Professional Claims Payment Logic

At Prevea360, we are committed to processing claims in a consistent and accurate manner. To support this ongoing effort, our claims logic is reviewed frequently to ensure compliance with nationally recognized sources.

CPT and HCPCS Codes

Current Procedural Terminology, Fourth Edition (CPT-4) is 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. Proper CPT and HCPCS coding is essential to the accurate reimbursement of a claim.

Prevea360Processing	Additional Detail	Source	LOB
Only current CPT and HCPCS codes will be reimbursed	Deleted codes that have a one-to-one mapping to a valid code will be recoded and reimbursed. Codes that cannot be recoded will be denied for a more appropriate code.	AMA CMS	All lines
CPT/HCPCS codes should be consistent with the patient's age and gender based on the definition	Codes that have a one-to-one mapping will be processed under the more appropriate code. Services and procedures that cannot be recoded will be denied for a more appropriate code.	AMA CMS	All lines
The CPT/HCPCS chosen must accurately identify the service performed	"Unbundled" services will either be denied or recoded to a more appropriate code. For example, if a brain CT scan without contrast is reported (70450) in conjunction with a brain CT scan with contrast (70460), both codes will be replaced with 70470 (Brain CT without and with contrast).	AMA CMS	All lines
Add-on codes will not be reimbursed when the primary code is absent or has been denied for other reasons	Per CPT, "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.	AMA CMS	All lines
Separate procedures will not be separately reimbursed when billed with an associated major procedure	Per CPT, 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-9 CM Volumes 1, 2 and 3

Included in the HIPAA code set for diagnosis reporting is the *"ICD-9-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.

Prevea360 Processing	Additional Detail	Source	LOB
All diagnosis codes on the claim should be valid and coded to the highest level of specificity	Don't forget the 4th and/or 5th digit when required.	CMS NCHS	All lines
Codes describing "External Causes of Injury and Poisoning" should not be submitted as the sole or primary diagnosis	E-codes (E800-E999) should always be reported as a secondary diagnosis.	CMS NCHS	All lines
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. The index of ICD-9-CM indicates which code must be reported first.	CMS NCHS	All lines
Chemotherapy administration codes should not be the only diagnoses on the claim	V58.11 or V58.11 should be listed as the primary diagnosis when a patient encounter is solely for the administration of chemotherapy or immunotherapy. The malignancy for which the therapy is being administered would be assigned as a secondary diagnosis.	CMS NCHS	All lines
Diagnosis codes should be appropriate for the patient's gender and age	Additional information on the age and gender requirements for a code is found in the index of ICD-9-CM.	CMS NCHS	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.

Preve360Processing	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	AMA CMS	All lines

	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.		
Diagnostic and outpatient non-rehabilitation services billed with therapy services modifiers -GN, -GO, -GP will not be reimbursed	Per CMS, therapy services modifiers -GN (speech-language), -GO (occupational) or -GP (physical) should only be appended to those codes that describe therapy services. For additional information on the appropriate use of these modifiers, please see the WPS LCD L28531 entitled "Outpatient Rehabilitation Therapy Services billed to Medicare Part B" and its associated "Coding and Billing Guidelines".	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 the WPS LCD L28531.	CMS	Medicare Medicaid
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
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	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

period by the same provider			
Portable x-ray transportation services will not be reimbursed when reported without an x-ray transportation modifier	A portable x-ray transportation services (R0075) requires one of the following modifiers to indicate the total number of patients served. -UN (two patients served), -UP (three patients served), -UQ (four patients served), -UR (five patients served) or -US (six or more patients served).	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

Evaluation and Management (E/M) Services

Prevea360 Processing	Additional Detail	Source	LOB
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
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

Place of Service (POS)

In a 2009 audit, the Office of the Inspector General (OIG) estimated that Medicare carriers overpaid physicians $20.2 million for incorrectly coded services provided during a 2-year period that ended December 31, 2006. For 129 of the 150 services sampled, an office place of service was used for services performed in an outpatient hospital or ASC setting.

A reminder that 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

Prevea360 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. However, dressing changes sent home with the patient may be separately reimbursed when billed with the correct POS code.	AMA CMS	All lines
"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	Reimbursement for physical therapy services provided by a PT, OT, or a speech-language	CMS	All lines

physical/occupational therapist will not be reimbursed if billed in an inpatient or outpatient hospital setting	pathologist is included in the payment to the facility in which the services were rendered.		

National Correct Coding Initiative (NCCI)

Prevea360 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

Prevea360 Processing	Additional Detail	Source	LOB
Column II procedure codes will not be reimbursed when submitted with a code from Column I	For both the Mutually Exclusive and C1/C2 tables, 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,	CMS	All lines

	discussion of follow-up, and the review of the medical record. 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

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. 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

Prevea360 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

Multiple Procedure Reduction

Multiple procedures performed by the same provider during the same session are subject to multiple procedure reduction rules. Prevea360 assigns the primary procedure based on the relative value unit (RVU) assigned to the code for that place of service. Secondary procedures are reimbursed at a reduced rate. 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

Prevea360 Processing	Additional Detail	Source	LOB
Covered procedures with the highest RVU will be reimbursed at 100%. Subsequent procedures will be reimbursed at 50%	Modifier -51 will be used to ensure the appropriate multiple procedure reduction is taken.	CMS	Commercial Medicare
Covered procedures with the highest RVU will be reimbursed at 100%. Subsequent procedures will be reimbursed at 50/25/13/13	Modifier -51 will be used to ensure the appropriate multiple procedure reduction is taken.	CMS	Medicaid
A 50% multiple procedure reduction will be applied to the technical component (TC) of radiology services when multiple imaging codes from the same family are billed on the same date of service	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	All lines

Global Surgical Package / Global Period – Prevea360 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

Prevea360 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 medical or surgical service will not be reimbursed separately	Payment for post-operative care is included in the medical or surgical service performed. However, an unrelated E/M performed during the post-operative period of another procedure may be separately reimbursed when reported appropriately.	AMA CMS	All lines
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	Payment for post-operative pain	CMS	All

or subarachnoid continuous drug administration (01996) will not be separately reimbursed when performed by the operating surgeon on the same day as the procedure	management is included in the global surgical fee.		lines

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

Prevea360 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 have been paid if a single physician provided all services.	AMA CMS	All lines

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.

Prevea360 Processing	Additional Detail	Source	LOB
Those antepartum and delivery services which are included in global obstetrical package, will not be separately reimbursed when billed on the same day as the delivery	The American College of Obstetricians (ACOG) and the American Medical Society (AMA) have defined the global obstetrical package as including the services listed above.	AMA ACOG	All lines
Multiple delivery codes will not be separately reimbursed when billed without a multiple gestation code	For example, a global vaginal delivery (59400) will not be separately billed when billed with a global cesarean delivery code (59510) if the diagnosis does not reflect a multiple gestation (V27.2-V27.9, 651-651.93 etc.).	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

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.

Prevea360 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

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	These services are bilateral in nature. Bilateral	CMS	All

indicator of "2" will not be reimbursed at 150%	reimbursement is already reflected.		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

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.

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	The services of a physician assistant at surgery is	CMS	Commercial Medicaid

modifiers -80, -81, -82 will be reimbursed at 20% of the allowable amount. Modifier -AS will be reimbursed at 10%	reimbursed at a different percentage than those of a PA or NP		
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 an 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
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

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

Multiple Endoscopy Policy

CMS has established special rules for the payment of multiple endoscopic procedures performed on the same date of service based on related or unrelated families. A related endoscopic procedure, for example, would be two different upper gastrointestinal endoscopies performed on the same date. An unrelated, would be an upper and lower gastrointestinal endoscopy. For each family there is a base endoscopy procedure which is considered to be a component of all other endoscopies within that family. Reimbursement for multiple endoscopic procedures is calculated by deducting the cost of the base endoscopy from the related endoscopy

Multiple Endoscopy indicators assigned to codes 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 a multiple procedure indicator of "3", will be processed according to CMS Multiple Endoscopy rules	The highest RVU priced endoscopy will be reimbursed at 100%. Subsequent related endoscopies are calculated at the difference of their RVU price from the base endoscopy RVU	CMS	Medicare

	price.		
Standard multiple procedure rules will apply when related endoscopies are performed with non-endoscopy services	Covered procedures with the highest RVU will be reimbursed at 100%. Subsequent procedures will be reimbursed at 50%.	CMS	Medicare

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 or -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
Neither modifiers -26 or -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 or- 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 or -TC should	These are global only codes. There are other	AMA	All lines

be used with codes assigned a PC/TC indicator of "4"	associated codes for the technical and professional components.	CMS	
Neither modifier -26 or -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	Prevea360 will reimburse up to the global amount for covered procedures. Modifiers should be used to indicate a repeat procedure or one that was performed by a different physician so that the appropriate additional reimbursement can be made.	CMS	All lines

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, Prevea360 is following WPS Medicare guidelines. Please see their LCD on Chiropractic Services for more information.	CMS	Medicare

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
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, Prevea360 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

CMS National Coverage Determination (NCD) Policies for Laboratory Testing – Prevea360 has adopted NCD policies for a number of laboratory tests. For the most up-to-date listing of diagnosis-to-procedure requirements, please see the CMS website at:
http://www.cms.gov/CoverageGenInfo/04_LabNCDs.asp#TopOfPage

Description	Detail	Source	LOB
Total thyroxine, free thyroxine and thyroid hormone uptake/binding ratio will only be reimbursed when performed for a covered diagnosis	Codes 84436, 84439 and 84479 will only be reimbursed when billed with diagnosis codes listed in the CMS Lab NCD.	CMS	All lines
Cholesterol, lipoprotein, and triglyceride testing will only be reimbursed when performed for a covered diagnosis	Codes 82465, 83700, 83701, 83704, 83718, 83721, 84478 will only be reimbursed when billed with diagnosis codes listed in the CMS Lab NCD.	CMS	All lines
Lipid panel testing is allowed once or twice per year depending on clinical indication.	When used in conjunction with one of the diagnosis codes listed in the CMS Lab NCD, 80061 will be allowed twice per year. All other indications are allowed once per year.	CMS	All lines
Gonadotropin will only be reimbursed when performed for a covered diagnosis	84702 will only be reimbursed when billed with diagnosis codes listed in the CMS Lab NCD.	CMS	All lines

Drugs and Biologicals

Description	Detail	Source	LOB
Rituximab (Rituxan®) will only be reimbursed for labeled indications	Rituximab (Rituxan®) will only be reimbursed for labeled indications such as non-Hodgkin's and Hodgkin's lymphoma, chronic lymphoid leukemia, systemic lupus erythematosus and rheumatoid arthritis.	Drug label	All lines
Zoledronic Acid (Reclast®) will only be reimbursed for labeled indications	Zoledronic Acid (Reclast®) will only be reimbursed for labeled indications such as osteoporosis and pathologic fracture of hip.	Drug label	All lines
Sodium Hyaluronate or Derivative (Hyalagan®, Supartz®, Synvisc®, Euflexxa®, Orthovisc®) and it's administration fee will only be reimbursed for labeled indications	Sodium Hyaluronate or derivative (J7321-J7325) is indicated for the treatment of pain associated to osteoarthritis of the knee in patients who have failed to respond adequately to conservative nonpharmacologic therapy and simple analgesics.	Drug label	All lines
Leuprolide Acetate Depot, 3.75 mg (Lupron Depot®, Eligard®) will only be reimbursed for labeled	Leuprolide Acetate Depot, 3.75 mg (Lupron Depot®, Eligard®) will only be reimbursed for labeled indications such as endometriosis,	Drug label	All lines

indications	uterine leiomyomata and breast cancer		
Injections of darbepoetin alfa, 1 mcg (non-ESRD use) and epoetin alfa, (for non-ESRD use), 1000 units will not be reimbursed without the appropriate anemia modifier	J0881 and/or J0885 require the submission of an appropriate anemia modifier: • EA (ESA, anemia, chemo-induced), • EB (ESA, anemia, radio-induced), or • EC (ESA, anemia, non-chemo/radio).	CMS	All lines

Other Policies

Description	Detail	Source	LOB
Pre-diabetic screening tests for non-diabetic patients will be reimbursed once per year and should be billed with diagnosis V77.1	Pre-diabetic screening includes 82947, 82950 and 82651.	CMS	All lines
For patients that have been diagnosed as pre-diabetic, screening tests are limited to one test every 6 months and should be billed with diagnosis V77.1	Follow-up screening (82947, 82950, 82951) will be allowed when billed with modifier –TS.	CMS	All lines
Allergen specific IgE testing (86003) is limited to forty (40) times in one year	Per WPS, if a food allergy is not suspected, few than 30 tests are usually sufficient. Rarely, are more than 50 indicated.	CMS	All lines
Ocular photography performed more than twice per year will not be reimbursed	It is rarely necessary for ocular photography to be performed more than twice in a year.	CMS	All lines
Integumentary photography performed more than once per year will not be reimbursed	Integumentary photography (96904) is not allowed more frequently than once per year.	CMS	All lines