

Section 11: Billing Requirements

By using the correct procedure codes when you bill PacificSource, you enable us to process your claims accurately and efficiently. Our policy regarding billing follows the HCPCS guideline: If a valid CPT code is available, providers must bill with the CPT instead of the HCPC. In efforts to keep administrative costs down and to ensure timely and accurate claims reimbursement, we require that services performed on the same day by the same provider be billed on the same claim form. This will help eliminate reprocessing of claim refund requests.

11.0 Incident to Billing

PacificSource requires all eligible Providers rendering services to be individually credentialed before they are considered participating under the provider contract. This includes, but is not limited to nurse practitioners, physician assistants and other mid-level providers.

PacificSource requires the provider that rendered the service to be indicated in box 31 on the CMS 1500 claim form or electronic claim equivalent. We do not accept "IncidentTo" billing.

11.1 Osteopathic Manipulation Treatment

Osteopathic Manipulative Treatment—CPT codes: 98925—98929

It is PacificSource policy not to allow an evaluation & management service (E&M) on the same date of service as osteopathic manipulative treatment (OMT). Consistent with CPT coding guidelines, E&M services may only be reported if the work provided is above and beyond what is associated with pre-service and post-service manipulative treatment.

According to the American Medical Association, E&M services may be reported separately if, and only if, the patient's condition requires significant, separately identifiable E&M service, which may be in connection to a new patient or a second diagnosis. However, the presence of a second diagnosis does not necessarily qualify an E&M service as "separately identifiable"

PacificSource policy for considering a second diagnosis will be as follows:

- If a second diagnosis represents a new condition, and requires significant evaluation and management of a separate body system, an E&M code may be reported. Modifier -25 must be attached to the E&M

code. PacificSource reserves the right to determine, by chart note evaluation, whether or not an E&M service is warranted.

- If a second diagnosis represents a brief recheck of an ongoing, but unrelated condition, an E&M service is not approved (provider write-off).
- If a second diagnosis represents the same body system and/or condition, an E&M service is not approved (provider write-off).

Modifier -25—Significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure or other service. The physician may need to indicate that on the day he or she performed a CPT code-identified procedure, the patient's condition required a significant, separately identifiable E&M service above and beyond the other service provided.

11.2 Global Period

A global period is the period of time when services must be included in the surgical allowance; no additional charge may be added. PacificSource uses the number of days indicated in the "Global Period" column of the Federal Register as the standard.

Time periods designated for the following services are considered global:

- Immediate preoperative care beginning when the decision for surgery has been made
- The surgical procedure (including local infiltration, digital block, or topical anesthesia)
- Normal, uncomplicated follow-up care for the period indicated (refer to Federal Register "Global Period")

Preoperative services not encompassed in the global period include:

- Evaluation and management services unrelated to the primary procedure
- Services required to stabilize the patient for the primary procedure
- Procedures provided during the immediate preoperative period that are usually not part of the basic surgical procedure (for example, bronchoscopy prior to chest surgery)

11.3 Obstetric and Gynecology Care Billing Guidelines

11.3.1 Global OB Care

Please use one of the CPT codes listed below when you provide global OB care. Global care includes all obstetrical care for a patient, including delivery, antepartum, and postpartum care. Global OB care should be billed after the delivery date.

- 59400 Routine obstetrical care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
- 59510 Routine obstetric care including antepartum care, cesarean delivery and postpartum care
- 59610 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery
- 59618 Routine obstetric care including antepartum care, cesarean delivery and postpartum care, following attempted vaginal delivery after previous cesarean delivery

11.3.2 Partial Services

If you provide only partial services instead of global OB care, please bill us for that portion of maternity care only. Please use the codes below for billing antepartum-only, postpartum-only, delivery-only, or delivery and postpartum-only services. Only one of the following options should be used, not a combination.

For antepartum care only

- For 1 to 3 visits: Use evaluation and management codes
- For 4 to 6 visits: 59425
- For 7 or more visits: 59426

Additional evaluation and management visits during the antepartum period must be billed with modifier -25 to support an evaluation and management service for a medical condition unrelated to the pregnancy. As always, you may bill for lab work, nonstress tests, ultrasounds and other ancillary services, in addition, and will be reimbursed

according to contract benefits.

For postpartum care only

59430

Delivery only

- 59409 Vaginal delivery only (with or without episiotomy and/or forceps).
- 59514 Cesarean delivery only
- 59612 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
- 59620 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery

Delivery and postpartum care only

- 59410 Vaginal delivery only (with or without episiotomy and/or forceps), including postpartum care
- 59515 Cesarean delivery only; including postpartum care
- 59614 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps), including postpartum care
- 59622 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care

11.3.3 Multiple Births

Multiple births are not generally subject to additional reimbursement for a given practitioner. The CPT codes and case rates for obstetrical care anticipate that some birthing situations require additional time and intensity of care, while others require much less. Some singleton births are complicated by significant delays in delivery or need for additional practitioner monitoring or interventions, while some multiple births proceed without difficulty. Further, some singleton pregnancies are carried post dates, while many multiple pregnancies tend to deliver early. Thus, there are multiple variations inherent in these birthing scenarios.

The codes and relative values were established with these variations in mind. The case rate reimbursement tends to average the excessive care situations with the bulk of others that proceed normally (and sometimes with little or no intervention from the practitioner). Absent a better methodology to reimburse less for those that require little additional practitioner intervention and somewhat

more for those few that require more time or services, the conventional approach has been to average the difficult cases with the less difficult cases.

PacificSource does not routinely reimburse additionally for multiple births. However, it is acknowledged that certain prenatal care and/or labor and delivery situations may, in fact, require significant additional procedural services on the part of the attending physician or practitioner. In those cases, by report, the Medical Director may review the case to determine if significant "unusual procedural services" were rendered. If so, modifier -22 may be assigned to the claim, allowing some additional reimbursement.

11.3.4 Annual Gynecological Exams

Routine gynecological exams are allowed once each calendar year for most PacificSource health plans. (As some plans do not include this benefit, please verify member benefits with our Customer Service Department.)

Annual gynecological exams may include the following*:

- Routine gynecological examination
- Weight and blood pressure
- Laboratory tests**
 - Occult blood
 - Urinalysis
 - Complete blood count
 - Pap smear

*Subject to change; for up-to-date information, please contact our Customer Service Department by phone at (541) 684-5582 or toll-free at (888) 977-9299, or by e-mail at cs@pacificsource.com.

**Any laboratory tests performed in absence of diagnosis are subject to the standard preventive care benefits and maximums.

11.3.5 Screening Papanicolaou Smear—HCCPS code Q0091

PacificSource considers the collection of the pap specimen to be included in the E&M code when services are provided for a gynecological (GYN) exam (CPT codes 99381 through 99397).

- When Q0091 is billed alone with a diagnosis for a GYN exam; the service will be processed as an

annual GYN exam.

- If Q0091 is billed in conjunction with an E&M code for the GYN exam, Q0091 will be denied as "provider write-off." Allowance for the handling of the specimen using CPT 99000 will be denied as bundled when billed in conjunction with the GYN exam.
- We will consider Q0091 for payment, if billed with an E&M code using a diagnosis other than the GYN exam if modifier -25 is used with the E&M code. Diagnosis and chart notes must support use of the E&M code in conjunction with Q0091.
- If Q0091 is billed with an E&M code without modifier -25, Q0091 will not be approved and will be denied as provider write-off.

11.4 Emergency Services

PacificSource provides coverage without preauthorization for emergency medical conditions "of sufficient severity that a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy." This could include claims within a pre-existing (waiting) exclusion period and/or services not ordinarily covered on the plan.

Coverage includes emergency medical screening exams to determine the nature and extent of an emergency medical condition, emergency services provided in an emergency department and all ancillary services associated with the visit to the extent they are required for the stabilization of the patient.

Routinely, emergency room claims will be processed according to the information provided and benefits available to the member. Claims not approved are subject to automatic review by PacificSource.

See below for current contract definition of an Emergency Service.

"Emergency" shall mean a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.

“Emergency Services” shall mean those Covered Services that are Medically Necessary to treat Emergency conditions.

11.4.1 Emergency Room Claims Not Approved

In order to apply “prudent person” determination as mentioned above, all claims for services performed or provided in an emergency room setting (place of service code 23) will be reviewed prior to approval.

PacificSource will thoroughly review billing information for any indication that the member presented in the emergency room with what they perceived to be a medical emergency. If further information is needed, chart notes will be requested. Health Services will be consulted if clinical opinion becomes necessary.

11.4.2 Emergency and After-Hours Codes Defined

(including but not limited to)

99050 Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed, such as holidays or weekends.

PacificSource Policy: Claims submitted by an extended hours, urgent care, or immediate care facility must include supporting documentation to be allowed. Claims submitted by an ED physician or provider will be processed as provider write-off.

99051 Services provided in the office during regularly scheduled evening, weekend, or holiday office hours.

PacificSource Policy: This CPT code will be denied to provider write-off regardless of documentation.

99053 Services provided between 10:00 p.m. and 8:00 a.m. at a 24-hour facility. This code is only allowed for Emergency Departments and should not be billed by any other provider type.

PacificSource Policy: CPT code 99053 will not be approved and will be processed as provider write-off for the following reasons:

- To account for the complexity and acute

nature of the conditions being seen, the basic emergency room CPT already has a higher level of reimbursement built in as compared to a routine office visit CPT.

- *The emergency room provider is working his or her regular schedule, and therefore additional reimbursement for a late shift is not appropriate.*
- *The basic facility charge billed with revenue code 450 includes the cost of maintaining a 24-hour facility, which would include staffing of medical providers and support staff.*

99056 Services typically provided in-office, provided out of the office at the request of the patient.

PacificSource Policy: This code will not be paid and will be denied as patient responsibility.

99058 Services provided on an emergency basis in and out of the office, which disrupts other scheduled office services, in addition to the basic service.

Criteria:

This CPT code will be denied up front. The provider may resubmit claims with documentation. Documentation will be reviewed and payment is not guaranteed.

Any claim with this code will be reviewed to see if the situation falls under the PacificSource definition of emergency. If the diagnosis does not meet the emergency condition definition, the charge will be denied as provider write-off.

PacificSource Policy: PacificSource will review any claim with this code to see if the situation falls under our emergency definition (above). If so, the claim will be released for payment. If not, the charge will be processed as provider write-off unless supporting documentation is included.

99060 Service provided on an emergency basis out of the office, which disrupts other scheduled office services.

PacificSource Policy: This CPT code will be denied to provider write-off regardless of documentation.

11.5 Surgery

11.5.1 Bilateral Procedures

Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day. The terminology for some procedure codes includes the term “bilateral” or “unilateral or bilateral.”

If a procedure is not identified by CPT terminology as bilateral (unilateral or bilateral) procedure, the procedure should be reported with modifier 50. Bilateral procedures may be billed as a separate charge line for each procedure, using a modifier on the second line, or on one line with modifier 50 and ‘2’ in the services.

Example 1: Bilateral procedures billed as separate charge lines for each procedure, using modifier 50 on the second line.

CPT	Modifier	Description	\$ Charges	Days or Units
31238		Nasal/sinus endoscopy, surgical, with control epistaxis	\$500.00	1
31238	-50	Nasal/sinus endoscopy, surgical, with control epistaxis	\$500.00	1

Example 2: Billed as one line (2 services)

CPT	Description	# Svcs	Days or Units	Billed Amount
31238-50	Nasal/sinus endoscopy, surgical, with control epistaxi	2		\$1,000.00

To ensure accurate payment, please make sure you bill the full billed amount, rather than the pre-cut amount. Our system will not recognize if the claim has been pre-cut, and it will cut again according to bilateral surgery guidelines.

11.5.2 Multiple Procedures

Multiple surgeries are separate procedures performed during the same operative session or on the same day, for which separate billing is allowed. Please follow these guidelines to ensure correct payment:

- When multiple procedures, other than E&M services, are performed on the same day or at the same session by the same provider, the primary procedure or service should be reported as listed.
- Any additional procedures or services should be ranked in descending Relative Value Order (RVU) order and identified by the use of modifier -51 on each additional procedure/service.
- Procedure codes that are classified as multiple procedures in the CMS Billing Manual will be processed according to our multiple procedure guidelines. If the code is modifier -51 exempt or an add-on code, it will be processed using 100 percent of the contracted allowed.
- Six or more procedures will require review by PacificSource and chart notes may be requested.

PacificSource uses the following payment structure for multiple procedure claims. Be sure to bill full charges for all services in order to receive the correct payment.

- Primary procedure: 100 percent of the fee allowance
- Second procedure: 50 percent of the fee allowance
- Third through fifth procedures: 25 percent of the fee allowance

Idaho

PacificSource uses the following payment structure for multiple procedure claims.

- Primary procedure: 100 percent of the fee allowance

- Second procedure: 50 percent of the fee allowance
- Third through fifth procedures: 50 percent of the fee allowance

To ensure accurate payment, please make sure when you are billing for multiple procedures that you submit the full billed amount, rather than the pre-cut amount. Our system will not recognize the claim has been pre-cut and will cut again according to the multiple surgery guidelines.

11.5.3 Surgical Assistant Guidelines

Payment is made only if an assistant surgeon is allowed on the Federal Register.

Modifier 80—Assistant Surgeon (MD, DMD, DDS, DO)

- The allowance for modifier 80 is 20 percent of the surgery CPT allowance.

Modifier 81—Minimum Assistant Surgeon (MD, DMD, DDS, DO)

- The allowance for modifier 81 is ten percent of the surgery CPT allowance.
- This modifier is used when the doctor performed minimal assistance.

Modifier AS—Non-physician Assistant (PA, RN, CRNFA, CST, CNM, SA)

- The allowance for modifier AS is ten percent of the surgery CPT allowance.

To ensure accurate payment, please make sure when you are billing assistant surgeon claims that you submit the full billed amount, rather than the pre-cut amount. Our system will not recognize that the claim has been pre-cut (adjusted to show the assistant surgeon payment percentage), and it will be cut again according to the assistant surgeon guidelines.

Note: Certified Nurse First Assist, Certified First Assist (CFS), Certified Surgical Technicians, Surgical Assistants, and Registered Nurse cannot bill independently. These providers must bill under the overseeing doctor's tax identification number.

11.5.4 Office Surgery Suites and Fees

PacificSource will allow for the use of an office surgery suite for surgical procedures not requiring hospital outpatient or ambulatory surgery center admission. The allowance for an office surgical suite is calculated according to the relative value of the surgical procedure.

To be eligible for payment, the provider must include office/surgical suite charges when billing the surgery to PacificSource. To expedite these claims, surgical suite should be identified by the use of modifier -FF.

For surgical procedures performed in the office, the following table will be used to calculate the PacificSource surgical suite allowance when a provider contract does not state specific surgical suite allowances.

RBRVS Surgical Relative Value Unit	% of PacificSource Surgical Allowance
00.01 through 02.09	Billed
02.10 through 08.75	40%*
08.76 through 14.60	30%*
14.61 and greater RVUs	25%*

*Percentage is based on PacificSource allowance for the surgical procedure(s), not the amount billed.

The surgical suite allowance includes usage of room, lights, cautery, dressings, sutures, sterile tray, optical or other equipment, and any services of an assistant (e.g., MD, RN, PA). If any of these supplies are billed separately, it will not be approved as

“provider write-off.” Surgical Suite reimbursement will only be allowed if there is a dedicated room or space in which surgical procedures are performed. Service done in an exam room or area that is utilized for dual purposes will not be considered a surgical suite and will be denied.

Colonoscopy

Screening colonoscopies: Effective September 23, 2010, as PacificSource groups renew, colonoscopy screenings will be covered at 100 percent for ages 50-75 when billed by a participating provider.

Medical colonoscopies for members under age 50 or when billed with a medical diagnosis will be paid under the surgery benefit. The facility claim will be paid under the outpatient facility or ambulatory surgery center benefit.

CT or MR colonography, also known as “virtual colonoscopy” is not covered and is considered as Experimental/Investigational.

Preauthorization: Colonoscopies do not require prior authorization on group or individual policies.

Elective procedure in a waiting period: Screening colonoscopy is considered an elective procedure and is subject to the six-month waiting period.

Colonoscopy with E&M: If a provider bills a colonoscopy with an Evaluation and Management service and the diagnosis is for screening, the E&M service will be denied to provider write-off regardless of participating status.

Visits prior to the diagnostic exam: Pre-visits prior to a screening colonoscopy are inclusive and are reflected in the RVU for the colonoscopy.

11.5.5 Payment Rules for Multiple Scope Procedures

Related Scope Procedures: Scope surgeries are related procedures (same code family) performed during the same operative session and through the same body orifice/incision on the same day.

The scope with the highest RVU is allowed at 100 percent of the fee allowance.

The second and subsequent procedures are priced by subtracting the fee allowance for the “base” procedure from the code’s usual fee allowance.

Unrelated Scope Procedures: When the Scope Procedures are unrelated (not in the same family), multiple surgery rules will apply instead.

Related and Unrelated Scope Procedures on the same day: First, the related scope procedure rule applies, and if the scope is determined to be unrelated then the multiple surgery rule will apply.

Examples of Scope Procedure Families:	
45378 Base procedure	45379, 45380, 45382, 45383, 45384, 45385, 45386, 45387
Examples of Laparoscopy Families:	
49320 Base procedure	38570, 49321, 49322, 49323, 58550, 58551, 58660, 58661, 58662, 58670, 58671, 58672, 58673

Example 1: The procedures performed are 45378 (B), 45385, and 45380 and are based on 2009 Fully Implemented Facility RVUs.

CPT CPT	RRR Description D	RVUs	Allowed RVUs	RVU Minus Base	Total RVU
45378 (B)	Colonoscopy	5.87	5.87		9.63
45385	With direct submucosal injection(s), any substance	8.41	2.54	(8.41-5.87)	
45380	With biopsy, single or multiple	7.09	1.22	(7.09-5.87)	

Example 2: The procedures performed are 45380 and 45385 (base code not billed) and are based on 2009 Fully Implemented Facility RVUs.

CPT CPT	RR Description D	RVUs	Allowed RVUs	RVU Minus Base	Total RVU
45378 (B)	Colonoscopy	5.87			9.36
45385	With direct submucosal injection(s), any substance	8.41	8.41		
45380	With biopsy, single or multiple	7.09	1.22	(7.09-5.87)	

Example 3: The procedures performed are 49320(B), 58660, and 58661, and are based on the 2009 Fully Implemented Facility RVUs.

CPT CPT	RR Description D	RVUs	Allowed RVUs	RVU Minus Base	Total RVU
49320 (B)	Laparoscopy	8.25	8.25		26.20
58660	Laparoscopy, surgical; with lysis of adhesions	17.62	9.37	(17.62-8.25)	
58661		16.83	8.58	(16.83-8.25)	

Example 4: The procedures performed are 58660 and 58661 (base code not billed) and are based on 2009 Fully Implemented Facility RVUs.

CPT CPT	RR Description D	RVUs	Allowed RVUs	RVU Minus Base	Total RVU
49320 (B)	Laparoscopy	8.25			26.20
58660	Laparoscopy, surgical; with lysis of adhesions	17.62	17.62		
58661		16.83	8.58	(16.83-8.25)	

If you have further questions about this allowance or need more information about when it is appropriate to bill for these services, please contact our Provider Network Department by phone at (541) 684-5580 or toll-free at (800) 624-6052, ext. 2580, or by e-mail at providernet@pacificsource.com.

Note: Multiple Scope payment rules are exempt for Idaho providers. Idaho utilizes multiple surgery guidelines of 100/50/50 for multiple scope services.

11.6 Evaluation and Management (E&M) Billing Guidelines

11.6.1 Preventive Visits and E&M Billed Together

According to the CPT codebook, it is appropriate to bill for both preventive services and evaluation and management (E&M) services during the same visit only when significant additional services or counseling are required.

PacificSource's Policy for Modifier 25

If the provider provides both a service or procedure and an evaluation and management (E&M) on the same day, it must be significant, separate, and identifiable. Documentation must support both services and show that the E&M was above and beyond the service or procedure provided. Please note that random audits may be performed, in the event the service is selected for audit please be prepared to provide chart notes for review.

When we receive a claim that includes a preventive care charge and an office visit charge, chart notes are required for review. If the chart note is attached the claim will be pended while our Claims Research Analyst reviews the attached notes.

If no notes are present, the charges for the office visit will be processed as provider write-off with the explanation code stating that allowable charges are limited to one office or hospital visit per day, and that the patient is not responsible for the difference.

- If notes are attached, the claim will be pended to the research analyst who will then review the notes and, based on the content, determine if the office visit is allowable. The research analyst then redirects the claim to the Adjudicator to either process the office visit or indicate that the current or original processing of the claim stands.
- Claims received as rebills with notes will be forwarded to the Claims Research Analyst and the process in the second bullet above will be followed.

Examples

Examples of when both charges would not be appropriate:

- A patient who has a history of hypertension is scheduled for a routine physical. You make brief mention of the hypertension and re-fill the patient's prescription.
- During an annual gynecological exam, a patient mentions that she is having hot flashes, and you

order blood work to check hormone level.

- A child is seen for a well-child checkup and you note that he has an ear infection and prescribe antibiotics.

Examples of when both charges would be appropriate:

- A patient is scheduled for a routine physical with a history of hypertension, and upon examination, you discover that the patient's blood pressure is extremely high. The patient says he is having lightheadedness and ringing in the ears. You take measures to reduce the blood pressure and counsel the patient on how to monitor the condition.
- During an annual gynecological exam, you find a lump in a patient's breast and order additional blood work and radiological procedures. You also take additional time to go over treatment options with the patient.

Prolonged Physician Service

Charges for Prolonged Physician Services CPT codes 99354-99357 involve the total duration of direct patient care that is beyond the usual service provided in an inpatient or outpatient setting. Prolonged Physician Services CPT 99358 and 99359 are not allowed because they are non face-to-face services with the patient.

Anytime prolonged services are billed, chart notes are required for review, regardless of the modifier billed. Chart notes must include the amount of time the provider spent with the patient in order to review for possible coverage. The notes must clearly indicate the time the E&M visit began, and when the prolonged portion of the visit began and ended. If the provider indicates that greater than 50 percent of the visit was counseling, they must bill to highest CPT for the E&M portion of the visit before any prolonged would be allowed. Note counseling is built into the E&M code and does not constitute prolonged services by itself.

If chart notes are not submitted the Prolonged Service, will deny as supporting documentation is required.

If the claim contains the necessary documentation, it will be reviewed and if the chart notes support the prolonged service charge, the claim will be processed to allow the prolonged service. Note this is determined on a case by case basis.

Prolonged services are only allowed when billed with other times based codes, per CPT guidelines.

Prolonged services would not be allowed for Maternity care, personal counseling or emotional support.

11.6.2 Appropriate Use of CPT Code 99211

Because the appropriate use of CPT code 99211 is often confusing, we offer the following guidelines. According to the CPT Code Book, 99211 is intended for “an office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician.” The key points to remember regarding 99211 are:

- The service must be for evaluation and management (E&M).
- The patient must be established, not new (see guidelines below).
- The service must be separated from other services performed on the same day.
- The provider-patient encounter must be face-to-face, not via telephone.

Code 99211 will be accepted only when documentation shows that services meet the minimum requirements for an E&M visit. For example, if the patient receives only a blood pressure check or has blood drawn, 99211 would not be appropriate. Please remember, all E&M visits require a copayment/coinsurance from the member; therefore, if another CPT code more accurately describes the service, that code should be reported instead of 99211.

11.6.3 Anticoagulant Management Codes

Anticoagulant services are defined as the outpatient management of warfarin therapy. This includes communication with the patient, International Normalized Ratio (INR) testing (ordering, review, and interpretation), and dosage adjustments as appropriate.

The following codes and guidelines should be applied for anticoagulant management:

- 99363—Initial 90 days of therapy (must include a minimum of eight INR measurements). Submit claim for 99363 after the eighth visit has been completed.
- 99364—Submit claims for 99364 after each additional 90 days of therapy (must include a minimum of three INR measurements).
- Do not bill 99211 with 99363 or 99364 unless a significant, separately identifiable E/M service is performed and documentation can support it. 99211 will not be approved to Provider write-off when billed in place of 99363 or 99364.

- If treatment with 99211 was already underway on January 1, 2007, when codes 99363 and 99364 became effective, PacificSource will allow payment of 99363 the first time it is billed.

Anticoagulant management work itself is not a basis for an E/M service code or Care Plan Oversight time during the reporting period. Codes 99371—99373 and 0074T do not apply with telephone or online services. However, if a significant, separately identifiable E/M service is performed, report the appropriate E/M service code using modifier 25.

For more information on the use of these codes, please refer to your CPT book.

11.6.4 Distinction Between New and Established Patients

The American Medical Association (AMA) defines a new patient as one who has not received professional services from the physician (or another physician of the same specialty who belongs to the same group practice), within the past three years. Conversely, an established patient is one who has received face to face professional services within the past three years.

Please be aware of this distinction when billing new patient CPT codes.

11.7 Ambulatory Surgery Center (ASC) Payment Guidelines

When contracting directly with an Ambulatory Surgery Center (ASC), PacificSource uses the St. Anthony's Payment Manual for ASC and contracts at a percentage of the CMS fee schedule for Oregon providers.

In Idaho, please refer to your fee schedule for non grouper reimbursements.

Modifier SG—Ambulatory Surgery Center (ASC)

The SG modifier must be used to bill services provided in an Ambulatory Surgery Center (ASC).

The following table will be used to calculate the PacificSource ASC fee allowance for those procedures not assigned to a group in the St. Anthony's Payment Manual for ASC.

RBRVS Surgical Relative Value Unit	Percentage of PacificSource ASC fee allowance for nongrouped procedures
00.01 through 02.09	140%
02.10 through 08.75	120%
08.76 through 14.60	100%
14.61 through greater RVUs	80%

11.7.1 Services included in the ASC Facility Payment:

Nursing services, services of technical personnel, and other related services: These services include any nurses, orderlies, technical personnel, and others involved in patient care.

Patient use of the ASC facilities: Use of the operating room, recovery room, patient prep areas, waiting room, and other areas used by the patient or offered for use to the patient's relatives in connection with the procedure are all included within the facility payment.

Drugs and biologicals: These include drugs or biologicals commonly furnished by the ASC in connection with surgical procedures. It is limited to those items that cannot be self-administered.

Surgical dressings: This includes primary surgical dressings applied at the time of the surgery, and therapeutic and protective coverings applied to lesions or openings in the skin that were required for the surgical procedure. (Ace bandages, pressure garments, Spence boots, and similar items are considered secondary dressings.) Surgical dressings for reapplication by the patient or other caregiver obtained on a provider's order from a supplier, i.e., drugstore, are not included in the facility payment and are separately reimbursable to the supplier.

Supplies, splints, and casts: Only those supplies, splints and casts applied at the time of surgery are included in the facility fee. However, such items furnished later are generally furnished "incident to" a physician's service and are not an ASC facility service. Items provided "incident to" a provider's services are subject to other regulations and definitions, and are generally included in the provider fee. Supplies include all those required for the patient or ASC personnel, such as gowns, drapes, masks, and scalpels.

Appliances and equipment: Appliances and equipment

used within the surgical procedure are included within the facility payment. However, prosthetics and orthotics (other than IOLs) are not included and will be separately reimbursed. IOLs are included in the facility payment. DME furnished to the patient is separately reimbursable to enrolled DME providers.

Diagnostic or therapeutic items and services: Diagnostic services performed by the ASC may be included in the ASC facility payment. However, if the laboratory of the ASC is not certified, items such as routine simple urinalysis or hemograms should not be billed. Tests performed by a certified ASC laboratory are billed by the laboratory and are separately reimbursable. Similarly, tests performed under an arrangement with an independent or hospital laboratory are billed directly by the provider. Radiology, EKGs, and other preoperative tests are generally not included in the facility payment when used to determine the suitability of an ASC setting. Other diagnostic and therapeutic tests directly connected to the procedure are included in the facility payment.

Administrative, recordkeeping, and housekeeping items and services: These include administrative functions necessary to run the facility.

Materials for anesthesia: These include any supplies, drugs, or gases are included within the facility payment.

IOLs: Payment for the IOL is included as a component of the facility payment.

11.7.2 Services not included in the ASC Facility Payment:

- **Physician services:** This includes services of anesthesiologists administering or supervising the administration of and recovery from anesthesia. Physician services also include any routine pre- or postoperative services, such as office visits, consultations, diagnostic tests, removal of stitches, changing of dressings, and other services that the individual physician usually includes in a set global fee for a given surgical procedure.
- **DME:** Includes items for the sale, lease, or rental to ASC patients for use in their home.
- **Prosthetic and orthotic devices;** and leg, arm, back, and neck braces (except IOLs).
- **ASC furnished ambulance services.**
- **Diagnostic tests performed directly by an ASC.**
- **Physical and occupational therapy services.**

11.8 Ultrasound: Same-day Billing of Transvaginal and Standard

Our claims editing system recommends the denial of payment for transvaginal ultrasound when billed with any pelvic or abdominal ultrasound on the same date of service. After careful review, PacificSource has decided to cover both, but will reduce payment the transvaginal ultrasound by 50 percent when billed in conjunction with another ultrasound.

11.9 Never Events Policy

PacificSource has determined that if a healthcare service is deemed a “never event” that neither PacificSource nor the Member will be responsible for payments for said services. Healthcare Facilities and Providers will not seek payment from PacificSource, or its members for additional charges directly resulting from the occurrence of such a “never event” if:

- The event results in a increased length of stay, level of care or significant intervention
- An additional procedure is required to correct an adverse event that occurred in the previous procedure or provision of a healthcare service
- An unintended procedure is performed
- Re-admission is required as a result of an adverse event that occurred in the same facility
- These guidelines do not apply to the entire episode of care, but only the care made necessary by the serious adverse event.

11.9.1 Surgical Events

Pursuant to the above guidelines, a healthcare facility or provider will not seek payment for costs directly resulting from the occurrence of the following events:

- Surgery performed on the wrong body part
- Surgery performed on the wrong patient
- Wrong surgical procedure on a patient
- Retention of a foreign object in a patient after surgery or other procedure
- Intraoperative or immediately post-operative death in an otherwise healthy patient (defined as a Class 1 patient for purposes of the American Society of Anesthesiologist patient safety initiative).

11.9.2 Product or Device Events

Pursuant to the above guidelines, a healthcare facility or provider will not seek payment for costs directly resulting from the occurrence of the following events:

- Patient death or serious disability associated with the use of contaminated drugs, devices, or biologicals provided by the healthcare facility
- Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended
- Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances

11.9.3 Patient Protection Events

Pursuant to the above guidelines, a healthcare facility or provider will not seek payment for costs directly resulting from the occurrence of the following events:

- Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products
- Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)
- Maternal death or serious disability associated with labor or delivery on a low-risk pregnancy while being cared for in a healthcare facility
- Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility
- Death or serious disability (kernicterus) associated with failure to identify and treat hyperbillirubinemia in neonates
- Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility
- Patient death or serious disability due to spinal manipulation therapy
- Patient death or serious disability associated with an electric shock or elective cardioversion while being cared for in a healthcare facility
- Patient death or serious disability associated with a fall while being cared for in a healthcare facility

- Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility
- Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility

The formulation of this policy is the result of guidelines established by the Centers for Medicare and Medicaid (CMS), Oregon Association of Hospitals and Health Systems, Oregon Patient Safety Commission, and the National Quality Forum.

11.10 Modifiers

22—Increased Procedural Services: Documentation is required when billing with this modifier. A short explanation of why this modifier was applied will also help expedite the processing of claims.

24—Unrelated E&M Service by Same Physician

During a Postoperative Period: Used when a physician performs an E&M service during a postoperative period for a reason(s) unrelated to the original procedure.

25—Significant, Separately Identifiable E&M Service by the Same Physician on the Same Day of the Procedure or Other Service:

Used by provider to indicate that on the same date of service, the provider performed two significant, separately identifiable services that are not “unbundled”

26 or PC—Professional Component: Certain procedures are a combination of a physician component and a technical component, and this modifier is used when the physician is providing only the interpretation portion.

TC—Technical Component: Certain procedures are a combination of a provider component and a technical component, and this modifier is used when the provider is performing only the technical portion of a service.

32—Mandated Services: Services related to mandated consultation and/or related services (e.g., third party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

47—Anesthesia by Surgeon: Regional or general anesthesia provided by a surgeon may be reported by adding this modifier to the surgical procedure. Amount allowed is 25% of the surgical procedure allowance.

50—Bilateral Procedures: Bilateral surgeries are

performed on both sides of the body during the same operative session or on the same day. Unless otherwise identified, bilateral procedures should be identified with this modifier. A separate procedure code should be billed for each procedure, using modifier -50 on the second one. Refer to Bilateral Procedures 11.5.1 of the Provider Manual.

51—Multiple Procedures: Procedures performed at the same operative session, which significantly increase time. Multiple procedures should be listed according to value. The primary procedure should be of the greatest value and should not have modifier -51 added. Subsequent procedures should be listed using modifier -51 in decreasing value. Refer to Bilateral Procedures 11.5.2 of the Provider Manual.

52—Reduced Services: Informational modifier only. Allowed amount to be reduced to 80% (cut by 20%), then processed according to the contract benefits.

53—Discontinued Procedure: Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Allowed amount will be reduced by 75% (cut by 25%), then processed according to contract benefits.

54—Surgical Care Only: Used with surgery procedure codes with a global surgery period only. Fee allowance is reduced to 70% of the original allowed. See modifiers 55 and 56 below for additional details on pre- and post-op care only.

55—Postoperative Management Only: Reimbursement is limited to the post-op management services only. Used with the surgery CPT code, auto adjudication reduces fee allowance to 30% of the total allowed.

56—Preoperative Management Only: Reimbursement is limited to the pre-op management services only. Used with the surgery CPT code, auto adjudication reduces fee allowance to 10% of the total allowed.

57—Decision for Surgery: This modifier identifies an E&M service(s) that resulted in the initial decision for surgery and are not included in the “global” surgical package.

59—Distinct Procedural Service: Indicates that a procedure or service was distinct or independent from other services performed on the same day. Example: An E&M service for an ear infection and a surgical code billed for removal of a wart at the same visit.

62—Two Surgeons (MD, DMD, DO): When two surgeons work together as primary surgeons performing distinct part(s) of a single procedure, each surgeon should add modifier 62 to the CPT code. The combined allowable for co-surgeons is 125% of the full CPT allowable. This amount will be split 50-50 between the two surgeons, unless otherwise indicated on the claim form.

63—Procedure Performed on Infants less than 4kg: Documentation is required when billing with this modifier. A short explanation of why this modifier was applied will also help expedite the processing of claims.

66—Surgical Team (MD, DO, PA, CRNFA, RN, SA): When a team of surgeons (two or more) are required to perform a specific procedure, each surgeon bills the procedure with modifier 66. Fee allowance is increased to 120% of the basic fee allowance to 120% for the procedure.

76—Repeat Procedure by Same Physician: This modifier is used to indicate that a repeat procedure on the same day was necessary, or a repeat procedure was necessary and it is not a duplicate bill for the original surgery or service.

77—Repeat Procedure by Another Physician: This modifier is used to indicate that a procedure already performed by another physician is being repeated by a different physician. This sometimes occurs on the same date of service.

78—Return to the OR for a Related Procedure During the Post-op Period: Indicates that a surgical procedure was performed during the post-op period of the initial procedure, was related to the first procedure, and required use of the operating room. This modifier also applies to patients returned to the operating room after the initial procedure, for one or more additional procedures as a result of complications.

79—Unrelated Procedure or Service by the Same Physician During the Post-op Period: Indicates that an unrelated procedure was performed by the same physician during the post-op period of the original procedure.

80—Assistant Surgeon (MD, DMD, DO): Only one first assistant may be reimbursed for a CPT code, except for open-heart surgery, where two assistants are allowed. Payment will be allowed only if an assistant surgeon is allowed by our claims editing system. The fee allowance is automatically reduced to 20% of the surgical fee allowance as billed by the primary surgeon. Refer to Surgical Assistant Guidelines 11.5.3 of the Provider Manual.

81—Minimum Assistant Surgeon (CNM, CRNFA, NP, PA, RN, SA): Use this modifier when the services of a second or third assistant surgeon are required during a procedure. Use with surgical CPT codes only. The allowance is automatically reduced to 10% of the surgical fee allowance as billed by the primary surgeon. Refer to Minimum Assistant Surgeon (MD, DMD, DDS, DO) 11.5.3 of the Provider Manual.

82—Assistant Surgeon: This modifier is used when a qualified resident surgeon is not available. This is a rare occurrence.

90—Reference (Outside) Laboratory: This modifier is used when laboratory procedures are performed by a party other than the treating or reporting physician. Allowed should fall to contracted lab fees.

91—Repeat Clinical Diagnostic Laboratory Test: This modifier is used when a provider needs to obtain additional test results to administer or perform the same test(s) on the same day and same patient. It should not be used when the test(s) are rerun due to specimen or equipment error or malfunction. Nor should this code be used when basic procedure code(s) (such as CPT 82951) indicate that a series of test results are to be obtained.

***Have You Tried InTouch?
With InTouch for
Providers, you can verify
eligibility and check
claims status, EOPs,
preauthorizations,
referrals, and much
more online! Visit
PacificSource.com to get
started.***

99—Multiple Modifiers: Under certain circumstances two or more modifiers may be necessary to completely describe a service.

FF—Facility Fee:

- LT—HCPCS—Left Side of Body
- PC—Professional Component (See Modifier -26)
- RT—HCPCS—Right Side of Body
- TC—Technical Component (See Modifier -27)

JW—JW Modifier is now billable for single dose medications purchased for a specific patient when a portion must be discarded. Please note that this modifier is very specific and is not to be used for any other types of medications you may need to discard, such as expired medications or multi-dose vials.

SG—Ambulatory Surgery Center: This modifier is used when the services billed were provided at an Ambulatory Surgery Center (ASC).

**** When rebilling a change in diagnosis or CPT, codes you must send supporting documentation with the new claim.**

11.11 Place of Service Codes For Professional Claims

Listed below are place of service codes. These codes should be used on professional claims to specify the entity where services were rendered. Place of service descriptions are available on the CMS Web site at <http://www.cms.hhs.gov/states/posdata.pdf>. If you would like to comment on a code or description, please e-mail your request to posinfo@cms.hhs.gov.

Places of Service Code(s)	Place of Service Name	Facility (F) Or Non-Facility (NF)
01	Pharmacy	NF
02	Unassigned	
03	School	NF
04	Homeless Shelter	NF
05	Indian Health Services Free-standing Facility	NF
06	Indian Health Services Provider-based Facility	NF
07	Tribal 638 Free-standing Facility	NF
08	Tribal 638 Provider-based Facility	NF
09	Prison/Correctional Facility	NF
10	Unassigned	
11	Office	NF
12	Home	NF
13	Assisted Living Facility	NF
14	Group Home	NF
15	Mobile Unit	NF

continued on next page.

Places of Service Code(s)	Place of Service Name	Facility (F) Or Non-Facility (NF)
16	Temporary Lodging	
17	Walk-in Retail Health Clinic	
18-19	Unassigned	
20	Urgent Care Facility	NF
21	Inpatient Hospital	F
22	Outpatient Hospital	F
23	Emergency Room—Hospital	F
24	Ambulatory Surgical Center	F
25	Birth Center	NF
26	Military Treatment Facility	F
27-30	Unassigned	
31	Skilled Nursing Facility	F
32	Nursing Facility	NF
33	Custodial Care Facility	NF
34	Hospice	F
35-40	Unassigned	
41	Ambulance—Land	F
42	Ambulance—Air or Water	F
43-48	Unassigned	
49	Independent Clinic	NF
50	Federally Qualified Health Center	NF
51	Inpatient Psychiatric Facility	F
52	Psychiatric Facility-Partial Hospitalization	F
53	Community Mental Health Center	F
54	Intermediate Care Facility/Mentally Retarded	NF
55	Residential Substance Abuse Treatment Facility	NF
56	Psychiatric Residential Treatment Center	F
57	Nonresidential Substance Abuse Treatment Facility	NF
58-59	Unassigned	NF
60	Mass Immunization Center	
61	Comprehensive Inpatient Rehabilitation Facility	F
62	Comprehensive Outpatient Rehabilitation Facility	F
63-64	Unassigned	
65	End-Stage Renal Disease Treatment Facility	NF
66-70	Unassigned	
71	Public Health Clinic	NF
72	Rural Health Clinic	NF

continued on next page.

Places of Service Code(s)	Place of Service Name	Facility (F) Or Non-Facility (NF)
73-80	Unassigned	
81	Independent Laboratory	NF
82-98	Unassigned	
99	Other Place of Service	NF

11.12 Lab Handling Codes

The following procedure has been updated to follow PacificSource claims editing software:

Lab Handling Codes

- 36415—Collection of venous blood by venipuncture.

Our claims editing system may deny as unbundled when billed with any E&M, lab or other procedure codes.
- 36416—Collection of capillary blood specimen.

Our claims editing system may deny as unbundled when billed with any E&M, lab or other procedure codes.
- 99000—Handling and/or conveyance of specimen for transfer from physician’s office to a lab.

This code will deny as unbundled when billed with an E&M code.
- 99001—Handling and/or conveyance of specimen for transfer from the patient in other than a physicians office to a laboratory.

This code will deny as unbundled when billed with an E&M code.
- 99002—Handling, conveyance, and/or any other service in connection with implementation of an order involving devices (e.g. designing, fitting, packaging, handling, delivering, or mailing) when devices such as orthotics, protectives, or prosthetics are fabricated by an outside laboratory or shop but which items have been designed, and are to be fitted and adjusted by the attending physician.

This code will deny as unbundled when billed with an E&M code.

11.13 Clinical Lab Services

PacificSource Health Plans follow Medicare guidelines for billing of professional, technical, and total components of laboratory tests. We will not make separate payment for the pathologist’s professional services in the hospital.

Pacificsource will no longer allow payment for the following laboratory procedure codes when billed with modifier 26 or TC.

80047—80076	80100—80103
80150—80299	80400—80440
80500—80502	81000—81099
82000—83018	83021—83909
83913—84163	84202—84999
85002—85055	85130—85385
85397—85557	85597—85999
86000—86063	86140—86243
86277—86318	86329—86332
86336—86480	86485—86580
86590—86849	87001—87158
87166—87206	87209—87999

Please note these codes are subject to change based on the National Physician Fee Schedule Relative Value File updates.

11.14 Editing Software for Facility and Professional Claims

11.14.1 Professional Claims

PacificSource Health Plans has used the Ingenix iCES Professional Editing application as the clinical editing solution for professional medical claims for many years. Using claims editing software helps to promote correct coding and standardized editing of the claims we receive on behalf of our members. The coding guidelines contained in the knowledge base are well researched, clearly defined and documented in support of transparency requirements. We apply these guidelines to both participating and

nonparticipating professional providers. Edits made to claims are considered to be a provider adjustment and not billable to the member.

11.14.2 Facility Claims

Historically, PacificSource has relied on facility providers to bill us using correct coding methods. To ensure that the facility claims we receive are also properly coded, we have implemented the Ingenix iCES Facility Editing application and will begin applying clinical editing rules to all facility claims as of July, 2010. This will align our payment policies on both professional and facility claims and positions us to more closely follow general clinical editing and coding standards within the industry today. Edits will be applied to both participating and nonparticipating facilities. All claims edited for correct coding will be considered to be a facility adjustment and not billable to the member.

11.14.3 Sample Edit Criteria

Listed below are some examples and definitions of edits that providers/facilities may encounter:

Mutually Exclusive: Mutually exclusive codes are those codes that cannot reasonably be done in the same session, or the coding combination represents two methods of performing the same service.

Incidental: Includes procedures that can be performed along with the primary procedure, but are not essential to complete the procedure. They do not typically have a significant impact on the work and time of the primary procedure. Incidental procedures are not separately reimbursable when performed with the primary procedure.

OCE/CCI: Based on coding conventions defined in the AMA's CPT Manual, current standards of medical and surgical coding practice, input from specialty societies, and analyses of current coding practice. Edits always consist of pairs of HCPCS codes using the correct coding edits table and the mutually exclusive edit table.

MUE Hospital: Unlikely number of units billed for services rendered.

Multiple/Bilateral procedures without modifier: Any instance when a claim is submitted for primary surgery along with additional surgery codes for either multiple procedures and/or bilateral procedures without appropriate modifier.

Unbundling: Includes procedures that are basic steps necessary to complete the primary procedure and are by definition included in the reimbursement of that primary procedure.

Revenue Code requires HCPCS code: Any instance where a revenue code requires the HCPCS code to be billed for payment.

Inpatient only procedures: Any instance of a procedure typically performed in the inpatient setting billed as an outpatient place of service.

Your PacificSource Provider Service Representative is available any time you have a question or concern. If you're not sure who your representative is, please visit our Provider Service Staff Directory at PacificSource.com.

11.14.4 Other Generalized Edits

Age/Gender/Diagnosis/procedure specific conflicts:

Age related code development is based on CPT/HCPCS/ICD-9 guidelines and/or code descriptions identifying specific ages. Gender-specific procedures are determined by body site, anatomical structure, and description of procedure performed. Diagnosis edits identify inconsistent coding relationships as well as diagnosis codes that are not allowed for reporting alone or as a primary diagnosis.

Hospital High-Dollar Audits: PacificSource contracts with an outside vendor for our high-dollar hospital audits (claims over \$20,000). After the claim is submitted for auditing, PacificSource will price the claim at 95 percent of the contracted allowed amount until the audit is completed. For example, if the contract allowed is \$25,000.00, the interim allowed amount would be \$23,750.00 until the audit is complete. Once the audit is complete, the claim will be reprocessed based on the audited amount and contracted allowance.

