Independent Health

Participating Practitioner Reimbursement Manual

This manual is confidential and proprietary information of the Individual Practice Association of Western New York, Inc. (IPA/WNY), Independent Health Association, Inc. (IHA) and Independent Health Corporation (IHC) and its affiliates. You thereby agree to keep this manual and any of its contents confidential and agree not to disclose such information to any person, party, or entity whatsoever, without the prior written consent of the IPA/WNY, IHA and IHC, which consent may be withheld in IPA/WNY's, IHA's or IHC's sole discretion. You further agree that in the event you disclose this manual or its contents to any person, party, or entity without IPA/WNY's, IHA's and IHC's prior written consent, you have materially breached the Participating Physician Agreement, which may be grounds for termination, and/or other sanctions.

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Introduction

The Independent Health Participating Practitioner Reimbursement Manual is a reference document for all participating practitioners with Independent Health. A *practitioner* is defined as an individual who is engaged in the delivery of healthcare services and licensed or certified by the state to engage in that activity in the respective state. This document includes relevant information regarding processes, policies and procedures for reimbursement activities. This manual also includes billing information relevant to ancillary providers including but not limited to; Durable Medical Equipment Providers, Prosthetic and Orthotic Providers, Mental Health Facilities, and Chemical Dependency Facilities.

If you have any suggestions/comments to help enhance the manual with respect to professional billing and reimbursement, please email us at ReimbursementManual@independenthealth.com. Please include your Practitioner Number(s), Tax Identification Number and contact information within the email.

*****You will find updated material and/or sections highlighted in yellow*****

Contact Information

Below is a list of departments that frequently receive inquiries from practitioners along with a description of the types of inquiries you may contact each of these departments for.

Provider Relations: Authorization or referral requirements, benefit clarification, claim inquiries, voucher clarification, billing issues
e-Commerce: Transaction assistant, electronic billing questions, issues with setup, testing issues upon initial setup, external REVEAL setups and troubleshooting
Credentialing: Status of application for participation
National Imaging Associates (NIA): Authorization requests and information
Pharmacy Authorization Department: Status of authorization request
Reliance RX: Status of authorization request, questions about drug access, drug authorization inquiries, help with patient assistance program enrollment, clinical questions, patient compliance and adherence issues

CONTACT LIST				
Department	Phone Number	Fax Number	Email Address	Hours
Provider Relations	(716) 631-3282 (800) 736-5771	(716) 635-3890	providerservice@servicing.independenthealth.com	Monday – Friday 8 a.m. – 6 p.m.
e-Commerce	(716) 635-3911	(716) 929-1062	e-commerce@independenthealth.com	Monday – Friday 8 a.m. – 5 p.m.
Credentialing	(716) 635-7824	(716) 635-3763		Monday – Friday 8 a.m. – 4 p.m.
National Imaging Associates (NIA)	(800) 642-7452			Monday – Friday 8 a.m. – 8 p.m.
Pharmacy Authorization Department	(716) 631-2934 or (800) 247-1466 Ext. 5311	(716) 631-9636		Monday – Friday 8 a.m. – 5 p.m.
Reliance RX	(716) 929-1000 or (800) 809-4763	(716) 532-7360	https://www.reliancerxsp.com/	

Provider Website Information

Independent Health's website is a great resource for practitioners. Links to various online tools, applications, forms and policies are available to you. Below is the website and login information for all practitioners:

Website: www.independenthealth.com/providers
Username: partners
Password: partners

If you have any questions regarding our website, please contact our Provider Relations Department. Refer to *page 4* for the contact information.

Communication

Independent Health's primary source for communicating reimbursement changes is via *Blast Fax*. Please be sure your facsimile number on file with Independent Health is current so that you will be sure to receive these important notifications.

Participating practitioners can also register to receive emails from Independent Health. Visit http://bit.ly/IHemail to register.

Demographic Information Changes

If you need to change or add a location to your practitioner record, you must complete the *Provider Information Change Form* which can be found on our website at www.independenthealth.com/providers under Resources >Office Forms >Administration Forms. This form must be completed for each location change. All completed forms may be faxed to the Network Contract Management Department at (716) 250-7167. Please be sure to include a W-9 form for any tax identification changes. All changes are updated within five (5) days of receipt of request.

Policies and Procedures

All Independent Health policies can be found at www.independenthealth.com/providers.

Independent Health reserves the right to monitor and audit practitioners for compliance with established policies, procedures, rules and regulations. Participating practitioners are subject to the monitoring and audit activities.

Physician or Other Qualified Health Care Professional

Independent Health follows the designations set forth by CPT:

"A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff". A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional, and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specific professional service, but does not individually report that professional service."

Accurate and Complete Diagnosis and Procedure Coding

Independent Health accepts and initiates the processing of practitioner claims utilizing the American Medical Association (AMA) Current Procedural Terminology (CPT) codes, reporting guidelines and conventions and the CMS Health Care Common Procedure Coding System (HCPCS). Additionally accurate and complete ICD-10-CM diagnosis code(s) must be included on all claims. CPT, ICD-CM and HCPCS are added, deleted, or revised at various times throughout the year and Independent Health will implement updates accordingly.

The acceptance of a practitioner claim, however, does not preclude Independent Health from determining that the claim is ineligible for payment in full or in part based on a determination that the claim is not complete as defined by 11 NYCRR 217.

All practitioners are encouraged to have current coding books/materials so that guidelines and requirements are readily available. Below you will find some tips for accurate and complete diagnosis coding.

- The primary diagnosis code represents the main reason for the procedure/visit.
- Additional diagnosis codes should be reported that affect the procedure/visit and are documented within the patient's medical record.
- Code only confirmed diagnoses and not those that are described as suspected, possible, or to rule out.
- Do not code from the alphabetic index; always verify code in the tabular section.
- Follow all relevant guidelines along with any coding notes that are within the tabular list.
- Read any instructional notes under main category or subcategory
    - Example: Z68 Body Mass Index (BMI); NOTE: BMI adult codes are for use for persons 21 years of age or older. BMI pediatric codes are for use for persons 2-20 years of age.

- Inappropriate primary diagnosis codes, in most instances, can be recognized by terms in the tabular list such as: “In diseases classified elsewhere” (manifestation codes), “code first” (underlying condition should be sequenced first).
- Code “not elsewhere classified” or “not otherwise specified” diagnoses sparingly and only when warranted
- Diagnosis codes must be billed to the highest specificity; there are many codes that require a fourth or fifth digit when indicated in the tabular list.
- Age and Sex Edit Symbols that appear in the tabular list of diseases to the right of the code description are Medicare Code Edits:
    - Used by Medicare Administrative Contractors (MACs) and many payers to check the coding accuracy on claims
    - In most circumstances, they should not be used as the age range when choosing a diagnosis code
    - For a code description that specifies “infant/infantile”, provider should use this code for a patient who is 0-12 months of age.
    - For a code description that specifies “pediatric”, provider should use this code for a patient who is 2-20 years of age.
    - For a code description that specifies “adult”, provider should use this code for a patient who is 21 years of age and older.
- ICD-10-CM Diagnosis Codes are updated effective October 1 of each calendar year.
- Effective October 1, 2015, the transition to ICD-10 Diagnosis Codes will be required for everyone covered by the Health Insurance Portability and Accountability Act (HIPAA). For claims with dates of service on or after October 1, 2015, ICD-9 Diagnosis Codes will no longer be accepted.

Medicaid Updates

For the latest Medicaid Updates, visit
http://www.health.ny.gov/health_care/medicaid/program/update/main.htm.

Vaccines

Independent Health follows the Advisory Committee for Immunization Practices (ACIP) guidelines/ recommendations which can be found on the Centers for Disease Control (CDC) website at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

ACIP | Home | Advisory Committee on Immunization Practices | CDC (Advisory Committee on Immunization Practices) is a Federal Advisory Committee whose role is to provide advice and guidance to the Secretary and the Assistant Secretary for Health and Human Services, and the Director, Centers

for Disease Control and Prevention (CDC), regarding the most appropriate selection of vaccines and related agents for control of vaccine-preventable diseases in the civilian population of the United States.

Vaccines for Children Claims

Vaccines for Children (VFC) applies only to children with Medicaid Managed Care (MediSource) or Child Health Plus coverage. All practitioners administering vaccines to children under age 19 in the above products should obtain the vaccine from the New York Vaccine for Children (NYVFC) program. For more information about VFC and how to get vaccines, practitioners should visit the CDC website at http://www.cdc.gov/vaccines/programs/vfc/index.html. The eligible vaccines are also listed on the CDC website.

For dates of service on or after July 1, 2017, when a vaccine obtained through the Vaccine for Children Program (VFC) is administered, you must bill the appropriate vaccine code and append modifier SL [State Supplied Vaccine] in order for your claim line for the administration code to be reimbursed. Claims for vaccine administration codes that do not contain a corresponding vaccine product code with modifier SL will be denied. The vaccine product codes with modifier SL will continue to not be eligible for any reimbursement.

Electronic Claims Submission

Independent Health strongly encourages you to submit claims electronically. Electronic claims submission is the preferred method for rendered services. Electronic claims are fast, accurate and reliable. Practitioners must bill with current CPT and/or HCPCS Codes. In addition, claims can only be submitted after the service is rendered.

How to Submit Paper Claims

In the event you do not have access or the ability to submit claims electronically, practitioners may submit a claim on paper but must do so on a CMS-1500 form for most professional services in accordance with HIPAA claims formats and standards. Claims submitted to all payors, including Medicare, must include an NPI to identify each provider for which data is reported on the claims. Submitted claims must contain all services rendered on the date of service. All paper claims can be mailed to the following address:

Independent Health
P.O. Box 9066
Buffalo, NY 14231

Submitting Claims for Mid-Level Practitioners/Non-Physician Practitioners

When submitting claims to Independent Health, mid-level practitioners [Nurse Practitioners (NPs), Physician Assistants (PAs), Certified Nurse Midwives (CNMs), Certified Registered Nurse Anesthetists (CRNAs), and Registered Nurse First Assistant (RNFA)] must be credentialed and must include their NPI. For information on the credentialing process for an RNFA, please review the Credentialing policy: *Registered Nurse First Assistant Credentialing and Recredentialing Policy and Procedures.*

Registered Nurse First Assistants (RNFA) must bill with their NPI number and are reimbursed in accordance with their individual contract.

Incident to Billing

Effective May 1, 2017, Independent Health began to recognize "Incident to" billing practices for our Commercial, Medicare Advantage and Self-Funded Products; "Incident to" continues to not be permitted for our State Products (MediSource, MediSource Connect, Child Health Plus, Essential Plan). Prior to May 1, 2017, "Incident to" billing was prohibited for all lines of business.

"Incident to" services are those services or supplies that are provided as integral, although incidental, to the physician professional services in the course of diagnosis or treatment of an injury or illness.

Independent Health utilizes Medicare's guidelines when billing for these services and requires specific medical record documentation, participation status and sign-off as indicated below:

- The participating physician must perform the initial, direct, personal professional service to initiate the course of treatment for the condition/injury/illness which has not been previously indicated in the patient's record
- "Incident to" may not be billed for a new patient visit
- "Incident to" may not be billed when an established patient presents with a new problem different from that of the initial visit with the participating physician
- The service must be part of your patient's normal course of treatment (of a diagnosis or illness); if a change in the care plan is needed, the visit cannot be billed as "incident to"
- The participating physician personally performs the initial service and remains actively involved in the course of treatment
    - Independent Health's definition of "actively involved" includes subsequent services by the participating physician of a clinically relevant frequency, which must be well documented in the medical record, to support their continuing involvement in the management of the specified course of treatment. Simple statements in the medical records which read; "I agree", "Seen and agree", "Discussed and agree" will not be enough evidence to support active involvement under "Incident to".

- The participating supervising physician must be present in the office suite and immediately available to render assistance, if necessary to meet the direct supervision requirements
- Independent Health will require that the medical record be signed by the participating non-physician practitioner and countersigned by the participating physician whose NPI the service(s) will be billed under
- The medical record must clearly indicate the participating supervising physician, and his/her immediate availability in the office at the time of the service
- The medical record must document the essential requirements for "incident to" service
- Services that meet ALL of the "incident to" billing and documentation requirements may be billed under the participating supervising Physician NPI; failure to meet all documentation requirements will result in payment retractions
- In accordance with the CMS 1500 claim form, Version 02/12 instructions, the ordering physician's name must be billed in Item 17 along with Qualifier DK and the ordering physician's NPI number in Item 17b
- The mid-level provider performing the face-to-face service must be participating with Independent Health; recognition of "incident to" billing practices does not nullify our requirement that mid-level providers be fully credentialed.

Please ensure that your billing staff is aware of the current Medicare guidelines; additional information on "incident to" billing can be found by clicking the resources below:

CMS MLN Resource

CMS Claims Processing Manual Chapter 12

NGS Incident To Services

NGS Incident To Office Guidelines

Timely Filing

Independent Health requires that all participating practitioners submit claims in a timely manner.

Participating practitioners should submit all claims as soon as possible after rendering service. Please refer to your Participating Provider Agreements for the time limit with which claims will be accepted. Claims submitted after that time limit will be denied for late filing.

REVEAL

Independent Health's REVEAL tool provides you with immediate access to all existing voucher information, physician overpayment notifications as well as member rosters for all primary care physicians.

Primary care physicians and practitioners that are current electronic submitters may register to access REVEAL. If you would like to register for REVEAL and need a username and password, please contact Independent Health's e-Commerce Department. Refer to *page 4* for the contact information.

Additional information regarding the REVEAL online tool can be found on the "REVEAL" page in the "Tools" section of our provider website at www.independenthealth.com/providers under Tools >Reveal.

Fee Schedules

All practitioners are provided, upon request and at the time of application, a copy of their fee schedule. The fee schedule is included in the practitioner application packet in a CD format, which is sent to practitioners when they request participation with Independent Health. The signed Participating Provider Agreement between Independent Health and the practitioner indicates acceptance of the fee schedule(s). The community Physician and Mid-Level Practitioner fee schedule is reviewed annually (and quarterly) for coding and Relative Value Unit (RVU) updates. Rate changes will be communicated accordingly. The annual code and rate updates will be communicated to your office through fax or mail; this takes place in December each year.

The community Physician and Mid-Level Practitioner fee schedules are available through the REVEAL online tool. Additionally, the community Durable Medical, Prosthetic, Orthotic and Supply (DMEPOS) Fee Schedule will be available through Reveal; it is located within the Com_Fee_Schedule [Physician&Mid-LevelFeeSchedule] file.

If you are a registered user of REVEAL, the file can be obtained as such:

1. Log in to REVEAL
2. Click on the button next to the "exd reports" folder
3. Click on the button next to the "reports" sub-folder
4. Double click on "Com_Fee_Schedule [Physician&Mid-LevelFeeSchedule]" to open the fee schedule

The following community provider types should also reference the fee schedule in Reveal for their rates: Mobile Diagnostics, Oral Surgery, Podiatry.

Alternatively, the community Physician and Mid-Level Practitioner fee schedules can be received as a PDF on a CD, delivered by mail or via email.

For all other Physician, Mid-Level and Ancillary Practitioners fee schedules, contact our Provider Relations Department to request a copy. Refer to *page 4* for the contact information.

Guidelines and reimbursement rates for injectable drugs, radiopharmaceuticals and vaccines can be found on Independent Health's Injectable Drug Formulary at www.injectabledrugformulary.com.

For Physicians who dispense covered Durable Medical Equipment, the rates will mirror those on the DMEPOS Fee Schedule. Please ensure that your practice is following all Credentialing, Medical Management and Reimbursement policies that pertain to DMEPOS.

The following information will be required for all requests:

- Practitioner Number
- Tax Identification Number
- Practitioner Specialty/Taxonomy
- E-Mail Address

For all other fee schedule requests, providers should contact our Provider Relations Department. Refer to *page 4* for the contact information.

Code Additions / Fee Schedule Requests

If you would like to request that a code be added to your professional fee schedule, please complete the *Professional Coding Request Form* which can be found under Resources >Office Forms >Administration Forms of our provider website at www.independenthealth.com/providers (you must login to view this page on the website). Prior to submission, please be sure to review your fee schedule to assure that the code(s) is not already on your current fee schedule or requires privileging in accordance with a Credentialing Policy. Please note that each request may require review by multiple departments. Therefore, there is no standard turnaround time, and some requests may take up to thirty (30) days to complete. You will be notified in writing once a decision has been made and whether claims adjustments will result from the request. Questions pertaining to current reimbursement methodologies should be submitted in writing to Independent Health at the address below.

Completed request forms may be faxed to (716) 250-7147 or mailed to the following address:

Independent Health
Attn: Provider Network Reimbursement
511 Farber Lakes Drive
Buffalo, NY 14221

The *Professional Coding Request Form* should not be used for non-participating providers or Hospital / Facility requests.

Notes:

- Unlisted CPT codes are not added to fee schedules
- When submitting a request due to a denial for a code(s) that is not on your fee schedule, please include the documentation of the service(s) with your request
- Upon initial review, you may be asked to supply peer reviewed literature
- Submitting a request post service is not a guarantee of payment
- New codes for the upcoming New Year should not be requested to be added to the fee schedule. All new codes follow the same review process each year. Newly active codes added to the fee schedule(s) for the upcoming year are communicated with the yearly faxes and letters detailing the changes and updates.

Claims Editing

Independent Health edits claims via the Optum product, ***Optum Claims Editing System*** *(CES)* Version 5.2.1. CES deploys industry standard claim edits sourced from the National Correct Coding Initiative (NCCI) as well as the current CPT, HCPCS, and ICD-10 coding guidelines. CES is also utilized to enforce our published Independent Health reimbursement policies.

Independent Health enforces the following statement from the 2017 publication of the National Correct Coding Initiative Edits:

"MUE and NCCI PTP edits are based on services provided by the same physician to the same beneficiary on the same date of service. Physicians should not inconvenience beneficiaries nor increase risks to beneficiaries by performing services on different dates of service to avoid MUE or NCCI PTP edits."

NCCI information is online at http://go.cms.gov/17J823u and the NCCI Tools are at http://go.cms.gov/1aCyv6B.

The NCCI Tools website offers comprehensive information and tips for utilizing the NCCI Manuals and Edit Tables. There is also a detailed section to assist you in understanding which code(s) would require modifiers, when appropriate, to override the NCCI Edits.

The NCCI Tool includes screen shots of where to look up current NCCI Procedure to Procedure Edits as well as how to understand the column in the edit files. The edit tables are a primary source of information for claim edits including the effective and expiration date of the PTP edit, along with whether or not a modifier can be used on the edit. See the example below:

Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable	PTP Edit Rationale
25000	36420		20090401	*	1	Standards of medical / surgical practice
25000	36425		20090401	*	1	Standards of medical / surgical practice
25000	36430		20090401	*	1	Standards of medical / surgical practice
25000	36440		20090401	*	1	Standards of medical / surgical practice
25000	36591		20151001	*	0	CPT Manual or CMS manual coding instructions
25000	36592		20151001	*	0	CPT Manual or CMS manual coding instructions
25000	36600		20090401	*	1	Standards of medical / surgical practice

We often see that claims contain the modifiers on the incorrect code which can cause denials or a delay of payment.

Please be advised that NCCI is our primary editing source and in the event of a discrepancy between NCCI and another source (eg. AMA), NCCI will be enforced.

Below are some highlights of some other edits you may see:

- Invalid modifiers or invalid modifier combinations
- Invalid age or gender
- Add-on procedure without appropriate base code
- Excessive units (aligned with CMS's MUEs)
- New patient visits exceeded
- ICD-10 not a primary diagnosis code
- ICD-10 diagnosis code not to the highest specificity
- Status B Codes (based on the Physician Status Code from the CMS RVU File)
- Status P Codes (based on the Physician Status Code from the CMS RVU File)
- Status T Codes (based on the Physician Status Code from the CMS RVU File)
- Global surgical package and follow-up days
- Multiple procedure reduction utilizing total RVUs
- NCCI code pair bundles

As a reminder, clinical authorization for a particular code does not guarantee payment; all claims are subject to industry standard editing and bundling requirements.

Below are some of the most common inquiries we receive regarding claim edits:

- Claim line denying with modifier 59 or 25 could be a result of overuse of the modifier. Under NCCI Editing, when the same modifier is applied to multiple claim lines the edits still apply. The modifier to override the edit should ONLY be placed on the bundled code, which is found in Column 2.
- Claim line denying with modifier 59 could be due to the fact that some code combinations do not permit for a modifier to override the edit as indicated in the applicable edit table.
- Adding modifier 51 to the incorrect claim line will cause the claim to pay/deny inappropriately under the Multiple Procedure Reduction Rules.
- Claim line(s) denying for either an invalid primary diagnosis code or an incomplete diagnosis code. These claim denials are not adjusted. If a denial is received, provider should be reviewing the coding guidelines and either appending an appropriate primary diagnosis code or a diagnosis code that is coded to the highest specificity.
- Claim line(s) denying for procedures that are performed within the follow up days of another procedure by the same physician/group. Per the correct coding guidelines, if an unrelated procedure is performed within the follow up days of another procedure, provider should be appending an appropriate modifier to indicate the procedure is unrelated.
- Claim line(s) denying indicating provider is billing for an inpatient admission and we already have another provider who billed for the admission. Provider would need to send in documentation to support they were the admitting physician, and not just providing a consultation or inpatient visit. If they were not the admitting physician of record, they would then need to submit a corrected claim on a provider inquiry.
- Claim line(s) denied for exceeding units. This is in most cases the result of providers billing multiple times for the same service(s). If an original claim denies and provider would like it reviewed, or needs to send a correction, this must be sent in on a Provider Inquiry Form and not resubmitted multiple times.
- Claim line(s) denied for exceeding the maximum frequency per day. Maximum frequencies are set based on the current Medically Unlikely Edits; in the event your units exceed the Medically Unlikely Edits, the claim line will be denied and you will need to either send in a corrected claim or medical documentation to support the excessive units, either one should be accompanied by a Provider Inquiry Form.

Injectable Drug Formulary

For plan specific injection drug coverage policies, authorization guidelines and reimbursement rates for injectable drugs, radiopharmaceuticals, biologics and vaccines, please refer to Independent Health's Injectable Drug Formulary at www.injectabledrugformulary.com.

Medical Records

Independent Health may request medical record documentation in order to process or adjust a claim. **Do not highlight** on any documentation that is sent to Independent Health for review. Documentation may be required for processing claims with the following: this is not an inclusive list, and additional situations may arise where Independent Health may request documentation prior to processing a claim):

- Modifier 22 – increased procedural services (review Reimbursement Policy: Modifier 22-Documentation Requirements for additional information)
- Modifier 24 – unrelated E/M during a postoperative period
- Modifier 25 – significant, separately identifiable E/M on same day
- Modifier 52 – reduced services
- Modifier 53 – discontinued procedure
- Modifier 57 – decision for surgery
- Modifier 59, X {E,P,S,U} – distinct procedural service
- Modifier 62 – two surgeons
- Unlisted drug codes to ensure dosing is billed correctly

This is not an inclusive list, and additional situations may arise where Independent Health may request documentation prior to processing a claim.

Additionally, documentation may be requested when reimbursement has yet to be established for a particular service or procedure.

Claims billed with an unspecified code will require documentation in order to be processed. Please review the Reimbursement policy: *Unlisted Service or Procedure – Documentation Requirements.* Unspecified codes include unlisted, not otherwise specified, miscellaneous and unclassified codes. When submitting documentation for review, the following requirements must be met:

- Unspecified Diagnostic and Therapeutic Procedures
  - You must underline in the medical record the procedure(s) that is represented by the unspecified code(s) – do not highlight
- Unspecified Laboratory Service

- You must include all laboratory/pathology reports including sample/slide preparations

- Unspecified Radiology Service
  - You must include copies of the imaging report
- Unspecified DME, Prosthetic, Orthotic or Supply
  - You must include a copy of the original invoice without redaction and show the actual amount paid for the item – invoices with redacted costs will not be accepted
  - You must include the invoice applicable for the claim, meaning that the timeframe and/or member information must be a reasonable match.
  - The DOS of the invoice should correspond with the claim date of service. It would not be appropriate to have an invoice date later than the DOS on the claim.

Making Changes to the Medical Record

Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents containing amendments, corrections or addenda must:

1. Clearly and permanently identify any amendment, correction or delayed entry as such, and
2. Clearly indicate the date and author of any amendment, correction or delay entry, and
3. Clearly identify all original content, without deletion.

Paper Medical Records: When correcting a paper medical record, the author of the alteration must:

1. Use a single line strike through so the original content is still readable, and
2. Sign and date the revision.

Amendments or delayed entries to paper records must be clearly signed and dated upon entry into the record. Amendments or delayed entries to paper records may be initiated and dated if the medical record contains evidence associating the provider's initials with their name.

Electronic Health Records (EHR): Medical record keeping within an EHR deserves special considerations; however, the principles specified above remain fundamental and necessary for document submission. Records sourced from electronic systems containing amendments, correction or delayed entries must:

a. Distinctly identify any amendment, correction or delayed entry, and
b. Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.

Reference: Recordkeeping Principles (Medicare Program Integrity Manual, Ch. 3, 3.3.2.5)

Inquiring About the Status of a Claim

Practitioners may contact Independent Health's Provider Relations Department to inquire about the status of a claim. Refer to *page 4* for the contact information.

Provider Inquiry Forms

Practitioners are required to submit a completed and current Provider Inquiry Form for the following reasons:

1. Coordination of Benefits
2. Requesting reconsideration of previously processed claim with supporting documentation (i.e., office notes, operative reports, invoices, billing history, etc.)
3. Request for correcting a previously adjudicated / denied claim
4. Payment withdrawal requests
5. If a provider is disputing an NCCI Edit, the provider must submit documentation sourced from CMS, AMA or ICD-10 (WHO) to support their dispute for review.

The *Provider Inquiry Form* can be found under Resources >Office Forms > Administration Forms of our provider website at www.independenthealth.com/providers. Please ensure that your office staff is using the more recent version of the Provider Inquiry Form.

Submission of a Provider Inquiry Form for Matters of Reimbursement

- All information must be completed on the form, including a detailed explanation of the request in the provider comments field.
- Request must include the original claim number submitted for the date of service in question.
- When applicable, a single, complete corrected claim with all lines for the date of service in question must be accompanied by a Provider Inquiry Form.
- Attach the office notes/operative report/invoice for the date of service in question when appropriate. Documentation must be sent for all services rendered on the date of service.
- **Do not highlight** on any documentation that is sent to Independent Health for review.
- Electronic re-submission of a claim for the same member, provider and date of service, will likely result in a duplicate denial.

Examples of attachments to include on a Provider Inquiry Form:

- Addition of Modifier 59 or X{EPSU}
  - Include a single, complete corrected claim and all notes/reports for all services rendered for the date of service in question

- Unlisted code
  - Include office notes, invoice, operative report – whichever is appropriate. When an unlisted code and other established codes, or more than one unlisted code, are billed for the same date of service, indicate in the report (underline) the portion of the report that represents the unlisted code. (see Unlisted Service or Procedure - Documentation Requirements Policy on the Independenthealth.com/providers website for additional information).

- CMS NCCI edits (eg., bundling)
  - Include notes/reports for all services rendered on the date of service along with a single, complete corrected claim with the addition/removal of modifiers where appropriate.

- Modifier 22
  - Include operative report (see Modifier 22 – Documentation Requirements Policy on the Independenthealth.com/providers website for additional information).

Submission of an Appeal Form for Matters of Reimbursement

In the event you need to follow the appeal process for a reimbursement related inquiry, ensure that:

- You submit an Appeal Form only when a Provider Inquiry response results in an Uphold Letter and the Provider/Practitioner disagrees with the response.
- All information is completed on the form, including a detailed explanation of the reason for disagreement in the free text field.
- You include any/all information to support the Appeal

Anesthesia Billing

Please be advised that all Certified Registered Nurse Anesthetists (CRNA) who provide services to Independent Health members are required to be credentialed and must bill for anesthesia services with their NPI.

The credentialing process will include all CRNAs who work for anesthesia group practices, hospitals, ambulatory surgery centers as well as those who work for independent physician practices. For questions regarding credentialing, practitioners should contact our Credentialing Department. Refer to *page 4* for the contact information. When billing for anesthesia services on a Professional claim, ensure that claims are submitted under the rendering practitioner information. Claims submitted without the individual rendering practitioner information may result in a denial.

The following information pertains to correct coding and billing for anesthesia services.

Anesthesia service begins when the anesthesiologist begins prepping the patient for anesthesia induction and ends when the anesthesiologist is no longer needed to be in personal attendance. Anesthesia services include the following:

- Preoperative and postoperative visits
- Anesthesia care during the procedure
- Administration of fluids and/or blood and usual monitoring services (i.e., ECG, temperature, blood pressure, oximetry, capnography, etc.)

For claims with dates of service on or after April 1, 2015, Independent Health reimburses anesthesia services when billed using a valid CPT Anesthesia Code with the following modifiers:

Modifier	**Description**
AA	Anesthesia services performed personally by the anesthesiologist
QK	Medical direction by a physician of two, three or four concurrent anesthesia procedures
QY	Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist
QX	CRNA service; with medical direction by a physician
QZ	CRNA service; without medical direction by a physician

The anesthesia modifier must be in the first modifier position in order to ensure correct processing.

AA, QK, QY are billable only by an Anesthesiologist

QX, QZ are billable only by a CRNA

Practitioners are required to submit the number of minutes in the units field on the claim. Independent Health will convert the minutes into increments of 15-minute time units. The minutes will be rounded up to the nearest time unit. If you bill using time units, your claim will be underpaid and a corrected claim will be required.

In the event multiple surgical procedures are performed during an anesthesia encounter, the most complex anesthesia CPT code should be billed and the time submitted on your claim should be the combined time for all of the procedures.

Independent Health only reimburses for general anesthesia or MAC services in the office based setting when performed in offices accredited as an office-based surgery practice in New York State. Reimbursement will be the same as in facility places of service.

Anesthesia services are reimbursed using the following calculation formula:

(Base Units + Time Units) x Conversion Factor = Allowed Amount

Modifiers AA and QZ will be reimbursed at 100% of the allowed amount.

Example:

Conversion Factor is $10.00
CPT Anesthesia Code on the claim allows 3 base units
The units on the claim equals 60 (service was performed for 60 minutes)
(3 + 4) x $10.00 = **$70.00** Allowed Amount (less any applicable member liability)

Modifiers QY, QK and QX are reimbursed 50% of the allowed amount.

Example:

Conversion Factor is $5.00 (This is 50% of the $10.00 Conversion Factor)
CPT Anesthesia Code on the claim allows 3 base units
The units on the claim equals 60 (service was performed for 60 minutes)
(3 + 4) x $5.00 = **$35.00** Allowed Amount (less any applicable member liability)

When an Anesthesiologist or CRNA is performing a non-anesthesia service, the above listed modifiers must not be appended to the claim. The valid CPT or HCPCS Code should be billed.

Anesthesia for Preventive Colonoscopy and Sigmoidoscopy

For claims with dates of service on or after April 1, 2015, when anesthesia services are furnished for the purpose of a screening colonoscopy or sigmoidoscopy, CPT Anesthesia Code 00810 with Modifier 33 in the second position should be billed. The Modifier 33 indicates that the anesthesia services were performed in conjunction with a preventive service; hence member liability would not apply.

Anesthesia for Delivery

When billing for epidural analgesia / anesthesia for delivery, please refer to the following:

- Bill under CPT Anesthesia Code 01967 for epidural analgesia for obstetrics
- A maximum of 30 units will be reimbursed (combining base units + time units) for the epidural anesthesia and the vaginal delivery
- A maximum of 30 units will be reimbursed for the epidural anesthesia for a cesarean-section delivery. The cesarean-section CPT Code may be billed separately and is not combined with the epidural's maximum of 30 units.

Additional reimbursement is not made based on physical status modifiers or qualifying circumstances.

Independent Health's anesthesia base units can be found on REVEAL within the Physician and Mid-Level Practitioner fee schedules. For further information, please refer to the REVEAL section of this manual.

For claims with dates of service prior to April 1, 2015, Independent Health reimbursed anesthesia services when billed under a valid CPT or HCPCS procedural code.

Moderate (Conscious) Sedation Billing

Effective for claims with dates of service on or after January 1, 2017, Independent Health will follow the updated AMA CPT Code guidelines for reporting of conscious sedation services. Appendix G will be deleted from the CPT Book and it will now be appropriate to bill for conscious sedation separately.

There are 6 new CPT Codes effective January 1, 2017 to be used to report moderate sedation services; 99151, 99152, 99153, 99155, 99156, 99157. The 2017 CPT provides extensive coding and billing guidelines for billing these new codes. Below are some important highlights:

- The codes that were previously included in the former Appendix G of the CPT Book have been revised with the removal of the moderate (conscious) sedation symbol.
- The new codes should not be used to report administration of medications used for pain control, minimal sedation, deep sedation or monitored anesthesia care.

- For purposes of reporting, intraservice time of moderate sedation is used to select the appropriate code(s). Intraservice time begins with the administration of the sedating agent(s) and ends when the procedure is complete, the patient is stable, and the provider providing the moderate sedation has ended their face-to-face time with the patient.
- Preservice activities required for moderate sedation are included in the new codes and would not be reported separately.
- At least 10 minutes of total intraservice time must be completed in order to bill for moderate sedation.
- There is an extensive chart within the 2017 AMA CPT Code Book that provides billing examples based on intraservice time.
- Additional information/guidance on reporting moderate (conscious) sedation services can be found in the guidelines for codes 99151-99157.

Moderate (Conscious) Sedation for Gastrointestinal Endoscopies

In addition to the new codes above, there is also a new code for moderate sedation for gastrointestinal endoscopy. Effective January 1, 2017, HCPCS Code G0500 should be billed for moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that requires sedation. This applies to our Commercial, Medicare Advantage and Self-Funded products; code 99152 should not be used to report the first 15 minutes for gastrointestinal endoscopies. Each additional 15 minutes of moderate sedation would be billed under the 99153. For our State Products, codes 99151 or 99152 are the billable codes for the first 15 minutes of moderate (conscious) sedation for all services, including gastrointestinal endoscopies. State Products are our MediSource, Child Health Plus, MediSource Connect and Essential Plan products.

Vouchers / Voucher Requests

A voucher is an Explanation of Benefits for claims processed that is sent to each practitioner. Vouchers can include claim information for multiple patients' claims. Information regarding claims processed in one week will be compiled and included in the weekly voucher. Information includes claim payment, member financial liability and denial codes if applicable for each claim. Vouchers and checks are sent to practitioners weekly. Information regarding adjustments for payments and retractions are included on vouchers.

Practitioners can locate vouchers on REVEAL. Practitioners who have internet access can access the REVEAL tool on the website to pull copies of vouchers.

National Imaging Associates (NIA)

Independent Health has collaborated with National Imaging Associates (NIA) to administer several of our programs.

For further information regarding these programs, please refer to our website at www.independenthealth.com/providers under Policies & Guidelines >Radiology Programs. Additional information can also be found on our website at www.independenthealth.com/providers under Policies & Guidelines >Provider Manual.

WNY HealtheNet

WNY HealtheNet is a tool used by providers to verify member eligibility, check claim status, create referrals, referral and authorization inquiries on a real-time basis. To access WNY HealtheNet, visit www.wnyhealthenet.com.

Please contact our Provider Relations Department if you have any questions about WNY HealtheNet. Refer to *page 4* for the contact information.

HEALTHeLINK

HEALTHeLINK, the Western New York Clinical Information Exchange (WNYCIE), is a non-profit organization established to develop a privacy-protected, community-based system for health care providers and patients to electronically share important medical and clinical information more efficiently.

To access HEALTHeLINK, visit www.wnyhealthelink.com. If you have any questions, please contact HEALTHeLINK directly at (716) 206-0993, ext. 311.

Coding Topics and Updates

In this section you will find some of the common coding topics and also updates to the new CPT and HCPCS codes. This is not an all-inclusive list. *Inclusion of a code in this section does not guarantee coverage or reimbursement for a particular procedure.*

General Billing Guidelines and Requirements

When submitting claims to Independent Health, please ensure that you are following the billing standards below; failure to do so may result in additional processing time, record requests or denials.

- Corrected claims must be submitted on a Provider Inquiry Form and include all claim lines.
- When submitting a corrected claim, you are required to include all claim lines that were rendered for the date of service. DO NOT submit only the claim lines that are corrected/added/changed. DO NOT break services out onto multiple claim forms. DO NOT leave off reporting codes or measurement codes from your corrected claim.
- Electronic re-submission of a claim for the same member, provider and date of service, will likely result in a duplicate denial.
- For a given date of service for the same provider and member a single claim should be submitted; if an additional CMS-1500 paper form is needed for additional lines, please indicate as a continuation – e.g.; page 1 of 2, page 2 of 2 and the claim total must be summed on the last page of a multi-page claim submission.
- If you are billing for a "global" service in the office setting do not bill multiple lines with modifiers 26 and TC. Mobile Diagnostic providers see Reimbursement policy: *Mobile Diagnostics Reimbursement Guidelines* for billing requirements.
- When multiple practitioners of the same specialty in the same group practice perform E&M services on the same date of service for a given member, only one E&M service is billable and should be coded to the highest specificity of the combined services.
- Ensure that claims are submitted under the correct rendering practitioner information.
- Ensure that claims are submitted under the correct member information.
- Ensure that claims with a date range contain the correct number of units.
- The date of service on a claim, should represent the date in which the service, in its entirety, is completed in accordance with the definition of the given service code.

Annual and Quarterly Coding Updates

In this section you will find information regarding recent updates to CPT and HCPCS Codes. This is not a full listing of updates, but rather highlights. Please ensure your practice is staying up-to-date on code and edit changes to enable accurate claims processing. Also in this section you will find guidance when submitting certain codes. Please note that this is not all-encompassing code guidance.

Please click on the links below for updates that specifically pertain to new code updates for the indicated year. Please be advised that additional information on these new codes may also be found within the manual itself.

January 2017

January 2016

January 2015

Additional Views for Mammogram, CT/CTA, MRI/MRA

Separate findings and impressions must be noted for each procedure/service performed.

Arthroscopic Shoulder Debridement (CPT Codes 29822 and 29823)

As stated in the CMS 2017 NCCI Manual "Shoulder arthroscopy procedures include limited debridement (e.g., CPT code 29822) even if the limited debridement is performed in a different area of the same shoulder than the other procedure. With three exceptions, shoulder arthroscopy procedures include extensive debridement (e.g., CPT code 29823) even if the extensive debridement is performed in a different area of the same shoulder than the other procedure. CPT codes 29824 (arthroscopic claviculectomy including distal articular surface), 29827 (arthroscopic rotator cuff repair), and 29828 (biceps tenodesis) may be reported separately with CPT code 29823 if the extensive debridement is performed in a different area of the same shoulder".

Antepartum Care Billing and Reimbursement effective 7/1/14

When the Provider/Provider group provides the antepartum care ONLY, and delivery is by a Practitioner not in the group/practice, the antepartum care only codes (59425 or 59426) should be reported as follows:

- A single claim submission for the antepartum care only, excluding confirmatory visit (which may be separately reported).
- The units should be one (1).
- The dates reported should be the range of time the antepartum care was provided.

Additional information for OB care can be found under Reimbursement Policies, "Obstetric Care Reimbursement Policy", on our provider website at www.independenthealth.com/providers.

Assist at Surgery

Independent Health follows the Center for Medicare and Medicaid Services (CMS) list of procedures eligible for surgical assist. Documentation must establish medical necessity and the surgeon should indicate in the operative report what the assistant actually did. Simply listing the assistant's name would not warrant additional payment.

Avastin Ophthalmologic Injections

Retinal Specialists billing for intraocular Avastin injections may bill HCPCS Code J9035 with one (1) unit of service per eye, and will be reimbursed $40.00 for all lines of business.

Cardiac Monitoring Services

When billing for cardiac monitoring services which include "recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional"; the date of service on the claim must be the date of service when all components of the monitoring service are complete.

Consultations

Although the Centers for Medicare and Medicaid Services (CMS) discontinued the use of the consultation codes (99241-99255) effective January 1, 2010, Independent Health continues to utilize and reimburse under the consultation codes for ALL lines of business. Practitioners performing and billing for consults must follow all billing guidelines contained in the most recent publication of the CPT Book as well as any applicable NCCI guidelines.

Cystourethroscopy (e.g. 52000) or Cystourethroscopy with ureterscopy (e.g. CPT 52351)

When a cystourethroscopy is performed near the termination of an intra-abdominal, intra-pelvic, or retroperitoneal surgical procedure to assure that there was no intraoperative injury to the ureters or urinary bladder and that they are functioning properly, it is not separately reportable with the surgical procedure.

Evaluation and Management Guidelines

Independent Health recognizes the Center for Medicare & Medicaid Services 1995 & 1997 Evaluation & Management guidelines as a benchmark for documentation guidelines. We also consult the information contained in the Evaluation & Management section of the American Medical Association CPT coding manual. See the Reimbursement Policy: Evaluation and Management Reimbursement Criteria, Number M070801682 for additional information.

General Health Panel CPT Code 80050

CPT code 80050 is a reimbursable lab panel for the Commercial, Self-Funded and Medicare Advantage lines of business. The individual lab codes that make up this panel should **NOT** be billed separately. When billing for a State Product member, the individual lab codes that make up this panel **MUST** be billed separately. Failure to follow these billing requirements may result in denials or delayed processing time.

Gynecological Examination and Collection of Pap Smear Specimen

For our Medicare Advantage members, the following codes are billable for a screening pap test and pelvic examination (including clinical breast exam).

- G0101 – Cervical or vaginal cancer screening; pelvic and clinical breast examination
- Q0091 – Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory

If a significant and separately identifiable problem-oriented Evaluation and Management service is performed, and clinical documentation clearly supports the level of decision making, the applicable office visit E&M code is billable. Also of note, the G0101 is an examination code which makes it ineligible

for modifier 59; in the event a modifier is required for your claim, an appropriate E&M modifier would be utilized.

As a reminder, since Q0091 is billable for a *screening* pap, it should not be billed when a specimen is collected as part of a problem-oriented Evaluation and Management service as it is included in the physical exam portion of that E&M in order to address the symptoms, disease or illness.

Imaging Guidance

When imaging guidance or imaging supervision and interpretation is included in a surgical procedure, guidelines for image documentation and report included in the guidelines for radiology (including nuclear medicine and diagnostic ultrasound) will apply.

AMA revised the radiology section introductory guidelines under "Written Report" as shown in italics and underlined below:

A written report *(e.g., handwritten or electronic)* signed by the interpreting individual should be considered an integral part of a radiologic procedure or interpretation. *With regard to CPT descriptors for radiography services, "images" refer to those acquired in either an analog (i.e., film) or digital (i.e., electronic) manner.*

Immune Globulin Codes

Prior to submitting a claim containing an immune globulin CPT Code [90384-90399], please ensure that the NDC code does not correspond with a valid J-Code. For example, we see many providers billing 90384 when in fact it should be billed as J279x.

Impacted Cerumen

Below are documentation requirements when billing for impacted cerumen removal under CPT Codes:

- 69209 – Removal impacted cerumen using irrigation/lavage, unilateral
- 69210 – Removal impacted cerumen requiring instrumentation, unilateral

The physician or other qualified healthcare professional must document one of the following considerations to indicate the cerumen was clinically impacted:

- ✓ Visual considerations: Cerumen impairs exam of clinically significant portions of the external auditory canal, tympanic membrane, or middle ear condition.
- ✓ Qualitative considerations: Extremely hard, dry, irritated cerumen causing symptoms such as pain, itching, hearing loss, etc.
- ✓ Inflammatory considerations: Associated with foul odor, infection, or dermatitis.
- ✓ Quantitative considerations: Obstructive, copious cerumen that cannot be removed without magnification and multiple instrumentations requiring physician skills.

The documentation must clearly indicate the following to substantiate billing of the procedure:

- Equipment used in the removal of the impacted cerumen.
- By what means magnification was achieved.
- The outcome of the procedure (objective, subjective)
- Patient instructions/education

Of note, in accordance with NCCI Edit Criteria, HCPCS Code G0268 [Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing] should only be billed when a physician's expertise is needed to remove impacted cerumen on the same day as audiologic function testing, performed by an employed audiologist. This code should not be used when the audiologist removes the cerumen, because removal of cerumen is considered to be part of the diagnostic testing and is not paid separately.

Initial Hospital Care Codes 99221-99223

Only the admitting provider is able to submit CPT codes 99221-99223 for the initial inpatient encounters. All other rendering providers must submit with the appropriate consultation or subsequent hospital care codes. Per CPT Guidelines, "For initial inpatient encounters by physicians other than the admitting physician, see initial inpatient consultation codes (99251-99255) or subsequent hospital care codes (99231-99233) as appropriate."

Modifiers

- Global Surgery Rules when appending Modifiers
  - *Modifier 24* – postoperative E/M services unrelated to recovery from the surgical procedure during the postoperative period for both major and minor surgical procedures, by the same physician, may append modifier 24. E/M services related to complications of the surgery are included in the global surgical package and not separately reported.
  - *Modifier 25* – significant and separate identifiable E/M service. If unrelated to the decision to perform the minor surgical procedure, and is beyond the usual pre-operative and post-operative care associated with the minor procedure or service, modifier 25 may be appended. In general E/M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The same rules would apply to a "new" patient. A minor surgical procedure has a global period of 000 to 010 days.
  - *Modifier 24 & 25* or *57* - If an unrelated E&M service is performed within the global follow up days, it requires -24 modifier be appended. If this E&M is also performed on the same day as a minor or major procedure, it will need to have an additional modifier (-25 or -57) appended depending on the number of follow-up days for the procedure.

- *Modifier 54 & 55* – refer to reimbursement policy: Global Surgery Split Reimbursement Methodology, policy M100201763, at: www.independenthealth.com/MyProviderAccount/Policies/Reimbursement
- *Modifier 57* – decision for surgery. This modifier is appended to a CPT E/M code to identify a visit that results in the initial decision to perform a major surgical procedure. A major surgical procedure has a global period of 090 days.
- *Modifier 58* – Staged or related procedure or service by the same physician during the post-operative period. Modifier 58 is appended to the staged procedure's CPT indicating that the service during the post-operative period was either planned prospectively or at the time of the original procedure, more extensive than the original procedure, or for therapy following a diagnostic surgical procedure.
- *Modifier 78* – Unplanned return to the operating or procedure room by the same physician following initial procedure for a related procedure during the post-operative period. When a procedure is related to the first, and requires the use of the operating/procedure room, it may be reported by adding the modifier 78 to the related procedure. Modifier 78 may not be used with place of service 11 (office).
- *Modifier 79* – Unrelated procedure or service by the same physician during a post-operative period. A new post-operative period begins when the unrelated procedure is billed.
  Example 1: A surgeon performs right cataract surgery and two weeks later left cataract surgery for the same patient. Modifier 79 needs to be appended in addition to the RT/LT modifier when utilized. Appending RT/LT alone will result in a denial and the need for a corrected claim.
  Example 2: A surgeon performs fracture repair on a right ankle. One week later the same patient falls and breaks the right wrist and care is rendered by the same surgeon. Modifier 79 would need to be appended to the second surgery to process appropriately.

Note: Modifier 58, 78, and 79 are not valid to use with an E/M procedure code.

Professional/Technical Component modifiers

- The only codes that are eligible for billing are the codes with a TC/26 modifier split in the current Medicare Physician Fee Schedule Relative Value Unit (MPFSRVU) file.
- Mod 26 – Professional component. When the physician or other qualified health care professional component is reported separately, the service must be identified by adding modifier 26 to the usual procedure number.
- Mod TC – Technical component. Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure number. Practitioners performing services in a facility setting are not permitted to bill for the TC component. Professional claims for facility places of service (ex. 21, 22, 23, 24) are not permitted to bill for the global or TC component.

NOTE: If the technical and professional components of the service are billed by the same provider for the same date of service, it would not be appropriate to bill the components separately. The global service (unmodified) should be utilized except in the case of Mobile Diagnostic providers in accordance with policy: Mobile Diagnostics Reimbursement Guidelines, Policy number M110408110.

Modifier 51

- Modifier 51 does not apply to procedures classified as "add-on", "Modifier 51 exempt", E/M services, Physical medicine and rehab services, or provision of supplies (eg. vaccines)
- As we have historically done in the past, Independent Health will apply the 51 modifier to the appropriate claim line
- Adding modifier 51 to the incorrect claim line will cause the claim to pay/deny inappropriately
- For additional information on modifier reduction and modifier 51 go to NGSMedicare.com/Medical Policy&Review/Policy Education Topics/Modifiers/Modifier 51.

Add-On Code modifiers

- In most scenarios, modifier 59 should not be appended to an add-on code
- Add-on codes are exempt from the multiple procedure concept and modifier 51 cannot be appended to these codes
- Add-on codes must be reported on same claim as the primary procedure
- Refer to Appendix D of the CPT book for a comprehensive list of all add-on CPT codes

Modifier KX for Gender Edits

- Modifier KX- Requirements specified in the medical policy have been met
- When performing a service on a member for whom gender specific editing will apply, based on the member's gender status or chosen identification, the "KX" modifier is to be applied to the claim in order for our claims editing system to appropriately allow payment for the service(s).

New Patient Visits

A "New Patient" is one who has not received any professional, face-to-face services from a practitioner or another practitioner of the exact same specialty who belong to the same group practice (Tax ID), in the past three (3) years. In the event a practitioner changes practices, this does not constitute billing of a new patient visit, since professional, face-to-face services have occurred with the member.

Please reference the Evaluation and Management Section in a current CPT Book for further details.

Office/Outpatient Visit Established - CPT 99211

Please review NCCI edits when billing this code as it frequently bundles with many services and a modifier is not permitted to override the bundling. Some examples are:

- Do not report with chemotherapy and non-chemotherapy drug/substance administration codes 96360-96375 and 96401-96425
- Do not report with vaccine administration HCPCS/CPT codes 90460-90474, G0008-G0010
- Do not report for drawing blood for laboratory analysis or when performing other diagnostic tests

Pulmonary Diagnostic Testing and Therapies

CPT code 94060 (bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration)

- Describes a diagnostic test that is utilized to assess patient symptoms that might be related to reversible airway obstruction. It does not describe treatment of acute airway obstruction.
- Includes the administration of a bronchodilator.
- Do not report 94640 for the administration of the bronchodilator which is included in CPT code 94060. The bronchodilator medication may be reported separately.

CPT code 94640 (pressurized or non-pressurized inhalation treatment for acute airway obstruction...)

- Describes either treatment of acute airway obstruction with inhaled medication or the use of an inhalation treatment to induce sputum for diagnostic purposes.
- Should only be reported once during an episode of care regardless of the number of separate inhalation treatments that are administered.
- If used for treatment of acute airway obstruction, spirometry measurements before and/or after the treatment(s) should not be reported separately.
- Do not report with CPT 94060. The inhaled medication may be reported separately.
- In general, should not be reported with CPT code 94664 (demonstration and/or evaluation of patient utilization of an aerosol generator...) for the same patient encounter. The demonstration and/or evaluation described by CPT code 94664 is included in CPT code 94640 if it utilizes the same device (e.g., aerosol generator) that is used in the performance of CPT code 94640. If performed at separate patient encounters on the same date of service, the two services may be reported separately.

Psychotherapy Add-On Codes

When performing a 30, 45, or 60 minute psychotherapy service, in conjunction with an evaluation and management service, the appropriate add-on CPT code to represent the psychotherapy CPT code (90833, 90836, or 90838) should be submitted. Both CPT codes (for the evaluation and management service and psychotherapy service) should be submitted on the same claim form. In the event CPT codes 90832, 90834, or 90837 are submitted along with an evaluation and management code it will deny per

the CMS NCCI edits to the evaluation and management code. Adding modifier -59 to 90832, 90834, or 90837 will NOT bypass this edit.

"Separate Procedure"

If the code descriptor of a HCPCS/CPT code includes the phrase, "separate procedure", the procedure is subject to NCCI PTP edits based on this designation. Separate reporting of a procedure designated as a "separate procedure" when performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach is not allowed.

Suture Removal

When a different physician or other qualified health care provider, removes the sutures than who placed them, the appropriate E/M code would be submitted for payment.

Reporting Time

- A unit of time is attained when the mid-point is passed
- The preferred practice is to include clock times or start and stop times in the documentation
- The documentation should describe the substance of the time spent and be sufficient enough to support the time noted

Twin Delivery

Independent Health follows ACOG coding guidelines for twin deliveries. Twin deliveries should be billed as follows when billing the total obstetric (OB) package:

- If vaginal delivery of twins is performed, report code 59400 and 59409-59.
- If cesarean delivery of twins is performed, report code 59510 only. If significant, additional physician work was necessary modifier -22 may be reported. Billing modifier -22 does not guarantee additional reimbursement. Review the *Modifier 22 – Documentation Requirements* policy for further information.
- If one twin is delivered vaginally and the other is delivered by cesarean, report code 59510 and 59409-59.

Vaccine Administration Coding

Vaccines and administration codes must be billed on the same claim. Add-on codes are to be utilized for each additional component or vaccine administered. The add-on code must be on the same claim as the base code. CPT code 90471 is only to be billed once per encounter. To bill for any additional immunization administration services the applicable add-on CPT code is to be utilized. If CPT code 90471 is reported multiple times, on the same date of service, it will result in a denial.