MDwise Marketplace Reimbursement Manual

Contents

Introduction........................................................................................................................................... 4

ABC - Abortion Coverage..................................................................................................................... 5

ANP - Advanced Practice Nurses, Physician Assistants & Dieticians................................................. 10

AMT - Ambulance Transportation......................................................................................................... 17

ASC - Ambulatory Surgical Centers....................................................................................................... 25

ANS - Anesthesia .................................................................................................................................... 34

BHS - Behavioral Health Services.......................................................................................................... 46

CRS - Cardiac Rehab Services ............................................................................................................... 57

DNT - Dental Services ............................................................................................................................ 60

DBE - Diabetic Equipment, Education, & Supplies.............................................................................. 62

DHS - Diagnostic Health Services........................................................................................................... 66

DLS - Dialysis Services .......................................................................................................................... 74

DME – DME Medical Supplies ............................................................................................................... 81

EMP - Emergency and Post-Stabilization Services .............................................................................. 91

HMC - Home Care .................................................................................................................................. 96

HSP - Hospice .......................................................................................................................................... 107

HTT - Human Organ and Tissue Transplant ....................................................................................... 116

IHS - Inpatient Hospital Services .......................................................................................................... 120

MNP - Manipulation Therapy ................................................................................................................. 130

MTS - Maternity Services ....................................................................................................................... 134

OHS - Outpatient Hospital Services ...................................................................................................... 144

PST - Outpatient Physical, Occupational, & Speech Therapy............................................................... 158

PHM - Pharmacy and Biologicals .......................................................................................................... 166

PMR - Physical Medicine and Rehab Services .................................................................................... 178

PHY - Physician Services ....................................................................................................................... 183

POD - Podiatry Services ......................................................................................................................... 204

PRV - Preventative Services ................................................................................................................... 217

PLR - Pulmonary Rehab .......................................................................................................................... 228
Dear Provider,

MDwise developed this reimbursement manual to provide guidance in interpreting certain specific Marketplace benefits. We hope that you find this reimbursement manual helpful, but please do not consider this manual all inclusive.

Each chapter in this manual is dedicated to a type of service rendered. For certain services, take for example “Preventative Services”, providers may need to read multiple chapters.

Chapters are then further broken down into the following sections.

**Benefit Coverage**
This section outlines the extent of coverage for a type of service and includes definitions of phrases that are key to understanding the MDwise Marketplace benefit.

**Benefit Limitations and Exclusions**
Information on limitations and exclusions for the particular benefit will be found in this section. Providers can also find the exclusion list at the end of this manual. Please note that these lists are not all inclusive and there may be other limitations or exclusions not included. You may find additional exclusions in the MDwise Marketplace Individual and Child-Only contracts.

**Provider Reimbursement and Submission Requirements**
This section details required modifiers, service provider requirements, and limits on associated charges.

**Procedure Codes and Claim Consideration**
We have included applicable CPT and ICD-10 codes for you to reference. Please note that the codes included are for clarity, and may not be the full list of applicable codes.

**Prior Authorization (PA) Requirements**
Prior authorization requirements for the particular benefit can be found here. You should also refer to our prior authorization quick reference guide which can be found at MDwise.org/forms. Please note that all services rendered by an out of network provider or facility require prior authorization, except in the case of emergencies.

**Disclaimer:** MDwise has developed this Marketplace policy and procedure based upon the current available information as of the most recent effective date. The intention of this policy is to provide guidance in interpreting certain standard Marketplace benefits. This information may not be all inclusive. As the claims payer entity, and the MDwise’s delegate, the claims payer has the responsibility to review coding and billing related issues and policy updates affecting claims processing and implement those changes. If there is a discrepancy between claims administration information, provider billing issues and MDwise policy, please notify MDwise immediately.
ABC - Abortion Coverage

1. Benefit Coverage

1.1. MDwise reimburses for therapeutic treatment of spontaneous or missed abortion and services relevant to this treatment.

1.2. An elective abortion is an abortion that a doctor performs because the mother has chosen to terminate the pregnancy. In accordance with IC 16-34-1-8 MDwise may only cover an elective abortion in the following cases:
   - The pregnant woman became pregnant through an act of rape or incest.
   - An abortion is necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

1.3. For an elective abortion to be covered by MDwise one of the following is necessary:
   - A physician has found, and certified in writing on the basis of his professional judgment, that the life of the mother would be endangered if the fetus were carried to term. The certification must contain the name and address of the patient, or
   - If the pregnancy is the result of an act of rape or incest, signed documentation must be received from a law enforcement agency or public health service stating:
     o That the person upon whom the medical procedure was performed was reported to have been the victim of an incident of rape or incest
     o The date on which the incident occurred
     o The date on which the report was made, which must have been within 60 days of the date on which the incident occurred; the name and address of the victim; and the name and address of the person making the report (if different from the victim)
     o That the report included the signature of the person who reported the incident

2. Benefit Limitations and Exclusions

2.1. The following benefit limitations or exclusions apply to abortion services:
   - Except for the reasons stated in section 1.2., elective abortions are not covered.
   - With the exception of emergency services, all services provided by out of network providers require prior authorization.

3. Provider Reimbursement & Submission Requirements

3.1. An elective abortion is reimbursed only if submitted with appropriate documentation (as outlined in 1.3). Providers must attach the documentation to the paper claim form or send it separately as an attachment to the electronic claim transaction. Correct documentation must be submitted with a claim before the abortion or any directly related service can be reimbursed. The primary service provider should forward copies of the physician certification to the related service provider to bill for these services.

3.2. MDwise does not require supporting documentation for spontaneous, missed, or threatened abortions (See Table 3). MDwise reimburses for therapeutic treatment of spontaneous or missed
abortion, and services relevant to this treatment, according to the provider's contracted allowable amount.

3.3. Reimbursement methodology related to covered elective abortions and services is based on the place of service (e.g. outpatient office, clinic, provider's office) and type of abortion (e.g. surgical versus non-surgical). Please see the applicable BCCP for provider reimbursement specifics.

4. **Procedure Codes and Claim Considerations**

4.1. The diagnosis or procedure codes listed in the tables below indicate a possible elective abortion was performed. The claims payer should suspend claims that have one of the diagnoses from Table 1 or one of the procedure codes from Table 2 for claims examiner review of appropriate documentation supporting coverage of the elective abortion. If appropriate documentation is not submitted with the claim, then the claim must be denied. The exception is a claim with one of the diagnosis codes provided in Section 4.2.

In addition to the diagnosis/procedure list below, use of G7 modifier (the pregnancy resulted from rape or incest, or pregnancy certified by physician as life threatening) may also be used to indicate that appropriate documentation must be reviewed.

**Table 1 - Diagnosis Codes that Suspend for Review of Documentation**

<table>
<thead>
<tr>
<th>Diagnosis Code (ICD-10)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>O04.5</td>
<td>Genital tract and pelvic infection following (induced) termination of pregnancy</td>
</tr>
<tr>
<td>O04.6</td>
<td>Delayed or excessive hemorrhage following (induced) termination of pregnancy</td>
</tr>
<tr>
<td>O04.7</td>
<td>Embolism following (induced) termination of pregnancy</td>
</tr>
<tr>
<td>O04.80</td>
<td>(Induced) termination of pregnancy with unspecified complications</td>
</tr>
<tr>
<td>O04.81</td>
<td>Shock following (induced) termination of pregnancy</td>
</tr>
<tr>
<td>O04.82</td>
<td>Renal failure following (induced) termination of pregnancy</td>
</tr>
<tr>
<td>O04.83</td>
<td>Metabolic disorder following (induced) termination of pregnancy</td>
</tr>
<tr>
<td>O04.84</td>
<td>Damage to pelvic organs following (induced) termination of pregnancy</td>
</tr>
<tr>
<td>O04.85</td>
<td>Other venous complications following (induced) termination of pregnancy</td>
</tr>
<tr>
<td>O04.86</td>
<td>Cardiac arrest following (induced) termination of pregnancy</td>
</tr>
<tr>
<td>O04.87</td>
<td>Sepsis following (induced) termination of pregnancy</td>
</tr>
<tr>
<td>O04.88</td>
<td>Urinary tract infection following (induced) termination of pregnancy</td>
</tr>
<tr>
<td>O04.89</td>
<td>(Induced) termination of pregnancy with other complications</td>
</tr>
<tr>
<td>O07.0</td>
<td>Genital tract and pelvic infection following failed attempted termination of pregnancy</td>
</tr>
<tr>
<td>O07.1</td>
<td>Delayed or excessive hemorrhage following failed attempted termination of pregnancy</td>
</tr>
<tr>
<td>O07.2</td>
<td>Embolism following failed attempted termination of pregnancy</td>
</tr>
<tr>
<td>O07.30</td>
<td>Failed attempted termination of pregnancy with unspecified complications</td>
</tr>
<tr>
<td>O07.31</td>
<td>Shock following failed attempted termination of pregnancy</td>
</tr>
<tr>
<td>O07.32</td>
<td>Renal failure following failed attempted termination of pregnancy</td>
</tr>
<tr>
<td>O07.33</td>
<td>Metabolic disorder following failed attempted termination of pregnancy</td>
</tr>
<tr>
<td>O07.34</td>
<td>Damage to pelvic organs following failed attempted termination of pregnancy</td>
</tr>
<tr>
<td>Diagnosis Code (ICD-10)</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>O07.35</td>
<td>Other venous complications following failed attempted termination of pregnancy</td>
</tr>
<tr>
<td>O07.36</td>
<td>Cardiac arrest following failed attempted termination of pregnancy;</td>
</tr>
<tr>
<td>O07.37</td>
<td>Sepsis following failed attempted termination of pregnancy</td>
</tr>
<tr>
<td>O07.39</td>
<td>Failed attempted termination of pregnancy with other complications</td>
</tr>
<tr>
<td>O07.4</td>
<td>Failed attempted termination of pregnancy without complication</td>
</tr>
<tr>
<td>Z33.2</td>
<td>Encounter for elective termination of pregnancy</td>
</tr>
</tbody>
</table>

**Table 2 - Procedure Codes that Suspend for Review of Documentation**

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>59100</td>
<td>Hysterotomy, abdominal</td>
</tr>
<tr>
<td>59200</td>
<td>Insertion of cervical dilator, (e.g., luminaria, prostaglandin) (separate procedure)</td>
</tr>
<tr>
<td>59840</td>
<td>Induced abortion, by dilation and curettage</td>
</tr>
<tr>
<td>59841</td>
<td>Induced abortion, by dilation and evacuation</td>
</tr>
<tr>
<td>59850</td>
<td>Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines;</td>
</tr>
<tr>
<td>59851</td>
<td>Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation</td>
</tr>
<tr>
<td>59852</td>
<td>Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with hysterotomy (failed intra-amniotic injection)</td>
</tr>
<tr>
<td>59855</td>
<td>Induced abortion, by 1 or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines;</td>
</tr>
<tr>
<td>59856</td>
<td>Induced abortion, by 1 or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation</td>
</tr>
<tr>
<td>59857</td>
<td>Induced abortion, by 1 or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines; with hysterotomy (failed medical evacuation)</td>
</tr>
<tr>
<td>59866</td>
<td>Multifetal pregnancy reduction(s) (MPR)</td>
</tr>
<tr>
<td>50190</td>
<td>Mifepristone, oral, 200 mg</td>
</tr>
<tr>
<td>50191</td>
<td>Misoprostol, oral, 200 mcg</td>
</tr>
</tbody>
</table>

**ICD 10 Procedure Codes**

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10A00ZZ</td>
<td>Abortion of products of conception, open approach</td>
</tr>
<tr>
<td>10A03ZZ</td>
<td>Abortion of products of conception, percutaneous approach</td>
</tr>
<tr>
<td>10A04ZZ</td>
<td>Abortion of products of conception, percutaneous endoscopic approach</td>
</tr>
<tr>
<td>10A07Z6</td>
<td>Abortion of products of conception, vacuum, via natural or artificial opening</td>
</tr>
<tr>
<td>10A07ZW</td>
<td>Abortion of products of conception, laminaria, via natural or artificial opening</td>
</tr>
<tr>
<td>10A07ZX</td>
<td>Abortion of products of conception, abortifacient, via natural or artificial opening</td>
</tr>
<tr>
<td>10A07ZZ</td>
<td>Abortion of products of conception, via natural or artificial opening</td>
</tr>
<tr>
<td>10A08ZZ</td>
<td>Abortion of products of conception, via natural or artificial opening endoscopic</td>
</tr>
</tbody>
</table>

**4.2. Exclusions.** MDwise excludes the following codes in Table 3 from the abortion criteria. If a claim contains a procedure code from Table 2 and one of the diagnosis codes below, the claim should not be suspended for review of appropriate documentation.
Table 3 – Excluded Abortion Criteria

<table>
<thead>
<tr>
<th>Diagnosis Code (ICD-10)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>O01.XXX</td>
<td>Hydatidiform mole</td>
</tr>
<tr>
<td>O02.XXX</td>
<td>Other abnormal product of conception, includes missed abortion</td>
</tr>
<tr>
<td>O03.XXX</td>
<td>Spontaneous abortion, includes miscarriage, spontaneous abortion, and complications</td>
</tr>
<tr>
<td>O20.0X</td>
<td>Threatened abortion</td>
</tr>
<tr>
<td>O20.8X</td>
<td>Other specified hemorrhage in early pregnancy</td>
</tr>
<tr>
<td>O20.9X</td>
<td>Unspecified hemorrhage in early pregnancy</td>
</tr>
<tr>
<td>O36.4XX</td>
<td>Intrauterine death</td>
</tr>
<tr>
<td>O44.XXX</td>
<td>Placenta previa</td>
</tr>
<tr>
<td>O45.XXX</td>
<td>Abruptio placenta</td>
</tr>
<tr>
<td>O46.XXX</td>
<td>Antepartum hemorrhage</td>
</tr>
</tbody>
</table>

4.3. Non-Surgical Abortions. MDwise only reimburses the Food and Drug Administration (FDA)-approved regimen for medically induced abortions using orally administered mifepristone and misoprostol. MDwise does not reimburse what is commonly known as the evidence-based regimen for medical abortion with mifepristone and misoprostol, which includes at-home or vaginal administration of misoprostol.

The FDA-approved regimen for these medications is as follows: Recommended gestational age – 49 days from last menstrual period (LMP) Mifepristone dose – 600 mg orally administered on day one office visit. Providers must use HCPCS code S0190–Mifepristone, oral, 200mg, to bill Mifepristone and use code S0191–Misoprostol, oral, 200 mcg to bill Misoprostol. Medical abortion by oral ingestion of Mifepristone and Misoprostol requires three separate office visits to complete the procedure.

Confirmation of pregnancy status must occur prior to the day one office visit. The day one office visit must occur after the 18 hour counseling and waiting period required by IC § 16-34-2-1.1. Claims for day one and day three office visits are held, pending submission of required documentation. To be reimbursed for services, MDwise requires providers to submit all necessary documentation with claims for these office visits, as outlined in 1.3.

Table 4 provides the billing guidelines for these office visits and the medications provided during the office visits. Providers must bill all claims for medical abortion by oral ingestion of Mifepristone and Misoprostol on the CMS-1500 claim form or via electronic transaction. Codes S0190 & S0191 are to be reimbursed under the medical benefit.
Table 4 – Mifepristone and Misoprostol Billing Guidelines

<table>
<thead>
<tr>
<th>Office Visit</th>
<th>Documentation/Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Day One:</strong></td>
<td><strong>Member reviews and signs the Patient Agreement</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Provider orally administers three 200 mg tablets of mifepristone.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Provider bills HCPCS code S0190–Mifepristone, oral, 200 mg, three units.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Provider bills the appropriate evaluation and management (E/M) code for the office visit.</strong></td>
</tr>
<tr>
<td><strong>Day Three:</strong></td>
<td><strong>Provider checks pregnancy status with clinical examination or ultrasound (US) exam.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>If an US is performed, provider bills the appropriate code for the service provided.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Provider orally administers two 200 mcg tablets of misoprostol</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Provider bills HCPCS code S0191–Misoprostol, oral, 200 mcg, two units.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Provider bills appropriate E/M code for the office visit.</strong></td>
</tr>
<tr>
<td><strong>Day 14:</strong></td>
<td><strong>Provider verifies pregnancy termination with clinical examination or US exam.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Provider bills appropriate E/M code for the office visit.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>If an US is performed, the provider bills the appropriate code for the service provided.</strong></td>
</tr>
</tbody>
</table>

5. **Prior Authorization (PA) Requirements**

5.1. Claims received for abortion services are processed in accordance with the MDwise Marketplace Prior Authorization requirements.
ANP - Advanced Practice Nurses, Physician Assistants & Dieticians

1. Benefit Coverage

1.1. Covered Advanced Practice Nurses and Physician Assistant (PA) services include:

- Office Visits for preventive care, primary care, and for medical care and consultations to examine, diagnose, and treat an illness or injury.
- Therapy Services when given in the office of a Physician (e.g. clinical nurse specialist)
- Inpatient Services
- Surgical Services (assistant).
- Diagnostic Health Services when required to diagnose or monitor a symptom, disease or condition.
- Home Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in member’s home
- Emergency room services

1.2. Primary Care Practitioner. A primary care practitioner is defined as a participating provider in the member’s delivery system who has agreed to assume primary responsibility for the member’s medical care and is one of the following specialties:

- A physician who has a primary specialty designation of family medicine, internal medicine, gynecology, obstetrics, or pediatrics
- A nurse practitioner who practices in a primary care setting

1.3. Inpatient Services. The following advanced practice nurse and PA services are covered during an inpatient stay:

- Medical care visits
- Assistance with surgery and the administration of general anesthesia.

1.4. The services of advanced practice nurse or PA may be covered if all of the following conditions are met:

- They are the type that are considered physician’s services if furnished by a doctor of medicine or osteopathy (MD/DO);
- The practitioner is legally authorized to perform the services in the State in which they are performed;
- They are performed in collaboration with an MD/DO; and
- They are not otherwise precluded

1.5. Nutrition counseling. According to ACA Preventive Services Regulations, nutritional counseling is covered without member cost sharing for adults with hyperlipidemia, and other known risk factors for cardiovascular and diet-related chronic disease. Nutrition counseling and behavioral interventions are also covered to promote sustained weight loss for obese adults and children age six years and older. Screening for obesity in children, adolescents and adults is also covered. A licensed dietician can provide these services.
2. **Benefit Limitations and Exclusions**

2.1. The following benefit limitations apply to NP, PA and dietician services:

- New patient office visits are limited to one (1) per member, per provider within the last three (3) years. New patient is defined as a member who has not received any professional services from the provider or another provider of the same specialty within the same group practice within the last three (3) years.
- Medical care visits limited to one visit per day by any one NP or PA

2.2. The following exclusions apply to NP, PA and dietician services:

- Consultation codes (99241 – 99245, 99251 – 99255), Care Plan Oversight (99374 – 99380) and prolonged physician services (CPT code 99354) are not covered.
- Physician standby services (CPT code 99360), team conferences (codes 99361-99362), and telephone calls (codes 99371-99373) are not covered.
- Physician or Other Practitioners’ charges for consulting with Enrollees by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Enrollee except as otherwise described in this Contract.
- Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.
- Physician standby services.

2.3. With the exception of emergency services, all services provided by out of network providers require prior authorization.

3. **Provider Reimbursement & Submission Requirements**

3.1. All professional services for contracted providers are paid at the lesser of the contracted provider’s rate (based on the percentage of Medicare Physician Fee Schedule (MPFS) or billed charges. If there is not a Medicare rate for the covered service provided on the Medicare fee schedule, the base payment is 150% of the Medicaid (IHCP) Fee Schedule. The provider’s contracted percentage of MPFS is then applied to the fee amount.

3.2. If a provider has more than one delivery system (i.e. has signed with multiple delivery systems), the highest contract rate will apply to services to members not assigned to a contracted delivery system.

3.3. For non-contracted providers, in which a PA was received, or the service was an emergency service, the lowest QHP rate is used to calculate the reimbursement rate. For professional claims this is 125%.
3.4. **Nurse Practitioners and CNSs.** NPs and CNSs are paid for covered services at 85% of what a physician is paid under the MPFS, or if no Medicare rate, 150% of Medicaid. The provider’s contracted percentage of MPFS is then applied to the fee amount.

When a NP or CNS actively assists a physician in performing a surgical procedure and furnishes more than just ancillary services, the NP’s and CNSs’ services are eligible for payment as assistant-at-surgery services. NP and CNS assistant-at-surgery services are reimbursed at the lesser of the actual charge or 85 percent of the 16 percent that a physician is paid under the MPFS. Since physicians are paid at 16 percent of the surgical payment amount under the MPFS for assistant-at-surgery services, the actual payment amount that NPs and CNSs receive for assistant-at-surgery services is 13.6 percent of the amount paid to physicians. Only the AS modifier must be reported on the claim form when a NP or CNS bills assistant-at-surgery services.

3.5. **Certified nurse-midwife (CNM).** Payment for CNM services is made at 100% of the physician fee schedule amount for the same service performed by a physician.

Payment for covered drugs and biologicals furnished incident to CNMs’ services is made according to the Part B drug/biological payment methodology. Covered clinical diagnostic lab services furnished by CNMs are paid according to the clinical diagnostic lab fee schedule.

3.6. **Physician assistant (PA) services.** PAs are paid at 85% of what a physician is paid under the MPFS or if no Medicare rate, 150% of Medicaid. The provider’s contracted % of MPFS is then applied to the fee amount.

When a PA actively assists a physician in performing a surgical procedure and furnishes more than just ancillary services, the PA’s services are eligible for payment as assistant-at-surgery services. Covered PA assistant-at-surgery services at 80 percent of the lesser of the actual charge or 85 percent of what a physician is paid under the MPFS. Since physicians are paid at 16 percent of the surgical payment amount under the MPFS for assistant-at-surgery services, the actual payment amount that PAs receive for assistant-at-surgery services is 13.6 percent of the amount paid to physicians. Only the AS modifier must be reported on the claim form when a NP or CNS bills assistant-at-surgery services.

3.7. **Dieticians.** NPs and CNSs are paid for covered services at 85% of what a physician is paid under the MPFS, or if no Medicare rate, 150% of Medicaid. The provider’s contracted % of MPFS is then applied to the fee amount. Dieticians may provide covered nutritional counseling and medical nutrition therapy services.

3.8. **Site of Service Adjustment.** Under the MPFS, some procedures have a separate Medicare fee schedule rate for a practitioner’s professional services when provided in a facility and a non-facility setting. The CMS furnishes both fees in the MPFS update. The Site of Service adjustment is also applicable to services performed by a NP, CNS, CNA, or PA.

The place of service code (POS) is used to identify where the procedure is furnished. The list of facilities where a practitioner’s professional services are paid at the facility rate include:
- Outpatient Hospital-Off Campus (POS code 19)
- Hospitals (POS code 21-23);
- Ambulatory surgical center (ASC) (POS code 24)
- Skilled Nursing Facilities (SNF) (POS code 31);
- Hospice (POS 34)
• Ambulance (POS 41, 42)
• Inpatient psychiatric facilities (POS 51);
• Psychiatric facility – partial hospitalization (POS 52)
• Community Mental Health Centers (CMHC) (POS code 53);
• Comprehensive inpatient rehabilitation facilities (POS 61);

Some services, by nature of their description or type of procedure, are performed only in certain settings and have only one maximum allowable fee per code. Some examples of these services include:
• Evaluation and management (E&M) codes which specify the site-of-service (SOS) within the description of the procedure codes (e.g., initial hospital care);
• Major surgical procedures that are generally performed only in hospital settings.

NOTE: If there is a separate rate for services performed in a facility or non-facility setting payment is based on the applicable rate for the POS (facility (#) or non-facility) that is billed on the claim. If only one rate is indicated on the Medicare Physician’s Fee Schedule that rate should be paid when that service is billed on a claim in any setting. Certain procedures would only be performed in a facility setting, such as, procedure code 19301 (partial mastectomy).

3.9. Same Day Services. When a patient is seen in the hospital or outpatient/office setting for more than one visit on the same day by a practitioner in the same billing group, same specialty, reimbursement will be paid to one practitioner and the other service(s) will be denied for inclusive to the other service code on that day.

Specialist claims billed on the same day as another practitioner but of a different specialty or group will be reimbursed according the MPFS.

Preventive service performed on the same day as an Evaluation and Management service are allowable and payable when billed in conjunction with and E/M visit and the appropriate modifier code.

3.10. Bundled Services/Supplies. There are a number of services/supplies that are covered under Medicare and that have HCPCS codes, but they are services for which Medicare bundles payment into the payment for other related services. MDwise will follow the Medicare bundling rule and NCCI edits, except as indicated in the supplemental Medicaid covered code list.

For example, injection services included in the fee schedule generally are not paid for separately if the practitioner is paid for an E/M service rendered at the same time. Reimbursement is only available for those injection services if no other physician fee schedule service is being paid. In either case, the drug is separately payable. If, for example, code 99211 is billed with an injection service, pay only for code 99211 and the separately payable drug.

3.11. Global Surgical Procedures. When a mid-level practitioner furnishes services to a patient during a global surgical period, the level of the practitioner’s involvement in furnishing part of the surgeon’s global surgical package must be determined consistent with the policy for processing physician surgical claims. Billing requirements and adjudication of claims requirements for global surgeries are outlined in BCCP #22, Physician Services. The same processing requirements apply to surgical services provided by a mid-level practitioner, including multiple surgery, bilateral surgery, and team surgeon processing guidelines.
3.12. **Inpatient Services.** Both Initial Hospital Care (CPT codes 99221 – 99223) and Subsequent Hospital Care codes are “per diem” services and may be reimbursed only once per day by the same practitioner of the same specialty from the same group practice. In a hospital inpatient situation involving one physician covering for another, if physician A sees the patient in the morning and practitioner B, who is covering for A, sees the same patient in the evening, practitioner B is not reimbursed for the second visit.

If the practitioners are each responsible for a different aspect of the patient’s care, both visits may be covered if the practitioners are in different specialties.

Only one hospital discharge day management service is payable per patient per hospital stay. Physicians or qualified nonphysician practitioners, other than the attending physician, who have been managing concurrent health care problems not primarily managed by the attending physician, and who are not acting on behalf of the attending physician, should use Subsequent Hospital Care (CPT code range 99231 – 99233) for a final visit. A subsequent hospital visit billed in addition to hospital discharge day management service on the same day by the same practitioner is not reimbursable.

3.13. **Observation Care.** Payment for an initial observation care code is for all the care rendered by the ordering practitioner on the date the patient’s observation services began. Similar to initial observation codes, payment for a subsequent observation care code is for all the care rendered by the treating practitioner on the day(s) other than the initial or discharge date. All other practitioners who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient observation services must bill the appropriate outpatient service codes.

For example, if an internist orders observation services and asks another practitioner to additionally evaluate the patient, only the internist may bill the initial and subsequent observation care codes. The other practitioner who evaluates the patient must bill the new or established office or other outpatient visit codes as appropriate.

If the same practitioner who ordered hospital outpatient observation services also admits the patient to inpatient status before the end of the date on which the patient began receiving hospital outpatient observation services, pay only an initial hospital visit for the evaluation and management services provided on that date. Payment for the initial hospital visit includes all services provided to the patient on the date of admission by that practitioner, regardless of the site of service.

The global surgical fee includes payment for hospital observation (codes 99217, 99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, and 99236) services unless the criteria for use of CPT modifiers “-24,” “-25,” or “-57” are met.

3.14. **When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician’s or the NP’s NPI number. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient’s medical record) then the service may only be billed under the NP’s NPI.**

3.15. **Physician Shortage Area (PSA).** No PSA or Health Profession Shortage Area (HPSA) payments are made for the Marketplace product.
4. **Procedure Codes and Claim Considerations**

4.1. **Modifiers.** There are a number of modifiers (for example AS and mod 25) that can be used by practitioners and can affect payment of claim. The complete list can be found in the CMS manual, on the CMS website, or at [www.wpsmedicare.com](http://www.wpsmedicare.com).

E/M services should be billed with modifier 25 when on claim with preventive services. If the modifier is not included, then in accordance with NCCI edits, the preventive service codes should be reimbursed and the E/M service should deny for included in the primary service.

4.2. MDwise pays for an evaluation and management service on the day of or on the day before a procedure with a 90-day global surgical period if the practitioner uses CPT modifier “-57” to indicate that the service resulted in the decision to perform the procedure. MDwise does not pay for an evaluation and management service billed with the CPT modifier “-57” if it was not provided on the day of or the day before a procedure with a 0 or 10-day global surgical period.

5. **Prior Authorization (PA) Requirements**

5.1. NP, CNS, PA, and dietician claims are processed in accordance with the MDwise Marketplace Prior Authorization requirement.

6. **Copays and Coinsurance**

6.1. Refer to the MDwise Marketplace Individual Policy for the Schedule of Benefits which summarizes applicable coinsurance and copays related to coverage of PMP and specialist services (which includes nurse practitioners, certified nurse midwives, dieticians, and physician assistants). Please also note:

- If the rendering nurse practitioner is the member’s PMP, or is part of a PMP group (billing entity), then the PMP copay rules apply, not the specialist copay.
- If the rendering certified nurse midwife or physician assistant is part of a PMP group (billing entity), then the PMP copay rules apply, not the specialist copay.
- If multiple items that require copay are on the same bill (e.g. x-ray and E/M service), there is only one copay amount that is applied. The copay to be applied is the highest copay amount considering all services rendered and the copays associated with those services.
- Surgical services performed in an office setting will be subject to the office visit copay. The office visit copay will be applied to the office visit charge and surgical services until the copay has been reached up to the allowed amount.
- Coinsurance applies to drugs and biologicals received in the office setting, in addition to the office copay.
AMT - Ambulance Transportation

1. Benefit Coverage

1.1. Ambulance services are a Covered Health Service only when Medically Necessary, except when ordered by an employer, school, fire or public safety official and the member is not in a position to refuse, or when a member is required by MDwise to move from a Non-Participating Provider to a Participating Provider.

1.2. Ambulance Services are transportation by a vehicle (including ground, water, fixed wing and rotary wing air transportation) designed, equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians, paramedics, or other certified medical professionals from or between any of the following listed below.
   - From the member’s home, scene of accident or medical Emergency to a Hospital,
   - Between Hospitals,
   - Between a Hospital and Skilled Nursing Facility, or
   - From a Hospital or Skilled Nursing Facility to the member’s home.

1.3. The marketplace covers ambulance services, including fixed wing and rotary wing ambulance services, only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated. The member’s condition must require the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary.

1.4. Payment is based on the level of service provided, not on the vehicle used. Occasionally, local jurisdictions require the dispatch of an ambulance that is above the level of service that ends up being provided to the member. In this, as in most instances, the Marketplace pays only for the level of service provided, and then only when the service provided is medically necessary.

1.5. Ambulance trips must be made to the closest local facility that can give Covered Health Services appropriate for the member’s condition. If none of these facilities are in the member’s local area, they are covered for trips to the closest facility outside their local area.

1.6. Definitions
   - “Advanced life support”, for purposes of IC 16-31, and as defined in the IAC, Title 836, the Indiana Emergency Medical Services Commission (EMSC) defines advanced life support (ALS) as follows:
     - Care given at the scene of an accident, act of terrorism if the governor has declared a disaster emergency under IC 10-14-3-12 in response to the act of terrorism, or illness, during transport, given at the hospital by a paramedic, emergency medical technician intermediate, and care that is more advanced than the care usually provided by an emergency medical technician or an emergency medical technician-basic advanced. The term may include any of the following:
       - Defibrillation
       - Endotracheal intubation
       - Parenteral injection of appropriate medications
       - Electrocardiogram interpretation
Emergency management of trauma and illness

- "Basic life support" is defined by the EMSC as the following:
  - Assessment of emergency patients.
  - Administration of oxygen.
  - Use of mechanical breathing devices.
  - Application of anti-shock trousers.
  - Performance of cardiopulmonary resuscitation.
  - Application of dressings and bandage materials.
  - Application of splinting and immobilization devices.
  - Use of lifting and moving devices to ensure safe transport.
  - Use of an automatic or a semiautomatic defibrillator if the defibrillator is used in accordance with training procedures established by the commission.
  - Administration by an emergency medical technician or emergency medical technician-basic advanced of epinephrine through an auto-injector.
  - For an emergency medical technician-basic advanced, the following:
    - Electrocardiogram interpretation.
    - Manual external defibrillation.
    - Intravenous fluid therapy.
    - Other procedures authorized by the commission, including procedures contained in the revised national emergency medical technician-basic training curriculum guide.

Except as defined by the EMSC and the training and certifications standards established under IC 16-31-2-9(4), and under IC 16-31-2-9(5), the term basic life support and BLS services do not include invasive medical care techniques or advanced life support.

- Emergency is defined as a medical condition manifesting itself by acute symptoms, including severe pain, of sufficient severity that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:
  - Serious jeopardy to the health of the individual, or in the case of a pregnant woman, the woman or her unborn child,
  - Serious impairment to bodily functions, or
  - Serious dysfunction of any bodily organ or part.

- Prudent layperson is an evaluation of whether a condition meets the "Emergency definition". A prudent layperson is a person who is without medical training and who draws on his or her practical experience when making a decision regarding the need to seek emergency medical treatment. A prudent layperson is considered to have acted "reasonably" if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that emergency medical treatment was necessary. Severe pain and other symptoms may constitute such emergency cases. (Source: NCQA) Prudent layperson review is conducted to determine whether ambulance services meet the definition of an emergency medical condition.

2. Benefit Limitations and Exclusions

2.1. The following benefit limitations or exclusions apply to ambulance services:
• Non-Covered Services for Ambulance include any of the following.
  o Trips to a Physician’s office or clinic, lab, or a morgue or funeral home.
  o Ambulance usage when another type of transportation can be used without endangering the member’s health.
  o Ambulance usage for the convenience of the member, family or Provider.
  o Medi-Car, Medi-Van, or wheelchair ambulance
• Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

3. Provider Reimbursement & Submission Requirements

3.1. Reimbursement for ambulance services is based on Medicare ambulance fee schedule.

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/index.html

The fee schedule payment for ambulance services equals a base rate for the level of service, plus payment for mileage and the following applicable adjustment factors:
  • Money amount that serves as a nationally uniform base rate, or CF, for all ground ambulance services
  • Relative value unit (RVU) assigned to each type of ground ambulance service
  • Geographic adjustment factor (GAF) for each ambulance fee schedule locality area (geographic practice cost index [GPCI])
  • Nationally uniform loaded mileage rate
  • Additional amount for certain mileage for a rural point-of-pickup

Payment under the fee schedule for ambulance services:
  • Includes a base rate payment plus a payment for mileage;
  • Covers both the transport of the member to the nearest appropriate facility and all items and services associated with such transport; and
  • Does not include a separate payment for items and services furnished during the transport (e.g. drugs and biological, EKG, extra attendants, etc.).

In accordance with the Marketplace policy:
  • The Medicare rate is multiplied by the provider’s contracted rate
  • If the provider is not contracted the lowest QHP rate is used to calculate the reimbursement rate. For facilities, this is 133%, and for professional claims, 125%.
  • In some case, the authorization could contain the non-contracted provider reimbursement for the service in question.
  • In all cases, if the billed amount is less than the contracted payment amount, the billed amount is to be reimbursed.

3.2. Air Ambulance Service Levels. The base payment rate for the applicable type of air ambulance service is adjusted by the GAF and, when applicable, by the appropriate risk assessment factor (RAF) to determine the amount of payment. Air ambulance services have no CF or RVUs. This amount is compared to the actual charge. The lesser of the charge or the adjusted GAF rate amount is added to the payment rate per mile, multiplied by the number of miles that the
beneficiary was transported. When applicable, the appropriate RAF is also applied to the air mileage rate as follows:

- Nationally uniform base rate for fixed wing transportation and a nationally uniform base rate for rotary wing transportation
- GAF for each ambulance fee schedule locality area (GPCI)
- Nationally uniform loaded mileage rate for each type of air service
- Rural adjustment to the base rate and mileage for services furnished for a rural point-of-pickup

Air ambulance services may be paid only for ambulance services to a hospital.

3.3. Run Sheets. Ambulance suppliers (both air and ground) should include the complete address of the origin and destination for each transport on the run sheet and on the claim submitted to MDwise Marketplace. The origin is the point where the load mileage begins and the destination is the point where the load mileage ends. Load mileage only includes the miles where the patient is on board the ambulance. The provider’s documentation must contain mileage from mapping software or odometer readings indicating starting and ending trip mileage.

3.4. DX. Ambulance claims must include a diagnosis in order to process the claim. Although emergency medical technicians cannot diagnose, they are instructed to code what they observed such as respiratory distress (786.09).

3.5. Determination of Coverage – Emergency Ambulance Services. Coverage of ambulance transportation services is partially tied to payment of the associated emergency services (e.g. emergency room visit) as outlined in this manual’s chapter on Emergency Services.

Ambulance claims for diagnosis not listed on the MDwise ER Auto-Pay list or for which there is no authorization, are subject to medical review according to the prudent layperson standard and paid according to the review determination.

3.6. Ambulance Claims billed as Non-Emergent. All scheduled transports will be considered non-emergency. For example, transports to nursing homes, patient homes and ESRD facilities are considered non-emergency. For ambulance services that were billed as non-emergency (e.g. non-emergent HCPCS code, no y indicator in box 24c on CMS 1500 or emergency indicator on 837), prior authorization is required. The claims payer must check to see if the non-emergent service was authorized. If there is no authorization, the claim should be denied. If the service was authorized, the claim may be reimbursed, even if a run sheet was not included.

Effective for claims with dates of service on and after October 1, 2013, payment for non-emergency Basic Life Support (BLS) transports of individuals to and from renal dialysis treatment facilities will be reduced by 10%. The payment reduction affects transports to and from both hospital-based and freestanding renal dialysis treatment facilities for dialysis services provided on a non-emergency basis. The reduced rate will be calculated and applied to HCPCS code A0428 when billed with origin or destination modifier code “G” (hospital-based ESRD) or “J” (freestanding ESRD facility) and the associated mileage, represented by HCPCS code A0425.

Multiple Patient Transports. When more than one patient is transported in an ambulance, the allowed charge for each individual is a percentage of the allowed charge for a single member transport. The applicable percentage is based on the total number of patients transported, including both Marketplace and non-marketplace patients. The policy applies to both ground and air
transports. Providers should report this situation using the GM Modifier. Refer to value code 32 which indicates the number of patients transported.

If two patients are transported at the same time in one ambulance to the same destination, then the Marketplace will allow 75% of the single-patient allowed amount for the level of service furnished to a member, plus 50% of the total mileage payment allowance for the entire trip.

If three or more patients are transported at the same time in one ambulance to the same destination, then the Marketplace will allow 60% of the single-patient allowed amount for the level of service furnished that member. In addition, the total mileage allowed amount would be divided by the number of all patients onboard.

3.7. Ambulance Services for Deceased Member
The following information states the Marketplace policy related to the death of a beneficiary and the payment for ambulance services.

- **The patient is pronounced dead after the ambulance is dispatched but before transport.** Ground providers can bill a BLS service along with the QL modifier. Air providers can use the appropriate code with the QL modifier. There will be no rural allowance or mileage reimbursed.
- **The patient is pronounced dead after being loaded into the ambulance.** Pronouncement is made en route or upon arrival. Payment is made following the usual reimbursement rules.
- **No payment will be made if the patient was pronounced dead prior to the ambulance being dispatched.** For air ambulance services, no payment will be allowed if the dispatcher had received pronouncement of death in sufficient time to permit the flight to be aborted before take-off.

3.8. Inpatient Stays. Hospital bundling rules exclude payment to independent suppliers of ambulance services for members during a hospital inpatient stay. Ambulance services with a date of service that is the same as the admission or discharge date on an inpatient claim are separately payable and not subject to the bundling rules. Please see this manual’s chapter on Inpatient Hospital Services for additional information about coverage of ambulance services during an inpatient stay.

3.9. Hospice. Ambulance services not related to Hospice care can be covered; however services related to or caused by the terminal illness should be submitted to the hospice. Documentation is required to verify the reason for the ambulance trip is not related to the terminal illness or is prior to the start of hospice. Modifiers GV and GB are not applicable to ambulance suppliers. Please see this manual’s chapter on Hospice Services for additional information about coverage of ambulance services for a member that has elected hospice coverage.

4. Procedure Codes and Claim Considerations

4.1. Providers must include the applicable procedure code(s) from the Ambulance Transportation Code set below to be reimbursed for ambulance services. If the ambulance service was for an
emergency, the provider must use the Y indicator in Field 24c on the CMS 1500 or the Emergency Indicator on the 837 P. If an ambulance provider submits a claim for ALS or BLS emergent services however does not include the emergency indicator, the claim may be denied.

The level of service is determined based on the patient condition, not the vehicle used.

**Ground Ambulance Provider Code Set**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0425</td>
<td>Ground mileage, per loaded mile;</td>
</tr>
<tr>
<td>A0426</td>
<td>Ambulance service, advanced life support, nonemergency transport, level 1 (ALS1)</td>
</tr>
<tr>
<td>A0427</td>
<td>Ambulance service, advanced life support, emergency, level 1 (ALS1-emergency)</td>
</tr>
<tr>
<td>A0428</td>
<td>Ambulance service, basic life support, nonemergency transport (BLS)</td>
</tr>
<tr>
<td>A0429</td>
<td>Ambulance service, basic life support, emergency transport, one way (BLS-emergency)</td>
</tr>
<tr>
<td>A0433</td>
<td>Advanced ALS (Level 2)</td>
</tr>
<tr>
<td>A0434</td>
<td>Specialty Care Transport</td>
</tr>
</tbody>
</table>

Separate payment is not allowed for supplies and ancillary services (e.g., waiting time, extra attendants, injections, and EKGs). The payments for those are included in the base rate.

**Air Ambulance Code Set**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0430</td>
<td>Ambulance service, conventional air service transport, one way (fixed wing)</td>
</tr>
<tr>
<td>A0431</td>
<td>Ambulance service, conventional air service, transport, one way (rotary wing)</td>
</tr>
<tr>
<td>A0431 QL</td>
<td>Ambulance service, conventional air service, transport, one way (rotary wing); if the member is pronounced dead after takeoff to point of pickup, but before the member is loaded</td>
</tr>
<tr>
<td>A0435</td>
<td>Fixed wing, air mileage</td>
</tr>
<tr>
<td>A0436</td>
<td>Rotary wing air mileage, per statute mile</td>
</tr>
</tbody>
</table>

4.2. **Modifiers.** Modifiers identifying place of origin and destination of the ambulance trip must be submitted on all ambulance claims. Each of the modifiers may be utilized to make up the first and/or second half of a two letter modifier. The first letter must describe the origin of the transport, and the second letter must describe the destination (Example: if a patient is picked up at his/her home and transported to the hospital, the modifier to describe the origin and destination would be – RH).

The following is a list of the only valid modifiers to be used by ambulance suppliers:
<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>Diagnostic or therapeutic site other than P or H when these are used as origin codes</td>
</tr>
<tr>
<td>E</td>
<td>Residential, domiciliary, custodial facility (other than 1819 facility)</td>
</tr>
<tr>
<td>G</td>
<td>Hospital based ESRD facility</td>
</tr>
<tr>
<td>H</td>
<td>Hospital</td>
</tr>
<tr>
<td>I</td>
<td>Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport</td>
</tr>
<tr>
<td>J</td>
<td>Freestanding ESRD facility</td>
</tr>
<tr>
<td>N</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>P</td>
<td>Physician’s office</td>
</tr>
<tr>
<td>R</td>
<td>Residence</td>
</tr>
<tr>
<td>S</td>
<td>Scene of accident or acute event</td>
</tr>
<tr>
<td>X</td>
<td>Intermediate stop at physician’s office on way to hospital (destination code only)</td>
</tr>
</tbody>
</table>

### Additional modifiers for ambulance services:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>QM</td>
<td>Provided under arrangement by a provider of services (used by institutional providers)</td>
</tr>
<tr>
<td>QN</td>
<td>Ambulance service furnished directly by a provider of services</td>
</tr>
<tr>
<td>QL</td>
<td>Use when the patient is pronounced deceased after the ambulance is called. The patient is pronounced dead after the ambulance is called but before transport. Ground providers can bill a BLS service along with the QL modifier. Air providers can use the appropriate air base rate code (fixed wing or rotary wing) with the QL modifier.</td>
</tr>
<tr>
<td>GM</td>
<td>When more than one patient is transported in an ambulance and document details of the transport. Used by both ground and air transports.</td>
</tr>
</tbody>
</table>

### 4.3. Point of Pick-up (POP).

All claims for services must include the ZIP code for the point of pickup. Ambulance Pricing is determined by the zip code of the POP which determines if the urban or rural rate is used for the base. The POP can be identified by the Provider:

- On an attached run sheet
- On the claim image in a detail line
- Above the “rendering address” on HCFA(box 32)
- For electronic/EDI claims the POP should be populated in the comments field on line 1

If the point of pickup cannot be identified, then the claim will be denied. The following are exceptions to the claim being denied for a POP:

- Out of state provider are reimbursed using the urban rate, and the applicable percentage applied as indicated in Section 4.1.
- Eskenazi Hospital is priced from the Medicare Urban rate.

For point of pickup outside the United States ambulance providers should report the point of pickup ZIP codes according to the following:
• For ground or air transport outside of the United States to a drop off outside of the United States (in Canada or Mexico), the closest United States ZIP code to the actual point of
• For water transport from the territorial waters of the United States to the United States, use the ZIP code for the port of entry.
• For ground transport from Canada to Mexico to the United States, use the ZIP code at the United States border at the point of entry into the United States.

4.4. The Marketplace contains a restriction that miles beyond the closest available facility should not be billed. In accordance with Medicare billing guideline, non-covered miles beyond the closest facility however can be billed with HCPCS procedure code A0888 (“non-covered ambulance mileage per mile, e.g., for miles traveled beyond the closest appropriate facility”). These non-covered line items can be billed on claims also containing covered charges. Ambulance claims may use the –GY modifier on line items for such non-covered mileage.

5. Prior Authorization (PA) Requirements

5.1. Claims received for ambulance services are processed in accordance with the MDwise Marketplace Prior Authorization requirements.

5.2. The following requires authorization

• Facility to facility and/or non-emergent ambulance transfers require prior authorization
• Fixed wing air ambulance transport
• Retrospective review of rotary wing air ambulance

5.3. Please note: Non-par emergency ambulance claims do not require an authorization.
ASC - Ambulatory Surgical Centers

1. Benefit Coverage

1.1. Coverage for ambulatory surgical services includes but is not limited to the list below
   - Performance of accepted operative and other invasive procedures
   - The correction of fractures and dislocations.
   - Operative and cutting procedures.
   - Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy.
   - Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.
   - Sterilization
   - Temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders if provided within MDwise guidelines.
   - Intraocular lens implantation for the treatment of cataract or aphakia.
   - Other procedures approved by MDwise

1.2. Reconstructive Services - Certain Reconstructive Services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive Services required due to prior therapeutic process are payable only if the original procedure would have been a covered service under the members contract.

Covered Reconstructive Services are limited to the following list.
   - Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child.
   - Breast reconstruction resulting from a mastectomy.
   - Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger.
   - Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactyli.
   - Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect.
   - Tongue release for diagnosis of tongue-tied.
   - Congenital disorders that cause skull deformity such as Crouzon’s disease.
   - Cleft lip.
   - Cleft palate.

1.3. Mastectomy – A member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will also receive coverage for all of the following listed below.
   - Reconstruction of the breast on which the mastectomy has been performed.
   - Surgery and reconstruction of the other breast to produce a symmetrical appearance.
• Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

1.4. An ASC is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients. An ASC is either independent (i.e., not a part of a provider of services or any other facility), or operated by a hospital (i.e., under the common ownership, licensure or control of a hospital). A hospital-operated facility has the option of being considered by Medicare (for reimbursement purposes) to either be an ASC or to be a provider-based department of the hospital.

2. Benefit Limitations and Exclusions

2.1. The following benefit limitations or exclusions apply to outpatient services:

• Any procedures, services, equipment or supplies provided in connection with cosmetic services. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the member was covered by another plan prior to MDwise coverage. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to myocardial infarction, pulmonary embolism, thrombophlebitis, and exacerbation of co-morbid conditions.

• Abortion, except in the following cases.
  o The pregnant woman became pregnant through an act of rape or incest.
  o An abortion is necessary to avert the pregnant woman’s death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

• Surgical treatment of gynecomastia.

• Reconstructive Health Services except as specifically stated in Section 1.3 or as required by law.

• Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

• Treatment of telangiectatic dermal veins (spider veins) by any method.

• Surgical treatment of flat feet, subluxation of the foot, weak, strained, unstable feet, tarsalgia, metatarsalgia, hyperkeratosis

• Bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery, or Gastroplasty, or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric
surgery, as determined by MDwise, are not covered. This exclusion applies even if the original treatment or surgery was performed while the member was covered by another plan prior to MDwise coverage. Directly related means that the treatment or surgery occurred as a direct result of the bariatric surgery and would not have taken place in the absence of the surgery. This exclusion does not apply to conditions including but not limited to myocardial infarction, pulmonary embolism, thrombophlebitis, and exacerbation of co-morbid conditions.

- Services to reverse voluntarily induced sterility.

- Eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

- Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing. Effective with dates of service 1.1.16 and beyond, the exclusion related to erectile dysfunction and surgeries for sexual dysfunction is no longer in effect and such services are eligible for coverage. Effective with dates of service 1.1.17 and beyond, the exclusion related to gender transition is no longer in effect and such services are eligible for coverage (45 CFR § 92.207(b)(4) 45 CFR § 92.207(b)(5)).

- With the exception of emergency services, all services provided by out of network providers require prior authorization.

Please also refer to MDwise Marketplace Contract Individual Policy: Article 4 Exclusions, Section 4.1 for a comprehensive list of exclusions.

3. Provider Reimbursement & Submission Requirements

3.1. Covered ASC services are those surgical procedures that are identified by CMS on a listing that is updated at least annually. Some surgical procedures covered by Medicare are not on the ASC list of covered surgical procedures. For surgical procedures not covered in ASCs, the related professional services may be billed by the rendering provider however, the facility charges are non-covered (except as outlined in 4.1 below).

CMS also publishes quarterly updates to the lists of covered surgical procedures and covered ancillary services to establish payment indicators and payment rates for newly created Level II HCPCS and Category III CPT codes. The complete lists of ASC covered surgical procedures and ASC covered ancillary services, the applicable payment indicators, payment rates for each covered surgical procedure and ancillary service before adjustments for regional wage variations, the wage adjusted payment rates, and wage indices are available on the CMS Web site at:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html.

3.2. Claims are billed on the UB04. The ASC payment includes operating and recovery rooms, patient
preparation areas, waiting rooms, and all services and procedures provided in connection with covered surgical procedures furnished by nurses, technical personnel and others involved in patient care. The payment does not include physician services or medical and other health services for which payment may be made under other Medicare provisions (e.g., services of an independent laboratory located on the same site as the ASC, anesthetist professional services, non-implantable DME). Physicians’ services also includes any routine pre- or post- operative services, such as office visits, consultations, diagnostic tests, removal of stitches, changing of dressings, and other services which the individual physician usually includes in the fee for a given surgical procedure.

3.3. ASC services for which payment is included in the ASC payment for a covered surgical procedure include, but are not limited to:

- Use of the facility where the surgical procedures are performed (e.g. OR room, recovery room, prep area, etc.)
- Nursing, technician, and related services;
- Laboratory testing;
- Drugs and biologicals for which separate payment is not allowed under the Outpatient Prospective Payment System (OPPS) medical and surgical supplies not on pass-through status
- Equipment;
- Surgical dressings;
- Implanted prosthetic devices, including intraocular lenses (IOLs), and related accessories and supplies not on pass-through status
- Implanted DME and related accessories and supplies not on pass-through status
- Splints and casts and related devices;
- Radiology services for which separate payment is not allowed under the OPPS, and other diagnostic tests or interpretive services that are integral to a surgical procedure;
- Administrative, recordkeeping and housekeeping items and services;
- Materials, including supplies and equipment for the administration and monitoring of anesthesia; and supervision of the services of an anesthetist by the operating surgeon.

The above items and services fall within the scope of ASC facility services, and payment for them is packaged into the ASC payment for the covered surgical procedure. ASCs must incorporate charges for packaged services into the charges reported for the separately payable services with which they are provided. Facilities may not be paid appropriately if they unbundle charges and report those charges for packaged codes as separate line-item charges.

3.4. Covered ancillary items and services that are integral to a covered surgical procedure and for which separate payment to the ASC is allowed include:

- Brachytherapy sources; Medicare pays the same amount for brachytherapy sources to ASCs as it pays hospitals under the OPPS
- Certain implantable items that have pass-through status under the OPPS;
- Certain items and services that CMS designates as contractor-priced, including, but not limited to, the procurement of corneal tissue (V2785); Payment for corneal tissue acquisition is based on acquisition cost or invoice.
- Certain drugs and biologicals for which separate payment is allowed under the OPPS. These drugs are paid the same amount as indicated in the OPPS. New drugs and biologicals for which product-specific HCPCS codes do not exist and are billed by ASCs using HCPCS code C9399 (unclassified drug or biological), and are priced at 95% of the average wholesale price (AWP).
- Certain radiology services for which separate payment is allowed under the OPPS.
These items and services must be provided integral to covered surgical procedures, that is, immediately before, during, or immediately after the covered surgical procedure.

3.5. Coverage of Services in ASCs Which Are Not ASC Facility Services or Covered Ancillary Services

- A number of items and services covered under the Marketplace may be furnished in an ASC which are not considered ASC services, and which payment for ASC services does not include. These non-ASC services are covered and paid for under the different fee schedules. In addition, the ASC may be part of a medical complex that includes other entities, such as an independent laboratory, supplier of durable medical equipment, or a physician’s office, which are covered as separate entities.

<table>
<thead>
<tr>
<th>Examples items not included in payment for ASC services</th>
<th>Who may receive payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians’ services (including surgical procedures excluded from ASC payment)</td>
<td>Physician</td>
</tr>
<tr>
<td>The purchase or rental of non-implantable durable medical equipment (DME) to ASC patients for use in their homes</td>
<td>Supplier. An ASC can be a supplier of DME if it has a supplier number from the National Supplier Clearinghouse (NSC).</td>
</tr>
<tr>
<td>Non-implantable prosthetic devices</td>
<td>Supplier. An ASC can be a supplier of non-implantable prosthetics if it has a supplier number from the NSC</td>
</tr>
<tr>
<td>Ambulance services</td>
<td>Ambulance provider</td>
</tr>
<tr>
<td>Leg, arm, back and neck braces</td>
<td>Supplier. An ASC can be a supplier of non-implantable prosthetics if it has a supplier number from the NSC</td>
</tr>
<tr>
<td>Artificial legs, arms, and eyes</td>
<td>Supplier. An ASC can be a supplier of non-implantable prosthetics if it has a supplier number from the NSC</td>
</tr>
<tr>
<td>Services furnished by an independent laboratory</td>
<td>Certified lab. ASCs can receive lab certification and a CLIA number.</td>
</tr>
</tbody>
</table>

- Non-implantable Durable Medical Equipment & prosthetics - If the ASC furnishes items of non-implantable DME to beneficiaries, it is treated as a DME supplier, and all the rules and conditions ordinarily applicable to DME are applicable, including obtaining a supplier number.
- Ambulance Services - If the ASC furnishes ambulance services, the facility may obtain approval
as an ambulance supplier to bill covered ambulance services.

- Services of Independent Laboratory - In most cases, diagnostic tests performed directly by an ASC are not considered ASC facility services. In order to bill for diagnostic tests as a laboratory, an ASC’s laboratory must be CLIA certified and enrolled as a laboratory and the certified clinical laboratory must bill for the services provided in the ASC. Otherwise, the ASC makes arrangements with a covered laboratory or laboratories for laboratory services.

3.6. Multiple Surgeries. When the ASC performs multiple surgical procedures in the same operative session that are subject to the multiple procedure discount, reimbursement is as follows:

- 100 percent of the fee schedule amount for the highest valued procedure;
- 50 percent of the fee schedule amount for the remaining procedures;

The OPPS/ASC final rule for the relevant payment year specifies whether or not a surgical procedure is subject to multiple procedure discounting for that year.

The ASC surgical services billed with modifier -73 and -52 shall not be subjected to further pricing reductions. (i.e., the multiple procedure price reduction rules do not apply). Payment for an ASC surgical procedure billed with modifier -74 may be subject to the multiple procedure discount if that surgical procedure is indicated as eligible for multiple procedure discount.

A procedure performed bilaterally in one operative session is reported as two procedures, either as a single unit on two separate lines or with “2” in the units field on one line. The multiple procedure reduction of 50 percent applies to all bilateral procedures subject to multiple procedure discounting. For example, if lavage by cannulation; maxillary sinus (antrum puncture by natural ostium) (CPT code 31020) is performed bilaterally in one operative session, the provider reports 31020 on two separate lines or with “2” in the units field. Depending on whether the claim includes other services to which the multiple procedure discount applies, apply the multiple procedure reduction of 50 percent to the payment for at least one of the CPT code 31020 payment rates.

3.7. Payment Rates. The payment rates established for ASC procedures are standard base rates that have been adjusted to remove the effects of regional wage variations. When processing claims for ASC services, the base rates must be adjusted to reflect the wage index value applicable to the area in which the ASC is located.

There is no adjustment for geographic wage differences for the following:

- Corneal tissue acquisition;
- Drugs and devices that have pass-through status under the OPPS;
- Brachytherapy sources;
- Payment adjustment for NTIOLs; and
- Separately payable drugs and biologicals.

In accordance with the Marketplace policy:

- The Medicare adjusted ASC rate (of if no Medicare rate 150% of Medicaid) is multiplied by the provider’s contracted rate, for example 163% for a QHP 1 contracted provider.
- If the provider is not contracted the lowest QHP rate is used to calculate the reimbursement
rate. For facilities, this would be 133%. In some case, the authorization could contain the non-contracted provider reimbursement for the service in question. In all cases, if the billed amount is less than the contracted payment amount, the billed amount is to be reimbursed.

3.8. Payment Indicators. The CMS Ambulatory Surgery Center provider page contains a list of ASC payment indicators that are used in the pricing of ASC services. The payment indicators represent policy-relevant characteristics of HCPCS codes related to their payment status in ASCs; for example, whether a code is designated as packaged, office-based, or device-intensive.

- Services for HCPCS with payment indicators M6 (No payment made; paid under another fee schedule), U5 (Surgical unlisted service excluded from ASC payment, No payment made.), or X5 (Unsafe surgical procedure in ASC. No payment made) are to be denied.

- Services for CPT codes with payment indicators E5 (Surgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made.), or Y5 (Non-surgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made.) should also be denied, unless they are on the MDwise Marketplace list of covered IHCP codes.

- Services for HCPCS codes with the following payment indicators should not be reimbursed unless they are on the MDwise Marketplace list of covered IHCP codes:
  - L1 (Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made)
  - NI (Packaged service/item; no separate payment made) or
  - S1 (Service not surgical in nature; and not a radiology service payable under the OPPS, drug/biological, or brachytherapy source. Packaged item/service; no separate payment made)

3.9. Offset for Payment for Pass-Through Devices - There can be situations where the approved payment amount for specifically identified procedures are reduced when provided in conjunction with a specific pass-through device. This reduction would only be applicable when services for specific pairs of codes are provided on the same day by the same provider. Code pairs subject to this policy are updated on a quarterly basis. CMS informs payers of the code pairs and the percent reduction taken from the procedure payment rate through a “look-up” table.

3.10. Payment When a Device is furnished with No Cost or With Full or Partial Credit. ASCs are paid a reduced amount for certain specified procedures when a specified device is furnished without cost or for which either a partial or full credit is received (e.g., device recall).

For specified procedure codes that include payment for a device, ASCs are required to include modifier –FB on the procedure code when a specified device is furnished without cost or for
which full credit is received. If the ASC receives a partial credit of 50 percent or more of the cost of a specified device, the ASC is required to include modifier –FC on the procedure code if the procedure is on the list of specified procedures to which the -FC reduction applies. The pricing determination related to modifiers –FB and -FC is made prior to the application of multiple procedure payment reductions. Tables listing the procedures and devices to which the payment adjustments apply, and the full and partial adjustment amounts, are available on the CMS Web site.

3.11. Sterilization. A sterilization may be performed in an ASC, however does require prior authorization. It is the provider’s responsibility to obtain the required consent from the member. During the authorization process, it will be confirmed with the provider that the proper consent has been obtained and documented. A consent form may be attached to the sterilization claim; however the provider is not required to submit the consent form with the claim. Reimbursement is available without submission of the consent form.

4. Procedure Codes and Claim Considerations

4.1. Inpatient Only Services. According to Medicare rules, certain services are reimbursable only if provided in an inpatient setting. However, these “Medicare inpatient only” services may be eligible for reimbursement under the Marketplace in both outpatient and inpatient settings. Medicare inpatient only services are identified with a Status C5 indicator. If an outpatient claim has a service with a Status C5 indicator, the entire claim should be processed according to outpatient reimbursement methodology outlined in the IHCP Provider Manual following ASC pricing logic. To determine pricing, base ASC rate should be calculated at 150% of Medicaid fee schedule (to determine Medicare equivalency). The provider’s contracted percent of Medicare rate is then applied. Outpatient reimbursement rules, such as multiple surgeries, bilateral surgeries and the payment of stand-alone and add on services should be followed in the pricing of the claim.

If a “Medicare inpatient only” surgical procedure is performed for which there is no ASC numeric code on the IHCP fee schedule (see IHCP fee schedule and the ASC assigned numeric code located to the right of the pricing information) or there is a service for which no fee amount is assigned, notify MDwise via email that there is no pricing for this service. MDwise will then determine pricing.

4.2. Payment for Terminated Procedures. The following criteria determine the appropriate ASC facility payment for a scheduled surgical procedure that is terminated due to medical complications which increase the surgical risk to the patient
• Deny payment when an ASC submits a claim for a procedure that is terminated before the patient is taken into the treatment or operating room. For example, payment is denied if scheduled surgery is canceled or postponed because the patient on intake complains of a cold or flu.
• Pay 50 percent of the rate if a surgical procedure is terminated due to the onset of medical complications after the patient has been prepared for surgery and taken to the operating room but before anesthesia has been induced or the procedure initiated. Facilities use a 73 modifier to indicate that the procedure was terminated prior to induction of anesthesia or initiation of the procedure.

• Make full payment of the surgical procedure if a medical complication arises which causes the procedure to be terminated after anesthesia has been induced or the procedure initiated. Facilities use a 74 modifier to indicate that the procedure was terminated after administration of anesthesia or initiation of the procedure.

• Apply a 50 percent payment reduction for discontinued radiology procedures and other procedures that do not require anesthesia. Facilities use the -52 modifier to indicate the discontinuance of these applicable procedures.

• ASC surgical services billed with the -52 or -73 modifiers are not subject to the multiple procedure discount. Fifty percent of the full OPPS amount is paid if a procedure for which anesthesia is planned is discontinued after the patient is prepared and taken to the room where the procedure is to be performed but before anesthesia is provided. These situations are indicated by Modifier 73.

5. **Prior Authorization (PA) Requirements**

5.1. Claims received from ASCs are processed in accordance with the MDwise Marketplace Prior Authorization requirements.
ANS - Anesthesia

1. Benefit Coverage

1.1. MDwise reimburses qualified anesthesia providers within the scope of practice for covered anesthesia services that include the provision of general and regional anesthesia and supportive services performed for covered obstetrical, surgical, medical and pain management services.

1.2. For payment purposes, qualified non physician anesthetist includes CRNAs.

1.3. Examples of various methods of anesthesia include general anesthesia, regional anesthesia, monitored anesthesia care (MAC), and moderate sedation ("conscious sedation").

The following types of anesthesia are eligible for separate reimbursement when provided by a physician other than the operating surgeon:

- Epidural
- Field block
- Inhalation
- Intravenous
- Nerve block
- Regional
- Spinal

1.4. Anesthesia and Hospital charges for dental care, for an Enrollee less than 19 years of age or an Enrollee who is physically or mentally disabled, are covered if the Enrollee requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. This Coverage does not apply to treatment for temporal mandibular joint disorders (TMJ). Extraction of teeth to prepare the jaw for radiation treatment or neoplastic disease is covered.

1.5. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Enrollee’s condition under general anesthesia.

1.6. As per Dental care provisions required IC 27-13-7-15, the regulations state the health maintenance organization may:

- Require prior authorization for hospitalization or treatment in an ambulatory outpatient surgical center for dental care procedures in the same manner that prior authorization is required for hospitalization or treatment of other covered medical conditions; and
- Restrict coverage to include only procedures performed by a licensed dentist who has privileges at the hospital or ambulatory outpatient surgical center.
2. **Benefit Limitations and Exclusions**

2.1. Please refer to MDwise Marketplace Contract Individual Policy: Article 4 Exclusions, Section 4.1. for a comprehensive list of exclusions.

3. **Provider Reimbursement & Submission Requirements**

3.1. Claims are billed on a CMS 1500 form or its electronic equivalent.

3.2. The Medicare fee amount will be calculated based upon whether the procedure is medically directed, or medically supervised by a physician; the vendor pays the lesser of the actual charge or the anesthesia fee schedule amount.

3.3. The American Society of Anesthesiologists (ASA) anesthesia codes and the Anesthesia Unit System are only used to calculate professional reimbursement.

3.4. Physicians involved with two concurrent cases with residents. The physician can bill base units and time units based on the amount of time the physician is actually present with the resident during each of the two concurrent cases.

3.5. General, regional, or epidural anesthesia administered by the same provider performing the surgical or obstetrical delivery procedure is not reimbursable, because it is included in the surgical delivery fee.

3.6. The provider reimbursement is as per contracted rate utilizing the appropriate Medicare physician fee schedule as the base rate.
   - Use the Medicare payment amount, if available; then apply the provider’s contracted percent of Medicare. If not, and the service code is covered, then use the Medicaid payment amount as the base. 150% of Medicaid is deemed equivalent to the Medicare rate; then apply the provider’s contracted percent of Medicare. If there is no Medicare or Medicaid rate and the service is covered, the item must be manually priced.

   If the provider is not contracted, and the service is authorized, then the following rate is applied to the applicable Medicare fee amount (or 150% of the Medicaid payment amount as the Medicare equivalent when no fee in Medicare is available and it is a covered service), unless in some case, the authorization could contain the non-contracted provider rate:
   - Facility 133%,
   - Professional I claims 125%

   • Site of service (non facility and facility services) fees may apply to certain service codes

   • In all cases, if the billed amount is less than the contracted payment amount, the billed amount is to be reimbursed

3.7. When billing regional anesthesia as the anesthesia type for a given surgical procedure that is performed by a qualified anesthesia professional, provider’s bill regional anesthesia in the same manner as a general anesthetic, such as base units plus time, and it will be reimbursed the same way. Do not use the bilateral procedure code modifier 50 in conjunction with anesthesia modifiers.
3.8. **MDwise Marketplace Ologist Rule** When an anesthesiologist (311) or Certified Registered Nurse Anesthetist (094) perform services in these service settings or places of service, regardless of whether the provider is contracted with the delivery system or any delivery system, these specialty types should be reimbursed for covered services in accordance with Marketplace reimbursement methodology and the applicable BCCP.

The processing rules for these provider types include reimbursing covered services in these service settings, including inpatient services (POS 21) regardless of whether an authorization was obtained when required.

The only exceptions to this rule are those services that are on the Marketplace prior authorization list that are performed by an anesthesiologist, radiologist, or pathologist or submitted by a lab. This includes, for example an MRA performed by a radiologist, pain management services performed by an anesthesiologist, and genetic testing submitted by a lab or pathologist. In each of these cases, if there is no prior authorization for the service, the claim should be denied, regardless of contracting status.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>PA Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiologist or CRNA</td>
<td></td>
</tr>
<tr>
<td>IP contracted Anesthesiologist</td>
<td>No PA</td>
</tr>
<tr>
<td>IP non-contracted Anesthesiologist</td>
<td>No PA</td>
</tr>
<tr>
<td>POS 22 and 23 non-contracted</td>
<td>No PA unless anesthesiology service is listed on PA</td>
</tr>
<tr>
<td>Anesthesiologist</td>
<td>list</td>
</tr>
<tr>
<td>POS 11 non-contracted Anesthesiologist</td>
<td>No PA unless anesthesiology service is listed on PA</td>
</tr>
<tr>
<td>POS 24 non-contracted Anesthesiologist</td>
<td>No PA unless anesthesiology service is listed on PA</td>
</tr>
</tbody>
</table>

3.9. **General Payment Rule.** The CMS Medicare fee schedule amount for physician anesthesia services is, with the exceptions noted, based on allowable base and time units multiplied by an anesthesia conversion factor specific to that locality. The base unit for each anesthesia procedure is communicated by means of the HCPCS file released annually.

- **Payment at Personally Performed Rate.** The fee schedule payment determination is made by recognizing the base unit for the anesthesia code and one time unit per 15 minutes of anesthesia time if:
  - The physician personally performed the entire anesthesia service alone;
  - The physician is involved with one anesthesia case with a resident, the physician is a teaching physician
  - The physician is involved in the training of physician residents in a single anesthesia case, two concurrent anesthesia cases involving residents or a single anesthesia case involving a resident that is concurrent to another case paid under the medical direction rules.
  - The physician is continuously involved in a single case involving a student nurse anesthetist;
  - If the physician is involved with a single case with a CRNA (or AA) may pay the
physician service and the CRNA (or AA) service in accordance with the medical direction payment policy; or

- The physician and the CRNA (or AA) are involved in one anesthesia case and the services of each are found to be medically necessary. Documentation must be submitted by both the CRNA and the physician to support payment of the full fee for each of the two providers. The physician reports the “AA” modifier and the CRNA reports the “QZ” modifier for a nonmedically directed case.

- **Payment at the Medically Directed Rate.** Payment for the physician’s medical direction service is determined on the basis of 50 percent of the allowance for the service performed by the physician alone. Medical direction occurs if the physician medically directs qualified individuals in two, three, or four concurrent cases and the physician performs the following activities:
  - Performs a pre-anesthetic examination and evaluation;
  - Prescribes the anesthesia plan; Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;
  - Ensures that any procedures in anesthesia plan that her or she does not perform are performed by a qualified anesthetist;
  - Monitors the course of anesthesia at frequent intervals;
  - Remains physically present and available for immediate diagnosis and treatment of emergencies;
  - Provides indicated post-anesthesia care;
  - Please also refer to Anesthesia Claims Modifiers Section 3.6

- **Payment at Medically Supervised Rate.** Only three base units per procedure are allowed when the anesthesiologist is involved in furnishing more than four procedures concurrently or is performing other services while directing the concurrent procedures. An additional time unit may be recognized if the physician can document he or she was present at induction.

- **Billing and Payment for Multiple Anesthesia Procedures.** Payment can be made under the fee schedule for anesthesia services associated with multiple surgical procedures or multiple bilateral procedures.
  - Payment is determined based on the base unit of the anesthesia procedure with the highest base unit value and time units based on the actual anesthesia time of the multiple procedures;
  - Physicians bill for the anesthesia services associated with multiple bilateral surgeries by reporting the anesthesia procedure with the highest base unit value with the multiple procedure modifier “-50.” They report the total time for all procedures in the line item with the highest base unit value;
  - If the same anesthesia CPT code applies to two or more of the surgical procedures, billers enter the anesthesia code with the “-51” modifier and the number of surgeries to which the modified CPT code applies.

- **Monitored Anesthesia Care.** Payment for reasonable and medically necessary monitored anesthesia care services is made on the same basis as other anesthesia services. Anesthesiologists use modifier QS to report monitored anesthesia care cases. Monitored anesthesia care involves the intra-operative monitoring by a physician or qualified individual under the medical direction of a physician or of the patient’s vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure. It also includes the
performance of a pre-anesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral or parenteral medications (e.g., atropine, demerol, valium) and provision of indicated postoperative anesthesia care. Payment is made under the fee schedule using the payment rules in accordance if the physician personally performs the monitored anesthesia care case or under the applicable rules if the physician medically directs four or fewer concurrent cases and monitored anesthesia care represents one or more of these concurrent cases.

- **Moderate Conscious Sedation.** Moderate sedation is a drug induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Moderate sedation does not include minimal sedation, deep sedation or monitored anesthesia care. The moderate (conscious) sedation codes are carrier priced under the Medicare physician fee schedule.

CPT codes are subject to billing rules as indicated for same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, a second physician or other qualified health care professional other than the health care professional performing the diagnostic or therapeutic services providing moderate sedation in the facility setting, and in conjunction with codes listed in Appendix G of the current CPT AMA code book (Summary of CPT codes that include moderate(conscious) sedation. The CPT includes Appendix G, Summary of CPT Codes That Include Moderate (Conscious) Sedation. This appendix lists those procedures for which moderate (conscious) sedation is an inherent part of the procedure itself. CPT coding guidelines instruct practices not to report CPT codes 99143 to 99145 in conjunction with codes listed in Appendix G. The National Correct Coding Initiative has established edits that bundle CPT codes 99143 and 99144 into the procedures listed in Appendix G.

In the unusual event when a second physician other than the health care professional performing the diagnostic or therapeutic services provides moderate sedation in the facility setting for the procedures listed in Appendix G, the second physician can bill 99148 to 99150. The term, facility, includes those places of service listed in Chapter 23 Addendum -- field 29. However, when these services are performed by the second physician in the nonfacility setting, CPT codes 99148 to 99150 are not to be reported.

- If the anesthesiologist or CRNA provides anesthesia for diagnostic or therapeutic nerve blocks or injections and a different provider performs the block or injection, then the anesthesiologist or CRNA may report the anesthesia service using CPT code 01991. The service must meet the criteria for monitored anesthesia care.

- If the anesthesiologist or CRNA provides both the anesthesia service and the block or injection, then the anesthesiologist or CRNA may report the anesthesia service using the conscious sedation code and the injection or block. However, the anesthesia service must meet the requirements for conscious sedation and if a lower level complexity anesthesia service is provided, then the conscious sedation code should not be reported.

- There is no CPT code for the performance of local anesthesia and as payment for this service is considered in the payment for the underlying medical or surgical service.

- **Payment for Medical and Surgical Services Furnished in Addition to Anesthesia Procedure.** Payment may be made under the fee schedule for specific medical and surgical
services furnished by the anesthesiologist as long as these services are reasonable and medically necessary or provided that other rebundling provisions (see §30 and Chapter 23, CMS Manual) do not preclude separate payment. These services may be furnished in conjunction with the anesthesia procedure to the patient or may be furnished as single services, e.g., during the day of or the day before the anesthesia service. These services include the insertion of a Swan Ganz catheter, the insertion of central venous pressure lines, emergency intubation, and critical care visits.

- **General Anesthesia for Dental Procedures.** The scope of this policy is limited to medical plan coverage of the facility and/or monitored anesthesia care (MAC)/general anesthesia services provided in conjunction with dental treatment, and not the dental or oral surgery services.

Anesthesia and Hospital charges for dental care, for an Enrollee less than 19 years of age or an Enrollee who is physically or mentally disabled, are covered if the Enrollee requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Enrollee’s condition under general.

- **Preoperative/Postoperative Visits**
  - Consistent with CMS, will not separately reimburse an E/M service (excluding critical care CPT codes 99291-99292) when reported by the same specialty physician or other health care professional on the same date of service as an anesthesia management service.
  - Critical care CPT codes 99291-99292 are not considered included in an anesthesia management service and will be separately reimbursed.
  - The same specialty physician or other health care professional is defined as physicians and/or other health care professionals of the same group and same specialty reporting the same Federal Tax Identification number.

3.10. Pain Management

- **Postoperative Pain Management Services**
  - Postoperative epidural catheter management or subarachnoid drug administration services are reimbursed using procedure code 01996.
  - Does not pay separately for procedure code 01996 on the same day the epidural is placed. Limit to one unit of service for each day of management.
  - No modifier when this procedure is monitored by an anesthesia provider.
  - If the anesthesiologist continues with the patient's care after discharge, the appropriate Evaluation and Management code should be used.

- **Services related to Pain Management Services as Outpatient**
  - Certain pain management therapy services (e.g., injectibles) performed by an anesthesiologist/pain management specialist are considered covered as per deemed medically necessary.
3.11. Anesthesia services performed by CRNA:

The allowance for the anesthesia service furnished by a CRNA, medically directed or not medically directed is based on allowable base and time units on the Medicare Physician Fee Schedule.

(1) The allowance for an anesthesia service furnished by a medically directed CRNA is based on a fixed percentage of the MPFS allowance recognized for the anesthesia service personally performed by the physician alone. The CRNA is reimbursed at 80% of this allowable charge (non-medically directed).

If the CRNA is medically directed, reimbursement is 50% of the MPFS allowable charge.

2) The CF for an anesthesia service furnished by a CRNA not directed by a physician may not exceed the CF for a service personally performed by a physician.

Modifier QS and QZ, are informational modifiers and will not determine any pricing logic. Modifiers G8 and G9 are region specific per the Medicare Payer and MDwise does not require the G8 or G9. These modifiers are informational and do not impact payment.

Procedure Code Modifiers-Anesthesia (CRNA): See table below

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>QS</td>
<td>Monitored anesthesia care services</td>
</tr>
<tr>
<td>QX</td>
<td>CRNA with medical direction by a physician</td>
</tr>
<tr>
<td>QZ</td>
<td>CRNA without medical direction by a physician</td>
</tr>
</tbody>
</table>

Note: CRNA providers use the same physical status modifiers that apply to the anesthesiologist.

3.12. Anesthesia for Vaginal or Cesarean Delivery

Provider uses the anesthesia CPT vaginal or cesarean delivery CPT codes. (Obstetric Anesthesia services 01958 - 01969). This method of billing is the same for any other surgery and for obstetrical anesthesia, regardless of the type of anesthesia provided (such as general or regional), including epidural anesthesia.

When the anesthesiologist starts an epidural for labor, and switching to a general anesthetic for the delivery becomes necessary, combine and bill the total time for the procedure performed, such as vaginal delivery or cesarean section (C-section).

The actual time of the procedure should be indicated in minutes in field 24G on the CMS-1500 claim form. The same method of billing applies to anesthesia for all services.

System is to calculate total units by adding base units to the number of time units based on the number of minutes billed on the claim. Convert each 15-minute block of time to one time unit.

Per CMS, for the obstetrical add-on codes, such as 01968 or 01969, the anesthesia time is separately reported with each of the primary and the add-on code based on the amount of time appropriately associated with either code. Thus, recognize both the base unit and the time units for the primary and the add-on obstetrical anesthesia codes.

Procedure codes 01960 and 01967, calculates one time unit for each 15-minute block of time
billed in the first hour of service and, for subsequent hours of service, calculates one unit of service for every 60-minute block of time or portion billed.

EXAMPLE: Code 01967 is billed with 01968. Make two separate calculations. Price code 01967 using 5 base units and anesthesia time units and price code 01968 using 2 base units and anesthesia time units.

When a provider, other than the surgeon or obstetrician, bills for epidural anesthesia, the plan reimburses that provider in the same manner as for general anesthesia.

3.13. Anesthesia Time and Calculation of Anesthesia Time Units
Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care.

- Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service.
- Actual anesthesia time in minutes is reported on the claim.

Anesthesia Reimbursement Rate Calculation - (Base Units + Time Units + Modifier Units + Qualifying Circumstance Units) x Medicare Conversion Factor.

The fee schedule amount for an anesthesia service personally performed by a physician on the basis of an anesthesia-specific fee schedule Conversion Factor (CF) and unreduced base units and anesthesia time units. One anesthesia time unit is equivalent to 15 minutes of anesthesia time, and fractions of a 15-minute period are recognized as fractions of an anesthesia time unit. Units are indicated in Box 24G of the CMS1500. Providers should indicate the actual time of the service rendered, in minutes, in the units field of the CMS-1500 claim form. The claims payer should systematically convert minutes to units and add the assigned base units in addition to units for modifying circumstances for a total unit value times the anesthesia conversion factor.

Anesthesia Time Table
Anesthesia Time is figured by allowing one time unit for every 15 minutes (or portion thereof) of anesthesia time billed. The table below will act as guide in translating time to units.

<table>
<thead>
<tr>
<th>Time</th>
<th>Units</th>
<th>Time</th>
<th>Units</th>
<th>Time</th>
<th>Units</th>
<th>Time</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-15</td>
<td>1</td>
<td>61-75</td>
<td>5</td>
<td>121-135</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16-30</td>
<td>2</td>
<td>76-90</td>
<td>6</td>
<td>136-150</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31-45</td>
<td>3</td>
<td>91-105</td>
<td>7</td>
<td>151-165</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>46-60</td>
<td>4</td>
<td>106-120</td>
<td>8</td>
<td>166-180</td>
<td>12</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Qualifying Circumstances: See table below**

<table>
<thead>
<tr>
<th>Qualifying Circumstance</th>
<th>Description</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>99100</td>
<td>Anesthesia for patient of extreme age less than 1, or greater than 70.</td>
<td>Add 1 additional unit</td>
</tr>
<tr>
<td>99140</td>
<td>Anesthesia complicated by emergency conditions</td>
<td>Add 1 additional unit</td>
</tr>
<tr>
<td>99116</td>
<td>Anesthesia complicated by utilization of total body hypothermia.</td>
<td>Deny-Non-covered</td>
</tr>
<tr>
<td>96135</td>
<td>Anesthesia complicated by utilization of total body hypotension.</td>
<td>Deny-Non-covered.</td>
</tr>
</tbody>
</table>

**Status Modifiers- see table below**

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Elective</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>A normal healthy patient for an elective operation</td>
<td>0 units</td>
</tr>
<tr>
<td>P2</td>
<td>A patient with mild systemic disease</td>
<td>0 units</td>
</tr>
<tr>
<td>P3</td>
<td>A patient with severe systemic disease</td>
<td>1 unit</td>
</tr>
<tr>
<td>P4</td>
<td>A patient with a severe systemic disease that is a constant threat to life</td>
<td>2 units</td>
</tr>
<tr>
<td>P5</td>
<td>A moribund patient who is not expected to survive without the operation</td>
<td>3 units</td>
</tr>
<tr>
<td>P6</td>
<td>A declared brain-dead patient whose organs are being removed for donor purposes</td>
<td>0 units</td>
</tr>
</tbody>
</table>

**Anesthesia Claims Modifiers**

Physicians report the appropriate anesthesia modifier to denote whether the service was personally performed, medically directed, or medically supervised.

For medical-directed anesthesia services, the allowance for both the physician and the Certified Registered Nurse Anesthetist (CRNA) is 50 percent of the allowance for the anesthesia service if performed by the physician or CRNA alone.

Specific anesthesia modifiers include:

| AA   | Anesthesia Services performed personally by the anesthesiologist;            |
| AD   | Medical Supervision by a physician; more than 4 concurrent anesthesia procedures; |
| G8 | Monitored anesthesia care (MAC) for deep complex complicated, or markedly invasive surgical procedures; |
| G9 | Monitored anesthesia care for patient who has a history of severe cardio-pulmonary condition; |
| QK | Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals; |
| QS | Monitored anesthesia care service; The QS modifier is for informational purposes. Providers must report actual anesthesia time on the claim. |
| QX | CRNA service; with medical direction by a physician; |
| QY | Medical direction of one certified registered nurse anesthetist by an anesthesiologist; |
| Q  | CRNA service: without medical direction by a physician; and |
| GC | These services have been performed by a resident under the direction of a teaching physician. The GC modifier is reported by the teaching physician to indicate he/she rendered the service in compliance with the teaching physician requirements in §100.1.2. One of the payment modifiers must be used in conjunction with the GC modifier. |

**Medicare Anesthesia Conversion Factor**

Resource: WPS Medicare Part B Specialty Pricing for Michigan and Indiana Providers for file of current conversion and base units utilized in pricing

- **2017 Anesthesia Conversion Factors [ZIP, 11KB]** - These are the anesthesia conversion factors used to compute allowable amounts for anesthesia services under CPT codes 00100 to 01999. (Updated 12/31/2012)
- **2014 Anesthesia Base Units by CPT Code [ZIP, 13KB]** - These are the anesthesia base units used to compute allowable amounts for anesthesia services under CPT codes 00100 to 01999.

**Medicare Conversion Factor**

The chart below lists the **revised FSY 2017** anesthesia zero percent participating, non-participating and limiting charge conversion factors (CFs) effective for dates of service January 1, 2017 through December 31, 2017. For physician-directed anesthesia services, the allowance for both the physician and the Certified Registered Nurse Anesthetist (CRNA) is 50 percent of the allowance for the anesthesia service if performed by the physician or CRNA alone.

The Medicare approved amount for an anesthesia service is calculated as follows:

\[(\text{Base Units} + \text{Time Units}) \times \text{Conversion Factor} = \text{Approved Amount}\]

To determine the medically directed rate, multiply the approved amount by 50%.
<table>
<thead>
<tr>
<th>State</th>
<th>Locality</th>
<th>Participating Physician and CRNA CF</th>
<th>Non-participating Physician CF</th>
<th>Limiting Charge CF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indiana</td>
<td></td>
<td>$ 21.09</td>
<td>$ 20.04</td>
<td>$ 23.05</td>
</tr>
</tbody>
</table>

**Frequency of Rate Updates:** Annually or on an as needed basis per Medicare Regulation

4. **Procedure Codes and Claim Considerations**

4.1. Refer also to Section 3 above.

4.2. Anesthesia services under CPT codes 00100 to 01999.

4.3. Following is a list of applicable anesthesia codes. The list is may not be all inclusive.

99143-99145  Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified healthcare professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status [includes codes 99143, 99144, 99145]

99148-99150  Moderate sedation services (other than those services described by codes 00100-01999) provided by a physician or other qualified healthcare professional other than the health care professional performing the diagnostic or therapeutic service that the sedation supports [includes codes 99148, 99149, 99150]

**CPT**  **Potential anesthesia services / pain management**

62310  Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic

62311  Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar, sacral (caudal)

62318  Injection(s), including catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic

62319  Injection(s), including catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s)(including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar, sacral (caudal)
64400-64450  Introduction/injection of anesthetic agent (nerve block), diagnostic or therapeutic [when used for regional anesthesia; includes codes 64400, 64402, 64405, 64408, 64410, 64412, 64413, 64415, 64416, 64417, 64418, 64420, 64421, 64425, 64430, 64435, 64445, 64446, 64447, 64448, 64449, 64450]

This list of dental related anesthesia codes included as potential billed codes for covered anesthesia services for dental care as outlined in the policy may not be all-inclusive.

The scope of this policy is limited to medical plan coverage of the facility and/or monitored anesthesia care (MAC)/general anesthesia services provided in conjunction with dental treatment, and not the dental or oral surgery services.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9220</td>
<td>Deep sedation/general anesthesia, first 30 minutes</td>
</tr>
<tr>
<td>D9221</td>
<td>Deep sedation/general anesthesia; each additional 15 minutes</td>
</tr>
<tr>
<td>01999</td>
<td>Unlisted anesthesia procedure(s)</td>
</tr>
</tbody>
</table>

5. **Prior Authorization (PA) Requirements**

5.1. Claims received for Anesthesia services are processed in accordance with the MDwise Marketplace Prior Authorization requirements.

5.2. PA entered for inpatient stay serves as global authorization that covers anesthesia provider services provided during inpatient stay.

5.3. Certain Pain Management services require PA. Please refer to this manual’s chapter on Pain Management Services.
BHS - Behavioral Health Services

I. Benefit Coverage

1.1. MDwise Marketplace covered behavioral health services include the following general category of services.

- Inpatient psychiatric and substance abuse services
- Emergency/crisis services
- Alcohol and drug abuse services (substance abuse)
- Therapy and counseling, individual, group or family
- Psychiatric drugs included on MDwise PDL
- Laboratory and radiology services for medication regulation and diagnosis
- Screening and evaluation and diagnosis
- Neuropsychology and psychological testing
- Medication management
- Acute outpatient services (i.e. Partial Hospitalization, Intensive Outpatient Services)

1.2. Mental Health Parity. The Mental Health Parity and Addictions Act MHPAEA of 2008, provides for full mental health parity in the MDwise Marketplace’s covered services. MDwise may not apply treatment limitations or financial requirements on the coverage of mental health care services or substance abuse services if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

1.3. Autism Spectrum Disorder. In accordance with IC 27-13-7-14.7, MDwise provides coverage for individuals with autism spectrum disorders. Services provided to a member are limited to services that are prescribed by the members’ treating physician in accordance with a treatment plan. The treatment plan must be updated at least every six months. Services may include medically necessary speech, occupational, and/or physical therapy.

Services may also include medically necessary behavioral health services to address maladaptive behavior, parenting, emotional regulation, and other symptoms of a behavioral health nature. This could include psychiatric diagnostic evaluations, and other covered behavioral health services, as outlined in this BAP, related to individual, family, group therapy, applied behavior analysis (ABA), and medication management. Such services may not be subject to dollar limits, deductibles, copayments, or coinsurance provisions that are less favorable to a member than the dollar limits, deductibles, copayments, or coinsurance provisions that apply to physical illness.

Prior to initiating ABA therapy, the provider must obtain prior approval. The initial assessment (CPT codes 96150, or 90791) does not require an authorization. However prior to initiating health and behavior interventions, approval must be obtained. This applies to CPT codes 96151 through 96155 for diagnoses codes 299.0 or 299.8. For other therapies initiated for persons with Autism Spectrum Disorder prior authorizations will follow the requirements as outlined in this Attachment B.

Providers who deliver behavioral health services to members with Autistic Spectrum Disorder must be a licensed Behavioral Health Provider such as a Psychiatrist or Health Service Provider in Psychology (HSPP. The BCBA credential is not recognized by the State of Indiana and thus this credential alone is not sufficient to provide the services.
1.4. Inpatient Psychiatric Care. Acute psychiatric and substance abuse inpatient services are mental health interventions used to stabilize and manage people with severe symptoms and behaviors that have or may result in harm to self and/or others.

Depending on the needs of the member, acute psychiatric and substance abuse inpatient services often include, but are not limited to, 24-hour psychiatric and medical services, inpatient detoxification continuous monitoring, medication management, treatment planning, individual therapy, family therapy, and group therapy.

Behavioral health emergency admissions are reimbursable only in cases of a sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in one (1) of the following:

1. Danger to the individual.
2. Danger to others.
3. Death of the individual.

Please refer to Section 1.20 regarding coverage and reimbursement for behavioral health services provided in an emergency room.

Prior Authorization: With the exception of emergency admissions, prior authorization is required for any psychiatric admission, including admissions for substance abuse and observation stays. Emergency admissions that require prior authorization must be reported to MDwise within 48 hours of admission. If the end of the 48-hour period falls on a weekend or legal holiday, emergency admissions must be reported on the next business day after the weekend or holiday. At that time, the same standards for PA are applied as would have been applied if the authorization had been requested before the admission.

1.5. Facility Types. Coverage is available for inpatient psychiatric and substance abuse services in an acute care hospital or a licensed freestanding psychiatric hospital, regardless of the number of beds.

1.6. Psychiatric/Substance Abuse Inpatient Stay Reimbursement. The Inpatient Psychiatric Facility Prospective Payment System (IPFPPS) is used for freestanding psychiatric hospitals and some certified psychiatric units of general acute care hospitals. Payments under the IPF PPS are based on a federal per diem base rate that includes both inpatient operating and capital-related costs (including routine and ancillary services), but excludes certain pass-through costs (i.e., bad debts, and graduate medical education). Psychiatric hospitals and distinct part psychiatric units of acute care hospitals are included in the IPF PPS and can be determined by the facilities OSCAR number.

Reimbursement for substance abuse and chemical dependency admissions in other acute care hospitals, generally those that don’t have distinct units, is based on the Medicare Severity adjusted diagnosis-related grouping (MS-DRG) payment methodology that reimburses a per case rate according to diagnoses, procedures, age, gender, and discharge status. The MS-DRG reimbursement rates are intended to cover all inpatient hospital costs, including the costs of inpatient routine care and ancillary services. Reimbursable psychiatric and substance abuse/chemical dependency MS-DRGs include 880 through 887 & 895 through 897.

Additional payments to hospitals are provided for the following:

- Capital costs
• DSH payment, if applicable
• IME – Capital only
• Outlier payment, if applicable

Direct care services of physicians including psychiatric evaluations, are excluded from the AP-DRG rate and are billable separately by the rendering provider on the CMS-1500 claim form or 837P transaction. In addition, claims for other behavioral health providers (e.g. HSPP, mid-level BH practitioner, clinical nurse specialist) may, as appropriate, be reimbursable. Appropriate billing would be, for example, if the BH provider is not an employee of the facility or is not paid directly by the facility for the BH service.

Effective January 1, 2016, a nurse practitioner (NP) or clinical nurse specialist (CNS) who performs evaluation and management (E/M) rounding in the inpatient mental health setting is reimbursable separately from the per diem rate paid to the facility. Certified registered nurse anesthetists (CRNAs) are excluded from this reimbursement policy change. E/M rounding includes initial, subsequent, and discharge-day management. Unlike for physicians, psychiatric services, such as group and individual therapy, performed by an NP or CNS will not be reimbursed separately. These services, when performed by an NP or CNS, are included in the facility’s per diem rate.

Please note: An inpatient claim may not be denied because the provider fails to include a DRG on the claim. It is the expectation that the payer will run the claim through the DRG grouper to determine applicable payment.

1.7. Transfers/Readmissions/ Outpatient Services within Three Days of an Inpatient Stay/Observation Stays/Less than 24-Hour Stays. Behavioral health care services for the above events follow the same coverage, prior authorization, and reimbursement policies and procedures for these events as described in the Medicare Claims Payment Manual and MDwise policies.

1.8. Residential Treatment, Psychiatric, Eating Disorders, Substance Abuse Disorders
Effective 1.1.2016, coverage in available for Residential Treatment related to psychiatric, eating, and substance abuse disorders. Residential treatment facilities offer a sub-acute level of care which provides 24-hour/7-day assessment and diagnostic services, and active behavioral health treatment services to members who do not require intensive nursing care, medical monitoring, and physician services that are offered in an acute care facility. Treatment is offered in a highly structured and supervised environment and includes individual and group therapy and may also include skilled nursing care and family therapy. The course of treatment in Residential Rehabilitation is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that rehabilitation can be safely, efficiently and effectively continued in a less intensive level of care. Treatment in a residential treatment center is limited to 60 days.

Residential treatment facilities are reimbursed on a per diem basis, as determined by the Provider’s contract. The per diem is inclusive of all services except:
• Physician services
• Pharmaceuticals

Pharmaceuticals that are billed separately are paid by the pharmacy benefit manager, not through the medical benefit.
Prior Authorization: Authorization is required and is generally approved for 14 days and subsequent approval is needed for additional days.

1.9. Behavioral Health Professional Services During Medical/Surgical Stay. Inpatient psychiatric consultations, evaluations, medication management and psychotherapy services may be provided by a behavioral health provider to a member during a medical surgical stay and are covered benefits. Such services would be covered under the global authorization obtained by the inpatient facility. The exception is diagnostic interviews (CPT codes 90791 & 90792 along with CPT code 90785 if included as add on code). Only one diagnostic interview should be provided during an inpatient stay. Additional diagnostic interviews would require prior authorization.

1.10. Psychiatric diagnostic interviews (CPT code 90791 or 90792). Reimbursement is available for one unit of psychiatric diagnostic interview, CPT code 90791 or 90792, per recipient, per billing provider, per calendar year without prior authorization. A maximum of two (2) units (diagnostic interview interviews) per member per calendar year is allowed without prior authorization when a member is separately evaluated both by a physician or HSPP and a mid-level practitioner.

It is MDwise policy that an advanced practice nurse may perform the diagnostic interview in lieu of a physician. Therefore, of the two (2) units allowed without PA, one unit may be provided by a physician, an advanced practice nurse, or a HSPP and one by another mid-level practitioner (e.g. LCSW, MSW, etc.). All additional units require prior authorization.

Please Note: A diagnostic interview provided in emergency room or during an inpatient stay may be reimbursed without prior authorization in addition to maximum # of units outlined above. Please refer to Section D.1.2.14 regarding coverage of Emergency Behavioral Health Services.

Prior Authorization:
Members may self-refer to any MDwise contracted behavioral health professional for a diagnostic interview without authorization. If the provider is not contracted with MDwise prior authorization is required.

Example: A Community Mental Health Center (CHMC) as a billing provider, may conduct a diagnostic interview by both a psychiatrist or an HSPP, and a mid-level practitioner and be reimbursed without prior authorization. If another psychiatrist or HSPP within the same CMHC wanted to conduct a diagnostic interview in the same year, prior authorization would be required.

1.11. Psychotherapy (individual group & family). Reimbursement is available for medically necessary psychotherapy services according to MDwise behavioral health guidelines, and consistent with prior authorization requirements as outlined below.

Prior Authorization:
- For contracted MDwise behavioral health providers, in addition to a 90791 or 90792 members can receive up to twelve (12) therapy sessions without prior authorization per billing provider. This includes CPT codes: 90832, 90834, 90837, 90846, and 90847
- When appropriate, CPT code 90785, interactive complexity may be reimbursed in addition to the CPT codes outlined above.
- All other therapy visits require prior authorization. All services for out-of-network providers require prior authorization.
1.12. **Pharmacological (medication) management (with or without psychotherapy services).** Members may receive a medical E/M service on the same day as a psychotherapy service when performed by the same physician or other qualified healthcare professional. When psychotherapy is provided in addition to medical management, an appropriate add-on psychotherapy code with E/M may be reimbursed (CPT codes 90833, 90836, or 90838). If a provider is only providing pharmacologic management during the visit, they cannot use the psychotherapy add-on codes and must instead bill the applicable E/M service code, based on the complexity of the visit (e.g. 99211 vs. 99212).

In addition to psychiatrists, nurse practitioners and clinical nurse specialists who have prescription authority can also provide and bill for the psychotherapy and pharmacological management services with the above listed codes. MDwise does not reimburse clinical social workers, psychologists, or any other licensed BH provider, including nurse practitioners and clinical nurse specialists without prescription authority, for those codes.

1.13. **Interactive complexity (add on code).** Interactive complexity (CPT code 90785) refers to specific communication factors that complicate the delivery of a psychiatric procedure. Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients.

CPT code 90785 is an add-on code to a psychotherapy service and may not be billed as a stand-alone code. The code may be billed in conjunction with the following procedure codes when appropriate:
- Diagnostic evaluation codes: 90791 and 90792
- Psychotherapy codes: 90832, 90834, and 90837
- Psychotherapy when performed with an evaluation and management (E/M) service: CPT codes 90833, 90836, 90838, 99201-99255, 99304-99337, and 99341-99350
- Group psychotherapy: CPT code 90853

The service may not be billed in conjunction with:
- Crisis psychotherapy procedure codes 90839 & 90840
- E/M services when no psychotherapy is performed

Only one unit of service (CPT code 90875) may be billed, per day, per member.

Prior Authorization:
Interactive complexity does not require a separate authorization. If the psychiatric service to which CPT code 90875 is being added is authorized, then this authorization also applies to the add-on service.

1.14. **Electroconvulsive therapy (ECT).** Electroconvulsive therapy (CPT code 90870) may be performed while a member is hospitalized or as an outpatient procedure. In either case, it is done under brief general anesthesia (CPT 00104). Outpatient ECT services require prior authorization. Inpatient ECT services are authorized as part of the inpatient stay (see D.1.2). Outpatient facility charges are reimbursed based on Medicare ambulatory payment classification (APC) rates.

1.15. **Neuropsychological & Psychological Testing.** Medically necessary psychological testing and neuropsychological testing are covered services, however with the exception of CPT code 96110, require prior authorization. This applies to CPT codes 96101, 96102, 96103, 96105, 96111,
96116, 96118, 96119, & 96120. Psychological testing may only be provided by physician, or HSPP, with the exception of codes 96102 and 96119 which may be rendered by a midlevel practitioner under the direct supervision of a physician or HSPP.

1.16. **Partial Hospitalization.** Reimbursement is available for partial hospitalization services provided for individuals who require less than full-time hospitalization, but need more extensive or structured treatment than intermittent outpatient mental health services. Partial hospitalization services require prior authorization. The number of days per week required is determined by what is medically necessary and indicated in the member’s treatment plan.

Covered outpatient partial hospitalization services are billed on a facility claim and are reimbursed according to the following:

<table>
<thead>
<tr>
<th>Service</th>
<th>Revenue Code</th>
<th>CPT Code</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial Hospitalization – all-inclusive per diem payment of three to five hours (half day)</td>
<td>912</td>
<td>H0035</td>
<td>$159.75</td>
</tr>
<tr>
<td>Partial Hospitalization – all-inclusive per diem payment of six or more hours (full day)</td>
<td>913</td>
<td>H0035</td>
<td>$213.00</td>
</tr>
</tbody>
</table>

The base rate for partial hospitalization is then multiplied by the provider’s contracted rate. For example in qualified health plan 1, the provider’s contracted rate would be 163%. The half-day PH per diem rate for that provider would be $259.09.

Covered partial hospitalization professional services provided by a physician, physician assistant, HSPP, clinical nurse specialist, and/or nurse practitioners can be reimbursed in addition to the facility charge. The services of other practitioners (including clinical social workers and occupational therapists), are bundled for partial hospitalization services.

1.15. **Intensive Outpatient (IOP) Services.** Reimbursement is available for intensive outpatient services provided for individuals who require less than full-time hospitalization and partial hospitalization, but need more extensive or structured treatment than intermittent outpatient mental health services. IOP services require prior authorization. The number of days per week required is determined by what is medically necessary and indicated in the member’s treatment plan.

IOP outpatient facility services are billed on a facility claim and are reimbursed according to the following:

<table>
<thead>
<tr>
<th>Service</th>
<th>Revenue Code</th>
<th>CPT Code</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric IOP –per diem rate</td>
<td>905</td>
<td>S9480</td>
<td>$86.54</td>
</tr>
<tr>
<td>Substance Abuse IOP – per diem rate</td>
<td>906</td>
<td>H0015</td>
<td>$86.54</td>
</tr>
</tbody>
</table>

The base rate for IOP is then multiplied by the provider’s contracted rate. For example in QHP 1, the provider’s contracted rate would be 163%. The IOP per diem rate for that provider would be $141.06.

1.16. **Screening and Brief Intervention Services (SBI).** SBI identifies and intervenes with individuals who are at risk for substance abuse-related problems or injuries.

SBI services use established systems (generally in non-behavioral health environment), such as trauma centers, emergency rooms, community clinics, and school clinics, to screen patients who
are at risk for substance abuse and, if necessary, provide them with brief interventions or referrals to appropriate treatment. SBI services are not typically billed by behavioral health clinics as screening and interventions are already included in behavioral health assessment/treatment CPT codes (e.g. G0396, G0397).

Reimbursable procedure codes include:
- 99408 – Alcohol and/or substance abuse structured screening and brief intervention services, 15-30 minutes
- 99409 – Alcohol and/or substance abuse structured screening and brief intervention services, greater than 30 minutes
- G0396 – Alcohol and/or substance abuse structured screening and brief intervention services, 15-30 minutes
- G0397 – Alcohol and/or substance abuse structured screening and brief intervention services, greater than 30 minutes

Providers can bill one of the above procedure codes only after an individual has been screened for alcohol or drug abuse by a healthcare professional and it appears that a brief intervention is needed. SBI services are limited to one structured screening and brief intervention per member per year when billed by the same billing provider.

Reimbursement for SBI services will be restricted to the following place of service (POS) and corresponding POS Codes:
- 04 - Homeless shelter
- 11 – Office
- 20 – Urgent care facility
- 23 – Emergency room
- 50 – Federally Qualified Health Center (FQHC)
- 72 – Rural health clinic (RHC)

Prior Authorization:
- One of the above procedure codes are allowed without prior authorization, per member, per billing provider.
- Non-contracted providers must receive prior authorization for SBI services, except if provided as an emergency service.

1.17. Smoking Cessation Treatment Services. Smoking cessation treatment is available for two individual smoking cessation counseling treatments per member per calendar year. Prior authorization is not required for this treatment. In accordance with BCCP 23, Preventive Services, Smoking cessation is considered a preventive benefit and thus member cost-sharing (e.g. copays) does not apply.

Each attempt may include a maximum of four (4) intermediate and/or intensive sessions, with a total benefit covering up to 8 sessions per year per member who uses tobacco. The provider and member have the flexibility to choose between intermediate (more than 3 minutes but less than 10 minutes), or intensive (more than 10 minutes) cessation counseling sessions for each attempt.

Smoking cessation services are to be billed with a primary diagnosis code of F17.2XX or Z87.891.

Smoking cessation counseling services are to be reimbursed using the following procedure codes:
- 99406: Smoking and tobacco cessation counseling visit; intermediate, greater than 3 minutes,
up to 10 minutes
- 99407: Smoking and tobacco cessation counseling visit patient; intensive, greater than 10 minutes
- G0436: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes
- G0437: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes

When providers and practitioners furnish a service to the general public at no charge, including smoking cessation counseling services, they cannot receive marketplace reimbursement for that service.

Treatment services must be prescribed by a licensed practitioner within the scope of license under Indiana law.

1.18. Telepsychiatry. MDwise reimburses for telemedicine services, only when the hub and spoke sites are greater than 20 miles apart. This 20 mile rule does not apply to CMHCs, Federally Qualified Health Centers, Rural Health Centers, or Critical Access Hospitals. The member must be present and able to participate in the visit.

The following CPT codes are reimbursable for providers that render services via telemedicine at the hub site. Modifier GT (Via interactive audio and video telecommunications system) must be used to denote telemedicine services. The payment amount is equal to the current fee schedule amount for the following services multiplied by the provider’s contracted percentage rate:

- Office or other outpatient visit – 99201 to 99205 and 99211 to 99215
- Individual psychotherapy – 90833 to 90838
- Psychiatric diagnostic interview – 90791, 90792
- Individual and group health and behavior assessment and intervention (96150 – 96154)
- Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services (99408, 99409, G0396 and G0397)
- Smoking cessation services - (99406,99407,G0436 and G0437)

The following HCPCS code and revenue code are reimbursable for providers that render services via telemedicine at the spoke site. Modifier GT (Via interactive audio and video telecommunications system) must be used to denote telemedicine services.

- Spoke services are reimbursed using HCPCS code Q3014 Telehealth originating site facility fee. The GT modifier must be used to denote telemedicine services.
- Revenue code 780 represents telemedicine services. If a different, separately reimbursable treatment room revenue code is provided on the same day as the telemedicine consultation; the appropriate treatment room revenue code should also be included on the claim. Documentation must be maintained in the patient’s record to indicate that services were provided separate from the telemedicine visit.
- If spoke site services are provided in a physician’s office and other services are provided on the same date as the spoke service, the medical professional should bill Q3014 as a separate line item from other professional services.
- Any existing service limitation for office visits is applicable. All telemedicine services billed using the codes listed above section will be counted against the office visit limit and prior authorization requirements.
1.19. **Observation Stays.** Psychiatric and substance/chemical abuse observation stays in acute care hospitals and freestanding psychiatric hospitals are reimbursable. Providers should bill any inpatient stay that is less than 24 hours as an outpatient service (e.g. observation stay).

Providers can retain members for more than one 23-hour observation period when the member has not met criteria for admission but the treating physician believes that allowing the member to leave the facility would likely put the member at serious risk. This observation period can last **not more than three days or 72 hours and is billed as an outpatient claim**. Outpatient facility charges are reimbursed based on Medicare ambulatory payment classification (APC) rates.

**Prior Authorization:**
- With the exception of emergency admissions as outlined in Section D.1.2.14, observation stays **require prior authorization**.
- An observation stay may have been initially authorized as an inpatient admission. In these situations the inpatient authorization must apply to the observation stay for claim payment purposes.

1.20. **Emergency Behavioral Health Services.** Emergency behavioral health services provided in an emergency room are covered services in accordance with MDwise MM BAP 02, *Emergency and Post-Stabilization Services*. A covered service provided by a behavioral health provider in an emergency room is reimbursable under the behavioral health benefit. However, services provided in an emergency room and/or provided by an emergency room physician (or other medical provider) are reimbursable under the medical benefit.

A diagnostic interview (CPT code 90791 or 90792) provided in emergency room may be reimbursed without prior authorization in addition to maximum # of units outlined 1.20.

MDwise does not require prior authorization for emergency services.

2. **Benefit Limitations and Exclusions**

2.1. The following are non-covered services
- Long term or custodial care including: domiciliary, convalescent care, skilled nursing facilities used for long-term care and custodial care, nursing home care, home-based respite care, group homes, halfway homes, or residential facilities
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services at a residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.
- Wilderness camps.
- Weight loss programs, whether or not they are pursued under medical or Physician
supervision, unless specifically listed as Covered in this Contract. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

- Marital counseling.
- Self-help training and other forms of non-medical self-care, except as otherwise provided in enrollee Contract.
- Alternative or complementary medicine including, but not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, reiki therapy, massage therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.
- Services for any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers’ Compensation Act or other similar law.
- Services that are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- A condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
- Care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
- Court ordered testing or care unless Medically Necessary.
- Physician or Other Practitioners’ charges for consulting with Enrollees by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Enrollee except as otherwise described in this Contract.
- Telephone consultations or consultations via electronic mail or internet/web site, except as required by law, authorized by MDwise.
- Any services which are not deemed to be medically necessary as determined by MDwise or that are experimental/investigative.

3. Provider Reimbursement and Submission Requirements

3.1. Behavioral health claims must include a primary behavioral health diagnosis code.
- For inpatient or outpatient facility claims, a behavioral health diagnosis code must be in the primary diagnosis field on a UB 04/837I.
- For professional claims, a behavioral health diagnosis code must be included in the procedure line first diagnosis pointer (CMS-1500/837P Box 24E).

If a behavioral health provider does not include a behavioral health diagnosis in one of these fields in combination with a procedure code or revenue code within the scope of this policy, the claim could be denied with the appropriate denial message. Consideration would however need to be given to whether claim could instead be covered as a medical service. For example, medically necessary neuropsychological testing performed by a HSPP to evaluate the effects of brain damage is a covered service (with PA), however the primary diagnosis may not be a behavioral health diagnosis that is included in A.1. Another example is health and behavior assessment procedure codes (96150-96155) that are used to assess factors that may affect the recovery or progression of
a diagnosed physical health problem (e.g. diabetes). Psychologists that provide this service should utilize a physical health diagnosis.

3.2. Documentation on the member’s condition is to be maintained in the provider’s member chart. All claims, regardless of the date of service, are subject to post payment review of documentation regarding medical necessity.

4. Procedure Codes and Claim Consideration

4.1. Please see the detailed coding information found in the benefit coverage section of this chapter.

5. Prior Authorization (PA) Requirements

5.1. Admissions and Observations Stays
- With the exception of emergency admissions as outlined in Section 1.20, observation stays require prior authorization.
- An observation stay may have been initially authorized as an inpatient admission. In these situations the inpatient authorization must apply to the observation stay for claim payment purposes.
- With the exception of emergency admissions, prior authorization is required for any psychiatric admission, including admissions for substance abuse and observation stays. Emergency admissions that require prior authorization must be reported to MDwise within 48 hours of admission. If the end of the 48-hour period falls on a weekend or legal holiday, emergency admissions must be reported on the next business day after the weekend or holiday. At that time, the same standards for PA are applied as would have been applied if the authorization had been requested before the admission.

5.2. Members may self-refer to any MDwise contracted behavioral health professional for a diagnostic interview without authorization. If the provider is not contracted with MDwise prior authorization is required.

5.3. For contracted MDwise behavioral health providers, in addition to a 90791 or 90792, members can receive up to twelve (12) therapy sessions without prior authorization per billing provider. This includes CPT codes: 90832, 90834, 90837, 90846, and 90847
- When appropriate, CPT code 90785, interactive complexity may be reimbursed in addition to the CPT codes outlined above.
- Interactive complexity does not require a separate authorization. If the psychiatric service to which CPT code 90875 is being added is authorized, then this authorization also applies to the add-on service.

5.4. Medication Management and Psychotherapy
- For contracted MDwise psychiatrists and nurse practitioners/clinical nurse specialists who have prescription authority, 19 visits without prior authorization are allowed for the following CPT codes per member, per billing provider: 99201-99205, 99211-99215, and 99241-99245. These services are cumulative by billing provider. Thus, a MDwise contracted billing provider (e.g. CMHC) may receive 19 total visits without authorization for any of these CPT codes whether provided by a psychiatrist, nurse practitioner or clinical nurse specialist.
• In addition to the E/M codes above, add-on psychotherapy codes 90833 and 90836 may be provided without prior authorization for 19 visits. These psychotherapy codes do not require a separate authorization as they are add-on codes to an E/M service and may not be used as a stand-alone service.
• Psychotherapy add-on code 90838 (60 minutes) however does however require a separate authorization.

5.5. Partial hospitalization services require prior authorization. The number of days per week required is determined by what is medically necessary and indicated in the member’s treatment plan.

5.6. Screening and Brief Intervention
• One G0396 or G0397 is allowed without prior authorization, per member, **per billing provider**.
• Non-contracted providers must receive prior authorization for SBI services, except if provided as an emergency service.
CRS - Cardiac Rehab Services

1. Benefit Coverage

1.1. Covered Cardiac Rehabilitation Services are medically necessary services to restore an individual's functional status after a cardiac event. Cardiac rehabilitation and intensive cardiac rehabilitation must be prior authorized to determine level of service required. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, ongoing conditioning and maintenance are not covered.

1.2. Cardiac Rehab (CR) Services are furnished in a physician’s office/clinic or an ambulatory/hospital outpatient facility setting and as per MDwise individual policy contract language, physician home visits and must adhere to 42 CFR 410.49 a, b, d, e, and f. For Intensive Cardiac Rehabilitation (ICR), the hospital outpatient setting or physician’s office/clinic must provide ICR using an approved ICR program. ICR services mean a physician-supervised program that furnishes the same items/services under the same conditions as a CR program but must also adhere to all requirements for ICR as described in 42 CFR 410.49a, including outcome measurement.

Cardiac programs include the following:

- Physician-prescribed exercise
- Psychosocial assessment
- Outcomes assessment
- An individualized treatment plan
- Cardiac risk factor modification including education, counseling and training tailored to the patient’s needs

1.3. Evaluation and Management (E/M) services, ECGs and other diagnostic services may be covered on the day of cardiac rehabilitation if these services are separate and distinct from the cardiac rehabilitation program and are medically necessary.

1.4. Forms of counseling, such as dietary counseling, psychosocial intervention, lipid management and stress management are considered components of the cardiac rehabilitation program and are not separately reimbursed.

2. Benefit Limitations and Exclusions

2.1. Limitations

- Up to 36 visits when medically necessary and rendered as Physician Home Visits and Office Services or Outpatient Services.

2.2. Exclusions

- Home programs, on-going conditioning and maintenance are not covered.
3. **Provider Reimbursement & Submission Requirements**

3.1. The provider reimbursement is as per contracted rate utilizing the appropriate Medicare physician fee schedule or applicable outpatient prospective payment system (OPPS) pricing/outpatient pricer as the base rate.

- Use the Medicare payment amount, if available; then apply the provider’s contracted percentage of Medicare. If not, and the service code is covered, then use the Medicaid payment amount as the base. 150% of Medicaid is deemed equivalent to the Medicare rate; then apply the provider’s contracted percentage of Medicare. If there is no Medicare or Medicaid rate and the service is covered, the item must be manually priced.

- If the provider is not contracted, and the service is authorized, then the following rate is applied to the applicable Medicare fee amount (or 150% of the Medicaid payment amount as the Medicare equivalent when no fee in Medicare is available and it is a covered service), unless in some case, the authorization could contain the non-contracted provider rate:
  - Facility 133%
  - Professional 125%

- Site of service (nonfacility and facility services) fees may apply to certain service codes

- In all cases, if the billed amount is less than the contracted payment amount, the billed amount is to be reimbursed.

3.2. The provider bills on Form CMS-1450 (aka UB-04 at present) or CMS 1500 or their electronic equivalent.

4. **Procedure Codes and Claim Considerations**

4.1. Claims are to be submitted with following:

- Revenue code 0943: hospital outpatient facility
- POS 22 Hospital outpatient setting
- POS 11: Office setting/Clinic

CPT/HCPCS Codes:

93797: Cardiac rehab
93798: Cardiac rehab/monitor
G0422: Intensive cardiac rehabilitation, with or without continuous ECG monitoring with exercise, per session
G0423: Intensive cardiac rehabilitation, with or without continuous ECG monitoring without exercise, per session

Physician or other qualified health care professional services for outpatient cardiac rehabilitation include those applicable claims edits utilized by MDwise e.g., bundled services as billed included as part of one cardiac rehab visit.
5. **Prior Authorization (PA) Requirements**

5.1. Claims received for Cardiac Rehab services are processed in accordance with the MDwise Marketplace Prior Authorization requirements.

5.2. Cardiac Rehabilitation requires prior authorization
DNT - Dental Services

1. Benefit Coverage

1.1. Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient’s condition.

Covered Health Services for Accidental Dental include, but are not limited to all of the following:

- Oral examinations
- X-rays
- Tests and laboratory examinations
- Restorations
- Prosthetic services
- Oral surgery
- Mandibular/maxillary reconstruction
- Anesthesia

1.2. Extraction of teeth to prepare the jaw for radiation treatment or neoplastic disease is covered. (MDwise Marketplace Adult or Child contract Section 3.4)

1.3. Providers of dental services include licensed Doctor of Dental Surgery, “D.D.S.”, or a Doctor of Medical Dentistry, “D.M.D.”.

1.4. Treatment for pain is only covered if it is the result of an accidental injury.

1.5. Injury as a result of chewing or biting is not considered an accidental injury.

1.6. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair.

For a Child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

1.7. This policy does not apply to covered treatment rendered for temporal mandibular joint disorders (TMJ).

1.8. Anesthesia and Hospital charges for dental care, for an Enrollee less than 19 years of age or an Enrollee who is physically or mentally disabled, are covered if the Enrollee requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Enrollee’s condition under general anesthesia.
2. Benefit Limitations and Exclusions

2.1. Limitations
   • $3,000 max/Benefit Period per accident
   • The benefit limit will not apply to Outpatient facility charges, anesthesia billed by a Provider other than the Physician performing the service, or to services that we are required by law to cover.

2.2. Non-covered
   • Routine dental care is not a Covered Health Service under this Contract

2.3. Exclusions
   2.3.1. Coverage is not provided for any of the following:
   o Dental treatment, regardless of origin or cause, except as specified elsewhere in this Contract. “Dental treatment” includes but is not limited to Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including, but not limited to the list below.
      o Extraction, restoration and replacement of teeth.
      o Medical or surgical treatments of dental conditions.
      o Services to improve dental clinical outcomes.
   o Treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Health Service.
   o Dental implants.
   o Dental braces.
   o Dental x-rays, supplies and appliances and all associated expense, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following listed below.
      o Transplant preparation.
      o Initiation of immunosuppressives.
      o Direct treatment of acute traumatic injury, cancer or cleft palate.
   o Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.

Refer to MDwise Marketplace Adult and Child Individual Contract Policy, Article 4, Exclusions, Section 4.1 for list of excluded services.

3. Claims Considerations

   • The provider bills on Form CMS 1500 or CMS-1450 (aka UB-04 at present) or its electronic equivalent.

   • Date of accident to be included in applicable field of claim form. Claim may be denied if date of accident is not submitted. Emergency Services (POS 23) claims are processed in accordance with the emergency services BAP and claims policy.

4. Prior Authorization (PA) Requirements
   4.1. Claims received for Dental Services are processed in accordance with the MDwise Marketplace Prior Authorization requirements.
DBE - Diabetic Equipment, Education, & Supplies

1. Benefit Coverage

1.1. MDwise will reimburse medical necessary covered services as determined for diabetes education, training, equipment and supplies.

1.2. Diabetes Self-Management Training (DSMT) for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when all of the following requirements listed below are met:
   • Ordered in writing by a physician or a podiatrist
   • Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this provision, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association. Non-physician Health Care Professional includes those qualified advanced practice nurses, physician assistants and registered dieticians licensed in Indiana.

1.3 Diabetes Equipment (such as blood sugar monitors and external insulin pumps) is covered as a DME benefit and in accordance with the Prior Authorization requirements. For equipment that does not require a prior authorization, covered diabetes equipment is reimbursed without a prior authorization unless exceeds cost limitations per DME authorization policy.

1.4 Diabetes Supplies that are routinely covered include lancets, spring-powered lancing devices, test strips, control solution, gauze, needles, syringes, and alcohol swabs, are covered as a pharmacy item and will be processed through the PBM.

1.5 Covered Health Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes pursuant to the following chapters in this manual: Medical Supplies, Durable Medical Equipment and Appliances, Physician Home Visits and Office Services, and Preventive Care Services.

2. Benefit Limitations and Exclusions

2.1 Limitations
   • Diabetes Self-Management Training/Education
     o MDwise covers 10 hours of initial training within a continuous 12-month period for a member who has been diagnosed with diabetes. Additional hours require prior authorization.
     o The initial training must be completed no more than 12 months from the time training is commenced.
     o MDwise members are eligible to receive 2 hours follow-up training each calendar following the year in which member received initial training. The member may receive the 2 hours of follow-up training when ordered even in the event that no initial training claim(s) have been received. Additional hours beyond two hours require prior authorization.
- The number of initial or follow-up hours ordered can be fewer than 10 hours or 2 hours allowed.
- The 10 hours of training can be done in any combination of 30 minute increments.
- Follow-up training is furnished in increments of no less than 30 minute increments.

**Diabetes Supplies.** A 90 day supply of testing materials may be obtained at one time. If testing is required above routine testing parameters for non-insulin diabetics and insulin dependent diabetics, additional supply volume can be prior authorized as medically necessary upon request by physician. For items available on the formulary, prior authorization will be required through the pharmacy benefit manager.

### 3. Provider Reimbursement & Submission Requirements

**3.1.** The provider reimbursement is as per contracted rate utilizing the appropriate Medicare physician fee schedule for the base rate for the education and equipment/DME. Specific diabetes supplies as indicated in this policy are processed through the pharmacy benefit manager.

- Use the Medicare payment amount, if available; then apply the provider’s contracted percentage of Medicare. If not, and the service code is covered, then use the Medicaid payment amount as the base. 150% of Medicaid is deemed equivalent to the Medicare rate; then apply the provider’s contracted percentage of Medicare. If there is no Medicare or Medicaid rate and the service is covered, the item must be manually priced.

- If the provider is not contracted, and the service is authorized, then the following rate is applied to the applicable Medicare fee amount (or 150% of the Medicaid payment amount as the Medicare equivalent when no fee in Medicare is available and it is a covered service), unless in some case, the authorization could contain the non-contracted provider rate:
  - Facility 133%
  - Professional 125%

- Site of service (nonfacility and facility services) fees may apply to certain service codes

- In all cases, if the billed amount is less than the contracted payment amount, the billed amount is to be reimbursed.

**3.2. Manual Pricing.** CPT codes billed for the marketplace, which fall under the manual pricing logic should follow the published Medicaid rate methodology, as outlined in the below table and in the IHCP Bulletin, BT 200940 and 201213. Except for drugs and biological, which have special pricing, HCPCS codes which indicate manual pricing will be reimbursed at 60% of billed charges, or for DME products, 60% of the Manufacturers Suggested Retail Price (MSRP). For the pricing of drugs and biological, refer to **BCCP 20, Pharmacy & Biologicals**.

To determine the base Medicare rate for CPT codes, the applicable Medicaid rate, based on the below table is multiplied by 150%. The provider’s contracted rate is then applied to the base Medicare rate.

For HCPCS codes that are paid at 60% of billed charges, there is no additional percentage applied (Medicare equivalency or additional provider contracted amount).
3.3. Payment to non-physician practitioners billing on behalf of a DSMT program (G0108 or G0109). For the purpose of this policy, non-physician billing includes qualified licensed nurse practitioner, licensed dietician or physician assistant as governed by state regulations and within their scope of practice. Qualifications as stated in Section I includes having obtained current certification in diabetes education by the American Diabetes Association.

**NOTE:** Diabetes self-management training may be obtained in a Federally Qualified Health Center (FQHC). Effective January 1, 2006, payment for DSMT provided in a Federally Qualified Health Clinic (FQHC) that meets all of the requirements identified in Pub. 100-04, chapter 18, section 120 may be made in addition to one other visit the beneficiary had during the same day.

3.4. Per MDwise Individual Contract Policy: No Copay/Coinsurance applies to certain diabetic and asthmatic supplies, up to the Allowed Amount when obtained from a Participating Pharmacy. These supplies are covered as medical supplies, durable medical equipment, and appliances if obtained from a Non-Participating Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copay/Coinsurance.

### 4. Procedure Codes and Claim Considerations

#### 4.1. ICD diagnosis of diabetes is required on the claim

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E08.9, E09.8 E09.9</td>
<td>Secondary diabetes mellitus</td>
</tr>
<tr>
<td>(E09.-), (E13.9), E08 (E08.0 - E08.9)</td>
<td>Drug or chemical induced diabetes mellitus</td>
</tr>
<tr>
<td>(E10.-)</td>
<td>Type 1 diabetes mellitus</td>
</tr>
<tr>
<td>(E11.-)</td>
<td>Type 2 diabetes mellitus</td>
</tr>
<tr>
<td>(E13.-)</td>
<td>Other specified diabetes mellitus</td>
</tr>
<tr>
<td>024.4-024.319</td>
<td>Maternal diabetes mellitus complicating pregnancy, childbirth, or the puerperium</td>
</tr>
<tr>
<td>028</td>
<td>Abnormal findings on antenatal screening of mother</td>
</tr>
<tr>
<td>024.4-</td>
<td>Gestational Diabetes</td>
</tr>
</tbody>
</table>

#### 4.1. HCPCS codes for DSMT:
- G0108 Diabetes outpatient self-management training services, individual, per 30 minutes or
• G0109 Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes

5. **Prior Authorization (PA) Requirements**

5.1. Claims received for Diabetes Education, Equipment, and Supplies are processed in accordance with the MDwise Marketplace Prior Authorization requirements.

5.2. Diabetic education if more than the initial 10 hours or more than 2 hours for subsequent years.
DHS - Diagnostic Health Services

1. Benefit Coverage

1.1. Diagnostic Health Services are those covered tests or procedures performed when a member has specific symptoms to detect or monitor his/her condition. Covered services indicated as necessary for diagnosing include those services provided as part of Physician Home Visits & Office Services, Inpatient Services, Outpatient Services, Home Care Services and Hospice Services covered benefits.

1.2. For Diagnostic Health Services other than those approved to be received in a Physician’s office, Enrollee may be required to use Participating independent laboratory or medical diagnostic service Provider.

1.3. Coverage for Diagnostic Health Services includes but is not limited to those services listed below.
   - X-ray & other radiology services, including mammograms for any person diagnosed with breast disease.
   - Magnetic Resonance Angiography (MRA)
   - Magnetic Resonance Imaging (MRI).
   - Computer Tomography and Computer Axial Tomography Scans (CAT).
   - Laboratory and pathology services.
   - Cardiographic, encephalographic, and radioisotope tests.
   - Nuclear cardiology imaging studies.
   - Ultrasound services.
   - Allergy tests.
   - Electrocardiograms (EKG).
   - Electromyograms (EMG) except that surface EMG’s are not Covered Services.
   - Echocardiograms.
   - Bone density studies.
   - Positron emission tomography (PET scans)
   - Echographies.
   - Doppler studies.
   - Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
   - Brainstem evoked potentials (BAER).
   - Somatosensory evoked potentials (SSEP).
   - Visual evoked potentials (VEP).
   - Nerve conduction studies.
   - Muscle testing.
   - Electrocorticograms.

1.4. Central supply (IV tubing) or pharmacy necessary (e.g. intravenous dye) to perform tests are Covered as part of the test, whether performed in a Hospital or Physician’s office.

1.5. Indiana Code Requirements for diagnostic screenings
Indiana code requirement, therefore will need to pay in addition to the preventive benefits and will be paid under diagnostic benefit.

**Diagnostic Breast Cancer Screening Mammography.** The following breast cancer screening mammography Health Services are Covered Diagnostic Health Services.

- If the female Enrollee is at least 35 years of age, she may have one (1) Covered baseline breast cancer screening mammography performed before she becomes 40 years of age.

- If the Enrollee is less than 40 years of age and is high risk, she may have one (1) breast cancer screening mammography performed every year.
  - A woman is considered “high risk” if she meets at least one (1) of the following:
    - Has a personal history of breast cancer.
    - Has a personal history of breast disease proven benign by biopsy.
    - Has a mother, sister, or daughter who has had breast cancer.
    - Is at least 30 years of age and has not given birth.

- Any additional mammography views that are required for proper evaluation.

- Ultrasound services, if determined Medically Necessary by the physician treating the Enrollee.

1.6. **High Breast Density Screening.** High breast density screening is a Covered Diagnostic Health Service for an Enrollee who is at least 40 years of age and who has been determined to have high breast density. High breast density is a condition in which there is a greater amount of breast and connective tissue in comparison to fat in the breast.

1.7. **Diagnostic Colorectal Cancer Screening.** Colorectal cancer screening is a Covered Diagnostic Health Service under the age of fifty (50) if at high risk for colorectal CA according to the most recent published guidelines of the American Cancer Society.

1.8. **Diagnostic Prostate Cancer Screening.** One (1) prostate specific antigen test Covered annually if at least 50 years of age, if less than 50 years of age and at high risk for prostate CA according to most recent published guidelines of the American Cancer Society, one (1) prostate specific antigen test is Covered annually.

2. **Benefit Limitations and Exclusions**

2.1. **Limitations**

- For Diagnostic Health Services other than those approved to be received in a Physician's office, the member may be required to use MDwise Participating independent laboratory or medical diagnostic service Provider.

- Hospice providers should note that they must not include costs for services, such as laboratory and X-rays, with the attending physician's billed charges. The daily hospice care rates include these costs, and they are expressly the responsibility of the hospice provider.

- Radiology services furnished to skilled nursing facility (SNF) patients cannot be billed separately for the technical component - payment is included in the comprehensive per diem. When an outside entity performs a diagnostic test for an SNF patient, the outside entity must bill the SNF.
• The policy for the payment window for outpatient services treated as inpatient services requires payment for certain outpatient services provided to a beneficiary on the date of an inpatient admission or during the 3 calendar days (or 1 calendar day for a non-IPPS hospital or, in the case of a non-subsection (d) hospital,) prior to the date of an inpatient admission to be bundled (i.e., included) with the payment for the beneficiary’s inpatient admission if those outpatient services are provided by the admitting hospital or an entity that is wholly owned or wholly operated by the admitting hospital. The policy applies to all diagnostic outpatient services and non-diagnostic services (i.e., therapeutic) that are related to the inpatient stay. Ambulance and maintenance renal dialysis services are not subject to the payment window. An outpatient service is related to the admission if it is clinically associated with the reason for a patient’s inpatient admission.

2.2. Exclusions
• Diagnostic testing or treatment related to infertility is excluded.
• Surface EMG’s are not Covered Services

3. Provider Reimbursement & Submission Requirements

3.1. Diagnostic Services are paid per contracted percentage rate based on Indiana Medicare reimbursement using the applicable pricers or fee schedules for the place of service for the date(s) of service as the base rate (e.g. Medicare Physician Fee Schedule, Lab Fee Schedule, ASC, pricers - OPPS, APC, Dialysis, Rehab, MSDRG, and Hospice and SNF per diem methodologies.)
• Use the Medicare payment amount, if available; then apply the provider’s contracted percent of Medicare. If not, and the service code is covered, then use the Medicaid payment amount as the base. 150% of Medicaid is deemed equivalent to the Medicare rate; then apply the provider’s contracted percent of Medicare.
• If the provider is not contracted, and the service is authorized, then the following rate is applied to the applicable Medicare fee amount (or 150% of the Medicaid payment amount as the Medicare equivalent when no fee in Medicare is available and it is a covered service), unless in some case, the authorization could contain the non-contracted provider rate:
  • Facility 133%,
  • Professional I claims 125%
• Site of service (nonfacility and facility services) fees may apply to certain service codes
• In all cases, if the billed amount is less than the contracted payment amount, the billed amount is to be reimbursed

3.2. If lab/radiology/imaging service is done in the office and they are billed on the claim with the office visit the office copay will incorporate the x-ray/lab/imaging service. If x-ray/lab/imaging service is billed separately on a different claim, the copay/coinsurance amount will be owed on that service. If multiple items that require copay are on the same bill, there is only one copay/coinsurance amount that applies.

3.3. There is no member liability for out of network provider payment when in the event a Tier 1 or Tier 2 provider, or emergency service provider, sends labs to an out of network lab, other than routine copay or coinsurance payments.
3.4. Place of service code (POS) is used to identify where the procedure is furnished. The list of facilities where a physician’s professional services are paid at the facility rate include:

- Hospitals (POS code 21-23);
- Skilled nursing facilities (SNF) for a Part A resident (POS code 31);
- Comprehensive inpatient rehabilitation facilities (POS 61);
- Inpatient psychiatric facilities (POS 51);
- Community mental health centers (CMHC) (POS code 53);
- Approved ambulatory surgical center (ASC) for a HCPCS code included on the ASC approved list of procedures (POS code 24); and
- Medicare-approved ASC for a procedure not on the ASC list of approved procedures with dates of service on or after January 1, 2008. (POS code 24)
- SNFs to Part B residents - (POS code 32);
- Patient’s home (POS code 12); and
- Facility or institution other than a hospital, skilled nursing facility, community mental health center or ASC (POS codes 49 or 99).


When a pathologist (341), anesthesiologist (311), Certified Registered Nurse Anesthetist (094), or radiologist (333) perform services in these service settings or places of service, regardless of whether the provider is contracted with the delivery system or any delivery system, these specialty types should be reimbursed for covered services in accordance with Marketplace reimbursement methodology.

The processing rules for these provider types include reimbursing covered services in these service settings, including inpatient services (POS 21) regardless of whether an authorization was obtained when required.

The only exceptions to this rule are those services that are on the Marketplace prior authorization list that are performed by an anesthesiologist, radiologist, or pathologist or submitted by a lab. This includes, for example an MRA performed by a radiologist, pain management services performed by an anesthesiologist, and genetic testing submitted by a lab or pathologist. In each of these cases, if there is no prior authorization for the service, the claim should be denied, regardless of contracting status.
<table>
<thead>
<tr>
<th>Type of Service</th>
<th>PA Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Radiologist</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient (IP) Contracted Radiologist</td>
<td>No PA</td>
</tr>
<tr>
<td>IP Non-contracted Radiologist</td>
<td>No PA</td>
</tr>
<tr>
<td>POS 11 non-contracted Radiologist</td>
<td>No PA unless the radiology service is listed on PA list</td>
</tr>
<tr>
<td>POS 22 and 23 non-contracted Radiologist</td>
<td>No PA unless the radiology service is listed on PA list</td>
</tr>
<tr>
<td>POS 24 non-contracted Radiologist</td>
<td>No PA unless the radiology service is listed on PA list</td>
</tr>
<tr>
<td><strong>Pathologist</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient contracted Pathologist</td>
<td>No PA</td>
</tr>
<tr>
<td>Inpatient non-contracted Pathologist</td>
<td>No PA</td>
</tr>
<tr>
<td>POS 11 non-contracted Pathologist</td>
<td>No PA unless the pathology service is listed on PA list</td>
</tr>
<tr>
<td>POS 22 and 23 non-contracted Pathologist</td>
<td>No PA unless the pathology service is listed on PA list</td>
</tr>
<tr>
<td>POS 24 non-contracted Pathologist</td>
<td>No PA unless the pathology service is listed on PA list</td>
</tr>
<tr>
<td><strong>Anesthesiologist</strong></td>
<td></td>
</tr>
<tr>
<td>IP contracted Anesthesiologist</td>
<td>No PA</td>
</tr>
<tr>
<td>IP non-contracted Anesthesiologist</td>
<td>No PA</td>
</tr>
<tr>
<td>POS 22 and 23 non-contracted Anesthesiologist</td>
<td>No PA unless anesthesiology service is listed on PA list</td>
</tr>
<tr>
<td>POS 11 non-contracted Anesthesiologist</td>
<td>No PA unless anesthesiology service is listed on PA list</td>
</tr>
<tr>
<td>POS 24 non-contracted Anesthesiologist</td>
<td>No PA unless anesthesiology service is listed on PA list</td>
</tr>
<tr>
<td><strong>LABs</strong></td>
<td></td>
</tr>
<tr>
<td>Non-contracted independent labs (POS 81)</td>
<td>No PA unless lab service is on PA list</td>
</tr>
</tbody>
</table>

3.6. **Laboratory/Pathology/Imaging Services**

- Providers bill services on a CMS-1500 or UB-04 claim form or the electronic equivalent.

- All physician lab services should be billed with an appropriate code, any claim submitted without a lab CPT code will deny.

- When billing for clinical diagnostic tests, providers must indicate the appropriate CPT or HCPCS code on the claim form. If the provider administers the procedure more than one time in the same day, the provider should bill it as only one line item, with an indication of the number of units of service given that day.
• For lab services billed twice on the same day, the appropriate repeat modifier (91) should be present on the claim, or the second service line will deny as a duplicate.

• Modifier QW is not a pricing modifier; so the claim should be reimbursed according to the rate located on the lab fee schedule. The QW is a CLIA designated modifier to show the office is allowed to perform the service being billed.

• Unbundling of laboratory service code panels is not permitted. The bundled lab CPT Codes should be billed when a series of labs are completed at the same time. Deny any lines billed individually when there is one CPT code that applies to the panel of labs. Do not pay each individual line item.

**Lab Panels.** Organ or disease-oriented panels were developed to allow for coding of a group of tests. Providers are expected to bill the lab panel when all the tests listed within each panel are performed on the same date of service. When one or more of the tests within the panel are not performed on the same date of service, providers may bill each test individually. Providers may not bill for a panel and all the individual tests listed within that panel on the same day. However, tests performed in addition to those listed on the panel on the same date of service may be reported separately in addition to the panel code. Providers must follow CPT coding guidelines when reporting multiple panels. For example, providers cannot report 80048 with 80053 on the same date of service because all the same lab codes in 80048 are components of 80053.

**Interpretation of Clinical Laboratory Services.** The CMS has identified certain procedures as clinical lab tests that frequently require a laboratory physician to interpret. Payment may be made under the Medicare physician fee schedule for the professional component of physician laboratory or physician pathology services furnished to hospital inpatients or outpatients by hospital physicians or by independent laboratories. The physician can bill these codes with the 26 modifier.

3.7. **Radiology/Imaging Services.** Outpatient Facility billing radiological services should be billed on a UB-04 claim form. When a service is performed in an outpatient setting including the ER, Observation or treatment room the radiological services will be processed under the Medicare APC (OPPS) system logic. A majority of outpatient radiological services are assigned a status indicator that allows the radiology service to be paid under a separate fee schedule rate. When a separate payment is allowed the rate is identified on the Medicare Physician Fee Schedule. Facilities are reimbursed at the TC or technical component rate indicated on the schedule.

Services provided are billed using revenue codes, HCPCS code/CPT code, line item dates of service, units, and applicable modifiers.

• Modifiers: TC, 26, 50, 76

Radiology services can be billed on a CMS-1500.

Reimbursement for radiology services are based on the covered code and rate published in the Medicare Physician Fee Schedule. This includes the professional component of outpatient radiology services.

The professional component for a physician to read the test can be billed on a CMS 1500 and reimbursed based on the CMS Medicare Fee Schedule.
When a physician or radiologist is billing for just the professional component/interpretation, claim is submitted using the appropriate CPT code along with the modifier 26. Reimbursement is based on the Medicare Physician Fee Schedule and will have the professional rate indicated separately with a 26 identifier on the fee schedule.

When billing only the technical component, providers use Modifier TC, Technical component, with the appropriate CPT code.

When billing for professional and technical components of service, providers should use no modifiers.

When a service is billed globally, the provider is reimbursed for the equipment, supplies, and technical support, as well as the interpretation of the results and the report. A diagnostic service or test that cannot be distinctly split between TC and PC is considered to be a global test or service. Examples of global tests/services are radiation treatment delivery (CPT codes 77401-77416).

CPT codes for which providers should use these modifiers to bill are listed in the Federal Register under RVUs and related information.

For freestanding or office’s billing for the use of the machine and the physician interpretation payment should be made according to the global rate identified on the Physician Fee Schedule. Global rates are indicated on the Fee Schedule as a total rate and do not have any modifier indications listed.

Under the physician fee schedule, some procedures have a separate Medicare fee schedule rate for a physician’s professional services when provided in a facility and a non-facility setting. The CMS furnishes both fees in the MPFSDB update.

4. Procedure Codes and Claim Considerations

4.1. Refer to the CPT / HCPCS references for complete listing of laboratory/pathology/radiology/imaging codes. Revenue and CPT/HCPCS submission, as per billing/pricing requirements.
   - Modifier GG is used to show that the diagnostic test performed on the same date as the screening test is appropriate. This modifier is for tracking purposes only.
   - Place of service code (POS) is used to identify where the procedure is furnished. The list of facilities where a physician’s professional services are paid at the facility rate include:
     - Hospitals (POS code 21-23)
     - Skilled nursing facilities (SNF) for a Part A resident (POS code 31)
     - Comprehensive inpatient rehabilitation facilities (POS 61)
     - Inpatient psychiatric facilities (POS 51)
     - Community mental health services (CMHC) (POS code 53)
     - Approved ambulatory surgical center (ASC) for a HCPCS code included on the ASC approved list of procedures (POS code 24)
     - Medicare approved ASC for a procedure code not on the ASC list of approved procedures with dates of service on or after January 1, 2008 (POS code 24)
If the radiologist orders additional films based on the condition discovered during the screening mammogram, both procedures may be coded. When this occurs, append modifier GG - Performance and payment of a screening mammography and diagnostic mammography on same patient, same day to the diagnostic mammography code.

- Modifier GG indicates the test changed from a screening test to a diagnostic test. If not performed on both breasts, it is also important to append the appropriate anatomic modifier, RT or LT, to indicate on which side the diagnostic mammogram was performed.

5. **Prior Authorization (PA) Requirements**

5.1. Claims received for Diagnostic Services are processed in accordance with the MDwise Marketplace Prior Authorization requirements.

6. **Copay and Coinsurance**

6.1. Copays and coinsurance amounts are applied as directed by MDwise and the Marketplace contract.
1. **Benefit Coverage**

1.1. Dialysis treatments of an acute or chronic kidney ailment (e.g. end stage renal disease) which may include the supportive use of an artificial kidney machine, is a covered service.

1.2. There are two types of renal dialysis procedures in common clinical usage: hemodialysis and peritoneal dialysis. Both are acceptable modes of treatment for end stage renal disease (ESRD) and are covered by the Marketplace. Peritoneal dialysis is particularly suited for:
   - Patients without family members to assist in self-dialysis;
   - Children;
   - Patients with no peripheral sites available for fistula or cannula placement;
   - Patients who have difficulty learning the more complex hemodialysis technique; and
   - Elderly patients with cardiovascular disease who are unable to tolerate intravascular fluid shifts associated with hemodialysis.

1.3. If a member requires dialysis treatment and the nearest MDwise participating provider dialysis facility is more than 30 miles from the member’s home, they may receive dialysis services at a facility nearest to their home.

1.4. **Dialysis Service.** Covered dialysis services include:
   - Acute Dialysis - Dialysis given to patients who are not ESRD patients, but who require dialysis because of temporary kidney failure due to a sudden trauma; e.g., traffic accident or ingestion of certain drugs.
   - Back-Up Dialysis - Dialysis given to patients under special circumstances. Examples are: dialysis of a home dialysis patient in a dialysis facility when the patient’s equipment fails, inpatient dialysis when a patient’s illness requires more comprehensive care on an inpatient basis, and preoperative and postoperative dialysis provided to transplant patients.
   - Inpatient Dialysis - Dialysis, which, because of medical necessity, is furnished to an ESRD patient on a temporary inpatient basis in a hospital (paid on DRG basis)
   - Outpatient Dialysis - Dialysis furnished on an outpatient basis at a renal dialysis center or facility.
   - Home Dialysis - Dialysis performed by an appropriately trained patient (and the patient’s caregiver) and at home. This can be hemodialysis or peritoneal dialysis.
   - Self-Dialysis and Home Dialysis Training - A program that trains ESRD patients to perform self-dialysis or home dialysis with little or no professional assistance, and trains other individuals to assist patients in performing self-dialysis or home dialysis.

1.5. **Dialysis Coverage Under the Hospice Benefit.** If the patient’s terminal condition is not related to ESRD or temporary kidney failure, the patient may receive covered dialysis services in addition to the hospice benefit. A patient does not need to stop dialysis treatment to receive care under the hospice benefit.

2. **Benefit Limitations and Exclusions**
2.1. The following benefit limitations or exclusions apply to dialysis services:

- With the exception of emergency services, all services provided by out of network providers require prior authorization.

3. Provider Reimbursement & Submission Requirements

3.1. MDwise follows Medicare reimbursement methodology for dialysis services and utilizes the end stage renal disease (ESRD) prospective payment system (PPS). The ESRD PPS provides a single payment to ESRD facilities that covers all of the resources used in furnishing an outpatient dialysis treatment, including supplies and equipment used to administer dialysis (in the ESRD facility or at a patient’s home), drugs, biologicals, laboratory tests, training, and support services.

All ESRD related services and supplies are paid to the ESRD facility through the ESRD PPS. Other entities providing ESRD related services, including laboratories, suppliers and physicians billing for ESRD related drugs must look to the ESRD facility for payment. Billing edits established should deny or reject claims to other providers and suppliers billing for ESRD related labs, drugs and supplies.

In accordance with the Marketplace policy:

- The Medicare adjusted PPS rate is multiplied by the provider’s contracted rate, for example 163% for a QHP 1 contracted provider.
- If the provider is not contracted, the lowest QHP rate is used to calculate the reimbursement rate. For facilities, this would be 133%. In some cases, the authorization could contain the non-contracted provider reimbursement for the service in question.
- In all cases, if the billed amount is less than the contracted payment amount, the billed amount is to be reimbursed.

**Note:** Services not included in the PPS that remain separately payable, include blood and blood processing, preventive vaccines and telehealth services. There are also some labs and drugs that are not covered under the composite rate, but that may be medically necessary for some patients receiving dialysis. The list of drugs and biologicals used for the ESRD PPS consolidated billing may be viewed at: [http://www.cms.gov/Medicare?medicare-Fee-for-Service-Payment/ESRDpayment/ConsolidatedBilling.html](http://www.cms.gov/Medicare?medicare-Fee-for-Service-Payment/ESRDpayment/ConsolidatedBilling.html)

ESRD facilities billing for any labs or drugs will be considered part of the bundled PPS payment unless billed with the member AY.

The ESRD PPS per-dialysis treatment base rate is subsequently adjusted to reflect differences in:

- Facility-level adjustments (e.g. wage levels among the areas in which ESRD facilities are located)
- Patient-level adjustments for case-mix
- An outlier adjustment (if applicable)
- A training add-on (if applicable)

**Facility-level Adjustments.** The facility’s payment rate is adjusted using the wage index for the Core-Based Statistical Area (CBSA) in which the facility is located. Each facility is classified as either urban or rural. Urban facilities use the wage index for the CBSA in which the facility is located and rural facilities use the rural wage index. The facility-level adjustments also include an adjuster for facilities treating a low volume of dialysis treatments. To determine a facility's actual payment rate, the labor portion of the appropriate base rate is first adjusted by an area wage index and then added to the nonlabor portion.
**ESRD PPS:** Facility information needed in the payment calculation for ESRD facilities can be found at: [http://cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/End-Stage-Renal-Disease-ESRD-Payment-Regulations-and-Notices-Items/CMS-1526-F.html](http://cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/End-Stage-Renal-Disease-ESRD-Payment-Regulations-and-Notices-Items/CMS-1526-F.html)

This includes CBSA assignments, urban vs. rural locations, independent vs. hospital status, and whether the provider is low volume.

**Low-Volume Facility Adjustment:** Providers will receive an adjustment to their ESRD PPS rate when the facility furnished less than 4,000 treatments in each of the three years preceding the payment year and has not opened, closed or received a new provider number due to a change in ownership during the three years preceding the payment year.

**Please Note:** Pediatric dialysis treatments are not eligible for the low volume facility adjustment.

**Adult Patient-level Adjustments.** Included in the case-mix adjusters for adults are those variables that were previously used in basic case-mix adjusted composite payment system, that is, age, body surface area (BSA) and low body mass index (BMI). In addition to those adjusters that are currently used, the ESRD PPS will also incorporate adjustments for six co-morbidity categories and an adjustment for the onset of renal dialysis.

**Co-morbid Adjustments:** The ESRD PPS provides for three categories of chronic co-morbid conditions and three categories for acute co-morbid conditions. A single adjustment will be made to claims containing one or more of the co-morbidity conditions. The highest co-morbid adjustment applicable will be applied to the claim. The acute co-morbid adjustment may be paid no greater than four consecutive months for any reported acute co-morbid condition, unless there is a reoccurrence of the condition.

The three chronic co-morbid categories eligible for a payment adjustment are:

- Hereditary hemolytic and sickle cell anemia
- Monoclonal gammopathy (in the absence of multiple myeloma)
- Myelodysplastic syndrome

The three acute co-morbid categories eligible for a payment adjustment are:

- Bacterial Pneumonia
- Gastrointestinal Bleeding
- Pericarditis

Information related to the comorbid conditions eligible for adjustment can be found at: [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Comorbidity_Conditions.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Comorbidity_Conditions.html)

**Onset of Dialysis Adjustment:** An adjustment will be made for patients that have marketplace coverage during their first four months of dialysis. This adjustment will be determined by the dialysis start date as included by the provider. When the onset of dialysis adjustment is provided, the claim is not entitled to a co-morbid adjustment or a training adjustment.

**Adjustments Specific to Pediatric Patients.** The pediatric model incorporates separate adjusters based on two age groups (<13, 13-17) and dialysis modality (hemodialysis, peritoneal dialysis). The per-treatment base rate as it applies to pediatric patients is the same base rate that applies for adult patients, which is also adjusted by the area wage index. However, due to the lack of
statistical robustness, the base rate for pediatric patients is not adjusted by the same patient-level case-mix adjusters as for adult patients. Treatments furnished to pediatric patients:

- Can qualify for a training add-on payment (when applicable)
- Are eligible for an outlier adjustment

**Outlier Adjustment.** ESRD facilities that are treating patients with unusually high resource requirements, as measured through their utilization of identified services beyond a specified threshold, will be entitled to outlier payments. Such payments are an additional payment beyond the otherwise applicable case-mix adjusted prospective payment amount.

ESRD outlier services are the following items and services that are included in the ESRD PPS bundle:

- ESRD-related drugs and biologicals that were or would have been, prior to January 1, 2011, separately billable
- ESRD-related laboratory tests that were or would have been, prior to January 1, 2011, separately billable
- Medical/surgical supplies, including syringes, used to administer ESRD-related drugs that were or would have been, prior to January 1, 2011, separately billable
- Renal dialysis service drugs that were or would have been, prior to January 1, 2011, covered, notwithstanding the delayed implementation of ESRD-related oral-only drugs effective January 1, 2014

Information related to the outlier services eligible for adjustment can be found at the following website: [http://cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Outlier_Services.html](http://cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Outlier_Services.html)

This list may be updated as often as quarterly in January, April, July and October of each year.

All drugs reported on the ESRD claim under revenue codes 0634, 0635 and 0636 with a rate available on the ASP file will be considered in the Medicare allowed payment (MAP) amount for outlier consideration with the exception of any drugs reported with the AY modifier and drugs included in the original composite rate payment system.

**Note:** Services not included in the PPS that remain separately payable, including blood and blood processing, preventive vaccines and telehealth services are not considered outlier services.

**Training Add-on.** Facilities that are certified to furnish training services will receive a training add-on payment amount of $33.44, which is adjusted by the geographic area wage index to account for an hour of nursing time for each training treatment that is furnished. The training add-on applies to both peritoneal dialysis (PD) and hemodialysis (HD) training treatments.

3.2. CMS publishes the ESRD PPS rates in a “Federal Register” notice when CMS incorporates new cost data or wage index. These rates are updated using new program data or revising the payment methodology.

3.3. **Laboratory Services.** All ESRD-related laboratory tests are included in the ESRD PPS. If laboratory services are billed by a laboratory other than the ESRD facility and the laboratory service furnished is ESRD-related, the claim will be denied.

In the event that an ESRD-related laboratory service or drug was furnished to an ESRD beneficiary
for reasons other than for the treatment of ESRD, the provider may submit a claim for separate payment using modifier “AY”.

The consolidated billing edit for laboratory services will be bypassed when billed in conjunction with an emergency room service on a hospital outpatient claim and the AY modifier will not be necessary. The intent of the bypass is to acknowledge that there are emergency circumstances where the reason for the patient’s illness is unknown and the determination of a laboratory test as being ESRD-related is not known.

3.4. Drugs and Biologicals. Drugs used in the dialysis procedure are covered under the ESRD PPS and may not be reimbursed separately. When a drug or biological is billed by providers other than the ESRD facility and the drug or biological furnished is designated as a drug or biological that is included in the ESRD PPS (ESRD-related), the claim will be denied. In the event that an ESRD-related drug or biological was furnished to an ESRD member for reasons other than for the treatment of ESRD, the provider may submit a claim for separate payment using modifier AY.

The ESRD PPS includes some drugs and biologicals when these drugs can be used as equivalents to ESRD-related injectable drugs and biologicals. These drugs may be reported on the renal dialysis facility claim for consideration of outlier payments. For the ESRD-related drugs and biologicals that do not have an assigned HCPCS, ESRD facilities should bill using revenue code 0250 and report the national drug code (NDC).

3.5. Home Dialysis Services. The payment of home dialysis items and services, regardless of home treatment modality, are included in the ESRD PPS payment rate. Therefore, all home dialysis claims must be submitted by a renal dialysis facility. Separate billing for covered ESRD supply HCPCS codes may be reimbursable by DME suppliers when submitted for services not related to the beneficiary’s ESRD dialysis treatment and such services are billed with the AY modifier.

3.6. Blood and Blood Services Furnished in Hospital Based and Independent Dialysis Facilities. Facility staff time used to perform any service in the dialysis unit, including time to administer blood, is included in the ESRD PPS. However, the following may be paid in addition to the ESRD PPS rate.

- Blood;
- Supplies used to administer blood; and
- Blood processing fees (e.g. blood typing and cross-matching) that are charged by the blood supplier or lab.

Payment is made on a made at the lower of the actual charge on the bill, or at the Medicare rate (or at 150% of the Medicaid rate if there is no Medicare rate), or a reasonable cost basis in the same way as for any other member receiving blood on an outpatient.

HCPCS codes and related charges are reported by both hospital-based and independent renal facilities. In general, blood processing charges are billed under revenue center 039x. Patient specific lab blood processing charges are processed as lab services under the revenue center 030x. For supplies, facilities use revenue code 0270.

3.7. Parenteral/enteral nutrition (PEN) administered during dialysis may be covered, but it is not part of the Medicare ESRD benefit. Therefore, an ESRD facility or PEN supplier may bill separately from the composite rate for PEN solution if the patient received prior authorization.

3.8. Physicians’ services furnished to ESRD patients, for direct patient care in connection with the renal
condition or any other condition, are covered in addition to the ESRD PPS rate.

4. Procedure Codes and Claim Considerations

4.1. Diagnosis Codes. Dialysis services may be provided for the following diagnosis codes:

<table>
<thead>
<tr>
<th>DIAGNOSIS CODE (ICD-10)</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>N17.0</td>
<td>Acute kidney failure with tubular necrosis</td>
</tr>
<tr>
<td>N17.1</td>
<td>Acute kidney failure with acute cortical necrosis</td>
</tr>
<tr>
<td>N17.2</td>
<td>Acute kidney failure with medullary necrosis</td>
</tr>
<tr>
<td>N17.8</td>
<td>Other acute kidney failure</td>
</tr>
<tr>
<td>N17.9</td>
<td>Acute kidney failure, unspecified</td>
</tr>
<tr>
<td>N18.1</td>
<td>Chronic kidney disease, stage 1</td>
</tr>
<tr>
<td>N18.2</td>
<td>Chronic kidney disease, stage 2 (mild)</td>
</tr>
<tr>
<td>N18.3</td>
<td>Chronic kidney disease, stage 3 (moderate)</td>
</tr>
<tr>
<td>N18.4</td>
<td>Chronic kidney disease, stage 4 (severe)</td>
</tr>
<tr>
<td>N18.5</td>
<td>Chronic kidney disease, stage 5</td>
</tr>
<tr>
<td>N18.6</td>
<td>End stage renal disease</td>
</tr>
<tr>
<td>N18.9</td>
<td>Chronic kidney disease, unspecified</td>
</tr>
<tr>
<td>I13.11</td>
<td>Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease</td>
</tr>
<tr>
<td>I13.2</td>
<td>Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease</td>
</tr>
<tr>
<td>O03.32</td>
<td>Renal failure following incomplete spontaneous abortion</td>
</tr>
<tr>
<td>O03.82</td>
<td>Renal failure following complete or unspecified spontaneous abortion</td>
</tr>
<tr>
<td>O04.82</td>
<td>Renal failure following (induced) termination of pregnancy</td>
</tr>
<tr>
<td>O07.32</td>
<td>Renal failure following failed attempted termination of pregnancy</td>
</tr>
<tr>
<td>O08.4</td>
<td>Renal failure following ectopic and molar pregnancy</td>
</tr>
<tr>
<td>P96.0</td>
<td>Congenital renal failure</td>
</tr>
</tbody>
</table>

4.2. Revenue Codes. Providers must use one of the following revenue codes, based on the applicable treatment modality to determine the PPS rate. Services included in the PPS rate and related charges are not to be submitted on the bill separately. Services which are provided that are not included in the PPS rate may be billed separately as described in earlier sections.

0821 - Hemodialysis - Outpatient or Home Dialysis -
0831 - Peritoneal Dialysis - Outpatient or Home -
0841 - Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient
4.3. ESRD facilities are required to bill certain condition codes, value codes, and diagnosis codes so that claims can be priced correctly through the ESRD PPS. For a comprehensive ESRD billing guide, along with value and condition codes explanations, refer to.


5. Prior Authorization (PA) Requirements

5.1. Claims received for dialysis services are processed in accordance with the MDwise Marketplace Prior Authorization requirements.
DME – DME Medical Supplies

1. Benefit Coverage

1.1. MDwise will reimburse medically necessary covered services related to durable medical equipment, medical supplies, prosthetics and orthotics. Copays and coinsurance amounts are applied as directed by MDwise and the Marketplace policy contract.

1.2. Durable Medical Equipment (DME) is considered medical equipment that meets the following requirements.
   • Can withstand repeated use and is not disposable, i.e., could normally be rented, and used by successive patients
   • Is primarily and customarily used to serve a medical purpose,
   • Is generally not useful to a person in the absence of a Sickness or Injury,
   • Is appropriate for use in the home, and
   • Is the most cost-effective type of medical apparatus appropriate for the condition.

DME providers may be reimbursed for the rental (or, at MDwise option, the purchase) of covered durable medical equipment prescribed by a Physician or other Provider and as deemed medically necessary. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment.

Rental costs must not be more than the purchase price. The Contract will not pay for rental for a longer period of time than it would cost to purchase equipment. Rentals may be required for a 30-90 day period prior to purchase in order to determine response to treatment and/or compliance with equipment.

Equipment should be purchased when it costs more to rent it than to buy it. Repair of purchased medical equipment is covered as deemed necessary.

The cost for delivering and installing the equipment are Covered Health Services.

Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental, or the equipment is owned by the Enrollee, medically fitting supplies may be paid separately.

Covered Health Services include the following:
   • Hemodialysis equipment
   • Crutches and replacement of pads and tips
   • Pressure machines
   • Infusion pump for IV fluids and medicine
   • Glucometer
   • Tracheotomy tube
   • Cardiac, neonatal and sleep apnea monitors
   • Augmentive communication devices are covered when MDwise approves based on the Enrollee's condition.
• CPAP machines when indicated for sleep apnea.

1.3. **Oxygen and Oxygen Equipment.** Reimbursement of medical necessary oxygen and oxygen equipment covered liquid and gaseous oxygen systems are as rental only items, subject to PA. Reimbursement for oxygen contents is included in the reimbursement of the oxygen system and is not separately reimbursable for rented systems. Oxygen contents may be separately reimbursable when a third party has purchased an oxygen system, as determined medically necessary. Accessories and supplies including but not limited to cannulas, masks, and tubing are also included in the allowance for rented systems and are not separately reimbursable unless used with a purchased system.

1.4. MDwise covers **oral infant nutritional formula** as medically necessary for the treatment of inborn errors of metabolism or inherited metabolic diseases. For example, phenylketonuria (PKU).

1.5. **Medical and surgical supplies** are considered to be Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose as well as Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician’s office, including but not limited to, Depo-Provera and Remicade. Covered Health Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Covered Health Services include the following.

- Allergy serum extracts
- Chem strips, Glucometer, Lancets *(NOTE: Please refer to PBM covered diabetic supplies)*
- Clinitest
- Needles/syringes
- Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Health Services
- Contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants. *(NOTE: Please also refer to BCCP 23 Preventive Care Services, Screening & Immunizations regarding services that do not require copay.)*

Covered medical supplies are reimbursed when are supplies that are necessary for the effective use of covered DME items/device (e.g., oxygen tubing or mask, or tubing for a delivery pump).

In the case of prescription drugs, other than oxygen, used in conjunction with durable medical equipment, prosthetic, orthotics, and supplies (DMEPOS) or prosthetic devices, the entity that dispenses the drug must furnish it directly to the patient for whom a prescription is written.

1.6. **Prosthetics** are considered artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Health Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that replace all or part of a missing body part and its adjoining tissues, or replace all or part of the function of a permanently useless or malfunctioning body part.

Prosthetic devices should be purchased not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are covered.

Covered Health Services include, the following.
• Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.

• Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).

• Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women’s Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.

• Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.

• Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Health Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are Covered when they replace the function of the human lens for conditions caused by cataract surgery or injury, the first pair of contact lenses or eyeglasses are Covered. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Enrollee selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.

• Cochlear implant.

• Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.

• Restoration prosthesis (composite facial prosthesis).

• Wigs (the first one following cancer treatment resulting in hair loss, not to exceed one per Benefit Period).

1.7. Orthotic Devices that are covered health services can be reimbursed for the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

The cost of casting, molding, fittings, and adjustments are included. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

Applicable tax, shipping, postage and handling charges are also covered.

Covered Health Services for Orthotic Devices include the following.
• Cervical collars.
• Ankle foot orthotic.
• Corsets (back and special surgical).
• Splints (extremity).
• Trusses and supports.
• Slings.
• Wristlets.
• Built-up shoe.
• Custom made shoe inserts.

Orthotic appliances may be replaced once per year per Enrollee when Medically Necessary in the Enrollee’s situation. However, additional replacements will be allowed for Enrollees under age 18 due to rapid growth, or for any Enrollee when an appliance is damaged and cannot be repaired.

Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

1.8. Prosthetic limbs & Orthotic custom fabricated brace or support. Prosthetic limbs (artificial leg or arm) and a medically necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if they satisfy both requirements listed below.
   o Determined by Your Physician to be Medically Necessary to restore or maintain Your ability to perform activities of daily living or essential job related activities, and
   o Not solely for comfort or convenience.

• Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program.

• Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

• Prosthetic limbs and Orthotic custom fabricated braces or supports designed as components for a prosthetic limb are covered the same as any other medically necessary items and services and will be subject to the same annual Deductible, Coinsurance, Copay provisions otherwise applicable under the Contract.

• Orthopedic shoes are not covered with the exception of therapeutic shoes for diabetics. Note: This exclusion does not apply to orthopedic shoes that are an integral part of a leg brace.

1.9. Replacements and Repairs
   Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by MDwise.

• The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if all of the following requirements are satisfied.
• The equipment, supply or appliance is a covered service.
• The continued use of the item is medically necessary.
• There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

• In addition, replacement of purchased equipment, supplies or appliance may be covered if any of the following are satisfied.
  • The equipment, supply or appliance is worn out or no longer functions.
  • Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
  • Individual’s needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
  • The equipment, supply or appliance is damaged and cannot be repaired.

2. Benefit Limitations and Exclusions

2.1. Limitations
• Orthotic appliances may be replaced once per year per enrollee when medically necessary in the enrollee’s situation. However, additional replacements will be allowed for Enrollees under age 18 due to rapid growth, or for any Enrollee when an appliance is damaged and cannot be repaired.

• Benefits for repairs and replacement do not include those listed below.
  • Repair and replacement due to misuse, malicious breakage or gross neglect.
  • Replacement of lost or stolen items.

• Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period.

• Eyeglasses (for example bifocals) including frames or contact lenses are Covered when they replace the function of the human lens for conditions caused by cataract surgery or injury, the first pair of contact lenses or eyeglasses are Covered. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lens following surgery.

• Wigs (the first one following cancer treatment resulting in hair loss, not to exceed one per Benefit Period).

2.2. Non-covered items
• Non-Covered DME items include the following.
  • Air conditioners
  • Ice bags/coldpack pump
  • Raised toilet seats
  • Rental of equipment if the Enrollee is in a Facility that is expected to provide such equipment
  • Translift chairs
• Treadmill exerciser
• Tub chair used in shower

• Non-Covered Medical Supply Health Services include the following.
  o Adhesive tape, band aids, cotton tipped applicators
  o Arch supports
  o Doughnut cushions
  o Hot packs, ice bags
  o Vitamins
  o Medjectors

• Non-Covered Prosthetic appliances include the following.
  o Dentures, replacing teeth or structures directly supporting teeth.
  o Dental appliances.
  o Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
  o Artificial heart implants.
  o Wigs (except as described under Prosthetics regarding following cancer treatment).

• Non-Covered Health Services for Orthotic Devices include the following.
  o Orthopedic shoes (except therapeutic shoes for diabetics).
  o Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
  o Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies).
  o Garter belts or similar devices.

• Benefits for repairs and replacement do not include those listed below.
  o Repair and replacement due to misuse, malicious breakage or gross neglect.
  o Replacement of lost or stolen items.

3. Provider Reimbursement & Submission Requirements

3.1. Reimbursement to providers for covered Durable Medical Equipment, Enteral and Parenteral products/Infusion, Prosthetics, Orthotics, and Medical Supplies is calculated using the applicable Medicare Fee Schedule. The Medicare DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, & Supplies) fee schedule amounts for Indiana for applicable services as the base rate.

• Use the Medicare payment amount, if available; then apply the provider’s contracted percent of Medicare. If not, and the service code is covered, then use the Medicaid payment amount as the base. 150% of Medicaid is deemed equivalent to the Medicare rate; then apply the provider’s contracted percent of Medicare. If there is no Medicare or Medicaid rate and the service is covered, the item must be manually priced.

• If the provider is not contracted, and the service is authorized, then the following rate is applied to the applicable Medicare fee amount (or 150% of the Medicaid payment amount as the Medicare equivalent when no fee in Medicare is available and it is a covered service), unless in some case, the authorization could contain the non-contracted provider rate:
  o Facility 133%,
• Professional I claims 125%
• Site of service (nonfacility and facility services) fees may apply to certain service codes
• In all cases, if the billed amount is less than the contracted payment amount, the billed amount is to be reimbursed

3.2. Preventive Care Services, Screening & Immunizations regarding services that do not require copay.)

3.3. Manual Pricing. CPT codes billed for the marketplace, which fall under the manual pricing logic should follow the published Medicaid rate methodology, as outlined in the below table and in the IHCP Bulletin, BT 200940 and 201213. Except for drugs and biological, which have special pricing, HCPCS codes which indicate manual pricing will be reimbursed at 60% of billed charges, or for DME products, 60% of the Manufacturers Suggested Retail Price (MSRP). For the pricing of drugs and biological, refer to BCCP 20, Pharmacy & Biologicals.

To determine the base Medicare rate for CPT codes, the applicable Medicaid rate, based on the below table is multiplied by 150%. The provider’s contracted rate is than applied to the base Medicare rate.

For HCPS codes that are paid at 60% of billed charges, there is no additional percentage applied (Medicare equivalency or additional provider contracted amount).

<table>
<thead>
<tr>
<th>Procedure Code Range</th>
<th>Codes Billed on CMS-1500</th>
<th>Codes Billed on UB-04</th>
</tr>
</thead>
<tbody>
<tr>
<td>10000-19999</td>
<td>20% of billed Amount</td>
<td>20% of billed Amount</td>
</tr>
<tr>
<td>20000-29999</td>
<td>20% of billed Amount</td>
<td>10% of billed Amount</td>
</tr>
<tr>
<td>30000-39999</td>
<td>20% of billed Amount</td>
<td>10% of billed Amount</td>
</tr>
<tr>
<td>40000-49999</td>
<td>20% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
<tr>
<td>50000-59999</td>
<td>35% of billed Amount</td>
<td>10% of billed Amount</td>
</tr>
<tr>
<td>60000-69999</td>
<td>20% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
<tr>
<td>70000-79999</td>
<td>25% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
<tr>
<td>80000-89999</td>
<td>30% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
</tbody>
</table>

3.3. DMEPOS provided under a home health plan of care may be billed either by the Home Health Agency or by the supplier (including the HHA with a supplier number if the HHA prefers to bill that way).

3.4. Reimbursement for home infusion is per the Medicare Durable Medical Equipment Prosthetic, Orthotic, and Supplies (DMEPOS) fee schedule for applicable services as stated above.

3.5. Services and supplies commonly furnished in physicians’ offices are covered under the incident to provision.

3.6. Covered implantable devices including durable medical equipment (DME), prosthetics and those used in diagnostic testing are paid under the hospital outpatient prospective payment system (OPPS).
3.7. **Note** – No Copay/Coinsurance applies to certain diabetic and asthmatic supplies, up to the Allowed Amount when obtained from a Participating Pharmacy. These supplies are covered as medical supplies, durable medical equipment, and appliances if obtained from a Non-Participating Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copay/Coinsurance.

3.8. **Therapeutic Shoes (depth or custom-molded) along with inserts for Person with Diabetes** Reimbursement for covered diabetic shoes (orthotics) is made to the provider according to the DME payment methodology stated above. Providers must include a diagnosis code of diabetes on the claim form for reimbursement.

3.9. **Surgical Dressings** The Medicare DMEPOS fee schedule applies to all surgical dressings except those applied incidentally to a physician’s professional services, those furnished by a home health agency (HHA), and those applied while a patient is being treated in an outpatient department or as an acute care inpatient.

3.10. **Rentals or Purchases**
Reimbursement for monthly rentals may be up to the purchase price. Reimbursement is not allowed in excess of the purchase price, whether the charge is for rental or purchase.

Monthly rentals will only be paid up to the purchase price unless categorized as a “Capped” item. For these items that fall into the “Capped” category, the provider is paid the fee schedule amounts and provider’s contracted % as described above in Section 3., on a monthly rental not to exceed a period of 15 months continuous use.

DME rentals must be tracked to purchase price, or 36 occurrences (oxygen), or 15 months (Capped DME). If Oxygen or Oxygen Equipment Related DME, 36 occurrences will need to be monitored, for example using CPT codes E1353, E1390 and E1405

Payment policies for enteral feeding pumps generally follow the rules for capped rental items.

The following DME require rental and the rental price would apply to the purchase price:
- CPAP/BiPAP, TENS units, hospital beds and oxygen
- Rental would be limited to 90 days and re-review by MDwise Medical Management would occur to determine compliance and re-asses the member’s needs. If compliance is established then steps would be initiated to purchase with rental money applied to the purchase price.

4. **Procedure Codes and Claim Considerations**

4.1. DME/HME, Prosthetics, Orthotics and Medical Supplies are generally billed on Form CMS-1500 or the electronic equivalents.

4.2. All DME service should be billed using the appropriate HCPCs code, in addition to any applicable modifiers. Please see list of the applicable modifiers for DME below.

**Applicable DME Modifiers or as revised per current modifiers for DME**

RR: Rental
NU: New/purchase
AU: Item furnished in conjunction with a urological, ostomy, or tracheostomy supply
AV: Item furnished in conjunction with a prosthetic device, prosthetic or orthotic
AW: Item furnished in conjunction with a surgical dressing
AX: Item furnished in conjunction with dialysis service
KF: Modifier KF is a pricing modifier. Item designated by FDA as class III device
KL: Item Delivered Via Mail
KM: Replacement of facial prosthesis including new impression/moulage
KN: Replacement of facial prosthesis using previous master model.
UEP: Used/Purchase
QE: Prescribed amount of oxygen is less than 1 LPM
QG: Prescribed amount of oxygen is greater than 4 LPM
QF: Prescribed amount of oxygen exceeds 4 LPM and portable oxygen is prescribed
QR: Item or service has been provided in a specified study
QH: Oxygen conserving device is being used with oxygen delivery system

Capped Rental Modifiers
Capped rental modifiers identify which rental month the beneficiary is in:
KH - Month 1
KI - Months 2-3
KJ - Months 4-13

To distinguish between the repair and the replacement of an item, the following two modifiers were added to the HCPCS:
RA – Replacement of a DME item
RB – Replacement of a part of DME furnished as part of a repair

Considerations in claims processing for DME billed with RR or NU:
- Authorization in system for payment and claim submitted with RR but not a DME that has fees when billed with RR modifier in the Medicare fee schedule or Medicaid fee schedule the claim will be denied.
- Authorization in system for purchase and Medicare has no fee for purchase only rental, but there is a Medicaid rate for purchase: Pay at 150% of the Medicaid fee as base rate and apply provider’s contract percentage of Medicare.
- Authorization in system for purchase and claim submitted with an RR modifier the claim will be denied.

4.3. Enteral formula is reimbursed based on the number of “units” of a specific covered formula provided to a member.

4.4. Administration supply reimbursement is based on the method of administration (e.g., syringe/bolus, gravity, and pump) and each supply kit is assigned a specific rate based on HCPCS coding. IV poles are reimbursed as a rental item on a monthly basis.

4.5. Frequency of Rate Updates: Quarterly fee schedule updates occur and on an as needed basis per, Medicare Regulations and Medicaid, as applicable. The Medicare updates can be found on the Medicare List Service as well as correspondence such as Medicare Transmittals, and IHCP Provider Manual updates, Fee Schedule, Bulletins and Banners are to be monitored.
The CMS issues quarterly updates to a fee schedule file that contains rates by HCPCS code and also identifies the classification of the HCPCS code within the following categories.

<table>
<thead>
<tr>
<th>Category Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>IN</td>
<td>Inexpensive and Other Routinely Purchased Items</td>
</tr>
<tr>
<td>FS</td>
<td>Frequently Serviced Items</td>
</tr>
<tr>
<td>CR</td>
<td>Capped Rental Items</td>
</tr>
<tr>
<td>OX</td>
<td>Oxygen and Oxygen Equipment</td>
</tr>
<tr>
<td>OS</td>
<td>Ostomy, Tracheostomy &amp; Urological Items</td>
</tr>
<tr>
<td>SD</td>
<td>Surgical Dressings</td>
</tr>
<tr>
<td>PO</td>
<td>Prosthetics &amp; Orthotics</td>
</tr>
<tr>
<td>SU</td>
<td>Supplies</td>
</tr>
<tr>
<td>TE</td>
<td>Transcutaneous Electrical Nerve Stimulators</td>
</tr>
</tbody>
</table>

5. **Prior Authorization (PA) Requirements**

5.1. Claims received for DME, Medical Supplies, Orthotics and Prosthetics are processed in accordance with the MDwise Marketplace Prior Authorization requirements.
EMP - Emergency and Post-Stabilization Services

1. Benefit Coverage

1.1. MDwise will cover and reimburse emergency services, including screening services, which are provided to evaluate or stabilize emergency medical conditions as defined by the applicable State and Federal law and ACA requirements.

1.2. Definitions

- **Emergency** is defined as a medical condition manifesting itself by acute symptoms, including severe pain, of sufficient severity that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:
  - Serious jeopardy to the health of the individual, or in the case of a pregnant woman, the woman or her unborn child,
  - Serious impairment to bodily functions, or
  - Serious dysfunction of any bodily organ or part.

- Prudent layperson is an evaluation of whether a condition meets the “Emergency definition”. A prudent layperson is a person who is without medical training and who draws on his or her practical experience when making a decision regarding the need to seek emergency medical treatment. A prudent layperson is considered to have acted “reasonably” if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that emergency medical treatment was necessary. Severe pain and other symptoms may constitute such emergency cases. (Source: NCQA) Prudent layperson review is conducted to determine whether ambulance services meet the definition of an emergency medical condition.

- **Stabilize** - to provide Health Services to a member in an Emergency as may be necessary to assure, within reasonable medical probability that material deterioration of the Enrollee’s condition is not likely to occur. This includes Emergency Health Services provided to a member in a Hospital's care setting throughout or during the following discharge, transfer to another health care facility, or transfer to the Hospital's inpatient setting.

- **Authorized representative** is defined as an employee or contractor of the organization who directs the member to seek services. For example, an advice nurse, network physician, physician assistant or customer service representative may act as the organization's authorized representative. (Source: NCQA).

1.3. MDwise will cover medically necessary emergency services as defined above which are provided to evaluate or stabilize an emergency medical condition.

- This policy applies to professional emergency service claims that are billed with a place of service 23 (CMS 1500) and outpatient hospital claims (UB 04) with bill type 13X that are for emergency services only and no additional services/codes indicating inpatient admission charges. In accordance with Medicare payment logic, outpatient services (including ER services) that occur within three days preceding an inpatient admission to the same facility for
the same or related diagnosis are considered part of the corresponding inpatient admission. Hospitals are required to bill these services on one inpatient claim (72 hour payment rule). The exception is for services that are not clinically associated with the reason for a patient’s inpatient admission.

• MDwise covers emergency services. Coverage includes treatment of emergency medical conditions and emergency screening and stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an emergency medical condition based upon the patient's presenting symptoms and conditions. Benefits for emergency care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility. Copayments apply to emergency services.

• Care and treatment provided once the member is stabilized is no longer considered Emergency Care. For an Inpatient admission resulting from the presenting emergency condition precertification is not required. However, the member (or member’s Physician) must notify MDwise of the admission status within 48 hours or as soon as possible within a reasonable period of time. MDwise medical management will then determine whether the observation or inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary.

• Continuation of care from a Non-Participating Provider beyond that needed to evaluate or stabilize the member’s condition in an emergency may be covered if the continued care is authorized. Transfer to a participating provider will be made available to persons receiving post-stabilization care in a non-participating provider facility.

• Health Services rendered by non-participating providers are not covered (1) if the member or provider fails to notify MDwise within 48 hours of the admission or as soon as reasonably possible thereafter, or (2) choose to remain in a Non-Participating facility after MDwise has notified the member of the intent to transfer them to a participating facility.

• Claims incurred outside the United States for Emergency Care and treatment must be submitted in English or with an English translation. Foreign claims must include the applicable medical records in English to show proper Claim Documentation.

• Payment for a claim may not be denied for treatment obtained when:
  o A member had an emergency medical condition, even if the outcomes, in the absence of immediate medical attention, would not have been those specified in the definition of emergency medical condition.

  o A representative of MDwise or the delivery system instructs the member to seek emergency services. All referrals from providers must be documented in the delivery system’s medical management system.

1.4. COVERED EMERGENCY SERVICES – REIMBURSEMENT FOR NON CONTRACTED PROVIDERS
  • The following applies to the reimbursement of emergency services received by a member from a non-contracted provider. An emergency services claim is defined as: Professional Claim billed with location code = 23 and procedure code of 99281-99285 or Institutional Claim billed with a bill type = 13X and a Revenue Code 450.
• **Coverage determination** – If a claim is received for emergency services as defined above in which any diagnoses on the claim matches with the MDwise ER Auto-Pay list or if there is an authorization for service on file, the services are covered in accordance with the remainder of section C.2. If a claim is received for emergency services in which the diagnosis(es) is not listed on the MDwise ER Auto-Pay list or there is not an authorization on file, the claim will be pended for medical review to determine if it meets the prudent layperson standard. If the provider has not submitted the medical records, the claim is denied with a request for medical records.

• **Prudent layperson determination and coverage** – Determination of whether the emergency service meets the prudent layperson standard is based upon medical record review by the member’s delivery system. Review must take into account that the decision to seek emergency services was made by a prudent layperson (rather than a medical professional).

• The member’s presenting symptoms upon arrival at the emergency room are the primary factors in determining whether an Emergency Medical Condition exists. Retrospective emergency services review is conducted through various review levels according to the prudent layperson standard and definition of emergency medical condition.

• The discharge diagnosis is considered in the determination to approve the claim payment and is not to be the basis for a decision to deny or reduce payment of the claim. At any point in the review process if it is determined that it meets the prudent lay standard, the claim is approved for payment.

• Upon completion of medical record review, all emergency services are paid according to the coverage determination (e.g. facility charge, professional fee).

• If the situation is determined to meet the prudent layperson standard, medically necessary and covered services provided to the member up to the point of stabilization, must be paid. If review results in a determination that the prudent layperson standard has not been met, the claim will be denied.

• **ER service claims submitted after original claim has been reviewed.** If a professional or facility emergency services claim has already been reviewed according to the prudent layperson standard (C 2.2 above) subsequent emergency services claims for the same emergency service visit should pay according to the review determination. For example, if a facility claim is determined through delivery system review to meet the prudent layperson standard, the ER provider claim should also be considered to meet the emergency services definition and should be adjudicated accordingly.

• **ER Physicians/Nurse Practitioners in Emergency Department.** Coverage is provided for federally required medical screening exams conducted by physicians in an emergency department that are determined to be medically necessary (e.g. diagnosis on autopay list, prior authorization in system or medical record review determines service met prudent layperson standard).
• **Emergency Room Service (Facility Charge).** Coverage is provided for emergency room services that are determined to be medically necessary (e.g. diagnosis on autopay list, prior authorization in system or medical record review determines service met prudent layperson standard).

• Emergency Room Services are reimbursed using the Hospital Outpatient Prospective Payment System (OPPS) pricer.

• **Ancillary Services and Diagnostic Testing (eg. Non ER Physicians, Laboratory and Radiology Services, DME, etc.) Related to Emergency Services.** Payment is provided for all covered ancillary services and non-ER physicians (e.g. Cardiologist, Anesthesiologist, Radiologist, Pathologist, etc.) related to the ER visit for non-contracted providers without an authorization.

1.5. EMERGENCY SERVICES – REIMBURSEMENT FOR CONTRACTED PROVIDERS

• The following applies to the reimbursement of emergency services received by a member from a contracted emergency room provider.

• Covered emergency services received in a contracted facility are reimbursed according to the terms outlined in the provider contract.

• Covered emergency services received by a contracted ER provider (eg. ER physician/Nurse Practitioner) are reimbursed according to the terms outlined in the provider contract.

2. Benefit limitations and exclusions

2.1. MDwise does not cover services that do not meet the definition of “emergency services,” unless the provider has prior authorization before furnishing the services.

2.2. Subsequent follow-up care by Non-Participating Providers after the condition is no longer an emergency is not covered without prior authorization.

3. Provider Reimbursement and Submission Requirements

3.1. **ER Copay.** The member’s copay amount shall be deducted from the contracted facility emergency room claim. For example, if the member’s copay amount is $100.00, the 100.00 shall be deducted from the emergency room claim prior to reimbursing the contracted emergency room provider.

• A copay, collected by the Emergency Room provider, applies to emergency services

• For emergency room services that are covered, there are no additional member copays or coinsurance applied for services received during the visit. For example, a copay is not applied to the physician claim and coinsurance is not applied to diagnostic services or DME received during the visit.

• If the member is admitted as an inpatient directly from a hospital emergency room, the Emergency Room Services Copay for that Emergency Room visit will be waived.
4. Procedure and Claim Coding Consideration

4.1. None at this time

5. Prior Authorization

5.1. MDwise does not require prior authorization for emergency services.

5.2. Emergency services provided by non-contracted providers are exempt from prior authorization; however continuation of treatment and hospitalization is subject to the prior authorization requirements of MDwise.

5.3. Emergency admissions must be reported to the applicable MDwise delivery system within 48 hours of admission. If the end of the 48-hour period falls on a weekend or legal holiday, emergency admissions must be reported on the next business day after the weekend or holiday. At that time, the same standards for PA are applied as would have been applied if the authorization had been requested before the admission.
HMC - Home Care

1. Benefit Coverage

1.1. Covered Health Services performed by a Home Health Care Agency or other Provider in the member’s residence may be reimbursed as deemed medically necessary. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Enrollee must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis.

1.2. Covered Home Care Health Services are provided on an intermittent basis and include the following.

- Intermittent Skilled Nursing Services by an R.N. or L.P.N.
- Medical/Social Services.
- Diagnostic Health Services
  - As per MDwise Individual Exchange Policy, Section 3.6 Diagnostic Health Services: Diagnostic Health Services are tests or procedures performed when specific symptoms exist to detect or monitor one’s condition. Coverage for Diagnostic Health Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services includes but is not limited to those services listed in Section 3.6.
- Nutritional Guidance
- Home Health Aide Services
  - The Enrollee must be receiving skilled nursing or therapy for HH Aide Services.
  - Health Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide Health Services only when approved by MDwise, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services
  - Therapy Services include Physical, Occupational and Speech therapies
  - Massage, Music, and Manipulation Therapy will not be covered when rendered in the home.
  - Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Private Duty Nursing
  - Private Duty Nursing services are covered in the home on a part-time or intermittent visiting basis when considered medically necessary.
  - Private Duty Nursing is provided on an hourly basis by a Registered Nurse or Licensed Practical Nurse.
  - Services are provided as defined a treatment plan, under the direction of a physician, to achieve the desired clinical outcome.
Private Duty Nursing services are not intended to be provided on a permanent ongoing basis.

Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in the "Covered Services" section.

1.3. Home infusion therapy benefit includes a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy. Home infusion therapy will be paid only if prior approval is obtained.

1.4. MDwise will reimburse medically necessary home Tocolytic Infusion therapy services and home uterine monitoring device through home health agency provider. Only those home health agencies that meet the guidelines to provide the service are allowed to bill for home tocolytic infusion therapy using a home uterine monitoring device.

1.5. Oral infant nutritional formula is covered as medically necessary for the treatment of inborn errors of metabolism or inherited metabolic diseases. Coverage for nutritional formula is generally limited to oral infant formula for the treatment of inborn errors of metabolism and inherited metabolic diseases.

1.6. Covered supplies may be reimbursed as allowable for those used during home health agency (HHA) skilled nursing visit, provided the supplies are ordered by a physician and prescribed for the treatment of the member’s existing illness / injury or used for a diagnostic / therapeutic purpose in a specific situation. These "non-routine" supplies used for direct client care during the visit include, for example gauze dressings, catheters, ostomy pouches, needles, syringes. Medical Supplies are covered when supplies for DME items/devices that are necessary for the effective use of the item/device (e.g., tubing for a delivery pump) are covered.

2. Benefit Limitations and Exclusions

2.1. Limitations

- Annual Visit Limitation:
  - Home Care Services: 100 visits combined.
    - Note: For each individual type of therapy service (PT, OT, ST) per DOS = One visit per discipline type billed. If a member seen by multiple nursing service types (RN, LPN, and/or HHA) on the same date of service, each discipline billed would be a visit to count toward the limitation.
    - Maximum annual visit limitation for Home Care Services does not include Home Infusion Therapy or Private Duty Nursing rendered in the home.

  - Private-Duty Nursing: 82 visits annually
    - Private Duty Nursing is billed in hourly increments
    - Note: One hour = One visit.
• Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.

2.2. Non-covered services

- Non-Covered Home Health Care Services include the following:
  - Food, housing, homemaker services and home delivered meals.
  - Home or Outpatient hemodialysis services as such services are Covered under Therapy Services.
  - Helpful environmental materials such as hand rails, bath stools ramps, telephones, air conditioners, and similar services, appliances and devices.
  - Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
  - Services provided by a member of the patient’s immediate family.
  - Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.
  - Massage, Music, and Manipulation Therapy will not be covered when rendered in the home.
  - Manipulation Therapy Services rendered in the home as part of Home Care Services are not covered.

3. Provider Reimbursement & Submission Requirements

3.1. Reimbursement for Covered Services listed under the Home Care Services Benefits in the MDwise Individual Exchange Policies are based on the applicable Medicare payment amounts and provider’s contract percentage of Medicare OR 150% of Medicaid payment amounts as the base rate and then apply the provider’s percentage of Medicare. Additional details are provided below that include statewide providers and manual pricing of covered services without a Medicare fee or Medicaid fee.

3.2. Home care services for the purpose of the following reimbursement guidelines those services that fall within this methodology are those services performed by a Home Health Care Agency or other Provider in the member’s residence. These covered home Health Care includes the professional, technical, and health aide services. Covered health services include Intermittent Skilled Nursing Services by an R.N. or L.P.N, Medical/Social Services, Diagnostic Health Services, Nutritional Guidance, Home Health Aide Services, and Therapy Services.

- The provider reimbursement for the professional (RN, LPN, PT, OT, ST, MSW) and Home Health aide services will be 150% of the Indiana Health Coverage Programs (IHCP) Hoosier Healthwise home care schedule of payment rates as the base rate, then apply the provider’s contracted percent of Medicare.

- The reimbursement mechanisms shall follow the IHCP Hoosier Healthwise home care claims payment methodology outlined in the IHCP Provider Manual and related bulletins and banners, with any noted exceptions or instructions included in this policy. IHCP publishes the updated rates annually via an IHCP bulletin.

3.3. Covered Durable Medical Equipment (DME), Home Medical Equipment (HME) and medical supplies will be reimbursed at the rate on the associated Medicare DME fee schedule.
(DMEPOS) for Indiana locality as the base rate, then apply the provider’s contracted percent of Medicare. If there is no Medicare or Medicaid rate and the service is covered, the item must be manually priced. (see below)

- If the provider is not contracted, and the service is authorized, then the following rate is applied to the applicable Medicare fee amount (or 150% of the Medicaid payment amount as the Medicare equivalent when no fee in Medicare is available and it is a covered service), unless in some case, the authorization could contain the non-contracted provider rate:
  - Facility 133%
  - Professional claims 125%

- Site of service (nonfacility and facility services) fees may apply to certain service codes
- In all cases, if the billed amount is less than the contracted payment amount, the billed amount is to be reimbursed.

3.4. The provider bills for these home care services on the Form CMS-1450 (aka UB-04 at present) or its electronic equivalent. The service is billed entering the revenue code and HCPCS codes designating type of service and number of units, as applicable.

- Each line item identifies services billed using HCPCS codes and service dates.
- Providers must bill each date of service as a separate line item and bill each level of service, such as registered nurse (RN) or licensed practical nurse (LPN), provided on the same date as a separate line item.
- The procedure code description defines the unit of service.
- When home health providers perform the same service, such as multiple RN visits on the same date of service, they must bill those services on the same claim form and on one detail with the total number of units of services provided. Billing separate lines for the same service with the same date of service causes claims to be denied as exact duplicates.
- Revenue code 0294 "Supplies/Drugs for DME Effectiveness may be used by HHAs.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>420</td>
<td>G0151</td>
<td>421</td>
<td>G0151</td>
<td>422</td>
<td>G0151</td>
</tr>
<tr>
<td>423</td>
<td>G0151</td>
<td>424</td>
<td>97001</td>
<td>429</td>
<td>G0151</td>
</tr>
<tr>
<td>430</td>
<td>G0152</td>
<td>431</td>
<td>G0152</td>
<td>432</td>
<td>G0152</td>
</tr>
<tr>
<td>433</td>
<td>G0152</td>
<td>434</td>
<td>97003</td>
<td>439</td>
<td>G0152</td>
</tr>
<tr>
<td>440</td>
<td>G0153</td>
<td>441</td>
<td>G0153</td>
<td>442</td>
<td>G0153</td>
</tr>
<tr>
<td>443</td>
<td>G0153</td>
<td>444</td>
<td>92506</td>
<td>449</td>
<td>G0153</td>
</tr>
<tr>
<td>552</td>
<td>99600 TE</td>
<td>552</td>
<td>99600 TD</td>
<td>559</td>
<td>S9349</td>
</tr>
<tr>
<td>559</td>
<td>99601, 572</td>
<td>99600</td>
<td>56X</td>
<td>G0155</td>
<td></td>
</tr>
<tr>
<td></td>
<td>99602</td>
<td></td>
<td></td>
<td>S9127</td>
<td></td>
</tr>
</tbody>
</table>
### Service/Procedure Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>99600 TD</td>
<td>Registered Nurse (RN)</td>
</tr>
<tr>
<td>99600 TE</td>
<td>License Practical Nurse (LPN)</td>
</tr>
<tr>
<td>99600</td>
<td>Home Health Aide</td>
</tr>
<tr>
<td>G0151</td>
<td>Physical Therapy</td>
</tr>
<tr>
<td>G0152</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>G0153</td>
<td>Speech Therapy</td>
</tr>
<tr>
<td>G0155</td>
<td>Clinical social worker in home health</td>
</tr>
</tbody>
</table>

#### 3.5. Home health rates

Effective July 1, 2015 through June 30, 2016 and continue to June 30, 2017. IHCP Bulletin BT201535 and BT201631.

The following tables specify the home health rates for DOS July 1, 2015 through June 30, 2017. The provider reimbursement for those covered home care services will be 150% of the ICHP Hoosier Healthwise home care schedule of payment rates as the base rate, then apply the provider’s contracted percentage of Medicare.

<table>
<thead>
<tr>
<th>Service/ procedure code</th>
<th>Billing unit</th>
<th>Base Rate Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurse (RN) – 99600 TD</td>
<td>Hourly</td>
<td>$43.34</td>
</tr>
<tr>
<td>Licensed Practical Nurse (LPN) – 99600 TE</td>
<td>Hourly</td>
<td>$27.82</td>
</tr>
<tr>
<td>Home Health Aide – 99600</td>
<td>Hourly</td>
<td>$18.80</td>
</tr>
<tr>
<td>Physical Therapist – G0151</td>
<td>15-minute increments</td>
<td>$17.45</td>
</tr>
<tr>
<td>Occupational Therapist – G0152</td>
<td>15-minute increments</td>
<td>$17.19</td>
</tr>
<tr>
<td>Speech Pathologist – G0153</td>
<td>15-minute increments</td>
<td>$18.48</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service/Procedure Code</th>
<th>Billing Unit</th>
<th>Base rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Social Worker in home health G0155</td>
<td>each 15 minutes</td>
<td>$18.99</td>
</tr>
</tbody>
</table>

(current IHCP Fee schedule as of 6.03.16 taking .50 of 30 minute fee amount of 50.65 = 25.33 @ 75% (Mid- level provider))

No fee per CMS for SW visit or IHCP fee schedule. Using 90832 code IHCP fee schedule amount to establish fee amount for 15 minutes. 90832 code definition and fee amount is for 30 minutes.

CPT codes billed for the marketplace, which fall under the manual pricing logic should follow the published Medicaid rate methodology, as outlined in the below table and in the IHCP Bulletin, BT 200940 and 201213. Except for drugs and biological, which have special pricing, HCPCS codes which indicate manual pricing will be reimbursed at 60% of billed charges, or for DME products, 60% of the Manufacturers Suggested Retail Price (MSRP). For the pricing of drugs and biological, refer to BCCP 20, Pharmacy & Biological.

To determine the base Medicare rate for CPT codes, the applicable Medicaid rate, based on the below table is multiplied by 150%. The provider’s contracted rate is then applied to the base Medicare rate.

For HCPS codes that are paid at 60% of billed charges, there is no additional percentage applied (Medicare equivalency or additional provider contracted amount).

<table>
<thead>
<tr>
<th>Procedure Code Range</th>
<th>Codes Billed on CMS-1500</th>
<th>Codes Billed on UB-04</th>
</tr>
</thead>
<tbody>
<tr>
<td>10000-19999</td>
<td>20% of billed Amount</td>
<td>20% of billed Amount</td>
</tr>
<tr>
<td>20000-29999</td>
<td>20% of billed Amount</td>
<td>10% of billed Amount</td>
</tr>
<tr>
<td>30000-39999</td>
<td>20% of billed Amount</td>
<td>10% of billed Amount</td>
</tr>
<tr>
<td>40000-49999</td>
<td>20% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
<tr>
<td>50000-59999</td>
<td>35% of billed Amount</td>
<td>10% of billed Amount</td>
</tr>
<tr>
<td>60000-69999</td>
<td>20% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
<tr>
<td>70000-79999</td>
<td>25% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
<tr>
<td>80000-89999</td>
<td>30% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
</tbody>
</table>

3.3. Private Duty Nursing

Private duty nursing is typically prescribed on an hourly basis for skilled nursing services for a person that requires continuous nursing care. Private duty nursing is distinguished from skilled nursing home care provided by home care agencies that is prescribed on an intermittent (per visit) basis.

The provider reimbursement for covered home care services will be 150% of the IHCP Hoosier Healthwise home care schedule of payment rates (this includes manually priced codes) as the base rate, then apply the provider’s contracted percent of Medicare.

- If the provider is not contracted, and the service is authorized, then the following rate is applied to the applicable Medicare fee amount (or 150% of the Medicaid payment amount as the Medicare equivalent when no fee in Medicare is available and it is a covered service), unless in some case, the authorization could contain the non-contracted provider rate:
  - Facility 133%,
  - Professional I claims 125%

- Site of service (nonfacility and facility services) fees may apply to certain service codes.

- In all cases, if the billed amount is less than the contracted payment amount, the billed amount is to be reimbursed.
### 3.4. Home Infusion

Home infusion therapy benefit includes a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Four provider types may bill for home infusion and enteral therapy services and supplies:

- Durable medical equipment (DME)
- Home medical equipment (HME)
- Home health agencies (HHAs)
- Pharmacies

Providers must bill separately for the components for home infusion and enteral therapy.

Home health agencies or infusion provider bill services provided in the home by an RN, or LPN on a UB-04 claim form or 837I transaction using the appropriate HCPCS codes for infusion therapy services provided.

- The provider reimbursement for covered home care services will be 150% of the IHCP Hoosier Healthwise home care schedule of payment rates (this includes manually priced codes) as the base rate, then apply the provider’s contracted percent of Medicare.

### Service/ procedure code | Billing unit | Medicaid Base rate effective for DOS 7.1.15 through 6.30.17
--- | --- | ---
Registered Nurse (RN) − 99600 TD | Hourly | $43.34
Licensed Practical Nurse (LPN) − 99600 TE | Hourly | $27.82

### 3.5. Durable Medical Equipment (DME) and Home Medical Equipment (HME)

Covered durable medical equipment (DME), Home Medical Equipment (HME), Parenteral and enteral nutrition (PEN), and medical supplies will be reimbursed at the rate on the associated Medicare DME fee schedule (DMEPOS) for Indiana locality as the base rate.

- Use the Medicare payment amount, if available; then apply the provider’s contracted percent of Medicare. If not, and the service code is covered, then use the Medicaid payment amount as the base. 150% of Medicaid is deemed equivalent to the Medicare rate; then apply the provider’s contracted percent of Medicare. If there is no Medicare or Medicaid rate and the service is covered, the item must be manually priced.

- If the provider is not contracted, and the service is authorized, then the following rate is applied to the applicable Medicare fee amount (or 150% of the Medicaid payment amount as the Medicare equivalent when no fee in Medicare is available and it is a covered service),
unless in some case, the authorization could contain the non-contracted provider rate:

- Facility 133%,
- Professional I claims 125%

Site of service (nonfacility and facility services) fees may apply to certain service codes.

- In all cases, if the billed amount is less than the contracted payment amount, the billed amount is to be reimbursed.

3.6. DME and HME providers bill all supplies, equipment, and formulas used for home infusion and enteral therapy on the CMS-1500 claim form or 837P transaction using the appropriate HCPCS codes.

3.7. Home Tocolytic Infusion Therapy Using a Home Uterine Monitoring Device

HHAs may bill all three components using the proper billing forms and appropriate codes if the HHA maintains multiple enrollments as an HHA, Pharmacy and DME, or HME provider.

Providers meeting guidelines to provide covered services will be reimbursed at 150% of Medicaid fee schedule rate as base rate, then apply % of contracted rate of Medicare. OR the delivery system medical management, if negotiated a per diem rate or established a global rate, provides that rate to the payer with the authorization (S9349 total global package).

Three codes, 99601 and 99602 are assigned to home tocolytic infusion therapy using a home monitoring device.

Codes 99601 and 99602 are used if a member meets the criteria for home tocolytic infusion therapy and the agency is providing the home uterine monitoring and skilled nursing components of the Indiana Health Coverage Programs therapy only.

When the home health agency bills 99601 and 99602, the tocolytic drugs and other supplies must be supplied and billed separately through another provider. The home health agency should provide only the home uterine monitor and the skilled nursing components of the home tocolytic infusion therapy.

Codes 99601 and 99602 cover the following items:

- Home uterine monitor
- Skilled nursing services that include the following:
  - Initial nursing assessment
  - Instructions given to the patient about the proper use of the monitor
  - Home visits to monitor signs and symptoms of preterm labor
  - Twenty-four hour telephone support for troubleshooting the monitoring equipment and for reporting patient symptoms
- This package also includes any costs involved in transmitting reports to the physician electronically, such as fax or telephone modem.

4. Procedure Codes and Claims Considerations

4.1. Home health providers follow the general billing directions for completing the UB-04 claim form with the exception of the service date, local codes, and the additional type of bill codes. In field 44, HCPCS/RATES, providers must enter the HCPCS/CPT) code for the service provided, not the rate.
Each line item identifies services billed using HCPCS codes and service dates. Providers must bill each date of service as a separate line item and bill each level of service, such as registered nurse (RN) or licensed practical nurse (LPN), provided on the same date as a separate line item.

The procedure code description defines the unit of service. When home health providers perform the same service, such as multiple RN visits on the same date of service, they must bill those services on the same claim form and on one detail with the total number of units of services provided. Billing separate lines for the same service with the same date of service or on separate claim forms causes claims to be denied as duplicate service.

4.2. The billing units of home health visits for therapists, home health aides, LPNs, and RNs are as follows:

- For therapy visits – If the therapist is in the home eight minutes or more, the provider can round the visit up to the 15-minute unit of service. If the therapist is in the home for seven minutes or less, the provider cannot round this up and therefore, cannot bill for it. Therapy codes are measured as one unit equals 15 minutes.

- For home health aides, LPN, or RN visits – If the home health aide, LPN, or RN is in the home for fewer than 29 minutes, providers can bill for the entire first hour only if they provided a service. For subsequent hours in the home, providers should use the partial unit procedure as outlined in the Partial Units of Service. Nursing services are measured as one unit equals one hour.

**Partial Units of Service**
Providers must round partial units of service to the nearest whole unit when calculating reimbursement. Round up any partial unit of service of 30 minutes or more to the next highest unit, and round down any partial unit of service of 29 minutes or less to the next lowest unit. Nursing services are measured as one unit of service equals 60 minutes, while therapies are measured as one unit equals 15 minutes.

Example 1: 85 minutes spent on billable patient care activities is rounded down to one unit.
Example 2: 95 minutes spent on billable patient care activities is rounded up to two units.

- If the therapist, home health aide, LPN, or RN enters the home and the member refuses service, providers cannot bill for any unit of service.

4.3. Providers enrolled as multiple provider types, such as pharmacy, DME, HME, and home health agencies, can bill all three components using the proper billing forms and appropriate codes.

4.4. Unless enrolled as multiple provider types as indicated above, Providers must bill separately for the components for home infusion and enteral therapy. Pharmacies must bill for compounded prescriptions or any drugs used in parenteral therapy on the appropriate claim form.

- HME providers bill all supplies and formulas used for home infusion and enteral therapy on the CMS-1500 claim form or 837P transaction using the appropriate HCPCS codes.
- Home health agencies bill services provided by an RN, LPN, or home health aide on a UB-04 claim form or 837I transaction using the appropriate HCPCS codes for services provided. Providers must bill the IHCP for such services using HCPCS codes billed on the CMS-1500 claim form.

4.5. A home health agency (HHA) that is dually enrolled as a pharmacy provider must submit all compound drugs and any drugs used in parenteral therapy on a drug claim form or via the NCPDP.
D.0 transaction using the appropriate NDC.

4.6. Covered medical supplies are billed by the home health agency using revenue code 027X and the appropriate HCPCS.

4.7. Covered drugs will be reimbursed using the Medicare ASP fee schedule.

4.8. Pharmacies must bill for compounded prescriptions or any drugs used in parenteral therapy on the appropriate Compound Prescription Claim Form or National Council for Prescription Drug Programs (NCPDP) Pharmacy Drug Claim Form or via the NCPDP D.0 transaction using the appropriate National Drug Code(s) (NDC).

Please also refer to this manual’s chapter on Pharmacy and Biologicals.

5. Prior Authorization (PA) Requirements

5.1. Claims received for Home Care, Infusion and Private Duty Services are processed in accordance with the MDwise Marketplace Prior Authorization requirements.
1. Benefit Coverage

1.1. Hospice care may be provided in the home or at a Hospice facility where medical, social and psychological services are given to help treat patients with a terminal illness. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as certified by the attending physician and hospice Medical Director. Covered Health Services will continue if the member lives longer than six months, provided the hospice medical director or other hospice doctor recertifies that the member is terminally ill.

1.2. To be covered, hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care and a certification that the individual is terminally ill must be completed by the patient's attending physician (if there is one) or the member's PMP, and the hospice Medical Director. Certification of terminal illness is based on the physician's or medical director’s clinical judgment regarding the normal course of an individual’s illness. Hospice services must be considered medically necessary, and prior authorization is required for each continuous period of election (see 1.5 below).

1.3. In the event patient survival is longer than six months, the physician recertifies that the patient is terminally ill in order for hospice benefits to continue.

1.4. Once a patient is certified as terminally ill with six months or less to live and elects hospice services, an initial plan of care is established, and with some exceptions, as noted in this policy, all treatment of the patient's terminal illness is provided by or through the hospice.

1.5. An individual (or his authorized representative) must elect hospice care to receive it. The first election is for a 90-day period. An individual may elect to receive MDwise Marketplace coverage for an unlimited number of election periods of hospice care. The periods consist of two 90-day periods, and an unlimited number of 60-day periods. If the individual (or authorized representative) elects to receive hospice care, he or she must file an election statement with a particular hospice.

1.6. Covered Hospice Services include the following list.

1.6.1. Skilled Nursing Services by an R.N. or L.P.N.
1.6.2. Diagnostic Health Services to determine need for palliative care.
1.6.3. Physical, speech and inhalation therapies if part of a treatment plan.
1.6.4. Medical supplies, equipment and appliances directed at palliative care.
1.6.5. Counseling services.
1.6.6. Inpatient confinement at a Hospice.
1.6.7. Prescription Drugs given by the Hospice.
1.6.8. Home health aide functioning within home health care guidelines.

1.7. MDwise covers the following levels of hospice care services when medical necessity criteria has been met:
1.7.1. Home care when less than eight hours of primarily nursing care, which may be intermittent, are required in a 24-hour period.

1.7.2. Continuous home care for the relief of acute medical symptoms, when at least a total of eight hours of primarily skilled care, which may be intermittent, is required in a 24-hour period.

1.7.3. Inpatient respite care that is short term (i.e., up to five days) and provided as part of the overall treatment plan, to relieve the primary caregiver at home and only if coverage for respite care is available under the plan.

1.7.4. Inpatient hospice care when the intensity or scope of care needed is not practical in the home setting will be short-term, and when the individual treatment plan is specifically directed at acute symptom management and/or pain control.

1.8. To be covered, hospice care must meet all of the requirements listed below.

1.8.1. Is provided by a licensed Hospice Care Agency,

1.8.2. Focuses on palliative rather than curative treatment, and

1.8.3. Provides supportive measures to member with a prognosis of less than six months to live.

1.9. Discharge from Hospice Services. Discharge from hospice may be appropriate in some situations. If the hospice team determines the patient is no longer considered terminally ill, discharge from hospice is appropriate. In addition, hospice discharge may also be appropriate if the patient refuses services or is uncooperative, moves out of the area, or transfers to another hospice program. In the event a patient is discharged from hospice, benefit coverage would be available under core medical benefits as long as the patient remained eligible for coverage of medical services. Prior to discharge, the hospice must obtain a written physician discharge order from the hospice medical director.

2. Benefit Limitations and Exclusions

2.1. The following benefit limitations or exclusions apply to hospice services:

2.1.1. Inpatient respite care is available for fourteen (14) days annually. Up to 5 consecutive days may be covered per inpatient stay.

2.1.2. Services, supplies, procedures, or pharmaceuticals that are directed towards curing the terminal condition

2.1.3. Care from any hospice provider that wasn’t set up by the originating hospice medical team. The hospice care that the member receives for their terminal illness must be given by or arranged by the hospice team. They cannot get the same type of hospice care from a different provider, unless the hospice provider is changed through prior authorization. Duplication of services is not allowed.

2.1.4. Care in an emergency room, inpatient facility care, or ambulance transportation, unless it’s either arranged by the hospice team or is unrelated to the terminal illness.

2.1.5. Services provided by volunteers and housekeeping services.

3. Provider Reimbursement & Submission Requirements

3.1. Level of Care Payments. Medicare payment for hospice care is made at one of several predetermined rates for each day that a member is under the care of the hospice. The rates are
prospective rates and vary depending on the level of care furnished to the beneficiary. The level of care is based on patient needs with documented level of service in the plan of care.

The levels of care into which each day of care is classified include:

<table>
<thead>
<tr>
<th>Revenue Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0651*</td>
<td>Hospice Care - Routine Home Care</td>
</tr>
<tr>
<td>0652*</td>
<td>Hospice Care - Continuous Home Care</td>
</tr>
<tr>
<td>0655**</td>
<td>Hospice Care - Inpatient Respite Care</td>
</tr>
<tr>
<td>0656**</td>
<td>Hospice Care - General Inpatient Care</td>
</tr>
</tbody>
</table>

*Reporting of value code 61 should be reported with these revenue codes, however the claim should not be denied if value code is not included.

**Reporting of value code G8 should be reported with these revenue codes however the claim should not be denied if value code is not included.

Hospices must also report a HCPCS code along with each level of care revenue code (651, 652, 655 and 656) to identify the type of service location where that level of care was provided (e.g. Q5001 ? Q5010). If a corresponding HCPCS code is not provided, the claim may be denied.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5001</td>
<td>HOSPICE CARE PROVIDED IN PATIENT'S HOME/RESIDENCE</td>
</tr>
<tr>
<td>Q5002</td>
<td>HOSPICE CARE PROVIDED IN ASSISTED LIVING FACILITY</td>
</tr>
<tr>
<td>Q5003</td>
<td>HOSPICE CARE PROVIDED IN NURSING LONG TERM CARE FACILITY (LTC) OR NON-SKILLED NURSING FACILITY (NF)</td>
</tr>
<tr>
<td>Q5004</td>
<td>HOSPICE CARE PROVIDED IN SKILLED NURSING FACILITY (SNF)</td>
</tr>
<tr>
<td>Q5005</td>
<td>HOSPICE CARE PROVIDED IN INPATIENT HOSPITAL</td>
</tr>
<tr>
<td>Q5006</td>
<td>HOSPICE CARE PROVIDED IN INPATIENT HOSPICE FACILITY</td>
</tr>
<tr>
<td>Q5007</td>
<td>HOSPICE CARE PROVIDED IN LONG TERM CARE HOSPITAL (LTC)</td>
</tr>
<tr>
<td>Q5008</td>
<td>HOSPICE CARE PROVIDED IN INPATIENT PSYCHIATRIC FACILITY</td>
</tr>
<tr>
<td>Q5009</td>
<td>HOSPICE CARE PROVIDED IN PLACE NOT OTHERWISE SPECIFIED (NOS)</td>
</tr>
<tr>
<td>Q5010</td>
<td>HOSPICE HOME CARE PROVIDED IN A HOSPICE FACILITY</td>
</tr>
</tbody>
</table>

For each day that a member is under the care of a hospice, the hospice is reimbursed an amount applicable to the type and intensity of the services furnished to the member for that day. For continuous home care the amount of payment is determined based on the number of hours, reported in increments of 15 minutes, of continuous care furnished to the member on that day. For the other categories a single rate is applicable for the category for each day.

- **Routine Home Care**: Effective for hospice services with dates of service on or after January 1, 2016, a hospice day billed at RHC level of care will be paid one of two RHC rates based upon the following:
  - If the day occurs during the first 60 days of an episode, the RHC rate will be equal to the RHC 'High' Rate.
• If the day occurs during days 61 and beyond, the RHC rate will be equal to the RHC 'Low' Rate.

• For a hospice patient who is discharged and readmitted to hospice within 60 days of that discharge, his/her prior hospice days will continue to follow the patient and count toward his/her patient days for determining whether the receiving hospice may bill at the high or low RHC rate

• For a hospice patient who has been discharged from hospice care for more than 60 days, a new election to hospice will initiate a reset of the patient’s 60-day window, paid at the RHC 'High' Rate upon the new hospice election.

Multiple RHC days are reported on a single line item on the claim. The line item date of service represents the first date at the level of care and the units represent the number of days. As a result, both high and low RHC rates may apply to a single line item.

Service Intensity Add-On Payment (SIA) Also effective with dates of service on and after January 1, 2016, a hospice claim will be eligible for an end of life (EOL) Service Intensity Add-On (SIA) payment if the following criteria are met:

- The day is an RHC level of care day.
- The day occurs during the last seven days of life (and the member is discharged dead).
- Service is provided by a Registered Nurse (RN) or social worker that day for at least 15 minutes and up to 4 hours total.
- The service is not provided by a social worker via telephone.

The SIA Payment equals:

- The number of hours (in 15 minute increments) of service provided by an RN or social worker during the last seven days of life for a minimum of 15 minutes and up to 4 hours total per day;
- Multiplied by the current hospice Continuous Home Care (CHC) hourly rate per 15 minutes x visit units (not greater than 16).
- Adjusted for geographic differences in wages.

The G codes associated with skilled nursing in the below table distinguish between nursing care provided by a RN and nursing care provided by a LPN. The SIA daily payment calculated by the Hospice PRICER is entered on the first applicable visit line item for each date of service payable.

Levels of Hospice Care

- **Routine Home Care**: Routine home care is the basic level of care provided, often by an interdisciplinary hospice team to support a patient with a terminal illness. It may be provided in a private residence, a hospital residential care facility, or an adult care home. It may also be provided in a nursing facility when the facility has a contractual agreement with the hospice agency. This level of care typically requires fewer than eight hours of primarily nursing care per day and is based on the patient's individual needs. The hospice is paid the routine home care rate for each day the patient is under the care of the hospice and not receiving one of the other categories of hospice care. This daily rate is paid without regard to the volume or
Intensity of routine home care services provided on any given day, and is also paid when the patient is receiving outpatient hospital care for a condition unrelated to the terminal condition. For example, if the terminal illness is related to lung cancer, they could still be receiving outpatient dialysis services for acute kidney failure.

- **Continuous Home Care**: Continuous home care is provided in the patient's home and is often provided during a medical crisis that would otherwise require inpatient admission. Continuous home care is not paid during a hospital, skilled nursing facility or inpatient hospice facility stay. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. Parts of an hour are identified through the reporting of time for continuous home care days in 15 minute increments and these increments are used in calculating the payment rate. Only patient care provided during the period of crisis is to be reported. Payment is based upon the number of 15-minute increments that are billed for 32 or more units. Units should only be rounded to the nearest increment. A minimum of eight hours of primarily nursing care is required, half of which must be provided by a registered nurse, licensed practical nurse or nurse practitioner. The nursing care need not be continuous. Homemaker or home health aide services may also be provided to supplement nursing care.

- **Inpatient Respite Care**: Inpatient respite care is short-term care that is provided to relieve family members and other unpaid caregivers who care for the patient in their private residence. Respite care may be provided in a hospice facility, hospital or nursing home. The hospice is paid at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of 5 continuous days at a time including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate. More than one respite period (of no more than 5 days each) is allowable in a single billing period. If the beneficiary dies under inpatient respite care, the day of death is paid at the inpatient respite care rate. Inpatient respite care is available for fourteen (14) days annually.

- **General Input Care**: General inpatient hospice care is provided in an inpatient setting for the purpose of managing symptoms or to perform procedures for pain control that cannot be performed in other settings. The inpatient services may be provided in a hospice inpatient facility, hospital facility, or nursing facility under the arrangement of a hospice agency.

- **Hospice Services**

3.2. **Billing Guidelines.** Hospice claims are required to report separate line items for the level of care each time the level of care changes. This includes revenue codes 0651, 0655 and 0656. For example, if a patient begins the month receiving routine home care followed by a period of general inpatient care and then later returns to routine home care all in the same month, in addition to the one line reporting the general inpatient care days, there should be two separate line items for routine home care.

Hospices are also required to report additional detail for visits on their claims. For all Routine Home Care (RHC), Continuous Home Care (CHC) and Respite care billing, hospice claims should report each visit performed by nurses, aides, and social workers who are employed by the hospice, and their associated time per visit in the number of 15 minute increments, on a separate line. The visits should be reported using revenue codes:
<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Required HCPCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>042x Physical Therapy</td>
<td>G0151</td>
</tr>
<tr>
<td>043x Occupational Therapy</td>
<td>G0152</td>
</tr>
<tr>
<td>044x Speech Therapy – Language Pathology</td>
<td>G0153</td>
</tr>
<tr>
<td>055x Skilled Nursing</td>
<td>G0154(before 01/01/2016), G0299 or G0300 (on or after 01/01/2016)</td>
</tr>
<tr>
<td>056x Medical Social Services</td>
<td>G0155</td>
</tr>
<tr>
<td>057x Home Health Aide</td>
<td>G0156</td>
</tr>
<tr>
<td>0569 Other Medical Social Services</td>
<td>G0155</td>
</tr>
</tbody>
</table>

Hospices are also required to include as applicable: 0250 Non-injectable prescription drugs, 029X Infusion pumps, and 0636 Injectable drugs.

3.2. Payment Rates. CMS publishes general hospice payment rates annually to be used for revenue codes 0651, 0652, 0655, and 0656. The hospice per diem for both routine and continuous home hospice is adjusted using the wage index for the city or county where the member resides. Hospice reimbursement for inpatient hospice care is adjusted using the wage index of the city or county where the hospice facility is located.

These national per diem rates are adjusted as follows:
- Rate Components: The rate is has two components; a wage amount component and a non-weighted component
- Adjustment to Wage Component - The wage amount component is adjusted (multiplied) by the wage index for the location of the place of service for all levels of care.
- The adjusted wage component is then added to the non-weighted component. This is the payment rate for the year.

The hospice wage index is published in the Federal Register notice each year, and is effective October 1 of that year through September 30 of the following year. To select the proper index for the hospice area, it must be determined if the member is located in one of the Urban Areas listed in Table A of the Federal Register notice. If so, the index shown for the area must be used. If the member is not located in one of the Urban Areas, the index number of the rural area for the State, listed in Table B of the Federal Register notice should be used.

3.3. In accordance with Medicare reimbursement methodology, MDwise requires members enroll in the Hospice program and all other providers bill the Hospice for services and receive their reimbursement from the Hospice. With a few exceptions, the providers may no longer bill MDwise for services provided to the member.

3.4. MDwise will pay for medically necessary ambulance transports of hospice patients to their home which may occur on the effective date of hospice election, through the ambulance benefit rather than through the hospice benefit. Ambulance transports of a hospice patient, which are related to the terminal diagnosis and which occur after the effective date of election, are the responsibility of the hospice.

3.5. For dates of service on or after October 1, 2016, services for the vaccines provided by a hospice may be billed on an institutional claim to MDwise. Since these services are not part of the hospice benefit, they must be billed on a separate claim that includes only the vaccines and their administration.
3.6. A Hospice may use chemotherapy, radiation therapy, and other modalities for palliative purposes if it determines that these services are needed. This determination is based on the patient’s condition and the Hospice care giving philosophy. No additional MDwise payment is made regardless of the cost of the services.

3.7. Billing and Payment for Hospice Services Provided by a Physician (Rev Code 657)

3.7.1. Hospice Attending Physician Services. Under the hospice benefit, an attending physician is defined as an MD, DO, or a nurse practitioner (NP) who is identified by the patient, at the time he/she elects hospice coverage, as having the most significant role in the determination and delivery of his or her medical care. Payment for physicians or nurse practitioners serving as the attending physician, who provide direct patient care services and who are hospice employees or working under arrangement with the hospice, is made in the following manner:

- Hospices establish a charge and bill for these services using revenue code 657 with the applicable CPT code. The hospice is paid at the lesser of the actual charge or 100 percent of the Medicare physician fee schedule for physician services or 85 percent of the fee schedule amount for nurse practitioner services. This payment is in addition to the daily hospice rates.

- Payment for physicians’ administrative and general supervisory activities is included in the hospice payment rates and cannot be billed separately. These activities include participating in the establishment, review and updating of plans of care, supervising care and services and establishing governing policies.

- No payment is made for physician or nurse practitioner services furnished voluntarily.

- No payment is made for nurse practitioner services that can be performed by a registered nurse, nor is payment made for nurse practitioner services that are performed outside of the attending physician role. Nurse practitioner services are generally encompassed in the per diem payment rate. The only payment that can be made for services of a nurse practitioner is made for services furnished in the role of an attending physician.

3.7.2. Independent Attending Physician Services. When hospice coverage is elected, the member waives all rights to payments for professional services that are related to the treatment and management of his/her terminal illness during any period his/her hospice benefit election is in force, except for professional services of an independent attending physician, who is not an employee of the designated hospice nor receives compensation from the hospice for those services. As outlined above, an attending physician means an individual who is an MD, DO, or NP and is identified by the individual, at the time he/she elects hospice coverage, as having the most significant role in the determination and delivery of their medical care.

Professional services related to the hospice patient's terminal condition that were furnished by an independent attending physician are separately reimbursable. The independent attending physician codes services with the GV modifier when billing his/her professional services furnished for the treatment and management of a hospice patient's terminal condition. When the independent attending physician furnishes a terminal illness related service that includes
both a professional and technical component (e.g., x-rays), he/she bills the professional component of such services on a professional claim and looks to the hospice for payment for the technical component. Likewise, the independent attending physician would look to the hospice for payment for terminal illness related services furnished that have no professional component (e.g., clinical lab tests). Payment is made to the independent attending physician based on the payment and deductible rules applicable to each covered service.

If another physician covers for a hospice patient’s designated attending physician, the services of the substituting physician are billed by the designated attending physician. In such instances the attending physician bills using the GV modifier in conjunction with either the Q5 or Q6 modifier.

3.8. Billing and Payment for Services Unrelated to Terminal Illness. MDwise is liable for covered benefits for health problems that aren’t related to the terminal illness, for example, care for an injury or accident. Applicable co-pays and coinsurance will apply.

Any covered services not related to the treatment of the terminal condition for which hospice care was elected, and which is furnished during a hospice election period, may be billed by the rendering provider using professional or institutional claims for non-hospice payment. On professional claims, these services are coded with the GW modifier service not related to the hospice patient’s terminal condition. On institutional claims, these services are coded with condition code 07 Treatment of Non-terminal Condition for Hospice. Process services coded with the GW modifier or condition code 07 in the normal manner for coverage and payment determinations.

Professional services of attending physicians, furnished to hospice beneficiaries are coded with modifier GV. For members enrolled in hospice, the claims processor must deny any services on professional claim that are submitted without either the GV or GW (services unrelated to terminal illness) modifier. The processor shall deny claims for all other services related to the terminal illness furnished by individuals or entities other than the designated attending physician, who may be a nurse practitioner. Such claims include bills for any DME, supplies or independently practicing speech-language pathologists or physical therapists that are related to the terminal condition. These services are included in the hospice rate and paid through the institutional claim.

4. Procedure Codes and Claim Considerations

4.1. Pre-election evaluation (G0337). MDwise allows payment to a hospice for specified hospice pre-election evaluation and counseling services when furnished by a physician who is either the medical director of or employee of the hospice. A one- time only payment may be made on behalf of a member who is terminally ill, (defined as having a prognosis of 6 months or less if the disease follows its normal course), has no previous hospice elections, and has not previously received hospice pre-election evaluation and counseling services.

HCPCS code G0337 “Hospice Pre-Election Evaluation and Counseling Services” is used to designate that these services have been provided by the medical director or a physician employed by the hospice. Hospice agencies bill this service using HCPCS G0337 with Revenue Code 0657. No other revenue codes may appear on the claim.

4.2. When it is determined through prior authorization that a member is approved for hospice coverage, the claims payer must have a mechanism in place to flag that member so that claims are paid correctly according to the hospice benefit.
4.3. **Claims after the End of Hospice Election Period.** Upon revocation of coverage of hospice care for a particular election period, an individual resumes coverage of the benefits waived when hospice care was elected. MDwise must process and pay for covered, medically necessary services furnished to patients after their hospice benefits are revoked even if the patient remains under the care of the hospice. Such services are billed without the GV or GW modifiers. After revocation, professional claims for covered services that hospice employed physicians may furnish can be reimbursed.

5. **Prior Authorization (PA) Requirements**

5.1. Hospice care requires a prior authorization and will deny without proper authorization. Prior authorization is required for each continuous period of election.

6. **Copays and Coinsurance**

6.1. Refer to the MDwise Marketplace Individual Policy for the Schedule of Benefits which summarizes applicable coinsurance related to coverage of hospice services. Coinsurance, not the office visit copay applies to PMP or specialist services provided in place of service 34 (hospice).
1. **Benefit Coverage**

1.1. Covered services may include medically necessary human organ and stem cell/bone marrow transplants and transfusions as determined by MDwise including necessary acquisition procedures, harvest and storage, and medically necessary preparatory myeloablative therapy.

1.2. The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following list.
   - Cornea and kidney transplants, and
   - Any Covered Health Services related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period during the time the member is enrolled in MDwise Marketplace member.

For those services bulleted above as not applicable to the Transplant Services benefits or requirement, covered health services related to those bullets for enrolled MDwise Marketplace members are included within the covered benefits and services stated in the other sections of the MDwise Marketplace individual contract and plan documents, subject to co-pay and coinsurance. For example, the above Health Services may be covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Enrollee cost shares.

Certain services may require prior authorization and are subject to medical necessity.

1.3. Please note that the initial evaluation and any necessary additional testing to determine eligibility as a candidate for transplant and the harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure during the period of time a member is enrolled in MDwise Marketplace benefit regardless of the date of service.

1.4. There are instances where requests for approval for HLA testing, donor searches and/or a harvest and storage of stem cells occur prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

1.5. **Transplant Benefit Period.** Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period in those specific case rates/global rates agreements per medical management negotiations, otherwise applicable to time period where reimbursement is according to the contracted MS-DRG rate.. The number of days will vary depending on the type of transplant received and the Participating Transplant Provider agreement or DRG. Specific Participating Transplant Provider information for Health Services received at or coordinated by a Participating Transplant Provider Facility is entered by the Case Manager or
starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Transplant Provider Facility.

Prior to and after the Transplant Benefit Period, Covered Health Services will be paid accordingly to those covered health services outlined in the MDwise Marketplace Individual contract, for example, as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.

1.6. Transportation and Lodging. MDwise will provide assistance with reasonable and necessary travel expenses when patient is required to travel more than 75 miles from residence to reach the facility where the Covered Transplant Procedure will be performed. The covered transplant procedure is a transplant procedure approved by the utilization management team at a center contracted by the MDwise delivery system in which the member is enrolled. Assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. All transportation and lodging expenses must be pre-approved by the authorizing delivery system.

MDwise will base reimbursement on federal GSA guidelines for per diem, transportation, and lodging as found on the GSA website: http://www.gsa.gov/portal/content/104877

MDwise will assist in pre-arranging the MDwise authorized reasonable and necessary travel and lodging assistance with expenses. The Enrollee must submit itemized receipts for those transportation and lodging expenses in a form satisfactory to MDwise when claims are filed for those expenses determined reasonable and necessary by MDwise prior to obtaining.

1.7. Live Donor Health Services billed on the member’s claim are covered as determined by the Contract.

2. Benefit Limitations and Exclusions

2.1 Limitations
Non-Covered Services for transportations and lodging include the following.
- Child care.
- Mileage.
- Rental cars, buses, taxis, or shuttle services, except as specifically approved by MDwise.
- Frequent Flyer miles.
- Coupons, Vouchers, or Travel tickets.
- Prepayments or deposits.
- Services for a condition that is not directly related, or a direct result, of the transplant.
- Telephone calls.
- Laundry.
- Postage.
- Entertainment.
- Interim visits to a medical care facility while waiting for the actual transplant procedure.
- Travel expenses for donor companion/caregiver.
- Meals, except those served during the inpatient stay for the transplant procedure.
• Return visits for the donor for a treatment of a condition found during the evaluation.

2.2. Certain Human Organ and Tissue Transplant Services may be limited.

2.3. Any Covered Health Services related to a Covered Transplant Procedure received prior to or after the Transplant Benefit Period may not be applicable to the specific benefit structure during that period for those related transplant types. Those covered health services can be covered under other covered benefit structure as applicable outside of the Transplant Benefit Period, with appropriate co-pay or coinsurance.

Please note: the initial evaluation and any necessary additional testing to determine eligibility as a candidate for transplant and the harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

2.4. The following limitations apply to those transplants that are applicable to the Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits:

• Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure
  o Covered, as approved by the Contract, up to a $30,000 per covered transplant Participating Transplant Provider
  o Covered, as approved by the Contract, up to a $30,000 benefit limit. Member will be responsible for 50% of search charges for authorized non-participating provider professional and ancillary providers. These charges will not apply to Out-of-Pocket Limit for Non-Participating Transplant Provider

• Transportation and Lodging
  o Covered, as approved by the Contract, up to a $10,000 limit covered transplant for Participating Transplant Provider. Subject to reasonable and necessary prior determination by MDwise.

2.5 Exclusions

• Please refer to MDwise Marketplace Contract Individual Policy: Article 4 Exclusions, Section 4.1. for comprehensive list of exclusions.

3. Provider Reimbursement & Submission Requirements

3.1. Organ transplant services are reimbursed according to the contracted MS-DRG rate. In some cases, a specific agreed upon rate between the provider and medical management and the acquisition cost may be entered in applicable authorization field.

• Payment for organ acquisition costs is outside of the DRG payment system
• Please also refer to the MDwise Marketplace BCCP 13 Inpatient Hospital Services. Specific Section 4.7 Transplants

4. Claim Considerations

• Service codes and diagnosis codes are based on the Organ that is being transplanted.
5. **Prior Authorization (PA) Requirements**

5.1. Claims received for transplant evaluation and transplant services are processed in accordance with the MDwise Marketplace Prior Authorization requirements.

5.2. Prior authorization/approval is to be obtained prior to an evaluation and/or work-up for a transplant. MDwise may require additional work-ups and/or treatments before determining eligibility for the transplant benefit (e.g. psychotherapy).
   - Even if MDwise issues a prior approval for the Covered Transplant Procedure for evaluation/work-up the MDwise Transplant Department must receive request for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

5.3. Please note that there are instances where requests for approval for HLA testing, donor searches and/or a harvest and storage of stem cells occur prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

5.4. Reasonable and necessary travel expenses as determined by MDwise may be provided when prior approval is obtained.
IHS - Inpatient Hospital Services

1. Benefit Coverage

1.1. Inpatient hospital services include all of the following:
   - Charges for Room, Board and General Nursing Services
   - Ancillary (related) services
     - Operating, delivery and treatment rooms and equipment.
     - Prescribed Drugs.
     - Anesthesia, anesthesia supplies and Health Services given by an employee of the Hospital or other Provider.
     - Medical and surgical dressings, supplies, casts and splints.
     - Diagnostic Health Services.
     - Therapy Services.
   - Professional Health Services from a Physician while an Inpatient

1.2. The Marketplace will pay the same amount for the room, board, and general nursing services whether the patient has a private room or semiprivate room.

1.3. Reconstructive Services - Certain Reconstructive Services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive Services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under the members contract. Covered Reconstructive Services are limited to the following list.
   - Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child.
   - Breast reconstruction resulting from a mastectomy.
   - Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger.
   - Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactyly.
   - Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect.
   - Tongue release for diagnosis of tongue-tied.
   - Congenital disorders that cause skull deformity such as Crouzon’s disease.
   - Cleft lip.
   - Cleft palate.

1.4. Mastectomy – A member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, is eligible for coverage for all of the following listed below.
   - Reconstruction of the breast on which the mastectomy has been performed.
   - Surgery and reconstruction of the other breast to produce a symmetrical appearance.
   - Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

2. Benefit Limitations and Exclusions

The following benefit limitations or exclusions apply to inpatient services:
• Any procedures, services, equipment or supplies provided in connection with cosmetic services. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the member was covered by another carrier/self-funded plan prior to MDwise coverage. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to myocardial infarction, pulmonary embolism, thrombophlebitis, and exacerbation of co-morbid conditions.

• Abortion, except in the following cases.
  o The pregnant woman became pregnant through an act of rape or incest.
  o An abortion is necessary to avert the pregnant woman’s death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

• Surgical treatment of gynecomastia.

• Reconstructive Health Services except as specifically stated in Section 1.2 or as required by law.

• Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

• Treatment of telangiectatic dermal veins (spider veins) by any method.

• Surgical treatment of flat feet, subluxation of the foot, weak, strained, unstable feet, tarsalgia, metatarsalgia, hyperkeratosis

• Bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery, or Gastroplasty, or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by MDwise, are not covered. This exclusion applies even if the original treatment or surgery was performed while the member was covered by another carrier/self-funded plan prior to MDwise coverage. Directly related means that the treatment or surgery occurred as a direct result of the bariatric surgery and would not have taken place in the absence of the surgery. This exclusion does not apply to conditions including but not limited to myocardial infarction, pulmonary embolism, thrombophlebitis, and exacerbation of co-morbid conditions.

• Services to reverse voluntarily induced sterility.

• Eye surgery to correct errors of refraction, such as near-sightedness, including LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

• Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This
Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing. Effective with dates of service 1.1.16 and beyond, the exclusion related to erectile dysfunction and surgeries for sexual dysfunction is no longer in effect and such services are eligible for coverage. Effective with dates of service 1.1.17 and beyond, the exclusion related to gender transition is no longer in effect and such services are eligible for coverage (45 CFR § 92.207(b)(4) 45 CFR § 92.207(b)(5)).

3. Provider Reimbursement & Submission Requirements

3.1. The Medicare Prospective Payment System (IPPS) is used to calculate payment based on Diagnosis Related Groups (DRG). MDwise uses the CMS MS-DRG Grouper which includes tables for all valid diagnoses, procedures and DRGs. The CMS MS-DRG Grouper also includes clinical edits that identify inconsistencies after evaluating a patient’s principal diagnosis, any secondary diagnoses, surgical procedures, age, sex, and discharge status for possible errors.

Components of DRG payment for the marketplace includes:

- **Operating Expense**: The federal base operating expense rate (divided into labor related and non-labor related and the labor related share) is adjusted by the wage index for the area where the hospital is located. The non-labor share is adjusted by a cost of living adjustment factor. An adjustment for DSH (disproportionate share) is then applied, as appropriate, which takes into account the special needs of hospitals that serve a disproportionate number of low-income patients or Medicare beneficiaries. The Readmissions Payment Factor is also applied, utilizing the CMS Readmission Supplemental Data files. The file contains the Readmissions Payment Adjustment Amount for each applicable facility. The readmissions adjustment factor is always less than 1.0000; therefore, the readmissions payment adjustment amount will always be a negative amount (i.e., a payment reduction). If a reduction is not applicable, the file will have a 1.0000 for that facility.

- **Capital Expense.** The national capital rate is first adjusted for local wage differences or geographic variations in cost. These factors are derived from the wage index values used by the operating portion of the PPS. Geographic Adjustment Factors (GAFs) are specific to the hospital’s geographic location (urban, rural, or re-classified) and are published in Tables 4A through 4C of the Final Rule. An adjustment for DSH (disproportionate share) is then applied and also for IME which is intended to compensate hospitals for the indirect costs of providing medical education.

For the marketplace product, the following are not included in the DRG calculations:
- IME (Med Ed) under operating portion of payment
- Value Based Purchasing Adjustment
- Organ acquisition payment
- Bad debt claimed and renal bad debt claimed
- Direct graduate medical education
- Nursing school pass through and other allied health programs
- Hospital readmission adjustments and hospital acquired conditions adjustments.

Payment to the hospitals include the capital and operating portion of the DRG, however will
not include Medicare non-IPPS payments, referred to as “per diem pass through” amounts. The per diem pass through is an amount paid in addition to the DRG for such things as capital for new hospitals, direct medical education, and organ acquisition expenses. These additional payments will not be made for the Marketplace.

In accordance with the Marketplace policy:
- The Medicare rate (of if no Medicare rate 150% of Medicaid) is multiplied by the provider’s contracted rate, for example 163% for a qualified health plan (QHP) 1 contracted provider.
- If the provider is not contracted the lowest QHP rate is used to calculate the reimbursement rate. For facilities, this is 133%, and for professional claims, 125%.
- In some case, the authorization could contain the non-contracted provider reimbursement for the service in question.
- In all cases, if the billed amount is less than the contracted payment amount, the billed amount is to be reimbursed.

3.2. Under the inpatient prospective payment system (IPPS), the DRG assigned at discharge is payment in full to the hospital for the inpatient stay, except for the following.
- Pneumococcal Vaccine - is billed by the hospital on the Form CMS-1450.
- Ambulance Service - If transportation is by a hospital owned and operated ambulance, the hospital bills separately on Form CMS-1450 as appropriate. Similarly, if the hospital arranges for the ambulance transportation with an ambulance operator, including paying the ambulance operator, it bills separately. However, if an ambulance is used for the transportation of a hospital inpatient to another facility for diagnostic tests or special treatment the ambulance trip is considered part of the DRG, and not separately billable.
- Hemophilia clotting factor – Is billed on claim with inpatient stay. Factor is paid using the blood-clotting factors HCPCS codes from the Medicare Part B Drug Pricing File, which is made available on a quarterly basis

Excluded from IPPS are Medicare defined children’s hospitals (identified by 3300-3399 in last four digits of provider number) and cancer hospitals (list can be found on CMS website), and hospitals located outside the 50 States. These excluded hospitals and units are paid on the basis of reasonable costs (See CMS Claims Processing Manual, Chapter 3).

3.3. Outliers. The actual determination of whether a case qualifies for outlier payments are determined by the Pricer, which takes into account both operating and capital costs. The combined operating and capital costs of a case must exceed the fixed loss outlier threshold to qualify for an outlier payment. The operating and capital costs are computed separately by multiplying the total covered charges by the operating and capital cost-to-charge ratios. The estimated operating and capital costs are compared with the fixed-loss threshold after dividing that threshold into an operating portion and a capital portion. The thresholds are also adjusted by the area wage index (and capital geographic adjustment factor) before being compared to the operating and capital costs of the case. Finally, the outlier payment is based on a marginal cost factor equal to 80 percent of the combined operating and capital costs in excess of the fixed-loss threshold (90 percent for burn MS-DRGs). For a more detailed explanation on the calculation of outlier payments, visit: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/outlier.html
3.4. The following MS-DRGs receive special attention:

- **MS-DRGs No. 981-983** - Represent discharges with valid data, but the surgical procedure is unrelated to the principal diagnosis. These DRGs have relative weights assigned to them and will be paid. However, the hospital may review the claim and determine that where either the principle diagnosis or surgical procedure was reported incorrectly and submit an adjustment bill.

- **MS-DRG No. 998** - Represents a discharge reporting a principle diagnosis that is invalid as a principal diagnosis. Examples include a diagnosis of diabetes mellitus or an infection of the genitourinary tract during pregnancy, both unspecified as to episode of care. These claims will be denied and the hospital must enter the corrected principal diagnosis for proper MS-DRG assignment and resubmit the claim.

- **MS-DRG No. 999** - Represents a discharge with invalid data, making it ungroupable. These claims will be denied for correction of data elements affecting proper MS-DRG assignment.

3.5. **Inpatient Stays Less than 24 Hours.** Providers should bill any inpatient stay that is less than 24 hours as an outpatient service. Inpatient stays less than 24 hours that are billed as an inpatient service will be denied.

3.6. **Newborn Services.** Per the member policy, covered Marketplace services for a newborn child (birth or adoption) may be reimbursed under the mother’s policy for the first 31 days of life. If a newborn obtains a Marketplace Policy and ID # prior to the end of the 31 days, providers are instructed to use the member’s ID# instead of the mother’s ID# for billing purposes. However, if a claim is submitted under the mother’s ID# and mother’s name in the first 31 days and the service is covered, the claim is eligible for reimbursement.

If the claims payer receives an inpatient claim with a length of stay of 32 days or longer under the mother’s ID# and mother’s name, the claim may be denied with a request to submit the claim under the member’s policy. If the mother fails to obtain coverage for the newborn, the Marketplace would be liable for that portion of the DRG and any applicable outlier that is related to the first 31 days of the inpatient stay.

If a newborn child is required to stay as an inpatient past the mother’s discharge date, the Health Services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Coinsurance/Copay.

3.7. **Psychiatric/Substance Abuse Inpatient Stay Reimbursement.** The Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) is used to reimburse freestanding psychiatric hospitals and some certified psychiatric units of general acute care hospitals. Payments under the IPF PPS are based on a federal per diem base rate that includes both inpatient operating and capital-related costs (including routine and ancillary services), but excludes certain pass-through costs (i.e., bad debts, and graduate medical education). Outlier payments may also be applicable in certain cases.

Psychiatric hospitals and distinct part psychiatric units of acute care hospitals included in the IPF PPS can be determined by the facilities OSCAR number. Providers with OSCAR numbers where the last 4 digits range from 4000-4499 are Psychiatric Hospitals and are priced through the IPF PPS. The standardized Federal per diem base rates and adjustment factors are updated annually. See [http://www.cms.hhs.gov/InpatientPsychFacilPPS/02_regulations.asp](http://www.cms.hhs.gov/InpatientPsychFacilPPS/02_regulations.asp)
Patient-level adjustments include a DRG, or MS-DRG, adjustment, comorbidity adjustment, an age adjustment, and a variable per diem adjustment.

The variable per diem adjustments account for the ancillary and certain administrative costs that occur disproportionately in the first days after admission to an IPF. The variable per diem adjustments decline each day of the patient’s stay through day 21. After day 21, the adjustments remain the same each day for the remainder of the stay.

Facility-level adjustments for the marketplace include the hospital wage index, a rural location adjustment, and an emergency department adjustment for qualifying EDs.

The wage index accounts for the geographic differences in labor costs. The IPF PPS uses the unadjusted, pre-floor, pre-reclassified hospital wage index in effect on July 1 of each year. The wage index is applied to the labor-related share of the Federal per diem base rate. Core-Based Statistical Area (CBSA) designations are used for assigning a wage index value for discharges.

There is a 17 percent adjustment if a facility is located in a rural area. The IPF PPS defines urban and rural areas at 42 CFR 412.402.

**Electroconvulsive Therapy (ECT) Payment.** IPFs receive an additional payment for each ECT treatment furnished during the IPF stay. The ECT base rate is based on the median hospital cost used to calculate the calendar year 2005 Outpatient Prospective Payment System amount for ECT and is updated annually by the market basket and wage budget neutrality factor. The ECT base rate is adjusted by the wage index and any applicable COLA factor.

An IPF must report revenue code 0901 along with the number of units of ECT on the claim. In addition, IPFs must include the ICD-10-CM procedure code for ECT (94.27) in the procedure code field and use the date of the last ECT treatment the patient received during their IPF stay.

**3.8. Long-Term Acute Care Hospitals.** A Long-Term Acute Care (LTAC) hospital is a freestanding general acute care hospital licensed under IC 16-21 that is designated by the Medicare program as a long-term care hospital (LTCH) and has an average inpatient length of stay greater than 25 days. Facilities that are designated as LTACs can be found in the Medicaid Supplemental Rate File within the zipped file titled “inpatient.loc”.

Based on the medical needs of the member, a delivery system may choose to authorize care in a LTAC for a designated number of days. As part of the authorization a per diem or case rate may be established. This rate should be included in the authorization for care, so that the claims payer knows how to price any claims received. The Medicaid per diem rate, as indicated in the supplemental rate file can be used as a guide.

If a delivery system selects Medicare payment methodology for the reimbursement of the facility, the authorization or contract will indicate the percent by which the LTCH PPS DRG rate shall be multiplied, based on the facility agreement in place. In calculating the LTCH PPS DRG rate, all applicable facility components shall be applied to the DRG calculation. This would include DSH, IME and any other facility related input to the pricing.

**4. Procedure Codes and Claim Considerations**

**4.1. Critical Access Hospitals (CAH)** CAH’s are reimbursed per the CMS reimbursement
rate set for their facility

4.2. Present on Admission Reporting and Provider Preventable Conditions. Hospitals are required to report whether each diagnosis on a claim was present on admission for inpatient claims. Claims submitted without the required Present on Admission (POA) indicators will be denied. For claims containing secondary diagnoses that are included in the list of Hospital Acquired Conditions (HACs) and for which the condition was not present on admission, the HAC secondary diagnosis will not be used for MS-DRG grouping. So the claim will be paid as though any secondary diagnoses listed below were not present on the claim.

The Marketplace also will not cover a surgical or other invasive procedure to treat particular medical conditions when the practitioner performs the surgery or invasive procedure erroneously, including:

- Incorrect surgical or other invasive procedures
- Surgical or other invasive procedures on the wrong body part
- Surgical or other invasive procedures on the wrong patient

Hospitalizations and other services related to these noncovered procedures are also not covered.

4.3. Readmissions. Applicable readmits should be denied. A readmission is defined as an admission within 3 days following a previous admission and discharge for the same or related condition. Same or related refers to the principal diagnosis code and is based on the first three digits of the ICD-10-CM code. If a second inpatient claim is billed for the same member with the same or related principal diagnosis code, the second claim will be denied.

4.4. Transfers. A discharge of a hospital inpatient is considered to be a transfer if the patient is admitted the same day to another hospital.

Please note: When a member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copay per admission in the Schedule of Benefits is waived for the second admission.

IPPS Transfers Between Hospitals. Payment to the transferring hospital is based upon a graduated per diem rate. The prospective payment rate is divided by the geometric mean length of stay for the specific MS-DRG into which the case falls. Hospitals receive twice the per diem rate for the first day of the stay and the per diem rate for every following day up to the full MS-DRG amount. If the stay is less than 1 day, 1 day is paid. A day is counted if the patient was admitted with the expectation of staying overnight.

The prospective payment rate paid is the hospital’s specific rate. Where a transfer case results in treatment in the second hospital under a MS-DRG different than the MS-DRG in the transferring hospital, payment to each is based upon the MS-DRG under which the patient was treated. The transferring hospital may be paid an outlier payment.

An exception to the transfer policy applies to MS-DRG 789. The weighting factor for this MS-DRG assumes that the patient will be transferred, since a transfer is part of the definition. Therefore, a hospital that transfers a patient classified into this MS-DRG is paid the full amount of the prospective payment rate associated with the DRG rather than the per diem rate, plus any outlier payment, if applicable.
Transfers from an IPPS Acute Care Hospital to Hospitals or Hospital Units
Excluded from the IPPS. When patients are transferred to hospitals or units excluded from IPPS, the full inpatient prospective payment is made to the transferring hospital. The receiving hospital is paid on the basis of reasonable costs or is made at the rate of its respective payment system (e.g., freestanding psych facility).

Postacute Care Transfers. A discharge of a hospital inpatient is considered to be a transfer when the patient’s discharge is assigned to one of the qualifying Postacute MS-DRGs and the discharge is made under any of the following circumstances:

- To a hospital or distinct part hospital unit excluded from the inpatient prospective payment system. Facilities excluded from IPPS are inpatient rehabilitation facilities and units (Patient Status Code 63), long term care hospitals (Patient Status Code 62), psychiatric hospitals and units (Patient Status Code 65), children’s hospitals, and cancer hospitals (Patient Status Code 05).
- To a skilled nursing facility (Patient Status Code 03).
- To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge (Patient Status Code 06).

For these cases, the transferring hospital is paid 50 percent of the appropriate inpatient prospective payment rate and 50 percent of the appropriate transfer payment.

Refer to Table 5 of the applicable Fiscal Year IPPS Federal Register for the list of qualifying Postacute MS-DRGs and Special Pay Postacute MS-DRGs.

4.5. Payment for Blood Clotting Factor Administered to Hemophilia Inpatients. Under the IPPS, hospitals receive a special add-on payment for the costs of furnishing blood clotting factors to inpatient members with hemophilia. The clotting factor add-on payment is calculated using the number of units (as defined in the HCPCS code long descriptor) billed by the provider.

The PPS Pricer software does not calculate the payment amount. The Fiscal Intermediary Shared System (FISS) calculates the payment amount and subtracts the charges from those submitted to Pricer so that the clotting factor charges are not included in cost outlier computations.

Blood clotting factors not paid on a cost or PPS basis are priced as a drug/biological under the Medicare Part B Drug Pricing File effective for the specific date of service. The average sales price (ASP) plus 6 percent is used. The provider’s contracted rate is not applied to this payment unless specified in contract.

Pricing requirements include:

- Edits must be in place to require HCPCS codes with Rev Code 0636. Multiple iterations of the revenue code are possible with the same or different HCPCS codes. Units are not edited except to ensure a numeric value;
- Charges forwarded to Pricer are reduced by the charges for hemophilia clotting factors in revenue code 0636.

Payment will be made for the blood clotting factor only if an ICD-10-CM diagnosis code for hemophilia is included on the bill.
### Diagnosis Code (ICD-10) | Description
---|---
D68.0 | Von Willebrand's disease
D68.1 | Hereditary factor XI deficiency
D68.2 | Hereditary deficiency of other clotting factors
D68.311 | Acquired hemophilia
D68.312 | Antiphospholipid antibody with hemorrhagic disorder
D68.318 | Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors
D68.32 | Hemorrhagic disorder due to extrinsic circulating anticoagulants
D68.4 | Acquired coagulation factor deficiency
D68.51 | Activated protein C resistance
D68.52 | Prothrombin gene mutation
D68.59 | Other primary thrombophilia
D68.61 | Antiphospholipid syndrome
D68.62 | Lupus anticoagulant syndrome
D68.69 | Other thrombophilia
D68.8 | Other specified coagulation defects
D68.9 | Coagulation defect, unspecified

### 4.6. Outpatient Services Treated as Inpatient Services

**Preadmission Diagnostic Services.** Diagnostic services (including clinical diagnostic laboratory tests) provided to a member by the admitting hospital, or by an entity wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), within 3 days prior to and including the date of the member's admission are deemed to be inpatient services and included in the inpatient payment. For example, if a patient is admitted on a Wednesday, outpatient services provided by the hospital on Sunday, Monday, Tuesday, or Wednesday are included in the inpatient payment.

This provision does not apply to ambulance services and maintenance renal dialysis services. Additionally, services furnished by skilled nursing facilities, home health agencies, and hospices are excluded from the payment window provisions.

For hospitals and units excluded from IPPS, this provision applies only to services furnished within one day prior to and including the date of the member's admission. The hospitals and units that are excluded from IPPS are: psychiatric hospitals and units; inpatient rehabilitation facilities (IRF) and units; long-term care hospitals (LTCH); children's hospitals; and cancer hospitals.

The 3-day (or 1-day) payment window policy does not apply when the admitting hospital is a critical access hospital (CAH). Therefore outpatient diagnostic services rendered to a member by a CAH, or by an entity that is wholly owned or operated by a CAH, during the payment window, is not bundled on the claim for the member's inpatient admission at the CAH.

For this provision, diagnostic services are defined by the presence on the bill of the following revenue and/or CPT codes:
<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0254</td>
<td>Drugs incident to other diagnostic services</td>
</tr>
<tr>
<td>0255</td>
<td>Drugs incident to radiology</td>
</tr>
<tr>
<td>030X</td>
<td>Laboratory</td>
</tr>
<tr>
<td>031X</td>
<td>Laboratory pathological</td>
</tr>
<tr>
<td>032X</td>
<td>Radiology diagnostic</td>
</tr>
<tr>
<td>0341, 0343</td>
<td>Nuclear medicine, diagnostic/Diagnostic Radiopharmaceuticals</td>
</tr>
<tr>
<td>035X</td>
<td>CT scan</td>
</tr>
<tr>
<td>0371</td>
<td>Anesthesia incident to Radiology</td>
</tr>
<tr>
<td>0372</td>
<td>Anesthesia incident to other diagnostic services</td>
</tr>
<tr>
<td>040X</td>
<td>Other imaging services</td>
</tr>
<tr>
<td>046X</td>
<td>Pulmonary function</td>
</tr>
<tr>
<td>0471</td>
<td>Audiology diagnostic</td>
</tr>
<tr>
<td>0481, 0489-</td>
<td>Cardiology, Cardiac Catheter Lab/Other Cardiology with CPT codes 93451-93464, 93503, 93505, 93530-93533, 93561-93568, 93571-93572, G0275, and G0278 diagnostic</td>
</tr>
<tr>
<td>0482</td>
<td>Cardiology, Stress Test</td>
</tr>
<tr>
<td>0483</td>
<td>Cardiology, Echocardiology</td>
</tr>
<tr>
<td>053X</td>
<td>Osteopathic services</td>
</tr>
<tr>
<td>061X</td>
<td>MRT</td>
</tr>
<tr>
<td>062X</td>
<td>Medical/surgical supplies, incident to radiology or other diagnostic services</td>
</tr>
<tr>
<td>073X</td>
<td>EKG/ECG</td>
</tr>
<tr>
<td>074X</td>
<td>EEG</td>
</tr>
<tr>
<td>0918</td>
<td>Testing- Behavioral Health</td>
</tr>
<tr>
<td>092X</td>
<td>Other diagnostic services</td>
</tr>
</tbody>
</table>

**Other Preadmission Services.** All outpatient nondiagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the date of a member’s inpatient admission are deemed related to the admission, and thus, must be billed with the inpatient stay. Also, outpatient nondiagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the first, second, and third calendar days for a hospital paid under the IPPS preceding the date of a member’s inpatient admission are deemed related to the admission, and thus, must be billed with the inpatient stay, unless the hospital attests to specific nondiagnostic services as being unrelated to the hospital claim (that is, the preadmission nondiagnostic services are clinically distinct or independent from the reason for the member’s admission) by adding a condition code 51 (definition “51 - Attestation of Unrelated Outpatient Non- diagnostic Services”) to the separately billed outpatient non-diagnostic services claim. Outpatient nondiagnostic services provided during the payment window that are unrelated to the admission may be separately billed.

### 4.7. Transplants.
- As outlined in Section 3.1, the organ acquisition cost is not added to the DRG payment for an organ transplant (per diem pass through).
- **Pancreas Transplants.** According to Medicare coverage and reimbursement
guidelines, pancreas transplants are covered for either simultaneous pancreas-kidney (SPK) transplantation or pancreas after kidney (PAK) transplantation. They are not covered for Pancreas Transplant Alone (PTA). However, PTA may be covered in the Marketplace with authorization and determination of medical necessity.

To determine pricing of a PTA, the claims payer must bypass any applicable PRICER edit for a PAK because a prior kidney transplant cannot be determined. In bypassing the edit, the PTA may be reimbursed using the PAK pricing.

Procedures must be reported using the current ICD-10-CM procedure codes for pancreas transplants. Providers must place at least one of the following transplant procedure codes on the claim:

- 52.80  Transplant of pancreas
- 52.82  Homotransplant of pancreas
- 0FYG0Z0 Transplantation of Pancreas, Allogeneic (ICD-10)
- 0FYG0Z1 Transplantation of Pancreas, Syngeneic (ICD-10)

5. Prior Authorization (PA) Requirements

5.1. With the exception of some maternity admissions, all inpatient stays require a prior authorization and will deny without proper authorization. The inpatient authorization is a global authorization such that all covered inpatient services (e.g. professional) should be reimbursed if the inpatient stay itself is authorized. Maternity admissions for normal vaginal delivery or C-Section do not require prior authorization.

6. Claims Editing Requirements

6.1. The Medicare Code Editor (MCE) is a front-end software program that edits claims to detect incorrect billing data. They include correct ICD-9 or ICD-10 coding, coverage, and clinical edits.

7. Copays and Coinsurance

7.1. Refer to the MDwise Marketplace Individual Policy for the Schedule of Benefits which summarizes applicable coinsurance related to coverage of inpatient services. Coinsurance, not the office visit copay applies to PMP or specialist services provided with a place of service 21 (inpatient hospital), 51 (inpatient psych hospital), or other inpatient facility.
MNP - Manipulation Therapy

1. Benefit Coverage

1.1 Covered services considered under Manipulation Therapy Services include medically necessary Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back.

Osteopathic Manipulative Treatment – Osteopathic Manipulative Treatment (OMT) is a form of manual treatment applied by a physician or other qualified health care professional (physical therapist) to eliminate or alleviate somatic dysfunction and related disorders. This treatment may be accomplished by a variety of techniques.

1.2. Covered chiropractic therapy includes services provided by a licensed chiropractor who meets specified qualifying requirements, but only for treatment by means of manual manipulation of the spine to correct a subluxation. MDwise covers limited chiropractic services when performed by a chiropractor licensed by the state or jurisdiction in which he/she resides. Chiropractic services by a chiropractor are limited to Manipulation Therapy, specifically limited to covered visits for treatment by means of manual spinal manipulation.

1.3. A number of different terms composed of the following words may be used to describe manual manipulation as defined above:

- Spine or spinal adjustment by manual means;
- Spine or spinal manipulation;
- Manual adjustment; and
- Vertebral manipulation or adjustment

2. Benefit Limitations and Exclusions

2.1. Limitations

- Annual limitation of 12 approved visits. Any visits approved apply toward limitation of 12 visits.

- Manipulation therapy services performed by any qualified provider type, for example chiropractor, physician, or physical therapist, the visit type will be counted toward maximum for Manipulation Therapy Services.

- Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Manipulation Therapy Services as specified in the Schedule of Benefits.
Manipulation. Coverage of chiropractic manual manipulation service is specifically limited to covered visits for treatment by means of manual manipulation, i.e., by use of hands. Additionally, manual devices (i.e., those that are hand-held with the thrust of the force of the device being controlled manually) may be used by chiropractors in performing manual manipulation of the spine. However, no additional payment is available for use of the device, nor is an extra charge for the device itself recognized.

If a chiropractor orders, takes, or interprets an x-ray or other diagnostic procedure to demonstrate a subluxation of the spine, the x-ray can be used for documentation. However, there is no coverage or payment for these services or for any other diagnostic, interpretive, or therapeutic service ordered or furnished by the chiropractor.

Range of motion testing is considered to be included in the patient visit or manipulative treatment and may not be billed or reimbursed separately.

Activities of daily living training services will be considered to be included in the patient manipulative treatment and may not be billed or reimbursed separately.

Note – If different types of Therapy Services are performed during one Physician Home Visit, Office Service, or Outpatient Service, then each different type of Therapy Service performed will be considered a separate Therapy Visit. Each Therapy Visit will count against the applicable Maximum Visits. For example, if both a Physical Therapy Service and a Manipulation Therapy Service are performed during one Physician Home Visit, Office Service, or Outpatient Service, they will count as both one Physical Therapy Visit and one Manipulation Therapy Visit.

2.2. Exclusions

- Manipulation Therapy Services rendered in the home as part of Home Care Services are not covered.

- Maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur is excluded. Maintenance therapy includes treatment that preserves present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

3. Provider Reimbursement & Submission Requirements

3.1. The provider reimbursement is as per contracted rate utilizing the appropriate Medicare physician fee schedule as the base rate.

- Use the Medicare payment amount, if available; then apply the provider’s contracted percent of Medicare. If not, and the service code is covered, then use the Medicaid payment amount as the base. 150% of Medicaid is deemed equivalent to the Medicare rate; then apply the provider’s contracted percent of Medicare. If there is no Medicare or Medicaid rate and the service is covered, the item must be manually priced.
• If the provider is not contracted, and the service is authorized, then the following rate is applied to the applicable Medicare fee amount (or 150% of the Medicaid payment amount as the Medicare equivalent when no fee in Medicare is available and it is a covered service), unless in some case, the authorization could contain the non-contracted provider rate:

  • Facility 133%,
  • Professional claims 125%

• Site of service (non-facility and facility services) fees may apply to certain service codes

• In all cases, if the billed amount is less than the contracted payment amount, the billed amount is to be reimbursed.

3.2. Frequency of visits is no more than one per day. If additional visits are billed, additional documentation of the necessity for additional treatment must be submitted with claim and claim will be pended for review

3.3. Chiropractic services are submitted on the CMS 1500 or electronic equivalent. Covered services billed by a physician or other qualified profession (physical therapist) are billed as service provided in clinic or outpatient setting using the CMS 1500 or CMS 1450 (aka UB 04 at present) or the electronic equivalent.

4. Procedure Codes and Claim Considerations

4.1. The precise level/location of the subluxation must be specified by the chiropractor to substantiate a claim for manipulation of the spine. This designation is made in relation to the part of the spine in which the subluxation is identified.

4.2. The level/location is indicated by one of the primary diagnosis listed in the table below.

<table>
<thead>
<tr>
<th>CPT/HCPCS Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>98940</td>
<td>CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, 1-2 REGIONS</td>
</tr>
<tr>
<td>98941</td>
<td>CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, 3-4 REGIONS</td>
</tr>
<tr>
<td>98942</td>
<td>CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, 5 REGIONS</td>
</tr>
</tbody>
</table>

Chiropractic Manipulative Treatment: A chiropractor provider is to bill utilizing the above codes. The chiropractic manipulative treatment codes include a pre-manipulation patient assessment.
4.3. Osteopathic Manipulative Treatment (OMT) applied by a physician or other qualified health care professional (not chiropractor) may include the following codes for billing.

- Body regions referred to are: head, cervical, thoracic, lower extremities, upper extremities, rib cage region, abdomen and viscera region

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>98925</td>
<td>Osteopathic manipulative treatment (OMT) 1-2 body regions involved</td>
</tr>
<tr>
<td>98926</td>
<td>3-4 body regions involved</td>
</tr>
<tr>
<td>98927</td>
<td>5-6 body regions involved</td>
</tr>
<tr>
<td>98928</td>
<td>7-8 body regions involved</td>
</tr>
<tr>
<td>98929</td>
<td>9-10 body regions involved</td>
</tr>
</tbody>
</table>

5. **Prior Authorization (PA) Requirements**

5.1. Claims received for Manipulation Therapy are processed in accordance with the MDwise Marketplace Prior Authorization requirements.

5.2. Chiropractic Spinal Manipulation for members less than 5 years old requires a prior authorization.
MTS - Maternity Services

1. Benefit Coverage

1.1. Covered maternity services include:
   - Inpatient Services, including delivery
   - Outpatient Services
   - Physician Home Visits
   - Office Services (prenatal and postpartum)

   Delivery services include admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or caesarean delivery.

1.2. Coverage for the inpatient postpartum stay for the mother and their newborn child will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care and Postnatal Care.

1.3. Covered Maternity Services include post-delivery care visits at the member’s residence by a participating provider performed no later than 48 hours following discharge from the hospital, with prior authorization. Coverage for this visit includes all of the following listed below.

   - Parent education,
   - Assistance and training in breast or bottle feeding, and
   - As authorized, performance of any maternal or neonatal tests routinely performed during the usual course of inpatient care for the mother or their newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

1.4. New Dependents as a Result of Birth, Adoption, or Placement for Adoption. If a member has a new dependent as a result of birth, adoption, or placement for adoption, according to the member policy, their new dependent would be covered for an initial period of 31 days from the date of birth or adoption. The effective Date for Coverage will be upon the earlier of the date of birth, adoption or placement for adoption or the date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption. Coverage will continue for the dependent beyond 31 days, provided the member submits a form through the Exchange to add the dependent to the Contract and pay the required premium. The form must be submitted to the Exchange within 60 days after the date of birth or adoption. If the form is not submitted to the Exchange within 60 days after the date of birth or adoption, coverage will cease on the expiration of the 31 day period provided above.

1.5. MDwise will cover an examination given at the earliest feasible time to the newborn child for the detection of the following disorders.

   - Phenylketonuria.
• Hypothyroidism.
• Hemoglobinopathies, including sickle cell anemia.
• Galactosemia.
• Maple Syrup urine disease.
• Homocystinuria.
• Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health.
• Physiologic hearing screening examination for the detection of hearing impairments.
• Congenital adrenal hyperplasia.
• Biotinidase deficiency.
• Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.
• HIV testing in infants exposed to HIV/AIDS.

Deliveries performed in home setting by contracted Tier 1 providers are covered. Certified nurse midwife services are also covered as outlined in this manual’s chapter on Advanced Practice Nurses and Physician Assistants.

2. **Benefit Limitations and Exclusions**

2.1. The following benefit limitations or exclusions apply to maternity care services:

- Reimbursement is not available for CPT® code 59072 – Fetal umbilical cord occlusion, including U.S. guidance as this procedure is designed to terminate a fetus.
- The following are not covered according to Marketplace policy:
  - Placental alpha microglobulin-1 [PAMG-1] – CPT code 84112. Effective with 1.1.15 dates of service, this code is covered.
  - Three-dimensional (3-D) or four-dimensional (4-D) ultrasounds – CPT codes 76376 & 76377
  - Salivary Estriol Tests (HCPCS code S3652)
- Any services or supplies provided to a person not covered under the contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
3. **Provider Reimbursement & Submission Requirements**

3.1. **Pregnancy Related Claims** should include the following:

- Last menstrual period (LMP) in field 14 on the CMS-1500 or Data Element 1251 on the 837P. Providers must indicate the LMP on all claims. MDwise does not process for payment any claims for pregnancy-related services submitted without an LMP.
- Pregnancy indicator P in field 24H on the CMS-1500.

3.2. **Global Maternity Care Billing.** Global maternity care includes: pregnancy-related antepartum care, labor and delivery, and uncomplicated postpartum care until six weeks postpartum. When the Same Provider Group Physician and/or Other Health Care Professional provide all components of the OB package, providers are required to bill using the global maternity care CPT codes (See Section 4.1). The provider who performs the delivery should bill for the global services. Please Note: For the purposes of this policy Same Provider Group Physician and/or Other Health Care Professional includes all physicians and/or other health care professionals of the same group reporting the same federal tax identification number.

Other antepartum services such as laboratory tests (excluding chemical urinalysis), diagnostic ultrasound, amniocentesis, cordocentesis, chorionic villus sampling, fetal stress test, and fetal non-stress test are not considered part of global maternity services. They are reimbursed separately.

Physicians from different group practices may provide individual components of maternity care to a patient throughout a pregnancy. Although OB related E/M Services should be billed as a global package, itemization may occur in the following situations:

- A patient transfers into or out of a physician or group practice
- A patient is referred to another physician during her pregnancy
- A patient has the delivery performed by another physician or other health care professional not associated with her physician or group practice
- A patient terminates or miscarry her pregnancy
- A patient changes insurers during her pregnancy or the member’s coverage started after the onset of pregnancy
- The patient’s coverage terminates prior to delivery
- The antepartum care provided by the same physician group is less than the typical number of visits (usually 13) during the global OB package as defined by ACOG.

If the prenatal care has been provided by one physician and the delivery provided by a different physician not in the same provider group, payment is made to both physicians for their rendered services. The physician providing the prenatal care should bill for rendered services as soon as it is known that he/she is not/will not be the physician doing the delivery.

3.3. **C-sections.** MDwise reimburses for only one caesarean procedure regardless of the number of babies delivered during the caesarean section. Therefore, only one detail line with one unit of service is reimbursed for caesarean delivery procedure codes. See Section 4.2 for additional information about billing multiple gestations.

3.4. **Multiple birth deliveries.** Multiple birth deliveries are subject to multiple surgery reimbursement. According to Medicare multiple surgery reimbursement policy 100% of the global fee is reimbursed for the most expensive procedure and remaining procedures are reimbursed at 50% of the global fee. See Section 4.2 for additional information about billing for multiple gestations.
3.5. Birthing centers. Professional services rendered at birthing centers should be billed on a CMS-1500 Professional claim form or the HIPAA 837P transaction with place-of-service code 25 – Birthing Center. Professional services rendered at birthing centers by an Advanced Practice Nurse with provider specialty of Certified Nurse Midwife and Physicians are payable.

4. Procedure Codes and Claim Considerations

4.1. Procedures for global billing. 
MDwise reimburses for the below global OB codes when all of the antepartum, delivery and postpartum care is provided by the Same Group Physician and/or Other Health Care Professional. Claims will be adjudicated with either a single date of service or a date span. To facilitate claims processing, providers should report one unit, whether submitted with a date span or a single date of service.

<table>
<thead>
<tr>
<th>Global Delivery CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>59400</td>
<td>Routine obstetric care including antepartum care, vaginal delivery and postpartum care</td>
</tr>
<tr>
<td>59510</td>
<td>Routine obstetric care including antepartum care, cesarean delivery and postpartum care</td>
</tr>
<tr>
<td>59610</td>
<td>Routine obstetric care including antepartum care, vaginal delivery and postpartum care, after previous cesarean delivery</td>
</tr>
<tr>
<td>59618</td>
<td>Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery</td>
</tr>
</tbody>
</table>

Services Included in the Global Obstetrical Package
Per CPT guidelines and the American Congress of Obstetricians and Gynecologists (ACOG), the following services are included in the global OB package.
- All routine prenatal visits until delivery (approximately 13 for uncomplicated cases)
- Initial and subsequent history and physical exams
- Recording of weight, blood pressures and fetal heart tones
- Routine chemical urinalysis (CPT codes 81000 and 81002)
- Admission to the hospital including history and physical
- Inpatient E/M service provided within 24 hours of delivery
- Management of uncomplicated labor
- Prolonged physician services for labor and delivery services (99354, 99355, 99356, 99357, 99358, 99359, 99415 and 99416)
- Vaginal or cesarean section delivery (except for Multiple Gestation as outlined below)
- Delivery of placenta (CPT code 59414)
- Administration/induction of intravenous oxytocin (CPT codes 96365 - 96367)
- Insertion of cervical dilator on same date as delivery (CPT code 59200)
- Repair of first or second degree lacerations*
- Simple removal of cerclage (not under anesthesia)
• Uncomplicated inpatient visits following delivery
• Routine outpatient E/M services provided within 6 weeks of delivery
• Postpartum care only (CPT code 59430)

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

MDwise will not separately reimburse the above services when reported separately from the global OB Code.

Services Excluded from the Global Obstetrical Package - Per CPT guidelines and ACOG, the following services are excluded from the global OB package and may be reported separately if warranted:

• Initial E/M to diagnose pregnancy if antepartum record is not initiated at this confirmatory visit. This confirmatory visit would be supported in conjunction with the use of ICD-10-CM diagnosis code Z32.01 (Encounter for pregnancy test, result positive)
• Laboratory tests (excluding routine chemical urinalysis)
• Maternal or fetal echography procedures (CPT codes 76801, 76802, 76805, 76810, 76811, 76812, 76813, 76814, 76815, 76816, 76817, 76818, 76819, 76820, 76821, 76825, 76826, 76827 and 76828)
• Amniocentesis, any method (CPT codes 59000 or 59001)
• Cordocentesis (59012)
• Chorionic villus sampling (CVS) (CPT code 59015)
• Fetal contraction stress test (CPT code 59020)
• Fetal non-stress test (CPT code 59025)
• Amnioinfusion (CPT code 59070)
• External cephalic version (CPT code 59412)
• Insertion of cervical dilator (CPT code 59200) more than 24 hours before delivery
• E/M services for management of conditions unrelated to the pregnancy (e.g., bronchitis, asthma, urinary tract infection) during antepartum or postpartum care; the diagnosis should support these services.
• Additional E/M visits for complications or high risk monitoring resulting in greater than the typical 13 antepartum visits; per ACOG these E/M services should not be reported until after the patient delivers. Append modifier 25 to identify these visits as separately identifiable from routine antepartum visits.
• Inpatient E/M services provided more than 24 hours before delivery
• Management of surgical problems arising during pregnancy (e.g., appendicitis, ruptured uterus, cholecystectomy)

4.2. Reimbursement for twin deliveries follows ACOG's coding guidelines as outlined in the below table. Providers are required to bill using the following:

<table>
<thead>
<tr>
<th>Vaginal</th>
<th>Baby A</th>
<th>59400</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baby B</td>
<td>59409-59</td>
</tr>
<tr>
<td>VBAC®</td>
<td>Baby A</td>
<td>59610</td>
</tr>
<tr>
<td></td>
<td>Baby B</td>
<td>59612-59</td>
</tr>
<tr>
<td>Cesarean Delivery</td>
<td>Baby A &amp; Baby B</td>
<td>59510</td>
</tr>
<tr>
<td>Repeat Cesarean Delivery</td>
<td>Baby A &amp; Baby B</td>
<td>59618</td>
</tr>
<tr>
<td>Vaginal Delivery + Cesarean Delivery</td>
<td>Baby B</td>
<td>59510</td>
</tr>
</tbody>
</table>
4.3. Delivery Services Only. Following are the CPT defined delivery only codes:
- 59409 - Vaginal delivery only (with or without episiotomy and/or forceps)
- 59514 - Cesarean delivery only
- 59612 - Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
- 59620 - Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery

The delivery only codes should be reported by the Same Provider Group Physician and/or Other Health Care Professional for a single gestation when:
- The total OB package is not provided to the patient by the same single physician or group practice and itemization of services needs to occur.
- Only the delivery component of the maternity care is provided and the postpartum care is performed by another physician or group of physicians

According to CPT and ACOG coding guidelines, the following services are included in the delivery services codes and are not reimbursed separately:
- Admission to the hospital
- The admission history and physical examination
- Management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps, with or without vacuum extraction), or cesarean delivery, external and internal fetal monitoring provided by the attending physician
- Intravenous (IV) induction of labor via oxytocin (CPT codes 96365 - 96367)
- Delivery of the placenta; any method
- Repair of first or second degree lacerations
- Hospital visits related to the delivery during the delivery confinement
- Insertion of cervical dilator (CPT 59200) if performed on the same date of delivery

4.4. Delivery Only Including Postpartum Care.
If a physician performs the delivery and postpartum care with minimal or no antepartum care the following delivery plus postpartum care codes are used.
- 59410 - Vaginal delivery only including postpartum care
- 59515 - Cesarean delivery only; including postpartum care
- 59614 - Vaginal delivery only, after previous cesarean delivery including postpartum care
- 59622 - Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care

These codes should be reported by the Same Provider Group Physician and/or Other Health Care Professional for a single gestation when:
- The delivery and postpartum care services are the only services provided
- The delivery and postpartum care services are provided in addition to a limited amount of antepartum care (e.g., CPT code 59425).

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

- Hospital visits related to the delivery during the delivery confinement
- Uncomplicated outpatient visits related to the pregnancy
- Discussion of contraception

4.5. **Postpartum Care Only (CPT Code 59430)**

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

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

Evaluation and management of problems or complications related to the pregnancy when reported subsequent to CPT code 59430 are separately reimbursable.

The postpartum care only code should be reported by the Same Provider Group Physician and/or Other Health Care Professional that provides the member with postpartum care only. If a physician provides any component of antepartum along with postpartum care, but does not perform the delivery, then the services should be itemized by using the appropriate antepartum care code and postpartum care code.

4.6. **Antepartum Care Only**

As outlined in Section 3.2., although OB related E/M Services should be billed as a global package, there are circumstances where antepartum services may be billed separately. Antepartum codes 59425 (4-6 visits) and 59426 (7 or more visits) may need to be billed separately to accommodate situations when all the routine antepartum care (usually 13 visits) or global OB care may not be provided Same Group Physician and/or Other Health Care Professional.

If the patient is treated for antepartum services only, or if antepartum care provided is less than the typical number of visits (usually 13) in the global OB package, the physician and/or other health care professional should use:

- CPT code 59426 if 7 or more visits are provided
- CPT code 59425 if 4-6 visits are provided, or
- Itemize each E/M visit if only providing 1-3 visits (99211 – 99215 CPT codes).

4.7. **High Risk/Complications**

A member may be seen more than the typical 13 antepartum visits due to high risk or complications of pregnancy. The submission of these high risk or complication services is to occur at the time of delivery, because it is not until then that appropriate assessment for the number of antepartum visits can be made. MDwise will separately reimburse for E/M services associated with high risk and/or complications when modifier 25 is appended to indicate it is significant and separate from the routine antepartum care and the claim is submitted with diagnosis code O09.xxx.

4.8. **Maternal-Fetal Medicine Specialists**

A patient may see a Maternal-Fetal Medicine (MFM) Specialist in addition to a regular OB/GYN physician. The reporting of these services is dependent on whether the MFM specialists are part of the same group practice as the OB/GYN physician. If the MFM has the same federal tax identification number as the OB/GYN physician, the specialist should report the E/M services with modifier 25 to indicate significant and separately identifiable E/M services. Use of modifier 25 will indicate that the MFM service is not part of the routine antepartum care supplied by that physician group. However, if the MFM is in a different group practice than the physician(s) and
other health care professionals supplying the routine antepartum care, modifier 25 is not necessary.

4.9. Ultrasounds
MDwise allows two fetal ultrasounds per pregnancy for the following diagnosis and CPT codes (see applicable CPT codes in Table 1 below) without prior authorization (PA), during the term of the member's pregnancy. Additional ultrasounds may be authorized if determined to be medically necessary.

<table>
<thead>
<tr>
<th>Diagnosis Code (ICD-10)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>O00.xx</td>
<td>Ectopic pregnancy</td>
</tr>
<tr>
<td>O01.xx</td>
<td>Hydatidiform mole</td>
</tr>
<tr>
<td>O02.xx</td>
<td>Other abnormal products of conception</td>
</tr>
<tr>
<td>O03.xx</td>
<td>Spontaneous abortion</td>
</tr>
<tr>
<td>O08.xx</td>
<td>Complications following ectopic and molar pregnancy</td>
</tr>
<tr>
<td>O09.xx</td>
<td>Supervision of high risk pregnancy</td>
</tr>
<tr>
<td>O10.0x - O16.1x</td>
<td>Edema, proteinuria and hypertensive disorders in pregnancy, childbirth and the puerperium</td>
</tr>
<tr>
<td>O20.0x - O29.9x</td>
<td>Other maternal disorders predominantly related to pregnancy</td>
</tr>
<tr>
<td>O30.0x - O48.1x</td>
<td>Maternal care related to the fetus and amniotic cavity and possible delivery</td>
</tr>
<tr>
<td>O60.0.0x</td>
<td>Preterm labor without delivery</td>
</tr>
<tr>
<td>O88.xx</td>
<td>Obstetric embolism</td>
</tr>
<tr>
<td>O98.0x - O9A.4x</td>
<td>Other obstetric conditions, not elsewhere classified</td>
</tr>
<tr>
<td>Z34.xx</td>
<td>Encounter for supervision of pregnancy</td>
</tr>
</tbody>
</table>

Table 1: CPT Codes Subject to Allowance of Twp Diagnostic Ultrasound without PA

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>76801</td>
<td>Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (&lt;14 weeks 0 days), transabdominal approach; single or first gestation</td>
</tr>
<tr>
<td>76802</td>
<td>Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (&lt;14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>76805</td>
<td>Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (&gt; or = 14 weeks 0 days), transabdominal approach; single or first gestation</td>
</tr>
</tbody>
</table>
Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)

Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation

Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)

Ultrasound, pregnant uterus, real time with image documentation, limited (e.g., fetal heartbeat, placental location, fetal position and/or qualitative amniotic fluid volume), one or more fetuses

Ultrasound, pregnant uterus, real time with image documentation, follow-up (e.g., re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus

Ultrasound, pregnant uterus, real time with image documentation, transvaginal

MDwise does not cover the following 3D or 4D ultrasounds for pregnant members because each is considered experimental, investigational, or unproven.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>76376</td>
<td>3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; not requiring image postprocessing or an independent workstation.</td>
</tr>
<tr>
<td>76377</td>
<td>3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; requiring image postprocessing or an independent workstation.</td>
</tr>
</tbody>
</table>
4.10. E/M Service with an Obstetrical Ultrasound Procedure

An E/M service may be separately reimbursed in addition to an OB ultrasound procedures (CPT codes 76801-76817 and 76820-76828) only if the E/M service has modifier 25 appended to the E/M code. If the patient is having an OB ultrasound and an E/M visit on the same date of service, per ACOG coding guidelines, the E/M service may be reported in addition to the OB ultrasound if the visit is identified as distinct and separate from the ultrasound procedure.

17P. MDwise considers weekly injections of 17 alpha hydroxyprogesterone (17P) between weeks 16 and 36 of gestation medically necessary in pregnant women with a prior history of preterm delivery before 37 weeks of gestation. Use of 17P as a technique to prevent preterm labor in other pregnant women who do not meet the above criteria and in those with other risk factors for preterm delivery, including but not limited to multiple gestations, short cervical length, or positive tests for cervicovaginal fetal fibronectin, continues to be considered investigational, and, therefore, remains a noncovered therapy. Prior authorization is required for 17P and is covered through the pharmacy benefit, not the medical benefit.

4.11. Home Tocolytic Infusion Therapy

Coverage is available for home tocolytic infusion therapy utilizing a home uterine monitoring device. To qualify for this therapy, the member must, at a minimum meet the following criteria:

- Be at least 24 to 34 weeks gestation
- Be in current preterm labor. Preterm labor is defined as greater than or equal to six contractions per hour
- Have a cervical dilation of greater than or equal to one centimeter, or an effacement of greater than or equal to 75 percent
- Have direct home telephone access to providers, which means having a working telephone
- Have experienced secondary failure to wean from infused tocolytics, or have failed oral therapy and require continued infusion therapy
- Have an OB/GYN as the referring physician, or have had a consultation with an OB/GYN

Cases of premature labor treated with oral medication only or requests for home uterine monitoring devices alone for the purpose of screening high-risk pregnancies will not be approved. Members who receive only oral medications or who require only home uterine monitoring devices do not qualify for tocolytic infusion therapy.

Prior authorization is required for home tocolytic infusion therapy and all PA requests will be forwarded to a physician for review and determination.
Tocolytic Therapy Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9349</td>
<td>Home infusion therapy, tocolytic infusion therapy, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
<tr>
<td>99601</td>
<td>Home infusion/specialty drug administration, per visit (up to 2 hours);</td>
</tr>
<tr>
<td>99602</td>
<td>Home infusion/specialty drug administration, per visit (up to 2 hours); each additional hour (List separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>

CPT® procedure codes 99601 and 99602 are used if a member meets the criteria for home tocolytic infusion therapy and the agency is providing the home uterine monitoring and skilled nursing components of the therapy only (rather than the entire package noted in S9349). When the home health agency bills 99601 and 99602, the tocolytic drugs and other supplies must be supplied and billed separately through another provider. The home health agency should provide only the home uterine monitor and the skilled nursing components of the home tocolytic infusion therapy. The home health agency may bill 99601 for the first two hours of therapy and bill 99602 for each additional hour of therapy, up to 22 additional hours for each 24-hour period.

HHAs may bill for S9349, 99601, and 99602 using standard home health care billing guidelines. All supplies for each therapy are bundled into a daily rate, and HHAs are not allowed to bill separately for any supplies associated with these therapies.

Providers are allowed to bill one unit of service daily and should use revenue code 559 when billing S9349, 99601, and 99602.

4.12. Other Outpatient Office Visits. Coverage is allowed for CPT procedure codes 99211–99215 or 99241-99245 for outpatient office visits rendered to pregnant members, if the service is related to a concurrent medical condition requiring medical care or consultative referral. Additionally, coverage is allowed for an E/M code on the first prenatal visit. The concurrent condition must be identified as either a primary or secondary condition by a valid ICD-10-CM diagnosis code.

4.13. Newborn Services. Per the member policy, covered Marketplace services for a newborn child (birth or adoption) may be reimbursed under the mother’s policy for the first 31 days of life. If a newborn receives a Marketplace Policy and ID# prior to the end of the 31 days, providers are instructed to use the member’s ID# instead of the mother’s ID# and mother’s name for billing purposes. However, if a claim is submitted under the mother’s ID# and mother’s name in the first 31 days and the service is covered, the claim is eligible for reimbursement.
If a claim is received for a newborn past the 31 days with the mother’s ID # and mother’s name, the claim may be denied with a request to submit the claim under the member’s policy.

The mother has 60 days after the date of birth or adoption to submit the policy request through the exchange. If the form is not submitted within 60 days, coverage will cease on the expiration of the 31 day period.

Regarding inpatient services, if a newborn inpatient stay is longer than 31 days, then the inpatient stay should be reimbursed under the newborn’s policy, not the mother’s policy. If the claims payer receives an inpatient claim with a length of stay of 32 days or longer under the mother’s ID# and mother’s name, the claim may be denied with a request to submit the claim under the member’s policy. If the mother fails to obtain coverage for the newborn, the Marketplace would be liable for that portion of the DRG and any applicable outlier that is related to the first 31 days of the inpatient stay.

If a newborn child is required to stay as an inpatient past the mother’s discharge date, the Health Services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Coinsurance/Copay.

5. Prior Authorization (PA) Requirements

5.1. Claims received for maternity care services are processed in accordance with the MDwise Marketplace Prior Authorization requirements. The following require prior authorization:
- More than 2 OB ultrasound per pregnancy
- Home Tocolytic Infusion Therapy
- Genetic Testing (e.g. trisomy testing, First Trimester Fetal Nuchal Translucency Ultrasound – CPT codes 76813, 76814, 84163, 84702, 84703, 84704)
- Home health services

6. Copays and Coinsurance

6.1. According to the schedule of benefits, the following apply to coverage of maternity benefits.

- For prenatal and post-partum care services, there are no member cost-sharing requirements. This includes any prenatal or postpartum care claim (non-inpatient) with the following primary diagnosis:

**ICD-10 Diagnoses Codes**

<table>
<thead>
<tr>
<th>O00.xx - O03.xx</th>
<th>O09.xx</th>
<th>O10.01x</th>
</tr>
</thead>
<tbody>
<tr>
<td>O10.11x O10.41x</td>
<td>O10.21x</td>
<td>O10.31x O11.x</td>
</tr>
<tr>
<td>O10.91x</td>
<td>O11.x</td>
<td>O11.x</td>
</tr>
<tr>
<td>O20.0x - O23.9x</td>
<td>O24.01x</td>
<td>O24.11x</td>
</tr>
<tr>
<td>O24.31x</td>
<td>O24.41x</td>
<td>O24.81x</td>
</tr>
<tr>
<td>O24.91x</td>
<td>O25.1x</td>
<td>O26.0x - O26.61x</td>
</tr>
<tr>
<td>O26.71x</td>
<td>O26.8x - O28.9x</td>
<td>O30.xxx - O31.xxx</td>
</tr>
<tr>
<td>O34.xxx</td>
<td>O36.xxx</td>
<td>O40.xxx - O41.xxx</td>
</tr>
<tr>
<td>O43.xxx - O48.1x</td>
<td>O60.0.0x</td>
<td>O88.xx - O88.11x</td>
</tr>
<tr>
<td>O88.12x</td>
<td>O88.31x</td>
<td>O88.81x</td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>O91.01x</td>
<td>O91.11x</td>
<td>O91.21x</td>
</tr>
<tr>
<td>O92.01x</td>
<td>O92.21x</td>
<td>O98.01x</td>
</tr>
<tr>
<td>O98.11x</td>
<td>O98.21x</td>
<td>O98.31x</td>
</tr>
<tr>
<td>O98.41x</td>
<td>O98.51x</td>
<td>O98.71x</td>
</tr>
<tr>
<td>O98.81x</td>
<td>O98.91x</td>
<td>O99.01X</td>
</tr>
<tr>
<td>O99.11x</td>
<td>O99.210 - 213</td>
<td>O99.280 - 283</td>
</tr>
<tr>
<td>O99.51x</td>
<td>O99.61x</td>
<td>O99.71x</td>
</tr>
<tr>
<td>O99.810</td>
<td>O99.820</td>
<td>O99.830</td>
</tr>
<tr>
<td>O99.840x</td>
<td>O9A.11x</td>
<td>O9A.21x</td>
</tr>
<tr>
<td>O9A.31x</td>
<td>O9A.41x</td>
<td>O9A.51x</td>
</tr>
<tr>
<td>Z34.xx</td>
<td>Z36</td>
<td>Z39.x</td>
</tr>
</tbody>
</table>
OHS - Outpatient Hospital Services

1. Benefit Coverage

1.1. Outpatient hospital services include surgery, therapy, laboratory, radiology, chemotherapy, renal dialysis, clinic, treatment room, and emergency department care.

1.2. Coverage for outpatient hospital surgical services includes but is not limited to the list below

- Performance of accepted operative and other invasive procedures
- The correction of fractures and dislocations.
- Operative and cutting procedures.
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy.
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.
- Sterilization
- Temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders if provided within MDwise guidelines.
- Other procedures approved by MDwise

1.3. Reconstructive Services - Certain Reconstructive Services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive Services required due to prior therapeutic process are payable only if the original procedure would have been a covered service under the members contract.

Covered Reconstructive Services are limited to the following list.

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child.
- Breast reconstruction resulting from a mastectomy.
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger.
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia.
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect.
- Tongue release for diagnosis of tongue-tied.
- Congenital disorders that cause skull deformity such as Crouzon’s disease.
- Cleft lip.
- Cleft palate.

1.4. Mastectomy

A member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will also receive Coverage for all of the following listed below.

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
• Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

2. Benefit Limitations and Exclusions

2.1. The following benefit limitations or exclusions apply to outpatient services:

• Any procedures, services, equipment or supplies provided in connection with cosmetic services. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the member was covered by another plan prior to MDwise coverage. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to myocardial infarction, pulmonary embolism, thrombophlebitis, and exacerbation of co-morbid conditions.

• Abortion, except in the following cases.
  o The pregnant woman became pregnant through an act of rape or incest.
  o An abortion is necessary to avert the pregnant woman’s death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

• Surgical treatment of gynecomastia.

• Reconstructive Health Services except as specifically stated in Section 1.3 or as required by law.

• Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

• Treatment of telangiectatic dermal veins (spider veins) by any method.

• Surgical treatment of flat feet, subluxation of the foot, weak, strained, unstable feet, tarsalgia, metatarsalgia, hyperkeratosis

• Bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery, or Gastroplasty, or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by MDwise, are not covered. This exclusion applies even if the original treatment or surgery was performed while the member was covered by another plan prior to MDwise coverage. Directly related means that the treatment or surgery occurred as a direct result of the bariatric surgery and would not have taken place in the absence of the surgery. This exclusion does not apply to conditions including but not limited to myocardial infarction, pulmonary embolism, thrombophlebitis, and exacerbation of co-morbid conditions.

• Services to reverse voluntarily induced sterility.

• Eye surgery to correct errors of refraction, such as near-sightedness, including without
limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

- Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. Effective with dates of service 1.1.16 and beyond, the exclusion related to erectile dysfunction and surgeries for sexual dysfunction is no longer in effect and such services are eligible for coverage. Effective with dates of service 1.1.17 and beyond, the exclusion related to gender transition is no longer in effect and such services are eligible for coverage (45 CFR § 92.207(b)(4) 45 CFR § 92.207(b)(5)).

- Outpatient Intravenous Insulin Treatment (OIVIT).

- With the exception of emergency services, all services provided by out of network providers require prior authorization.

3. Provider Reimbursement & Submission Requirements

3.1. Outpatient hospital services are reimbursed according to the Medicare Ambulatory Payment Classification (APC) system, using the Hospital Outpatient Prospective Payment System (OPPS) pricer. Services are billed on a UB-04 claim form. Each line on the claims is evaluated for payment or nonpayment using the status indicator. The status indicator is assigned for each procedure or service performed and determines the payment mechanism to be applied for that line.

The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. For example, services with status indicator A are paid under a fee schedule or payment system other than the OPPS. Services with status indicator N are paid under the OPPS, but their payment is packaged into payment for a separately paid service. Services with status indicator T are paid separately under OPPS but a multiple procedure payment reduction applies when two or more services with a status indicator of T are billed on the same date of service. The full list of status indicators and their definitions is published in Addendum D1 of the OPPS/ASC proposed and final rules each year. The status indicator for each HCPCS code is shown in OPPS Addendum B.

If the claim contains only services payable under a fee schedule, such as clinical diagnostic laboratory tests, and also contains services that would be packaged services if an APC were payable, the packaged services are not separately payable. If the claim contains only services payable under cost reimbursement, such as corneal tissue, and services that would be packaged services if an APC were payable, then the packaged services are not separately payable. If a claim contains services payable under cost reimbursement, services payable under a fee schedule, and services that would be packaged services if an APC were payable, the packaged services are not separately payable.

3.2. Packaging Types under the OPPS

- Unconditionally packaged services are services for which separate payment is never made because the payment for the service is always packaged into the payment for other services. Unconditionally packaged services are identified in the OPPS Addendum B with status indicator
of N.

- STV-packaged services are services for which separate payment is made only if there is no service with status indicator S, T, V or X reported with the same date of service on the same claim. If a claim includes a service that is assigned status indicator S, T, V, or X reported on the same date of service as the STVX-packaged service, the payment for the STVX-packaged service is packaged into the payment for the service(s) with status indicator S, T, V or X and no separate payment is made for the STVX-packaged service. STVX-packaged services are assigned status indicator Q1.

- T-packaged services are services for which separate payment is made only if there is no service with status indicator T reported with the same date of service on the same claim. When there is a claim that includes a service that is assigned status indicator T reported on the same date of service as the T-packaged service, the payment for the T-packaged service is packaged into the payment for the service(s) with status indicator T and no separate payment is made for the T-packaged service. T-packaged services are assigned status indicator Q2.

- A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Services mapped to composite APCs are assigned status indicator Q3.

- Comprehensive APCs provide a single payment for a primary service, and payment for all adjunctive services reported on the same claim is packaged into payment for the primary service. With few exceptions, all other services reported on a hospital outpatient claim in combination with the primary service are considered to be related to the delivery of the primary service and packaged into the single payment for the primary service. HCPCS codes assigned to comprehensive APCs are designated with status indicator J1.

- Conditionally packaged laboratory services - Status indicator “Q4” designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “J1,” “J2,” “S,” “T,” “V,” “Q1,” “Q2,” or “Q3.” The “Q4” status indicator was created to identify 13X bill type claims where there are only laboratory HCPCS codes that appear on the Clinical Laboratory Fee Schedule, change their status indicator to “A,” and pay them separately at the CLFS payment rates.

### 3.3. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting as outlined below.

### 3.4. Procedure codes are required for all outpatient hospital services unless specifically excluded as outlined in the Medicare Claims Processing manual. When medical and surgical supplies (other than prosthetic and orthotic devices as described in the Medicare Claims Processing Manual, Chapter 20, §10.1) described by HCPCS codes with status indicators other than “H” or “N” are provided incident to a physician’s service by a hospital outpatient department, the HCPCS codes for these items do not to be included because these items represent supplies. When hospital outpatient staff provide a prosthetic or orthotic device, and the HCPCS code that describes that device includes the fitting, adjustment, or other services necessary for the patient’s use of the item, the hospital should not bill a visit or procedure.

### 3.5. In cases where there are separate codes for the technical component, professional component, and/or complete procedure, hospitals should report the code that represents the technical component for their facility services. If there is no separate technical component code for the service, hospitals should report the code that represents the complete procedure.

### 3.6. Reimbursement Rates. In accordance with the Marketplace policy, the APC rate(s) returned from the pricer are then multiplied by the provider’s contracted rate, for example 163% for a Qualified Health Plan (QHP) I contracted provider. If there is no Medicare rate, and the service
code is covered, use 150% of the Medicaid payment amount. 150% of Medicaid is deemed equivalent to the Medicare rate; then apply the provider’s contracted percent of Medicare.

If the provider is not contracted the lowest QHP rate is used to calculate the reimbursement rate. For facilities, this would be 133%, and for professional claims, 125%. In some case, the authorization could contain the non-contracted provider reimbursement for the service in question.

- In all cases, if the billed amount is less than the contracted payment amount, the billed amount is to be reimbursed.

3.7. Inpatient Stays Less than 24 Hours. Providers should bill any inpatient stay that is less than 24 hours as an outpatient service. Inpatient stays less than 24 hours that are billed as an inpatient service will be denied. Claims grouping to AP-DRG 637 – Neonate, died w/in one day of birth, born here or DRG 638 – Neonate, died w/in one day of birth, not born here are exempt from this policy because they are specific to one-day stays.

3.8. Multiple Surgeries. Multiple surgeries can be determined by the presence of the “-51” modifier and the billing of more than one separately payable surgical procedure performed on the same patient on the same day. The OPPS pricer determines whether standard payment policy rules apply to a multiple surgery, or whether special payment rules apply. Payment for each OPPS eligible procedure is based on the lower of the billed amount, or:

- 100 percent of the fee schedule amount for the highest valued procedure;
- 50 percent of the fee schedule amount for the remaining procedures;

3.9. Bilateral Surgeries. Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day. The payment adjustment rules for bilateral surgeries do not apply to procedures identified by CPT as “bilateral” or “unilateral or bilateral” since the fee schedule reflects any additional work required for bilateral surgeries.

Modifier -50, while it may be used with diagnostic and radiology procedures as well as with surgical procedures, should be used to report bilateral procedures that are performed at the same operative session as a single line item. Modifiers RT and LT are not used when modifier -50 applies. A bilateral procedure is reported on one line using modifier -50. Modifier -50 applies to any bilateral procedure performed on both sides at the same session.

Note: Please also refer to Medicare Claims Processing Manual, Chapter 4 for additional information regarding surgical processing guidelines.

3.10. Observation Care. The Marketplace allows a member to be under observation care for up to 72 hours.

Hospitals are required to report observation charges under the following revenue codes:

- 0760 General Classification category
- 0762 Observation Room
Other ancillary services performed while the patient receives observation services are reported using appropriate revenue codes and HCPCS codes as applicable.

Observation services are reported using HCPCS code G0378. G0378 for hourly observation services is assigned status indicator N, signifying that its payment is always packaged.

In certain circumstances when observation care is billed in conjunction with a high level clinic visit (Level 5), high level emergency department visit (Level 4 or 5), critical care services, or a direct referral as an integral part of a patient's extended encounter of care, payment may be made for the entire extended care encounter through one of two composite APCs when certain criteria are met.

- APC 8002 (Level I Extended Assessment and Management Composite) describes an encounter for care provided to a patient that includes a high level (Level 5) clinic visit or direct referral for observation in conjunction with observation services of substantial duration (8 or more hours).

- APC 8003 (Level II Extended Assessment and Management Composite) describes an encounter for care provided to a patient that includes a high level (Level 4 or 5) emergency department visit or critical care services in conjunction with observation services of substantial duration.

All of the following requirements must be met in order for a hospital to receive an APC payment for an extended assessment and management composite APC:

- The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.

- The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or the day before the date reported for observation:
  - An emergency department visit (CPT codes 99281 through 99285 or HCPCS code G0380 through G0384)
  - A clinic visit (HCPCS code G0463 beginning January 1, 2014; CPT code 99205 or 99215 prior to January 1, 2014)
  - Critical care (CPT code 99291); or
  - Direct referral for observation care reported with HCPCS code G0379 (APC 0604) must be reported on the same date of service as the date reported for observation services.
  - No procedure with a T or J1 status indicator can be reported on the same day or day before observation care is provided.
  - Only visits, critical care and observation services that are billed on a 13X bill type may be considered for a composite APC payment.

Non-repetitive services provided on the same day as either direct referral for observation care or observation services must be reported on the same claim because the OCE claim-by-claim logic cannot function properly unless all services related to the episode of observation care, including hospital clinic visits, emergency department visits, critical care services, and T status procedures, are reported on the same claim.
If a claim for services provided during an extended assessment and management encounter including observation care does not meet all of the requirements listed above, then the usual APC logic will apply to separately payable items and services on the claim; the special logic for direct admission will apply, and payment for the observation care will be packaged into payments for other separately payable services provided to the beneficiary in the same encounter.

Effective January 1, 2016, payment for qualifying extended assessment and management encounters is made through CMS’s newly created C-APC 8011 (Comprehensive Observation Services). Any clinic visit, emergency department, critical care visit, or direct referral for observation services furnished in a non-surgical encounter by a hospital in conjunction with observation services of eight or more hours, qualifies for comprehensive payment through C-APC 8011.

There is no limitation on diagnosis for payment of APC 8011; however, comprehensive APC payment will not be made when observation services are reported in association with a surgical procedure (T status procedure) or the hours of observation care reported are less than 8.

3.11. Direct Referral for Observation Care is reported using HCPCS code G0379. Hospitals report G0379 when observation services are the result of a direct referral for observation care without an associated emergency room visit, hospital outpatient clinic visit, or critical care service on the day of initiation of observation services. Hospitals report HCPCS code G0379 when a patient is referred directly to observation care after being seen by a physician in the community.

Payment for direct referral for observation care is made either separately as a low level hospital clinic visit under APC 0604 or packaged into payment for composite APC 8002.

Effective 1.1.16 payment for direct referral for observation care will be made either separately as a hospital visit under APC 5013 (Level 3 Examinations & Related Services) or packaged into payment for comprehensive APC 8011 (Comprehensive Observation Services) or packaged into the payment for other separately payable services provided in the same encounter.

The criteria for payment of HCPCS code G0379 under either APC 5013 or APC 8011 include:
- Both HCPCS codes G0378 and G0379 are reported with the same date of service.
- No service with a status indicator of T or V or Critical Care (APC 0617) is provided on the same day of service as HCPCS code G0379.
- If either of the above criteria is not met, HCPCS code G0379 will be assigned status indicator N and will be packaged into payment for other separately payable services provided in the same encounter.

3.12. Outpatient Service within Three Days of an Inpatient Stay. Outpatient services that occur within three days preceding an inpatient admission to the same facility for the same or related diagnosis are considered part of the corresponding inpatient admission. Providers are required to submit an inpatient claim only when the services, outpatient and inpatient, occur at their facility. If an outpatient claim is paid before the inpatient claim is submitted, the inpatient claim should deny with an explanation of benefits (EOB) code indicating that the provider should bill services on the inpatient claim. The provider can then void the outpatient claim and resubmit one inpatient claim. If an outpatient claim is submitted subsequent to the payment of an inpatient claim, the outpatient claim will deny with an EOB indicating that the inpatient claim may be adjusted to reflect the outpatient services provided to the patient. Ambulance and maintenance renal dialysis services are not subject to the payment window. A hospital may also attest to specific non-diagnostic services being unrelated to the inpatient claim by adding a condition code.
51 to the separately billed outpatient non-diagnostic services claim.

Note: Same or related refers to the principal diagnosis code and is based on the first three digits of the ICD-10-CM code. This policy is not applicable when the outpatient and inpatient services are provided by different facilities.

3.13. Outpatient Service within Three Days of a 24-Hour Inpatient Stay. Outpatient services within three days, preceding a less than 24-hour inpatient stay, are billed as an outpatient service. Because the inpatient service was less than 24 hours, it too should be billed as an outpatient service.

3.14. Partial Hospitalization (PH) and Intensive Outpatient (IOP) Services. PHI and IOP services are not priced through the OPPS for the Marketplace product. Please refer to Behavioral Health Services for reimbursement methodology related to these services.

4. Procedure Codes and Claim Considerations

4.1. Critical Access Hospitals (CAH) CAH’s are reimbursed per the CMS reimbursement rate set for their facility.

4.2. Inpatient Only Services. According to Medicare rules, certain services are reimbursable only if provided in an inpatient setting. However, these “Medicare inpatient only” services may be eligible for reimbursement under the Marketplace in both outpatient and inpatient settings. Medicare inpatient only services are identified through the OPPS pricer with a Status C indicator. If an outpatient claim has a service with a Status C indicator, the entire claim should be processed according to outpatient reimbursement methodology outlined in the IHCP Provider Manual following ASC pricing logic. To determine pricing, base ASC rate should be calculated at 150% of Medicaid fee schedule (to determine Medicare equivalency). The provider’s contracted percent of Medicare rate is then applied. Outpatient reimbursement rules, such as multiple surgeries, bilateral surgeries and the payment of stand-alone and add on services should be followed in the pricing of the claim. The exception to this policy concerns the following CPT codes:

- CPT code 44206 – Laparoscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure)
- CPT code 44207 – Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)
- CPT code 44208 – Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy
- CPT code 44213 – Laparoscopy, surgical, mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy

These codes are not covered in an outpatient setting by the IHCP, therefore they are only covered in the inpatient setting for the Marketplace.

If a “Medicare inpatient only” surgical procedure is performed for which there is no ASC numeric code on the IHCP fee schedule and the code is covered (see IHCP fee schedule and the ASC assigned numeric code located to the right of the pricing information) or there is a service for which no fee amount is assigned, notify MDwise via email that there is no pricing for this service. MDwise will then determine pricing.

Please note: The above reimbursement policy does not apply to inpatient only procedures that are provided to a patient in the outpatient setting on the date of the patient’s inpatient admission or during the 3 calendar days (or 1 calendar day for psychiatric hospitals and units, inpatient
rehabilitation hospitals and units, long-term care hospitals, children’s hospitals, and cancer hospitals). These services furnished by the hospital (or by an entity that is wholly owned or wholly operated by the hospital) for same or similar diagnosis are deemed to be related to the admission and are not reimbursable.

Please note: Effective with dates of service 1.1.2016 and beyond, the Marketplace follows CMS rules related to coverage of inpatient only services and Section 4.2. is no longer applicable.

4.3. **Modifiers.** There are a number of modifiers that can be used by providers and can affect payment of claim. The complete list can be found in the CMS manual, on the CMS website, or at www.wpsmedicare.com.

The Integrated Outpatient Code Editor (I/OCE) accepts all valid CPT and HCPCS modifiers on OPPS claims. Definitions for the following modifiers may be found in the CPT and HCPCS guides:

- **Level I (CPT) Modifiers**
  - -25, -27, -50, -52, -58, -59, -73, -74, -76, -77, -78, -79, -91

- **Level II (HCPCS) Modifiers**
  - -CA, -E1, -E2, -E3, -E4, -FA, -FB, -FC, -F1, -F2, -F3, -F4, -F5, -F6, -F7, -F8, -F9, -GA, -GG, -GH, -GY, -GZ, -LC, -LD, -LT, -QL, -QM, -RC, -RT, -TA, -T1, -T2, -T3, -T4, -T5, -T6, -T7, -T8, -T9

Modifiers may be applied to surgical, radiology, and other diagnostic procedures.

MDwise may receive claims for surgical procedures with more than one surgical modifier. For example, MDwise may receive a claim for surgical care only (modifier “-54”) for a bilateral surgery (modifier “-50”).

Effective January 1, 2016, modifier -PO is to be reported with every HCPCS code for all outpatient hospital items and services furnished in an off-campus provider-based department of a hospital. This modifier should not be reported for remote locations of a hospital, satellite facilities of a hospital, or for services furnished in an emergency department.

Effective January 1, 2016, modifier – CT is to be reported with certain Computed tomography (CT) scan CPT codes in which equipment is used that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) XR-29-2013 standard.” The applicable CT services are identified by HCPCS codes 70450 through 70498; 71250 through 71275; 72125 through 72133; 72191 through 72194; 73200 through 73206; 73700 through 73706; 74150 through 74178; 74261 through 74263; and 75571 through 75574 (and any succeeding codes). The use of this modifier will result in a payment reduction of 5% in CY 2016 for the applicable CT services when the service is paid separately. The payment reduction will also be applied to the APC payment for the HCPCS codes listed above that are subject to the multiple imaging composite policy.

4.4. **Discounting.** Fifty percent of the full OPPS amount is paid if a procedure for which anesthesia is planned is discontinued after the patient is prepared and taken to the room where the procedure is to be performed but before anesthesia is provided. These situations are indicated by Modifier 73.

Fifty percent of the full OPPS amount is paid if a procedure for which anesthesia is not planned is discontinued after the patient is prepared and taken to the room where the procedure is to be performed. These situations are indicated by Modifier 52.
Procedures that are discontinued, partially reduced or cancelled after the procedure has been initiated and/or the patient has received anesthesia will be paid at the full OPPS payment amount. Modifier -74 is used for these procedures.

4.5. Blood and Blood Supplies. Hospital outpatient departments receive a separate APC payment for blood processing in addition to the APC payment for the transfusion procedure.

- **Pass Thru on Blood and Blood Supplies**-When an OPPS provider furnishes blood or a blood product collected by its own blood bank for which only processing and storage costs are assessed, or when an OPPS provider procures blood or a blood product from a community blood bank for which it is charged only the processing and storage costs incurred by the community blood bank, the OPPS provider bills the processing and storage charges using Revenue Code 0390 (Blood Processing/Storage), 0392 (Blood Processing/Storage; Processing and Storage), or 0399 (Blood Processing/Storage; Other Processing and Storage), along with the appropriate blood HCPCS code, the number of units transfused, and the line item date of service (LIDOS). Processing and storage costs may include blood product collection, safety testing, retyping, pooling, irradiating, leukocyte-reducing, freezing, and thawing blood products, along with the costs of blood delivery, monitoring, and storage. In general, such categories of processing costs are not patient-specific. There are specific blood HCPCS codes for blood products that have been processed in varying ways, and these codes are intended to make payment for the variable resource costs of blood products that have been processed differently.

- **Blood Product Charges** - If an OPPS provider pays for the actual blood or blood product itself, in addition to paying for processing and storage costs when blood or blood products are supplied by either a community blood bank or the OPPS provider’s own blood bank, the OPPS provider must separate the charge for the unit(s) of blood or blood product(s) from the charge for processing and storage services. The OPPS provider reports charges for the blood or blood product itself using Revenue Code series 038X (excluding 0380, which is not a valid revenue code for Medicare billing) with the LIDOS, the number of units transfused, and the appropriate blood product HCPCS code and HCPCS modifier BL. The OPPS provider reports charges for processing and storage services on a separate line using Revenue Code 0390, 0392, or 0399 with the LIDOS, the number of units transfused, and the appropriate blood product HCPCS code and HCPCS modifier BL. The same LIDOS, the same number of units, the same HCPCS code, and HCPCS modifier BL must be reported on both lines. This requirement applies to all OPPS providers that transfuse blood and incur charges for both the blood itself and processing and storage. Effective for services furnished on or after July 1, 2005, the I/OCE will return to providers any claim that reports a charge for blood or blood products using Revenue Code 038X without a separate line for processing and storage services using Revenue Code 0390, 0392, or 0399. Moreover, in order to process to payment, both lines must report the same line item date of service, the same number of units, and the same HCPCS code accompanied by modifier BL. Payment for blood and blood products is based on the Ambulatory Payment Classification (APC) Group to which its HCPCS code is assigned, multiplied by the number of units transfused.

- For additional information about the reimbursement for blood products, please refer to Chapter 4 of the Medicare Claims Processing Manual.

4.6. Brachytherapy Sources. Brachytherapy sources (e.g., brachytherapy devices or seeds,
solutions) are paid separately from the services to administer and deliver brachytherapy in the OPPS, reflecting the number, isotope, and radioactive intensity of devices furnished, as well as stranded versus non-stranded configurations of sources. Therefore, providers must bill for brachytherapy sources in addition to the brachytherapy services with which the sources are applied, in order to receive payment for the sources. The separately payable sources are found in Addendum B of the most recent OPPS annual update published on the CMS web site. New sources meeting the OPPS definition of a brachytherapy source may be added for payment beginning any quarter, and the new source codes and descriptors are announced in recurring update notifications.

Each unit of a billable source is identified by the unit measurement in the respective source's long descriptor. Seed-like sources are generally billed and paid “per source” based on the number of units of the source HCPCS code reported, including the billing of the number of sources within a stranded configuration of sources. Providers therefore must bill the number of units of a source used with the brachytherapy service rendered.

4.7. Transitional Pass-Through for Designated Devices. Certain designated new devices are assigned to APCs and identified by the OCE as eligible for payment based on the reasonable cost of the new device reduced by the amount included in the APC for the procedure that reflects the packaged payment for devices used in the procedures assigned to the APC. All related payment calculations will be returned on the same APC line and identified as a designated new device.

Refer to https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html on the CMS website for the most current OPPS APC Offset File.

4.8. Corneal Tissue. Corneal tissue is paid on a cost basis, not under OPPS only when it is used in a corneal transplant procedure described by one of the following CPT codes: 65710, 65730, 65750, 65755, 65756, 65765, 6576, and any successor code or new code describing a new type of corneal transplant procedure that uses eye banked corneal tissue. In all other procedures corneal tissue is packaged. To receive cost based reimbursement hospitals must bill charges for corneal tissue using HCPCS code V2785.

4.9. Condition Code G0. Multiple medical visits on the same day in the same revenue center may be submitted on separate claims. Hospitals should report condition code G0 on the second claim. Appropriate reporting of Condition Code G0 allows for accurate payment under OPPS in this situation. The OCE contains an edit that will reject multiple medical visits on the same day with the same revenue code without the presence of Condition Code G0.

4.10. Hospital Dialysis Services. Hospital-based End Stage Renal Disease (ESRD) facilities must submit services covered under the ESRD benefit (maintenance dialysis and those items and services directly related to dialysis such as drugs, supplies) on a separate claim from services not covered under the ESRD benefit. Items and services not covered under the ESRD benefit must be billed by the hospital using the hospital bill type and be paid under the Outpatient Prospective Payment System (OPPS).

The Marketplace does not allow payment for routine or related dialysis treatments, which are covered and paid under the ESRD PPS, when furnished to ESRD patients in the outpatient department of a hospital, unless it is a certified ESRD facility. However, in certain medical situations in which the member cannot obtain her or his regularly scheduled dialysis treatment at a certified ESRD facility, payment is allowed for non-routine dialysis treatments furnished to ESRD outpatients in the outpatient department of a hospital. Payment for unscheduled dialysis furnished to ESRD outpatients and paid under the OPPS is limited to the following circumstances:
• Dialysis performed following or in connection with a dialysis-related procedure such as vascular access procedure or blood transfusions;
• Dialysis performed following treatment for an unrelated medical emergency; e.g., if a patient goes to the emergency room for chest pains and misses a regularly scheduled dialysis treatment that cannot be rescheduled, MDwise allows the hospital to provide and bill Medicare for the dialysis treatment; or
• Emergency dialysis for ESRD patients who would otherwise have to be admitted as inpatients in order for the hospital to receive payment.

In these situations, non-ESRD certified hospital outpatient facilities are to bill using HCPCS code G0257 (Unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not certified as an ESRD facility).

• HCPCS code G0257 may only be reported on type of bill 13X (hospital outpatient service) or type of bill 85X (critical access hospital) because HCPCS code G0257 only reports services for hospital outpatients with ESRD and only these bill types are used to report services to hospital outpatients.
• HCPCS code 90935 (Hemodialysis procedure with single physician evaluation) may be reported and paid only if the member does not have ESRD and is receiving hemodialysis in the hospital outpatient department. The service is reported on a type of bill 13X or type of bill 85X.

• CPT code 90945 (Dialysis procedure other than hemodialysis (e.g. peritoneal dialysis, hemofiltration, or other continuous replacement therapies)), with single physician evaluation, may be reported by a hospital paid under the OPPS on type of bill 12X, 13X or 85X.

4.11. Nuclear Medicine Procedures. Hospitals are required to submit the HCPCS code for a radiolabeled product on the same claim as the HCPCS code for the nuclear medicine procedure. Hospitals are instructed to use HCPCS code C9898 (Radiolabeled product provided during a hospital inpatient stay) on outpatient claims for nuclear medicine procedures to indicate that a radiolabeled product that provides the radioactivity necessary for the reported diagnostic nuclear medicine procedure was provided during a hospital inpatient stay. This HCPCS code is assigned status indicator “N” because no separate payment is made for the code under the OPPS. Because the OPPS requires that there be a charge for each HCPCS code reported on the claim, hospitals should always report a token charge of less than $1.01 for HCPCS code C9898. The date of service reported on the claim for HCPCS code C9898 should be the same as the date of service for the nuclear medicine procedure HCPCS code.

4.12. Outpatient Intravenous Insulin Treatment (OIVIT). CMS has determined that the evidence does not support a conclusion that OIVIT improves health outcomes in members. In accordance with this ruling, as well as review of other applicable research studies, MDwise does not cover OIVIT.

This includes the following procedure codes:
G9147 | Outpatient Intravenous Insulin Treatment (OIVIT) either pulsatile or continuous, by any means, guided by the results of measurements for: respiratory quotient; and/or, urine urea nitrogen (UUN); and/or, arterial, venous or capillary glucose; and/or potassium concentration

94681 | Oxygen uptake, expired gas analysis; including CO₂ output, percentage oxygen extracted (should not be used in conjunction with OIVIT or diabetes-related conditions)

4.13. **Manual Pricing.** CPT codes billed for the marketplace, which fall under the manual pricing logic should follow the published Medicaid rate methodology, as outlined in the below table and in the IHCP Bulletin, BT 200940 and 201213. Except for drugs and biological, which have special pricing, HCPCS codes which indicate manual pricing will be reimbursed at 60% of billed charges, or for DME products, 60% of the Manufacturers Suggested Retail Price (MSRP). For the pricing of drugs and biological, refer to BCCP 20, Pharmacy & Biologicals.

To determine the base Medicare rate for CPT codes, the applicable Medicaid rate, based on the below table is multiplied by 150%. The provider’s contracted rate is than applied to the base Medicare rate.

For HCPS codes that are paid at 60% of billed charges, there is no additional percentage applied.

<table>
<thead>
<tr>
<th>Procedure Code Range</th>
<th>Codes Billed on CMS-1500</th>
<th>Codes Billed on UB-04</th>
</tr>
</thead>
<tbody>
<tr>
<td>10000-19999</td>
<td>20% of billed Amount</td>
<td>20% of billed Amount</td>
</tr>
<tr>
<td>20000-29999</td>
<td>20% of billed Amount</td>
<td>10% of billed Amount</td>
</tr>
<tr>
<td>30000-39999</td>
<td>20% of billed Amount</td>
<td>10% of billed Amount</td>
</tr>
<tr>
<td>40000-49999</td>
<td>20% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
<tr>
<td>50000-59999</td>
<td>35% of billed Amount</td>
<td>10% of billed Amount</td>
</tr>
<tr>
<td>60000-69999</td>
<td>20% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
<tr>
<td>70000-79999</td>
<td>25% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
<tr>
<td>80000-89999</td>
<td>30% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
<tr>
<td>90000-99999</td>
<td>40% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
</tbody>
</table>

5. **Prior Authorization**
5.1. Outpatient hospital claims are processed in accordance with the MDwise Marketplace Prior Authorization requirements.

6. Claims Editing Requirements
   6.1. Institutional Outpatient Code Edits (IOCE) within OPPS pricer, NCCI Edits

7. Copays and Coinsurance

Refer to the MDwise Marketplace Individual Policy for the Schedule of Benefits which summarizes applicable coinsurance related to coverage of outpatient hospital services. Coinsurance, not the office visit copay applies to PMP or specialist services provided with a place of service 22 (outpatient hospital). The exception to this rule includes:

- Those cases in which a member receives evaluation and management services from a PMP or specialist at an office located on the hospital campus, and POS 22 is submitted on the professional claim. In these situations, the applicable office visit copay for a specialist or PMP applies instead of coinsurance. This applies to POS 22 claims with the following range of CPT codes: 99201-99205 and 99211 – 99215. Coinsurance may be applied on other service lines of the claim (e.g. lab, x-ray, etc.), however if a member appeals these charges, the claims payer may be asked to override the coinsurance and re-adjudicate the claim.

- Behavioral health psychotherapy and medication management visits and testing received in place of service 22 (See MM BAP 01).

Please also note:

- There is no member cost share for claims billed with revenue code 51X for the facility cost of a medical or behavioral health service. The copay should be applied on the professional claim and not also on the corresponding facility claim.

- When Diagnostic Health Services (e.g. labs, x-rays) are received in an outpatient hospital setting (POS 22), coinsurance, not copays will apply to these Services.
PST - Outpatient Physical, Occupational, & Speech Therapy

1. Benefit Coverage

1.1 This policy addresses reimbursement for medically necessary physical, occupational and speech therapy covered services provided in an outpatient setting that includes clinic/office and hospital outpatient centers, rehab agencies or comprehensive outpatient rehabilitation facilities (CORF). PT, OT, and ST therapies provided through a home health provider are considered as a separate benefit with separate limitations. (See this manual's chapter on Home Care Services)

1.2 Definitions

- **Therapist** refers only to licensed qualified physical therapists, occupational therapists and speech-language pathologists. Qualified professionals may also include physical therapy assistants (PTA) and occupational therapy assistants (OTA) when working under the supervision of a qualified therapist, within the scope of practice allowed by state law. Outpatient therapy must be ordered/ under the care of a physician or appropriate practitioner.

1.3 Medically necessary covered therapy services include both Rehabilitative and Habilitative Services.

1.4. Medically necessary coverage is provided for the treatment of Autism Spectrum Disorders. Treatment is limited to Health Services prescribed by a Physician in accordance with a treatment plan. Therapy services are covered benefits for autism spectrum disorders as per MDwise Behavioral Health guidelines and P&Ps for the Treatment of Autistic Spectrum Disorders and MDwise Marketplace Mental Health Services and in accordance with the IC 27-13-7-14.7.

As outlined in the MDwise Marketplace Individual Contract, coverage for Autism Spectrum Disorders will not be subject to dollar limits, Deductibles, Copay or Coinsurance provisions that are less favorable than the dollar limits, Deductibles, Copays or Coinsurance provisions that apply to physical illness under this Contract.

2. Benefit Limitations and Exclusions

2.1. Limitations

**Annual Limitation Rehabilitative Services:** 20 visits per individual therapy discipline. Annual Visit Limitation

- **Physical Therapy:** 20 visits
- **Occupational Therapy:** 20 visits
- **Speech Therapy:** 20 visits

**Visits or Treatment Sessions:**
Visits or treatment sessions begin at the time the patient enters the treatment area (of a building, office or clinic) and continues until all services (e.g., activities, procedures, services) have been completed for that session.

**Note:** If different types of Therapy Services are performed (e.g. PT, OT and/or ST) during one Physician Home Visit, Office Service, or Outpatient Service date of service, then each different
type of Therapy Service performed will be considered a separate Therapy Visit for the purpose of annual visit limit accumulation.

When rendered in the home, Home Care Service limits apply. When applicable therapies rendered as part of physical therapy, for example, the Physical Therapy limit under home care services will apply instead of the limit listed here.

As outlined in the MDwise Marketplace Individual Contract, coverage for Autism Spectrum Disorders will not be subject to dollar limits, Deductibles, Copay or Coinsurance provisions that are less favorable than the dollar limits, Deductibles, Copays or Coinsurance provisions that apply to physical illness under this Contract.

2.2. Non-covered services:

- Non-Covered Physical Therapy Services include but are not limited to maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness, repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients), range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities, general exercise programs, diathermy, ultrasound and heat treatments for pulmonary conditions, diapulse, work hardening.

- Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Occupational Therapy Services include but are not limited to supplies (looms, ceramic tiles, leather, utensils), therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again, general exercises to promote overall fitness and flexibility, therapy to improve motivation, suction therapy for newborns (feeding machines), soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial, adaptations to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

- Services provided by those trained/licensed specifically in physical therapy, occupational therapy, or speech therapy can be considered as covered services. That means that the services of athletic trainers, massage therapists, recreation therapists, kinesiotherapist, low vision specialist may not be billed as therapy services.

3. Provider Reimbursement & Submission Requirement

3.1. The provider reimbursement is as per contracted percentage rate utilizing the appropriate Medicare Physician Fee Schedule or Medicare Ambulatory Payment Classification (APC) outpatient pricer fee as the base rate.

- Use the Medicare payment amount, if available; then apply the provider’s contracted percent of Medicare.
• If not, and the service code is covered, then use the Medicaid payment amount as the base. 150% of Medicaid is deemed equivalent to the Medicare rate; then apply the provider’s contracted percent of Medicare.

• If there is no Medicare or Medicaid rate and the service is covered, the item must be manually priced.

• For providers that are statewide (DME, Lab, Home Health) and they cross multiple QHPs, the provider’s contracted percent of Medicare is the 130% blended rate. For a provider servicing only 1 qualified health plan, the delivery system will set the contracted percent of Medicare to apply.

• If the provider is not contracted, and the service is authorized, then the following rate is applied to the applicable Medicare fee amount (or 150% of the Medicaid payment amount as the Medicare equivalent when no fee in Medicare is available and it is a covered service), unless in some case, the authorization could contain the non-contracted provider rate:
  o Facility 133%,
  o Professional l claims 125%

• Site of service (nonfacility and facility services) fees may apply to certain service codes

• In all cases, if the billed amount is less than the contracted payment amount, the billed amount is to be reimbursed.

3.2. Outpatient Rehab Services reimbursed according to the Medicare Ambulatory Payment Classification (APC) system.

Services are billed on a UB-04 or 837I claim form. HCPCS codes are to be submitted along with the applicable revenue code. Each line on a claim is evaluated for payment or nonpayment using various criteria. The outcome of the evaluation results in a status indicator assigned to each line. These status indicators determine the payment mechanism to be applied. Lines that are determined to be payable may be priced using multiple mechanisms. Medicare applies a multiple procedure payment reduction (MPPR) for outpatient rehabilitation services. The MPPR applies to all therapy services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, for example, physical therapy, occupational therapy, or speech-language pathology. Full payment is made for the unit or procedure with the highest payment and the appropriate MPPR to the remaining services is applied. (Refer to Section 10.7 CMS Claims Payment Manual)

• CORF services are paid utilizing the Medicare Fee Schedule MPFS for outpatient rehabilitation services.

• Please also refer to this manual’s chapters on: Preventive Care Services, Screening & Immunizations regarding services, Outpatient Hospital Services, and Mental Health Services

The therapy provider bills for services on Form CMS-1450 (aka UB-04 at present) or CMS 1500 or their electronic equivalent. Providers are required to report line item dates of service per
revenue code line for outpatient rehabilitation services. CORFs are also required to report their full range of CORF services by line item date of service. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence.

3.3. CORF services should be billed on a CMS-1500 Professional claim form or the Health Insurance Portability and Accountability Act (HIPAA) 837P transaction using place-of-service code 62 – CORF.

Providers are required to report the number of units based on the procedure or service (based on the HCPCS code). For HCPCS codes where procedure is not defined by a specific timeframe, the number of units entered is “1”. Providers are required to report line item dates of service per revenue code line for outpatient rehabilitation services. CORFs are also required to report their full range of CORF services by line item date of service. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence.

3.4. Supplies furnished by CORFs/OPTs are considered part of the practice expense. The cost of supplies (e.g., theraband, hand putty, electrodes) used in furnishing covered therapy care is included in the payment for the HCPCS codes billed by the physical therapist, and are, therefore, not separately billable.

3.5. Appropriate portions of the therapy service may be performed by a physical therapy assistant (PTA), or an occupational therapy assistant (OTA), but ONLY under the supervision of a physical therapist or an occupational therapist. For Medicare reimbursement, the PTA or OTA may NOT perform PT directly "incident-to" a physician, because the PTA or OTA does not have all the qualifications of a therapist.

3.6. Medicare billing requires certain modifiers for functional purposes on payable and non-payable codes. This functional data reporting and collection system is effective for therapy services with dates of service on and after January 1, 2013.

Per CMS these requirements apply to all claims for services furnished under the Medicare Part B outpatient therapy benefit and the PT, OT, and SLP services furnished under the CORF benefit. They also apply to the therapy services furnished personally by and incident to the service of a physician or a nonphysician practitioner (NPP), including a nurse practitioner (NP), a certified nurse specialist (CNS), or a physician assistant (PA), as applicable.

Certain codes are "always therapy" services. The claims must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered:
- GN Services delivered under an outpatient speech-language pathology plan of care;
- GO Services delivered under an outpatient occupational therapy plan of care; or,
- GP Services delivered under an outpatient physical therapy plan of care.

Therapy modifiers are present based on revenue codes 042X, 043X, or 044X. Revenue codes and modifiers are reported in the following combinations:
- Revenue code 42x (physical therapy) lines may only contain modifier GP
- Revenue code 43x (occupational therapy) lines may only contain modifier GO
Revenue code 44x (speech-language pathology) lines may only contain modifier GN. There must be the presence of a HCPCS code when the above revenue codes are reported.

**Therapy Severity/Complexity Modifiers**

Appropriate usage is in connection with the function related G series codes for physical therapy (PT), occupation therapy (OT), and speech language pathology (SLP). The modifier is used to report the severity/complexity for the specific functional measure.

- Modifier CH 0 percent impaired, limited or restricted
- Modifier CI At least 1 percent but less than 20 percent impaired, limited or restricted
- Modifier CJ At least 20 percent but less than 40 percent impaired, limited or restricted
- Modifier CK At least 40 percent but less than 60 percent impaired, limited or restricted
- Modifier CL At least 60 percent but less than 80 percent impaired, limited or restricted
- Modifier CM At least 80 percent but less than 100 percent impaired, limited or restricted
- Modifier CN 100 percent impaired, limited, or restricted

4. **Procedure Codes and Claim Considerations**

   4.1. HCPCS codes for PT, OT, and ST evaluation:

   - 92521-24 Evaluation of speech production, receptive language and expressive language abilities
   - 92610 Evaluation of oral and pharyngeal swallowing function
   - 97001 Physical therapy evaluation
   - 97003 Occupational therapy evaluation

5. **Prior Authorization**

   5.1. Claims received for outpatient therapy services outlined in this policy are processed in accordance with the MDwise Marketplace Prior Authorization requirements.

6. **Copays and Coinsurance**

   6.1 Copays and coinsurance amounts are applied as directed by MDwise and the Marketplace policy contract.

   6.2 In the event more than one therapy session by discipline (e.g. PT and OT) is billed on the same claim, applicable copay or coinsurance is applied to the claim received, not by individual service (service) line billed.

   6.3 When a member has physical therapy, speech therapy or occupational therapy in an outpatient hospital setting the outpatient hospital deductible and coinsurance applies.
PNM - Pain Management Services

1. Benefit Coverage

1.1. Covered pain management programs and certain pain management services (e.g., injectibles) performed by a physician/ anesthesiologist/ pain management specialist can be considered covered as per deemed medically necessary through prior authorization.

These covered pain management program/services/devices, when determined as medically necessary, may be reimbursed as an outpatient service provided by the physician or device/supply/items (e.g. DME) as prescribed by the physician.

1.2. Postoperative pain management services during an inpatient stay may be billed by the anesthesiologist according to the following:

- Postoperative epidural catheter management or subarachnoid drug administration services are reimbursed using procedure code 01996.

- Does not pay separately for procedure code 01996 on the same day the epidural is placed. Limit to one unit of service for each day of management.

- No modifier when this procedure is monitored by an anesthesia provider.

If the anesthesiologist continues with the patient’s care after discharge, the appropriate Evaluation and Management code should be used, upon receipt of the requested prior approval medical necessity determination when service requires a PA.

2. Benefit Limitations and Exclusions

2.1. Limitations

Please refer to this manual’s chapter on Manipulation Therapy

2.2. Exclusions

Coverage for any of the following is not provided.

- Health Services that are not Medically Necessary.

- Health Services that are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by MDwise. The fact that a service is the only available for a condition will not make it eligible for Coverage if MDwise deems it to be Experimental/Investigative

- Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis,
aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

3. Provider Reimbursement & Submission Requirements

3.1. The provider reimbursement is as per contracted rate utilizing the appropriate Medicare physician fee schedule, DMEPOS, or applicable hospital outpatient prospective pricing system (OPPS) pricing/outpatient pricer, ambulatory payment classification (APC), as the base rate.

- Use the Medicare payment amount, if available; then apply the provider’s contracted percent of Medicare. If not, and the service code is covered, then use the Medicaid payment amount as the base. 150% of Medicaid is deemed equivalent to the Medicare rate; then apply the provider’s contracted percent of Medicare. If there is no Medicare or Medicaid rate and the service is covered, the item must be manually priced (see below).

- For providers that are statewide (DME, Lab, Home Health) and they cross multiple QHPs, the provider's contracted percent of Medicare is the 130% blended rate. For a provider servicing only 1 qualified health plan, the delivery system will set the contracted percent of Medicare to apply.

- If the provider is not contracted, and the service is authorized, then the following rate is applied to the applicable Medicare fee amount (or 150% of the Medicaid payment amount as the Medicare equivalent when no fee in Medicare is available and it is a covered service), unless in some case, the authorization could contain the non-contracted provider rate:
  o Facility 133%
  o Professional I claims 125%

- Site of service (nonfacility and facility services) fees may apply to certain service codes

- In all cases, if the billed amount is less than the contracted payment amount, the billed amount is to be reimbursed.

3.2. Manual Pricing. CPT codes billed for the marketplace, which fall under the manual pricing logic should follow the published Medicaid rate methodology, as outlined in the below table and in the IHCP Bulletin, BT 200940 and 201213. Except for drugs and biological, which have special pricing, HCPCS codes which indicate manual pricing will be reimbursed at 60% of billed charges, or for DME products, 60% of the Manufacturers Suggested Retail Price (MSRP). For the pricing of drugs and biological, refer to BCCP 20, Pharmacy & Biologicals.

To determine the base Medicare rate for CPT codes, the applicable Medicaid rate, based on the below table is multiplied by 150%. The provider’s contracted rate is then applied to the base Medicare rate.
For HCPS codes that are paid at 60% of billed charges, there is no additional percentage applied (Medicare equivalency or additional provider contracted amount).

<table>
<thead>
<tr>
<th>Procedure Code Range</th>
<th>Codes Billed on CMS-1500</th>
<th>Codes Billed on UB-04</th>
</tr>
</thead>
<tbody>
<tr>
<td>10000-19999</td>
<td>20% of billed Amount</td>
<td>20% of billed Amount</td>
</tr>
<tr>
<td>20000-29999</td>
<td>20% of billed Amount</td>
<td>10% of billed Amount</td>
</tr>
<tr>
<td>30000-39999</td>
<td>20% of billed Amount</td>
<td>10% of billed Amount</td>
</tr>
<tr>
<td>40000-49999</td>
<td>20% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
<tr>
<td>50000-59999</td>
<td>35% of billed Amount</td>
<td>10% of billed Amount</td>
</tr>
<tr>
<td>60000-69999</td>
<td>20% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
<tr>
<td>70000-79999</td>
<td>25% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
<tr>
<td>80000-89999</td>
<td>30% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
</tbody>
</table>

4. **Procedure Code and Claim Considerations**
   
   4.1. The provider bills on Form CMS-1450 (aka UB-04 at present) or CMS 1500 or their electronic equivalent.

5. **Prior Authorization (PA) Requirements**
   
   5.1. Claims received for Pain Management Services are processed in accordance with the MDwise Marketplace Prior Authorization requirements.

6. **Claims Editing Requirements**
   
   6.1. NCCI Edits and Visium Edits that MDwise has chosen to utilize.

7. **Copays and Coinsurance**
   
   7.1. Copays and coinsurance amounts are applied as directed by MDwise and the Marketplace policy contract.
Please Note: The MDwise Marketplace pharmacy benefit is managed by MDwise through its contracted PBM Vendor, Medimpact. This policy addresses those drugs that will not be processed through Medimpact such as those billed by physician (e.g. injectable), as well as biologicals (e.g. blood products, vaccines, etc.).

1. **Benefit Coverage**

1.1. Covered, prescription drug benefits include the following.

- Prescription Legend Drugs.
- Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Oral contraceptive Drugs, injectable contraceptive drugs and patches are covered when obtained through an eligible Pharmacy.
- If certain supplies, equipment or appliances are not obtained by Mail Service or from a Participating Pharmacy then they are covered as Medical Supplies, Equipment and Appliances instead of under Prescription Drug benefits and may be subject to applicable DME Copays or Coinsurance.
- Self-administered injectables
- Medical food that is medically necessary and prescribed by a Physician for the treatment of an inherited metabolic disease. Medical good means a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered internally under the direction of a Physician.

1.2. Covered pharmaceuticals and biological that will be processed through the medical benefit include the following:

- Injectables provided at medical provider location (e.g. physician, outpatient hospital, inpatient hospital, etc.)
- Chemotherapy for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- Hemophilia clotting factor
- Medically necessary home IV therapy including, but is not limited to injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.
1.3. Generally, drugs and biologicals referred to in this policy are covered only if all of the following requirements are met:

- They are approved by the U.S. Food & Drug Administration (FDA)
- They are not typically self-administered
- They meet all the general requirements for coverage of items as incident to a physician’s services;
- They are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered according to accepted standards of medical practice;
- They are not excluded as noncovered immunizations

2. Benefit Limitations and Exclusions

2.1. The following benefit limitations or exclusions apply to pharmacy and biologicals:

- Coverage for any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which MDwise determines to be Experimental/Investigative.
- Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product.
- Off label use, except as otherwise prohibited by law or as approved by MDwise
- Drugs not approved by the FDA.
- Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Contract may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Prior to 1.1.16, drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. Drugs may be covered with 1.1.16 dates of service and beyond.
- Fertility Drugs.
- Human Growth Hormone for children born small for gestational age. It is only a Covered...
Service in other situations when authorized.

- Certain brand name Prescription Drugs, for which there are lower cost clinically equivalent alternatives available, are not covered, unless otherwise required by law or approved by MDwise. “Clinically equivalent” means Drugs that, for the majority of members, can be expected to produce similar therapeutic outcomes for a disease or condition.

3. Provider Reimbursement & Submission Requirements

3.1. Average Sales Price (ASP) Methodology. The majority of drugs and biologicals are priced based on the ASP methodology and are reimbursed using the CMS ASP fee schedule. There are some exceptions as follows:

- Most drugs for patients in a Prospective Payment System (PPS) hospital are included in the Diagnosis-Related Group (DRG) amount and are not billable.

- Ambulatory Payment Classification (APC) payments for outpatient services, priced through the Outpatient Prospective Payment System (OPPS) generally include payment for Outpatient drugs and biologicals drugs except for certain new drugs or drugs granted "pass-through" status. Drugs and biologicals with pass-through status are priced based on the ASP methodology.

For HCPCS that are not priced on the Medicare ASP Fee schedule; the reimbursement rate will be 150% of the Indiana Medicaid Fee Schedule. If the billed amount is less than the applicable fee schedule amount, the billed amount is to be reimbursed.

The ASP drug pricing files are updated on a quarterly basis and can be located at: [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html)

Exceptions to Average Sales Price (ASP) Payment Methodology

- The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File, other than new drugs that are produced or distributed under a new drug application (or other application) approved by the FDA are based on the published Wholesale Acquisition Cost (WAC) or invoice pricing, except under the hospital outpatient prospective payment system (OPPS) where the payment allowance limit is 95 percent of the published AWP. The payment limit is 106 percent of the lesser of the lowest-priced brand or median generic WAC. In determining the payment limit based on WAC, follow the methodology specified in the Medicare Claims Processing Manual, Chapter 17, for calculating the Average Wholesale Price (AWP), but substitutes the WAC for AWP.

- The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the Food and Drug Administration, and that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File, are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPPS where the payment allowance limit is 95 percent of the published AWP.

- Vaccines that are not covered by Medicare are reimbursed at 150% of the IHCP rate.
If there is no WAC pricing available in a CMS approved published compendia (e.g. Red Book) an invoice must be submitted. When pricing by invoice, the Marketplace manual pricing logic is followed and the invoice should be reimbursed at 60% of cost.

Please refer to the CMS Claims Processing Manual, Chapter 17 for additional information regarding the pricing of drugs and biologicals.

3.2. Provider Contracted Rate. There is no additional contracted provider percentage applied to drugs and biologicals. Thus, the rate is the same for all providers, regardless of the QHP in which they are located. This applies to any place of service, including outpatient hospital settings, the home, offices, clinics, etc.

3.3. Miscellaneous Drug Codes. Unless there is a Medicare or Medicaid rate, Miscellaneous Drug codes or unspecified drugs, J3490, are manually priced and, and providers must submit an invoice. As outlined above, the reimbursement rate is then 60% of the invoice amount.

Providers can use a nonspecific CPT or HCPCS code only when no code is available with a narrative that accurately describes the drug being administered or the drug’s route of administration. For all CMS-1500 claims or 837P transactions billed with a nonspecific code, providers must write the NDC qualifier, NDC, NDC unit of measure, and number of units administered on the claim itself; otherwise, DST must deny the claim. For electronic 837 transactions, providers can indicate the NDC for the drug dispensed in the NDC field. The NDC quantity and unit of measure must also be provided.

3.4. Vaccines. Vaccines are reimbursed according to the Indiana Medicare Physician Fee schedule (MPFS) or the Medicare ASP drug files, dependent upon the CPT or HCPCS code being billed. In some instances, Medicare does not have rates for specific vaccines; reimbursement for those codes would be based on 150% of the allowable Indiana Medicaid Fee Schedule rate. All covered vaccine codes are to be billed using the appropriate CPT codes, and administration codes. Administration codes include the HCPCS code G0008, G0009, and G0010.

3.5. Hemophilia Clotting Factors. Blood clotting factors not paid on a cost or prospective payment system basis are priced as a drug/biological under the drug pricing fee schedule effective for the specific date of service. During an inpatient stay the clotting factors are paid in addition to the DRG payment. For a SNF subject to SNF/PPS, the payment is bundled into the SNF/PPS rate. For hospitals subject to OPPS, the clotting factors are paid the APC.

A clotting factor furnishing fee is separately payable to entities that furnish clotting factor unless the costs associated with furnishing the clotting factor is paid through another payment system. The clotting factor furnishing fee is updated each calendar year based on the percentage increase in the consumer price index (CPI) for medical care.

CMS includes this clotting factor furnishing fee in the nationally published payment limit for clotting factor billing codes. When the clotting factor is not included on the ASP Drug Pricing File or NOC Pricing File, the furnishing fee would be reimbursed according to manual pricing logic.

3.6. Inpatient Hospital and Skilled Nursing Facilities. Drugs for inpatient hospital and inpatient skilled nursing facility (SNF) members are included in the respective prospective payment system (PPS) rates, except for hemophilia clotting factors for hospital inpatients.
3.7. **Outpatient Hospital.** All hospital outpatient drugs are excluded from Single Drug Pricing (SDP) because the payment allowance for such drugs is determined by a different methodology. Non pass-through drugs with estimated per day costs less than or equal to the applicable drug packaging threshold that are furnished to hospital outpatients are packaged under the outpatient prospective payment system (OPPS). Their costs are recognized and included but paid as part of the ambulatory payment classification (APC) group payment for the service with which they are billed. Non pass-through drugs with estimated per day costs greater than the applicable drug packaging threshold are paid separately.

Payment for drugs, biologicals and radiopharmaceuticals under the OPPS is inclusive of both the acquisition cost and the associated pharmacy overhead or nuclear medicine handling cost.

3.8. **Pass-Through Drugs, Biologicals, and Radiopharmaceuticals.** Payment for drugs, biologicals, and radiopharmaceuticals may be made under the pass-through provision which provides additional payments for drugs, biologicals, and radiopharmaceuticals that meet certain requirements relating to newness and relative costs. For the process and information required to apply for transitional pass-through payment status for these items, visit [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html). Pass-through payment rates are updated quarterly. Please visit [http://cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html](http://cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html) for the all-inclusive list of billable drugs, biologicals, and radiopharmaceuticals (Addendum B) eligible for pass-through payment.

3.9. **Radiopharmaceuticals.** The OPPS divides radiopharmaceuticals into two groups for payment purposes: diagnostic and therapeutic. The OPPS claims editor (I/OCE) requires claims with separately payable nuclear medicine procedures to include a radiolabeled product (i.e., diagnostic radiopharmaceutical, therapeutic radiopharmaceutical, or brachytherapy source). Hospitals are required to submit the HCPCS code for the radiolabeled product on the same claim as the HCPCS code for the nuclear medicine procedure.

There are rare situations where a hospital provides a radiolabeled product to an inpatient, and then the patient is discharged and later returns to the outpatient department for a nuclear medicine imaging procedure but does not require additional radiolabeled product. In these situations, hospitals are to include HCPCS code C9898 (Radiolabeled product provided during a hospital inpatient stay) with a token charge (of less than $1.01) on the same claim as the nuclear medicine procedure in order to receive payment for the nuclear medicine procedure. HCPCS code C9898 should only be reported under the circumstances described above, and the date of service for C9898 should be the same as the date of service for the diagnostic nuclear medicine procedure.

3.10. **Hospital Billing for New, Unclassified Drugs and Biologicals.** Beginning on or after the date of FDA approval, hospitals may bill for the drug or biological using HCPCS code C9399, Unclassified drug or biological. The National Drug Code (NDC) must be included. Payment for an outpatient drug or biological that is furnished as part of covered outpatient department services for which a product-specific HCPCS code has not been assigned shall be paid an amount equal to 95% of average wholesale price (AWP). This provision applies only to payments under the hospital outpatient prospective payment system (OPPS).
4. Procedure Codes and Claim Considerations

4.1. All drug and biological claims should be billed using the appropriate HCPCs code and NDC. Physicians and other providers should ensure that the units billed do not exceed the maximum number of units per day based on the code descriptor, reporting instructions associated with the code, and/or other CMS local or national policy.

4.2. Injection Services. Where the sole purpose of an office visit was for the patient to receive an injection, payment may be made for the injection service (if it is covered) and the applicable drug. Conversely, injection services (codes 90782, 90783, 90784, 90788, and 90799) included in the Medicare Physician Fee Schedule (MPFS) are not paid for separately if the physician is paid for any other physician fee schedule service furnished at the same time.

Cancer chemotherapy injections (CPT codes 96400-96549) can be paid in addition to the visit furnished on the same day, with an applicable modifier (see NCCI edits). CPT code 99211 however should be denied if it is billed with a drug administration service such as chemotherapy or nonchemotherapy drug infusion code or a therapeutic or diagnostic injection code.

When a medically necessary, significant and separately identifiable E/M service (which meets a higher complexity level than CPT code 99211) is performed, in addition to one of the drug administration services, the appropriate E/M CPT code should be reported with modifier -25.

If more than one injection is given on the same date of service and no E/M code is billed, providers may bill a separate administration fee for each injection using the appropriate codes.

All medical claims must include the specific name of the drug, strength, and dosage as applicable, and the product NDC.

4.3. Erythropoetin Stimulating Agents (ESAs) Administered to Non-End Stage Renal Disease (ESRD) Patients.

All claims billing HCPCS J0881 and J0885 must report one of the following modifiers when ESAs are administered to non-ESRD patients:

- EA: ESA, anemia, chemo-induced
- EB: ESA, anemia, radio-induced
- EC: ESA, anemia, non-chemo/radio

Claims that do not report one of the above modifiers will be denied.

Non-ESRD ESA services for HCPCS J0881 or J0885 billed with modifier EA (ESA, anemia, chemo-induced) shall be denied for anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia when a hemoglobin > 10 g/dL or hematocrit > 30% is reported.

Non-ESRD ESA services for HCPCS J0881 or J0885 billed with modifier EB (ESA, anemia, radio-induced) shall be denied.

Non-ESRD ESA services for HCPCS J0881 or J0885 billed with modifier EC (ESA, anemia, non-chemo/radio) shall be denied when any one of the following diagnosis codes is present on the claim:

Modified on July 14, 2017
• Any anemia in cancer or cancer treatment patients due to folate deficiency
  o ICD-10 codes D52.0, D52.1, D52.8, and D52.9
• Any anemia in cancer or cancer treatment patients due to B-12 deficiency
  o ICD-10 codes D51.1, D51.2, D51.3, D51.8, D51.9, and D53.1
• Any anemia in cancer or cancer treatment patients due to iron deficiency
  o ICD-10 codes D50.0, D50.8, D50.1, D50.8, and D50.9
• Any anemia in cancer or cancer treatment patients due to hemolysis
  o ICD-10 codes D58.0, D55.0, D55.1, D58.9, D59.0, D59.1, D59.4, D59.2, D59.4, D59.5, D59.6, D59.8, and D59.9
• Anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML)
  o ICD-10 codes C92.00, C92.40, C92.50, C92.60, C92.A0, C92.01, C92.41, C95.51, C92.61, C92.A, C92.02, C92.42, C92.52, C92.62, C92.A2, C92.10, C92.11, C92.12, C92.20, C92.21, C92.20, C92.21, C92.21, C92.22, C92.90 and C92.91
• Anemia associated with the treatment of erythroid cancer
  o ICD-10 codes C94.00, C94.01, C94.02, D45, C94.20, C94.21, C94.22, C94.30, C94.80, C94.31, and C94.81

In addition, non-ESRD ESA services for HCPCS J0881 or J0885 billed with modifier EC (ESA, anemia, non-chemo/radio) shall be denied in any one of the following clinical scenarios:
• Any anemia in cancer or cancer treatment patients due to bone marrow fibrosis
• Anemia of cancer not related to cancer treatment
• Prophylactic use to prevent chemotherapy-induced anemia
• Prophylactic use to reduce tumor hypoxia
• Patients with erythropoietin-type resistance due to neutralizing antibodies
• Anemia due to cancer treatment if patients have uncontrolled hypertension

**Self-Administered Drugs.** The Marketplace generally reimburses self-administered drugs through the pharmacy benefit. The following considerations are used in determining coverage of self-administered drugs under the medical benefit, versus the pharmacy benefit:
• Absent evidence to the contrary, drugs delivered intravenously should be presumed to be not usually self-administered by the patient.
• Absent evidence to the contrary, drugs delivered by intramuscular injection should be presumed to be not usually self-administered by the patient.
• Absent evidence to the contrary, drugs delivered by subcutaneous injection should be presumed to be usually self-administered by the patient.
• Absent evidence to the contrary, oral drugs, suppositories, topical medications and inhaled medications are considered to be usually self-administered by the patient.
• Additional consideration will be given to whether the condition being treated by the drug is acute or chronic and the frequency of administration.

The list of drugs identified below has been determined, following the above guidelines, to be usually self-administered by the patients who use them and are excluded from payment under the medical benefit. The list will be reviewed periodically and updated as further determinations are made. If a claim is received for a drug on this list, the claim may be denied with direction to submit the claim to the pharmacy vendor.
<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor Generic Name</th>
<th>Descriptor Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0135</td>
<td>Injection, adalimumab, 20 mg</td>
<td>Humira</td>
</tr>
<tr>
<td>J0270</td>
<td>Injection, alprostadil, 1.25 mcg</td>
<td>Caverject, Edex</td>
</tr>
<tr>
<td>J0275</td>
<td>Alprostadil urethral suppository</td>
<td>Muse</td>
</tr>
<tr>
<td>J0630</td>
<td>Injection, calcitonin salmon, up to 400 units</td>
<td>Calcimar, Miacalcin</td>
</tr>
<tr>
<td>J0717</td>
<td>Injection, certolizumab pegol, 1 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not when drug is self-administered)</td>
<td>Cimzia</td>
</tr>
<tr>
<td>J1324</td>
<td>Injection, enfuvirtide, 1 mg</td>
<td>Fuzeon</td>
</tr>
<tr>
<td>J1438</td>
<td>Injection, etanercept, 25 mg</td>
<td>Enbrel</td>
</tr>
<tr>
<td>J1595</td>
<td>Injection, glatiramer acetate, 20 mg</td>
<td>Copaxone</td>
</tr>
<tr>
<td>J1744</td>
<td>Injection, icatibant, 1 mg</td>
<td>Firazyr</td>
</tr>
<tr>
<td>J1815</td>
<td>Injection, insulin, per 5 units</td>
<td>Apidra, Humalog, Humulin, Lantus, Levetir, Novolin, NovoLog</td>
</tr>
<tr>
<td>J1817</td>
<td>Insulin for administration through DME (i.e., insulin pump)</td>
<td>Apidra, Humalog.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Brand Names</td>
</tr>
<tr>
<td>-------</td>
<td>------------------------------------------------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>J1826</td>
<td>Injection, interferon beta-1a, 11 mcg for intramuscular use.</td>
<td>Avonex, Rebi</td>
</tr>
<tr>
<td>J1830</td>
<td>Injection, interferon beta-1b, 0.25 mg (code may be used for Medicare when</td>
<td>Betaseron, Extavia</td>
</tr>
<tr>
<td></td>
<td>drug administered under the direct supervision of a physician, not when</td>
<td></td>
</tr>
<tr>
<td></td>
<td>drug is self-administered)</td>
<td></td>
</tr>
<tr>
<td>J2170</td>
<td>Injection, mecasermin, 1 mg</td>
<td>Iplex, Incrlex</td>
</tr>
<tr>
<td>J2940</td>
<td>Injection, somatrem, 1 mg</td>
<td>Protropin</td>
</tr>
<tr>
<td>J2941</td>
<td>Injection, somatropin, 1 mg</td>
<td>Genotropin, Humatrope,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Norditropin, Nutropi</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Omnitrope, Saizen, Serostim,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tev-Tropin, Zortbive</td>
</tr>
<tr>
<td>J3110</td>
<td>Injection, teriparatide, 10 mcg</td>
<td>Forteo</td>
</tr>
<tr>
<td>J3357</td>
<td>Injection, ustekinumb, 1 mg</td>
<td>Stelara</td>
</tr>
<tr>
<td>J7303</td>
<td>Contraceptive supply, hormone containing vaginal ring, each</td>
<td>NuvaRing</td>
</tr>
<tr>
<td>J7304</td>
<td>Contraceptive supply, hormone containing patch, each</td>
<td>OrthoEvra, Xulane</td>
</tr>
<tr>
<td>J7500</td>
<td>Azathioprine, oral, 50 mg</td>
<td>Azasan, Imuran</td>
</tr>
<tr>
<td>J7502</td>
<td>Cyclosporine, oral, 100 mg</td>
<td>Gengraf, Neoral, Sandimmune</td>
</tr>
<tr>
<td>J7506</td>
<td>Prednisone, oral, per 5mg</td>
<td>prednisone</td>
</tr>
<tr>
<td>J7507</td>
<td>Tacrolimus, immediate release, oral, 1 mg</td>
<td>Hecoria, Prograf</td>
</tr>
<tr>
<td>J7508</td>
<td>Tacrolimus, extended release, oral, 0.1 mg</td>
<td>Astagraf XL</td>
</tr>
<tr>
<td>J7509</td>
<td>Methylprednisolone oral, per 4 mg</td>
<td>Medrol</td>
</tr>
<tr>
<td>J7510</td>
<td>Prednisolone oral, per 5 mg</td>
<td>Millipred</td>
</tr>
<tr>
<td>J7515</td>
<td>Cyclosporine, oral, 25 mg</td>
<td>Gengraf, Neoral, Sandimmune</td>
</tr>
<tr>
<td>J7517</td>
<td>Mycophenolate mofetil, oral, 250 mg</td>
<td>Cellcept</td>
</tr>
<tr>
<td>J7518</td>
<td>Mycophenolic acid, oral, 180 mg</td>
<td>Myfortic</td>
</tr>
<tr>
<td>J7520</td>
<td>Sirolimus, oral, 1 mg</td>
<td>Rapamune</td>
</tr>
<tr>
<td>J7527</td>
<td>Everolimus, oral, 0.25 mg</td>
<td>Zortress</td>
</tr>
<tr>
<td>J8499</td>
<td>Prescription drug, oral, non-chemotherapeutic, NOS</td>
<td>&lt;various&gt;</td>
</tr>
<tr>
<td>J8501</td>
<td>Aprepitant, oral, 5 mg</td>
<td>Emend</td>
</tr>
<tr>
<td>J8510</td>
<td>Busulfan, oral, 2 mg</td>
<td>Myleran</td>
</tr>
<tr>
<td>J8515</td>
<td>Cabergoline, oral, 0.25 mg</td>
<td>cabergoline</td>
</tr>
<tr>
<td>J8520</td>
<td>Capecitabine, oral, 150 mg</td>
<td>Xeloda</td>
</tr>
<tr>
<td>J8521</td>
<td>Capecitabine, oral, 500 mg</td>
<td>Xeloda</td>
</tr>
<tr>
<td>J8530</td>
<td>Cyclophosphamide, oral, 25 mg</td>
<td>cyclophosphamide</td>
</tr>
<tr>
<td>J8540</td>
<td>Dexamethasone, oral, 0.25 mcg</td>
<td>dexamethasone</td>
</tr>
<tr>
<td>J8560</td>
<td>Etoposide; oral, 50 mg</td>
<td>etoposide</td>
</tr>
<tr>
<td>J8562</td>
<td>Fludarabine phosphate, oral, 10 mg</td>
<td>fludarabine phosphate</td>
</tr>
<tr>
<td>J8565</td>
<td>Gefitinib, oral, 250 mg</td>
<td>Iressa</td>
</tr>
<tr>
<td>J8597</td>
<td>Antiemetic drug, oral, not otherwise specified</td>
<td>&lt;various&gt;</td>
</tr>
<tr>
<td>J8600</td>
<td>Melphalan, oral, 2 mg</td>
<td>Alkeran</td>
</tr>
<tr>
<td>J8610</td>
<td>Methotrexate, oral, 2.5 mg</td>
<td>Rheumatrex, Trexall</td>
</tr>
<tr>
<td>J8650</td>
<td>Nabilone, oral, 1 mg</td>
<td>Cesamet</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Brand Name</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>J8700</td>
<td>Temozolomide, oral, 5 mg</td>
<td>Temodar</td>
</tr>
<tr>
<td>J8705</td>
<td>Topotecan, oral, 0.25 mg</td>
<td>Hycamtn</td>
</tr>
<tr>
<td>J8999</td>
<td>Prescription drug, oral, chemotherapeutic, nos</td>
<td>&lt;various&gt;</td>
</tr>
<tr>
<td>J9212</td>
<td>Injection, interferon alfa-con-1, recombinant, 1 microgram</td>
<td>Interferon</td>
</tr>
<tr>
<td>J9213</td>
<td>Injection, interferon, alfa-2a, recombinant, 3 million units</td>
<td>Roferon A</td>
</tr>
<tr>
<td>J9214</td>
<td>Injection, interferon, alfa-2b, recombinant, 1 million units</td>
<td>Intron-A</td>
</tr>
<tr>
<td>J9216</td>
<td>Injection, interferon, gamma-1b, 3 million units</td>
<td>Actimmune</td>
</tr>
<tr>
<td>Q0144</td>
<td>Azithromycin dihydrate, oral, capsules/powder, 1 gram</td>
<td>Azithromycin</td>
</tr>
<tr>
<td>Q0161</td>
<td>Chlorpromazine hydrochloride, 5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen</td>
<td>Chlorpromazine</td>
</tr>
<tr>
<td>Q0162</td>
<td>Ondansetron 1 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen</td>
<td>Ondansetron</td>
</tr>
<tr>
<td>Q0163</td>
<td>Diphenhydramine hydrochloride, 50 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at time of chemotherapy treatment not to exceed a 48 hour dosage regimen</td>
<td>Diphenhydramine</td>
</tr>
<tr>
<td>Q0164</td>
<td>Prochlorperazine maleate, 5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen</td>
<td>Prochlorperazine</td>
</tr>
<tr>
<td>Q0166</td>
<td>Granisetron hydrochloride, 1 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 24 hour dosage regimen</td>
<td>Granisetron</td>
</tr>
<tr>
<td>Q0167</td>
<td>Dronabinol, 2.5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen</td>
<td>Dronabinol</td>
</tr>
<tr>
<td>Q0169</td>
<td>Promethazine hydrochloride, 12.5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen</td>
<td>Promethazine</td>
</tr>
<tr>
<td>Q0173</td>
<td>Trimethobenzamide hydrochloride, 250 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen</td>
<td>Trimethobenzamide</td>
</tr>
<tr>
<td>Q0174</td>
<td>Thiethylperazine maleate, 10 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen</td>
<td>Thiethylperazine</td>
</tr>
<tr>
<td>Q0175</td>
<td>Perphenazine, 4 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an</td>
<td>Perphenazine</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Example</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen</td>
<td>Hydroxyzine pamoate, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen</td>
<td>hydroxyzine pamoate</td>
</tr>
<tr>
<td>Q0177</td>
<td>Dolasetron mesylate, 100 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 24 hour dosage regimen</td>
<td>dolasetron mesylate</td>
</tr>
<tr>
<td>Q0180</td>
<td>Unspecified oral dosage form, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen</td>
<td>&lt;various&gt;</td>
</tr>
</tbody>
</table>

**Please note:** Although Synagis, CPT code 90378 is not typically self-administered; coverage is provided through the pharmacy benefit rather than the medical benefit. Claims received for 90738 shall be denied with direction to submit the claim to the pharmacy vendor.

**Drugs Lacking J Codes that are Restricted to Pharmacy**
(These may be billed using the non-specific J codes J3490, J3590, or J9999)

- albiglutide (Tanzeum)
- anakinra (Kineret)
- dulaglutide (Trulicity)
- exenatide (Byetta)
- liraglutide (Victoza)
- methotrexate (Otrexup, Rasuvo)
- metreleptin (Myalept)
- mipomersen sodium (Kynamro)
- naloxone (Evzio)
- nitroglycerin lingual spray (Nitrolingual, NitroMist) or sublingual tablets (Nitrostat)
- pasireotide (Signifor)
- peginterferon alfa-2a (Pegasys)
- peginterferon alfa-2b (PegIntron, Sylatron)
- peginterferon beta-1a (Plegridy)
- pegvisomant (Somavert)
- pramlintide (Symlin)
- secukinumab (Cosentyx);
4.4. Pharmacy Supplying Fee and Inhalation Drug Dispensing Fee: The marketplace does not reimburse supplying fees for immunosuppressive drugs, oral anti-cancer chemotherapeutic drugs, and oral anti-emetic drugs used as part of an anti-cancer chemotherapeutic regimen. This includes the following codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q0510</td>
<td>First immunosuppressive prescription after a transplant</td>
</tr>
<tr>
<td>Q0511</td>
<td>Pharmacy supplying fee for immunosuppressive, oral anti-cancer, and oral anti-emetic drugs, first prescription in a one month period.</td>
</tr>
<tr>
<td>Q0512</td>
<td>Pharmacy supplying fee for immunosuppressive, oral anti-cancer and oral anti-emetic drugs – each subsequent prescription in a 30-day period.</td>
</tr>
<tr>
<td>Q0513</td>
<td>Pharmacy dispensing fee for inhalation drug(s); per 30-days furnished through DME regardless of the number of shipments or drugs dispensed during that time</td>
</tr>
<tr>
<td>Q0514</td>
<td>Pharmacy dispensing fee for inhalation drug(s); per 90-days furnished through DME regardless of the number of shipments or drugs dispensed during that time</td>
</tr>
<tr>
<td>G0333</td>
<td>Pharmacy dispensing fee for initial inhalation drug(s); initial 30 day supply furnished through DME regardless of the number of shipments or drugs dispensed during that time</td>
</tr>
</tbody>
</table>

4.5. Claims Processing Rules for ESAs Administered to Cancer Patients for Anti-Anemia Therapy. Non-ESRD ESA services for HCPCS J0881 or J0885 billed with modifier EC (ESA, anemia, non-chemo/radio) shall be denied when any one of the following diagnosis codes is present on the claim:

<table>
<thead>
<tr>
<th>Diagnosis Code (ICD-10)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D52.0, D52.1, D52.8, and D52.9</td>
<td>Any anemia in cancer or cancer treatment patients due to folate deficiency</td>
</tr>
<tr>
<td>D51.1, D51.2, D51.3, D51.8, D51.9, and D53.1</td>
<td>Any anemia in cancer or cancer treatment patients due to B-12 deficiency</td>
</tr>
<tr>
<td>D50.0, D50.8, D50.1, D50.8, and D50.9</td>
<td>Any anemia in cancer or cancer treatment patients due to iron deficiency</td>
</tr>
<tr>
<td>D58.0, D55.0, D55.1, D58.9, D59.0, D59.1, D59.4, D59.2, D59.4, D59.5, D59.6, D59.8, and D59.9</td>
<td>Any anemia in cancer or cancer treatment patients due to hemolysis</td>
</tr>
<tr>
<td>D62</td>
<td>Any anemia in cancer or cancer treatment patients due to bleeding</td>
</tr>
<tr>
<td>C92.00, C92.40, C92.50, C92.60, C92.A0, C92.01, C92.41, C92.51, C92.61, C92.A, C92.02, C92.42, C92.52, C92.62, C92.A2, C92.10, C92.11, C92.12, C92.20, C92.21, C92.Z0, C92.Z1, C92.Z2, C92.90 and C92.91</td>
<td>Anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML)</td>
</tr>
<tr>
<td>C94.00, C94.01, C94.02, D45, C94.20, C94.21, C94.22, C94.30, C94.80, C94.31, and C94.81</td>
<td>Anemia associated with the treatment of erythroid cancers</td>
</tr>
</tbody>
</table>
Non-ESRD ESA services for HCPCS J0881 or J0885 billed with modifier EB (ESA, anemia, radio-induced), shall be denied.

Non-ESRD ESA services for HCPCS J0881 or J0885 billed with modifier EA (ESA, anemia, chemoinduced) shall be denied for anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia when a hemoglobin 10.0g/dL or greater or hematocrit 30.0% or greater is reported.

5. Prior Authorization (PA) Requirements

5.1. Claims received for drugs and biologicals are processed in accordance with the MDwise Marketplace Prior Authorization requirements. Please refer to MDwise Marketplace prior authorization quick reference guide on MDwise.org for prior authorization requirements.

6. Copay and Coinsurance

6.1. According to the schedule of benefits, coinsurance for pharmaceuticals and biologics paid under the medical benefit will apply. Please note: The member responsibility is in addition to the copay or coinsurance for the setting (i.e., physician’s office, health center, urgent care center, outpatient hospital, ambulatory surgery center, member’s home) in which covered services are received.
PMR - Physical Medicine and Rehab Services

1. Benefit Coverage

1.1. This policy addresses reimbursement for medically necessary physical medicine and rehab covered services provided as a structured therapeutic program under the supervision of a physical medicine and rehabilitation specialist and developed treatment plan of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible, including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting.

1.2. Inpatient services for rehab can include services obtained in a hospital, free standing facility and Skilled Nursing Facility.

1.3. Physical Medicine and Rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

1.4. Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Health Services as deemed medically necessary.

A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours (4-8) a day, 2 or more days a week at a Day Hospital.

Day rehabilitation program services may consist of physiatrist services, PT, OT, ST, nursing services, and neuropsychological services.
- A minimum of two Therapy Services in Day Rehabilitation Program must be provided for this program to be a Covered Health Service.
- Physical Medicine Therapy through Day Rehabilitation Programs is subject to the Other Outpatient Services Copay/Coinsurance regardless of setting where Covered Services are received.

2. Benefit Limitations and Exclusions

2.1. Limitations

Annual Limitation for Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis): 60 days.

2.2. Non-covered services:

Non-Covered Physical Medicine and Rehabilitation Services include the following.
- Admission to a Hospital mainly for physical and/or occupational therapy.
- Long term rehabilitation in an Inpatient setting.
3. Provider Reimbursement & Submission Requirement

3.1. The provider reimbursement for inpatient rehab is as per provider’s contracted percentage utilizing the appropriate Medicare Inpatient Rehab Facility Prospective Payment System (PPS) Pricer as the base rate.

Reimbursement for day hospitalization services may be:

- based on a Delivery System and facility agreed upon case rate/per diem rate OR
- based on billing the individual therapy codes for services provided on the date of service.

The provider reimbursement is as per contracted percentage rate utilizing the appropriate Medicare Physician Fee Schedule or Medicare Ambulatory Payment Classification (APC) outpatient pricer fee as the base rate. Member’s copay/coinsurance applies to the claim for all covered/authorized services submitted for day hospital date of service billed.

- Use the Medicare payment amount, if available; then apply the provider’s contracted percent of Medicare.
- If not, and the service code is covered, then use the Medicaid payment amount as the base. 150% of Medicaid is deemed equivalent to the Medicare rate; then apply the provider’s contracted percent of Medicare.
- If there is no Medicare or Medicaid rate and the service is covered, then the item must be manually priced.
- If the provider is not contracted, and the service is authorized, then the following rate is applied to the applicable Medicare fee amount (or 150% of the Medicaid payment amount as the Medicare equivalent when no fee in Medicare is available and it is a covered service), unless in some case, the authorization could contain the non-contracted provider rate:
  - Facility 133%
  - Professional l claims 125%
- Site of service (nonfacility and facility services) fees may apply to certain service codes
- In all cases, if the billed amount is less than the contracted payment amount, the billed amount is to be reimbursed.

Outpatient Rehab Services reimbursed according to the Medicare Ambulatory Payment Classification (APC) system.

Services are billed on a UB-04 or 837I claim form. HCPCS codes are to be submitted along with the applicable revenue code. Each line on a claim is evaluated for payment or nonpayment using various criteria. The outcome of the evaluation results in a status indicator assigned to each line. These status indicators determine the payment mechanism to be applied. Lines that are determined to be payable may be priced using multiple mechanisms.

Please also refer this manual’s chapters on Outpatient Hospital Services, Outpatient Physical, Occupational, and Speech Therapy, Inpatient Hospital Services, and Physician Surgical and Medical Services.
3.2. **Inpatient Rehab Facility Services**

Reimbursement for inpatient rehab services is calculated by the Inpatient Rehab Facility PPS Pricer available on the CMS website. The Inpatient Rehab Facility Prospective Payment System (IRF PPS) is used for both freestanding Rehab hospitals and certified Rehab units of general acute care hospitals.

The IFR PPS groups cases into a Case-Mix Group (CMG) based on the clinical characteristics of the member. Payment is based on the CMGs as well as possible adjustments specific to the case and the facility characteristics. For case level adjustments, more than one case level adjustment may apply to the same case. For example, a case may be classified as a transfer, but may also receive additional payments because it meets the definition of an outlier case.

**Interrupted stays** are defined as those cases in which a member is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. The 3 consecutive calendar days begin with the day of the discharge from the IRF and ends on midnight of the third day. One CMG payment is made for interrupted stay cases and the payment is based on the initial assessment.

**Transfer cases** are defined as those in which a member is transferred to another rehabilitation facility, a long term care hospital, an inpatient hospital, or a nursing home AND the length of stay of the case is less than the average length of stay for a given CMG. The transfer policy consists of a per diem payment amount calculated by dividing the per discharge CMG payment rate by the average length of stay for the CMG. Medicare will pay transfer cases a per diem amount and include an additional half day payment for the first day. Transfer payments will be calculated by first adding the length of stay of the case to 0.5 (to account for the addition of the half day payment for the first day) and then multiplying the result by the CMG per diem amount.

**Other** The IRF PPS also includes a payment adjustment for certain cases, such as short-stay cases (for cases that do not meet the definition of a transfer case). A separate CMG payment (5001) is made for cases with a length of stay of 3 days or less, without consideration of the clinical characteristics of the patient. Further cases that expire with a length of stay of 3 days or less will also be classified to CMG 5001.

Separate CMGs are also made for cases that expire with a length of stay greater than 3 days. CMG 5101 is used for short-stay, orthopedic, expired cases. CMG 5102 is used for orthopedic expired cases where the length of stay is greater than or equal to 14 days. CMG 5103 is used for short-stay, non-orthopedic, expired cases. This CMG includes those cases that would not be grouped to the orthopedic RICs and the length of the stay is greater than 3 days, but less than or equal to 15 days. CMG 5104 is used for non-orthopedic expired cases where the length of stay is greater than or equal to 16 days.

4. **Procedure Codes and Claim Considerations**

4.1. **Inpatient Rehab Facility (IRF)**

- The revenue code, 0024, is used in conjunction with the HIPPS Rate Code to identify the CMG payment classification for the PPS reimbursement. This revenue code can appear on a claim only once.
5. Prior Authorization (PA) Requirements

5.1. Claims received for outlined in this policy are processed in accordance with the MDwise Marketplace Prior Authorization requirements.
PHY - Physician Services

1. Benefit Coverage

1.1. Covered physician services include:

- Office Visits for preventive care, primary care, and for medical care and consultations to examine, diagnose, and treat an illness or injury.
- Office visits also include allergy testing, injections and serum.
- Therapy Services for physical medicine therapies and other therapy services when given in the office of a physician or other professional provider.
- Inpatient Services
- Surgery and Surgical Services (including anesthesia and supplies). The surgical fee includes normal post-op care.
- Diagnostic Health Services when required to diagnose or monitor a symptom, disease or condition.
- Physician home visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in member’s home

1.2. Primary Care Practitioner. A primary care practitioner is defined as a participating provider in the member’s delivery system who has agreed to assume primary responsibility for the member’s medical care and is one of the following specialties:

- A physician who has a primary specialty designation of family medicine, internal medicine, gynecology, obstetrics, or pediatrics
- A nurse practitioner who practices in a primary care setting.

1.3. Inpatient Services. The following physician services are covered during an inpatient stay:

- Medical care visits
- Intensive medical care for treatment when the member’s condition requires it for a prolonged time.
- Concurrent care for a medical condition by a physician that is not the member’s surgeon while they are in the hospital for surgery.
- Care by two or more physicians during one Hospital stay when the nature or severity of the member’s condition requires the skills of separate physicians.
- Surgery and the administration of general anesthesia.
- Newborn exam. A physician other than the physician who performed the obstetrical delivery must do the examination.

2. Benefit Limitations and Exclusions

2.1. The following benefit limitations apply to physician services:

- New patient office visits are limited to one (1) per member, per provider within the last three (3) years. New patient is defined as a member who has not received any professional services from the provider or another provider of the same specialty within the same group practice within the last three (3) years.
- Medical care visits limited to one visit per day by any one Physician.
• Any Provider that is not a primary care practitioner as defined in Section 6 of this section is considered a Specialist and higher member copay’s apply. The exception is for a designated covering provider for the member’s primary medical provider (PMP). If a provider is covering for a member’s PMP, then PMP copays would apply, not specialist.

2.2. The following exclusions apply to physician services:

• Consultation codes (99241 – 99245, 99251 – 99255), Care Plan Oversight (99374 – 99380) and prolonged physician services (CPT code 99354) are not covered.

• Physician standby services (CPT code 99360), team conferences (codes 99361-99362), and telephone calls (codes 99371-99373) are not covered.

• Physician or Other Practitioners’ charges for consulting with Enrollees by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the enrollee except as otherwise described in this Contract.

• Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

• Treatment of telangiectatic dermal veins (spider veins) by any method.

• Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

• Treatment of hyperhidrosis (excessive sweating).

• Physician standby services.

• With the exception of emergency services and out-of-network services provided according to the ologist rule, all services provided by out of network providers require prior authorization.

3. Provider Reimbursement & Submission Requirements

3.1. All professional services for contracted physicians are paid at the lesser of the contracted provider’s rate, based on % of Medicare Physician Fee Schedule (MPFS) or billed charges. If there is not a Medicare rate for the covered service provided on the MPFS, the base payment is 150% of the Medicaid (IHCP) Fee Schedule. The provider’s contracted percent of MPFS is then applied to the fee amount.
3.2. If a provider has more than one Tier 1 contract (i.e. has signed with multiple delivery systems), the highest Tier 1 contract rate will apply when the provider sees members not assigned to a delivery system the provider is contracted with.

3.3. For non-contracted providers, in which a PA was received, or the service was an emergency service, the lowest qualified health plan (QHP) rate is used to calculate the reimbursement rate. For professional claims this is 125%.

3.4. **Site of Service Adjustment.** Under the MPFS, some procedures have a separate Medicare fee schedule rate for a physician’s professional services when provided in a facility and a non-facility setting. The CMS furnishes both fees in the MPFS update.

The place of service code (POS) is used to identify where the procedure is furnished. The list of facilities where a physician’s professional services are paid at the facility rate include:

- Outpatient Hospital-Off campus (POS code 19)
- Hospitals (POS code 21-23);  
- Ambulatory surgical center (ASC) (POS code 24)
- Skilled Nursing Facilities (SNF) (POS code 31);
- Hospice (POS 34)
- Ambulance (POS 41, 42)
- Inpatient psychiatric facilities (POS 51);  
- Psychiatric facility – partial hospitalization (POS 52)
- Community Mental Health Centers (CMHC) (POS code 53);
- Comprehensive inpatient rehabilitation facilities (POS 61);

Some services, by nature of their description or type of procedure, are performed only in certain settings and have only one maximum allowable fee per code. Some examples of these services include:

- Evaluation and management (E&M) codes which specify the site-of-service (SOS) within the description of the procedure codes (e.g., initial hospital care);
- Major surgical procedures that are generally performed only in hospital settings.

NOTE: If there is a separate rate for services performed in a facility or non-facility setting payment is based on the applicable rate for the POS (facility (#) or non-facility) that is billed on the claim. If only one rate is indicated on the Medicare Physician’s Fee Schedule that rate should be paid when that service is billed on a claim in any setting. Certain procedures would only be performed in a facility setting, such as, procedure code 19301 (partial mastectomy).
3.5. Same Day Services. When a patient is seen in the hospital or outpatient/office setting for more than one visit in the same day by physicians in the same billing group, same specialty, reimbursement will be paid to one physician and the other service(s) will be denied for inclusive to the other service code on that day.

Specialist claims billed on the same day as another physician but of a different specialty or group will be reimbursed according the Medicare Physician Fee Schedule (MPFS).

Preventive service performed on the same day as an Evaluation and Management service are allowable and payable when billed in conjunction with and E/M visit and the appropriate modifier code.

3.6. Bundled Services/Supplies. There are a number of services/supplies that are covered under Medicare and that have HCPCS codes, but they are services for which Medicare bundles payment into the payment for other related services. MDwise will follow the Medicare bundling rule and NCCI edits, except as indicated in the supplemental Medicaid covered code list and the MDwise NCCI deactivation list.

For example, injection services included in the fee schedule generally are not paid for separately if the practitioner is paid for an E/M service rendered at the same time. Reimbursement is only available for those injection services if no other physician fee schedule service is being paid. In either case, the drug is separately payable. If, for example, code 99211 is billed with an injection service, pay only for code 99211 and the separately payable drug.

3.7. Global Surgical Procedures. Services included in a global surgical package may be furnished in any setting, e.g., in hospitals, ASCs, physicians’ offices. Field 16 of the Medicare Fee Schedule Data Base (MFSDB) provides the postoperative periods that apply to each surgical procedure. The payment rules for surgical procedures apply to codes with entries of 000, 010, 090, and, sometimes, YYY.

Codes with “090” in Field 16 are major surgeries. Codes with “000” or “010” are either minor surgical procedures or endoscopies. Codes with “YYY” are generally manually priced codes (if no Medicaid fee), for which MDwise determine the global period (the global period for these codes will be 0, 10, or 90 days). If there is a “YYY” indicator and MDwise has not determined the global surgical period the claim will need to be pended and forwarded to MDwise for a determination. While codes with “ZZZ” are surgical codes, they are add-on codes that are always billed with another service. These codes are always included in the global period of the other service.

The Marketplace approved amount (based on Medicare rules) for surgical procedures includes payment for the following services related to the surgery when furnished by the physician who performs the surgery. Visits to a patient in an intensive care or critical care unit are also included if made by the surgeon. However, critical care services (99291 and 99292) are payable separately in some situations as outlined below.

- Preoperative Visits - Preoperative visits after the decision is made to operate beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures;
- Intra-operative Services - Intra-operative services that are normally a usual and necessary part of a surgical procedure;
- Complications Following Surgery - All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do
not require additional trips to the operating room;

- Postoperative Visits - Follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery; Postsurgical Pain Management - By the surgeon;

- Supplies - Except for those identified as exclusions; and

- Miscellaneous Services - Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples; lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

The Marketplace does not include the services listed below in the payment amount for a procedure with the appropriate indicator in Field 16 of the Medicare Fee Schedule Database. These services may be reimbursed separately.

- The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery (indicated by modifier 57). This policy only applies to major surgical procedures; the initial evaluation is always included in the allowance for a minor surgical procedure;

- Services of other physicians except where the surgeon and the other physician(s) agree on the transfer of care (see below);

- Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery (indicated by modifier 24 or 79);

- Significant E/M services on same date of procedure (indicated by modifier – 25). Claims containing evaluation and management codes with modifier “-25” are not subject to prepayment review except in the following situations.
  - All E/M services provided on the same day as inpatient dialysis are denied with the exception of CPT Codes 99221-9223, 99251-99255, and 99238. These codes may be billed with modifier “-25” and reviewed for possible allowance if the evaluation and management service is unrelated to the treatment of ESRD and was not, and could not, have been provided during the dialysis treatment
  - When preoperative critical care codes are being billed for within a global surgical period

- Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery;

- Diagnostic tests and procedures, including diagnostic radiological procedures;

- Clearly distinct surgical procedures during the postoperative period which are not re-operations or treatment for complications. (A new postoperative period begins with the subsequent procedure.) This includes procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure (indicated by modifier 58). Examples of this are procedures to diagnose and treat epilepsy (codes 61533, 61534-61536, 61539, 61541, and 61543) which may be performed in succession within 90 days of each other;
• Treatment for postoperative complications which requires a return trip to the operating room (OR), indicated by modifier 78. An OR for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient’s room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient’s condition was so critical there would be insufficient time for transportation to an OR). Refer to Field 18 of the MFSDB to determine the percentage of the global package for the post-op complications services. The fee schedule amount is multiplied by this percentage and rounded to the nearest cent. When an unlisted procedure is billed because no code exists to describe the treatment for complications, base payment on a maximum of 50 percent of the value of the intra-operative services originally performed.

• If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately;

• Immunosuppressive therapy for organ transplants (modifier 24)

• Critical care services (codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician. Modifier “-25” (for preoperative care) or “-24” (for postoperative care) must be used; along with an ICD-10-CM code in the range 800.0 through 959.9 (except 930-939), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

• Unusual circumstances - Surgeries for which services performed are significantly greater than usually required may be billed with the “-22” modifier added to the CPT code for the procedure. Surgeries for which services performed are significantly less than usually required may be billed with the “-52” modifier.

3.8. Minor Surgeries and Endoscopies. Visits by the same physician on the same day as a minor surgery or endoscopy are included in the payment for the procedure, unless a significant, separately identifiable service is also performed. The postoperative period for these procedures is indicated in Field 16 of the MFSDB. If the Field 16 entry is 010, the Marketplace does not allow separate payment for postoperative visits or services within 10 days of the surgery that are related to recovery from the procedure. If the Field 16 entry is 000, postoperative visits beyond the day of the procedure are not included in the payment amount for the surgery. Separate payment is made in this instance.

3.9. Determination of Global Period and Services in Global Package. To determine the global period for major surgeries, the Marketplace counts 1 day immediately before the day of surgery, the day of surgery, and the 90 days immediately following the day of surgery. To determine the global period for minor procedures, the Marketplace counts the day of surgery and the appropriate number of days immediately following the date of surgery.

To ensure the proper identification of services that are, or are not, included in the global package, the claims payer must be able to identify and process:

• **Procedure Codes and Modifiers.** Use of the modifiers apply to both major procedures with a 90-day postoperative period and minor procedures with a 10-day postoperative period (and/or a zero day postoperative period in the case of modifiers “-22” and “-25”).
• **Physicians in Group Practice.** When different physicians in a group practice participate in the care of the patient, the group bills for the entire global package. The physician who performs the surgery is shown as the performing physician.

• **Physicians Who Furnish Part of a Global Surgical Package.** Where physicians agree on the transfer of care during the global period, the following modifiers are used:
  
  o **“-54”** for surgical care only; or
  o **“-55”** for postoperative management only.

### 3.10. Physicians Furnishing Less Than the Full Global Package

If more than one physician provides services included in the global surgical package, payment for the postoperative, post-discharge care is split between two or more physicians where the physicians agree on the transfer of care. When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed what would have been paid if a single physician provides all services (except where stated policies, e.g., the surgeon performs only the surgery and a physician other than the surgeon provides preoperative and postoperative inpatient care, result in payment that is higher than the global allowed amount).

Shared global care does not apply to procedure codes with a global of "000."

Both the bill for the surgical care only and the bill for the postoperative care only, will contain the same date of service and the same surgical procedure code, with the services distinguished by the use of the appropriate modifier. The date on which care was relinquished or assumed, as applicable, must be shown on the claim.

**EXCEPTIONS:**

- Where a transfer of care does not occur, occasional post-discharge services of a physician other than the surgeon are reported by the appropriate evaluation and management code. No modifiers are necessary on the claim.
- If the transfer of care occurs immediately after surgery, the physician other than the surgeon who provides the in-hospital postoperative care bills using subsequent hospital care codes for the inpatient hospital care and the surgical code with the “-55” modifier for the post-discharge care. The surgeon bills the surgery code with the “-54” modifier.
- Physicians who provide follow-up services for minor procedures performed in an emergency department bill the appropriate level of office visit code. The physician who performs the emergency room service bills for the surgical procedure without a modifier.
- If the services of a physician other than the surgeon are required during a postoperative period for an underlying condition or medical complication, the other physician reports the appropriate evaluation and management code. No modifiers are necessary on the claim. An example is a cardiologist who manages underlying cardiovascular conditions of a patient.

### 3.11. Prepayment Edits to Detect Separate Billing of Services Included in the Global Package

For global surgeries, in addition to CCI edits, as outlined in the above sections, the payer must be capable of detecting certain other services included in the payment for a major or minor surgery or for an endoscopy. On a prepayment basis, the payer identifies the services that meet the following conditions:
• Preoperative services that are submitted on the same claim or on a subsequent claim as a surgical procedure; or
• Same day or postoperative services that are submitted on the same claim or on a subsequent claim as a surgical procedure or endoscopy; and,
• Services that were furnished within the prescribed global period of the surgical procedure;
• Services that are billed without modifier “-78,” “-79,” “-24,” “25,” or “-57” or are billed with modifier “-24” but without the required documentation; and
• Services that are billed with the same provider or group number as the surgical procedure or endoscopy.

Also, the payer must edit for any visits billed separately during the postoperative period without modifier “-24” by a physician who billed for the postoperative care only with modifier “-55.”

The following evaluation and management codes must be used in establishing edits for visits included in the global package.

**Evaluation and Management Codes for Edits**

<table>
<thead>
<tr>
<th>Code Range</th>
<th>Code Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>92012</td>
<td>92014</td>
</tr>
<tr>
<td>99211 - 99223</td>
<td>99231 - 99239</td>
</tr>
<tr>
<td>99241 - 99245</td>
<td>99251 - 99255</td>
</tr>
<tr>
<td>99261 - 99263</td>
<td></td>
</tr>
<tr>
<td>99271 - 99275</td>
<td>99291</td>
</tr>
<tr>
<td>99292</td>
<td>99301 - 99303</td>
</tr>
<tr>
<td>99311 - 99313</td>
<td>99315</td>
</tr>
<tr>
<td>99316</td>
<td></td>
</tr>
<tr>
<td>99331 - 99333</td>
<td>99347 - 99350</td>
</tr>
<tr>
<td>99374</td>
<td>99375</td>
</tr>
<tr>
<td>99377</td>
<td>99378</td>
</tr>
</tbody>
</table>

**NOTE:** In order for codes 99291 or 99292 to be paid for services furnished during the preoperative or postoperative period, modifier “-25” or “-24,” respectively, must be used and documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted. An ICD-10-CM code in the range 0S00.XX through T88.XX (except T15.XX), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

If a surgeon is admitting a patient to a nursing facility for a condition not related to the global surgical procedure, the physician should bill for the nursing facility admission and care with a “-24” modifier and appropriate documentation. If a surgeon is admitting a patient to a nursing facility and the patient’s admission to that facility relates to the global surgical procedure, the nursing facility admission and any services related to the global surgical procedure are included in the global surgery fee.

### 3.12. Multiple Surgeries

Multiple surgeries can be determined by the presence of the “-51” modifier and the billing of more than one separately payable surgical procedure by the same physician performed on the same patient on the same day.

Field 21 of the MFSDB indicates whether the standard payment policy rules apply to a multiple surgery, or whether special payment rules apply. Site of service payment adjustments (codes with an indicator of “1” in Field 27 of the MFSDB) should be applied before multiple surgery payment adjustments.
If Field 21 has an indicator of “2” surgeries are then ranked in descending order by the Medicare fee schedule amount. Base payment for each ranked procedure on the lower of the billed amount, or:

- 100 percent of the fee schedule amount for the highest valued procedure;
- 50 percent of the fee schedule amount for the remaining procedures;

If Field 21 for any of the multiple procedures contains an indicator of “0,” the multiple surgery rules do not apply to that procedure. Payment should be based on the lower of the billed amount or the fee schedule amount for each code unless other payment adjustment rules apply.

If Field 21 contains an indicator of “3,” and multiple endoscopies are billed, the special rules for multiple endoscopic procedures apply. Reimburse the full value of the highest valued endoscopy, plus the difference between the next highest and the base endoscopy. Access Field 31A of the MFSDB to determine the base endoscopy. If an endoscopic procedure with an indicator of “3” is billed with the “-51” modifier with other procedures that are not endoscopies the standard multiple surgery rules apply.

Apply the following rules where endoscopies are performed on the same day as unrelated endoscopies or other surgical procedures:

- Two unrelated endoscopies (e.g., 46606 and 43217): Apply the usual multiple surgery rules;
- Two sets of unrelated endoscopies (e.g., 43202 and 43217; 46606 and 46608): Apply the special endoscopy rules to each series and then apply the multiple surgery rules. Consider the total payment for each set of endoscopies as one service;
- Two related endoscopies and a third, unrelated procedure: Apply the special endoscopic rules to the related endoscopies, and, then apply the multiple surgery rules. Consider the total payment for the related endoscopies as one service and the unrelated endoscopy as another service.

If two or more multiple surgeries are of equal value, rank them in descending dollar order billed and base payment on the percentages listed above.

If any of the multiple surgeries are bilateral surgeries, consider the bilateral procedure at 150 percent as one payment amount, rank this with the remaining procedures, and apply the appropriate multiple surgery reductions.

In cases of multiple interventional radiological procedures, both the radiology code and the primary surgical code are paid at 100 percent of the fee schedule amount. The subsequent surgical procedures are paid at the standard multiple surgical percentages (50 percent, 50 percent, 50 percent and 50 percent).

3.12. Ranking of Same Day Multiple Surgeries When One Surgery Has a “-22” Modifier and Additional Payment is Allowed

Multiple surgeries are defined as separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same patient on the same day.
If the patient returns to the operating room after the initial operative session on the same day as a result of complications from the original surgery, the complications rules apply to each procedure required to treat the complications from the original surgery. The multiple surgery rules **would not** apply.

If the patient is returned to the operating room during the postoperative period of the original surgery, not on the same day of the original surgery, for multiple procedures that are required as a result of complications from the original surgery, the complications rules would apply. The multiple surgery rules would also not apply.

Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure. These intra-operative services, incidental surgeries, or components of more major surgeries are not separately billable. See Chapter 23 of the Medicare Claims Processing Manual for a description of edits to prevent separate payment for those procedures.

### 3.13. Bilateral Surgeries

Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day. The payment adjustment rules for bilateral surgeries do not apply to procedures identified by CPT as “bilateral” or “unilateral or bilateral” since the fee schedule reflects any additional work required for bilateral surgeries. Field 22 of the MFSDB indicates whether the payment adjustment rules apply to a surgical procedure.

If a procedure is not identified, by its terminology, as a bilateral procedure, physicians may use modifier “-50” on a single line item or, they may report the same code on separate lines reported once with modifier “-LT” and once with modifier “-RT”.

If Field 22 of the MFSDB contains an indicator of “1,” the base payment is the lower of the billed amount or 150 percent of the fee schedule amount. If Field 22 contains an indicator of “0,” “2,” or “3,” the payment adjustment rules for bilateral surgeries do not apply. Base payment is the lower of the billed amount or 100 percent of the fee schedule amount unless other payment adjustment rules apply. The provider’s contracted % rate of Medicare is then applied.

**NOTE:** Some codes which have a bilateral indicator of “0” in the MFSDB may be performed more than once on a given day. These are services that would never be considered bilateral and thus should not be billed with modifier “-50.” Where such a code is billed on multiple line items or with more than 1 in the units field and it is determined that the code may be reported more than once, bypass the “0” bilateral indicator and refer to the multiple surgery field for pricing.

**Note:** Please also refer to Medicare Claims Processing Manual, Chapter 12 for additional information regarding surgical processing guidelines.

### 3.14. Co-surgeon/Team surgeon Reimbursement

Co-surgeon services are generally reimbursed at 62.5% of the Medicare Physician Fee Schedule (MPFS) amount. For both surgeons to receive appropriate reimbursement, they must not be assisting each other, but performing distinct and separate parts of the same surgical procedure. Each surgeon bills for the procedure with a modifier “-62. If there are a team of surgeons modifier 66 is used.
The claims payer must access Field 24 or 25, as appropriate, of the MFSDB. These fields provide guidance on whether two or team surgeons are generally required for the surgical procedure.

- If the surgery is billed with a “-62” or “-66” modifier and Field 24 or 25 contains an indicator of “0,” payment adjustment rules for two or team surgeons do not apply and the second claim received from a surgeon will be denied.

- If the surgery is billed with a “-62” modifier and Field 24 contains an indicator of “1” or “2,” payment rules for two surgeons apply. Base payment for each physician on the lower of the billed amount or 62.5 percent of the fee schedule amount. Please note: According to Medicare methodology, an indicator of “1” requires manual suspension of the claim for review of need for co-surgeons. This policy will not be followed for the marketplace. Postpayment review may occur on as-needed basis.

- Modifier -66 describes highly complex procedures, requiring the concomitant services of more than one physician, often of different specialties. Team surgeons should generally do not submit the same HCPCS/CPT codes. When a provider reports an eligible procedure with modifier -66 appended (status indicator of “1” or “2”) reimbursement will be 100% of the allowable amount for each procedure (see 3.1). If there is more than one procedure performed, multiple surgery guidelines apply.

- If a claim is received with a “-66” modifier after one surgeon has been paid the full Medicare payment amount (on a bill without the modifier) the subsequent claim will deny.

3.15. Assistant at Surgery (Physician). Assistant-at-surgery services provided by a physician are reimbursed at 16 percent of the Medicare Physician Fee Schedule amount (base fee). The provider’s contracted fee amount would then be applied to the base fee. In addition to the assistant at surgery modifiers “-80,” “-81,” or “-82,” any procedures submitted with modifier AS are subject to the assistant surgeon’s policy as detailed in the Medicare physician fee schedule database.

3.16. Inpatient Services. Both Initial Hospital Care (CPT codes 99221 – 99223) and Subsequent Hospital Care codes are “per diem” services and may be reimbursed only once per day by the same physician or physicians of the same specialty from the same group practice. In a hospital inpatient situation involving one physician covering for another, if physician A sees the patient in the morning and physician B, who is covering for A, sees the same patient in the evening, physician B is not reimbursed for the second visit.

If the physicians are each responsible for a different aspect of the patient’s care, both visits may be covered if the physicians are in different specialties.

If a physician sees a patient in the emergency room and decides to admit the person to the hospital, only the initial hospital care is reimbursable for that physician. When the patient is admitted to the hospital via another site of service (e.g., physician’s office, nursing facility), all services provided by the physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission.
Only one hospital discharge day management service is payable per patient per hospital stay. Physicians or qualified nonphysician practitioners, other than the attending physician, who have been managing concurrent health care problems not primarily managed by the attending physician, and who are not acting on behalf of the attending physician, should use Subsequent Hospital Care (CPT code range 99231 – 99233) for a final visit. A subsequent hospital visit billed in addition to hospital discharge day management service on the same day by the same physician is not reimbursable.

3.17. Observation Care. Payment for an initial observation care code is for all the care rendered by the ordering physician on the date the patient’s observation services began. Similar to initial observation codes, payment for a subsequent observation care code is for all the care rendered by the treating physician on the day(s) other than the initial or discharge date. All other physicians who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient observation services must bill the appropriate outpatient service codes.

For example, if an internist orders observation services and asks another physician to additionally evaluate the patient, only the internist may bill the initial and subsequent observation care codes. The other physician who evaluates the patient must bill the new or established office or other outpatient visit codes as appropriate.

If the same physician who ordered hospital outpatient observation services also admits the patient to inpatient status before the end of the date on which the patient began receiving hospital outpatient observation services, pay only an initial hospital visit for the evaluation and management services provided on that date. Payment for the initial hospital visit includes all services provided to the patient on the date of admission by that physician, regardless of the site of service.

The global surgical fee includes payment for hospital observation (codes 99217, 99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, and 99236) services unless the criteria for use of CPT modifiers “-24,” “-25,” or “-57” are met.

3.18. Allergy Services. The MPFS fee amounts for allergy testing services billed under codes 95004-95078 are established for single tests. The numbers of tests are shown on the claim.

In accordance with Medicare reimbursement methodology, CPT codes 95120 through 95134 are not valid codes. Codes 95120 through 95134 represent complete services, i.e., services that include the injection service as well as the antigen and its preparation. Separate coding for injection only codes (i.e., codes 95115 and 95117) and/or the codes representing antigens and their preparation (i.e., codes 95144 through 95170) must be used.

If a physician bills both an injection code plus either codes 95165 or 95144, pay the appropriate injection code (i.e., code 95115 or code 95117) plus the code 95165 rate. When a provider bills for codes 95115 or 95117 plus code 95144, the payer must change 95144 to 95165 and pay accordingly. Code 95144 (single dose vials of antigen) should be billed only if the physician providing the antigen is providing it to be injected by some other entity. Single dose vials, which should be used only as a means of insuring proper dosage amounts for injections, are more costly than multiple dose vials (i.e., code 95165) and therefore their payment rate is higher. Allergists who prepare antigens are assumed to be able to administer proper doses from the less costly multiple dose vials. Thus, regardless of whether they use or bill for single or multiple dose vials at
the same time that they are billing for an injection service, they are paid at the multiple dose vial rate.

**Allergy Shots and Visit Services on the Same Day.** Office visits should not be billed with allergy injection services 95115 or 95117 unless the visit represents another separately identifiable service. In order for a physician to receive payment for a visit service provided on the same day that the physician also provides a service in the allergen immunotherapy series (i.e., any service in the series from 95115 through 95199), the physician is to bill a modifier 25 with the visit code, indicating that the patient’s condition required a significant, separately identifiable visit service above and beyond the allergen immunotherapy service provided.

The following tests related to allergy testing for the diagnosis listed below are not covered as they are considered experimental and investigational. If a claim includes one of the diagnosis in the below table and one of the following CPT codes, the claim may be denied.

**Non-Covered Allergy Testing CPT Codes**

<table>
<thead>
<tr>
<th>CPT* Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>82784</td>
<td>Gammaglobulin (immunoglobulin); IgA, IgD, IgG, IgM, each</td>
</tr>
<tr>
<td>83516</td>
<td>Immunoassay for analyte other than infectious agent antibody or infectious agent antigen, qualitative or semiquantitative; multiple step method</td>
</tr>
<tr>
<td>86001</td>
<td>Allergen specific IgG, quantitative</td>
</tr>
<tr>
<td>86021</td>
<td>Antibody identification; leukocyte antibodies</td>
</tr>
<tr>
<td>86140</td>
<td>C-reactive Protein</td>
</tr>
<tr>
<td>86160 - 86162</td>
<td>Compliment; antigen</td>
</tr>
<tr>
<td>86243</td>
<td>FcReceptor</td>
</tr>
<tr>
<td>86332</td>
<td>Immune complex assay</td>
</tr>
<tr>
<td>86343</td>
<td>Leukocyte histamine release test (LHR)</td>
</tr>
<tr>
<td>86352</td>
<td>Cellular Function Assay involving stimulation</td>
</tr>
<tr>
<td>86485</td>
<td>Skin test, candida</td>
</tr>
<tr>
<td>86628</td>
<td>Candida</td>
</tr>
<tr>
<td>88184</td>
<td>Flow cytometry</td>
</tr>
<tr>
<td>CPT* Codes</td>
<td>Description</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>88185</td>
<td>Flow cytometry</td>
</tr>
<tr>
<td>88342</td>
<td>Immunohistochemistry</td>
</tr>
<tr>
<td>88346</td>
<td>Immunoflourescent study</td>
</tr>
<tr>
<td>95060</td>
<td>Ophthalmic mucous membrane tests</td>
</tr>
<tr>
<td>95065</td>
<td>Direct nasal mucous membrane test</td>
</tr>
<tr>
<td>95831 - 95834</td>
<td>Muscle testing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD10 DX</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H10.11</td>
<td>Acute atopic conjunctivitis, right eye</td>
</tr>
<tr>
<td>H10.12</td>
<td>Acute atopic conjunctivitis, left eye</td>
</tr>
<tr>
<td>H10.13</td>
<td>Acute atopic conjunctivitis, bilateral</td>
</tr>
<tr>
<td>H10.45</td>
<td>Other chronic allergic conjunctivitis</td>
</tr>
<tr>
<td>J30.0</td>
<td>Vasomotor rhinitis</td>
</tr>
<tr>
<td>J30.1</td>
<td>Allergic rhinitis due to pollen</td>
</tr>
<tr>
<td>J30.2</td>
<td>Other seasonal allergic rhinitis</td>
</tr>
<tr>
<td>J30.5</td>
<td>Allergic rhinitis due to food</td>
</tr>
<tr>
<td>J30.81</td>
<td>Allergic rhinitis due to animal (cat) (dog) hair and dander</td>
</tr>
<tr>
<td>J30.89</td>
<td>Other allergic rhinitis</td>
</tr>
<tr>
<td>J30.9</td>
<td>Allergic rhinitis, unspecified</td>
</tr>
<tr>
<td>J45.20</td>
<td>Mild intermittent asthma, uncomplicated</td>
</tr>
<tr>
<td>J45.21</td>
<td>Mild intermittent asthma with (acute) exacerbation</td>
</tr>
<tr>
<td>J45.22</td>
<td>Mild intermittent asthma with status asthmaticus</td>
</tr>
<tr>
<td>J45.30</td>
<td>Mild persistent asthma, uncomplicated</td>
</tr>
<tr>
<td>ICD10 DX</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>J45.31</td>
<td>Mild persistent asthma with (acute) exacerbation</td>
</tr>
<tr>
<td>J45.32</td>
<td>Mild persistent asthma with status asthmaticus</td>
</tr>
<tr>
<td>J45.40</td>
<td>Moderate persistent asthma, uncomplicated</td>
</tr>
<tr>
<td>J45.41</td>
<td>Moderate persistent asthma with (acute) exacerbation</td>
</tr>
<tr>
<td>J45.42</td>
<td>Moderate persistent asthma with status asthmaticus</td>
</tr>
<tr>
<td>J45.50</td>
<td>Severe persistent asthma, uncomplicated</td>
</tr>
<tr>
<td>J45.51</td>
<td>Severe persistent asthma with (acute) exacerbation</td>
</tr>
<tr>
<td>J45.52</td>
<td>Severe persistent asthma with status asthmaticus</td>
</tr>
<tr>
<td>L20.0</td>
<td>Besnier’s prurigo</td>
</tr>
<tr>
<td>L20.81</td>
<td>Atopic neurodermatitis</td>
</tr>
<tr>
<td>L20.82</td>
<td>Flexural eczema</td>
</tr>
<tr>
<td>L20.84</td>
<td>Intrinsic (allergic) eczema</td>
</tr>
<tr>
<td>L20.89</td>
<td>Other atopic dermatitis</td>
</tr>
<tr>
<td>L23.XX</td>
<td>Allergic contact dermatitis</td>
</tr>
<tr>
<td>L24.XX</td>
<td>Irritant contact dermatitis</td>
</tr>
<tr>
<td>L27.2</td>
<td>Dermatitis due to ingested food `</td>
</tr>
<tr>
<td>L30.0</td>
<td>Nummular dermatitis</td>
</tr>
<tr>
<td>L30.2</td>
<td>Cutaneous autosensitization</td>
</tr>
<tr>
<td>L30.9</td>
<td>Dermatitis, unspecified</td>
</tr>
<tr>
<td>L50.0</td>
<td>Allergic urticaria</td>
</tr>
<tr>
<td>T50.905A</td>
<td>Adverse effect of unspecified drugs, medicaments and biological substances</td>
</tr>
<tr>
<td>T50.995A</td>
<td>Adverse effect of other drugs, medicaments and biological substances</td>
</tr>
<tr>
<td>T63.0XX</td>
<td>Toxic effect of snake venom</td>
</tr>
<tr>
<td>T63.2XX</td>
<td>Toxic effect of venom of scorpion</td>
</tr>
<tr>
<td>T63.3XX</td>
<td>Toxic effect of spider venom</td>
</tr>
<tr>
<td>T63.4XX</td>
<td>Toxic effect of venom of other arthropods</td>
</tr>
<tr>
<td>T78.0XX</td>
<td>Anaphylactic reaction to food</td>
</tr>
<tr>
<td>T78.2XX</td>
<td>Other Anaphylactic reaction</td>
</tr>
<tr>
<td>Z88.0</td>
<td>Allergy status to penicillin</td>
</tr>
<tr>
<td>Z88.1</td>
<td>Allergy status to other antibiotic agents status</td>
</tr>
<tr>
<td>Z88.8</td>
<td>Allergy status to other drugs, medicaments and biological substances status</td>
</tr>
<tr>
<td>Z91.010</td>
<td>Allergy to peanuts</td>
</tr>
<tr>
<td>Z91.048</td>
<td>Other nonmedicinal substance allergy status</td>
</tr>
<tr>
<td>Z91.09</td>
<td>Other allergy status, other than to drugs and biological substances</td>
</tr>
</tbody>
</table>
3.19. **Physician Shortage Area (PSA).** No PSA or Health Profession Shortage Area (HPSA) payments are made for the Marketplace product.


When a pathologist (341), anesthesiologist (311), radiologist (333) perform services in the below places of service, regardless of whether the provider is contracted with the delivery system or any delivery system, these specialty types should be reimbursed for covered services in accordance with Marketplace reimbursement methodology.

The processing rules for these provider types include reimbursing covered services in these service settings, including inpatient services (POS 21) regardless of whether an authorization was obtained when required.

The only exceptions to this rule are those services that are on the Marketplace prior authorization list that are performed by an anesthesiologist, radiologist, or pathologist or submitted by a lab. This includes, for example an MRA performed by a radiologist, pain management services performed by an anesthesiologist, and genetic testing submitted by a lab or pathologist. In each of these cases, if there is no prior authorization for the service, the claim should be denied, regardless of contracting status.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>PA Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Radiologist</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient (IP) Contracted Radiologist</td>
<td>No PA</td>
</tr>
<tr>
<td>IP Non-contracted Radiologist</td>
<td>No PA</td>
</tr>
<tr>
<td>POS 11 non-contracted Radiologist</td>
<td>No PA unless the radiology service is listed on PA list</td>
</tr>
<tr>
<td>POS 22 and 23 non-contracted Radiologist</td>
<td>No PA unless the radiology service is listed on PA list</td>
</tr>
<tr>
<td>POS 24 non-contracted Radiologist</td>
<td>No PA unless the radiology service is listed on PA list</td>
</tr>
<tr>
<td><strong>Pathologist</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient contracted Pathologist</td>
<td>No PA</td>
</tr>
<tr>
<td>Inpatient non-contracted Pathologist</td>
<td>No PA</td>
</tr>
<tr>
<td>POS 11 non-contracted Pathologist</td>
<td>No PA unless the pathology service is listed on PA list</td>
</tr>
<tr>
<td>POS 22 and 23 non-contracted Pathologist</td>
<td>No PA unless the pathology service is listed on PA list</td>
</tr>
</tbody>
</table>
### Type of Service | PA Requirement
--- | ---
POS 24 non-contracted Pathologist | No PA unless the pathology service is listed on PA list
Anesthesiologist | 
IP contracted Anesthesiologist | No PA
IP non-contracted Anesthesiologist | No PA
POS 22 and 23 non-contracted Anesthesiologist | No PA unless anesthesiology service is listed on PA list
POS 11 non-contracted Anesthesiologist | No PA unless anesthesiology service is listed on PA list
POS 24 non-contracted Anesthesiologist | No PA unless anesthesiology service is listed on PA list
LABs | 
Non-contracted independent labs (POS 81) | No PA unless lab service is on PA list

---

### 4. Procedure Codes and Claim Considerations

#### 4.1. Modifiers. There are a number of modifiers (for example AS and mod 25) that can be used by providers and can affect payment of claim. The complete list can be found in the CMS manual, on the CMS website, or at [www.wpsmedicare.com](http://www.wpsmedicare.com).

E/M services should be billed with modifier 25 when on claim with preventive services. If the modifier is not included, then in accordance with NCCI edits, the preventive service codes should be reimbursed and the E/M service should deny for included in the primary service.

Effective January 1, 2016, modifier – CT is to be reported with certain Computed tomography (CT) scan CPT codes in which equipment is used that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) XR-29-2013 standard.” The applicable CT services are identified by HCPCS codes 70450 through 70498; 71250 through 71275; 72125 through 72133; 72191 through 72218; 72194 through 72196; 73200 through 73206; 73700 through 73706; 74150 through 74178; 74261 through 74263; and 75571 through 75574 (and any succeeding codes). The use of this modifier will result in reducing payment for the technical component (and the technical component of the global fee) of the Physician Fee Schedule service (5 percent in 2016 and 15 percent in 2017).

MDwise may receive claims for surgical procedures with more than one surgical modifier. For example, since the global fee concept applies to all major surgeries, MDwise may receive a claim for surgical care only (modifier “-54”) for a bilateral surgery (modifier “-50”). They may also receive a claim for multiple surgeries requiring the use of an assistant surgeon. Please refer to the CMS Claims Processing Manual, Chapter 12 for a list of possible surgical modifier combinations.

#### 4.2. Supplies. MDwise makes a separate payment for supplies furnished in connection with a procedure only if the supply is a pharmaceutical or radiopharmaceutical diagnostic imaging agent (including codes A4641 through A4647); pharmacologic stressing agent (code J1245); or therapeutic radionuclide (CPT code 79900). Other agents may be used which do not have an assigned HCPCS code. The procedures performed are:
- Diagnostic radiologic procedures (including diagnostic nuclear medicine) requiring
pharmaceutical or radiopharmaceutical contrast media and/or pharmacologic stressing agent;

- Other diagnostic tests requiring a pharmacologic stressing agent;
- Clinical brachytherapy procedures (other than remote after-loading high intensity brachytherapy procedures (CPT codes 77781 through 77784) for which the expendable source is included in the TC RVUs); or
- Therapeutic nuclear medicine procedures.

Drugs are not supplies and may be paid incidental to physicians’ services.

4.3. MDwise pays for an evaluation and management service on the day of or on the day before a procedure with a 90-day global surgical period if the physician uses CPT modifier “-57” to indicate that the service resulted in the decision to perform the procedure. MDwise does not pay for an evaluation and management service billed with the CPT modifier “-57” if it was not provided on the day of or the day before a procedure with a 0 or 10-day global surgical period.

4.4. CPT code 99211 should be denied if it is billed with a drug administration service such as a chemotherapy or nonchemotherapy drug infusion code or a therapeutic or diagnostic injection code. When a medically necessary, significant and separately identifiable E/M service (which meets a higher complexity level than CPT code 99211) is performed, in addition to one of the drug administration services, the appropriate E/M CPT code should be reported with modifier -25.

4.5. Critical care. CPT code 99291 (critical care) is used to report the first 30 - 74 minutes of critical care on a given calendar date of service. It should only be reimbursed once per calendar date per patient by the same physician or physician group of the same specialty. CPT code 99292 is used to report additional block(s) of time, of up to 30 minutes each beyond the first 74 minutes of critical care. Critical care of less than 30 minutes total duration on a given calendar date is not reported separately using the critical care codes. This service should be reported using another appropriate E/M code such as subsequent hospital care.

Medically necessary critical care services provided on the same calendar date to the same patient by physicians representing different medical specialties that are not duplicative services are payable. The medical specialists may be from the same group practice or from different group practices.

Critical care services shall not be paid on the same calendar date the physician also reports a procedure code with a global surgical period unless the critical care is billed with CPT modifier -25 to indicate that the critical care is a significant, separately identifiable evaluation and management service that is above and beyond the usual pre and post-operative care associated with the procedure that is performed.

The following services when performed on the day a physician bills for critical care are included in the critical care service and should not be reimbursed separately:
- The interpretation of cardiac output measurements (CPT 93561, 93562);
- Chest x-rays, professional component (CPT 71010, 71015, 71020);
- Blood draw for specimen (CPT 36415);
- Blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data-CPT 99090);
• Gastric intubation (CPT 43752, 91105);
• Pulse oximetry (CPT 94760, 94761, 94762);
• Temporary transcutaneous pacing (CPT 92953);
• Ventilator management (CPT 94002 – 94004, 94660, 94662); and
• Vascular access procedures (CPT 36000, 36410, 36415, 36591, 36600).

No other procedure codes are bundled into the critical care services. Therefore, other medically necessary procedure codes may be billed separately.

When a hospital inpatient or office/outpatient evaluation and management service (E/M) are furnished on a calendar date at which time the patient does not require critical care and the patient subsequently requires critical care both the critical Care Services (CPT codes 99291 and 99292) and the previous E/M service may be paid on the same date of service. Hospital emergency department services are not paid for the same date as critical care services when provided by the same physician to the same patient.

4.6. Allowable Adjustments. The replacement code (CPT 69990) for modifier -20 - microsurgical techniques requiring the use of operating microscopes may be paid separately only when submitted with CPT codes:
• 61304 through 61546
• 61550 through 61711
• 62010 through 62100
• 63081 through 63308
• 63704 through 63710
• 64831
• 64834 through 64836
• 64840 through 64858
• 64861 through 64871
• 64885 through 64891
• 64905 through 64907

4.7. Cystourethroscopy with Fulguration and/or Resection of Tumors. (Codes 52234,52235, and 52240) The descriptors for codes 52234 through 52240 include the language “tumor(s).” This means that regardless of the number of tumors removed, only one unit of a single code is to be reimbursed on a given date of service. For these three codes only one unit may be billed for any of these codes, only one of the codes may be billed, and the billed code reflects the size of the largest tumor removed.

4.8. Manual Pricing. CPT codes billed for the marketplace, which fall under the manual pricing logic should follow the published Medicaid rate methodology, as outlined in the below table and in the IHCP Bulletin, BT 200940 and 201213. Except for drugs and biological, which have special pricing, HCPCS codes which indicate manual pricing will be reimbursed at 60% of billed charges, or for DME products, 60% of the Manufacturers Suggested Retail Price (MSRP). For the pricing of drugs and biological, refer to BCCP 20, Pharmacy & Biologicals.
To determine the base Medicare rate for CPT codes, the applicable Medicaid rate, based on the below table is multiplied by 150%. The provider’s contracted rate is then applied to the base Medicare rate.

For HCPS codes that are paid at 60% of billed charges, there is no additional percentage applied.

<table>
<thead>
<tr>
<th>Procedure Code Range</th>
<th>Codes Billed on CMS-1500</th>
<th>Codes Billed on UB-04</th>
</tr>
</thead>
<tbody>
<tr>
<td>10000-19999</td>
<td>20% of billed Amount</td>
<td>20% of billed Amount</td>
</tr>
<tr>
<td>20000-29999</td>
<td>20% of billed Amount</td>
<td>10% of billed Amount</td>
</tr>
<tr>
<td>30000-39999</td>
<td>20% of billed Amount</td>
<td>10% of billed Amount</td>
</tr>
<tr>
<td>40000-49999</td>
<td>20% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
<tr>
<td>50000-59999</td>
<td>35% of billed Amount</td>
<td>10% of billed Amount</td>
</tr>
<tr>
<td>60000-69999</td>
<td>20% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
<tr>
<td>70000-79999</td>
<td>25% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
<tr>
<td>80000-89999</td>
<td>30% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
<tr>
<td>90000-99999</td>
<td>40% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
</tbody>
</table>

4.9. **Provider Preventable Conditions.** The Marketplace also will not cover a surgical or other invasive procedure to treat particular medical conditions when the practitioner performs the surgery or invasive procedure erroneously, including:
- Incorrect surgical or other invasive procedures
- Surgical or other invasive procedures on the wrong body part
- Surgical or other invasive procedures on the wrong patient

Hospitalizations and other services related to these noncovered procedures are also not covered. Please refer to MDwise BAP 03, Hospital Acquired Conditions and Provider Preventable Conditions for additional information about processing requirements.

5. **Prior Authorization**

5.1. Physician claims are processed in accordance with the MDwise Marketplace Prior Authorization requirements.

6. **Copays and Coinsurance**

Refer to the MDwise Marketplace Individual Policy for the Schedule of Benefits which summarizes applicable coinsurance and copays related to coverage of physician services. Please also note:

- If the rendering physician holds a primary medical provider contract (PMP) or a Nurse Practitioner with panel contract, or is a PMP specialty type within a contracted Marketplace provider group, then the PMP copay applies to the office visit, not the specialist copay. PMP specialty types include the
following:

- 090 Pediatric Nurse Practitioner
- 091 Obstetric Nurse Practitioner
- 092 Family Nurse Practitioner
- 093 Nurse Practitioner
- 095 Certified Nurse Midwife
- 100 Physician assistant
- 316 Family Practitioner
- 318 General Practitioner
- 320 Geriatric Practitioner
- 328 Ob/gyn specialty type
- 335 Pediatrician
- 344 General Internist
- 345 General Pediatrician

Please refer to the below table for a PMP specialty type crosswalk to taxonomy codes:

<table>
<thead>
<tr>
<th>Taxonomy to PMP List</th>
<th>Specialty ID</th>
<th>Taxonomy Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>090 Pediatric Nurse Practitioner</td>
<td>363LP0200X</td>
<td>Nurse Practitioner – Pediatrics</td>
</tr>
<tr>
<td>090 Pediatric Nurse Practitioner</td>
<td>363LP0222X</td>
<td>Nurse Practitioner - Pediatrics, Critical Care</td>
</tr>
<tr>
<td>091 Obstetric Nurse Practitioner</td>
<td>363LX0001X</td>
<td>Nurse Practitioner - Obstetrics &amp; Gynecology</td>
</tr>
<tr>
<td>093 Nurse Practitioner</td>
<td>363LF0000X</td>
<td>Nurse Practitioner – Family</td>
</tr>
<tr>
<td>093 Nurse Practitioner</td>
<td>363L00000X</td>
<td>Nurse Practitioner - Nurse Practitioner</td>
</tr>
<tr>
<td>093 Nurse Practitioner</td>
<td>363LA2100X</td>
<td>Nurse Practitioner - Acute Care</td>
</tr>
<tr>
<td>093 Nurse Practitioner</td>
<td>363LA2200X</td>
<td>Nurse Practitioner - Adult Health</td>
</tr>
<tr>
<td>093 Nurse Practitioner</td>
<td>363LP2300X</td>
<td>Nurse Practitioner - Primary Care</td>
</tr>
<tr>
<td>093 Nurse Practitioner</td>
<td>363LP0808X</td>
<td>Nurse Practitioner - Psych/Mental Health</td>
</tr>
<tr>
<td>093 Nurse Practitioner</td>
<td>363LC1500X</td>
<td>Nurse Practitioner - Community Health</td>
</tr>
<tr>
<td>093 Nurse Practitioner</td>
<td>363LG0600X</td>
<td>Nurse Practitioner - Gerontology</td>
</tr>
<tr>
<td>093 Nurse Practitioner</td>
<td>363LW0102X</td>
<td>Nurse Practitioner - Womens Health</td>
</tr>
<tr>
<td>095 Certified Nurse Midwife</td>
<td>367A00000X</td>
<td>Midwife, Certified Nurse - Midwife, Certified Nurse</td>
</tr>
<tr>
<td>316 Family Practitioner</td>
<td>207Q0000X</td>
<td>Family Medicine - Family Medicine</td>
</tr>
<tr>
<td>316 Family Practitioner</td>
<td>207QS0010X</td>
<td>Family Medicine - Sports Medicine</td>
</tr>
<tr>
<td>316 Family Practitioner</td>
<td>207QA0505X</td>
<td>Family Medicine - Adult Medicine</td>
</tr>
<tr>
<td>316 Family Practitioner</td>
<td>207QA0000X</td>
<td>Family Medicine - Adolescent Medicine</td>
</tr>
<tr>
<td>318 General Practitioner</td>
<td>1223G0001X</td>
<td>General Practice</td>
</tr>
<tr>
<td>318 General Practitioner</td>
<td>208D00000X</td>
<td>General Practice - General Practice</td>
</tr>
<tr>
<td>320 Geriatric Practitioner</td>
<td>207RG0300X</td>
<td>Internal Medicine - Geriatric Medicine</td>
</tr>
<tr>
<td>320 Geriatric Practitioner</td>
<td>207QG0300X</td>
<td>Family Medicine - Geriatric Medicine</td>
</tr>
</tbody>
</table>
• If multiple items that require copay are on the same bill (e.g. x-ray and E/M service), there is only one copay amount that is applied. The copay to be applied is the office visit copay.
• The office visit copay only applies to the office visit charge up to the allowed amount and/or the copay amount whichever is less.
• Surgical services performed in an office setting will be subject to the office visit copay. The office visit copay will be applied to the office visit charge and surgical services until the copay has been reach up to the allowed amount.
• Coinsurance applies to drugs and biologicals and DME received in the office setting, in addition to the office copay.
• Coinsurance, not the office visit copay applies to PMP or specialist services provided in an inpatient or outpatient facility setting (e.g. POS 19, POS 22, and POS 23). The exception is professional claims received with a place of service 19 or 22 and an office visit E&M code. The applicable office visit copay applies to these services instead of coinsurance.
• Only one office visit copay per day per provider is assessed for POS codes 11, 50, and 72.

**Allergy Services**
  - If the member has an office visit for allergies and receives serum, both the specialist copay and the coinsurance for the allergy serum will be required. Subsequent visits for allergy shots only (e.g. no E/M code) do not require a member copay. Coinsurance will apply to additional serum if provided.
  - Allergy Services billed with CPT codes 95115 and 95117 performed in an office will not be subject to the office visit copay.
  - Allergy Services billed with CPT codes 95144 thru 95180 performed in an office setting will be subject to the office visit copay. The office visit copay will be applied to the office visit charge and the CPT codes until the copay has been reach up to the allowed amount.
1. Benefit Coverage

1.1. MDwise covers medically necessary therapeutic shoes for a member with diabetes under the Orthotic Devices Section 3.13 of the individual policy.

1.2. Podiatric services performed must be within the scope of the practice of the licensed podiatric profession as defined by Indiana law. Covered medically necessary services may include:
   • Diagnosis of foot disorders and
   • Mechanical, medical, or surgical treatment of these disorders,

1.3. While the MDwise Marketplace benefits generally excludes routine foot care services from coverage, there are specific indications or exceptions under which there are program benefits.

   The following services are considered to be components of routine foot care as provided by a licensed podiatry provider or physician:
   • Cutting or removal of corns and calluses;
   • Clipping, trimming, or debridement of nails,
   • Shaving, paring, cutting or removal of benign hyperkeratotic lesion (e.g. corn or callus);

   The above routine foot care treatments may be considered medically necessary in the presence of certain medical conditions that involve impaired peripheral circulation and loss of protective sensation.

   Payment for routine foot care may be considered for payment only if member’s condition meets the indications and criteria for coverage. These conditions describe the systemic diseases and their peripheral complications that increase the danger for infection and injury if a non-professional provides these services.

   There must be adequate medical documentation to demonstrate the need for routine foot care services as outlined in this policy. This documentation may be office records, physician notes or diagnoses characterizing the patient’s physical status as being of such severity to meet the criteria for exceptions to the Medicare routine foot care exclusion.

   1.4. Any other service by a licensed podiatrist that falls within the scope of practice that is not indicated specifically as a covered service in this policy or as an excluded service in the member’s Individual Policy will require a prior authorization request and subsequent review for medical necessity.

2. Benefit Limitations and Exclusions

2.1. Limitations

   • Orthotic appliances may be replaced once per year per Enrollee when Medically Necessary in the Enrollee’s situation. However, additional replacements will be allowed for Enrollees under age 18 due to rapid growth, or for any Enrollee when an appliance is damaged and cannot be repaired.
• Routine foot care services consistent with policy covered diagnoses, services and criteria are considered medically necessary up to 6 visits per year without an authorization.

2.2. Exclusions

• Routine foot care (including the cutting and removal of corns and calluses), Nail trimming, cutting and debriding, Hygienic and preventive maintenance foot care, including, but not limited to the following list.
  o Cleaning and soaking the feet.
  o Applying skin creams in order to maintain skin tone.
  o Other services that are performed when there is not a localized illness, injury or symptom involving the foot.
• Surgical treatment of flat feet, subluxation of the foot, weak, strained, unstable feet, tarsalgia, metatarsalgia, hyperkeratoses.

3. Provider Reimbursement & Submission Requirements

3.1. The provider reimbursement is as per provider’s contracted percentage utilizing the appropriate Medicare physician fee schedule or DMEPOS fee schedule as the base rate.
  • Use the Medicare payment amount, if available; then apply the provider’s contracted percent of Medicare. If not, and the service code is covered, then use the Medicaid payment amount as the base. 150% of Medicaid is deemed equivalent to the Medicare rate; then apply the provider’s contracted percent of Medicare. If there is no Medicare or Medicaid rate and the service is covered, the item must be manually priced. (see below)

  • If the provider is not contracted, and the service is authorized, then the following rate is applied to the applicable Medicare fee amount (or 150% of the Medicaid payment amount as the Medicare equivalent when no fee in Medicare is available and it is a covered service), unless in some case, the authorization could contain the non-contracted provider rate:
    o Facility 133%,
    o Professional l claims 125%

  • Site of service (nonfacility and facility services) fees may apply to certain service codes

  • In all cases, if the billed amount is less than the contracted payment amount, the billed amount is to be reimbursed.

3.2. Manual Pricing. CPT codes billed for the marketplace, which fall under the manual pricing logic should follow the published Medicaid rate methodology, as outlined in the below table and in the IHCP Bulletin, BT 200940 and 201213. Except for drugs and biological, which have special pricing, HCPCS codes which indicate manual pricing will be reimbursed at 60% of billed charges, or for DME products, 60% of the Manufacturers Suggested Retail Price (MSRP).
To determine the base Medicare rate for CPT codes, the applicable Medicaid rate, based on the below table is multiplied by 150%. The provider’s contracted rate is then applied to the base Medicare rate.

For HCPS codes that are paid at 60% of billed charges, there is no additional percentage applied (Medicare equivalency or additional provider contracted amount).

<table>
<thead>
<tr>
<th>Procedure Code Range</th>
<th>Codes Billed on CMS-1500</th>
<th>Codes Billed on UB-04</th>
</tr>
</thead>
<tbody>
<tr>
<td>10000-19999</td>
<td>20% of billed Amount</td>
<td>20% of billed Amount</td>
</tr>
<tr>
<td>20000-29999</td>
<td>20% of billed Amount</td>
<td>10% of billed Amount</td>
</tr>
<tr>
<td>30000-39999</td>
<td>20% of billed Amount</td>
<td>10% of billed Amount</td>
</tr>
<tr>
<td>40000-49999</td>
<td>20% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
<tr>
<td>50000-59999</td>
<td>35% of billed Amount</td>
<td>10% of billed Amount</td>
</tr>
<tr>
<td>60000-69999</td>
<td>20% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
<tr>
<td>70000-79999</td>
<td>25% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
<tr>
<td>80000-89999</td>
<td>30% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
</tbody>
</table>

4. Procedure Codes and Claim Considerations

4.1. Providers bill services on the CMS-1500 or 837P transaction.

4.2. Coding for therapeutic shoes for member with diabetes, includes the following, but may not be all inclusive. A diagnosis of diabetes must be present/linked on the claim in order to be paid. Please also refer to PA requirements if service requires a PA.

A5500 – A5510  Diabetic shoes, fitting, and modifications

A5512  For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees Fahrenheit or higher, total contact with patient’s foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer or 3/16 inch material of shore a 40 (or higher), prefabricated, each

A5513  For diabetics only, multiple density insert, custom molded from model of patient’s foot, total contact with patient’s foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer or higher, includes arch filler and other shaping material, custom fabricated, each

K0672  Addition to lower extremity orthosis, removable soft interface, all components, replacement only, each

L0112 – L4398  Orthotic devices, procedures

Please also refer to BCCP 10: Durable Medical Equipment, Medical Supplies, & Appliances

4.3. Routine Foot Care procedure codes as defined in this policy for the diagnoses indicated include the following. The CPT/HCPCS codes will be subject to procedure to diagnosis editing to
support evidence for coverage of routine foot care. If a covered diagnosis is not on the claim, in
compliance with the diagnosis and services entered as authorized/applicable template, the claim
should deny with an appropriate reason code that indicates the diagnosis code submitted does not
meet the criteria of service billed.

Procedure Codes
11055  PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG, CORN OR
CALLUS); SINGLE LESION
11056  PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG, CORN OR
CALLUS); 2 TO 4 LESIONS
11057  PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG, CORN OR
CALLUS); MORE THAN 4 LESIONS
11719  TRIMMING OF NONDYSTROPHIC NAILS, ANY NUMBER
11720  DEBRIDEMENT OF NAIL(S) BY ANY METHOD(S); 1 TO 5
11721  DEBRIDEMENT OF NAIL(S) BY ANY METHOD(S); 6 OR MORE
G0127 TRIMMING OF DYSTROPHIC NAILS, ANY NUMBER

ICD10 diagnosis codes for systemic conditions that meet criteria
for routine foot care per OMPP Medical Policy Podiatry Policy
and IHCP code set:

<table>
<thead>
<tr>
<th>ICD-10-CM Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B35.1</td>
<td>Tinea Unguium</td>
</tr>
<tr>
<td>E08.00 – E11.9, E13.42</td>
<td>Diabetes mellitus, other diabetes mellitus with diabetic polyneuropathy, diabetes with unspecified complications</td>
</tr>
<tr>
<td>G60.0, G60.1, G60.3, G60.8, G61.0, G62.0- G62.2, G63</td>
<td>Hereditary and idiopathic peripheral neuropathy, Guillain Barre, drug induced, alcoholic induced, and polyneuropathy due to other toxic agents</td>
</tr>
<tr>
<td>I70.201 – I70.299</td>
<td>Arteriosclerotic vascular disease of the lower extremities</td>
</tr>
<tr>
<td>I73.1</td>
<td>Thromboangiitis obliterans (Buerger's disease)</td>
</tr>
<tr>
<td>I79.8</td>
<td>Other disorders of arteries</td>
</tr>
<tr>
<td>I87.001 – I87.399</td>
<td>Post-phlebitis syndrome</td>
</tr>
<tr>
<td>L84</td>
<td>Corns and callosities</td>
</tr>
</tbody>
</table>

4.4. Q Modifier and Date Last Seen By Physician
For Medicare billing normally claims submitted with CPT codes 11055, 11056, 11057, 11719,
11720, 11721 and G0127 must have modifier Q7, Q8, or Q9 and diagnosis code listed in this
policy.

The presumption of coverage may be applied when the physician rendering the routine foot care
has identified:
Modifier Q7: A Class A finding
Modifier Q8: Two of the Class B findings; or
Modifier Q9: One Class B and two Class C findings

If the patient has evidence of neuropathy but no vascular impairment, the use of class findings
modifiers is not necessary.

For Medicare, for CPT codes: G0127, 11055, 11056, 11057, 11719 and 11720-11721 billed with
the appropriate Q modifier, a date last seen by a doctor of medicine or osteopathy (MD or DO)
for the treatment and/or evaluation of the complicating disease process occurs during the six (6)
month period prior to the rendition of the routine-type service or if the patient sees their primary care physician no later than 30 days after the services were furnished.

**Note:** In the event the appropriate Q modifier or date last seen by a doctor or medicine or osteopathy (MD or D) is not known, the claim should not be denied for either of those reasons.

5. **Prior Authorization (PA) Requirements**

5.1. Claims received for Podiatry Services are processed in accordance with the MDwise Marketplace Prior Authorization requirements.

5.2. The following require prior authorization:
- Any service that will be provided by a non-participating practitioner or facility
- Any podiatry service not listed as non-covered in the member policy, excluding the first covered service
- Covered routine foot care in addition to the 6 visits per year that meets the criteria requires prior authorization.

**Diagnosis Code Table (4.3. Routine Foot Care procedure codes as defined in this policy for the diagnoses indicated include the following)**

<table>
<thead>
<tr>
<th>Diagnosis Codes/Descriptions</th>
<th>Diagnosis Codes/Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>E08.00 Diabetes mellitus due to underlying condition with hyperosmolarity without nonketotic hyperglycemic - hyperosmolar coma (NKHHC)</td>
<td>E10.621 Type 1 diabetes mellitus with foot ulcer</td>
</tr>
<tr>
<td>E08.01 Diabetes mellitus due to underlying condition with hyperosmolarity with coma</td>
<td>E10.622 Type 1 diabetes mellitus with other skin ulcer</td>
</tr>
<tr>
<td>E08.10 Diabetes mellitus due to underlying condition with ketoacidosis without coma</td>
<td>E10.628 Type 1 diabetes mellitus with other skin complication</td>
</tr>
<tr>
<td>E08.11 Diabetes mellitus due to underlying condition with ketoacidosis with coma</td>
<td>E10.630 Type 1 diabetes mellitus with periodontal disease</td>
</tr>
<tr>
<td>E08.21 Diabetes mellitus due to underlying condition with diabetic nephropathy</td>
<td>E10.638 Type 1 diabetes mellitus with other oral complications</td>
</tr>
<tr>
<td>E08.21 Diabetes mellitus due to underlying condition with diabetic nephropathy</td>
<td>E10.63 Type 1 diabetes mellitus with oral complications</td>
</tr>
<tr>
<td>E08.22 Diabetes mellitus due to underlying condition with diabetic chronic kidney disease</td>
<td>E10.641 Type 1 diabetes mellitus with hypoglycemia with coma</td>
</tr>
<tr>
<td>E08.22 Diabetes mellitus due to underlying condition with diabetic chronic kidney disease</td>
<td>E10.649 Type 1 diabetes mellitus with hypoglycemia without coma</td>
</tr>
<tr>
<td>E08.29 Diabetes mellitus due to underlying condition with other diabetic kidney complication</td>
<td>E10.65 Type 1 diabetes mellitus with hyperglycemia</td>
</tr>
<tr>
<td>E08.311 Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy with macular edema</td>
<td>E10.69 Type 1 diabetes mellitus with other specified complication</td>
</tr>
<tr>
<td>Diagnosis Code/Description</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>E08.319 Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy without macular edema</td>
<td>E10.6 Type 1 diabetes mellitus with other specified complications</td>
</tr>
<tr>
<td>E08.321 Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema</td>
<td>E10.8 Type 1 diabetes mellitus with unspecified complications</td>
</tr>
<tr>
<td>E08.321 Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema</td>
<td>E10.9 Type 1 diabetes mellitus without complications</td>
</tr>
<tr>
<td>E08.329 Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema</td>
<td>E11.00 Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic hyperosmolar coma (NKHHC)</td>
</tr>
<tr>
<td>E08.331 Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema</td>
<td>E11.01 Type 2 diabetes mellitus with hyperosmolarity with coma</td>
</tr>
<tr>
<td>E08.339 Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema</td>
<td>E11.21 Type 2 diabetes mellitus with diabetic nephropathy</td>
</tr>
<tr>
<td>E08.341 Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema</td>
<td>E11.22 Type 2 diabetes mellitus with diabetic chronic kidney disease</td>
</tr>
<tr>
<td>E08.349 Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema</td>
<td>E11.29 Type 2 diabetes mellitus with other diabetic kidney complication</td>
</tr>
<tr>
<td>E08.351 Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema</td>
<td>E11.311 Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema</td>
</tr>
<tr>
<td>E08.359 Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema</td>
<td>E11.319 Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema</td>
</tr>
<tr>
<td>E08.35 Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy</td>
<td>E11.321 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema</td>
</tr>
<tr>
<td>E08.36 Diabetes mellitus due to underlying condition with diabetic cataract</td>
<td>E11.329 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema</td>
</tr>
<tr>
<td>Diagnosis Codes/Descriptions</td>
<td>Diagnosis Codes/Descriptions</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>E08.39 Diabetes mellitus due to underlying condition with other diabetic ophthalmic complication</td>
<td>E11.331 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema</td>
</tr>
<tr>
<td>E08.40 Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified</td>
<td>E11.339 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema</td>
</tr>
<tr>
<td>E08.41 Diabetes mellitus due to underlying condition with diabetic mononeuropathy</td>
<td>E11.341 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema</td>
</tr>
<tr>
<td>E08.42 Diabetes mellitus due to underlying condition with diabetic polyneuropathy</td>
<td>E11.349 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema</td>
</tr>
<tr>
<td>E08.43 Diabetes mellitus due to underlying condition with diabetic autonomic (poly)neuropathy</td>
<td>E11.351 Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema</td>
</tr>
<tr>
<td>E08.44 Diabetes mellitus due to underlying condition with diabetic amyotrophy</td>
<td>E11.359 Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema</td>
</tr>
<tr>
<td>E08.49 Diabetes mellitus due to underlying condition with other diabetic neurological complication</td>
<td>E11.35 Type 2 diabetes mellitus with proliferative diabetic retinopathy</td>
</tr>
<tr>
<td>E08.51 Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy without gangrene</td>
<td>E11.36 Type 2 diabetes mellitus with diabetic cataract</td>
</tr>
<tr>
<td>E08.52 Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy with gangrene</td>
<td>E11.39 Type 2 diabetes mellitus with other diabetic ophthalmic complication</td>
</tr>
<tr>
<td>E08.59 Diabetes mellitus due to underlying condition with other circulatory complications</td>
<td>E11.40 Type 2 diabetes mellitus with diabetic neuropathy, unspecified</td>
</tr>
<tr>
<td>E08.610 Diabetes mellitus due to underlying condition with diabetic neuropathic arthropathy</td>
<td>E11.41 Type 2 diabetes mellitus with diabetic mononeuropathy</td>
</tr>
<tr>
<td>E08.618 Diabetes mellitus due to underlying condition with other diabetic arthropathy</td>
<td>E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy</td>
</tr>
<tr>
<td>E08.620 Diabetes mellitus due to underlying condition with diabetic dermatitis</td>
<td>E11.43 Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy</td>
</tr>
<tr>
<td>E08.621 Diabetes mellitus due to underlying condition with foot ulcer</td>
<td>E11.44 Type 2 diabetes mellitus with diabetic amyotrophy</td>
</tr>
<tr>
<td>E08.622 Diabetes mellitus due to underlying condition with other skin ulcer</td>
<td>E11.49 Type 2 diabetes mellitus with other diabetic neurological complication</td>
</tr>
<tr>
<td>Diagnosis Codes/Descriptions</td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td></td>
</tr>
<tr>
<td>E08.628 Diabetes mellitus due to underlying condition with other skin complications</td>
<td>E11.51 Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene</td>
</tr>
<tr>
<td>E08.62 Diabetes mellitus due to underlying condition with skin complications</td>
<td>E11.52 Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene</td>
</tr>
<tr>
<td>E08.630 Diabetes mellitus due to underlying condition with periodontal disease</td>
<td>E11.59 Type 2 diabetes mellitus with other circulatory complications</td>
</tr>
<tr>
<td>E08.630 Diabetes mellitus due to underlying condition with periodontal disease</td>
<td>E11.610 Type 2 diabetes mellitus with diabetic neuropathic arthropathy</td>
</tr>
<tr>
<td>E08.638 Diabetes mellitus due to underlying condition with other oral complications</td>
<td>E11.618 Type 2 diabetes mellitus with other diabetic arthropathy</td>
</tr>
<tr>
<td>E08.641 Diabetes mellitus due to underlying condition with hypoglycemia with coma</td>
<td>E11.620 Type 2 diabetes mellitus with diabetic dermatitis</td>
</tr>
<tr>
<td>E08.649 Diabetes mellitus due to underlying condition with hypoglycemia without coma</td>
<td>E11.621 Type 2 diabetes mellitus with foot ulcer</td>
</tr>
<tr>
<td>E08.65 Diabetes mellitus due to underlying condition with hyperglycemia</td>
<td>E11.622 Type 2 diabetes mellitus with other skin ulcer</td>
</tr>
<tr>
<td>E08.69 Diabetes mellitus due to underlying condition with other specified complication</td>
<td>E11.628 Type 2 diabetes mellitus with other skin complications</td>
</tr>
<tr>
<td>E08.8 Diabetes mellitus due to underlying condition with unspecified complications</td>
<td>E11.630 Type 2 diabetes mellitus with periodontal disease</td>
</tr>
<tr>
<td>E08.9 Diabetes mellitus due to underlying condition without complications</td>
<td>E11.638 Type 2 diabetes mellitus with other oral complications</td>
</tr>
<tr>
<td>E09.00 Drug or chemical induced diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic -- hyperosmolar coma (NKHHC)</td>
<td>E11.641 Type 2 diabetes mellitus with hypoglycemia with coma</td>
</tr>
<tr>
<td>E09.01 Drug or chemical induced diabetes mellitus with hyperosmolarity with coma</td>
<td>E11.649 Type 2 diabetes mellitus with hypoglycemia without coma</td>
</tr>
<tr>
<td>E09.10 Drug or chemical induced diabetes mellitus with ketoacidosis without coma</td>
<td>E11.65 Type 2 diabetes mellitus with hyperglycemia</td>
</tr>
<tr>
<td>E09.11 Drug or chemical induced diabetes mellitus with ketoacidosis with coma</td>
<td>E11.69 Type 2 diabetes mellitus with other specified complication</td>
</tr>
<tr>
<td>E09.21 Drug or chemical induced diabetes mellitus with diabetic nephropathy</td>
<td>E11.8 Type 2 diabetes mellitus with unspecified complications</td>
</tr>
<tr>
<td>E09.22 Drug or chemical induced diabetes mellitus with diabetic chronic kidney disease</td>
<td>E11.9 Type 2 diabetes mellitus without complications</td>
</tr>
<tr>
<td>E09.29 Drug or chemical induced diabetes mellitus with other diabetic kidney complication</td>
<td>G61.0 -Guillain- Barre syndrome</td>
</tr>
<tr>
<td>E09.311 Drug or chemical induced diabetes</td>
<td>G62.0 - Drug- induced polyneuropathy</td>
</tr>
<tr>
<td>Diagnosis Codes/Descriptions</td>
<td>ICD-9 Codes</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>mellitus with unspecified diabetic retinopathy with macular edema</td>
<td></td>
</tr>
<tr>
<td>E09.319 Drug or chemical induced diabetes mellitus</td>
<td>G62.1 Alcoholic polyneuropathy</td>
</tr>
<tr>
<td>with unspecified diabetic retinopathy without macular edema</td>
<td></td>
</tr>
<tr>
<td>E09.321 Drug or chemical induced diabetes mellitus</td>
<td>G62.2 Polyneuropathy due to other toxic agents</td>
</tr>
<tr>
<td>with mild nonproliferative diabetic retinopathy with macular edema</td>
<td></td>
</tr>
<tr>
<td>E09.329 Drug or chemical induced diabetes mellitus</td>
<td>G63 Polyneuropathy in diseases classified elsewhere</td>
</tr>
<tr>
<td>with mild nonproliferative diabetic retinopathy without macular edema</td>
<td></td>
</tr>
<tr>
<td>E09.339 Drug or chemical induced diabetes mellitus</td>
<td>I70.201 Unspecified atherosclerosis of native arteries of extremities, right leg</td>
</tr>
<tr>
<td>with moderate nonproliferative diabetic retinopathy without macular edema</td>
<td></td>
</tr>
<tr>
<td>E09.341 Drug or chemical induced diabetes mellitus</td>
<td>I70.202 Unspecified atherosclerosis of native arteries of extremities, left leg</td>
</tr>
<tr>
<td>with severe nonproliferative diabetic retinopathy with macular edema</td>
<td></td>
</tr>
<tr>
<td>E09.349 Drug or chemical induced diabetes mellitus</td>
<td>I70.203 Unspecified atherosclerosis of native arteries of extremities, bilateral legs</td>
</tr>
<tr>
<td>with severe nonproliferative diabetic retinopathy without macular edema</td>
<td></td>
</tr>
<tr>
<td>E09.351 Drug or chemical induced diabetes mellitus</td>
<td>I70.211 Atherosclerosis of native arteries of extremities with intermittent claudication, right leg</td>
</tr>
<tr>
<td>with proliferative diabetic retinopathy with macular edema</td>
<td></td>
</tr>
<tr>
<td>E09.359 Drug or chemical induced diabetes mellitus</td>
<td>I70.212 Atherosclerosis of native arteries of extremities with intermittent claudication, left leg</td>
</tr>
<tr>
<td>with proliferative diabetic retinopathy without macular edema</td>
<td></td>
</tr>
<tr>
<td>E09.36 Drug or chemical induced diabetes mellitus</td>
<td>I70.213 Atherosclerosis of native arteries of extremities with intermittent claudication, bilateral legs</td>
</tr>
<tr>
<td>with diabetic cataract</td>
<td></td>
</tr>
<tr>
<td>E09.39 Drug or chemical induced diabetes mellitus</td>
<td>I70.221 Atherosclerosis of native arteries of extremities with rest pain, right leg</td>
</tr>
<tr>
<td>with other diabetic ophthalmic complication</td>
<td></td>
</tr>
<tr>
<td>E09.40 Drug or chemical induced diabetes mellitus</td>
<td>I70.222 Atherosclerosis of native arteries of extremities with rest pain, left leg</td>
</tr>
<tr>
<td>with neurological complications with diabetic neuropathy, unspecified</td>
<td></td>
</tr>
<tr>
<td>E09.41 Drug or chemical induced diabetes mellitus</td>
<td>I70.223 Atherosclerosis of native arteries of extremities with rest pain, bilateral legs</td>
</tr>
<tr>
<td>with neurological complications with diabetic mononeuropathy</td>
<td></td>
</tr>
<tr>
<td>E09.42 Drug or chemical induced diabetes mellitus</td>
<td>I70.231 Atherosclerosis of native arteries of right leg with ulceration of thigh</td>
</tr>
<tr>
<td>with neurological complications with diabetic polyneuropathy</td>
<td></td>
</tr>
<tr>
<td>Diagnosis Codes/Descriptions</td>
<td>ICD-10 Codes</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>E09.43</strong> Drug or chemical induced diabetes mellitus with neurological complications with diabetic autonomic (poly)neuropathy</td>
<td>170.232 Atherosclerosis of native arteries of right leg with ulceration of calf</td>
</tr>
<tr>
<td><strong>E09.44</strong> Drug or chemical induced diabetes mellitus with neurological complications with diabetic amyotrophy</td>
<td>170.233 Atherosclerosis of native arteries of right leg with ulceration of ankle</td>
</tr>
<tr>
<td><strong>E09.49</strong> Drug or chemical induced diabetes mellitus with neurological complications with other diabetic neurological complication</td>
<td>170.234 Atherosclerosis of native arteries of right leg with ulceration of heel and midfoot</td>
</tr>
<tr>
<td><strong>E09.51</strong> Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy without gangrene</td>
<td>170.235 Atherosclerosis of native arteries of right leg with ulceration of other part of foot</td>
</tr>
<tr>
<td><strong>E09.52</strong> Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy with gangrene</td>
<td>170.238 Atherosclerosis of native arteries of right leg with ulceration of other part of lower right leg</td>
</tr>
<tr>
<td><strong>E09.59</strong> Drug or chemical induced diabetes mellitus with other circulatory complications</td>
<td>170.239 Atherosclerosis of native arteries of right leg with ulceration of unspecified site</td>
</tr>
<tr>
<td><strong>E09.610</strong> Drug or chemical induced diabetes mellitus with diabetic neuropathic arthropathy</td>
<td>170.241 Atherosclerosis of native arteries of left leg with ulceration of thigh</td>
</tr>
<tr>
<td><strong>E09.618</strong> Drug or chemical induced diabetes mellitus with other diabetic arthropathy</td>
<td>170.242 Atherosclerosis of native arteries of left leg with ulceration of calf</td>
</tr>
<tr>
<td><strong>E09.620</strong> Drug or chemical induced diabetes mellitus with diabetic dermatitis</td>
<td>170.243 Atherosclerosis of native arteries of left leg with ulceration of ankle</td>
</tr>
<tr>
<td><strong>E09.621</strong> Drug or chemical induced diabetes mellitus with foot ulcer</td>
<td>170.244 Atherosclerosis of native arteries of left leg with ulceration of heel and midfoot</td>
</tr>
<tr>
<td><strong>E09.622</strong> Drug or chemical induced diabetes mellitus with other skin ulcer</td>
<td>170.245 Atherosclerosis of native arteries of left leg with ulceration of other part of foot</td>
</tr>
<tr>
<td><strong>E09.628</strong> Drug or chemical induced diabetes mellitus with other skin complications</td>
<td>170.248 Atherosclerosis of native arteries of left leg with ulceration of other part of lower left leg</td>
</tr>
<tr>
<td><strong>E09.630</strong> Drug or chemical induced diabetes mellitus with periodontal disease</td>
<td>170.249 Atherosclerosis of native arteries of left leg with ulceration of unspecified site</td>
</tr>
<tr>
<td><strong>E09.638</strong> Drug or chemical induced diabetes mellitus with other oral complications</td>
<td>170.261 Atherosclerosis of native arteries of extremities with gangrene, right leg</td>
</tr>
<tr>
<td><strong>E09.641</strong> Drug or chemical induced diabetes mellitus with hypoglycemia with coma</td>
<td>170.262 Atherosclerosis of native arteries of extremities with gangrene, left leg</td>
</tr>
<tr>
<td><strong>E09.649</strong> Drug or chemical induced diabetes mellitus with hypoglycemia without coma</td>
<td>170.263 Atherosclerosis of native arteries of extremities with gangrene, bilateral legs</td>
</tr>
<tr>
<td><strong>E09.65</strong> Drug or chemical induced diabetes mellitus with hyperglycemia</td>
<td>170.291 Other atherosclerosis of native arteries of extremities, right leg</td>
</tr>
<tr>
<td>Diagnosis Codes/Descriptions</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>E09.69 Drug or chemical induced diabetes mellitus with other specified complication</td>
<td>I70.292 Other atherosclerosis of native arteries of extremities, left leg</td>
</tr>
<tr>
<td>E09.6 Drug or chemical induced diabetes mellitus with other specified complications</td>
<td>I70.293 Other atherosclerosis of native arteries of extremities, bilateral legs</td>
</tr>
<tr>
<td>E09.8 Drug or chemical induced diabetes mellitus with unspecified complications</td>
<td>I73.1 Thromboangiitis obliterans [Buerger’s disease]</td>
</tr>
<tr>
<td>E09.9 Drug or chemical induced diabetes mellitus without complications</td>
<td></td>
</tr>
<tr>
<td>I70.29 Drug or chemical induced diabetes mellitus with unspecified complications</td>
<td></td>
</tr>
<tr>
<td>I70.293 Other atherosclerosis of native arteries of extremities, bilateral legs</td>
<td></td>
</tr>
<tr>
<td>E10.10 Type 1 diabetes mellitus with ketoacidosis without coma</td>
<td>I87.001 Postthrombotic syndrome without complications of right lower extremity</td>
</tr>
<tr>
<td>E10.11 Type 1 diabetes mellitus with ketoacidosis with coma</td>
<td>I87.002 Postthrombotic syndrome without complications of left lower extremity</td>
</tr>
<tr>
<td>E10.21 Type 1 diabetes mellitus with diabetic nephropathy</td>
<td>I87.003 Postthrombotic syndrome without complications of unspecified extremity</td>
</tr>
<tr>
<td>E10.22 Type 1 diabetes mellitus with diabetic chronic kidney disease</td>
<td>I87.011 Postthrombotic syndrome with ulcer of right lower extremity</td>
</tr>
<tr>
<td>E10.29 Type 1 diabetes mellitus with other diabetic kidney complication</td>
<td>I87.012 Postthrombotic</td>
</tr>
<tr>
<td>E10.311 Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema</td>
<td>I87.013 Postthrombotic syndrome with ulcer of bilateral lower extremity</td>
</tr>
<tr>
<td>E10.319 Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema</td>
<td>I87.021 Postthrombotic syndrome with inflammation of right lower extremity</td>
</tr>
<tr>
<td>E10.321 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema</td>
<td>I87.022 Postthrombotic syndrome with inflammation of left lower extremity</td>
</tr>
<tr>
<td>E10.329 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema</td>
<td>I87.023 Postthrombotic syndrome with inflammation of bilateral lower extremity</td>
</tr>
<tr>
<td>E10.32 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy</td>
<td>I87.031 Postthrombotic syndrome with ulcer and inflammation of right lower extremity</td>
</tr>
<tr>
<td>E10.331 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema</td>
<td>I87.032 Postthrombotic syndrome with ulcer and inflammation of left lower extremity</td>
</tr>
<tr>
<td>E10.339 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema</td>
<td>I87.033 Postthrombotic syndrome with ulcer and inflammation of bilateral lower extremity</td>
</tr>
<tr>
<td>E10.33 Type 1 diabetes mellitus with moderate nonproliferative diabetic</td>
<td>I87.09 Postthrombotic syndrome with other complications</td>
</tr>
</tbody>
</table>

Modified on July 14, 2017
<table>
<thead>
<tr>
<th>Diagnosis Codes/Descriptions</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>retinopathy</td>
<td></td>
</tr>
<tr>
<td>E10.341 Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema</td>
<td>I87.311 Chronic venous hypertension (idiopathic) with ulcer of right lower extremity</td>
</tr>
<tr>
<td>E10.349 Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema</td>
<td>I87.312 Chronic venous hypertension (idiopathic) with ulcer of left lower extremity</td>
</tr>
<tr>
<td>E10.34 Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy</td>
<td>I87.313 Chronic venous hypertension (idiopathic) with ulcer of bilateral lower extremity</td>
</tr>
<tr>
<td>E10.351 Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema</td>
<td>I87.319 Chronic venous hypertension (idiopathic) with ulcer of unspecified lower extremity</td>
</tr>
<tr>
<td>E10.359 Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema</td>
<td>I87.321 Chronic venous hypertension (idiopathic) with inflammation of right lower extremity</td>
</tr>
<tr>
<td>E10.35 Type 1 diabetes mellitus with proliferative diabetic retinopathy</td>
<td>I87.322 Chronic venous hypertension (idiopathic) with inflammation of left lower extremity</td>
</tr>
<tr>
<td>E10.36 Type 1 diabetes mellitus with diabetic cataract</td>
<td>I87.323 Chronic venous hypertension (idiopathic) with inflammation of bilateral lower extremity</td>
</tr>
<tr>
<td>E10.39 Type 1 diabetes mellitus with other diabetic ophthalmic complication</td>
<td>I87.329 Chronic venous hypertension (idiopathic) with inflammation of unspecified lower extremity</td>
</tr>
<tr>
<td>E10.40 Type 1 diabetes mellitus with diabetic neuropathy, unspecified</td>
<td>I87.331 Chronic venous hypertension (idiopathic) with ulcer and inflammation of right lower extremity</td>
</tr>
<tr>
<td>E10.41 Type 1 diabetes mellitus with diabetic mononeuropathy</td>
<td>I87.332 Chronic venous hypertension (idiopathic) with ulcer and inflammation of left lower extremity</td>
</tr>
<tr>
<td>E10.42 Type 1 diabetes mellitus with diabetic polyneuropathy</td>
<td>I87.333 Chronic venous hypertension (idiopathic) with ulcer and inflammation of bilateral lower extremity</td>
</tr>
<tr>
<td>E10.43 Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy</td>
<td>I87.339 Chronic venous hypertension (idiopathic) with ulcer and inflammation of unspecified lower extremity</td>
</tr>
<tr>
<td>E10.44 Type 1 diabetes mellitus with diabetic amyotrophy</td>
<td>I87.33 Chronic venous hypertension (idiopathic) with ulcer and inflammation</td>
</tr>
<tr>
<td>E10.49 Type 1 diabetes mellitus with other diabetic neurological complication</td>
<td>I87.391 Chronic venous hypertension (idiopathic) with other complications of right lower extremity</td>
</tr>
<tr>
<td>Diagnosis Codes/Descriptions</td>
<td>lower extremity</td>
</tr>
<tr>
<td>------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>E10.51 Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene</td>
<td>I87.392 - Chronic venous hypertension (idiopathic) with other complications of left lower extremity</td>
</tr>
<tr>
<td>E10.52 Type 1 diabetes mellitus with diabetic peripheral angiopathy with gangrene</td>
<td>I87.393 Chronic venous hypertension (idiopathic) with other complications of bilateral lower extremity</td>
</tr>
<tr>
<td>E10.59 Type 1 diabetes mellitus with other circulatory complications</td>
<td>I87.399 Chronic venous hypertension (idiopathic) with other complications of unspecified lower extremity</td>
</tr>
<tr>
<td>E10.610 Type 1 diabetes mellitus with diabetic neuropathic arthropathy</td>
<td>G60.0 Type 2 diabetes mellitus with unspecified complications</td>
</tr>
<tr>
<td>E10.618 Type 1 diabetes mellitus with other diabetic arthropathy</td>
<td>G60.1 Refsum's disease</td>
</tr>
<tr>
<td>E10.620 Type 1 diabetes mellitus with diabetic dermatitis</td>
<td>G60.3 Idiopathic progressive neuropathy</td>
</tr>
<tr>
<td>I70.209 Unspecified atherosclerosis of native arteries of extremities</td>
<td></td>
</tr>
<tr>
<td>I70.219 Atherosclerosis of native arteries of extremities with intermittent claudication</td>
<td></td>
</tr>
<tr>
<td>I70.229 Atherosclerosis of native arteries of</td>
<td></td>
</tr>
</tbody>
</table>
PRV - Preventive Services

1. Benefit Coverage

1.1. Preventive Care services include:
- Outpatient services and Office Services. Screenings and other Health Services are covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.
- Health Services with an “A” or “B” rating from the United States Preventive Services Task Force (USPSTF) and subject to guidelines by the USPSTF.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the diagnostic health services benefit or other applicable benefits.

The Patient Protection and Affordable Care Act (ACA) have designated specific resources that identify the preventive services required for coverage by the act.

- U.S. Preventive Services Task Force (USPSTF) A and B recommendations
- Advisory Committee on Immunization Practices (ACIP) recommendations that have been adopted by the Director of the Centers for Disease Control. Recommendations of the ACIP appear in four immunization schedules
- Comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). – Guidelines for infants, children and adolescents appear in two charts: the periodicity schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care and the Uniform Panel of the Secretary’s Advisory Committee on Heritable Disorders in Newborns and Children. Guidelines for women were released in August 2011 and June 2013.

1.2. In accordance with the Patient Protection and Affordable Care Act (ACA) the Marketplace covers certain preventive services and immunizations without any cost-sharing (i.e., co-pays, coinsurance, and application of deductible). When these services are part of an office visit, the office visit may not have cost-sharing if the primary reason for the visit is to receive preventive services. However, cost-sharing is permitted for an office visit when the office visit and covered preventive services are billed separately, and the primary purpose of the office visit is not delivery of the covered preventive services.

1.3. Services not covered under the preventive care benefit may be covered under another portion of the medical benefit plan.

1.4. The list of recommended preventive services covered will be updated as new recommendations and guidelines are issued, or as existing ones are revised or removed by the USPSTF, ACIP and the HRSA. Updates will occur no less frequently than required by the ACA.

2. Benefit Limitations and Exclusions

2.1. The following benefit limitations or exclusions apply to preventive services:
Examinations, screenings, testing, or immunizations are not covered when:
• required solely for the purposes of career, sports or camp, travel (including travel immunizations), employment, insurance, marriage or adoption, (Dx Z02.89, Z02.1, Z02.3)
• related to judicial or administrative proceedings or orders, or
• conducted for purposes of medical research, or
• required to obtain or maintain a license of any type.

**Unless** the service also qualifies as a preventive service in accordance with the diagnosis or CPT/HCPCS codes outlined in this policy

• Services that are investigational, experimental, unproven or not medically necessary are not covered.
• With the exception of emergency services, all services provided by out of network providers require prior authorization.

3. **Provider Reimbursement and Submission Requirements**

3.1. **Preventive vs. Diagnostic Services:**

Preventive services are those performed on a person who:

• has not had the preventive screening done before and does not have symptoms or other abnormal studies suggesting abnormalities; or
• has had screening done within the recommended interval with the findings considered normal; or
• has had diagnostic services results that were normal after which the physician recommendation would be for future preventive screening studies using the preventive services intervals.
• has a preventive service done that results in a therapeutic service done at the same encounter and as an integral part of the preventive service (e.g. polyp removal during a preventive colonoscopy), the therapeutic service would still be considered a preventive service.

When a service is done for diagnostic purposes it will be adjudicated under the applicable non preventive medical benefit. Diagnostic services are done on a person who:

• had abnormalities found on previous preventive or diagnostic studies that require further diagnostic studies; or
• had a symptom(s) that required further diagnosis.

3.2. **Modifier 33.** CPT modifier 33 was created to allow providers to identify that the service was preventive under applicable laws, and that patient cost-sharing does not apply. This modifier assists in identifying where it is appropriate to waive the deductible associated with copay or coinsurance and may be used when a service was initiated as a preventive service, which then resulted in a conversion to a therapeutic service.

CPT modifier 33 should be appended to codes representing the preventive services, unless the service is inherently preventive (see below). If multiple preventive medicine services are provided on the same day, the modifier is appended to the codes for each preventive service rendered on
that day.

For services represented by codes which may be used for either diagnostic, therapeutic or preventive services, modifier 33 must be appended to that code on the claim when the service was used for the preventive indication.

Example:

CPT code 45378, colonoscopy, may be performed for the 50-year-old asymptomatic individual as a routine screening for colorectal cancer. In this case, the colonoscopy is performed for preventive screening and modifier 33 should be appended, in addition to a well-person diagnosis code, such as Z12.11.

However, a colonoscopy, using this same code, may be performed in response to symptoms which a person exhibits. In that case, this service represents diagnostic colonoscopy. The diagnosis code would be one which would signify the symptoms exhibited and modifier 33 would not be appended.

When a separately submitted service is inherently preventive, modifier 33 is not used.

- Routine immunizations recommended to prevent communicable diseases are inherently preventive. Therefore modifier 33 would not be appended to these codes.

- Preventive medicine services (office visit services) represented by codes 99381-99387, 99391-99397, 99401-99404, and 99406-99412 are distinct from problem-oriented evaluation and management office visit codes and are inherently preventive. Therefore, modifier 33 would not be utilized with these codes.

- The CPT code for screening mammography is inherently preventive and therefore modifier 33 would not be used.

3.3. Preventive Care Services benefit and associated charges. Some preventive services involve ancillary charges or other associated expenses. For example:

- Blood drawing (venipuncture or finger or heel stick) is considered as payable under the preventive benefit if billed for a preventive lab service that requires a blood draw (e.g. 36415, 36416)

- Facility charges, anesthesia, physician charges, etc. related to a preventive screen must be covered without a member copay (e.g. preventive colonoscopy, abdominal aortic aneurysm screening).

- Women’s outpatient sterilization procedures (e.g. associated implantable devices, facility fee, as well as anesthesia, pathology, and physician fees) are considered to be related services and covered under the preventive benefit. However if a woman is admitted to an inpatient facility for another reason, and has a sterilization performed during that admission, the sterilization surgical fees (surgical fee, device fee, anesthesia, pathologist and physician fees), are covered under the preventive benefit. However, the facility fees are not covered under preventive benefits since the sterilization is incidental to and is not the primary reason for the admission.

Please note: Member cost-sharing does not apply to well-exams. If other services are obtained during the well-visit that are “non-preventive” and coinsurance applies to that service then the coinsurance should be deducted from the reimbursement amount for that particular service. However, if a member is seen for sick care and well-care by their PMP on the same day, the copay for the sick care may not be applied. The
entire visit is considered “preventive” for purposes of member cost-sharing.

4. Procedure Codes and Claim Consideration

4.1. Coding for preventive services. With some exceptions, preventive care services are to be submitted with an ICD-10 code that represents encounters with health services that are not for the treatment of illness or injury. The ICD-10 codes found in table 4.2 should be placed in the first diagnosis position of the claim form. If claims for preventive care services are submitted with diagnosis codes that represent treatment of illness or injury as the primary (first) diagnosis on the claim, the service may not be identified as preventive care and member claims will be paid using their normal medical benefits rather than preventive care coverage. CPT codes designated as “Preventive Medicine Evaluation and Management Services” should be used to differentiate preventive services from problem-oriented evaluation and management office visits. Non-preventive care services incorrectly coded as “Preventive Medicine Evaluation and Management Services” will not be covered as preventive care.

4.2. Table. The following table indicates the preventive services for which there is no member cost-sharing and the deductible is waived. The diagnosis codes in the list represent services that are not for treatment of illness or injury and should be submitted as the primary diagnosis for preventative services.

<table>
<thead>
<tr>
<th>Preventive coverage</th>
<th>ICD-9 &amp; ICD-10 codes</th>
<th>CPT codes/HCPCS codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comprehensive preventive evaluation and management services</strong> (preventive office visits for well-baby, well child and well adult, including well woman)</td>
<td>Payable as preventive regardless of diagnosis code</td>
<td>99381–99387 (new patient) 99391–99397 (established patient) 99461 (initial newborn care) G0438</td>
</tr>
<tr>
<td>These preventive E&amp;M services are represented by distinct CPT codes from those that represent problem-oriented E&amp;M services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine immunizations and administration of vaccines</strong></td>
<td>Payable as preventive regardless of diagnosis code</td>
<td>Administration codes: 90460, 90461 90471–90474, G0008, G0009, G0010 Vaccine codes: 90620, 90621, 90630, 90632, 90633, 90634, 90636, 90637, 90638, 90639, 90640, 90641, 90642, 90643, 90644, 90645, 90646, 90647, 90648, 90649, 90650, 90651, 90652, 90653, 90654, 90655, 90656, 90657, 90658, 90659, 90660, 90661, 90662, 90663, 90664, 90665, 90666, 90667, 90668, 90669, 90670, 90671, 90672, 90673, 90674, 90675, 90676, 90677, 90678, 90679, 90680, 90681, 90682, 90683, 90684, 90685, 90686, 90687, 90688, 90690, 90691, 90692, 90693, 90694, 90695, 90696, 90697, 90698, 90699, 90700, 90701, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90709, 90710, 90711, 90712, 90713, 90714, 90715, 90716, 90717, 90718, 90719, 90720, 90721, 90722, 90723, 90724, 90725, 90726, 90727, 90728, 90729, 90730, 90731, 90732, 90733, 90734, 90735, 90736, 90737, 90738, 90739, 90740, 90741, 90742, 90743, 90744, 90745, 90746, 90747, 90748</td>
</tr>
<tr>
<td>There are four immunization schedules on the website of the CDC. These represent the routine immunization services that are currently designated as preventive care by the PPACA regulations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Childhood: ages zero through six years, and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Childhood: ages seven through 18 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Childhood: catch-up schedule</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Adult schedule</td>
<td></td>
<td></td>
</tr>
<tr>
<td><a href="http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm#hcp">www.cdc.gov/vaccines/recs/schedules/child-schedule.htm#hcp</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td><a href="http://www.cdc.gov/vaccines/recs/schedules/adult-schedule.htm#hcp">www.cdc.gov/vaccines/recs/schedules/adult-schedule.htm#hcp</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vaccines include:</td>
<td></td>
</tr>
<tr>
<td>• Diphtheria, tetanus toxoids and acellular pertussis (DTaP) (Tdap) (Td)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Haemophilus influenzae type b conjugate (Hib)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hepatitis A (HepA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hepatitis B (HepB)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Preventive coverage

<table>
<thead>
<tr>
<th>Preventive coverage</th>
<th>ICD-9 &amp; ICD-10 codes</th>
<th>CPT codes/ HCPCS codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Human papillomavirus (HPV)</td>
<td></td>
<td>Q2034, Q2035, Q2036,</td>
</tr>
<tr>
<td>• Influenza vaccine</td>
<td></td>
<td>Q2037, Q2038, Q2039</td>
</tr>
<tr>
<td>• Measles, mumps and rubella (MMR)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Meningococcal (MCV)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pneumococcal (pneumonia)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Poliovirus (IPV)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Tetanus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Rotavirus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Varicella (chickenpox)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Zoster (shingles)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Screenings

The following laboratory and imaging screening procedures are the designated preventive services that are allowed without cost sharing to the member.

<table>
<thead>
<tr>
<th>Preventive coverage</th>
<th>Diagnosis codes</th>
<th>CPT codes/ HCPCS codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal aortic aneurysm screening by ultrasonography</td>
<td>ICD10: Z87.891, F17.210, F17.211,</td>
<td>76700, 76705, 76706,</td>
</tr>
<tr>
<td></td>
<td>F17.213, F17.218, F17.219</td>
<td>76770, 76775, G0389</td>
</tr>
<tr>
<td>Alcohol Misuse Screening and Behavioral Counseling Interventions in Primary Care,</td>
<td>Payable as preventive regardless of</td>
<td>99401, 99408, 99409,</td>
</tr>
<tr>
<td>Once a year per billing provider</td>
<td>diagnosis code</td>
<td>G0396, G0397, G0442,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>G0443</td>
</tr>
<tr>
<td>Blood Pressure Screening:</td>
<td></td>
<td>Provided as component</td>
</tr>
<tr>
<td>Screening for high blood pressure in adults aged 18 and older.</td>
<td></td>
<td>of the preventive E&amp;M visit</td>
</tr>
<tr>
<td>Breast cancer screening:</td>
<td>ICD10: Z00.00, Z12.31, Z12.39, Z80.3</td>
<td>77051, 77055, 77056,</td>
</tr>
<tr>
<td>women 40 and older; screening mammography with or without clinical breast exam,</td>
<td></td>
<td>77063, G0202, G0204</td>
</tr>
<tr>
<td>every year; Additional screenings may be conducted during year; however member</td>
<td></td>
<td>Revenue Code 403</td>
</tr>
<tr>
<td>cost-sharing would apply. Members younger than age 40 may also receive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>screening, based on recommendations of provider.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical cancer screening:</td>
<td>ICD10: Z00.00, Z00.01, Z11.419, Z11.51,</td>
<td>87620–25, 88141–43,</td>
</tr>
<tr>
<td>• Pap smear, women 21–65 every year</td>
<td>Z12.4, Z80.3, Z15.01, Z15.02</td>
<td>88147–48, 88150, 88152</td>
</tr>
<tr>
<td>• HPV DNA test in combination with Pap smear, women age 30–65, every year</td>
<td></td>
<td>– 88155, 88158, 88164–67,</td>
</tr>
<tr>
<td>• Additional screenings may be conducted during year; however member cost-sharing</td>
<td></td>
<td>88174–75,</td>
</tr>
<tr>
<td>would apply.</td>
<td></td>
<td>G0101, G0123–24, G0141,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>G0143–45, G0147–48,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P3000, P3001, Q0091</td>
</tr>
<tr>
<td>Chemoprevention of Breast Cancer (Counseling)</td>
<td>ICD10: Z80.3, Z80.41, Z15.01, Z15.02</td>
<td>99401, 99402</td>
</tr>
</tbody>
</table>

Modified on July 14, 2017
## Screenings

The following laboratory and imaging screening procedures are the designated preventive services that are allowed without cost sharing to the member.

<table>
<thead>
<tr>
<th>Preventive coverage</th>
<th>Diagnosis codes</th>
<th>CPT codes/HCPCS codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chlamydial infection screening</strong>: all sexually active women age 24 and younger, and older women at increased risk</td>
<td>ICD10: Z00.00, Z00.01, Z00.129, Z11.3, Z11.8, Z11.9, Z20.2: or a maternity diagnosis code</td>
<td>86631-32, 87110, 87270, 87320, 87490-92, 87810</td>
</tr>
<tr>
<td>Once a year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Additional screenings may be conducted during year; however member cost-sharing would apply</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cholesterol screening</strong> (dyslipidemia): children at risk due to known family history, when family history is unknown, or with personal risk factors such as obesity, high blood pressure or diabetes, after age two but by age 10 (periodicity schedule/Bright Futures)</td>
<td>ICD10: Z76.2, Z13.220</td>
<td>80061, 82172, 82465, 83695, 83718, 83719, 83721, 84478</td>
</tr>
<tr>
<td>Screening is covered as <strong>preventive</strong> once every 5 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cholesterol screening</strong> (dyslipidemia) in adults:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Men age 35 and older: or age 20–35 if risk factors for coronary heart disease are present</td>
<td>ICD10: Z00.00, Z00.01, Z13.220</td>
<td>80061, 82172, 82465, 83695, 83718, 83719, 83721, 84478</td>
</tr>
<tr>
<td>• Women age 45 and older: or age 20–45 if risk factors for coronary heart disease are present</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening is covered as <strong>preventive</strong> once every 5 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Colorectal cancer screening</strong>: beginning at age 50 by any of the following methods:</td>
<td>ICD10: Z00.00, Z00.01, Z12.10, Z12.11, Z12.12, Z12.13, Z80.0, Z83.71, Z83.79</td>
<td>00810, 44388, 44389, 44490, 44439, 45330, 45331, 45332, 45333, 45338, 45339, 45341, 45342, 45346, 45378, 45379, 45380, 45384, 45385, 45388, 81528, 82270, 82271, 82274, G0104, G0105, G0106, G0120, G0121, G0122, G0328, 99401, 99402</td>
</tr>
<tr>
<td>• Fecal occult blood testing (FOBT)/fecal immunochemical test (FIT), annually</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sigmoidoscopy every five years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Colonoscopy every 10 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Double contrast barium enema (DCBE) every five years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Additional screenings may be conducted; however member cost-sharing would apply</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Depression Screening</strong></td>
<td>Payable as preventive regardless of diagnosis code</td>
<td>96127, G0444 Also included as part of preventive visit</td>
</tr>
<tr>
<td>Adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One time annually per billing provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Developmental Screening</strong> for Children for children under age 3 annually as necessary <strong>Autism Screening</strong> for children at 18 &amp; 24 months.</td>
<td>ICD10: Z00.121, Z00.129, Z13.4</td>
<td>96110, G0451, Also part of annual examination and screenings</td>
</tr>
<tr>
<td><strong>Diabetes screening</strong>: adults with sustained blood pressure greater than 135/80 (whether treated or untreated)</td>
<td>ICD10: Z00.00, Z00.01, Z13.1</td>
<td>82947, 82948, 82950, 82951, 82952, 83036</td>
</tr>
<tr>
<td><strong>Domestic and interpersonal violence screening and counseling</strong></td>
<td>ICD10: Z69.010, Z69.011, Z69.021, Z69.11, Z69.12, Z91.40, Z91.411,</td>
<td>99401, 99402</td>
</tr>
</tbody>
</table>
## Screenings
The following laboratory and imaging screening procedures are the designated preventive services that are allowed without cost sharing to the member.

<table>
<thead>
<tr>
<th>Preventive coverage</th>
<th>Diagnosis codes</th>
<th>CPT codes/ HCPCS codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gonorrhea screening</strong>: sexually active women including pregnant women if they are at increased risk for infection</td>
<td>ICD10: Z00.00, Z00.01, Z00.121, Z00.129, Z11.3, Z11.9, Z20.2; or a maternity dx code</td>
<td>87590, 87591, 87592, 87850,</td>
</tr>
<tr>
<td><strong>Hepatitis B Screening</strong> - for people at high risk of infection.</td>
<td>ICD-10: Z57.8, Z00.00, Z00.01, Z11.59</td>
<td>87340, 87341, G0476, G0499</td>
</tr>
<tr>
<td><strong>Hepatitis C Screening</strong> - for adults at increased risk, and one time for everyone born 1945 – 1965</td>
<td>Payable as preventive regardless of diagnosis code</td>
<td>86803, 86804, G0472</td>
</tr>
<tr>
<td><strong>Hemoglobin or hematocrit</strong>: ages 1 to four, May be covered annually Additional screenings may be conducted during year; however member cost-sharing would apply</td>
<td>ICD10: Z00.129, Z00. 8</td>
<td>85013, 85014, 85018, 85025, 85027, 85041, G0306, G0307</td>
</tr>
<tr>
<td><strong>HIV screening</strong>: all members age 15 – 65, adolescents, and others at high risk</td>
<td>ICD10: Z00.00, Z00.01, Z00.121, Z00.129, Z20.2, Z11.59, or a maternity dx code</td>
<td>86689, 86701, 86702, 86703, 87389, 87390, G0432, G0433, G0435, G0475</td>
</tr>
<tr>
<td><strong>Lead screening</strong> for children at risk for lead exposure</td>
<td>ICD10: Z00.121, Z00.129, Z77.011, Z113.88</td>
<td>83655</td>
</tr>
<tr>
<td><strong>Lung cancer screening</strong> for adults at high risk for lung cancer because they’re heavy smokers or have quit in the past 15 years • Limited to one per year • Ages 55 - 80</td>
<td>ICD-10: F17.210, F17.211, 17.213, F17.218, 17.219, Z87.891</td>
<td>G0296, G0297</td>
</tr>
<tr>
<td><strong>Newborn Screenings (up to age 1)</strong></td>
<td>ICD10: Z00.121, Z00.129, Z13.29, Z13.288</td>
<td>84436, 84437, 84443</td>
</tr>
<tr>
<td>• Congenital hypothyroidism screening: newborns</td>
<td></td>
<td>85660, 83020, 83021, 83030, 83033, 83051</td>
</tr>
<tr>
<td>• Hemoglobinopathy screening for sickle cell disease</td>
<td></td>
<td>82017, 82136, 82261, 82775, 83498, 83516, 84437, 84443</td>
</tr>
<tr>
<td>• Newborn metabolic screening panel</td>
<td></td>
<td>84030</td>
</tr>
<tr>
<td>• Phenylketonuria (PKU) screening: newborns</td>
<td></td>
<td>May be a component of the preventive E&amp;M visit service or 92551, 92552, 92553</td>
</tr>
<tr>
<td>• Hearing screening</td>
<td></td>
<td>No specific code; typically included on hospital bill as</td>
</tr>
<tr>
<td>• Gonorrhea: prophylactic ocular medication for all newborns to prevent blindness (typically instilled at birth)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive coverage</td>
<td>Diagnosis codes</td>
<td>CPT codes/HCPCS codes</td>
</tr>
<tr>
<td>--------------------</td>
<td>-----------------</td>
<td>------------------------</td>
</tr>
<tr>
<td><strong>Screenings</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following laboratory and imaging screening procedures are the designated preventive services that are allowed without cost sharing to the member.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Obesity Screening and Counseling in Adults &amp; Children</strong></td>
<td>ICD10: Z71.3, Z71.89, Z72.3, Z72.4, Z13.89</td>
<td>99401, 99402 G0447, G0473 May also be performed as component of preventive E&amp;M visit</td>
</tr>
</tbody>
</table>
### Screenings

The following laboratory and imaging screening procedures are the designated preventive services that are allowed without cost sharing to the member.

<table>
<thead>
<tr>
<th>Preventive coverage</th>
<th>Diagnosis codes</th>
<th>CPT codes/ HCPCS codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oral Health Risk Assessment</strong> (including prevention of dental caries in preschool children, water fluoridation discussion and referral to dental home) Ages 0 – 10 years</td>
<td>Provided as component of the preventive E&amp;M visit</td>
<td></td>
</tr>
<tr>
<td><strong>Osteoporosis screening</strong>: women age 60 or older (or younger women at risk) One time annually *Requires PA for members under age 65.</td>
<td>ICD10: Z00.00, Z00.01, Z13.820, Z82.62</td>
<td>76977, 77078, 77080, 77081, 77082, 78350, 78351, G0130</td>
</tr>
<tr>
<td><strong>Ovarian cancer/breast cancer risk: referral/counseling</strong> for women whose family history is associated with increased risk for BRCA1 and BRCA2 gene mutations. Per HHS BRCA Mutation Testing also included if recommended by health care provider</td>
<td>ICD10: Z15.01, Z15.02, Z31.5, Z80.3, Z80.41, Z85.3, 96040</td>
<td>81211 through 81217, 81162</td>
</tr>
<tr>
<td><strong>Sexually Transmitted Infections Counseling</strong> Ages 12 and older Once per year (Additional screenings may be conducted during year; however member cost-sharing would apply)</td>
<td>ICD10: Z71.7, Z71.89, Z72.5X</td>
<td>99401, 99402, G0445</td>
</tr>
<tr>
<td><strong>Syphilis screening</strong>: all pregnant women and persons at increased risk of syphilis infection.</td>
<td>ICD10: Z00.00, Z00.01, Z00.121, Z00.129, Z11.3, Z11.9, Z20.2, 86580</td>
<td>86592, 86593</td>
</tr>
<tr>
<td><strong>Tobacco use</strong>: counseling and interventions for tobacco cessation in adults who smoke Two individual smoking cessation counseling treatments per calendar year are covered. Each attempt may include a maximum of 4 intermediate and/or intensive sessions, with a total benefit covering up to 8 sessions per year</td>
<td>ICD10: F17.2XX, Z87.891</td>
<td>99406, 99407; G0436, G0437</td>
</tr>
<tr>
<td><strong>Tuberculin testing</strong>: children and adolescents at high risk – up through age 17</td>
<td>ICD10: Z00.121, Z00.129, Z11.1</td>
<td>86580</td>
</tr>
<tr>
<td><strong>Visual impairment screening</strong>: At least once through age 5. Additional screenings may be conducted during year; however member cost-sharing would apply.</td>
<td>ICD10: Z00.121, Z00.129</td>
<td>99173</td>
</tr>
</tbody>
</table>

*Modified on July 14, 2017*
Screenings for Pregnant Women
The following screening procedures are designated preventive screening services that are covered without cost sharing to the member. See also BCCP 18 Maternity Services for additional services that are covered without member cost sharing.

<table>
<thead>
<tr>
<th>Preventive coverage</th>
<th>ICD-9 codes</th>
<th>CPT codes/HCPCS codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anemia screening</strong>, iron deficiency: pregnant women</td>
<td>ICD9: V22.0 – V22.2 V23.0 – V23.9 V28.3 - V28.4 630.00 – 633.91 634.00 – 634.92 640.00 – 676.94 677 – 679.14 764.00 – 764.99 ICD10: See BCCP 18 for list of pregnancy dx codes.</td>
<td>85013, 85014, 85018, 85025, 85027, 85041, G0306, G0307</td>
</tr>
</tbody>
</table>

| **Bacteriuria screening** with urine culture: pregnant women at 12–16 weeks gestation or at the first prenatal visit, if later | See above | 81007, 87086, 87088 |
| **Gestational diabetes**: pregnant women at first prenatal visit for those at risk; all pregnant women at 24 to 28 weeks gestation | See above | 82947, 82948, 82950, 82951, 82952, 83036 |
| **Hepatitis B screening**: pregnant women, first prenatal visit | See above | 87340, 87341, 86704, 86705, 86706, G0476, G0499 |
| **Rh incompatibility screening**: Rh (D) blood typing and antibody testing for all pregnant women at first visit and repeat for unsensitized Rh negative women at 24–28 weeks | See above | 86901, 86904 |

**Breast-feeding equipment and supplies**
Examples: Breast pump, manual E0602 NU or RR modifier

<table>
<thead>
<tr>
<th>Provision of breast pumps and supplies for postpartum women to ensure successful breast-feeding. Requires a prescription</th>
<th>Breast pump, electric (rental) E0603 Requires PA only if over $500.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast pump, manual</td>
<td>E0602 NU or RR modifier</td>
</tr>
<tr>
<td>Breast pump, electric (rental)</td>
<td>E0603 Requires PA only if over $500.00</td>
</tr>
<tr>
<td>Supplies</td>
<td>A4281–A4286</td>
</tr>
<tr>
<td>Breast feeding counseling &amp; support</td>
<td>ICD9: V24.1 ICD10: Z39.1, 99401, 99402</td>
</tr>
</tbody>
</table>

**Contraceptive services for women**
The following contraceptive methods are covered under the preventive benefit for women with reproductive capacity.

<table>
<thead>
<tr>
<th>Method/type</th>
<th>Examples</th>
<th>CPT/HCPCS codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services for insertion/removal of intrauterine devices, implants; fitting diaphragm or cervical cap</td>
<td>11976, 11981–11983, 57170, 58300–58301, A4264,</td>
<td></td>
</tr>
</tbody>
</table>
Contraceptive products covered at no cost share:
The following represent those contraceptives that may be reimbursed by the Marketplace claims payer, versus the pharmacy benefit manager. There are additional pharmacy-based contraceptive products that are provided with no member cost-sharing, however these are paid under the pharmacy benefit, not the medical benefit.

<table>
<thead>
<tr>
<th>Contraceptive Type</th>
<th>Brand Name</th>
<th>CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diaphragms and cervical caps</td>
<td>Solia Femcap, Ortho All-flex</td>
<td>A4261, A4266,</td>
</tr>
<tr>
<td>IUD devices</td>
<td>Mirena, ParaGard</td>
<td>J7297, J7298, J7300, Q0090</td>
</tr>
<tr>
<td>Injection</td>
<td>Depot medroxyprogesterone acetate</td>
<td>J1050, Q9986</td>
</tr>
<tr>
<td>Implants</td>
<td>Implanon, Nexplanon</td>
<td>J7301, J7306, J7307</td>
</tr>
<tr>
<td>Vaginal ring</td>
<td>Nuvaring</td>
<td>J7303</td>
</tr>
</tbody>
</table>

There are several instances in which the ACA regulations recommend the use of a prescription medication or an over-the-counter (OTC) medication. These medications and OTCs are administered under the pharmacy benefit and are not the responsibility of the medical claims payer.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Recommended for this population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin to prevent cardiovascular disease</td>
<td>Men ages 45–79, Women ages 55–79</td>
</tr>
<tr>
<td>Iron supplementation (OTC) (for children at increased risk for iron-deficiency anemia)</td>
<td>Children ages six–12 months</td>
</tr>
<tr>
<td>Folic acid supplementation (for women planning or capable of pregnancy)</td>
<td>Women of childbearing age</td>
</tr>
<tr>
<td>Oral fluoride supplementation (where water source does not contain fluoride)</td>
<td>Children ages six months to preschool</td>
</tr>
</tbody>
</table>

Travel Vaccines. Immunizations that are required solely for the purpose of travel (eg. Typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus) are not covered. This includes the following list of vaccines.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>90725</td>
<td>Cholera</td>
</tr>
<tr>
<td>90735, 90738</td>
<td>Japanese encephalitis</td>
</tr>
<tr>
<td>90727</td>
<td>Plague</td>
</tr>
<tr>
<td>90690 - 90693</td>
<td>Typhoid</td>
</tr>
<tr>
<td>90717</td>
<td>Yellow Fever</td>
</tr>
</tbody>
</table>

5. **Prior Authorization (PA) Requirements**

5.1. Preventive services are processed in accordance with the MDwise Marketplace Prior Authorization.

6. **Copays and Coinsurance**
6.1. According to the member schedule of benefits, there is no copay for preventative services as defined in the policy.
PLR - Pulmonary Rehab

1. Benefit Coverage

1.1. Covered Pulmonary Rehabilitation Services are medically necessary services provided to restore an individual's functional status after a pulmonary or cardiac event, or to improve respiratory capacity in persons with chronic lung conditions.

1.2. Pulmonary Rehabilitation includes services to restore an individual’s functional status after an illness or injury. Covered Pulmonary Rehabilitation Services include but are not limited to Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician’s office as indicated covered physician services including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary Rehabilitation Services in the acute Inpatient rehabilitation setting is not a Covered Health Service.

1.3. A pulmonary rehabilitation (PR) program is typically a physician-supervised, multidisciplinary program individually tailored and designed to optimize functional performance and autonomy of care for patients with chronic respiratory impairment. Exercise is combined with other training and support mechanisms to encourage long-term adherence to the treatment plan.

Conditions may include (including alpha-1 antitrypsin deficiency, asbestosis, asthma, emphysema, chronic airflow obstruction, chronic bronchitis, cystic fibrosis, fibrosing alveolitis, pneumoconiosis, pulmonary alveolar proteinosis, pulmonary fibrosis, pulmonary hemosiderosis, radiation pneumonitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, bronchopulmonary dysplasia, Guillain-Barre’ syndrome or other infective polyneuritis, muscular dystrophy, myasthenia gravis, paralysis of diaphragm, sarcoidosis, or scoliosis, lung cancer, and pre or post-surgical interventions.

Pulmonary Rehab Program Components include:
- Physician-prescribed exercise. This physical activity includes techniques such as exercise conditioning, breathing retraining, and step and strengthening exercises. Some aerobic exercise must be included in each PR session.
- Education or training.
- Psychosocial assessment. This assessment means a written evaluation of an individual’s mental and emotional functioning as it relates to the individual’s rehabilitation or respiratory condition.
- Outcomes assessment using objective data
- An individualized treatment plan describing the individual’s diagnosis and detailing how components are utilized for each patient approved by the physician

1.4. Pulmonary rehabilitation is expected to benefit the member, such that no concomitant condition is present that would undermine the effectiveness of the treatment, including conditions such as symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last 6 months, dysrhythmia, active joint disease, claudication, malignancy.
1.5. Pulmonary Rehabilitation items and services are routinely furnished in a physician's office/clinic setting or a hospital outpatient setting, and as per MDwise individual policy contract language, physician home visits.

2. Benefit Limitations and Exclusions

2.1. Limitation
- 20 visits when rendered as Physician Home Visits and Office Services or Outpatient Services.
- When rendered as part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.

2.2. Exclusions
- Pulmonary Rehabilitation Services in the acute Inpatient rehabilitation setting is not a Covered Health Service.

3. Provider Reimbursement & Submission Requirements

3.1. The provider reimbursement is as per contracted rate utilizing the appropriate percentage of the Medicare physician fee schedule or applicable OPPS pricing/outpatient pricer/APC as the base rate.
- Use the Medicare payment amount, if available; then apply the provider’s contracted percent of Medicare. If not, and the service code is covered, then use the Medicaid payment amount as the base. 150% of Medicaid is deemed equivalent to the Medicare rate; then apply the provider’s contracted percent of Medicare. If there is no Medicare or Medicaid rate and the service is covered, the item must be manually priced.
- If the provider is not contracted, and the service is authorized, then the following rate is applied to the applicable Medicare fee amount (or 150% of the Medicaid payment amount as the Medicare equivalent when no fee in Medicare is available and it is a covered service), unless in some case, the authorization could contain the non-contracted provider rate:
  - Facility 133%,
  - Professional l claims 125%
- Site of service (nonfacility and facility services) fees may apply to certain service codes
- In all cases, if the billed amount is less than the contracted payment amount, the billed amount is to be reimbursed.
4. Claim Considerations

4.1. The provider bills on Form CMS-1450 (aka UB-04 at present) or CMS 1500 or their electronic equivalent.

4.2. POS 22 Hospital Outpatient Setting
May include revenue code 0948: Other Therapeutic Services – Pulmonary Rehabilitation
POS 11: Office Setting/Clinic:

CPT/HCPCS Codes

G0237 Therapeutic procedures to increase strength or endurance of respiratory muscles, face-to-face, one-on-one, each 15 minutes (includes monitoring)
G0238 Therapeutic procedures to improve respiratory function, other than described by G0237, one-on-one, face-to-face, per 15 minutes (includes monitoring)
G0239 Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring)
G0302 Pre-operative pulmonary surgery services for preparation for Lung Volume Reduction Surgery (LVRS), complete course of services, to include a minimum of 16 days of services
Current CMS Physician fee schedule (WPS IN) does not price requested HCPCS code
G0303 Pre-operative pulmonary surgery services for preparation for LVRS, 10 to 15 days of services
Current CMS Physician fee schedule (WPS IN) does not price requested HCPCS code
G0304 Pre-operative pulmonary surgery services for preparation for LVRS, 1 to 9 days of services
Current CMS Physician fee schedule (WPS IN) does not price requested HCPCS code
G0305 Post discharge pulmonary surgery services after Lung Volume Reduction Surgery (LVRS), minimum of 6 days of services
Current CMS Physician fee schedule (WPS IN) does not price
G0424 Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to two sessions per day
S9473 Pulmonary rehabilitation program, non-physician provider, per diem
Current Physician fee schedule (WPS IN) does not price requested HCPCS code

Physician or other qualified health care professional services for outpatient pulmonary rehabilitation include those applicable claim edits utilized by MDwise (e.g. Bundled services) as billed included as part of one pulmonary rehab visit.

For example, Pulmonary rehab can be “bundled” procedure codes when provided as part of CR assessment, Interventions, monitoring (O2, ECG, BG, BP, etc) are included in the bundled service.

5. Prior Authorization (PA) Requirements

5.1. Claims received for Pulmonary Rehabilitation services are processed in accordance with the MDwise Marketplace Prior Authorization requirements.
RDT - Radiation Therapy Services

1. Benefit Coverage

1.1. Radiation Therapy Services may be covered for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies used in therapy, treatment planning as deemed medically necessary.

2. Benefit Limitations and Exclusions

2.1. Limitations
   - Any Simulation therapy should be restricted to one service per day

3. Provider Reimbursement & Submission Requirements

3.1. The provider reimbursement is as per contracted rate utilizing the appropriate Medicare physician fee schedule, Medicare Severity Diagnosis Related Groups (MSDR), or applicable hospital outpatient prospective payment system (OPPS) pricing/outpatient pricer, ambulatory payment classification (APC), as the base rate.
   - Use the Medicare payment amount, if available; then apply the provider’s contracted percent of Medicare. If not, and the service code is covered, then use the Medicaid payment amount as the base. 150% of Medicaid is deemed equivalent to the Medicare rate; then apply the provider’s contracted percent of Medicare. If there is no Medicare or Medicaid rate and the service is covered, the item must be manually priced.
   - If the provider is not contracted, and the service is authorized, then the following rate is applied to the applicable Medicare fee amount (or 150% of the Medicaid payment amount as the Medicare equivalent when no fee in Medicare is available and it is a covered service), unless in some case, the authorization could contain the non-contracted provider rate:
     o Facility 133%,
     o Professional 125%
   - Site of service (nonfacility and facility services) fees may apply to certain service codes
   - In all cases, if the billed amount is less than the contracted payment amount, the billed amount is to be reimbursed.

4. Procedure Codes and Claim Considerations
4.1. The provider bills on Form CMS-1450 (aka UB-04 at present) or CMS 1500 or their electronic equivalent.

4.2. Billing rules regarding simulation codes (those simulation codes to be billed only one per day are followed and those additional procedural codes limits as per defined radiation therapy code frequency edits and other rules specified within CPT code definition and per coding updates as published.

4.3. **Coding Guidelines (Source: CMS LCD)**

**Radiation - General**

- Radiation physics services (CPT codes 77300-77334, 77399) include a professional component (PC) and a technical component (TC). These services are covered following the same logic as other radiologic services that include PC and TC components.

- The physician’s professional component is covered in all settings when the billed service represents the physician’s (e.g., radiologist, radiation oncologist) involvement in the care. Radiation dosimetry calculations are payable by only when the physician personally performs the service described in the code, or when the physician participated in the provision of the service (e.g., reviewed or validated the physicist's calculation).

- The technical component is covered only in settings where the TC is payable (e.g., freestanding clinic). The services provided by a Radiation Physicist are considered a part of the TC. When the radiation physics service is provided in a hospital setting, it is considered as inpatient services. This is true whether the physicist is employed by a radiologist, or is employed by, or under contract with, the hospital. Therefore, Physicists may not:
  - direct bill for their services,
  - submit "incident to" billing for services furnished to hospital inpatients or outpatients, or
  - receive duplicate payment for the same services furnished by a radiation oncologist.

- When the radiation physics service is provided in a freestanding clinic, the physicist’s services are included in the global service billed by the physician.

  **Radiation Treatment Delivery (CPT codes 77401 - 77416)**

Radiation treatment delivery can be billed using a date range if the treatments are performed on consecutive days and the energy and level of service are the same, the total number being indicated in the CMS 1500 days or units field. If the dates of service are not consecutive or the energy or level of service is not the same, each date of service must be billed in a separate detail line.
• Radiation physics services (CPT codes 77336, 77370) are technical services only. These services are covered only in settings in which the technical component is payable (e.g., freestanding clinic).

• ICD10 codes must be used to the highest level of specificity.

• The following services are bundled into the radiation therapy codes: *May not be all inclusive as codes are revised/updated.*

- 11920, 11921, 11922, 16000, 16010, 16015, 16020, 16025, 16030, 36425, 53670, 53675, 99211, 99212, 99213, 99214, 99215, 99238, 99281, 99282, 99283, 99284, 99285, 90780, 90781, 90841, 90843, 90844, 90847, 99050, 99052, 99054, 99058, 99071, 99090, 99150, 99151, 99180, 99182, 99185, 99371, 99372, 99373

  o Anesthesia (whatever code billed)
  o Care of infected skin (whatever code billed)
  o Checking of treatment charts, verification of dosage, as needed (whatever code billed)
  o Continued patient evaluation, examination, written progress notes, as needed (whatever code billed)
  o Final physical examination (whatever code billed)
  o Medical prescription writing (whatever code billed)
  o Nutritional counseling (whatever code billed)
  o Pain management (whatever code billed)
  o Review & revision of treatment plan (whatever code billed)
  o Routine medical management of unrelated problem (whatever code billed)
  o Special care of ostomy (whatever code billed)
  o Written reports, progress notes (whatever code billed)
  o Follow-up examination and care for 90 days after last treatment (whatever code billed)
  o Please consult the latest version of Correct Coding Initiative (CCI) for rebundling combinations.

• For Treatment Devices, Designs, and Construction (CPT codes 77332-77334). The number of different anatomic sites determines the number of sets or ports involved except opposing fields (such as AP/PA) which represent one set. Each set must be submitted on the claim, with the appropriate level of complexity at the onset of therapy or as appropriate when additional devices are implemented during a course of treatment.

• Place of Service: Payment is limited to services furnished in office (POS 11), inpatient hospital (POS 21), and outpatient hospital (POS 22). A freestanding radiation oncology center is considered, for billing purposes, an office.

• Per MDwise 11/06/2013 – Freestanding radiation oncology centers will be considered an office and specialist copayment will be applied when billed on CMS 1500. If billed on a UB, applicable copay or coinsurance will be applied based on POS.
5. Prior Authorization (PA) Requirements

5.1. Claims received for Radiation Therapy Services are processed in accordance with the MDwise Marketplace Prior Authorization requirements.

5.2. The following services require prior authorization

- Radiation Therapy (specific radiation therapy requiring prior authorization)
- Intraoperative radiation therapy (IORT)
- Intensity modulated radiation therapy (IMRT)
- Proton beam radiotherapy (PBRT)
- Neutron beam therapy
- Brachytherapy
- Stereotactic radiosurgery
1. **Benefit Coverage**

1.1. **Definitions**
   - "**Routine Care Costs**" is defined as the cost of Medically Necessary services related to the care method that is under evaluation in a clinical trial.

1.2. Coverage may include those covered routine costs of approved clinical trials as well as reasonable and necessary covered items and services used to prevent complications and to diagnose and treat complications arising from participation in all clinical trials.

1.3. As outlined in the ACA, the health plan may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and may not discriminate against the individual on the basis of the individual's participation in such trial. ROUTINE PATIENT COSTS - routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial.

1.4. MDwise will adhere to federal guidelines published in the Federal Register when these become available.

1.5. Routine Care Costs as part of an approved clinical trial for the prevention, detection, or treatment of cancer or other life-threatening disease or condition if the Health Services are otherwise Covered Health Services under this Contract and the clinical trial is performed according to all of the following standards.(IC 27-8-25-2)
   - Using a particular care method to prevent, diagnose, or treat a cancer or other life-threatening disease or condition for which:
     - there is no clearly superior, non-investigational alternative care method, and
     - available clinical or preclinical data provides reasonable basis from which to believe that the care method used in the research study is at least as effective as any non-investigational alternative care method.
   - In a facility where personnel providing the care method to be followed in the research study have:
     - received training in providing the care method,
     - expertise in providing the type of care required for the research study, and
     - experience providing the type of care required for the research study to a sufficient volume of patients to maintain expertise, and
   - To scientifically determine the best care method to prevent, diagnose, or treat the cancer or other life-threatening disease or condition, and
• The trial is approved or funded by one of the following:
  o A National Institutes Health institute, CDC, AHRQ, CMS
  o A cooperative group of research facilities that has an established peer review program that is approved by a National Institutes of Health institute or center,
  o The federal Food and Drug Administration,
  o The United States Department of Veterans Affairs if the clinical trial complies with the standards set forth at IC 27-13-7-20.2(b) and 42 USC 300gg-8(d).
  o The United States Department of Defense, if the clinical trial complies with the standards set forth at IC 27-13-7-20.2(b) and 42 USC 300gg-8(d).
  o The United States Department of Energy, if the clinical trial complies with the standards set forth in 42 USC 300gg-8(d).
  o The institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks as provided in 45 C.F.R. 146.103, or
  o A research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.
  o Trials conducted under an investigational new drug application (IND) reviewed by the FDA. Drug trials that are exempt from having an IND under CFR § 312.2(b)(1).
  o A qualified non-governmental research entity in guidelines issued by the National Institutes of Health for center support grants.
  o A study or investigation done for drug trials which are exempt from the investigational new drug application.

1.6. Routine costs of covered health services can be covered in a clinical trial once the clinical trial meets the standards listed. The routine items must not be items that are otherwise excluded from coverage by the program.

1.7. MDwise covers medically necessary routine care costs consistent with Indiana Code (IC 27-13-7-20.2 Coverage for care related to cancer clinical trials) and within the framework of the CMS policy guidelines, as is applicable to this benefit.

1.8. MDwise covers the medically necessary routine patient care costs in the clinical trials in the same way that it reimburses medically necessary routine care for members not in clinical trials according but not limited to the following and the requirements and limitations outlined throughout this policy.
• All applicable plan limitations for coverage of out-of-network care will apply to routine patient care costs in clinical trials; and IC 27-13-7-20.2(f) The coverage that must be provided under this section is subject to the terms, conditions, restrictions, exclusions, and limitations that apply generally under the individual contract or group contract, including terms, conditions, restrictions, exclusions, or limitations that apply to health care services rendered by participating providers and nonparticipating providers. (c) As used in this section, "nonparticipating provider" means a health care provider that has not entered into an agreement described in IC 27-13-1-24.

• All utilization management rules and coverage policies that apply to routine care for members not in clinical trials will also apply to routine patient care for members in clinical trials; and
• Members must meet all applicable plan requirements for prior authorization, registration, and referrals.

2. Benefit Limitations and Exclusions

2.1. Limitations

The term "Routine Care Costs" does not include any of the following listed below.

• The health care service, item, or investigational drug that is the subject of the clinical trial.
• A health care service, item or drug that is the subject of the cancer clinical trial or is provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient.
• Any treatment modality that is not part of the usual and customary standard of care required to administer or support the health care service, item, or investigational drug that is the subject of the clinical trial.
• Any health care service, item, or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient.
• An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.
• Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that is associated with travel to or from a facility where a clinical trial is conducted.
• A service, item, or drug that is provided by a clinical trial sponsor free of charge for any new patient.
• A service, item, or drug that is eligible for reimbursement from a source other than an enrollee's individual contract or group contract, including the sponsor of the clinical trial.

3. Provider Reimbursement & Submission Requirements

3.1. The provider reimbursement is as per provider's contracted rate utilizing the applicable fee schedule or pricer (e.g. Medicare physician fee schedule, DMEPOS, lab, drug or supplies not billed to PBM, or applicable Medicare outpatient pricer, for example APC, ASC, OPPS) as the base rate. Covered inpatient hospital reimbursement is based on MS-DRGs.

• Use the Medicare payment amount, if available; then apply the provider's or facility's contracted percentage of Medicare.
• If not, and the service code is covered, then use the Medicaid payment amount (this includes manually priced codes) as the base. 150% of Medicaid is deemed equivalent to the Medicare rate; then apply the provider’s contracted percent of Medicare.
• If there is no Medicare or Medicaid rate and the service is covered, the item must be manually priced.
• If the provider is not contracted, and the service is authorized, then the following rate is applied to the applicable Medicare fee amount (or 150% of the Medicaid payment amount as the Medicare equivalent when no fee in Medicare is available and it is a covered service), unless in some case, the authorization could contain the non-contracted provider rate:
  o Facility 133%.
  o Professional I claims 125%
• Site of service (nonfacility and facility services) fees may apply to certain service codes
• In all cases, if the billed amount is less than the contracted payment amount, the billed
amount is to be reimbursed.

3.2. The provider bills on Form CMS 1500 or CMS-1450 (aka UB-04 at present) or its electronic equivalent.

3.3. The provider will submit claims to the PBM for pharmaceuticals and supplies paid through the PBM.

4. Claim Considerations

4.1. Documentation Requirements for Items and Services (Source: CMS Medicare Billing). Institutional clinical trial claims are identified through the presence of all of the following elements:
   - Value Code D4 and corresponding 8-digit clinical trial number (when present on the claim);
   - ICD-10 diagnosis code Z00.6;
   - Condition Code 30 (indicates that a condition applies to the bill that affects processing and payment of the claim) ; and
   - HCPCS modifier Q1: outpatient claims only.

4.2. HCPCS Modifier is used to identify clinical trial service.:  
   - Modifier Q1: Routine clinical service provided in a clinical research study that is in an approved clinical research study
   - Modifier Q0: Investigational clinical service provided in a clinical research study that is in an approved clinical research study

4.3. Practitioner/DME clinical trial claims are identified through the presence of all of the following elements: ICD-10 diagnosis code Z00.6; HCPCS modifier Q1; and 8-digit clinical trial number (when present on the claim).

4.4. On professional claims, the clinical trial registry number should be preceded by the two alpha characters of “CT” and placed in Field 19 of the paper Form CMS-1500 or it should be entered WITHOUT the “CT” prefix in the electronic 837P in Loop 2300 REF02(REF01=P4).

4.5. Other HCPCS codes related clinical trials:
   - S9988 Services provided as a part of a phase I clinical trial
   - S9990 Services provided as a part of a phase II clinical trial
   - S9991 Services provided as a part of a phase III clinical trial

5. Prior Authorization (PA) Requirements

5.1. Claims received for Clinical Trial Services are processed in accordance with the MDwise Marketplace Prior Authorization requirements.

5.2. Clinical Trials require prior authorization
6. **Copays and Coinsurance**

6.1. Copays and coinsurance amounts are applied as directed by MDwise and Marketplace policy contract.

6.2. Any covered health service normally covered when it is part of a clinical trial, the copays/coinsurance visit limitations/maximums as documented by covered health service categories in the MDwise individual and Child Marketplace Policy will be applied according to the schedule of benefits.
1. **Benefit Coverage**

1.1. MDwise reimburses covered charges for inpatient stays in a Skilled Nursing Facility (SNF) when it is determined it is medically necessary for the member to receive SNF covered services.

1.2. Inpatient Services include all of the following.
- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for Room, Board and General Nursing Services,
- Ancillary (related) services, and
- Professional Health Services from a Physician while an Inpatient.

1.3. A skilled nursing facility (SNF) is an institution (or a distinct part of an institution) that can meet the acute care needs requiring inpatient skilled nursing and related services and or rehabilitative care. SNF are provided under the supervision of physicians and covered based on medical necessity.

2. **Benefit Limitations and Exclusions**

2.1. **Annual Limitation**
- Skilled Nursing Facility SNF: 90 days
- Any days approved apply toward combined limitation of days.

2.2. **Exclusions**
- Long term or custodial care including domiciliary, convalescent care, skilled nursing facilities used for long-term care, state hospitals and custodial care, nursing home care, home-based respite care, group homes, halfway homes, residential facilities
- Bed hold days

3. **Provider Reimbursement & Submission Requirements**

3.1. Payment structure is based off of a per diem payment at the rate assigned to the billing SNF facility for each authorized day that the member is in the SNF.

The reimbursement is based on:
A per diem payment at 150% of the rate IHCP Medicaid Fee assigned to the billing SNF facility as the base rate and then apply the SNF’s contracted percentage for each authorized day that the member is in the SNF, OR
- Rate agreement with facility approved by medical OR
- RUG (Resource Utilization Group) rate all-inclusive facility rate, or as indicated by contract agreed upon by delivery system which may include carve outs
3.2. The Skilled Nursing Facility Payment structure is similar to the current HHW and HIP reimbursement process when utilizing IHCP facility per diem rates. The reimbursement is based on:

- A per diem payment at 150% of the rate IHCP Medicaid Fee assigned to the billing SNF facility as the base rate and then apply the SNF’s contracted percentage for each authorized day that the member is in the SNF. The IHCP SNF Medicaid Fee schedule is contained in the IHCP Rate Files passed on to the payer.

- Please also refer to the IHCP Provider Manual, Chapter 7 & 8 and IHCP banners and bulletins for additional details regarding reimbursement guidelines and exceptions.

3.3. Other payment structures may be indicated as:

- A per diem case rate as determined by the delivery system medical management and the SNF. If a specific negotiated per diem rate is obtained between the delivery system medical management and SNF, the medical management staff will enter per diem information with the authorization.

   OR

- RUG rate for facility or RUG rate and any carve outs as indicated by the facility agreement/contract. Reimbursement includes the CMS facility RUG rate at the provider contract %, if provider % is assigned per contract.

3.4. The provider bills on Form CMS-1450 (aka UB-04 at present) or its electronic equivalent.

4. Procedure Codes and Claim Considerations

4.1. SNFs bill for room and board charges using the applicable room and board revenue code. CMS defines POS code 31 as a Skilled Nursing Facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in the hospital.

SNF per diem levels based on level of care assigned may include 191-194, 199. Refer to applicable provider contract agreement for specific terms.

5. Prior Authorization (PA) Requirements

5.1. Claims received for Skilled Nursing Facilities are processed in accordance with the MDwise Marketplace Prior Authorization requirements.

5.2. All inpatient services, including skilled nursing facility require prior authorization.
TLM - Telemedicine / Telehealth Services

1. Benefit Coverage

1.1. Telemedicine (or Telehealth or Telemonitoring) is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance.

1.2. Coverage and payment for telemedicine services follow the Marketplace benefits and policies for covered services as outlined for medical and behavioral health covered physician and midlevel providers that includes office visits, individual psychotherapy, and pharmacologic management delivered via a telecommunications system. Prior Authorization requirements would apply for telemedicine service if that same service requires prior authorization if, for example, provided at clinic site.

1.3. Eligible places of service as an originating site are listed below. The term originating site means the location of an eligible member (aka spoke site) at the time the service being furnished via a telecommunications system occurs. Originating sites authorized by law are listed below:
   - The office of a physician or practitioner;
   - A hospital;
   - A critical access hospital (CAH);
   - A rural health clinic (RHC);
   - A federally qualified health center (FQHC);
   - A hospital-based or critical access hospital-based renal dialysis center (including satellites)
   - A skilled nursing facility (SNF);
   - A community mental health center (CMHC).
   - **NOTE**: Independent renal dialysis facilities are not eligible originating sites.

1.4. The use of a telecommunications system may substitute for an in-person encounter for covered office visits, office psychiatry services, and a limited number of other physician fee schedule (PFS) services, such as nutrition therapy. These services are listed below. **Codes are included in Section 4.**
   - Office or other outpatient visits
   - Subsequent nursing facility care services (with the limitation of one telehealth visit every 30 days)
   - Individual psychotherapy
   - Pharmacologic management
   - Psychiatric diagnostic interview examination
   - Individual and group medical nutrition therapy
   - End stage renal disease related services
   - Individual and group diabetes self-management training (DSMT) services (with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training)

   **NOTE**: Beginning January 1, 2010, CMS eliminated the use of all consultation codes, except for inpatient telehealth consultation G-codes. CMS no longer recognizes office/outpatient or inpatient consultation CPT codes for payment of office/outpatient or inpatient visits. Instead, physicians and
practitioners are instructed to bill a new or established patient office/outpatient visit CPT code or appropriate hospital or nursing facility care code, as appropriate to the particular patient, for all office/outpatient or inpatient visits.

1.5. The licensed physician of practitioner at the distant site (aka Hub site) who provides a covered telemedicine service (i.e., office and other outpatient visits, individual psychotherapy, and pharmacologic management) may submit a claim for this service when delivered via a telecommunications system.

Licensed Physicians/Practitioners who may bill for a covered telehealth service are listed below (subject to State law):
- Physician;
- Nurse practitioner;
- Physician assistant;
- Nurse midwife;
- Clinical nurse specialist;
- Clinical psychologist;
- LMFT Licensed Marital Family Therapist (LMFT)
- Licensed Mental Health Counselor (LMHC)
- Clinical social worker; and
- Registered dietitian.

* Clinical psychologists and clinical social workers cannot bill for psychotherapy services that include medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for the following CPT codes: 90792, 90833, 90836, 90838.

2. Benefit Limitations and Exclusions

2.1 Limitations
- Applicable limits apply to covered services that are billed as telemedicine services when those same services have limits applied in the clinic or other outpatient settings.
- Subsequent nursing facility care services are limited to one telehealth visit every 30 days.
- At least one monthly visit for end stage renal disease (ESRD)-related services must be furnished face-to-face “hands on” to examine the vascular access site by a licensed physician, clinical nurse specialist, nurse practitioner, or physician’s assistant.
- The member’s applicable copay/coinsurance is applied to the claim payment to the originating site. The term “originating site” (aka spoke site) means the location of the patient at the time the service being furnished via a telecommunications system occurs. (Revenue code 078X and includes HCPCS code “Q3014, telehealth originating site facility fee.”}

3. Provider Reimbursement and Submission Requirements

3.1 Definitions and Conditions of Payment
**Technology** For payment to occur, interactive audio and video telecommunications must be used, permitting real-time communication between the distant site physician or practitioner and the patient. As a condition of payment, the patient must be present and participating in the telehealth visit.

“**Store and forward**” For purposes of this instruction, “store and forward” means the asynchronous transmission of medical information to be reviewed at a later time by physician or practitioner at the distant site. A patient’s medical information may include, but not limited to, video clips, still images, x-rays, MRIs, EKGs and EEGs, laboratory results, audio clips, and text. The physician or practitioner at the distant site reviews the case without the patient being present. Store and forward substitutes for an interactive encounter with the patient present; the patient is not present in real-time. Store and forward technology to facilitate other reimbursable services is allowed; however, separate reimbursement of the spoke site payment is not provided. For IHCP, this is not a separately reimbursed telemedicine service.

**Telepresenters** A medical professional is not required to present the beneficiary to physician or practitioner at the distant site unless medically necessary. The decision of medical necessity will be made by the physician or practitioner located at the distant site.

**NOTE:** Asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patients’ condition and adequate for rendering or confirming a diagnosis and or treatment plan. Dermatological photographs, e.g., a photograph of a skin lesion, may be considered to meet the requirement of a single media format under this instruction. GQ: Telehealth service rendered via asynchronous telecommunications system.

3.2. The provider reimbursement is as per provider’s contracted percentage rate utilizing the Medicare Physician Fee Schedule or applicable Hospital Outpatient Prospective Payment System (OPPS) pricing/outpatient pricer as the base rate, with those exceptions for telehealth services under the CMS billing/reimbursement requirements indicated below.

- Use the Medicare payment amount, if available; then apply the provider’s contracted percent of Medicare. If not, and the service code is covered, then use the Medicaid payment amount as the base. 150% of Medicaid is deemed equivalent to the Medicare rate; then apply the provider’s contracted percent of Medicare.

If there is no Medicare or Medicaid rate and the service is covered, the item must be manually priced.
- If the provider is not contracted, and the service is authorized, then the following rate is applied to the applicable Medicare fee amount (or 150% of the Medicaid payment amount as the Medicare equivalent when no fee in Medicare is available and it is a covered service), unless in some case, the authorization could contain the non-contracted provider rate:
  - Facility 133%
  - Professional I claims 125%
• Site of service (nonfacility and facility services) fees may apply to certain service codes

• In all cases, if the billed amount is less than the contracted payment amount, the billed amount is to be reimbursed.

3.3. The term “distant site” (aka hub site) means the site where the physician or practitioner providing the professional service is located at the time the service is provided via a telecommunications system.

• The payment amount for the professional service provided via a telecommunications system by the physician or practitioner at the distant site is equal to the current Medicare physician fee schedule amount for the service.

• Payment for telehealth services should be made at the same amount as when these services are furnished without the use of a telecommunications system.

• For payment to occur, the service must be within a licensed physician/practitioner’s scope of practice under State law. The beneficiary is responsible for any applicable unmet deductible.

3.4. The term “originating site” (aka spoke site) means the location of the patient at the time the service being furnished via a telecommunications system occurs.

• The beneficiary is responsible for any applicable unmet deductible amount and applicable copay/coinsurance.

The originating site facility fee payment methodology for type of facility is clarified below.

• The originating site facility fee is a separately billable payment under Medicare reimbursement methodology. The contractor pays it outside of other payment methodologies.

• For services furnished on or after January 1 of each subsequent year, the originating site facility fee is updated by the Medicare Economic Index. The updated fee is included in the Medicare Physician Fee Schedule (MPFS) Final Rule, which is published by November 1 prior to the start of the calendar year for which it is effective. The updated fee for each calendar year is also issued annually in a Recurring Update Notification instruction for January of each year.

3.5. Originating site facility fee payment methodology as based on CMS payment methodology

• **Hospital outpatient department.**
  o Payment is not based on the OPPS payment methodology.

• **Hospital inpatient**
  o For hospital inpatients, payment for the originating site facility fee must be made outside the diagnostic related group (DRG) payment since this is a Part B benefit, similar to other services paid separately from the DRG payment.

  o When the originating site is a critical access hospital, make payment separately from the cost-based reimbursement methodology.
• Federally qualified health centers (FQHCs) and rural health clinics (RHCs).
  o The originating site facility fee for telehealth services is not an FQHC or RHC service.
  o When an FQHC or RHC serves as the originating site, the originating site facility fee must be paid separately from the center or clinic all-inclusive rate.
• Physicians’ and practitioners’ offices.
  o The carrier shall not apply the geographic practice cost index (GPCI) to the originating site facility fee. This fee is statutorily set and is not subject to the geographic payment adjustments authorized under the MPFS.
• Hospital-based or critical access-hospital based renal dialysis center (or their satellites).
  o When a hospital-based or critical access hospital-based renal dialysis center (or their satellites) serves as the originating site, the originating site facility fee is covered in addition to any composite rate or MCP amount.
• Skilled nursing facility (SNF).
  o The originating site facility fee is outside the SNF prospective payment system bundle and, as such, is not subject to SNF consolidated billing.
  o The originating site facility fee is a separately billable payment.
• Community Mental Health Center (CMHC).
  o The originating site facility fee is not a partial hospitalization service.
  o The originating site facility fee does not count towards the number of services used to determine payment for partial hospitalization services.
  o The originating site facility fee is not bundled in the per diem payment for partial hospitalization.
  o The originating site facility fee is a separately billable payment.
• Originating Site Facility Fee Payment (ESRD-Related Services)
  o With regard to ESRD-related services included in the MCP, the originating site facility fee payment may be made for each visit furnished through an interactive telecommunications system.
  o When the physician or practitioner at the distant site furnishes an ESRD-related patient visit(s) included in the MCP through an interactive telecommunications system, the originating site facility may bill for a telehealth facility fee.
  o The ESRD-related services included in the monthly capitation payment (MCP) with 2 or 3 visits per month and ESRD-related services with 4 or more visits per month may be paid as Medicare telehealth services. However, at least 1 visit must be furnished face-to-face “hands on” to examine the vascular access site by a physician, clinical nurse specialist, nurse practitioner, or physician’s assistant. An interactive audio and video telecommunications system may be used for providing additional visits required under the 2-to-3 visit MCP and the 4-or-more visit MCP.

4. Procedure Codes and Claims Considerations

4.1. Unless otherwise applicable, the originating site (spoke site) facility fee is reported under revenue code 078X and includes HCPCS code “Q3014, telehealth originating site facility fee.”
• If a different, separately reimbursable treatment room revenue code is provided on the same day as the telemedicine consultation, the appropriate treatment room revenue code should also be included on the claim. Documentation must be maintained in the patient’s record to indicate that services were provided separate from the telemedicine visit.
• If spoke site services are provided in a physician’s office and other services are provided on the same date as the spoke service, the medical professional should bill Q3014 as a separate line item from other professional services.

4.2. Distant Site Physicians/practitioners (hub site) submit the appropriate HCPCS procedure code for covered professional telehealth services along with the “GT” modifier (“via interactive audio and video telecommunications system”). The GT modifier is used to denote telemedicine/telehealth services

4.3. The various services and corresponding current procedure terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes that are used to submit claims for telemedicine services option are listed below. These billed services are compliant with the same covered services for physician and behavioral health benefits, claims requirements, and applicable prior authorization requirements when not provided through telemedicine/telehealth.

• Office or other outpatient visits (CPT codes 99201 - 99215);
• Subsequent nursing facility care services, with the limitation of one telehealth visit every 30 days (CPT codes 99307, 99308, 99309, and 99310) – Effective January 1, 2011;
• Pharmacologic management HCPCS code G0459 – Effective January 1, 2013;
• Individual psychotherapy (CPT codes 90833 - 90838)
• Psychiatric diagnostic interview examination (CPT codes 90791 -- 90792) – Effective January 1, 2013.
• Individual and group health and behavior assessment and intervention (CPT codes 96150 – 96154)
• Group and Family Psychotherapy (effective with 12.1.14 dates of service and beyond) – 90846, 90847, 90853
• Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services (HCPCS codes G0396 and G0397 and 99408, 99409).
• Smoking cessation services – (CPT codes 99406 and 99407 and HCPCS codes G0436 and G0437.
• End Stage Renal Disease (ESRD) related services (CPT codes 90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961) – Effective January 1, 2009;
• Individual and group medical nutrition therapy (HCPCS codes G0270, 97802, 97803, and 97804) – Individual effective January 1, 2006; group effective January 1, 2011;
• Individual and group diabetes self-management training (DSMT) services, with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training (HCPCS codes G0108 and G0109) - Effective January 1, 2011.

Please also refer this manual’s chapters on Preventive Care Services, Screening & Immunizations and Diabetic Equipment, Education, & Supplies

5. Prior Authorization (PA) Requirements

5.1. Claims received for Telemedicine/Telehealth Services are processed in accordance with the MDwise Marketplace Prior Authorization requirements.
5.2. Refer to the MDwise Marketplace PA reference guide and list for services that require a prior authorization. These services when done via telemedicine/telehealth service will require a prior authorization.

6. Copays and Coinsurance

6.1. Copays and coinsurance amounts are applied as directed by MDwise and the Marketplace policy contract.

6.2. The member’s applicable copay/coinsurance is applied to the claim payment to the originating site. The term “originating site” (aka spoke site) means the location of the patient at the time the service being furnished via a telecommunications system occurs.
TMJ - Temporomandibular or Cranomandibular Joint Disorder and Craniomandibular Jaw Disorder (TMJ)

1. Benefit Coverage

1.1. Benefits are provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders if provided within MDwise guidelines.

1.2. Requests for services including surgical interventions, procedures, therapy, pain management, and appliances or items may be covered as determined medically necessary for the diagnosis and treatment of TMJ, unless excluded from the benefit plan.

1.3. Other medically necessary services that may be covered for the treatment of TMJ, not specifically included within the PA section in this policy may also require PA for that service as outlined in the MDwise Marketplace list of services requiring prior authorization, e.g. physical therapy.

1.4. Provider types may include physicians and dental providers that include, Doctor of Dental Surgery, “D.D.S.”, or a Doctor of Medical Dentistry, “D.M.D.”, and oral surgeon/oral maxillary surgeon.

2. Benefit Limitations and Exclusions

2.1. Exclusions

2.1.1. Coverage for any of the following is not provided.

- Health Services that are not Medically Necessary.

- Health Services that are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by MDwise. The fact that a service is the only available for a condition will not make it eligible for Coverage if MDwise deems it to be Experimental/Investigative

- Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronisation technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

3. Claims Considerations

3.1. The provider bills on Form CMS-1450 (aka UB-04 at present) or CMS 1500 or their electronic equivalent.
4. Prior Authorization (PA) Requirements

4.1. Claims received for TMJ Services are processed in accordance with the MDwise Marketplace Prior Authorization requirements.

- Other services that require a prior authorization may be covered for treatment of TMJ when determined medically necessary, for example:
  - Durable Medical Equipment including insulin pumps, CPAP and supplies of $500 or more per claim, per rental or purchase
  - Prosthetics of $500 or more per claim per prosthetic
  - Orthotics
  - Pain Management
  - Speech/Occupational/Physical Therapy (after initial evaluation) including therapies provided at a Comprehensive Outpatient Rehab Facility (CORF)
UCC - Urgent Care Center Services

1. Benefit Coverage

1.1. The MDwise Marketplace Plan covers Urgent Care Services provided at an Urgent Care Center. An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It concerns the treatment of an unexpected sickness or injury that is not life or limb threatening but requires prompt medical attention. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an emergency room at a Hospital.

1.2. Definitions
   - **An Urgent Care Center** is a licensed medical service center that provides Urgent Care.

2. Benefit Limitations and Exclusions

2.1. The following benefit limitations or exclusions apply to urgent care center services:
   - Coverage for any device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which MDwise determines to be experimental/Investigative.
   - With the exception of emergency services, all services provided by out of network providers require prior authorization.

3. Provider Reimbursement & Submission Requirements

3.1. Depending on the type of urgent care facility, claims may be submitted both on a CMS 1450 (UB04) or CMS 1500. For example a hospital based urgent care center may bill revenue code 456 with the applicable CPT or HCPCS code. Other urgent care clinics may bill only for the professional services on a professional claim. Labs and other ancillary services may be billed in addition to the urgent care visit.

3.2. Some urgent care centers are located on the hospital campus. Hospital-based urgent care centers are reimbursed through the Outpatient Prospective Payment System using revenue code 456 along with any labs/radiology/ancillary services provided. The urgent care visit will be paid based on the applicable Ambulatory Payment Classification. Physician services may be reimbursed separately.

3.3. Urgent care centers or clinics that are not part of the hospital (e.g. CVS Minute Clinic), must submit the applicable professional charges, along with any ancillary charges on the CMS 1500. The services will be reimbursed according to the contracted provider’s % of Medicare fee schedule.
4. **Procedure Codes and Claim Considerations**

4.1. Urgent Care Centers billing on a CMS-1500 or 837P must include place of service 20, urgent care facility. This will properly identify the claim as an urgent care center claim.

5. **Prior Authorization (PA) Requirements**

5.1. Claims received for urgent care services are processed in accordance with the MDwise Marketplace Prior Authorization requirements. Services received at an out-of-network Urgent Care Center require an authorization.
VIS - Vision Services

1. Benefit Coverage

1.1. Covered medical vision services for both children and adult policy holders include
- Medically necessary ophthalmological services and surgeries to treat a medical condition related to the eye, except as outlined in this policy, or a member’s individual contract.
- Replacements for all or part of absent parts of the body, such as artificial eyes, if medically indicated.

1.2. A standard monofocal intraocular lens (IOL) implant is covered by MDwise as medically necessary for the following conditions:
- following cataract extraction
- trauma to the eye which has damaged the lens
- congenital cataract
- congenital aphakia
- lens subluxation/displacement
- anisometropia of 3 diopters or greater, and uncorrectable vision with the use of glasses or contact lenses.

Contact lenses or glasses are often prescribed following lens implantation and are covered services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury. The first pair of contact lenses or eyeglasses is covered. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the member selects eyeglasses and frames then reimbursement for both lenses and frames will be covered.

2. Benefit Limitations and Exclusions

2.1. The following benefit limitations or exclusions apply to vision services:
- Adult contract only - Prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a covered service or, effective 1.1.16 for those adult members that have selected a benefit plan that includes routine vision services. This exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition.
- One pair of conventional eyeglasses or conventional contact lenses furnished after each cataract surgery with insertion of an IOL is covered. Coverage is not available for replacement of lost or broken glasses or lenses.
- Vision orthoptic training is not covered.
- Eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive
keratectomy. There may be medical conditions which require necessitate LASIK surgery, however this requires prior authorization

- Any procedures, services, equipment or supplies provided in connection with cosmetic services. No benefits are available for surgery or treatments to change the size, shape or appearance of facial or body features (such as the member’s nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services treatment or surgery, as determined by MDwise is not covered.

- Coverage for any device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which MDwise determines to be experimental/Investigative (See list of procedures in Section 4).

- With the exception of emergency services and eyeglasses or contact lens following insertion of an IOL, all services provided by out of network providers require prior authorization.

### 3. Provider Reimbursement & Submission Requirements

3.1. Routine vision care services for children (through age 18) as defined by the individual contract the member holds, are reimbursed by VSP. Effective 1.1.16 this also includes adult members who have selected a benefit plan that includes routine vision services. Please refer to the list in section 4 for a list of applicable diagnosis codes and services that are to be paid by VSP. Routine vision care is not covered for members holding an adult contract, except as outlined above.

3.2. Claims for all members, that do not contain a routine diagnosis (see Section 4) are the responsibility of DST to adjudicate. For specific reimbursement methodology of medical vision-related claims by provider type, please refer to the applicable BCCP. For example, for reimbursement of ophthalmologists, refer to BCCP 22 Physician Services, for outpatient hospital vision related surgery refer to BCCP 14, for ambulatory surgery center services, BCCP 03, etc.

3.3. Payment for intraocular lenses (IOLs) inserted during or subsequent to cataract surgery in an ASC is included with the payment for facility services that are furnished in connection with the covered surgery (See BCCP 03).

### 4. Procedure Codes and Claim Considerations

4.1. Claims for members that hold a Child Contract with any of the following routine diagnosis should be denied with an applicable denial reason. Effective 1.1.16 this also includes adult members who have selected a benefit plan that includes routine vision services. The provider should be directed to submit the claim instead to the vision service provider. The vision service provider will process claims with a medical diagnosis as long as one of the following routine diagnosis code(s) is on the claim; the routine diagnosis does not need to be primary. If a routine diagnosis code is not on the claim, it is the responsibility for DST to process.
ICD-10 Routine Diagnosis Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z01.00,</td>
<td>Examination of eyes and vision</td>
</tr>
<tr>
<td>Z01.01</td>
<td></td>
</tr>
<tr>
<td>Z46.0</td>
<td>Spectacles and contact lenses</td>
</tr>
<tr>
<td>Z13.5</td>
<td>Screening for other eye conditions</td>
</tr>
<tr>
<td>H52.0X</td>
<td>Hypermetropia</td>
</tr>
<tr>
<td>H52.1X</td>
<td>Myopia</td>
</tr>
<tr>
<td>H52.20X</td>
<td>Astigmatism, unspecified</td>
</tr>
<tr>
<td>H52.22X</td>
<td>Regular Astigmatism</td>
</tr>
<tr>
<td>H52.21X</td>
<td>Irregular Astigmatism</td>
</tr>
<tr>
<td>H52.31</td>
<td>Anisometropia</td>
</tr>
<tr>
<td>H52.32</td>
<td>Aniseikonia</td>
</tr>
<tr>
<td>H52.4</td>
<td>Presbyopia</td>
</tr>
<tr>
<td>H52.52X</td>
<td>Paresis of accommodation</td>
</tr>
<tr>
<td>H52.51X</td>
<td>Total or complete internal ophthalmoplegia</td>
</tr>
<tr>
<td>H52.53X</td>
<td>Spasm of accommodation</td>
</tr>
<tr>
<td>H52.6</td>
<td>Other disorders of refraction &amp; accommodation (drug-</td>
</tr>
<tr>
<td></td>
<td>induced and/or toxic)</td>
</tr>
<tr>
<td>H52.7</td>
<td>Unspecified disorders of refraction &amp; accommodations</td>
</tr>
</tbody>
</table>

Except for child members and adult members that have selected a benefit plan that includes routine vision services, if a claim is received for any of the above routine vision diagnosis in the primary diagnosis position, the claim shall be denied as not covered under the member’s contract. The exceptions are ICD-10 code Z13.5 (Encounter for screening for eye disorders) or ICD-10 code Z46.0). Please see Section 4.6 related to circumstances in which a member may receive eyeglasses under the Adult Contract. If the member is eligible to receive eyeglasses, then Z46.0 may be an appropriate diagnosis to include on the claim. Dx Z13.5 could be related to a medical vision issue and may be appropriate to include on a non-routine vision claim.

4.2. **CPT code 92065.** Orthoptic and/or pleoptic training – CPT code 92065 is not covered regardless of diagnosis submitted.

4.3. **Refractive Surgeries.** Eye surgeries to correct refraction are not a covered benefit. Please refer to the table below for diagnosis codes related to refraction, for which the below surgical codes should not be paid.

<table>
<thead>
<tr>
<th>Refractive Surgery:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ICD-10 codes not covered below for retractive surgeries</strong></td>
</tr>
<tr>
<td>------------------------------------------</td>
</tr>
<tr>
<td>H52.XXX</td>
</tr>
<tr>
<td>H52.6</td>
</tr>
<tr>
<td>H52.7</td>
</tr>
<tr>
<td><strong>CPT/HCPCS surgical codes not covered for above diagnosis</strong></td>
</tr>
<tr>
<td>------------------------------------------</td>
</tr>
<tr>
<td>65400 – 65600</td>
</tr>
</tbody>
</table>
Standard keratomileusis (ALK): Photorefractive keratectomy (PRK) and Photoastigmatic keratectomy (PARK or PRK-A), Laser in-situ keratomileusis:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>65760</td>
<td>Keratophakia:</td>
</tr>
<tr>
<td>65765</td>
<td>Epikeratoplasty (or epikeratophakia):</td>
</tr>
<tr>
<td>65767</td>
<td>Astigmatic keratotomy (AK):</td>
</tr>
<tr>
<td>65772</td>
<td>Laser in situ keratomileusis (LASIK) - manual pricing</td>
</tr>
<tr>
<td>65775</td>
<td>Photorefractive keratectomy (PRK) – manual pricing</td>
</tr>
<tr>
<td>65771</td>
<td>Phototherapeutic keratectomy (PTK) – manual pricing</td>
</tr>
</tbody>
</table>

There are some medical conditions, following prior cataract, corneal, or scleral buckling surgery for retinal detachment, where LASIK, laser epithelial keratomileusis (LASEK), photorefractive keratectomy (PRK), and photoastigmatic keratectomy (PARK or PRK-A) may be considered medically necessary; however these services require prior authorization.

### 4.4. Non-Covered Surgical Codes – The below surgical codes are not covered, regardless of diagnosis

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>65710</td>
<td>Lamellar keratoplasty (non-penetrating keratoplasty):</td>
</tr>
<tr>
<td>65730,</td>
<td>Penetrating keratoplasty (PK) (corneal transplantation, perforating keratoplasty):</td>
</tr>
<tr>
<td>65750,</td>
<td></td>
</tr>
<tr>
<td>65755</td>
<td></td>
</tr>
<tr>
<td>0289T</td>
<td>PK (billed with keratoplasty code)</td>
</tr>
<tr>
<td>0290T</td>
<td>PK (billed with keratoplasty code)</td>
</tr>
<tr>
<td>65771</td>
<td>Radial keratotomy:</td>
</tr>
<tr>
<td>66840;</td>
<td>Clear lens extraction (CLE)</td>
</tr>
<tr>
<td>66850;</td>
<td></td>
</tr>
<tr>
<td>66852;</td>
<td></td>
</tr>
<tr>
<td>66920;</td>
<td></td>
</tr>
<tr>
<td>66930;</td>
<td></td>
</tr>
<tr>
<td>66940;</td>
<td></td>
</tr>
<tr>
<td>66999</td>
<td>Unlisted procedure</td>
</tr>
</tbody>
</table>

### 4.5. Intraocular lenses (IOLs) Covered Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>66982 - 66985</td>
<td>Extracapsular cataract removal with insertion of intraocular lens prosthesis</td>
</tr>
<tr>
<td>66986</td>
<td>Exchange of intraocular lens</td>
</tr>
<tr>
<td>C1780</td>
<td>Lens, intraocular (new technology) [standard fixed monofocal posterior chamber intraocular lenses (IOL) for aphakia only]</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td>V2630</td>
<td>Anterior chamber intraocular lens</td>
</tr>
<tr>
<td>V2631</td>
<td>Iris supported intraocular lens</td>
</tr>
<tr>
<td>V2632</td>
<td>Posterior chamber intraocular lens</td>
</tr>
<tr>
<td>V2702</td>
<td>Deluxe lens feature</td>
</tr>
<tr>
<td>V2755</td>
<td>U-V lens, per lens</td>
</tr>
<tr>
<td>V2797</td>
<td>Vision supply, accessory, and/or service component of another HCPCS vision</td>
</tr>
</tbody>
</table>

**IOL HCPCS codes not covered**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1004</td>
<td>New technology intraocular lens category 4 as defined in Federal Register</td>
</tr>
<tr>
<td>Q1005</td>
<td>New technology intraocular lens category 5 as defined in Federal Register</td>
</tr>
<tr>
<td>S0596</td>
<td>Phakic intraocular lens (PIOL)</td>
</tr>
<tr>
<td>V2787</td>
<td>Astigmatism correcting function of intraocular lens</td>
</tr>
<tr>
<td>V2788</td>
<td>Presbyopia correcting function of intraocular lens</td>
</tr>
<tr>
<td>743.30-743.39</td>
<td>Congenital cataract and lens anomalies</td>
</tr>
<tr>
<td>996.69</td>
<td>Infection and inflammatory reaction due to internal prosthetic device, implant and graft</td>
</tr>
</tbody>
</table>

**ICD-10 codes covered for IOL**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E08.3XX</td>
<td>Diabetes mellitus due to underlying condition with ophthalmic complications, including diabetic retinopathy</td>
</tr>
<tr>
<td>E08.65</td>
<td>Diabetes mellitus due to underlying condition with hyperglycemia</td>
</tr>
<tr>
<td>E09.3XX</td>
<td>Drug or chemical induced diabetes mellitus with ophthalmic complications</td>
</tr>
<tr>
<td>E10.3XX</td>
<td>Type 1 diabetes mellitus with ophthalmic complications</td>
</tr>
<tr>
<td>E10.65</td>
<td>Type 1 diabetes mellitus with hyperglycemia</td>
</tr>
<tr>
<td>E11.3XX</td>
<td>Type 2 diabetes mellitus with ophthalmic complications</td>
</tr>
<tr>
<td>E11.65</td>
<td>Type 2 diabetes mellitus with hyperglycemia</td>
</tr>
<tr>
<td>E13.3XX</td>
<td>Other specified diabetes mellitus with ophthalmic complications</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>H25.0XX</td>
<td>Age-related cataract</td>
</tr>
<tr>
<td>H25.10-H25.13</td>
<td>Age-related nuclear cataract</td>
</tr>
<tr>
<td>H25.20-H25.23</td>
<td>Age-related cataract, morgagnian type</td>
</tr>
<tr>
<td>H25.8XX</td>
<td>Other age-related cataract</td>
</tr>
<tr>
<td>H25.9</td>
<td>Unspecified age-related cataract</td>
</tr>
<tr>
<td>H26.0XX</td>
<td>Infantile and juvenile cataract</td>
</tr>
<tr>
<td>H26.1XX</td>
<td>Traumatic cataract</td>
</tr>
<tr>
<td>H26.20</td>
<td>Unspecified complicated cataract</td>
</tr>
</tbody>
</table>

**ICD-10 codes covered for IOL**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H26.211-H26.219</td>
<td>Cataract with neovascularization</td>
</tr>
<tr>
<td>H26.221-H26.229</td>
<td>Cataract secondary to ocular disorders (degenerative)</td>
</tr>
<tr>
<td>H26.231-H26.239</td>
<td>Glaucomatous flecks (subcapsular)</td>
</tr>
<tr>
<td>H26.30-H26.33</td>
<td>Drug-induced cataract</td>
</tr>
<tr>
<td>H26.8</td>
<td>Other specified cataract</td>
</tr>
<tr>
<td>H26.9</td>
<td>Unspecified cataract</td>
</tr>
<tr>
<td>H27.00-H27.03</td>
<td>Aphakia</td>
</tr>
<tr>
<td>H27.10</td>
<td>Unspecified dislocation of lens</td>
</tr>
<tr>
<td>H27.111-H27.119</td>
<td>Subluxation of lens</td>
</tr>
<tr>
<td>H27.121-129</td>
<td>Anterior dislocation of lens</td>
</tr>
<tr>
<td>H27.131-H27.139</td>
<td>Posterior dislocation of lens</td>
</tr>
<tr>
<td>H28</td>
<td>Cataract in diseases classified elsewhere</td>
</tr>
<tr>
<td>H40.89</td>
<td>Other specified glaucoma</td>
</tr>
<tr>
<td>H44.19</td>
<td>Other endophthalmitis</td>
</tr>
<tr>
<td>H54.XX</td>
<td>Blindness and low vision</td>
</tr>
<tr>
<td>Q12.XX</td>
<td>Congenital lens malformation</td>
</tr>
<tr>
<td>S05.10XA</td>
<td>Contusion of eyeball and orbital tissues, unspecified eye</td>
</tr>
<tr>
<td>T85.21xA-T85.21xS</td>
<td>Breakdown (mechanical) of intraocular lens, initial encounter</td>
</tr>
<tr>
<td>T85.22xA-T85.22xS</td>
<td>Displacement of intraocular lens, initial encounter</td>
</tr>
<tr>
<td>T85.29xA-T85.29xS</td>
<td>Other mechanical complication of intraocular lens, initial encounter</td>
</tr>
<tr>
<td>Z01.818</td>
<td>Encounter for other preprocedural examination</td>
</tr>
<tr>
<td>Z13.5</td>
<td>Encounter for screening for eye and ear disorders</td>
</tr>
<tr>
<td>Z96.1</td>
<td>Presence of intraocular lens</td>
</tr>
<tr>
<td>Z98.41-Z98.49</td>
<td>Cataract extraction status</td>
</tr>
</tbody>
</table>
4.6. Eyeglasses & Contact Lenses

As outlined in Section 1.2, eyeglasses and contact lenses are covered for adults only following lens implantation, except for those adult members who have selected a benefit package with routine vision coverage. To ensure that eyeglasses or contact lenses are reimbursed following a lens implantation, claims shall be pended for review. Prior to reimbursement, the claims examiner must validate evidence of a lens implantation anytime in the previous six months. If there is no evidence of a lens implantation the claim shall be denied.

Only one pair of eyeglasses or contact lenses is available for reimbursement. Coverage is not available for replacement of lost or broken glasses or lenses.

Coverage for eyeglasses and contact lenses following a lens implantation is provided without an authorization, regardless of whether the provider is contracted or not.

Under the medical benefit, MDwise considers the following eyeglass features not medically necessary:

<table>
<thead>
<tr>
<th>HCPS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2744</td>
<td>Tint, photochromatic, per lens</td>
</tr>
<tr>
<td>V2745</td>
<td>Additions to lens, tint, any color, solid, gradient or equal, excluded photochromatic, any lens material, per lens</td>
</tr>
<tr>
<td>V2750</td>
<td>Antireflective coating, per lens</td>
</tr>
<tr>
<td>V2756</td>
<td>Eyeglass cases</td>
</tr>
<tr>
<td>V2760</td>
<td>Scratch resistant coating</td>
</tr>
<tr>
<td>V2761</td>
<td>Mirror coating (colored, highly-reflective lens treatments)</td>
</tr>
<tr>
<td>V2762</td>
<td>Polarization</td>
</tr>
<tr>
<td>V2781</td>
<td>Progressive lens</td>
</tr>
</tbody>
</table>

The following HCPC codes must be accompanied by an optical lab invoice and report of type of lenses provided:

<table>
<thead>
<tr>
<th>HCPS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2199</td>
<td>Single vision lens not otherwise classified</td>
</tr>
<tr>
<td>V2299</td>
<td>Specialty bifocal</td>
</tr>
<tr>
<td>V2399</td>
<td>Specialty trifocal</td>
</tr>
<tr>
<td>V2499</td>
<td>Variable sphericity lens, other type</td>
</tr>
<tr>
<td>V2599</td>
<td>Variable sphericity lens, other type</td>
</tr>
<tr>
<td>V2799</td>
<td>Vision service, miscellaneous</td>
</tr>
</tbody>
</table>
4.7. VSP reimburses providers for the following services for child contract holders and adult members who selected adult vision coverage if the claim is submitted with a routine diagnosis code. If a claim is received without a routine diagnosis code, then the claim may be reimbursable by DST. The exception is any service for a diagnosis on the exclusions list (e.g. cosmetic).

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92002</td>
<td>Ophthalmological medical exam and evaluation; intermediate, new patient</td>
</tr>
<tr>
<td>92004</td>
<td>Ophthalmological medical exam and evaluation; comprehensive, new patient</td>
</tr>
<tr>
<td>92012</td>
<td>Ophthalmological medical exam and evaluation; intermediate, established patient</td>
</tr>
<tr>
<td>92014</td>
<td>Ophthalmological medical exam and evaluation; comprehensive, established patient</td>
</tr>
<tr>
<td>92015</td>
<td>Refraction</td>
</tr>
<tr>
<td>S0620</td>
<td>Routine Ophthalmological Examination Including Refraction; new patient</td>
</tr>
<tr>
<td>S0621</td>
<td>Routine Ophthalmological Examination Including Refraction; established patient</td>
</tr>
<tr>
<td>92072</td>
<td>Fitting of contact lens for management of keratoconus, initial fitting</td>
</tr>
<tr>
<td>92310</td>
<td>Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia</td>
</tr>
<tr>
<td>92311</td>
<td>Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye</td>
</tr>
<tr>
<td>92312</td>
<td>Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes</td>
</tr>
<tr>
<td>92313</td>
<td>Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens</td>
</tr>
<tr>
<td>92326</td>
<td>Replacement of contact lens</td>
</tr>
<tr>
<td>92340</td>
<td>Spectacles, monofocal</td>
</tr>
<tr>
<td>92341</td>
<td>Spectacles, bifocal</td>
</tr>
<tr>
<td>92342</td>
<td>Spectacles, multifocal other than bifocal</td>
</tr>
<tr>
<td>V2020</td>
<td>Frame</td>
</tr>
<tr>
<td>V2025</td>
<td>Deluxe Frame</td>
</tr>
<tr>
<td>V2100</td>
<td>Sphere, single vision, plano to plus or minus 4.00, per lens</td>
</tr>
<tr>
<td>V2101</td>
<td>Sphere, single vision, plus or minus 4.12 to plus or minus 7.00d, per lens</td>
</tr>
<tr>
<td>V2102</td>
<td>Sphere, single vision, plus or minus 7.12 to plus or minus 20.00d, per lens</td>
</tr>
<tr>
<td>V2103</td>
<td>Spherocylinder, single vision, plano to plus or minus 4.00d sphere, .12 to 2.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2104</td>
<td>Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2105</td>
<td>Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2106</td>
<td>Spherocylinder, single vision, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2107</td>
<td>Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00d sphere, .12 to 2.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2108</td>
<td>Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2109</td>
<td>Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2110</td>
<td>Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2111</td>
<td>Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, .25 to 2.25d cylinder, per lens</td>
</tr>
</tbody>
</table>
## Routine Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2112</td>
<td>Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.0d sphere, 2.25 to 4.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2113</td>
<td>Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2114</td>
<td>Spherocylinder, single vision, sphere over plus or minus 12.00d, per lens</td>
</tr>
<tr>
<td>V2115</td>
<td>Lenticular (myodisc), per lens, single vision</td>
</tr>
<tr>
<td>V2118</td>
<td>Aniseikonic lens, single vision</td>
</tr>
<tr>
<td>V2121</td>
<td>Lenticular lens, per lens, bifocal</td>
</tr>
<tr>
<td>V2199</td>
<td>Not otherwise classified, single vision lens</td>
</tr>
<tr>
<td>V2200</td>
<td>Sphere, bifocal, plano to plus or minus 4.00d, per lens</td>
</tr>
<tr>
<td>V2201</td>
<td>Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00d, per lens</td>
</tr>
<tr>
<td>V2202</td>
<td>Sphere, bifocal, plus or minus 7.12 to plus or minus 20.00d, per lens</td>
</tr>
<tr>
<td>V2203</td>
<td>Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, .12 to 2.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2204</td>
<td>Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2205</td>
<td>Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2206</td>
<td>Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2207</td>
<td>Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, .12 to 2.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2208</td>
<td>Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2209</td>
<td>Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2210</td>
<td>Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2211</td>
<td>Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00 sphere, .25 to 2.25d cylinder, per lens</td>
</tr>
<tr>
<td>V2212</td>
<td>Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2213</td>
<td>Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2214</td>
<td>Spherocylinder, bifocal, sphere over plus or minus 12.00d, per lens</td>
</tr>
<tr>
<td>V2215</td>
<td>Lenticular (myodisc), per lens, bifocal</td>
</tr>
<tr>
<td>V2218</td>
<td>Aniseikonic, per lens, bifocal</td>
</tr>
<tr>
<td>V2219</td>
<td>Bifocal seg width over 28mm</td>
</tr>
<tr>
<td>V2220</td>
<td>Bifocal add over 3.25d</td>
</tr>
<tr>
<td>V2221</td>
<td>Lenticular lens, per lens, bifocal</td>
</tr>
<tr>
<td>V2299</td>
<td>Specialty bifocal (by report)</td>
</tr>
<tr>
<td>V2300</td>
<td>Sphere, trifocal, plano to plus or minus 4.00d, per lens</td>
</tr>
<tr>
<td>V2301</td>
<td>Sphere, trifocal, plus or minus 4.12 to plus or minus 7.00d, per lens</td>
</tr>
<tr>
<td>V2302</td>
<td>Sphere, trifocal, plus or minus 7.12 to plus or minus 20.00d, per lens</td>
</tr>
<tr>
<td>V2303</td>
<td>Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, .12 to 2.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2304</td>
<td>Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 2.25 to 4.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2305</td>
<td>Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2306</td>
<td>Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2307</td>
<td>Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, .12 to 2.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2308</td>
<td>Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2309</td>
<td>Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2310</td>
<td>Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2311</td>
<td>Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, .25 to 2.25d cylinder, per lens</td>
</tr>
<tr>
<td>V2312</td>
<td>Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, .25 to 4.00d cylinder, per lens</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>V2313</td>
<td>Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere,</td>
</tr>
<tr>
<td></td>
<td>4.25 to 6.00d cylinder, per lens</td>
</tr>
<tr>
<td>V2314</td>
<td>Spherocylinder, trifocal, sphere over plus or minus 12.00d, per lens</td>
</tr>
<tr>
<td>V2315</td>
<td>Lenticular (myodisc), per lens, trifocal</td>
</tr>
<tr>
<td>V2318</td>
<td>Aniseikonic lens, trifocal</td>
</tr>
<tr>
<td>V2319</td>
<td>Trifocal seg width over 28mm</td>
</tr>
<tr>
<td>V2320</td>
<td>Trifocal add over 3.25d</td>
</tr>
<tr>
<td>V2321</td>
<td>Lenticular lens, per lens, trifocal</td>
</tr>
<tr>
<td>V2399</td>
<td>Specialty trifocal (by report)</td>
</tr>
<tr>
<td>V2410</td>
<td>Variable asphericity lens, single vision, full field, glass or plastic, per</td>
</tr>
<tr>
<td></td>
<td>lens</td>
</tr>
<tr>
<td>V2430</td>
<td>Variable asphericity lens, bifocal, full field, glass or plastic, per lens</td>
</tr>
<tr>
<td>V2499</td>
<td>Variable asphericity lens, other type</td>
</tr>
<tr>
<td>V2500</td>
<td>Contact lens, PMMA, spherical, per lens</td>
</tr>
<tr>
<td>V2501</td>
<td>Contact lens, PMMA, toric or prism ballast, per lens</td>
</tr>
<tr>
<td>V2502</td>
<td>Contact lens, PMMA, bifocal, per lens</td>
</tr>
<tr>
<td>V2503</td>
<td>Contact lens, PMMA, color vision deficiency, per lens</td>
</tr>
<tr>
<td>V2510</td>
<td>Contact lens, gas permeable, spherical, per lens</td>
</tr>
<tr>
<td>V2511</td>
<td>Contact lens, gas permeable, toric, prism ballast, per lens</td>
</tr>
<tr>
<td>V2512</td>
<td>Contact lens, gas permeable, bifocal, per lens</td>
</tr>
<tr>
<td>V2513</td>
<td>Contact lens, gas permeable, extended wear, per lens</td>
</tr>
<tr>
<td>V2520</td>
<td>Contact lens, hydrophilic, spherical, per lens</td>
</tr>
<tr>
<td>V2521</td>
<td>Contact lens, hydrophilic, toric, or prism ballast, per lens</td>
</tr>
<tr>
<td>V2522</td>
<td>Contact lens, hydrophilic, bifocal, per lens</td>
</tr>
<tr>
<td>V2523</td>
<td>Contact lens, hydrophilic, extended wear, per lens</td>
</tr>
<tr>
<td>V2530</td>
<td>Contact lens, scleral, gas impermeable, per lens</td>
</tr>
<tr>
<td>V2531</td>
<td>Contact lens, scleral, gas permeable, per lens</td>
</tr>
<tr>
<td>V2599</td>
<td>Contact lens, other type</td>
</tr>
<tr>
<td>V2700</td>
<td>Balance lens, per lens</td>
</tr>
<tr>
<td>V2702</td>
<td>Deluxe lens feature</td>
</tr>
<tr>
<td>V2710</td>
<td>Slab off prism, glass or plastic, per lens</td>
</tr>
<tr>
<td>V2715</td>
<td>Prism, per lens</td>
</tr>
<tr>
<td>V2718</td>
<td>Press-on-lens, Fresnell prism, per lens</td>
</tr>
<tr>
<td>V2730</td>
<td>Special base curve, glass or plastic, per lens</td>
</tr>
<tr>
<td>V2744</td>
<td>Tint, photochromatic, per lens</td>
</tr>
<tr>
<td>V2745</td>
<td>Addition to lens, tint, any color, solid, gradient or equal, exclude photoch</td>
</tr>
<tr>
<td></td>
<td>romatic, any lens material, per lens</td>
</tr>
<tr>
<td>V2750</td>
<td>Anti-reflective coating, per lens</td>
</tr>
<tr>
<td>V2755</td>
<td>UV lens, per lens</td>
</tr>
<tr>
<td>V2760</td>
<td>Scratch-resistant coating, per lens</td>
</tr>
<tr>
<td>V2761</td>
<td>Mirror coating, any type, solid, gradient or equal, any lens material, per l</td>
</tr>
<tr>
<td></td>
<td>en</td>
</tr>
<tr>
<td>V2762</td>
<td>Polarization, any lens material, per lens</td>
</tr>
<tr>
<td>V2770</td>
<td>Occluder lens, per lens</td>
</tr>
<tr>
<td>V2780</td>
<td>Oversize lens, per lens</td>
</tr>
<tr>
<td>V2781</td>
<td>Progressive lens, per lens</td>
</tr>
<tr>
<td>V2782</td>
<td>Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbon</td>
</tr>
<tr>
<td></td>
<td>ate, per lens</td>
</tr>
</tbody>
</table>
### Routine Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2783</td>
<td>Lens, index greater than or equal to 1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate, per lens</td>
</tr>
<tr>
<td>V2784</td>
<td>Lens, polycarbonate or equal, any index, per lens</td>
</tr>
<tr>
<td>V2786</td>
<td>Specialty occupational multifocal lens, per lens</td>
</tr>
<tr>
<td>V2797</td>
<td>Vision supply, accessory and/or service component of another HCPCS vision code</td>
</tr>
<tr>
<td>V2799</td>
<td>Vision service, miscellaneous</td>
</tr>
</tbody>
</table>

5. **Prior Authorization (PA) Requirements**

5.1. Claims received for vision services are processed in accordance with the MDwise Marketplace Prior Authorization requirements.

6. **Copays and Coinsurance**

6.1. Coverage of medical vision services are based on the place and type of service provided. Please refer to the individual member contract for copays or coinsurance required.

6.2. Intraocular lens implantation, as described in Section 1.2, falls under the prosthetic benefit according to the member’s contract. In addition to the implant, medically necessary contact lenses or glasses following lens implantation is included under this same benefit.
Appendix: Manual Pricing

**Manual Pricing.** CPT codes billed for the marketplace, which fall under the manual pricing logic should follow the published Medicaid rate methodology, as outlined in the below table and in the IHCP Bulletin, BT 200940 and 201213. Except for drugs and biological, which have special pricing, HCPCS codes which indicate manual pricing will be reimbursed at 60% of billed charges, or for DME products, 60% of the Manufacturers Suggested Retail Price (MSRP). For the pricing of drugs and biological, refer to BCCP 20, Pharmacy & Biologicals.

To determine the base Medicare rate for CPT codes, the applicable Medicaid rate, based on the below table is multiplied by 150%. The provider’s contracted rate is than applied to the base Medicare rate.

For HCPS codes that are paid at 60% of billed charges, there is no additional percentage applied (Medicare equivalency or additional provider contracted amount).

<table>
<thead>
<tr>
<th>Procedure Code Range</th>
<th>Codes Billed on CMS-1500</th>
<th>Codes Billed on UB-04</th>
</tr>
</thead>
<tbody>
<tr>
<td>10000-19999</td>
<td>20% of billed Amount</td>
<td>20% of billed Amount</td>
</tr>
<tr>
<td>20000-29999</td>
<td>20% of billed Amount</td>
<td>10% of billed Amount</td>
</tr>
<tr>
<td>30000-39999</td>
<td>20% of billed Amount</td>
<td>10% of billed Amount</td>
</tr>
<tr>
<td>40000-49999</td>
<td>20% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
<tr>
<td>50000-59999</td>
<td>35% of billed Amount</td>
<td>10% of billed Amount</td>
</tr>
<tr>
<td>60000-69999</td>
<td>20% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
<tr>
<td>70000-79999</td>
<td>25% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
<tr>
<td>80000-89999</td>
<td>30% of billed Amount</td>
<td>15% of billed Amount</td>
</tr>
</tbody>
</table>
Appendix: Provider Reimbursement Rates

In accordance with the Marketplace policy, the Medicare rate is multiplied by the provider’s contracted rate. If there is no Medicare rate, and the service code is covered, use 150% of the Medicaid payment amount. 150% of Medicaid is deemed equivalent to the Medicare rate; then apply the provider’s contracted percent of Medicare.

If the provider is not contracted with any delivery system the lowest rate is used to calculate the reimbursement rate. For facilities, this would be 133%, and for professional claims, 125%. In some cases, the authorization could contain the non-contracted provider reimbursement for the service in question.

If a provider is contracted with at least one delivery system, they will be paid their contracted rate for all services. If a provider is contracted with two out of three delivery systems, MDwise will find the rate that is lowest between their two contracted rates and the provider will be paid that rate for the one delivery system the provider is not contracted with.

More information can be found in each benefit chapter. For mid-level provider reimbursement please see the chapter on Advanced Practice Nurses and Physician Assistants.