Dean Health Plan Claim Processing Edits for Professional Claims

CPT and HCPCS Codes

Current Procedural Terminology, Fourth Edition (CPT-4) is primarily updated annually and distributed by the American Medical Association (AMA), for use in reporting physician and other health related services. *Healthcare Common Procedure Coding System* (HCPCS) is updated quarterly and is distributed by CMS.

DHP Processing	Additional Detail	Source	LOB
Only current CPT and HCPCS codes will be reimbursed.	Proper CPT and HCPCS coding is essential to the accurate reimbursement of a claim.	AMA CMS	All lines
The CPT/HCPCS chosen must accurately identify the service performed.	"Do not select a CPT code that merely approximates the service provided. If not such specific code exists, then report the service using the appropriate unlisted procedure or service". *Current Procedural Terminology, Fourth Edition*	AMA CMS	All lines
Add-on codes will not be reimbursed when the primary code is absent or has been denied for other reasons.	"Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code". All add-on codes are exempt from multiple procedure reduction rules. *Current Procedural Terminology, Fourth Edition*	AMA CMS	All lines
Separate procedures will not be separately reimbursed when billed with an associated major procedure.	Separate procedures are those services that are "commonly carried out as an integral component of a total service". These codes should not be reported in addition to the code for the total procedure or service.	AMA CMS	All lines

ICD-10 CM Volumes 1, 2 and 3

Included in the HIPAA code set for diagnosis reporting is the *"ICD-10-CM Official Guidelines for Coding and Reporting"*. These guidelines are updated and published each October and are available on the CDC website at http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm. The following are a few of the key points.

DHP Processing	Additional Detail	Source	LOB
All diagnosis codes on the claim should be valid and coded to the highest level of specificity.	Diagnosis codes are to be reported at their highest number of characters available. ICD-10-CM codes may be 3, 4, 5, 6 or 7 characters.	CMS	All lines
"Unspecified" codes are reimbursed under limited, specific circumstances.	"Unspecified codes should be reported when they are the codes that most accurately reflect what is known about the patient's condition at the time of that particular encounter". *ICD-10-CM Official Guidelines for Coding and Reporting* Unspecified/unlisted codes are not a replacement for an accurate and complete clinical note.	CMS	All lines

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Manifestation codes should not be submitted as the sole or primary diagnosis.	Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology.	CMS	All lines
Laterality is required when applicable.	The ICD-10 code reported should reflect the laterality of the condition. Separate codes for both the left and right side should be reported when a bilateral code is not available.	CMS	All lines
Codes describing "External Causes of Morbidity" should not be submitted as the sole or primary diagnosis	Codes V00-Y99 should always be reported as a secondary diagnosis.	CMS	All lines
ICD-10 CM codes reflecting the administration of chemotherapy, immunotherapy and radiation therapy should not be the only diagnoses reported.	The appropriate Z51.__ code should be listed as the primary diagnosis when a patient encounter is solely for the administration of chemotherapy or immunotherapy. The diagnosis for which the therapy is being administered would be assigned as a secondary diagnosis.	CMS	All lines

Modifier Policy

Modifiers are used to add additional specificity to a procedure or service without changing the meaning of the associated CPT or HCPCS code. Special care should be used to ensure that the modifier reported is appropriate for both the code and the clinical scenario.

DHP Processing	Additional Detail	Source	LOB
Services reported with inappropriate anatomical and/or distinct services modifiers will not be reimbursed.	Anatomic and distinct services modifiers are intended for use with specific procedures or services. For example, anatomical modifier –F5 (right hand, thumb) should not be appended to an E/M service. Or, modifier -25 (significant, separately identifiable service) should not be appended to a surgical code. Modifiers should be used appropriately so that they add specificity to a procedure or service.	AMA CMS	All lines
Physical medicine and rehabilitation services billed without therapy modifiers -GN, -GO or -GP will not be reimbursed.	Physical medicine and rehabilitation services are considered "always therapy" regardless of provider and require a therapy modifier. For additional information on the appropriate use of these modifiers, please see MLN Matters Article MM10176 available at CMS.gov	CMS	All lines
A procedure with modifier -77 will not be reimbursed when the same procedure code has been billed by the same provider on the same date of service.	Modifier -77 indicates that a procedure was repeated by a different physician. If the same physician performed the repeat procedure, then modifier -76 should be reported.	AMA CMS	All lines

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A procedure with modifier -76 will not be reimbursed when the same procedure code has not been billed by the same provider on the same date of service.	Modifier -76 indicates that a procedure was repeated by the physician. If a different physician performed the repeat procedure, then modifier -77 should be reported.	AMA CMS	All lines
A procedure with modifier -78 will not be reimbursed when the same or different 10- or 90-day procedure code has not been billed in the respective post-operative period by the same provider.	Following an initial procedure, an unplanned return to the operating room by the same physician during the postoperative period should be reported with modifier -78.	AMA CMS	All lines
A procedure with modifier -79 will not be reimbursed when the same or different 0-, 10- or 90-day procedure code has not been billed in the respective post-operative period by the same provider.	Modifier -79 should be used to report a second, unrelated procedure performed by the same physician during the post-operative period of the previous surgery.	AMA CMS	All lines
Procedures billed with modifier -27, -73, -74 or -CA will not be reimbursed if billed by a professional provider.	Modifiers -27, -73, -74 and -CA were created for use by facility providers only.	AMA CMS	All lines
Unlisted hemodialysis services will not be reimbursed when billed without modifiers G1-G6 in an ESRD facility.	When hemodialysis services (90999) are rendered in an ESRD facility (POS 65), modifier G1-G6 must be reported to show the adequacy of the service.	CMS	All lines

Place of Service (POS)
The POS code reported should reflect the entity where the service was rendered. These codes are another one of the HIPAA code sets and are maintained by CMS. For additional information, please visit their website at http://www.cms.gov/PlaceofServiceCodes/01_Overview.asp#TopOfPage

DHP Processing	Additional Detail	Source	LOB
Services billed under the incorrect place-of-service code will not be reimbursed.	The POS code reported should reflect the entity where the service was rendered	AMA CMS	All lines
C-codes will not be reimbursed when billed by a professional provider.	HCPCS codes C1000-C9999 represent the supplies, implants, drugs and the technical component associated to specific services and procedures. They were developed as part of Outpatient Prospective Payment System (OPPS) and are intended for use by outpatient facilities only.	CMS	All lines
Surgical dressings will not be separately reimbursed when billed in an office setting.	Surgical dressings applied in the office are considered incidental to the professional service.	AMA CMS	All lines

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	However, dressing changes sent home with the patient may be separately reimbursed when billed with the correct POS code.		
"Incident to" services will not be reimbursed when billed with a place of service code 21, 22, 23, 24, 26, 31, 34, 41, 42, 51, 52, 53, 56, 61, 62, or 65.	"Incident-to" guidelines are applicable to services provided in an office setting	CMS	All lines
Laboratory services provided outside of the office are reimbursed to physicians only in limited situations.	Reimbursement for laboratory tests (80000-89999) is included in the payment to the facility in which the services were rendered. Those tests with a professional component may be separately reimbursed when performed by an appropriate specialty, such as pathology, dermatopathology and genetics.	CMS	All lines
Physical therapy services provided by a speech-language pathologist or physical/occupational therapist will not be reimbursed if billed in an inpatient or outpatient hospital setting.	Reimbursement for physical therapy services provided by a PT, OT, or a speech-language pathologist is included in the payment to the facility in which the services were rendered.	CMS	All lines

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Maximum Units Policy

Each CPT/HCPCS code has been assigned a maximum number of units that may be billed per day for a member. Where available, DHP has accepted the CMS Medically Unlikely Edit (MUE) value. All other codes have been assigned a maximum-unit-of-service based on the code definition, anatomical site, clinical guidelines and industry standards.

DHP Processing	Additional Detail	Source	LOB
Procedures and services billed with a unit amount that is in excess of the assigned value, will not be reimbursed	Each CPT/HCPCS code has been assigned a maximum number of units that may be billed per day for a member	CMS	All lines

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Multiple Procedure Reduction / Multiple Endoscopy Reduction

"Most medical and surgical procedures include pre-procedure, intra-procedure, and post-procedure work. When multiple procedures are performed at the same patient encounter, there is often overlap of the pre-procedure and post-procedure work. Payment methodologies for surgical procedures account for the overlap of the pre-procedure and post-procedure work." *National Correct Coding Initiative (NCCI) Policy Manual, Chapter 1.*

DHP Processing	Additional Detail	Source	LOB
Multiple Procedure Reduction When multiple non-endoscopic surgical procedures are performed on the same patient on the same day by a physician in the same group practice, the standard 100%, 50%, 25% applies.	Identified by Status Indicator '2' on the PFS Relative Value File, the intent of multiple procedure reduction is to address duplication in the physician pre- and post-procedure work.	CMS	Commercial Medicare

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Multiple Procedure Reduction When multiple non-endoscopic surgical procedures are performed on the same patient on the same day by a physician in the same group practice, Subsequent procedures will be reimbursed at 50%, 25%, 13%, 13%	The intent of multiple procedure reduction is to address duplication in the physician pre- and post-procedure work.	CMS	Medicaid
Multiple Endoscopy Reduction When multiple endoscopies in different families are billed, standard multiple procedure reduction (MPR)	The primary procedure is the code with the highest RVU.	CMS	All lines
Multiple Endoscopy Reduction When multiple endoscopies in the same family are billed, the most extensive endoscopy will be reimbursed at 100% as determined by the Relative Value Unit (RVU) assigned. Payment for any secondary endoscopic procedure is based on a percentage amount derived from CMS 'National Payment Amount' assigned to the code.	Identified by Status Indicator '3'on the PFS Relative Value File, The intent of the multiple endoscopy reduction is to address the overlap in endoscopic procedures included in the same base family. A diagnostic endoscopy is always bundled to the surgical endoscopy.	CMS	Commercial Medicare

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Multiple Procedure Payment Reduction (MPPR)

Section 3134 of the Affordable Care Act (ACA) added section 1848(c)(2)(K) to the Social Security Act which specified that potentially misvalued codes be identified by examining those codes which are frequently billed together to furnish a single service. Payment-reduction rules were subsequently enacted to account for efficiencies in the practice expense (PE) component of therapy services and the technical component (TC) for cardiovascular and ophthalmology services. All procedures should be reported at full fee to ensure appropriate reimbursement.

The PFS Relative Value File assigns RVUs to most codes. Commonly known as the Medicare Physician Fee Schedule Database (MPFSDB), this file is available on the CMS website at http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp#TopOfPage

DHP Processing	Additional Detail	Source	LOB
Multiple Procedure Reduction for Therapy Services. When multiple "Always Therapy" codes are billed, the procedure with the highest RVU for the PE component is reimbursed at 100% of the contractual allowed amount. A 50% reduction will	In 2011, Medicare implemented payment-reduction rules to account for the efficiencies in the practice expense (PE) when multiple therapies are performed during the same session. Per the Centers for Medicare and Medicaid Services (CMS): "There is inherent duplication in	CMS	Commercial Medicare

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be applied to the PE component for subsequent units and procedures.	the PE associated with those services which are frequently furnished together".		
Multiple Procedure Reduction for Diagnostic Cardiovascular Procedures When multiple diagnostic cardiovascular codes are billed, the procedure with the highest RVU for the technical component will be reimbursed at 100% of the contractual allowed amount. A 25% reduction will be applied to the technical component for subsequent units and procedures. *Multiple Procedure Reduction for Ophthalmology Services* When multiple ophthalmology codes are billed, the procedure with the highest RVU for the technical component will be reimbursed at 100% of the contractual allowed amount. A 20% reduction will be applied to the technical component for subsequent units and procedures.	In 2013, Medicare implemented payment-reduction rules to account for the efficiencies in the technical component (TC) for multiple diagnostic cardiovascular services or multiple ophthalmology services performed during the same session. Per the Centers for Medicare and Medicaid Services (CMS): "When multiple diagnostic tests are furnished to the same patient on the same day, most of the clinical labor activities and some supplies are not furnished twice. Examples include: greeting and gowning the patient; preparing the room, equipment and supplies; taking history and vitals; reviewing prior test results, and preparing and positioning the patient.	CMS	Commercial Medicare
Multiple Procedure Reduction for Radiology Services When multiple imaging codes from the same family are billed on the same date of service, A 50% reduction will be applied to the technical component (TC) and a 5% reduction will be applied to the professional component (PC) of the secondary radiology services.	Multiple Procedure Reduction for Radiology rules apply when a provider performs two or more diagnostic imaging services from the same code family. The procedure with the highest non-facility RVU price for the technical component is reimbursed at 100%. The technical component for all secondary procedures is reduced by 50%.	CMS	Commercial Medicare

Bilateral Procedures

A bilateral procedure is defined as one that is performed on both sides of the body at the same session or on the same date of service.

Dean Health Plan requires that bilateral procedures be reported on a single line. When a procedure is performed bilaterally and the bilateral indicator is "1" or "3", modifier 50 should be appended to the procedure code and submitted on a single line. One (1) unit of service should be reported.

Bilateral indicators assigned to each code determine reimbursement and are available in the PFS Relative Value File. Commonly known as the Medicare Physician Fee Schedule Database (MPFSDB), this file is available on the CMS website at http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp#TopOfPage

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Description	Detail	Source	LOB
Bilateral procedures submitted inappropriately will not be reimbursed.	Bilateral procedures will be processed according to the indicator assigned in the Medicare Physician Fee Schedule Database.	CMS	All lines
Codes assigned a bilateral indicator of "0" will not be reimbursed at 150%.	Either the description specifically states that the code is unilateral in nature, or the physiology or anatomy makes a bilateral procedure unlikely.	CMS	All lines
Codes assigned a bilateral indicator of "1" will be reimbursed at 150%.	When performed bilaterally, these procedures should be reported with modifier -50.	CMS	All lines
Codes assigned a bilateral indicator of "2" will not be reimbursed at 150%.	These services are bilateral in nature. Bilateral reimbursement is already reflected.	CMS	All lines
Codes assigned a bilateral indicator of "3" will be reimbursed at 100% for each side.	These services are payable at 100% for each side when billed bilaterally.	CMS	All lines
Codes assigned a bilateral indicator of "9" will not be reimbursed at 150%.	The bilateral concept does not apply to these codes.	CMS	All lines

Professional, Technical and Global Services Policy
Certain procedures are comprised of a professional (physician) component and a technical (facility) component. The combination of the professional and technical component is considered the global service.

- **Modifier -26** – "Professional Component". Modifier -26 is appended to the procedure when only the professional component is performed.
- **Modifier -TC** – "Technical Component". Modifier -TC is appended to the procedure when only the facility component is performed.

To report the global service, the procedure code should be billed without a modifier. It would not be appropriate to report:

1. The procedure code with both -26 and -TC on the same line (xxxxx-26, TC), or
2. The procedure code on two lines with either the -26 or -TC (xxxxx-26 and xxxxx-TC).

PC/TC indicators assigned to each code determine reimbursement and are available in the PFS Relative Value File. Commonly known as the Medicare Physician Fee Schedule Database (MPFSDB), this file is available on the CMS website at http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp#TopOfPage

Description	Detail	Source	LOB
Neither modifiers -26 nor -TC should be used with codes assigned a PC/TC indicator of "0".	These are physician service codes that identify physician services. The PC/TC concept does not apply.	AMA CMS	All lines

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Neither modifiers -26 nor -TC should be used with codes assigned a PC/TC indicator of "2".	These are professional component only codes that describe the physician work portion of a diagnostic test. Other associated codes are available for the reporting of the technical component only and global tests.	AMA CMS	All lines
Neither modifiers -26 nor -TC should be used with codes assigned a PC/TC indicator of "3".	These are technical component only codes that describe the technical (staff and equipment costs) of a diagnostic test. Other associated codes are available for the reporting of the professional component only portion.	AMA CMS	All lines
Neither modifier -26 nor -TC should be used with codes assigned a PC/TC indicator of "4".	These are global only codes. There are other associated codes for the technical and professional components.	AMA CMS	All lines
Neither modifier -26 nor -TC should be used with codes assigned a PC/TC indicator of "9".	The PC/TC concept does not apply to these codes.	AMA CMS	All lines
Multiple submissions of professional or technical components of the same service will not be reimbursed.	Reimbursement of diagnostic tests and radiology services will be limited to no more than the amount for the global service regardless of whether the billing is from the same or different provider(s).	CMS	All lines
Neither the professional component of a radiology service nor consultations on x-ray exams made elsewhere, will be separately reimbursed when reported with an E/M service.	Radiology services billed with CPT code 76140 and/or modifier -26 are considered part of the E/M.	CMS	All lines
Technical component only codes and procedures billed with modifier -TC in either the inpatient or outpatient facility setting will not be reimbursed when billed by a professional provider.	These services should be billed by the facility in which they were performed.	CMS	All lines
Clinical laboratory services that do not have an associated professional component, will not be reimbursed when reported with modifier -26.	The interpretation of laboratory (80048-89399) results is included in the payment for E/M services. Additionally, CMS indicates that it is inappropriate for pathologists to bill for laboratory oversight and supervision through the use of this modifier. Reimbursement for laboratory oversight and supervision is obtained through the hospital or independent laboratory.	CMS	Medicare
Only one professional or technical component for the same service will be reimbursed.	DHP will reimburse up to the global amount for covered procedures. Modifiers should be used to indicate a repeat procedure or one that was	CMS	All lines

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	performed by a different physician so that the appropriate additional reimbursement can be made.		

Bundling and Other Reimbursement by Status Indicator
The work associated with some services and procedures is inherent to other more global procedures. Certain status indicators are available in the PFS Relative Value File to assist in identifying those codes.

DHP Processing	Additional Detail	Source	LOB
Codes assigned a status indicator of "P" will not be separately reimbursed when billed with any other payable services on the same day.	Bundled/excluded codes are considered incidental to other services provided by the same provider on the same date of service. There are no RVUs for these codes and they are not separately payable.	CMS	All lines
Codes assigned a status indicator of "B" will not be separately reimbursed.	Payment for bundled codes is always included in primary procedure, even when not performed on the same date of service.	CMS	All lines
Codes assigned a status indicator of "T" will not be separately reimbursed when billed with other payable services on the same day.	Codes assigned a status code of "T" are only reimbursable when there are no other services payable billed on the same date by the same provider.	CMS	All lines
Codes assigned a status indicator of "I" will not be separately reimbursed.	Codes assigned a status code of "I" are not valid for Medicare purposes. Per CMS, another code is required for the reporting of these services. Included in this grouping, are all HCPCS codes that begin with "S".	CMS	Medicare

Assistant Surgeon
An assistant-at-surgery provides an additional pair of hands for the operating surgeon. They differ from co-surgeons in that they do not have primary responsibility for, nor do they perform, distinct parts of the surgical procedure.

Modifiers should be used to indicate the type of assistant at surgery. All procedures should be reported at full fee to ensure appropriate reimbursement.

- **Modifier -80** - "Assistant Surgeon". One physician assists another in performing the entire procedure.
- **Modifier -81** - "Minimum Assistant Surgeon". One physician assists another in performing a portion of the procedure.
- **Modifier -82** - "Assistant Surgeon (when qualified resident surgeon not available)". Typically used by teaching hospitals.
- **Modifier -AS** - "Physician assistant, nurse practitioner; or clinical nurse specialist services for assistant at surgery". Surgeon is assisted by a non-physician provider, PA, NP or CNS.

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Assistant Surgeon indicators assigned to each code determine reimbursement and are available in the PFS Relative Value File. Commonly known as the Medicare Physician Fee Schedule Database (MPFSDB), this file is available on the CMS website at http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp#TopOfPage

Description	Detail	Source	LOB
Codes assigned an assistant surgeon indicator of '0', '1', and '9' will not be reimbursed.	Those procedures that require the services of an assistant surgeon, have been assigned a status indicator of "2"	CMS	All lines
Only one assistant surgeon is allowed per surgical procedure.	Only one assistant surgeon is allowed per surgical procedure	CMS	All lines
Covered procedures that qualify for an assistant-at-surgery that are reported with modifiers -80, -81, -82 will be reimbursed at 20% of the allowable amount. Modifier -AS will be reimbursed at 10%.	The services of a physician assistant at surgery is reimbursed at a different percentage than those of a PA or NP	CMS	Commercial Medicaid
Covered procedures that qualify for an assistant-at-surgery that are reported with modifiers -80, -81, -82, -AS will be reimbursed at 16% of the allowable amount.	The services of a physician assistant at surgery is reimbursed at a different percentage than those of a PA or NP	CMS	Medicare

Co-Surgeon

Under some circumstances, the individual skills of two surgeons are required to perform surgery on the same patient during the same operative session. This may be required due to the complex nature of the procedure(s) and/or the patient's condition. In these cases, the additional physicians are not acting as assistants-at-surgery.

Each surgeon should dictate separate operative reports and bill under the same code with modifier -62, "Two Surgeons". Additional procedures (including add-on procedures) may be reported with modifier -62 as long as the surgeons continue to work together. Bilateral and multiple procedure reduction rules apply along with any appropriate bundling edits. All procedures should be reported at full fee to ensure appropriate reimbursement.

Co-Surgeon indicators assigned to each code determine eligibility and are available in the PFS Relative Value File. Commonly known as the Medicare Physician Fee Schedule Database (MPFSDB), this file is available on the CMS website at http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp#TopOfPage

Description	Detail	Source	LOB
Codes assigned a co-surgeon indicator of "0", "1" and "9" will not be reimbursed.	Those procedures that require the services of a co-surgeon, have been assigned a status indicator of "2"	CMS	All lines
Modifier 62 will be reimbursed at 62.5% of the allowed amount.	The reimbursement for the total procedure is 125% of the allowable for an individual physician.	CMS	All lines

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Co-surgeon claims will not be reimbursed when both surgeons have the same subspecialty.	To qualify as a co-surgeon, each physician must have a different specialty.	AMA CMS	All lines

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Team Surgeon
Highly complex surgeries are carried out under the "surgical team" concept. These procedures require the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel and various types of complex equipment.

Each surgeon reports their participation in a team surgery once using the same code and modifier -66, "Surgical Team". Bilateral and multiple procedure reduction rules apply along with any appropriate bundling edits. Team surgeons are rare. When one surgeon assists another, modifiers -80, -81 or -82 may be more appropriate. All procedures should be reported at full fee to ensure appropriate reimbursement.

Team-Surgeon Indicators assigned to each code determine eligibility and are available in the PFS Relative Value File. Commonly known as the Medicare Physician Fee Schedule Database (MPFSDB), this file is available on the CMS website at http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp#TopOfPage

Description	Detail	Source	LOB
Codes assigned a team surgeon indicator of "0", "1" and "9" will not be reimbursed.	Those procedures that require the services of team surgeons, have been assigned a status indicator of "2"	CMS	All lines

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Split Surgical Care
When different physicians perform the pre-, intra- and post-operative portion of a 90-day procedure, each will be reimbursed a percentage of the global fee. The percentages allocated for each vary by procedure and are posted in the CMS PFS Relative Value File
http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp#TopOfPage

Modifiers should be used to indicate which portion each physician provided. All procedures should be reported at full fee to ensure appropriate reimbursement.

- **Modifier -54** - "Surgical Care Only". The physician who performs the surgery only should append modifier 54 to the appropriate surgical procedure code
- **Modifier -55** - "Post-operative Management Only. The physician who performs the post-operative care only should append modifier 55 to the appropriate surgical procedure code
- **Modifier -56** - "Pre-operative Management Only ". The physician who performs the pre-operative care only should append modifier 56 to the appropriate surgical procedure code

DHP Processing	Additional Detail	Source	LOB
Modifiers -54, -55 and -56 will be used to ensure that procedures with a 90-day global period are paid up to 100% of the global allowable.	The sum of the amount approved for all physicians performing pre-, intra- and post-operative services may not exceed what would	AMA CMS	All lines

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	have been paid if a single physician provided all services.		

Anesthesia
Services involving the administration of anesthesia should be reported using the five-digit anesthesia code (00100-01999).

- **Anesthesiologist -** Anesthesia modifiers are required to denote whether the anesthesiologist's service was personally performed, medically directed, medically supervised or represented monitored anesthesia care.
  - -AA – "Anesthesia services performed personally by an anesthesiologist"
  - -AD – "Medical supervision by a physician: more than 4 concurrent anesthesia procedures"
  - -QK – "Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals"
  - -QY – "Medical direction of one CRNA by an anesthesiologist"

- **CRNA** - CRNA's must report the appropriate anesthesia modifier to indicate whether the service was performed with or without physician supervision.
  - -QX – "CRNA Service: with medical direction by a physician"
  - -QZ – "CRNA Service: without medical direction by a physician"

- **Monitored Anesthesia modifiers**
  - -G8 (Monitored anesthesia care for deep, complex, complicated, or markedly invasive surgical procedure)
  - -G9 (Monitored anesthesia care for patient who has history of severe cardio-pulmonary condition)
  - -QS (Monitored anesthesia care service)

All procedures should be reported at full fee to ensure appropriate reimbursement.

Description	Detail	Source	LOB
Anesthesia billed under a surgical CPT code will be cross walked to a five-digit anesthesia code (00100-01999).	Services involving the administration of anesthesia should be reported using the five-digit anesthesia code (00100-01999).	CMS	All lines
General anesthesia services will not be reimbursed if billed without an appropriate modifier.	Anesthesia modifiers are required to denote whether the anesthesiologist's service was personally performed, medically directed, medically supervised or represented monitored anesthesia care. Similarly, CRNA's must report the appropriate anesthesia modifier to indicate whether the service was performed with or without physician supervision.	CMS	All lines

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If multiple general anesthesia service codes are received, only the highest submitted charge amount will be paid.	When multiple general anesthesia services are billed for the same day, only the anesthesia for the procedure with the highest base value, plus the time for all anesthesia services combined, should be reported. Excluded are: 01953, 01968, 01969, 01995, 01996	CMS	All lines
Modifiers AD, QK, QX and QY will be reimbursed at 50% of the allowed amount. Provider should report the charge at full fee, DHP will make the adjustment.	When a single anesthesia procedure involves both the medical direction of a physician and the services of medically directed CRNAs, the payment for all providers will be 50% of the allowance had the service been furnished by the anesthesiologist alone.	CMS	All lines
Patient demand event recording services billed with general anesthesia services will not be reimbursed.	Electrocardiography services are considered a component of general anesthesia services	CMS	All lines

Global Surgical Package / Global Period - Dean Health Plan has adopted the CMS definition and processing logic for the global surgical package.

- **Global Surgical Package**: Included in the global surgical package are: pre-and post-operative visits, intra-operative services, complications following surgery, supplies and miscellaneous services such as dressing changes, suture removal etc. Additional information on the global surgical package may be found in Chapter 12 of the Medicare Claims Processing Manual at http://www.cms.gov/manuals/downloads/clm104c12.pdf

- **Global Period:** Integral to the global surgical package is the global-period concept. The global period begins one-day prior to a procedure and extends to either 0-, 10- or 90-days after. Post-operative services during this time frame are considered incidental to the corresponding procedure. For major procedures, the global period is 90 days. Minor surgeries and endoscopies are assigned either 0- or 10-day global periods.

The PFS Relative Value File assigns global periods to most codes. Commonly known as the Medicare Physician Fee Schedule Database (MPFSDB), this file is available on the CMS website at http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp#TopOfPage

DHP Processing	Additional Detail	Source	LOB
E/M services performed the day prior to, or day of, a 90-day medical or surgical service will not be reimbursed separately.	Payment for the evaluation and management of the patient is included in the medical or surgical service performed unless the E/M was significant and separately identifiable or reflects the decision for surgery.	AMA CMS	All lines
E/M services performed during the post-operative period of a 10- or 90-day	Payment for post-operative care is included in the medical or surgical service performed. However, an unrelated E/M performed during	AMA CMS	All lines

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medical or surgical service will not be reimbursed separately.	the post-operative period of another procedure may be separately reimbursed when reported appropriately.		
E/M services performed the same day as a 0- or 10-day medical or surgical service will not be reimbursed separately.	Unless significant and separately identifiable, payment for E/M services is included in the medical or surgical service performed.	AMA CMS	All lines
Supplies will not be separately reimbursed when billed on the same date of service as a 0-, 10- or 90-day surgical procedure.	According to CMS policy, the practice expense for surgical procedures includes payment for the related supplies when furnished by the provider who performed the procedure.	AMA CMS	All lines
Surgical and medical services billed within the 10- or 90-day post-operative period for the corresponding global procedure codes will not be separately reimbursed.	Included in the global surgical package are all supplemental medical or surgical services required of the surgeon during the post-operative period which do not require additional trips to the operating room (OR). Procedures requiring a return to the OR should be billed with an appropriate modifier to indicate that the additional procedure is both distinct and separate.	AMA CMS	All lines
Anesthesia services provided by the surgeon will not be reimbursed.	This would include codes submitted with modifier -47.	CMS	All lines
Daily hospital management of epidural or subarachnoid continuous drug administration (01996) will not be separately reimbursed when performed by the operating surgeon on the same day as the procedure.	Payment for post-operative pain management is included in the global surgical fee.	CMS	All lines

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Global Obstetrical Package

According to CPT, “The services normally provided in uncomplicated maternity cases include antepartum care, delivery, and postpartum care”.

- **Antepartum Care** includes: The initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, visits (approximately 13).
- **Delivery Services** include: The admission to the hospital, the admission history and physical examination, management of uncomplicated labor, cesarean delivery or vaginal delivery (with or without episiotomy, forceps).
- **Postpartum Care** includes: Hospital and office visits following delivery.

DHP Processing	Additional Detail	Source	LOB
Those antepartum and delivery services which are included in global obstetrical package, will not be separately reimbursed	The American College of Obstetricians (ACOG) and the American Medical Society	AMA ACOG	All lines

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when billed on the same day as the delivery.	(AMA) have defined the global obstetrical package as including the services listed above.		
Multiple delivery codes will not be separately reimbursed when billed without a multiple gestation code.	For example, a global vaginal delivery will not be separately billed when billed with a global cesarean delivery code if the diagnosis does not reflect a multiple gestation	AMA ACOG	All lines
Cerclage removal will not be reimbursed separately when billed on the same date as the delivery code.	The reimbursement for cerclage removal is included in the payment for the delivery.	ACOG	All lines

Evaluation and Management (E/M) Services
"Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed." *CMS Medicare Claims Processing Manual 100-04, Chapter 12, Section 30.6.1.A.*

While there are many benefits to the Electronic Health Record (EHR), cloning, auto-fill and auto-prompts in the EHR system - which primarily impact the level of the History and Physical Exam component of the encounter - may result in the billing of a higher-level E/M code than the service actually provided, based on the level of Medical Decision Making required. To date, neither the 1995 or 1997 *Documentation Guidelines for Evaluation and Management* have addressed this significant change in technology.

Therefore, Dean Health Plan includes Medical Decision Making as a key component in the review of all E/M services.

DHP Processing	Additional Detail	Source	LOB
Providers identified as billing a higher-level E/M than their peers more than 50% of the time, may be included in DHP's E/M recoding program. Advance notice will be given to providers included in this program.	Level 4 or 5 E/M services may be recoded should the nature of the presenting problem be inconsistent with the level of service billed.	AMA CMS	All lines
A new patient E/M will not be reimbursed when used to report services for an established patient.	Per CPT, a new patient is one who has not received any professional service from the physician or another physician in the group of the same specialty, within the previous three years.	AMA CMS	All lines
An office consultation service will not be reimbursed when any other E/M service has been recently billed for the same diagnosis by same provider or provider group of the same specialty.	Per CPT, follow-up visits that are initiated by the physician consultant or patient are to be reported using the appropriate codes for established patients, not one for consults (99241-99245). Additional requests for office consultations are unlikely to occur within several months of the initial consult.	CMS	All lines

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Only one E/M is allowed per day from the same provider group and specialty.	Significant, separately identifiable E/M services might be reimbursed when billed with the appropriate modifier.	CMS	All lines
An interpretation and report only of a rhythm ECG will not be reimbursed when billed with an E/M service in the hospital setting.	Per CPT, It is not appropriate to use 93042 to report the review of a telemetry monitor strip taken from a monitoring system. There must be a specific order and separate, signed, retrievable report.	AMA CMS	All lines

National Correct Coding Initiative (NCCI)

Dean Health Plan uses the CMS' NCCI and its associated manual in its claims processing. According to CMS, these policies are based on a number of sources including; AMA coding conventions as defined in the CPT manual, national and local CMS policies, coding guidelines developed by national societies, analysis of standard medical and surgical practices and a review of current coding practices. NCCI tables and their associated manuals are available on the CMS website at http://www.cms.gov/NationalCorrectCodInitEd/01_overview.asp#TopOfPage

DHP Processing	Additional Detail	Source	LOB
Column II procedure codes will not be reimbursed when submitted with a code from Column I.	The Column II code is considered the component code.	CMS	All lines
Procedures considered to be inappropriately coded based on NCCI policies will not be separately reimbursed.	Not all edits are contained in the NCCI tables. Many general coding principles, issues and policies are addressed in the NCCI Policy Manual.	CMS	All lines
Allergy testing is not separately reimbursed when performed on the same date as immunotherapy of the same allergen.	In standard medical practice, allergy testing (95004-95078) is not performed on the same day as allergy immunotherapy (95115-95180).	CMS	All lines
E/M services that are not significant and separately identifiable from allergy testing or immunotherapy will not be reimbursed.	An E/M solely for the interpretation of an allergy test or to obtain informed consent for immunotherapy (95004-95199) is not separately reportable.	CMS	All lines
E/M services that are not significant and separately identifiable will not be reimbursed when billed on the same day as a stress test, stress echocardiography, myocardial perfusion imaging or pulmonary function testing.	Unless significant, separately identifiable, a limited history and physical exam is considered integral to a stress test, stress echocardiography, myocardial perfusion imaging (e.g. 78451-78454, 93015-93016, 93350-93351) or pulmonary function testing (e.g. 94010-94014, 94620-94621 etc).	CMS	All lines
E/M services performed by a radiologist will not be reimbursed when billed with a XXX-day global radiology service.	Physician interaction with a patient prior to a radiographic procedure generally involves a limited pertinent historical inquiry about reasons for the examination, the presence of allergies, acquisition of informed consent, discussion of follow-up, and the review of the medical record.	CMS	All lines

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	In this setting, a separate E/M service should not be reported.		
Operating microscopes may be separately reimbursable with specific procedures.	According to CMS policy, the use of an operating microscope may be separately reimbursed when used with one of the following procedures: 61304-61546, 61550-61711, 62010-62100, 63081-63308, 63704-63710, 64831, 64834-64836, 64840-64858, 64861-64871, 64885-64891, 64905-64907.	CMS	All lines
Reimbursement for local anesthesia, including lidocaine, is included the primary procedure.	An exception may be made for lidocaine used as a medication for heart arrhythmias.	CMS	All lines

Drugs and Biologicals

Drug and Biologicals payment policies enforce guidelines such as appropriate indications and frequency for use, dosing limits, etc.

Description	Detail	Source	LOB
Policies include, but may not be not limited to, the following: • The drug must be used for labeled or industry accepted off-labeled indications. • The dosage must be appropriate for the specific condition of the patient. • The frequency of administration must be appropriate for the diagnosis for which it is being used. • The drug must be appropriate for the age of the patient to whom it is being administered. • The drug should not be given with other drugs that might	Examples of drugs included in these policies include: Omalizumab (Xolair®), Bevacizumab (Avastin®), Pegfilgrastim (Neulasta®), Filgrastim (Neupogen®), Paclitaxel (Taxol®), Paclitaxel protein-bound particles (Abraxane®), Doxorubicin HCL (Doxil®), Docetaxel (Taxotere®), Infliximab (Remicade®), Trastuzumab (Herceptin®), Antihemophilic Factor VIII, Antihemophilic Factor IX, Rituximab (Rituxan®), Iron Sucrose, Iron Dextran, Zoledronic Acid (Zometa®), Zoledronic Acid (Reclast®), Palonosetron HCI (Aloxi®), Ranibizumab (Lucentis®), Amphotericin B Liposome (AmBisome®), Oxaliplatin (Eloxatin®), Bortezomib (Velcade®), Leuprolide Acetate (Lupron®), Leuprolide Acetate Depot (Lupron Depot®, Eligard®), Leuprolide Acetate Implant, Cetuximab	The primary source for these payment policies is the manufacturer's package insert (FDA approved indications). Other industry authority references include but are not limited to sources such as: Elsevier Gold Standard's Clinical Pharmacology, Thomson MICROMEDEX® (DRUGDEX®, DrugPoints®), American Hospital Formulary System (AHFS) DI, National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium, and Centers for Medicare and Medicaid Services (CMS) Regional Local Carrier Determinations (LCDs).	All lines

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cause an adverse reaction. • The drug should be administered by the appropriate route (i.e. injection, intravenous infusion, intralesional, intra-arterial, etc.).	(Erbitux®), Sodium Hyaluronate (Hyalagan®, Supartz®, Synvisc®, Euflexxa®, Orthovisc®), Darbepoetin Alfa (Aranesp®), Epoetin Alfa (Procrit®, Epogen®), Octreotide Acetate (Sandostatin LAR®), Velaglucerase Alfa, Alglucerase and Imiglucerase (VPRIVTM, Cerezyme®. Ceredase®), Fulvestrant (Faslodex®)		

Chiropractic Care

Description	Detail	Source	LOB
Chiropractic manipulative treatment will be allowed no more than once per day	98940-98942 will be allowed no more than once per day, when billed by any provider.	CMS	All lines
Chiropractic manipulation will not be reimbursed when billed without the requisite modifier	98940-98942 without the acute treatment modifier, -AT, will not be reimbursed. Maintenance therapy is not a covered benefit.	CMS	All lines
Chiropractic manipulation will only be reimbursed when performed for covered indications	For Medicare, please see National Government Services (NGS) Local Coverage Determination (LCD) on Chiropractic Services for more information.	CMS	Medicare

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