at increased risk for infection.	Z00.00, Z00.01, Z00.121, Z00.129, Z11.3, Z11.8, Z11.9, Z20.2, Z11.3, O09.00-O9A.53	87590 or 87591 or 87850

	Note: Bright Futures recommends sexually transmitted infection screening be conducted if risk assessment is positive between ages 11 years – 21 years.	Z36.89 Z34.00-Z34.93	
Syphilis	The USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection. The USPSTF recommends early screening for syphilis infection in all pregnant women.	Z00.00, Z00.01, Z00.121, Z00.129, Z11.3, Z11.8, Z11.9, Z20.2, Z11.3, O09.00-O9A.53 Z36.89 Z34.00-Z34.93	80055, 86592, 86780
Colorectal Cancer Screening	Screening for colorectal cancer using fecal occult blood testing or FIT on an annual basis, FIT-DNA every 3 years or sigmoidoscopy every 5 years or colonoscopy every 10 years recommended in adults beginning at age 50 and continuing until age 75. Includes related pathology and prescription bowel prep meds.	Z83.71, Z12.11, Z80.0	82270, 82274, 81528, 45330, 45331, 45333, 45334, 45338, 45339, 45378, 45380, 45382, 45383, 45384, 45385, 45388, 45390, 81528, 82270, 82274
Aspirin 81 mg when prescribed	Use of aspirin for men ages 45-79 or women ages 55-79 when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.	Prescription required. Handled through the pharmacy benefit.	
Depression Screening	Screening of adolescents and adults when adequate systems in place to ensure accurate diagnosis, effective treatment and follow-up.	Z13.31, Z13.32	96127, G0444
Behavioral Counseling	Licensed Registered Dietician visits are available up to 4 visits per year for hyperlipidemia and 2 visits per year for hypertension.	(obesity) E66.01-E66.2, E66.8-E66.9 (HTN)I10-I15.9, I67.4, O10.011-O11.9, O13.1-O13.9, O16.1-O16.9 (Chol) E78.0-E78.5	Counseling Included in Preventive office visit or 99401-99404 if sole service. LRDs use 97802, 97803, 97804.

Lipid Disorders (Cholesterol Screening)	1 every 5 years age 40-75	Z00.00, Z00.01, Z13.220	80061, 82465, 83718, 83719, 83721, 83722, 84478
High Blood Pressure Screening	USPTF recommends screening for high blood pressure in adults age 18 years or older. USPTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.	Z13.6, Z00.00-Z00.01	Screening included in preventive visit. Ambulatory Blood Pressure Monitoring 93784, 93786, 93788 or 93790
Intensive Behavioral Interventions for Obesity	Available for intensive behavioral interventions for obesity with a body mass index of 30 or higher.	Z00.00-Z00.01 E66.01-E66.2, E66.8-E66.9	Screening included in preventive visit, 97802, 97803, 97804 (req body mass index 30.0-39.9) G0447 (limited to once per year), G0473, S9470
Tobacco Counseling	2 quit attempt cycles per year. A quit attempt cycle includes 4 counseling visits and/or a 3-month supply of nicotine or non-nicotine replacement therapy.	Z71.6, Z72.0, F17.200-F17.299	99406, 99407 if sole service or included in preventive visit
TB Test	Screening for Latent Tuberculosis Infection	Z11.1	86580, 86480, 86481
Prevention of Falls in Community-Dwelling Older Adults	Exercise or physical therapy to prevent falls in community-dwelling adults aged 65 years or older who are at risk for falls.	Z91.81	97001-97002; 97110-97112, 97116; 97150; 97530 to address the interventions specified by the USPSTF.
Hepatitis C Virus (HCV)	Screen 1 time for HCV infection if: Born between 1945 and 1965; or Ever injected drugs; or received a blood transfusion before 1992.	Injectable drug dependence or in remission code from FXX range. Z11.59, Z72.51-Z72.53, Z22.52	86803, 86804, G0472
Hepatitis B Virus Infection in Nonpregnant Adolescents and Adults	Screen for hepatitis B virus (HBV) infection in persons at high risk for infection.	Z11.59, Z22.51	86704, 86706 87340, 87341

Screening for Lung Cancer	One per year, age 55-80, at least 30 pack-year of smoking history and/or current smoker or have quit within last 15 years.	Z12.2, Z87.891 F17.210-F17.219	G0297
Women's Preventive Services			
Annual visit	Includes an age and gender appropriate history; physical examination; counseling, anticipatory guidance, or risk factor reduction interventions; and the ordering of laboratory or diagnostic procedures.	Z00.00-Z00.01, Z01.411, Z01.419	99381-99387; 99391-99397 Laboratory tests including but not limited to urinalysis tests 81099-81025, 80050, 80053, 85025
Cervical Cytology (Pap Smear)	Screening for cervical cancer. 1 per Calendar year (No age restriction).	No diagnosis code requirements	G0101, G0123,G0124, G0141, G0143,G0144, G0145, G0147,G0148, P3000, P3001, Q0091
Cervical Cytology Laboratory	The USPSTF recommends screening every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology.	Z00.00, Z00.01, Z01.411, Z01.419, Z12.4	88141, 88142, 88143, 88147,88148, 88150, 88152, 88153, 88155, 88164, 88165, 88166, 88167, 88174, 88175
Human Papillomavirus (HPV) Testing	USPSTF recommends screening every 3 years beginning at age 30.	Z00.00, Z00.01, Z01.411, Z01.419, Z11.51, Z12.4	0500T, 87624, 87625, G0476
Screening and Counseling for Interpersonal and Domestic Violence	HRSA Recommends screening adolescents and women for interpersonal and domestic violence at least annually, and, when needed, providing or referring for initial intervention services.	Z00.00-Z00.01, Z01.411, Z01.419	Included in Preventive office visit or 99401-99404 if sole service
Counseling for sexually transmitted infections.	Annual Counseling on sexually transmitted infections for all sexually active women.	Z72.51-Z72.53, Z00.01, Z71.7	Included in Preventive office visit or 99401-

			99404 if sole service
Contraception	HRSA Requirement contraceptive care. No coverage for brochures or educational materials.	Z00.00-Z00.01, Z01.411-Z01.42, Z30.011-Z30.42, Z30.430-Z30.431, Z30.433-Z30.9	S0610, S0612, S0613, A4261, A4264, J7300, J7302, J7306, J7307, S4981, S4989, 11976, 11980, 11981, 57170, 58300, 58301, 58565, 58600, 58605, 58611, 58615, 58670, 58671, 96372 w/J1050. Including pregnancy test 81025.
Breast Cancer Screening; Screening mammography	USPSTF recommends 1 Screening mammography every 1-2 years for women age 40 with or without clinical breast examination.	No diagnosis code requirements	77063, 77067, Revenue Code 0403
Breast and Ovarian Cancer Susceptibility, Genetic Risk Assessment	BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing. **Preauthorization is required**.	Z80.3, Z80.41	BRCA test - 81162, 81163, 81164, 81212, 81165, 81166, 81215, 81216, 81167, 81217, 81432, 81433. Genetic counseling 96040, S0265, 99401-99404 or E/M CPT Code.
Osteoporosis Screening	Screening to measure bone mass for risk of osteoporosis once every 2 years, women over 65 years and older.	Z00.00, Z00.01, Z13.820, Z82.62	76977, 77078, 77080, 77081, G0130
Folic Acid	For women planning or capable of pregnancy to prevent neural tube defects. Does not include over-the-counter prenatal or multi-vitamins with folic acid.	Prescription required. Handled through the Pharmacy Benefit.	

Pregnant Women			
Screening for Gestational Diabetes	In pregnant women between 24 and 48 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.	Z34.00-Z34.93 O09.00-O9A.53 Z36.89, Z36.9, Z86.32	82947-82952, 83036
Breast Feeding Support	2 Lactation support and counseling visits by a trained provider per pregnancy to ensure the successful initiation and duration of breast feeding. Allow 1 breast feeding pump and supplies per pregnancy.	Z39.1	99401, 99402, 99403, S9443, E0602, E0603, A4281, A4282, A4283, A4284, A4285, A4286
Asymptomatic Bacteriuria	USPSTF recommends for pregnant women at 12 to 16 weeks gestation or at the first prenatal visit, or later to reduce the incidence of symptomatic maternal urinary tract infections and low birth weight.	Z34.00-Z34.93 O09.00-O9A.53 Z36.89	81007, 87086, 87088
Hepatitis B Screening (HBV)	Screen at the first prenatal visit to reduce perinatal transmission of HBV and the subsequent development of chronic HBV infection.	Z34.00-Z34.93 O09.00-O9A.53 Z36.89	80055 or 87340
Iron Deficiency Anemia Screening	Iron deficiency anemia during pregnancy has been associated with increased risk for low birth weight, preterm delivery and perinatal mortality.	009.00-09A.53, Z36.89 Z34.00-Z34.93	80055 or 85013 or 85014 or 85018
Rh Incompatibility	Screen for Rh(D) blood typing and antibody testing for pregnant women during their first visit for pregnancy- related care.	009.00-09A.53, Z36.89 Z34.00-Z34.93 Z31.82	80055 or 86901
Obstetrics Panel	This panel must include the following: Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Hepatitis B surface antigen (HBsAg) (87340) Antibody, rubella	Z34.00-Z34.93	80055 or 80081 (OB panel with HIV testing)

	(86762) Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART) (86592) Antibody screen, RBC, each serum technique (86850) Blood typing, ABO (86900) AND Blood typing, Rh (D) (86901).		
Men's Preventive Services			
Adult Aortic Aneurysm Screening	Once per lifetime screen for abdominal aortic aneurysm by ultrasonography in men ages 65-75 who have ever smoked.	F17.210, F17.211, F17.213, F17.218, F17.219, F87.891	76706
Prostate Cancer Screening	Annual digital rectal examination and an annual prostate-specific antigen test for males age 40 and older.	Z12.5	84152, 84153, 84154, G0103

Immunizations

Category:	Code(s)	Trade Name(s)	Description:	Age Group: (Pediatric, Adult, or Both)	Benefit Limits
Immunization Administration Preventive when included as part of a preventive immunization.	90460	N/A	Immunization administration **through 18 years of age** via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered.	Pediatric	For applicable age see code description.
	90461	N/A	Immunization administration **through 18 years of age** via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component.	Pediatric	For applicable age see code description.

			administered (List separately in addition to code for primary procedure).		
	90471	N/A	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid).	Both	-
	90472	N/A	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure).	Both	-
	90473	N/A	Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid).	Both	-
	90474	N/A	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure).	Both	-

	G0008	N/A	Administration of influenza virus vaccine.	Both	-
	G0009	N/A	Administration of pneumococcal vaccine.	Both	-
	G0010	N/A	Administration of hepatitis B vaccine.	Both	-
	0771 *(revenue code)*	N/A	Vaccine administration.	Both	-
Meningococcal (MenB; MenB-4C; MenB-Fhbp; Hib- MenCY; MPSV4; MCV4; MenACWY)	90620	Bexsero®	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB-4C), 2 dose schedule, for intramuscular use.	Both	**Benefit Limit: Age 10 and up.**
	90621	Trumenba®	Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB-FHbp), 2 or 3 dose schedule, for intramuscular use.	Both	**Benefit Limit: Age 10 and up.**
	90644	MenHibrix®	Meningococcal conjugate vaccine, serogroups C & Y and Haemophilus influenzae b vaccine (Hib-MenCY), 4 dose schedule, when administered to **children 2-15 months of age**, for intramuscular use.	Pediatric	For applicable age see code description.
	90733	Menomune®	Meningococcal polysaccharide vaccine, serogroups A, C, Y, W-135, quadrivalent (MPSV4) for subcutaneous use.	Both	-
	90734	Menactra® Menveo®	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135, quadrivalent (MCV4	Both	-

			or MenACWY), for intramuscular use.		
Hepatitis A	90632	Havrix® VAQTA®	Hepatitis A vaccine (HepA), **adult dosage,** for intramuscular use.	Adult	For applicable age see code description.
	90633	Havrix® VAQTA®	Hepatitis A vaccine (HepA), **pediatric/adolescent dosage**-2 dose schedule, for intramuscular use.	Pediatric	For applicable age see code description.
	90634	Havrix®	Hepatitis A vaccine (HepA), **pediatric/adolescent dosage**-3 dose schedule, for intramuscular use.	Pediatric	For applicable age see code description.
	90636	Twinrix®	Hepatitis A and hepatitis B vaccine (HepA-HepB**), adult dosage,** for intramuscular use.	Adult	For applicable age see code description.
Haemophilus influenza b (Hib)	90647	PedvaxHIB®	Haemophilus influenzae b vaccine (Hib), PRP-OMP conjugate, 3 dose schedule, for intramuscular use.	Both	**-**
	90648	ActHIB® Hiberix®	Haemophilus influenzae b vaccine (Hib), PRP-T conjugate, 4 dose schedule, for intramuscular use.	Both	**-**
Human Papilloma Virus (HPV)	90649	Gardasil4®	Human Papilloma virus vaccine, types 6, 11, 16, 18, quadrivalent (HPV4), 3 dose schedule, for intramuscular use.	Both	**Benefit Limit: Ages 9-26yrs. Ends on 27th birthday.**
	90650	N/A	Human Papilloma virus vaccine, types 16, 18, bivalent (HPV2), 3 dose schedule, for intramuscular use.	Both	**Benefit Limit: Ages 9-26yrs. Ends on 27th birthday.**

	90651	Gardasil9®	Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 2 or 3 dose schedule, for intramuscular use.	Both	**Benefit Limit: Ages 9-26yrs. Ends on 27th birthday.**
Seasonal Influenza ('flu') ***Note****: Additional new seasonal flu immunization codes that are recently FDA-approved, but are not listed here, may be eligible for preventive benefits as of the FDA approval date.*	90630	Fluzone® Intradermal Quadrivalent	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use.	Both	-
	90653	Fluad®	Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use.	Both	-
	90654	Fluzone® Intradermal Trivalent	Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use.	Adult	**Benefit Limit: 18 years-64 years. Ends on 65th birthday.**
	90655	Fluzone® No Preservative Pediatric	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.25 mL dosage, for intramuscular use.	Pediatric	**Benefit Limit: 6-35 months old.**
	90656	Afluria® Fluzone® No preservative Fluvirin® Fluarix® Flulaval®	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.5 mL dosage, for intramuscular use.	Both	**Benefit Limit: 3 years and up.**
	90657	Fluzone®	Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 mL dosage, for intramuscular use.	Pediatric	**Benefit Limit: 6-35 months old.**

	90658	Afluria® Flulaval® Fluvirin® Fluzone®	Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use.	Both	**Benefit Limit: 3 years and up.**
	90660	Flumist®	Influenza virus vaccine, trivalent, live (LAIV3), for intranasal use.	Both	**Benefit Limit: Ages 2-49 Years. Ends on 50th birthday**
	90661	Flucelvax™	Influenza virus vaccine, trivalent (ccIIV3), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use.	Adult	**Benefit Limit: Ages 4 years and up.**
	90662	High Dose Fluzone®	Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use.	Adult	**Benefit Limit: Ages 65 years and up**
	90664	Flumist®	Influenza virus vaccine, live (LAIV), pandemic formulation, for intranasal use.	Both	**Benefit Limit: Ages 2-49 Years. Ends on 50th birthday.**
	90666	N/A	Influenza virus vaccine (IIV), pandemic formulation, split virus, preservative free, for intramuscular use.	Both	**-**
	90667	N/A	Influenza virus vaccine (IIV), pandemic formulation, split virus, adjuvanted, for intramuscular use.	Both	**-**
	90668	N/A	Influenza virus vaccine (IIV), pandemic formulation, split virus, for intramuscular use.	Both	**-**

	90672	Flumist® (LAIV4)	Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use.	Both	**Benefit Limit: Ages 2 – 49 Years. Ends on 50th birthday.**
	90673	Flublok®	Influenza virus vaccine, trivalent (RIV3), derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use.	Adult	**Benefit Limit: Age 18 years and up.**
	90674	Flucelvax® Quadrivalent	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use.	Both	**Benefit Limit: Age 4 years and up.**
	90682	Flublok Quadrivalent®	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use.	Adult	**Benefit Limit: Age 18 years and up.**
	90685	Fluzone Quadrivalent ®	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL, for intramuscular use.	Pediatric	**Benefit Limit: 6–35 months old.**
	90686	Afluria® Quadrivalent Fluarix® FluLaval Quadrivalent® Fluzone Quadrivalent®	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use.	Both	**Benefit Limit: Ages 6 months and up.**
	90687	Fluzone Quadrivalent®	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 mL dosage, for intramuscular use.	Pediatric	**Benefit Limit: 6–35 months old.**

	90688	Afluria® Quadrivalent FluLaval Quadrivalent ® Fluzone Quadrivalent®	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use.	Both	**Benefit Limit: Ages 6 months and up.**
	90689	-	Influenza virus vaccine quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25mL dosage, for intramuscular use.	Both	-
	90756	Flucelvax Quadrivalent® (non-preservative free)	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use.	Both	-
	Q2034	Agriflu®	Influenza virus vaccine, split virus, for intramuscular use (Agriflu).	Adult	**Benefit Limit: Ages 18 years and up**
	Q2035	Afluria®	Influenza virus vaccine, split virus, when administered to individuals **3 years of age and older,** for intramuscular use (AFLURIA).	Both	For applicable age see code description.
	Q2036	Flulaval®	Influenza virus vaccine, split virus, when administered to individuals **3 years of age and older,** for intramuscular use (FLULAVAL).	Both	For applicable age see code description.
	Q2037	Fluvirin®	Influenza virus vaccine, split virus, when administered to individuals **3 years of age and older,** for intramuscular use (FLUVIRIN).	Both	For applicable age see code description.

	Q2038	Fluzone®	Influenza virus vaccine, split virus, when administered to individuals **3 years of age and older**, for intramuscular use (Fluzone).	Both	For applicable age see code description.
	Q2039	N/A	Influenza virus vaccine, not otherwise specified.	Both	-
Pneumococcal polysaccharide (PPSV23)	90732	Pneumovax 23®	Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to **individuals 2 years or older,** for subcutaneous or intramuscular use.	Both	For applicable age see code description.
Pneumococcal conjugate	90670	Prevnar 13® (PCV13)	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use.	Both	-
Rotavirus (RV1, RV5)	90680	Rotateq®	Rotavirus vaccine, pentavalent (RV5), 3 dose schedule, live, for oral use.	Pediatric	**Benefit Limit: 0 - 8 months old.**
	90681	Rotarix®	Rotavirus vaccine, human, attenuated (RV1), 2 dose schedule, live, for oral use.	Pediatric	**Benefit Limit: 0 - 8 months old.**
Diphtheria, tetanus toxoids, acellular pertussis and polio inactive (DTap-IPV)	90696	Kinrix® Quadracel®	Diphtheria, tetanus toxoids, acellular pertussis vaccine and inactivated poliovirus vaccine (DTaP-IPV), when administered to **children 4 through 6 years of age,** for intramuscular use.	Pediatric	For applicable age see code description.
Diphtheria, tetanus toxoids, acellular pertussis, haemophilus influenza B,	90698	Pentacel®	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Haemophilus influenzae type b, and inactivated poliovirus vaccine, (DTaP-	Both	-

and polio inactive (DTap-IPV/Hib)			IPV/Hib), for intramuscular use.		
Diphtheria, tetanus, acellular pertussis (DTap)	90700	Daptacel® Infanrix®	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to **individuals younger than 7 years**, for intramuscular use.	Pediatric	For applicable age see code description.
Diphtheria and tetanus (DT)	90702	N/A	Diphtheria and tetanus toxoids adsorbed (DT) when administered to individuals **younger than 7 years,** for intramuscular use.	Pediatric	For applicable age see code description.
Measles, Mumps, Rubella (MMR)	90707	MMR II®	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use.	Both	**-**
	90710	ProQuad®	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use.	Both	**-**
Polio (IPV)	90713	Ipol®	Poliovirus vaccine, inactivated (IPV), for subcutaneous or intramuscular use.	Both	**-**
Tetanus and diphtheria (Td)	90714	Tenivac® Decavac®	Tetanus and diphtheria toxoids adsorbed (Td), preservative free, when administered to **individuals 7 years or older,** for intramuscular use.	Both	For applicable age see code description.
Tetanus, diphtheria toxoids and acellular pertussis (Tdap)	90715	Adacel® Boostrix®	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered **to individuals 7 years or older**, for intramuscular use.	Both	For applicable age see code description.

Varicella (VAR) ('chicken pox')	90716	Varivax®	Varicella virus vaccine (VAR), live, for subcutaneous use.	Both	**-**
Diptheria, tetanus and acellular pertussis, hep B, and polio inactive (DTaP-HepB-IPV)	90723	Pediarix®	Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and inactivated poliovirus vaccine (DTaP-HepB-IPV), for intramuscular use.	Both	**Benefit Limit: Ages 0-6yrs. Ends on 7th birthday.**
Zoster / Shingles (HZV/ZVL, RZV)	90736	Zostavax®	Zoster (shingles) vaccine (HZV), live, for subcutaneous injection.	Adult	**Benefit Limit: Age 60 years and up.**
	90750	Shingrix®	Zoster (shingles) vaccine (HZV), recombinant, subunit, adjuvanted, for intramuscular use.	Adult	**Benefit Limit: Age 50 years and up.**
Hepatitis B	90739	HEPLISAV-B®	Hepatitis B vaccine (HepB), adult dosage, 2 dose schedule, for intramuscular use.	Adult	**Benefit Limit: Age 18 and up.**
	90740	Recombivax HB®	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 3 dose schedule, for intramuscular use.	Both	**-**
	90743	Recombivax HB®	Hepatitis B vaccine (HepB), **adolescent,** 2 dose schedule, for intramuscular use.	Pediatric *(adolescent only)*	For applicable age see code description.
	90744	Recombivax HB® Engerix-B®	Hepatitis B vaccine (HepB), **pediatric/adolescent dosage,** 3 dose schedule, for intramuscular use.	Pediatric	For applicable age see code description.
	90746	Recombivax HB® Engerix-B®	Hepatitis B vaccine (HepB), **adult dosage,** 3 dose schedule, for intramuscular use	Adult	For applicable age see code description.

	90747	Engerix-B®	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 4 dose schedule, for intramuscular use.	Both	-
	90748	N/A	Hepatitis B and Haemophilus influenza b vaccine (Hib- HepB), for intramuscular use.	Both	-

Preventive Medicine plus Evaluation and Management Visits

Preventive Medicine Services:

Preventive Medicine Services require documentation to support an “annual physical.” Includes an age and gender-appropriate history and physical examination, counseling or anticipatory guidance, and risk factor reduction interventions.

Evaluation and Management (E/M) Services:

Services that requires three key components; problem or comprehensive history examination; medical decision making; counseling and/or coordination of care with physician or other qualified health can provider.

Reimbursement is allowed for both a preventive medicine code and E/M code when Modifier 25 is applied to the E/M visit for the same patient, by the same provider, on the same date of service.

The preventive medicine code will be reimbursed at 100% of the allowable contracted rate. The E/M code, when billed with Modifier 25 to identify a separately identifiable service, will be subject to a 50% reduction. This payment reduction made on the E/M visit is due to the duplication of overlapping services (e.g. practice expense – costs associated with maintaining a practice) already being considered in the reimbursement of the preventive service.

Preventive Medicine Codes
99381-99387
99391-99397

E/M Codes
99201-99205
99211-99215
99241-99245

Rehabilitation Services – Physical Therapy, Occupational Therapy, Speech Therapy

Physical therapy is a branch of rehabilitative health that uses specially designed exercises and equipment to help patients regain or improve their physical abilities due to illness or injury.

- ñ CPT Codes 97010-971028, 9702-97036, and 97039 require a physician or therapist to be in constant attendance.
- ñ CPT Codes 97110-97124 should be used for physical therapy procedures.
- ñ CPT codes 97140-97542 and 97597-97606 should be used in accordance with the CPT code description.

Occupational therapy is a form of therapy to develop, improve, sustain, or restore daily living activities after an illness or injury. (Preauthorization is required)

- ñ The CPT physical medicine and rehabilitation codes, as well as other services such as splints, strapping, testing, and assessments 97010-97028, 97032-97036, 97039, 97110-97124, 97139, 97140, 97150, 97530-97542, 97546, 97597-97606, 97750-97755, 97760-97763, 97799, 29105-29131, 29505, 29515, 29240-29280, 92526, 92610-92617, 95831-95852, 95999, 96105, and96110-96111 may be submitted by an occupational therapist.
- ñ CPT codes 97165-97168 occupational therapy evaluations and re-evaluation services.
- ñ Occupational therapy for fine motor function may be reimbursed up to specific plan limits.

Speech therapy is the evaluation and treatment of patients with speech, language cognitive-communication and swallowing disorders. (Preauthorization is required)

Speech therapy may be reimbursed if medically necessary for the treatment of an illness or injury and the patient's condition must be expected to improve over a reasonable period of time.

- ñ CPT Code 92507-92508 should be used for speech therapy.
- ñ CPT code 92521-92524 should be used for speech evaluation services.

Modifiers:

The below informational Modifiers may be used to differentiate between different therapists (physical, occupational or speech):

- ñ GP- Services delivered under an outpatient physical therapy plan of care.
- ñ GO- Services delivered under an outpatient occupational therapy plan of care.
- ñ GN- Services delivered under an outpatient speech-language pathology plan of care.

Non-Covered Services:

Hot and cold packs CPT 97010 is not eligible for separate reimbursement and massage therapy services CPT 97124 is not a covered service.

Reimbursement will not be made to physical, occupational, or speech therapist for the evaluation and management CPT codes 99201-99499.

Occupational therapy for activities of daily living, academic learning, vocational or life skills, or developmental delays are not eligible for reimbursement.

Physical therapy, occupational therapy and speech therapy performed in the patient's home is subject to the outpatient plan benefit. All services rendered in the home require preauthorization.
Home Physical therapy, occupational therapy and speech therapy Revenue Codes are:

- ñ 042X Physical Therapy.
- ñ 043X Occupational Therapy.
- ñ 044X Speech Therapy Language Pathology.

Non-Reimbursable Services

This policy describes services that are not eligible for reimbursement.

Providers will not be reimbursed nor allowed to retain reimbursement for services considered to be Non-Reimbursable.

Services defined as Non-Reimbursable Services include, but are not limited to:

- Allergen provision plus administration combined codes. Services must be broken out and reported using separate codes representing each service (95120-95134).
- Chronic Care Case Management Services (99490).
- Codes identified as not payable to professional providers (e.g. 96040).
- Computer assisted musculoskeletal surgical navigational procedures (20985 0054T 0055T).
- Current Procedural Terminology (CPT®) category II supplemental tracking codes (0001F).
- HCPCS National "T" codes established for state Medicaid agencies (T1000-T5999).
- Medicare clinical trial codes (G0293-G0294).
- Medicare demonstration project codes (G9013-G9140).
- Medicare status 'B' codes (e.g. 36416, 90885). Note: an exception has been made for genetic counseling code 96040 as it specifically relates to Patient Protection and Affordable Care Act (PPACA) preventive legislation.
- Quality Measures (e.g., G8635-G8976, G9188).
- Services that are included in the facility reimbursement and not separately payable to professional providers (e.g. 99026, 99190).
- Services that are not direct face-to-face patient care (e.g. 99375).
- Services for which our health plan does not contract.
- Services which our health plan considers part of another service and therefore not separately reimbursable (e.g. 94760, 96904).
- Surgical techniques requiring use of robotic surgical system (S2900).
- Tests, procedures, or medical drugs that are considered obsolete in nature (e.g. 92560, P2028).
- Codes for which products are no longer available and/or have no National Drug Code (NDC) assigned (e.g. 90660).

Facility Non-Reimbursable Services and Supplies

This policy applies to inpatient and outpatient facility settings.

Policy Statement

The components of room and board are not separately reimbursable.

The following is a list, but not limited to, the items and services that are considered integral in the daily charge for regular and specialty settings and not separately reimbursable.

Admission kits	Continuous blood pressure	Neurological monitors in OR
Alcohol	Cord care supplies	Newborn hearing screening
Ambu Bag	Cord clamp	Nutritional supplements
Arm boards	Crash cart	Oximetry and related supplies
Baby clothing	Diapers (any kind/size)	Oxygen
Baby formula and bottles	Emesis basin	Perfusion equipment in OR
Bandages of any type	Evaluations or social services	Personal care items
Bassinettes	Eye droppers	Prep kits
Batteries/electrodes/leads	Fluoroscopy or Ultrasound in OR	Procedure specific instruments
Bed linens/towels any setting	Gloves (all)/ Gowns (all)	Rental equipment
Bedpan	Heat lamp	Restraints (any type)
Beds	Incubator	Scopes
Biliblanket	Instruments	Scrubs
Bladder scan equipment	Isolation supplies/precautions	Skin prep ointments
Blankets	Isolette	Soaps
Blood pressure cuffs	IV fluids administered in the ER	Stethoscopes
Breast Milk & breast pumps	IV pumps	Suction bulbs/machines
Car seat testing	Knee/elbow protectors	Thermometers
Cautery machines	Lasers	Urinals
Cell saver equipment	Monitoring equipment of any kind	Ventilators

Chux/incontinence pads	Monitoring pads	Warming/cooling blankets

The following nursing care is within the scope of normal nursing practice and not separately reimbursable:

- ñ Admission assessments
- ñ Patient care and monitoring in both non-intensive and intensive care settings
- ñ IV insertion
- ñ IV site care including assessments, infusion of fluids to keep lines patent
- ñ Infusion of fluids and medications
- ñ Blood transfusions including Massive Transfusion Protocol (MTP) and Intraoperative Autologous Transfusion (IAT)
- ñ Medication and TPN administration through peripheral and central lines
- ñ Procedures performed by an RN in both non-intensive and intensive care settings
- ñ Assisting with bedside procedures performed by surgeons, physicians or other qualified healthcare professionals.
- ñ Any respiratory treatments performed by an RN including but not limited to:
    - o Sputum inductions
    - o Administration of mucolytics
    - o Incentive spirometry
    - o Nebulizer treatment
    - o Administration of nebulized medications
- ñ Point of care testing performed manually or by mobile computer devices including but not limited to blood gases, electrolytes, and urinary retention.
- ñ Tube feedings
- ñ Urinary catheterization and care
- ñ Ventilator adjustments performed by an RN
- ñ Administration of member's own medications

The following pharmacy services are not separately reimbursable:

- ñ Pharmacy consultation for patient education and medication management
- ñ Preparation of medications and infusions regardless in both non-intensive and intensive care settings.
- ñ Member's own medications
- ñ Discharge planning including coordinating transfer to another inpatient facility, post-acute care facility, and home health services

The following laboratory services are part of the lab test and are not separately reimbursable regardless of setting or practitioner and regardless of the type of blood drawn:

- ñ Blood draws from arterial, capillary, peripheral or vascular access devices
- ñ Point of care testing performed manually or by a mobile computer device

The following respiratory services are within the scope of normal respiratory therapy practice and not separately reimbursable:

- ñ Ventilator system checks
- ñ Oxygen, CPAP and PEEP changes when member is on ventilator support
- ñ Ventilator weaning and extubation
- ñ Respiratory assessment with treatments
- ñ Endotracheal suctioning when member is on a ventilator including
    - o Sputum inductions
    - o Administration of mucolytics
    - o Incentive spirometry
    - o Nebulizer treatment
    - o Administration of nebulized medications

Use of member's own CPAP or BiPAP machines is not reimbursable.

References:

CMS Medicare Learning Network, Discharge Planning, Oct. 2014

CMS Medicare Claims Processing Manual, Chapter 16- Laboratory Services; 60.1 - Specimen Collection Fee

CMS Provider Reimbursement Manual, Chapter 22 – Determination of Cost of Services to Beneficiaries

Joint Commission International, Point of Care Testing

Utah Office of Administrative Rules, Rule R156-31b Nurse Practice Act Rule

NCQAC Advisory Opinion 13.02 Registered Nurse and Licensed Practical Nurse Scope of Practice

Radiologic Guidance for Needle Placement

This policy applies to inpatient and outpatient facility settings.

Radiologic guidance using CT, fluoroscopy, MRI, or ultrasound for needle placement procedures are considered part of the procedure and not separately reimbursable. Procedures requiring needle placement include but are not limited to aspiration, injection, biopsy, or device placement.

Radiologic supervision and interpretation of needle placement procedures using CT, fluoroscopy, MRI and ultrasound are considered part of the procedure and not separately reimbursable.

Medical supplies, surgical items (i.e. guide wires, catheters, needles, sheaths, introducers, stents, vascular closure devices, etc.) and drugs used during radiologic guidance procedures are considered part of the procedure and not separately reimbursable.

References:

CMS Medicare Claims Processing Manual - Chapter 13 - Radiology Services and Other Diagnostic Procedures

Reimbursement of Medications, IV Infusions, Compound Medications, and

Definitions:

Injection: substance injected into the body for therapeutic or diagnostic purposes. Injections can be intramuscular (IM), intravenous (IV), subcutaneous (SC), intradermal (ID), intrathecal (IC) or intra-arterial.

Infusion: the slow injection of a substance into a vein or tissue.

Policy Statement

Documentation of Medications

Medications will be reimbursed if they are reported in the Medication Administration Record (MAR). This includes all administration routes and medication types including injections, infusions, compounded medications, and admixtures such as TPN. Medications that are not reported in the MAR but reported in nursing notes or progress notes will not be reimbursed. The exception to this is anesthesia medications. These may be reimbursed if they are reported in the anesthesia notes only.

Hydration, Therapeutic, Prophylactic, Diagnostic Injections, and Infusions

Charges for following codes will not be reimbursed in the following facility settings regardless of modifiers that may be appended to the code. AMA coding guidelines clearly state that these injection and infusion services codes are not intended to be reported by the physician or other qualified health care professional in the facility setting.

Codes: 96360-96379, 96401, 96402, 96409-96425 and 96521-96523

Place of Service Code	Facility Type
19	Off Campus-Outpatient Hospital
21	Inpatient Hospital
22	On Campus-Outpatient Hospital
25	Birthing Center
31	Skilled Nursing Facility
32	Nursing Facility
34	Hospice, Free Standing
51	Inpatient Psychiatric Facility
52	Psychiatric Facility-Partial Hospitalization
54	Intermediate Care Facility/ Individuals with Intellectual Disabilities
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End-Stage Renal Dialysis Treatment Facility

Facility compounded medications and admixtures including TPN may not be unbundled into its component ingredients when administered in a single bag or syringe. Component ingredients that are separately billed will be denied. Providers may be reimbursed if the charges are rebilled as a single item. Physician orders which stipulate separate administration of one or

more components of TPN or admixtures and when documented in the MAR will be eligible for separate reimbursement.

The following supplies are not reimbursable:

- ñ Diluents which are required to prepare a drug for administration
- ñ IV tubing, poles, pumps, and bags
- ñ IV or TPN administration sets/kits whether commercial or hospital prepared

References
NCCI Policy Manual, Chapter XI
Current Procedural Terminology (CPT) Manual, American Medical Association.

Robotic Assisted Surgery

The purpose of this policy is to define the reimbursement criteria for robotic assisted surgery.

A Robotic Surgical Device is a type of surgical technique or approach that is not medically necessary to ensure the successful outcome of the procedure. Therefore, separate reimbursement for surgeries that are performed using a robotic technique will not be considered for additional reimbursement.

CPT code S2900- Surgical techniques requiring the use of a robotic surgical system (list separately in addition to code for primary surgical procedure. This is not eligible for separate reimbursement.)

Reimbursement for procedures in which a robotic surgical system is used will be based on the contracted rate for the base procedure.

- ñ Separate reimbursement is not allowed for the robotic surgical technique, whether reported under S2900, an unlisted code, or another code. The line item will be denied entirely.
- ñ If the surgical procedure itself is reported with an unlisted code due to the use of a robotic surgical system, the unlisted code will be manually priced based on the contracted fee for the listed procedure code for the base surgical procedure.
- ñ Additional reimbursement will not be approved if Modifier 22 is reported.
- ñ Separate reimbursement is not allowed for the robotic surgical device as a surgical assistant (Modifiers 80, 81 or 82) or an assistant surgeon (Modifier AS).

When robotic assisted surgeries are performed, MotivHealth will reduce the time-based anesthesia and operative charges by 50%. This is in addition to the denial of any line item that is specific to the robotic surgical technique (S2900, etc).

Reimbursement will not be made to hospitals, surgical centers, or other facilities for the use of a robotic surgical device or other specialized operating room equipment. These items are included in the operating room charge or facility fee for the base surgical procedure. Supplies related to the use of the robot are also not separately reimbursed.

Prolonged Services

Separate reimbursement will be made to physicians or other qualified health care professionals for Prolonged Services when reported in conjunction with E/M codes or other services.

Prolonged Services with Direct Patient Contact- When a physician or other qualified health care professional provides prolonged services beyond the usual service in either the inpatient or outpatient setting. Direct Patient Contact is face-to-face and includes additional non-face-to-face services on the patient's floor or unit in the hospital or nursing facility during the same session. This service is reported in addition to the designated evaluation and management services at any level and other services provided at the same session as evaluation and management services.

Prolonged Services without Direct Patient Contact- Prolonged Services without Direct Patient Contact are used when a prolonged service is provided that is neither face-to-face time in the office or outpatient setting, nor additional unit/floor time in the hospital or nursing facility setting during the same session of an evaluation and management service and is beyond the usual physician or other qualified health care professional service time.

Prolonged Service CPT Code	Place of Service	Description
99354	Office or Outpatient	For the first hour of prolonged physician or other qualified health care professional services. Use this code only once per day, must exceed 30 minutes in order to report this service.
99355	Office or Outpatient	For each additional 30 minutes beyond the first 60 minutes of prolonged physician or other qualified health care professional. Must exceed 15 minutes on order to report this service.
99356	Inpatient or Observation	First hour of prolonged physician or other qualified health care professional services. Use this code only once per date, must exceed 30 minutes on order to report this service.
99357	Inpatient or Observation	Each additional 30 minutes beyond the first 60 minutes of prolonged physician or other qualified health care professional services. Additional Services must exceed 15 minutes in order to report this service.
99358	Office, Outpatient, Inpatient, or Observation	First hour of prolonged physician or other qualified health professional services. Use this code only once per date, must exceed 30 minutes in order to report this service.
99359	Office, Outpatient, Inpatient, or Observation	Each additional 30 minutes beyond the first 60 minutes of prolonged physician or other qualified health care professional services. Additional Services must exceed 15 minutes in order to report this service.
99415	Office or Outpatient	First hour of prolonged clinical staff services of direct patient contact with physician supervision. Use this code only once per date, must exceed 30 minutes in order to report this service.

99416	Office or Outpatient	Each additional 30 minutes beyond the first 60 minutes of prolonged clinical staff services of direct patient contact with physician supervision. Additional Services must exceed 15 minutes in order to report this service.
G0513	Office or Outpatient	Prolonged preventive service, direct patient contact beyond the usual service first 30 minutes. List separately in addition to code for preventive service.
G0514	Office or Outpatient	Prolonged preventive service, direct patient contact beyond the usual service each additional 30 minutes. List separately in addition to G0513 for additional 30 minutes or preventive service.

Per CPT and HCPCS, prolonged service codes are considered add-on codes and should not be reported without the appropriate primary code.

In accordance with CMS and the AMA, Prolonged Services without Direct Patient Contact (CPT codes 99358-99359) will not be separately reimbursed with Care Management CPT codes 99484, 99487, 99490, 99492-99494 and Transitional Care Management CPT codes 99495 and 99496.

According to the American Congress of Obstetricians and Gynecologists (ACOG) coding guidelines, prolonged services are not separately reimbursed. Prolonged services are not reported for services that do not have a time component such as labor and delivery management.

Telehealth/Telemedicine Services

All claims are subject to audit services and medical records may be requested from the provider.

Modifiers:

Modifier GT: Via interactive audio and video telecommunications systems
Modifier 95: Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system.

Claims for professional services should be submitted using the appropriate CPT Code (Appendix P in the CPT manual) and the Modifier GT or 95 to differentiate a telemedicine encounter from an in-person encounter with the patient. When reporting Modifier GT or Modifier 95, the practitioner is attesting that services were rendered to a patient via an interactive audio and visual telecommunications system.

The information exchanged between the reporting provider and the patient while during the course of the telehealth/telemedicine visit must be of an amount and nature that would be sufficient to meet the key components/or requirements of the same service when rendered via face-to-face interaction.

Place of Service:

Place of Service 02 (“The location where Health Services and Health related services are provided or received, through a telecommunication system”) is required on the claim to indicate that the service was delivered via telemedicine.

Reimbursement for telemedicine services:

- ñ Provider Network participating providers with 02 Place of Service code - contractual Facility Fee Schedule rate.
- ñ Provider Network participating providers billed with all other place of service with telehealth Modifier(s)- 70% of contractual Fee Schedule rate.
- ñ First Health Network participating providers- Subject to the First Health contractual agreement.

Preventable Healthcare Acquired Events

Reimbursement Policy for Preventable Healthcare Acquired Events

No reimbursement will be made to hospitals, ASC's, or physicians for costs incurred as a result of Hospital Acquired Conditions, Iatrogenic Complications, Never Events for Serious Reportable Events.

Hospital Acquired Condition

Hospital Acquired Condition (HAC) is a condition that is not present with the patient is admitted to or arrived at the hospital or other facility but occurs during or after the stay. HCA's include but not limited to infections and medical errors.

Examples include:

- ñ Surgical site infections.
- ñ Post-Operative Hemorrhage.
- ñ Falls and Trauma.

Iatrogenic Complications

Iatrogenic Complications are any adverse conditions that are a direct result of treatment by a physician or other health care professional.

Examples include:

- ñ Air Embolism.
- ñ Blood incompatibility.
- ñ Misplaced instruments.

Never Events/Serious Reportable Events (SRE)

Never Events are errors in medical care that are of concern to both the public, health care professionals and providers and of a nature that the risk of occurrence is significantly influenced by the policies and procedure of the health care organization.

- ñ Performance of the wrong operation/procedure on a patient.
- ñ Performance of the correct operation/procedure on the wrong side of the body.
- ñ Unintended retention of a foreign object after surgery.
- ñ Patient death or serious injury associated with unsafe administration of blood products.

Serious Reportable Events that could have reasonably prevented through application of evidence-based guidelines. SRE's are commonly referred to as Never Events. These conditions are not present on admission, or when the patients are initially treated, but occurred during the course of treatment or stay.

Claim Submission Requirement for Never Events

Following CMS billing requirements, erroneous surgeries require reporting the following information on the UB04 and 1500 claim forms:

Inpatient Hospital Claims

Type of Bill 110 - no-pay claim. A no-pay claim should be submitted for all charges associated with the erroneous surgery. If there are other services/procedures that are unrelated to the erroneous surgery, they need to be billed on a separate claim.

Type of Bill 110 must have one of the following ICD-10 diagnosis codes reported on the hospital claim to identify the type of erroneous surgery performed.

- Y65.51 – Performance of wrong procedure (operation) on correct patient.
- Y65.52 – Performance of procedure (operation) on patient not scheduled for surgery.
- Y65.53 – Performance of correct procedure (operation) on wrong side of body parts.

Hospital Outpatient, Ambulatory Surgery Center (ASC), and Professional/1500 Claims Outpatient, ASC's and physicians or other health care professionals must report the applicable HCPCS Modifier(s) with the associated charges on all lines related to the surgical error.

- PA- Surgery Wrong Body Part.
- PB- Surgery Wrong Patient.
- PC- Wrong Surgery on Patient.

Present on Admission Indicators:

The Deficit Reduction Act of 2005 (DRA) requires a quality adjustment in Medicare Severity Diagnosis Related Group (MS-DRG) payments for certain hospital-acquired conditions. CMS has titled the provision "Hospital-Acquired Conditions and Present on Admission Indicator Reporting" (HAC & POA). Inpatient Prospective Payment System (IPPS) hospitals are required to submit POA information on diagnoses for inpatient discharges.

POA Reporting Requirements:

- Required on all IPPS claims with inpatient admissions.
- Present at the time of the inpatient admission order.
  - Includes conditions that develop during an outpatient encounter.
- Assigned to principal and secondary diagnosis.
- Claim billed with all appropriate charges regardless of POA.
- Adjustment for HAC will be made based on POAs on claim.

POA Indicators:

Indicator	Description
Y	Diagnosis was present at time of inpatient admission.
N	Diagnosis was not present at time of inpatient admission.
U	Documentation insufficient to determine if the condition was present at the time of inpatient admission.

W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
1	Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04, however; it was determined that blanks are undesirable when submitting this data via the 4010A.

Wasted or Discarded Drugs and

Definitions

Discarded Drug or Biologic: the amount of a single-use vial, single-dose vial or single-use package that remains after administering a dose/quantity of the drug or biologic and that has been appropriately discarded.

HCPCS Level II: the national procedure code set for healthcare practitioners, providers, and medical equipment suppliers when filing health plan claims for medical devices, supplies, medications, transportation services, and other items and services.

Medication Administration Record (MAR): The legal record of the drugs administered to a patient at a healthcare facility by a healthcare professional. The Medication Administration Record is a permanent part of the patient's medical records. The eMAR is an electronic version of the MAR.

Modifier JW: Modifier JW is a HCPCS Level II modifier with the descriptor, "*Drug/Biological amount discarded/not administered to any patient*". While modifier JW was created by CMS and CMS contractors may or may not require its use, the use of modifier JW is not limited to CMS members or plans. MotivHealth requires the use of modifier JW as indicated in the policy section below when reimbursement is sought for appropriately discarded drugs or biologics from single-dose vials or single-use packages for claims submitted by physicians' offices and outpatient hospital facilities.

Multi-dose vial: A multi-dose vial is a vial of liquid medication intended for parenteral administration (injection or infusion) that contains more than one dose of medication. Multi-dose vials are labeled as such by the manufacturer and typically contain an antimicrobial preservative to help prevent the growth of bacteria. The preservative has no effect on viruses and does not protect against contamination when healthcare personnel fail to follow safe injection practices. (CDC[3])

National Drug Code (NDC): is a unique 10-digit or 11-digit, 3-segment number, and a universal product identifier for human drugs in the United States. Each medication is assigned a number under Section 510 of the U.S. Federal Food, Drug and Cosmetic Act. It identifies the manufacturer, product and package size.

Overfill: Any amount of drug greater than the amount identified on the package or label.

Single-dose or Single-use Vial: a vial of liquid medication intended for parenteral administration (injection or infusion) that is meant for use in a single patient for a single case, procedure, injection. Single-dose or single-use vials are labeled as such by the manufacturer and typically lack an antimicrobial preservative. (CDC[1])

Single-use Package (Unit Dose Package): a package that contains one discrete pharmaceutical dosage form, i.e., one tablet.

Wastage: see definition for *Discarded Drug or Biologic* above.

Scope

This policy pertains to all facility providers including Critical Access Hospitals (CAH) and physicians' offices.

Background

Drugs and Biologics that are labeled as single-dose vial or single-use package should only be used for a single patient as part of a single case, procedure, injection and thus only require a single entry into the vial or package (CDC[1]). The CDC directs that, *"Even if a single-dose or single-use vial appears to contain multiple doses or contains more medication than is needed for a single patient, that vial should not be used for more than one patient nor stored for future use on the same patient."* The agency cites risk of contamination and outbreaks resulting from healthcare personnel using single-dose vials for multiple patients (CDC[2]).

The CDC recommends that single-use vials, single-dose vials and single-use packages of drugs and biologics should be discarded:

- ñ Whenever sterility is compromised or questionable.
- ñ At the end of the case/procedure for which the single-use vial or single-use package has been opened or accessed or the time period that the manufacturer specifies for the opened vial, whichever comes first. It should not be stored for future use.
- ñ According to the manufacturer's expiration date.

Policy

Waste or Discarded Drugs and Biologicals that are Separately Reimbursable

Discarded drugs and biologics are separately reimbursable when all the following requirements are met:

- ñ The drug or biologic is commercially available in only single-dose or single-use vials or single-use packages.

- ñ The units billed must correspond with the smallest dose vial/package available for purchase from the manufacturer that could provide the appropriate dose for the patient, thereby resulting in the least amount of waste.

- ñ MAR or eMAR must include the following information: name of the drug/biologic, amount administered, date and time administered, route of administration and amount of the drug/biologic wasted and the name and licensure of the person who wasted/discarded the drug/biologic. The NDC of the drug must also be provided if requested. In the case of anesthesia drugs or drugs administered in the emergency department, these documentation requirements may be recorded in the reports or flowsheets normally used for those areas.

- ñ Complete and legible records supporting the charge for discarded drugs or biologics are sent to MotivHealth promptly upon request. Once records are received, MotivHealth will deem them to be complete and in their entirety.

Waste or Discarded Drugs and Biologicals that are Not Separately Reimbursable

- **Undocumented Drug/Biologic Waste:** if only a portion of the single-use vial, single-dose vial or single-use package of a drug/biologic is administered and waste is not documented and the entire unit for the vial/package is billed, the charge may be denied or only partially reimbursed.

- **Overfill Wastage**: reimbursement will not be provided for wasted portions that are greater than the dose commercially available in the single-use vial, single-dose vial or single-use package less the units administered to the patient.

- **Unadministered Drugs/Biologics**: waste for drugs that were never administered to a patient even if the discarded units are reported in the medical record as wasted. This includes drugs that were specifically prepared for the patient and could not be administered regardless of the reason.

- **Inconsistent documentation**: if the wasted/discarded drug or biologic is reported in more than one location within the facility and it is found that the amount wasted is not consistent with the MAR or eMAR, the waste billed will be denied for lack of supporting documentation. Charge capture reports are not part of the medical record and will not be considered as acceptable documentation when determining reimbursement for drug waste charges.

  Example of an unsupported drug waste charge:
  Physician's order requires 15 mg of a drug.
  Pharmacy dispensed one single-dose vial of 20 mg of drug in the facility's Pyxis machine and documents: Dispensed 20 mg/Wasted 5 mg
  RN administered 15 mg but does not document waste of the 5 mg.

- **Excess Wastage**: If a larger vial size is used but the drug/biologic is commercially available in a smaller single-dose or single-use or single-package size, MotivHealth will calculate the waste for the smaller size and reimburse the waste on that calculation if possible, otherwise wastage charge will be denied. It is the responsibility of the provider to include in their formulary and have sufficient inventory to accommodate its patients' medication requirements.

  Example:
  Physician's order requires member to receive 80 mg of a drug that is manufactured in two sizes: 100 mg single-dose vial and 150 mg single-dose vial. If the provider uses the 150 mg single-dose vial and wastes 70 mg, MotivHealth will reimburse 20 mg waste or 25 percent of the billed charge for wastage. This is because the 100 mg vial could have been used resulting in less waste, 20 mg.

- **Inventory Shortages**: MotivHealth will not reimburse for the excess waste due to shortages in provider's inventory that are not related to documented national and/or civil emergency shortages. MotivHealth considers a provider's formulary and inventory processes to be provider business decisions. Consequently, any excess waste resulting

from those business decisions is a provider business expense and is not reimbursable. Drugs and biologics that are not commercially available due to documented national and/or civil emergency shortages around or near the date of administration and where the provider incurs excess waste will be paid as long as the requirements for reimbursement, as set forth above, are met.

- **Multi-use Vials or Multi-use Packages**: discarded portions of multi-use vials or multi-use packages are not eligible for separate reimbursement.

- **Insufficient Documentation**: once records are received, MotivHealth will deem them to be complete and in their entirety and appropriate for review. Inability to determine with reasonable accuracy the amount of wastage due to incomplete records, illegible records or insufficient documentation will render a denial of the charge for wasted drugs/biologics due to lack of supporting documentation. Additional documentation provided subsequent to our review will not be accepted for a billing review or an appeal of our original decision on reimbursement.

Billing Guidelines for Discarded Drugs and Biologics: ASC, Outpatient Facilities and Physicians' Offices

- Medications must be billed using the correct HCPCS Level II codes, number of billing units administered, and the number of billing units discarded. The NDC number must be provided if requested after claim submission so that reimbursement amounts can be correctly calculated. Not providing the NDC may result in denial of the charge.

- If the drug or biologic does not have a HCPCS Level II code, an unclassified drugs or biologicals code for outpatient facilities (C9399) should be used. A not otherwise classified, anti-neoplastic drug (J9999) or unclassified drugs (J3490), unclassified biologics (J3590) should be used by physicians' offices. Unlisted drug codes or unclassified drug codes should not be used for drugs and biologicals that have a HCPCS Level II code. Drugs/biologics billed with an unlisted or unclassified code should be reported in one billing unit increment. Modifier JW should not be appended to an unlisted or unclassified drug code.

- Each HCPCS Level II code has a defined unit of service for reporting purposes. A physician or outpatient facility should not report units of service for a HCPCS Level II code using a criterion that differs from the code's defined unit of service. (NCCI Policy Manual)

- Modifier JW must be appended to the HCPCS Level II code in order to obtain reimbursement for the discarded units on the CMS-1500. The units administered should be billed on one line and the discarded units should be billed on another line according to the HCPCS Level II billing units. Wasted drugs or biologics that are not billed with modifier JW appended to the HCPCS Level II code will be denied as a provider liability.

If reimbursement for discarded units is not being requested, the JW modifier is not required.

- MotivHealth claims systems do not recognize fractional billing units. If the actual dose of the drug or biologic is less than the billing unit for the drug, one unit should be billed on one line. Modifier JW should not be used to bill the discarded unit. Doing so would report two units and result in an overpayment.

  Example
  Physician's order requires member to receive 15 mgs of a medication. The drug is manufactured in one concentration in a single-dose vial of 20 mg/ml. The billing unit for the vial is one unit. One unit should be billed. The 5mg discarded portion should not be billed on a separate line.

- The JW Modifier does not apply to drugs assigned status indicator N. These items and services are packaged into APC Rates and not separately reimbursable.

Billing Guidelines for Discarded Drugs and Biologics: Inpatient Facilities including Critical Access Hospitals (CAHs)

- Medications must be billed using the correct revenue codes and billing units on the CMS-1450 (UB-04).

- Provider must supply an itemized billing of the UB-04 claim submission if requested. The itemized billing must include for both administered and discarded portions the drug name, date administered/discarded, Revenue code, HCPCS Level II code, number of billing units and total charge of both the administered and discarded portions. Modifier JW may be used on the itemized bill for the discarded portion but is not required for inpatient facility billings.

- The NDC number must be provided if requested so that reimbursement amounts can be correctly calculated. Not providing the NDC may result in denial of the charge.

- If the drug or biological does not have a HCPCS Level II code, a not otherwise classified, anti-neoplastic drug (J9999) and unclassified drugs (J3490), unclassified biologics (J3590) should be used by inpatient facilities. Unlisted drug codes and unclassified drugs should not be used for drugs and biologicals that have a HCPCS Level II code. Drugs/biologics billed with an unlisted or unclassified code should be reported in one billing unit increment.

- Each HCPCS Level II code has a defined unit of service for reporting purposes. A facility should not report units of service for a HCPCS Level II code using a criterion that differs from the code's defined unit of service. (NCCI Policy Manual)

- ñ Reimbursement for wasted or discarded drugs/biologics does not apply to claims paid to a DRG reimbursement methodology since drugs and biologicals are not separately payable.

- ñ If the facility is compounding drugs that are not a mixture of commercially available products report one unit of an appropriate unlisted drug code such as J9999 or J3490.

Cross References

REIMBURSEMENT OF MEDICATONS, IV INFUSIONS, COMPOUNDED MEDICATIONS, AND ADMIXTURES

References

CMS Publication 100-4, Claims Processing Manual, Chapter 17, § 40 (www.cms.hhs.gov/manuals/downloads/clm104c17.pdf)

Local coverage article, A53049, Approved Drugs and Biologicals; Includes Cancer Chemotherapeutic Agents

CMS. National Correct Coding Initiative Policy Manual. Chapter 1 General Correct Coding Policies, § A

CDC[1]: https://www.cdc.gov/injectionsafety/providers/provider_faqs_singlevials.html

(CDC[2]) Fischer GE et al. Hepatitis C Virus Infections from Unsafe Injection Practices at an Endoscopy Clinic in Las Vegas, Nevada, 2007-2008. *CID* 2010;51:267-273.

(CDC[3]) https://www.cdc.gov/injectionsafety/providers/provider_faqs_multivials.html

Modifier JW Captures Drug Waste of Single-use Vials: https://www.aapc.com/blog/39864-modifier-jw-captures-drug-waste-of-single-use-vials/

Centers for Medicare and Medicaid Services. Chapter 1, General Correct Coding Policies. In: National Correct Coding Initiative Policy Manual for Medicaid Services. Revised January 1, 2019. https://www.medicaid.gov/medicaid/program-integrity/ncci/reference-documents/index.html

Modifiers

Assistant Surgeon AS/80/81/82

This policy describes the reimbursement of Assistant at Surgery/Assistant Surgeon services. An Assistant at Surgery/Assistant Surgeon is a physician or other Qualified Health Care professional who is assisting a physician performing a surgical procedure. Only one assistant surgeon is reimbursable for each procedure.

The Assistant Surgeon policy is based on CMS National Physician Fee Schedule Relative Value File (NPFS) payment policy indicators.

All codes in the NPFS with payment code indicator “2” for Assistant at Surgery are considered to be reimbursable for Assistant surgery services, as indicated by an assistant surgeon Modifier.

Physicians (MD/DO):

A Physician billing assistant surgeon services is reimbursed based on CMS guidelines of 16% of the Allowable Amount for eligible surgical procedures.

Assistant surgeons who are physicians should submit the identical procedure code(s) as the primary surgeon with one of the following Modifiers to represent their service(s).

Modifier	Description
80	Assistant Surgeon
81	Minimum Assistant Surgeon
82	Assistant Surgeon (when qualified resident surgeon not available).

Qualified Health Care Professionals:

A Qualified Health Care Professional is a physician assistant, clinical nurse specialist, or nurse practitioner who does not have a Doctor of Medicine (MD) or a Doctor of Osteopathy (DO) degree.

Qualified Health care professionals billing assistant surgeon services is reimbursed based on CMS guidelines of 14% of the Allowable Amount for eligible surgical procedures.

Assistant surgeons who are Qualified Health Care Professionals should submit the identical procedure code(s) as the primary surgeon with one of the following Modifiers to represent their service(s).

Modifier	Description
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for Assistant-at-Surgery

Per CMS guidelines, surgical technicians are not listed as a qualified health care practitioner that can report Modifier AS. The services of a surgical technician assisting surgery are included in the reimbursement to the facility and not separately reimbursable.

Multiple Procedures

If an Assistant Surgeon submits multiple procedure codes, the multiple procedure reductions will apply.

Cesarean Section Assistant-at-Surgery:

Only a non-global cesarean section delivery code (without antepartum or postpartum components) is a reimbursable service when submitted with an appropriate assistant surgeon Modifier.

Assistant Surgeon Non-Global cesarean section codes:

59510 reimbursed using 59514
59515 reimbursed using 59514
59618 reimbursed using 59620
59622 reimbursed using 59620

Bilateral Modifiers 50/LT/RT

This policy describes unilateral procedures that can be performed on both sides of the body during the same session by the same individual physician or other qualified health care professional. These Modifiers are not to be reported with CPT or HCPCS codes with bilateral in their intent or with bilateral written in their descriptions.

This policy is based on the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) Relative Value File Status Indicators. All codes in the NPFS with a bilateral indicator (BI) of “1” or “3” are eligible for bilateral services indicated with a 50 Modifier.
0 - 150% payment adjustment for bilateral procedures does not apply.
1 - 150% payment adjustment for bilateral procedures applies.
2 - 150% payment adjustment does not apply.
3 - The usual payment adjustment for bilateral procedures does not apply.
9 - Concept does not apply

CMS’s payment adjustment methodology will be applied to bilateral eligible procedures with an indicator if “1” regardless of the Multiple Procedure Indicator when the procedure code is reported bilaterally with a 50 Modifier or on separate lines using RT and LT Modifier for the same structure. The procedure code will be reimbursed at 150% of the allowable amount for the single procedure code, not to exceed billed charges. This is one side reimbursed at 100% of allowable charges and the other side reimbursed at 50% of allowable charges. If another procedure is billed, it may be subject to the Multiple Procedure Reduction.

When a bilateral eligible code with a bilateral indicator of “3” is reported with a 50 Modifier and is not subject to the reductions under the Multiple Procedure Reduction, the code will be eligible for reimbursement at 100% of the allowable amount for each side for a total of 200% of the allowable amount not to exceed billed charges. These codes are usually diagnostic/radiology tests, they are not subject to the reduction.

Modifier 22 - Increased Procedural Services

Increased procedural services means a service provided by a physician or other health care professional that is substantially greater than typically required for the procedure or service as defined in the CPT description. Increased procedural services are reported using Modifier 22.

Modifier 22 is eligible for reimbursement at 120% of allowed amount not to exceed billed multiple surgery procedure and edits still apply. Medical documentation must be submitted with claims where Modifier 22 is reported.

To use Modifier 22 effectively, surgical and/or medical documentation must include all the following elements:

- ñ Must support the substantial additional work.
- ñ Reason for the additional work.
  - Increased intensity.
  - Time.
  - Technical difficulty of procedure.
  - Severity of patient's condition.
  - Physical and mental effort required.
- ñ Documentation includes separate paragraph clearly titled to describe how service is unusual compared to normal procedure.

Modifier 22 should not be appended to any CPT code listed in the E/M, Anesthesia. or Laboratory sections, or unlisted or non-specific CPT Codes. Additional reimbursement is only considered for services that are assigned a global period of 0, 10, 42, or 90 days.

Modifier 63 - Procedure Performed on Infants less than 4 kg

Procedures performed on infants less than 4 kg may involve significantly increased complexity and physician, or other qualified health care professional work commonly associated with these patients.

Modifier 63 is eligible for reimbursement at 120% of allowed amount not to exceed billed multiple surgery procedure and edits still apply. Medical documentation is required.

To use Modifier 63 effectively, surgical documentation must include all the following elements:

- ñ Must support the substantial additional work.
- ñ Reason for the additional work.
  - Increased intensity.
  - Time.
  - Technical difficulty of procedure.
  - Severity of patient's condition.
  - Physical and mental effort required.

Modifier 63 should only be appended to CPT code ranges 20005-69990 and not appended to any CPT code listed in the E/M services, Anesthesia, Radiology, Pathology/Laboratory, Medicine sections, or to any unlisted or non-specific CPT Codes

Modifier 52 - Reduced Services

This policy describes Modifier 52, reduced services. Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional.

For reimbursement, the below information needs to be included on the claim:

- ñ Include statement “reduced services” on line 19 on CMS-1500 form (or electronic equivalent).
- ñ Include brief reason for reduction.
- ñ Documentation includes complete reduction reason retained in patient's record.

Reimbursement will be 50% of allowed amount.

Incorrect Use:

- ñ Do not confuse with "terminated procedure" Modifier 53.
- ñ Inappropriate with E/M codes.
- ñ If a portion of the intended procedure was completed and a code exists which represents the completed portion of the intended procedure.

Modifier 53 - Discontinued Procedure

Modifier 53 is used to report a Discontinued Procedure designates a surgical or diagnostic procedure provided by a physician or other health care professional that was less than usually required for the procedure as defined in the CPT description. If another code exists which represents the portion of the procedure completed, it is not appropriate to report Modifier 53.

Under certain circumstances, such as a serious risk to the patient's well-being, a surgical or diagnostic procedure is terminated at the physician or other health care professional's direction. Under these circumstances the procedure provided should be identified by its usual procedure code and the addition of Modifier 53 signifying that the procedure was started but discontinued.

According to the Centers for Medicare & Medicaid Services (CMS) and CPT coding guidelines, Modifier 53 should be used with surgical codes or medical diagnostic codes. Modifier 53 should not be used with:

- Evaluation and management (E/M) services.
- Elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.
- When a laparoscopic or endoscopic procedure is converted to an open procedure or when a procedure is changed or converted to a more extensive procedure.

Reimbursement of Discontinued Procedures with Modifier 53 is 25% of the Allowable Amount for the unmodified primary procedure. Multiple procedure reductions will still apply.

Modifier 26 and/or TC - Professional and Technical Component PC/TC

Modifier 26 is the Professional Component of a global service or procedure and includes the provider work, associated overhead and professional liability insurance costs. This Modifier corresponds to the human involvement in a given service or procedure. When a physician or other qualified health care professional is reported separately, the service may be identified by adding Modifier 26 to the usual procedure code.

Modifier TC is the Technical Component of a global service or procedure and includes the cost of the supplies and equipment used to perform that service or procedure. This Modifier corresponds to the equipment/facility part of a given service or procedure. When the technical component is reported separately, the service may be identified by adding the Modifier TC to the usual procedure code.

This policy describes the reimbursement methodology for CPT and HCPCS codes based on the CMS National Physician Fee Schedule Relative Value File for Professional and Technical Component Indicators.

NPFS PC/TC Indicator	Description
0	Physician Service Code (PC/TC does not apply)
1	Diagnostic Tests (26 and TC can be used)
2	Professional Component Only Codes (26 and TC cannot be used)
3	Technical Component Only Codes (26 and TC cannot be used)
4	Global Test Only Codes (26 and TC cannot be used)
5	Incident to Codes (26 and TC cannot be used)
6	Laboratory Physician Interpretation Codes (TC cannot be used)
7	Physician Therapy Service
8	Physician interpretation Codes (inpatient facility only)
9	Not Applicable (PC/TC does not apply)

Indicator 0 codes are physician service only codes and the PC/TC concept does not apply.

Indicator 1 codes are diagnostic tests for radiology services. These codes have both a professional and technical component. Both Modifiers 26 and TC can be used with these codes.

Indicator 2 codes are professional component only codes that describe the work by the physician or other qualified health care professional. Neither Modifiers 26 nor TC can be used with these codes.

Indicator 3 codes are technical component only codes that describe the staff and equipment costs. Neither Modifiers 26 nor TC can be used with these codes.

Indicator 4 codes are global test only codes. These codes are stand-alone codes for which there are associates codes that describe either only the professional component of the test or only a technical component of the test. Modifiers 26 and TC cannot be used with these codes.

Indicator 5 codes are incident to codes. These are services covered incident to a physician’s services when provided by auxiliary personnel employed by and working under the physician.

Modifiers 26 and TC cannot be used. Services are not reimbursed when they are rendered to patients in inpatient or outpatient hospital setting.

Indicator 6 identifies clinical laboratory codes for which separate reimbursement for interpretations by laboratory physicians may be made. These codes are not considered eligible for reimbursement when submitted with Modifier TC.

Indicator 7 codes are for physician therapy services. Reimbursement is not eligible when the service is billed by an independently practicing physical or occupational therapist in an inpatient or outpatient hospital setting.

Indicator 8 codes are physician interpretation codes. This is for physician interpretation of an abnormal smear by a clinical laboratory service provider in an inpatient facility (place of service 21) setting only. TC billing is not recognized because payment for the clinical laboratory test is made to the hospital, generally through the PPS rate. Modifier 26 is not reported for Indicator 8 codes. This applies to CPT codes 88141 and 85060.

Indicator 9 codes are not applicable to the PC/TC concept.

CMS designates which procedure codes are valid for use with Modifiers 26 and TC. We utilize the CMS designations in determining procedure code/Modifier combinations.

Correct coding guidelines require that Modifier 26 be used when the professional component of a global service is the only service provided.

Modifier 26 must be reported with codes having a CMS PC/TC indicator of 1 by the interpreting physician or other qualified health care professional if the service is performed in a facility place of service setting. The facility will be reimbursed for the technical component portion of the service unless otherwise indicated in the facility contract.
Correct coding guidelines require that Modifier TC be reported when the service provided represents only the equipment or facility component of a global service and not the professional component of the same service. Hospitals frequently provide only the technical component of some services. Hospitals are not currently required to submit the TC Modifier; however, reimbursement is applied as if the TC had been reported.

A global procedure code should be reported when a single provider or entity performs both the professional and technical components of the service.

Modifier 25 - Significant, Separately Identifiable Evaluation and Management Service

According to the CPT® book "It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable (see Evaluation and Management (E/M)) service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service)."

The Modifier 25 is defined as a significant, separately identifiable Evaluation and Management (E/M) service by the same physician of other health qualified health care professional on the same day of a procedure or other service.

Medicare defines same physician as physicians in the same group practice who are of the same specialty. In this instance they must bill and be paid as though they were a single physician.

Modifier 25 indicates that on the day of a procedure, the patient's condition required a significant, separately identifiable E/M service, above and beyond the usual pre- and post-operative care associated with the procedure or service performed.

All E/M services provided on the same day as a procedure are part of the procedure and Medicare only makes separate payment if an exception applies.

Appropriate Use:

- ñ Use Modifier 25 with the appropriate level of E/M service.
- ñ An E/M service may occur on the same day as a procedure. Documentation must support the 25 Modifier and could be requested as necessary.
- ñ The procedure performed has a global period listed on the Medicare Fee Schedule Relative Value File.

Inappropriate Use:

- ñ Modifier 25 used by a physician other than the physician performing the procedure.
- ñ Documentation shows the amount of work performed is consistent with the level of effort normally performed and is not a significant, separately identifiable E/M service.
- ñ Modifier 25 should not be reported on procedure code 99211.

Exceptions:

- ñ Inpatient dialysis service- use Modifier 25 only on E/M same day as dialysis when:
  - o Unrelated to treatment of End Stage Renal Disease.
  - o E/M was not/could not be furnished during dialysis.
- ñ Critical Care Values- Use Modifier 25 only when:
  - o Critically ill; requires constant attention.
  - o Unrelated to specific injury/procedure.

Generally, separate payment is not made for E/M services performed on the same day as minor surgery.

Modifier 59, XE, XP, XS, XU - Distinct Procedural Service

Modifiers 59 - indicates a procedure or service is distinct or independent from other non-Evaluation and Management (E/M) services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must be present to support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

Modifier XE - indicates a procedure or service is distinct because it occurred during a separate encounter. Documentation must be present to support a procedure or service that occurred during a separate encounter.

Modifier XP - indicates a procedure or service is distinct because it was performed by a different practitioner. Documentation must be present to support the procedure or service was performed by a different practitioner on the same day as another service.

Modifier XS- indicates a procedure or service is distinct because it was performed by on a separate organ/structure. Documentation must be present to support a separate site or organ system, separate incision/excision, separate lesion, or separate injury not ordinarily encountered or performed on the same day by the same individual.

Modifier XU- indicates a procedure or service is distinct because it does not overlap usual components of the main service. Documentation must be present to support a distinct procedure or surgery not ordinarily encountered or performed as part of a main service.

Correct Use:

Different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.

- ñ Procedures are performed in different encounters on the same day.
- ñ Two services described by timed codes provided during the same encounter only when they are performed sequentially.
- ñ Diagnostic procedure which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure.
- ñ Diagnostic procedure which occurs subsequent to a completed therapeutic procedure only when the diagnostic procedure is not a common, expected, or necessary follow-up to the therapeutic procedure.

Incorrect Use:

- ñ Should not be appended to an E/M service.
- ñ Should not be used inappropriately if the basis for its use is that the narrative description of the two codes is different.
- ñ When another Modifier is more appropriate (e.g. Modifier 76 or 91).
- ñ Should not be used to bypass NCCI edits.

- ñ Does not replace Modifiers such as RT, LT, E1-E4, FA, F1-F9, TA, T1-T9, LC, LD, RC, LM, or RI.