# IntegraNet Medicare Advantage Payment Policies

In our effort to assist physicians, facilities, and other providers in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. Keep in mind that determination of coverage under a member's benefit plan does not necessarily ensure reimbursement. These policies may be superseded by state, federal, or Centers for Medicare and Medicaid Services (CMS) requirements. Providers and facilities are required to use industry standard codes for claim submissions. Services should be billed with Current Procedure Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. The billed code(s) should be fully supported in the medical record and/or office notes. Industry practices are constantly changing, and we reserve the right to review and revise policies periodically.

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, IntegraNet may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

IntegraNet's reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal, or Centers for Medicare and Medicaid Services (CMS) contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, IntegraNet strives to minimize these variations.

IntegraNet reserves the right to review and revise its policies periodically when necessary. When there is an update, we will publish the most current policy to this

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**Drug Screen Testing**

*IntegraNet* allows reimbursement for presumptive and definitive drug screen services unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

In certain circumstances, *IntegraNet* allows reimbursement for presumptive drug testing by instrumented chemistry analyzers and definitive drug screening services for the same member provided on the same day by a reference laboratory.

Definitive drug testing may be done to confirm the results of a negative presumptive test or to identify substances when there is no presumptive test available. Provider's

documentation and member's medical records should reflect that the test was properly ordered and support that the order was based on the result of the presumptive test.

In the event, a reference lab (POS = 81) performs both presumptive and definitive tests on the same date of service, records should reflect that the ordering/treating provider issued a subsequent order for definitive testing based on the results of the presumptive tests.

*IntegraNet* does not allow reimbursement for employment/pre-employment drug screening.

**Abortion (Termination of Pregnancy)**

*IntegraNet* allows reimbursement of induced abortions unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

Induced abortions are allowed only when the written voluntary and informed consent has been obtained from the woman upon whom the abortion is to be performed, and the provider performing the procedure certifies:

• The pregnancy is the result of an act of rape or incest.

• The woman suffers from a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

Reimbursement is based on the applicable fee schedule or contracted/negotiated rate.

Modifier G7 is required with the appropriate procedure code when requesting reimbursement for an induced abortion. *IntegraNet* does not require informed consent forms submitted with claims. Informed consent is not needed for the treatment of incomplete, missed or septic abortions. These procedures are not considered induced or elective abortions and are allowed under the criteria of medical necessity.

**Assistant at Surgery (Modifiers 80/81/82/AS)**

*IntegraNet* allows reimbursement for one assistant surgeon when eligible procedures are billed with Modifiers 80, 81, 82 or AS, as applicable unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. *IntegraNet* uses code editing software to process claims

billed for assistant at surgery. If an applicable modifier is not billed appropriately, the procedure may be denied.

When multiple procedures are performed where only some of the procedures are eligible for assistant at surgery reimbursement, only assistant at surgery services for the eligible procedures will be considered for reimbursement. The same multiple-procedure fee reductions and clinical edits apply to both the assistant at surgery and the primary surgeon.

The assistant at surgery should not report procedure codes different from the procedure codes reported by the primary surgeon, except if the primary surgeon bills an OB global code; then, the assistant at surgery would bill the specific surgery code with the appropriate modifier.

Assistant Surgeon services billed with Modifiers 80, 81, 82 or AS are eligible for reimbursement according to CMS reimbursement guidelines.

**Claims Requiring Additional Documentation**

Professional providers and facilities are required to submit additional documentation for adjudication of applicable types of claims. If the required documentation is not submitted, the claim may be denied. Applicable types of claims include:

• Upon request, claims for durable medical equipment, prosthetics, orthotics, and supplies, and home health and rehabilitation therapies.

• Claims with unlisted or miscellaneous codes.

• Claims for services requiring clinical review.

• Claims for services found to possibly conflict with covered benefits for covered persons after validity review of the member’s medical records.

• Claims for services found to possibly conflict with medical necessity of covered benefits for covered persons.

• Claims requesting an extension of benefits.

• Claims being reviewed for potential fraud, abuse or demonstrated patterns of billing/coding inconsistent with peer benchmarks.

• Claims for services that require an invoice.

• Claims for services that require an itemized bill.

• Claims for beneficiaries with other health insurance.

• Claims requiring a certificate of medical necessity.

• Appealed claims where supporting documentation may be necessary for determination of payment.

• Other documentation required by CMS and federal regulation

**Note**: Itemized bills must be submitted with the appropriate revenue code for each individual charge.

*IntegraNet* may request additional documentation, or notify the provider or facility of additional documentation required for claims, subject to contractual obligations. If documentation is not provided following the request or notification, *IntegraNet* may:

• Deny the claim, as the provider failed to provide required prepayment documentation.

• Recover and/or recoup monies previously paid on the claim, as the provider failed to provide required documentation for post payment review.

*IntegraNet* is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.

**Claims Timely Filing**

To be considered for reimbursement, an initial claim must be received and accepted in compliance with *IntegraNet* timely filing guidelines outlined below unless otherwise stipulated by contract. *IntegraNet* follows the standard of:

 95 days for participating providers and facilities.

 12 months for nonparticipating providers and facilities.

Timely filing is determined by subtracting the date of service from the date *IntegraNet* receives the claim and comparing the number of days to the *IntegraNet* standard. If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last day of service. Limits are based on calendar days unless otherwise specified. If the member has Other Health Insurance (OHI) that is primary, then timely filing is counted from the date of the Explanation of Payment (EOP) of the other carrier.

Claims filed beyond federal, or *IntegraNet* standard timely filing limits will be denied as outside the timely filing limit. Services denied for failure to meet timely filing

requirements are not subject to reimbursement unless the provider presents documentation proving a clean claim was filed within the applicable filing limit.

*IntegraNet* reserves the right to waive timely filing requirements on a temporary basis following documented natural disasters or under applicable state guidance.

**Claim Submission — Required Information for Facilities**

Institutional Providers (Facilities) are required, unless otherwise stipulated in their contract, to submit the original CMS UB-04/CMS-1450 Medicare Uniform Institutional Provider Bill to *IntegraNet* for payment of healthcare services. Providers must submit a properly completed UB-04/CMS-1450 for services performed or items/devices provided. If the

required information is not provided, *IntegraNet* can delay or deny payment without being liable for interest or penalties. The UB-04/CMS-1450 claim form must include the following information, if applicable:

 Billing provider information (name, address, and telephone number)

 Patient control number

 Medical record number

 Type of bill

 Federal Tax Identification Number

 Statement covers period (from-through)

 Patient information (name, member ID number, address, date of birth, and gender)

 Admission/start of care date

 Type of admission or visit

 Point of origin for admission or visit

 Patient discharge status

 Condition code(s), occurrence code(s) and date(s)

 Occurrence span code(s) and date(s) for inpatient services only

 Value codes and amounts

 Revenue code(s) and applicable corresponding CPT/HCPCS codes, if necessary; applicable claims billed only with the revenue code will be denied. Providers will be asked to resubmit with the correct CPT/HCPCS code in conjunction with the applicable revenue code.

 Date(s), unit(s), total charge(s), and noncovered charge(s) of service(s) rendered

 Clinical Laboratory Improvement Amendment (CLIA) certification number

 Insurance payer's information (name, provider number, and Coordination of Benefits (COB) secondary and tertiary payer information)

 Prior payments — payers insured's information (name, relationship to patient, member ID number, and insurance group name and number); principal, admitting, and other ICD-10 diagnosis codes and Present on Admission (POA) indicator, as applicable

 Diagnosis and procedure code qualifier (all seven digits for ICD-10) and date of principal procedure for inpatient services,

 Patient reason for visit code

 Attending and operating provider name and Tax ID, if applicable

 National provider identifier provider number (in accordance with CMS requirements)

 Claim reporting data elements in accordance with applicable state compliance requirements, including the following:

o Admission source code

o Applicable value code for billed admission type code

o Birth weight with applicable value and admission type codes

o Facility type code

o National drug code(s) (NDC) to include the NDC number, unit price, quantity, and composite measure per drug

*IntegraNet* cannot accept claims with alterations to billing information. Claims that have been altered will be returned to the provider with an explanation of the reason for the return.

Although *IntegraNet* prefers the submission of claims electronically (8371) through the Electronic Data Interchange (EDI), *IntegraNet* will accept paper claims. A paper claim must be submitted on an original claim form with dropout red ink, computer-printed or typed, and in a large, dark font to be read by optical character reading (OCR) technology. All claims must be legible. If any field on the claim is illegible, the claim will be rejected or denied.

**Code and Clinical Editing Guidelines**

*IntegraNet* applies Code and Clinical Editing Guidelines (CCEG) to evaluate claims for accuracy and adherence to accepted national industry standards and plan benefits unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

*IntegraNet* uses software products that ensure compliance with standard code edits and rules. These products increase consistency of payment for providers by ensuring correct coding and billing practices are followed. CCEG consists of the following measures:

• Code editing software, CMS National Correct Coding Initiative (NCCI) edits and outpatient code edits:

o Code editing software is updated to conform to changes in coding standards.

o NCCI edits are updated according to CMS published updates

• Clinical criteria

• Licensed clinical medical review

• Claims processing platform

Per state requirements, we publish its use of specific commercial code editing software. We only customize applicable CCEG measures due to compelling business reasons. We also use a coding algorithm approach to automatically adjudicate Evaluation and Management claims based on the applicable level of complexity or severity in accordance with diagnosis codes reported on the claims.

CCEG measures are updated as applicable and as needed to incorporate new codes, code definition changes, and edit rule changes.

All claims submitted after the configuration implementation date, regardless of service date, will be processed according to up to date CCEG measures. No retrospective payment changes, adjustments, and/or requests for refunds will be made when processing changes are a result of new code editing rules within a module update. The

member is not responsible and should not be balance billed for any procedures for which payment has been denied or reduced as the result of CCEG measures.

*IntegraNet* will not reimburse in the event of a conflict with CCEG.

**Corrected Claims**

*IntegraNet* allows reimbursement for a corrected claim when received within the applicable timely filing requirements of the original claim. Due to the initial claim not being considered a clean claim, the corrected claim must be received within the timely filing limit outlined below unless otherwise stipulated by contract. For participating and nonparticipating providers, *IntegraNet* follows the standard of 12 months from the date of service.

Providers resubmitting paper claims for corrections must clearly mark the claim Corrected Claim. Corrected claims submitted electronically must have the applicable frequency code. Failure to mark the claim appropriately may result in denial of the claim as a duplicate. Corrected claims filed beyond federal, state-mandated, or company standard timely filing limits will be denied as outside the timely filing limit. Services denied for failure to meet timely filing requirements are not subject to reimbursement unless the provider presents documentation proving a corrected claim was filed within the applicable filing limit.

*IntegraNet* reserves the right to waive corrected claim filing requirements on a temporary basis following documented natural disasters or under applicable state guidance.

Note: Corrected claims must be submitted separately for each member and episode of care and cannot be accepted by batch, bulk, or packaged submissions.

**Diagnoses Used in DRG Computation**

*IntegraNet* ensures that the diagnosis and procedure codes that generate the diagnosis-related groups (DRGs) are accurate, valid and sequenced in accordance with national coding standards and specified guidelines unless state, federal or CMS contracts and/or requirements indicate otherwise.

*IntegraNet* performs DRG audits to determine that the diagnostic and procedural information that led to the DRG assignment is substantiated by the medical record. The audits utilize coding criteria to limit the billed diagnosis used in DRG computation to those that:

• Are relevant to the patient’s care.

• Impact the patient's outcome, treatment, intensity of service or length of stay.

• Are supported by documentation within the medical record.

*IntegraNet* routinely monitors DRG billing patterns to ensure that hospitals perform fair and equitable coding and utilization.

**Distinct Procedural Services (Modifiers 59, XE, XP, XS, XU)**

*IntegraNet* allows reimbursement for a procedure or service that is distinct or independent from other service(s) performed on the same day by the same provider when

billed with Modifier 59, XE, XP, XS or XU (collectively known as X{EPSU}) unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

*IntegraNet* follows CMS National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) edit guidelines.

**Reimbursable:**

 National Correct Coding Initiative (NCCI) Column 1/Column 2 edits; Modifiers 59 or X{EPSU} may be appended to the paid or denied code.

 Modifier 59 should only be used if no more descriptive modifier is available such as XE, XP, XS, XU.

 Modifier 59 should not be appended to the same claim line item as X{EPSU}.

*IntegraNet* reserves the right to perform postpayment review of claims submitted with Modifier 59 and X{EPSU}. *IntegraNet* may request that providers submit additional documentation, including medical records or other documentation not directly related to the member, to support claims submitted by the provider. If documentation is not provided following the request or notification, or if documentation does not support the services billed for the episode of care, *IntegraNet* may:

 Deny the claim.

 Recover and/or recoup monies previously paid on the claim.

*IntegraNet* is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.

## DME Modifiers for New, Rented and Used Equipment

*IntegraNet* allows reimbursement for new, rented or used equipment appended with the appropriate modifier unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. The listed modifiers are considered reimbursement

modifiers and must be billed in the primary or first modifier field to determine appropriate reimbursement:

- Modifier NU: new equipment

- Modifier RR: rented equipment

- Modifier UE: purchase of used equipment

These modifiers are appropriate for durable medical equipment, prosthetics and orthotics. These modifiers are inappropriate for supplies unless required under state or CMS guidelines. Claims for supplies appended with Modifier NU, RR or UE may be denied.

Reimbursement will be based on the applicable fee schedule or contracted/negotiated rate for claims submitted for the equipment with the valid modifier identifying new, rented, or used equipment. Claims submitted for equipment without the appropriate reimbursement modifier may be denied.

## Durable Medical Equipment (Rent to Purchase)

*IntegraNet* allows reimbursement for durable medical equipment (DME) under specific guidelines unless otherwise noted by provider, state, federal or CMS contracts and/or requirements.

Reimbursement is based on the rental price up to the maximum allowed of the particular DME. The item is considered purchased once the purchase price has been met. There may be instances in which a particular item may be considered for direct purchase on a case-by-case basis.

## Components of Rental DME

Supplies and accessory components associated with rental DME are not separately reimbursed and considered all-inclusive in the rental reimbursement.

The reimbursement limit for rented DME for members covered under Medicare products is 13 months. After 13 months, claims submitted for the item will be denied and the item will be considered purchased.

**Circumstances Affecting Rental Reimbursement:**

 Rental periods that contain a break in coverage of more than 60 days will start the limitation count over.

 On the occasion a member changes suppliers during the rental period, a new rental period will not start over.

Reimbursement for oxygen equipment is allowed for a maximum of 36 months; however, *IntegraNet* will continue to reimburse for oxygen contents.

**Items Not Considered DME**

The following items are not considered DME:

 Prosthetics or orthotics

 Disposable medical supplies

**Note**: This policy does not apply to direct purchase DME.

**Non-reimbursable DME**

*IntegraNet* does not allow reimbursement for:

 Provision of DME that exceeds the benefit limit unless authorized through medical necessity.

 Repair or replacement of DME necessitated by abuse or neglect.

 Repair or replacement of DME during the warranty period.

 Enhancements or upgrades of DME for the convenience of the member or caregiver.

 The aesthetic appearance of DME for the preference of the member or caregiver.

 DME considered to be experimental or investigational.

 The purchase or rental of common household items that are not medically indicated.

 DME provided by a skilled nursing facility — This equipment is normally included as part of the facility charge and is not separately reimbursable unless otherwise stated in a provider contract.

**Proof of Timely Filing**

*IntegraNet* will reconsider reimbursement of a claim that is denied for failure to meet timely filing requirements unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise, when a provider can:

• Provide a date of claim receipt compliant with applicable timely filing requirements.

• Demonstrate Good Cause exists.

Documentation of Claim Receipt

The following information will be considered proof the claim was received timely. If the claim is submitted:

• By mail: The provider must provide official mailing service return receipt/delivery confirmation; additionally, the provider must provide a copy of the claim log that identifies each claim included in the submission.

• Electronically: The provider must provide the clearinghouse-assigned receipt date from the reconciliation reports.

The following information will not be considered proof the claim was received timely. If the claim is submitted:

• By fax: Facsimile transmission

• By hand delivery: A claim log that identifies each claim included in the delivery and a copy of the signed receipt

The mailed claims log maintained by providers must include the following information:

• Name of claimant

• Address of claimant

• Telephone number of claimant

• Claimant's federal tax identification number

• Name of addressee

• Name of carrier

• Designated address

• Date of mailing

• Subscriber name

• Subscriber ID number

• Member's name

• Date(s) of service/occurrence, total charge, and delivery method

Good Cause

Good Cause may be established by the following:

• If the claim includes an explanation for the delay (or other evidence that establishes the reason), *IntegraNet* will determine good cause based primarily on that statement or evidence.

• If the evidence leads to doubt about the validity of the statement, *IntegraNet* will contact the provider for clarification or additional information necessary to make a Good Cause determination.

Good Cause may be found when a provider claim filing delay was due to:

• Administrative error — incorrect or incomplete information furnished by official sources to the provider.

• Retroactive enrollment — Member subsequently received notification of enrollment effective retroactively to or before the date of service

• Incorrect information furnished by the member to the provider resulting in erroneous filing with another health insurance plan or with their State Medicaid plan.

• Unavoidable delay in securing required supporting claim documentation or evidence from one or more third parties despite reasonable efforts by the provider to secure such documentation or evidence.

• Unusual, unavoidable, or other circumstances beyond the service provider's control that demonstrates the provider could not reasonably be expected to have been aware of the need to file timely.

• Destruction or other damage of the provider's records unless such destruction or other damage was caused by the provider's willful act of negligence.

**Documentation Standards for Episodes of Care**

*IntegraNet* requires that documentation for all episodes of care must meet the following criteria unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise:

• Documentation must be legible to someone other than the writer.

• Documentation must be complete, dated, and timed.

• Documentation must reflect all aspects of care.

• Information identifying the member must be included on each page in the medical record.

• Each entry in the medical record must include author identification, which may be a handwritten signature, unique electronic identifier, or initials.

To be considered complete, documentation for episodes of care will include, at a minimum, the following elements when applicable:

• Member identifying information

• Consent forms

• Health history, including applicable drug allergies

• Physical examinations

• Physician orders

• Immunization records

• Medications prescribed

• Emergency care

• Smoking, alcohol, and substance abuse history

• Face-to-face evaluations

• Progress notes

• Referrals

• Consultation reports

• Laboratory reports

• Imaging reports (including X-ray)

• Surgical reports

• Admission and discharge dates and instructions

• Preventive services provided or offered, appropriate to member's age and health status

• Evidence of coordination of care between primary and specialty physicians

• Working diagnoses consistent with findings and test results

• Treatment plans consistent with diagnoses

• Recorded start and stop times for time-based procedures

Note: Documentation should support the procedure and modifier(s) usage. Depending on the episode of care, more specific documentation, in compliance with federal and state regulations, may be required for the medical record to be considered complete.

Providers should refer to standard data elements to be included for specific episodes of care as established by The Joint Commission, formerly the Joint Commission on Accreditation of Healthcare Organizations.

Other Documentation Not Directly Related to the Member

Other documentation not directly related to the member, but relevant to support clinical practice, may be used to support documentation regarding episodes of care, including:

• Policies, procedures, and protocols.

• Critical incident/occupational health and safety reports.

• Statistical and research data.

• Clinical assessments.

• Published reports/data.

*IntegraNet* may request that providers submit additional documentation, including medical records or other documentation not directly related to the member, to support claims submitted by the provider. If documentation is not provided following the request

or notification, or if documentation does not support the services billed for the episode of care, *IntegraNet* may:

• Deny the claim.

• Recover and/or recoup monies previously paid on the claim.

*IntegraNet* is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.

**Diagnosis-Related Group (DRG) Inpatient Facility Transfers**

In compliance with federal guidelines regarding facility transfers payment, *IntegraNet* allows payment for services rendered by both the sending and the receiving facility when a patient is admitted to one acute care facility and subsequently transferred to another acute care facility for same episode of care. *IntegraNet* uses the following criteria:

• Transferring facility receives a calculated per diem rate based on length of stay not to exceed the amount that would have been paid if the patient had been discharged to another setting

• Receiving facility receives full DRG payment

*IntegraNet* claims for members who leave against medical advice and are admitted to another acute care facility on the same day are considered transfers.

The appropriate discharge status code must be used on the transferring claim to indicate that the member was transferred from one acute care facility to another acute care facility.

Medicare Advantage Policy Update Inpatient Readmissions (Policy G-13001, effective 07/01/22) Effective July 1, 2022, when a member is readmitted within 30 days as part of a planned readmission and/or placed on a leave of absence, the admissions are considered to be one admission, and only one diagnosis-related group (DRG) will be reimbursed. For additional information, please review the Inpatient Readmission reimbursement policy at https://provider.IntegraNet.com/texas-provider/claims/reimbursement-policies

**DRG Newborn Inpatient Stays**

*IntegraNet* does not allow reimbursement for newborn inpatient stays with the appropriate normal newborn or sick baby diagnosis-related group code.

**Drugs and Injectable Limits**

*IntegraNet* will apply Clinical Unit Limits (CUL) to drugs that may be based on manufacturer's guidelines, U.S. Food and Drug Administration (FDA) approval, and/or code description unless provider, federal or CMS contracts and/or requirements indicate otherwise.

Drug claims must be submitted as required with applicable HCPCS or CPT procedure code(s), National Drug Codes (NDC), appropriate qualifier, unit of measure, and number of units. Units should be reported in the multiples included in the code descriptor used for the applicable HCPCS codes.

Reimbursement will be considered up to the CUL or state-mandated limits or CMS Medically Unlikely Edit (MUE) allowed for the prescribed/administered drug. When there is no MUE assigned by CMS, identified codes will have a CUL assigned or calculated based on the prescribing information, the FDA and established reference compendia.

Claims that exceed the CUL will be reviewed for documentation to support the additional units. If the documentation does not support the additional units billed, the additional units will be denied.

**Duplicate or Subsequent Services on the Same Date of Service**

*IntegraNet* allows reimbursement of a duplicate or subsequent service provided on the same date of service if billed with an appropriate modifier or with additional units, as applicable within benefit limits unless otherwise noted by provider, state, federal or CMS contracts and/or requirements.

Reimbursement of a duplicate or subsequent service

Reimbursement of duplicate or subsequent services is based on the correct usage of the below modifiers which indicate the service was appropriately repeated or additionally billed for the same member:

• Modifier 62: Co-Surgeons

• Modifier 66: Surgical Teams

• Modifier 76: Repeat Procedure by the Same Physician

• Modifier 77: Repeat Procedure by Another Physician

• Modifier 80: Assistant at Surgery Providing Full Assistance to the Primary Surgeon

• Modifier 81: Assistant at Surgery Providing Minimal Assistance to the Primary Surgeon

• Modifier 82: Assistant at Surgery, when a Qualified Resident Surgeon is not Available to Assist the Primary Surgeon

• Modifier AS: Assistant at Surgery who is a Nonphysician (e.g., physician assistant or nurse practitioner)

• Modifier 91: Repeat Clinical Diagnostic Laboratory Test

• Modifier GG: Performance and Payment of a Screening Mammogram and Diagnostic Mammogram on the Same Patient, Same Day

• Modifier GH: Diagnostic Mammogram Converted from Screening Mammogram on Same Day

*IntegraNet* may deny a duplicate or subsequent service provided on the same date of service, billed on the same or separate claims, unless billed with an appropriate modifier.

*IntegraNet* will review claims billed with suspected duplicate or subsequent services. Claims will be denied for services determined to be duplicate or subsequent claims without the appropriate modifier.

Reimbursement of bundled services

When a service is unbundled from a more complex or comprehensive service and billed individually on the same date of service as the more comprehensive service:

• The claim line for the individual service will be denied through code editing if billed on the same claim.

• The claim will be reviewed if billed on separate claims.

The following modifiers indicate an individual service is distinct and separate from the more comprehensive service:

• Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

• Distinct Procedural Services (Modifiers 59, XE, XP, XS, XU)

Note: Refer to specific modifier policies for applicability to individual states.

## Emergency Services: Nonparticipating Providers and Facilities

*IntegraNet* allows reimbursement for emergency services provided by nonparticipating professional providers and facilities unless provider, state, federal or CMS contracts

and/or requirements indicate otherwise. Unless otherwise required by federal regulation and/or contract, reimbursement is based on no more than the amount that would have been reimbursed to the provider if the beneficiary were enrolled in original Medicare.

*IntegraNet* adheres to the requirements of the Emergency Medical Treatment and Labor Act (EMTALA). *IntegraNet* will not limit consideration of reimbursement for emergency services on the basis of lists of diagnoses or symptoms; however, additional medical record documentation may be required in order to clearly identify and determine appropriate reimbursement of emergency services.

Claims for emergency services are subject to the Medicare Advantage Eligible Billed Charges, Code and Clinical Editing Guidelines, and Claims Requiring Additional Documentation reimbursement policies of *IntegraNet*.

## Facility Take-Home DME and Medical Supplies

*IntegraNet* does not allow reimbursement of durable medical equipment (DME) and medical supplies dispensed by a facility for take-home use for inpatient or outpatient hospital facilities. Facility claims submitted for DME and medical supplies billed with revenue codes denoting take-home use will be denied.

To be considered for reimbursement, claims for take-home DME and medical supplies should be submitted by a DME/supply vendor. Reimbursement is based on the:

• Contract or negotiated rate for participating vendors.

• Out-of-network fee schedule or negotiated rate for nonparticipating vendors.

*IntegraNet* allows reimbursement of facility claims for medical supplies dispensed to the member at discharge and billed with revenue codes other than take-home for the following items:

• Crutches

• No more than 72 hours of medical supplies if the provider was not able to obtain supplies from a vendor by discharge.

**Global Surgical Package for Professional Providers**

*IntegraNet* allows reimbursement for the global surgical package unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

*IntegraNet* follows CMS global surgery values. The global surgery package may be furnished in any setting and reimbursement applies to both minor and major surgical procedures as defined by their postoperative periods of 0, 10 or 90 days.

**Included in the Global Surgical Package**

Reimbursement for the following components is included within the global surgical package:

 Preoperative services rendered after the decision is made to operate, beginning with the day before major procedures and the day of surgery for minor procedures

 Intraoperative services that are normally a usual and necessary part of a surgical procedure

 Visits during the postoperative periods that are related to recovery from the surgery regardless of location

 Treatment for all additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications, which do not require additional trips to the operating room and that are not categorized as a hospital-acquired condition or present on admission

 Postsurgical pain management by the surgeon

 Miscellaneous surgical services and supplies used during the surgery

**Unlisted Surgical Procedures Included in Global Package**

Reimbursement for an unlisted surgical procedure is based on the review of the unlisted code on an individual claim basis. Claims submitted with unlisted codes must contain the following information and/or documentation describing the procedure or service performed for consideration during review:

 A written description

 Office notes

 An operative report

**Add-On Surgical Procedures Included in Global Surgical Package**

The global surgical period for an add-on surgical procedure will be based on the primary surgical code.

**Separately Reimbursable from Global Surgical Package**

The following services are not included in the payment amount for the global surgery and are separately reimbursable expenses:

 The initial consultation or evaluation by the surgeon to determine the need for a major surgical procedure

 Services of other physicians except where the surgeon and the other physician(s) agree on the transfer of care — the agreement must be in the form of a letter or an annotation in the discharge summary, hospital record or Ambulatory Surgical Center (ASC) record

 Visits during the postoperative period of surgery that are unrelated to the diagnosis of the surgery unless the visits occur due to complications of the surgery

 Treatment for an underlying condition or an added course of treatment, which is not part of the normal recovery from surgery

 Diagnostic tests and procedures

 Clearly distinct surgical procedures during the postoperative period that are not reoperations or treatment for complications

 Treatment for postoperative complications which require a return trip to the operating room

 The second procedure if a less extensive procedure fails, and a more extensive procedure is required

 Immunosuppressive therapy for an organ transplant

 Critical care services unrelated to the surgery where a seriously injured or burned member is critically ill and requires constant attendance of the physician

Providers must use applicable HIPAA-compliant modifiers for any services provided during the postoperative period.

**Hysterectomy**

*IntegraNet* allows reimbursement of nonelective and medically necessary hysterectomy procedures for covered members unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. Reimbursement is based on the applicable fee schedule or contracted/negotiated rate.

*IntegraNet* considers reimbursement for a hysterectomy only when the following criteria is met:

• The hysterectomy is medically necessary to treat an illness or injury.

• The member has given informed consent.

• The member or authorized representative is fully aware that the hysterectomy will render the member permanently incapable of reproducing and has orally and in writing expressed this understanding.

• The member or authorized representative has signed and dated an applicable Consent/Acknowledgement of Hysterectomy Form. The form is required regardless of the member's diagnosis or age.

**Note:** If the member was already sterile before the hysterectomy or if the individual required a hysterectomy because of a life-threatening emergency situation in which the physician determined that prior consent/acknowledgement was not possible:

• The Consent/Acknowledgement of Hysterectomy Form with the physician's certification will be required.

• The member's informed consent/acknowledgement of hysterectomy will not be required.

*IntegraNet* does not require a Consent/Acknowledgement of Hysterectomy Form to be submitted with claims.

A valid Consent/Acknowledgement of Hysterectomy Form has to be properly executed and include all required signatures:

• Member, except as noted

• Person obtaining the member's consent

• The physician performing the hysterectomy

If a hysterectomy is performed in conjunction with a delivery, then multiple surgery guidelines apply (refer to the Anthem Medicare Advantage Multiple and Bilateral Surgery policy).

**Nonreimbursable:**

*IntegraNet* does not allow reimbursement of a hysterectomy in the following circumstances:

• The hysterectomy is performed for the sole purpose of rendering the member permanently incapable of reproduction.

• There is more than one reason for the hysterectomy, but the primary reason is to render the member permanently incapable of reproduction.

• The hysterectomy is performed for the purpose of cancer prophylaxis.

**Inpatient Readmissions**

*IntegraNet* does not allow separate reimbursement for claims that have been identified as a readmission to the same hospital for the same, similar, or related condition, unless provider, federal, or CMS contracts and/or requirements indicate otherwise. *IntegraNet* uses the following standards:

• Readmission up to 30 days from discharge

• Same or related condition

*IntegraNet* will utilize clinical criteria and/or licensed clinical medical review to determine if the subsequent admission is for:

• The same or closely related condition or procedure as the prior discharge.

• An infection or other complication of care.

• A condition or procedure indicative of a failed surgical intervention.

• An acute decompensation of a coexisting chronic disease.

• A need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post-discharge follow-up period.

• An issue caused by a premature discharge from the same facility.

Planned Readmission/Leave of Absence

When a member is readmitted within 30 days as part of a planned readmission and/or placed on a leave of absence, the admissions are considered to be one admission, and only one diagnosis-related group (DRG) will be reimbursed.

Providers are to submit one bill for covered days and days of leave when the patient is ultimately discharged.

Readmissions occurring within 30 days for symptoms related to, or for evaluation and management of, the prior stay's medical condition are considered part of the original admission. *IntegraNet* considers a readmission to the same hospital for the same, similar, or related condition on the same date of service to be a continuation of initial treatment.

*IntegraNet* defines same day as services rendered within a 24-hour period (from time of discharge to time of readmission) for participating providers.

*IntegraNet* reserves the right to recoup and/or recover monies previously paid on a claim that falls within the guidelines of a readmission for a same, similar, or related condition as defined above.

Exclusions:

• Admissions for the medical treatment of:

    o Cancer

    o Neonatal/Newborn

    o Obstetrical deliveries

    o Behavioral Health

    o Rehabilitation care

    o Sickle Cell Anemia

    o Transplants

• Patient transfers from one acute care hospital to another

• Patient discharged from the hospital against medical advice

This policy only affects those facilities reimbursed for inpatient services by a DRG methodology.

## Locum Tenens Physicians/Fee-for-Time Compensation

*IntegraNet* allows reimbursement of Locum Tenens physicians unless provider, state, or federal contracts and/or requirements indicate otherwise.

*IntegraNet* will reimburse the member's regular physician or medical group for all covered services provided by a Locum Tenens physician during the absence of the regular physician in cases where the regular physician pays the Locum Tenens physician on a per diem or similar fee-for-time basis.

Reimbursement to the regular physician or medical group is based on the applicable fee schedule or contracted/negotiated rate. The Locum Tenens physician may not provide services to a member for longer than a period of sixty (60) continuous days. Services included in a global fee payment are not eligible for separate reimbursement when provided by a Locum Tenens physician.

A member's regular physician or medical group should bill the appropriate procedure code(s) identifying the service(s) provided by the Locum Tenens physician with a Modifier Q6 appended to each procedure code.

## Maternity Services

*IntegraNet* allows reimbursement for global obstetrical codes once per period of a pregnancy (defined as 279 days) when appropriately billed by a single provider or provider group reporting under the same federal TIN unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

Reimbursement is based on all aspects of the global obstetric care package (antepartum, delivery and postpartum) being provided by the provider or provider group reporting under the same TIN. If a provider or provider group reporting under the same TIN does not provide all antepartum, delivery and postpartum services, global obstetrical codes may not be used, and providers are to submit for reimbursement only the elements of the obstetric package that were provided.

*IntegraNet* will not reimburse for duplicate or otherwise overlapping services during the course of the pregnancy.

**Global services**

If global, delivery only, delivery/postpartum, antepartum only or postpartum only services have been paid for the same pregnancy, a claim for global services may be denied or may cause a previously paid claim to be recouped for overlapping services.

**Delivery only**

If global, delivery only or delivery/postpartum services have been paid for the same pregnancy, a claim for delivery only services may be denied. Delivery only services will be separately reimbursed to assistant surgeons only for cesarean deliveries if appended with the appropriate modifier.

**Delivery/postpartum**

If global, delivery only, delivery/postpartum, or postpartum only services have been paid during the same pregnancy, a claim for delivery/postpartum services may be denied or may cause a previously paid claim to be recouped for overlapping services.

**Antepartum only**

If global or antepartum only services have been paid during the same pregnancy, a claim for antepartum only services may be denied.

**Postpartum only**

Postpartum only claims may be denied if global, delivery/postpartum, or postpartum only services have already been paid during the same pregnancy.

**Included in the global package**

The following elements of the global package are not separately reimbursable when any CPT code for global services is billed:

 Initial and subsequent history and physical exams when pregnancy diagnosis has already been established

 All routine prenatal visits until delivery (typically monthly through 28 weeks, then biweekly until 36 weeks and weekly until delivery) — usually 13 visits

 Additional visits for a high-risk pregnancy, potential problems or history of problems that do not actually develop or are inactive in the current pregnancy

 Collection of weight, blood pressure and fetal heart tones

 Routine urinalysis

 Admission to the hospital including history and physical

 Inpatient evaluation and management (E/M) services that occur within 24 hours of delivery

 Management of uncomplicated labor (including administration of labor inducing agents)

 Insertion of cervical dilators on the same date of the delivery

 Simple removal of cerclage

 Vaginal (including forceps or vacuum assisted delivery) or cesarean delivery of single gestation

 Delivery of placenta

 Repair of first- or second-degree lacerations

 Uncomplicated inpatient visits following delivery

 Routine outpatient E/M services within 6 weeks of delivery

 Discussion of contraception

 Postpartum care only

 Education on breastfeeding, lactation, exercise, or nutrition

**Not included in the global package**

The following services may be billed separately from the global obstetrical package:

 Initial E/M visit to diagnose pregnancy when activities in the antepartum record are not initiated

 Laboratory testing (excluding routine urinalysis)

 Additional antepartum E/M visits (in excess of 13) for a high-risk complication that is active in the current pregnancy, these additional visits are to be submitted for payment only at the time of delivery; these visits must be submitted with a Modifier 25 and an appropriate high-risk diagnosis

 Additional E/M visits for conditions unrelated to pregnancy; these visits may be reported as they occur and must clearly not be related to pregnancy

 Maternal or fetal echocardiography procedures

 Amniocentesis

 Chorionic villus sampling

 Fetal contraction stress testing and nonstress testing

 Biophysical profile

 Amnioinfusion

 Insertion of cervical dilator that occurs more than 24 hours before delivery

 Inpatient E/M encounters that occur more than 24 hours before delivery

 Management of surgical problems arising during pregnancy

 Care provided by maternal fetal medicine specialists

 Ultrasound — Refer to Maternity Ultrasound in the Outpatient Setting medical policy

 External cephalic version

**Antepartum/postpartum care**

Providers should use the appropriate E/M codes for antepartum and postpartum care. *IntegraNet* reserves the right to request medical documentation to perform post-pay review of paid claims.

**Outcome of delivery/weeks of gestation**

Providers are required to use the appropriate diagnosis code on professional delivery service claims to indicate the outcome of delivery. Diagnosis codes that indicate the applicable gestational weeks of pregnancy are required on all professional delivery service claims and are recommended for all other pregnancy-related claims. Failure to report the appropriate diagnosis code will result in denial of the claim.

**Maximum Units Per Day**

*IntegraNet* allows reimbursement for a procedure or service that is billed for a single member, on a single date of service, by the same provider and/or provider group up to the maximum number of units allowed per day unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

When the number of units assigned to a procedure or service exceeds the daily maximum allowed, the units billed more than the maximum per day limit will not be eligible for reimbursement.

When a provider appropriately bills units that exceed the maximum units allowed, documentation must be provided for consideration of reimbursement.

Maximum units per day edits do not affect National Correct Coding Initiative (NCCI) edits. For more information on NCCI edits, please see our Code and Clinical Editing reimbursement policy.

Note: The maximum units per day are based on claims data analysis.

**Medical Recalls**

*IntegraNet* does not allow reimbursement for repair or replacement of items due to a medical recall unless provider, state, federal, CMS contracts and/or requirements indicate otherwise. The following are applicable items:

 Durable medical equipment

 Supplies

 Prosthetics

 Orthotics

 Drugs/vaccines

*IntegraNet* will allow reimbursement of medically necessary procedures to remove and replace recalled or replaced devices. *IntegraNet* will not be responsible for the full cost of a replaced device if an inpatient or outpatient facility is receiving a partial or full credit for a device due to recall. Payment will be reduced by the amount of the device credit.

*IntegraNet* will:

 Participate and provide any applicable documentation required in any applicable class action lawsuits due to a medical recall.

 Supply providers with medical recall information for dissemination to applicable members.

In circumstances where *IntegraNet* has reimbursed the provider for repair or replacement of items, or procedures related to items due to a medical recall, *IntegraNet*

is entitled to recoup or recover fees from the manufacturer and/or distributor, as applicable.

In circumstances where *IntegraNet* has reimbursed the provider the full or partial cost of a replaced device and the provider received a full or partial credit for the device, *IntegraNet* is entitled to recoup or recover fees from the provider.

In applicable circumstances, providers should bill the appropriate condition code, value code, modifier and/or diagnosis code to identify a medically recalled item.

**Modifier 22: Increased Procedural Service**

*IntegraNet* allows reimbursement for procedure codes appended with Modifier 22 unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

*IntegraNet* performs prepayment review to support the use of Modifier 22. If medical review of the documentation submitted with the claim supports the use of Modifier 22, reimbursement is based on 120% of the fee schedule or contracted/negotiated rate. The use of Modifier 22 should follow correct coding guidelines for claims submission.

Note: Modifier 22 is allowed with surgical procedures identified with a global period of 000, 010, 090 or YYY.

**Modifier 24: Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Healthcare Professional During the Postoperative Period**

*IntegraNet* allows limited reimbursement for physician or other qualified healthcare professional claims billed with Modifier 24 unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

Reimbursement is based on 100% of the applicable fee schedule or contracted/negotiated rate for the evaluation and management (E&M) service performed during the postoperative period of the original procedure if the following criteria are met:

 The appropriate level of E&M service is billed and appended with Modifier 24.

 A diagnosis code unrelated to the original procedure is indicated for the E&M service.

 The reason for the E&M service is clearly documented in the member’s medical record.

Failure to use Modifier 24 correctly may result in denial of the E&M service and/or claim payments may be recouped and/or recovered.

**Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service**

*IntegraNet* allows separate reimbursement for significant, separately identifiable evaluation and management (E&M)

services billed with Modifier 25 unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

Reimbursement is based on 100 percent of the applicable fee schedule or contracted/negotiated rate for the significant, separately identifiable E&M service performed by the same provider on the same day of the original service or procedure if all the following criteria are met:

• The appropriate level of E&M service is billed.

• Modifier 25 is appended to the E&M service, which is above and beyond the other service or procedure provided (including usual preoperative and postoperative care associated with the procedure).

• The reason for the E&M service is clearly documented in the member's medical record.

• The documentation supports that the member's condition required the significantly separate E&M service.

Failure to use Modifier 25 correctly may result in denial of the E&M service. *IntegraNet* reserves the right to perform post payment review of claims submitted with Modifier 25.

**Modifier 26 and TC: Professional and Technical Component**

*IntegraNet* allows reimbursement of the professional component and technical component of a global procedure or service when appended with Modifier 26 and Modifier TC unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise. Reimbursement is based on the following:

 The applicable fee schedule or contracted/negotiated rate

 Physician specialty and the place of service code submitted with the claim

**Professional Component (Modifier 26)**

The professional component is used to indicate when a physician or other qualified healthcare professional renders only the professional component of a global procedure or service. When reported separately, the professional component is denoted by adding Modifier 26 to the applicable procedure code.

**Technical Component (Modifier TC)**

When reported separately, the technical component is denoted by adding Modifier TC to the applicable procedure code. Services or procedures billed by a physician or other qualified healthcare professional that are performed in a facility, as defined in Exhibit A below, will not be reimbursed for the global procedure or the technical component (Modifier TC). Only the facility may be reimbursed for the technical component of the service or procedure. The physician or other qualified healthcare professional may be reimbursed only for the professional component (Modifier 26) of the service or procedure and, if applicable, should make an arrangement with the facility for reimbursement to perform any technical components of a service or procedure.

Portable X-ray suppliers should bill only for the technical component by appending Modifier TC.

**Global Procedure**

In the absence of Modifier TC and Modifier 26, *IntegraNet* will allow reimbursement of the global procedure if the same physician or other qualified health care professional performed both the professional component and technical component of that service.

**Nonreimbursable**

*IntegraNet* does not allow reimbursement for use of Modifier 26 or Modifier TC when it is reported with an evaluation and management code.

*IntegraNet* reserves the right to perform postpayment review of claims submitted with Modifier 26 or Modifier TC. *IntegraNet* may request additional documentation or notify the provider of additional documentation required for claims, subject to contractual obligations. If documentation is not provided following the request or notification, *IntegraNet* may recoup or recover monies previously paid on the claim as the provider failed to submit required documentation for post payment review.

**Modifier 57: Decision for Surgery**

*IntegraNet* allows separate reimbursement for an evaluation and management (E&M) visit provided on the day prior to or the day of a major surgery when it is billed with Modifier 57 to indicate the E&M visit resulted in the initial decision to perform the

major surgical procedure unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. A major surgery has a 90-day global period.

Reimbursement for the E&M visit is based on 100% of the applicable fee schedule or contracted/negotiated rate. *IntegraNet* reserves the right to request medical records for review to support payment for the E&M visit. Failure to use this modifier when appropriate may result in denial of the claim for the visit.

**Nonreimbursable**

*IntegraNet* does not allow reimbursement for services billed with Modifier 57 in the following circumstances unless federal or CMS contracts and/or requirements indicate otherwise:

• An E&M visit the day before or day of the surgery when the decision to perform the surgery was made prior to the E&M visit

• An E&M visit for minor surgeries (0- or 10-day global period) — Since the decision to perform a minor surgery is usually reached the same day or day before the procedure, it is considered a routine preoperative service.

• A service billed with CPT code other than an E&M code

**Modifier 62: Co-Surgeons**

*IntegraNet* allows reimbursement of procedures eligible for co-surgeons when billed with Modifier 62 unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

Reimbursement to each surgeon is based on 62.5% of the applicable fee schedule or contracted/negotiated rate. Co-surgeons must be from different specialties and performing surgical services during the same operative session. However, *IntegraNet* does not consider surgeons performing different procedures during the same surgical session as co-surgeons, and Modifier 62 is not required.

Each surgeon must bill the same procedure code(s) with Modifier 62, when applicable. If one or both surgeons fail to use the modifier appropriately, it is possible that one surgeon may receive 100% of the applicable fee schedule or negotiated/contracted rate,

and the other surgeon's claim may be denied or pended due to a duplicate or suspected duplicate service, respectively.

Assistant surgeon and/or multiple procedures rules and fee reductions apply if:

• A co-surgeon acts as an assistant in performing additional procedure(s) during the same surgical session

Note: Assistant surgeon rules do not apply to procedures appropriately billed with Modifier 62.

• Multiple procedures are performed

**Modifier 63: Procedure Performed on Infants Less Than 4 kg**

*IntegraNet* allows reimbursement for surgery on neonates and infants up to a present body weight of 4 kg when billed with Modifier 63 unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

Reimbursement is based on 100% of the applicable fee schedule or contracted/negotiated rate for the procedure code when the modifier is valid for services performed. The neonate weight should be documented clearly in the report for the service.

When an assistant surgeon is used and/or multiple procedures are performed on neonates or infants less than 4 kg in the same operative session, assistant surgeon and/or multiple procedure rules and fee reductions apply.

**Nonreimbursable**

*IntegraNet* does not allow reimbursement for Modifier 63 billed in the following circumstances:

• For facility billing

• With evaluation and management (E/M) codes

• With anesthesia codes

• With radiology codes

• With pathology/laboratory codes

• With medicine codes (other than those appropriate for the modifier)

• With Modifier 63-exempt codes

• In addition to Modifier 22 (Unusual Services) for the same procedure code(s)

• With codes denoting invasive procedures that include neonate or infant in the description since the reimbursement rate for the code already reflects the additional work

**Modifier 66: Surgical Teams**

*IntegraNet* allows reimbursement of procedures eligible for surgical teams when billed with Modifier 66 unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

Each physician participating in the surgical team must bill the applicable procedure code(s) for their individual services with Modifier 66. If any or all physicians participating in the surgery fail to use the modifier appropriately, claims may be denied or pended for duplicate or suspected duplicate services, respectively.

Multiple procedure rules and fee reductions apply if the surgical team performs multiple procedures unless surgeons of different specialties are each performing a different procedure. Assistant surgery rules and fee reductions apply if any member of the surgical team acts as an assistant performing additional procedure(s) during the same surgical session.

Note: Assistant surgeon rules do not apply to procedures appropriately billed with Modifier 66.

*IntegraNet* performs a prepayment review to support the use of Modifier 66. Providers must submit documentation with claims billed with Modifier 66. Claims submitted without documentation will be denied.

**Modifier 76: Repeat Procedure by the Same Physician**

*IntegraNet* allows reimbursement for applicable procedure codes appended with Modifier 76 to indicate a procedure or service was repeated by the same physician:

 Subsequent to the original procedure or service for professional provider claims

 On the same date as the original procedure or service for facility claims

Unless provider, state, federal or CMS contracts and/or requirements indicate otherwise, reimbursement is based on the following use of Modifier 76:

 For a nonsurgical procedure or service: 100% of the applicable fee schedule or contracted/negotiated rate

 For a surgical procedure: 100% of the applicable fee schedule or contracted/negotiated rate for the surgical component only limited to a total of two surgical procedures

Professional services, other than radiology, will be subject to clinical review for consideration of reimbursement. Providers must submit supporting documentation for the use of Modifier 76 with the claim. If a claim is submitted with Modifier 76 without supporting documentation, the claim will be denied. Providers will be asked to submit the required documentation for reconsideration of reimbursement. Failure to use Modifier 76 when appropriate may result in denial of the procedure or service.

If a repeated surgical procedure is performed with an assistant surgeon or in conjunction with multiple surgeries, assistant surgeon and/or multiple procedure rules and fee reductions apply.

**Nonreimbursable**

*IntegraNet* does not allow reimbursement for use of Modifier 76:

 With an inappropriate procedure code

o Evaluation and management codes

o Laboratory codes

 For any procedure repeated more than once

 For the preoperative or postoperative components of a surgical procedure

**Modifier 77: Repeat Procedure by Another Physician**

*IntegraNet* allows reimbursement for applicable procedure codes appended with Modifier 77 to indicate a procedure or service was repeated by another physician:

 Subsequent to the original procedure or service for professional claims.

 On the same date as the original procedure or service for facility claims.

Unless provider, state, federal or CMS contracts and/or requirements indicate otherwise, reimbursement is based on the following use of

**Modifier 77:**

 For a nonsurgical procedure or service: 100% of the applicable fee schedule or contracted/negotiated rate

 For a surgical procedure: 100% of the applicable fee schedule or contracted/negotiated rate for the surgical component only limited to a total of two surgical procedures.

Professional services, other than radiology, will be subject to clinical review for consideration of reimbursement. Providers must submit supporting documentation for the use of Modifier 77 with the claim. If a claim is submitted with Modifier 77 without supporting documentation, the claim will be denied. Providers will be asked to submit the required documentation for reconsideration of reimbursement. Failure to use Modifier 77 when appropriate may result in denial of the procedure or service.

If a repeated surgical procedure is performed with an assistant surgeon or in conjunction with multiple surgeries, assistant surgeon and/or multiple procedure rules and fee reductions apply.

**Nonreimbursable**

*IntegraNet* does not allow reimbursement for use of Modifier 77:

 With an inappropriate procedure code.

 For any procedure repeated more than once.

 For the preoperative or postoperative components of a surgical procedure.

 When appended to evaluation and management code.

**Modifier 78: Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative**

*IntegraNet* allows reimbursement for claims billed with Modifier 78 unless provider, federal or CMS contracts and/or requirements indicate otherwise, when the following criteria are met:

• The return to the operating or procedure room is unplanned.

• The procedure appended with Modifier 78 is:

  - o The appropriate surgical code for the procedure performed.
  - o Performed by the same physician who provided the initial procedure.
  - o Related to the initial procedure.
  - o Performed during the postoperative period of the initial procedure.

Reimbursement is based on a percentage calculated by the Medicare Physician's Fee Schedule database when the modifier is valid for services performed. Reimbursement is based on the surgical procedure only, not including preoperative or postoperative care. Procedures rendered during the postoperative period and not billed with Modifier 78 are normally denied as included in the global surgical package.

When an assistant surgeon is used during the global period in the same operative session, assistant surgeon rules apply.

**Nonreimbursable**

*IntegraNet* does not allow reimbursement for Modifier 78 billed in the following circumstances including, but not limited to:

• With nonsurgical codes.

• With codes denoting subsequent, related or redo in the description.

**Modifier 90: Reference (Outside) Laboratory and Pass-Through Billing**

*IntegraNet* does not allow pass-through billing for lab services. Claims appended with Modifier 90 in a place of service 11 (Office) will be denied unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

Reimbursement will be made directly to the laboratory that performed the clinical diagnostic laboratory test based on 100% of the applicable fee schedule or contracted/negotiated rate.

Note: This policy does not apply to laboratory and pathology providers allowed to bill in place of service 11 (Office).

**Repeat Clinical Diagnostic Laboratory Test**

*IntegraNet* allows reimbursement of claims for repeat clinical diagnostic laboratory tests appended with Modifier 91 unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

Reimbursement is based on 100% of the applicable fee schedule or contracted/negotiated rate of the clinical diagnostic laboratory test billed with Modifier 91.

Medical documentation may be requested to support the use of Modifier 91. It is inappropriate to use Modifier 91 when only a single test result is required.

Failure to use the modifier appropriately may result in denial of the repeated laboratory test as a duplicate service.

**Modifiers LT and RT: Left Side/Right Side Procedures**

*IntegraNet* allows reimbursement for procedure codes appended with Modifier LT and/or RT when indicating the side of the body for which the item, supply or procedure will be used unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

Reimbursement is based on 100 percent of the fee schedule or contracted/ negotiated rate of the procedure. Modifiers LT and RT are informational and do not affect reimbursement of the procedure.

It is inappropriate to use Modifier LT or Modifier RT when billing for bilateral procedures, or with procedure codes containing bilateral or unilateral or bilateral in their description. Modifiers LT and RT do not indicate a bilateral service. Claims submitted with Modifier LT and RT appropriately indicating a surgical procedure was performed on both the left side and right side of the body are subject to multiple surgery rules.

**Modifier Usage**

*IntegraNet* allows reimbursement for covered services provided to eligible members when billed with appropriate procedure codes and appropriate modifiers when applicable unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

Reimbursement is based on the code-set combinations submitted with the correct modifiers. The use of certain modifiers requires the provider to submit supporting documentation along with the claim. Refer to the specific modifier policies for guidance

on documentation submission. *IntegraNet* reserves the right to review adherence to correct coding for high-volume modifiers.

Applicable electronic or paper claims billed without the correct modifier in the correct format may be rejected or denied. The modifier must be in capital letters, if alpha or alphanumeric. Rejected or denied claims must be resubmitted with the correct modifier in conjunction with the code-set to be considered for reimbursement. Corrected and resubmitted claims are subject to timely filing guidelines. The use of correct modifiers does not guarantee reimbursement.

**Reimbursement modifiers**

Reimbursement modifiers (Exhibit A) affect payment and denote circumstances when an increase or reduction is appropriate for the service provided. The modifiers must be billed in the primary or first modifier field locator.

**Informational modifiers impacting reimbursement**

Informational modifiers determine if the service provided will be reimbursed or denied. Modifiers that impact reimbursement should be billed in modifier locator fields after reimbursement modifiers, if any.

**Informational modifiers not impacting reimbursement**

Informational modifiers are used for documentation purposes. Modifiers that do not impact reimbursement should be billed in the subsequent modifier field locators. *IntegraNet* reserves the right to reorder modifiers to reimburse correctly for services provided.

**Multiple Delivery Services**

*IntegraNet* allows reimbursement for multiple births by a same-delivery or combined-delivery method unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. For vaginal or cesarean deliveries involved in multiple births and performed using a same-delivery or combined-delivery method, professional reimbursement is based on the following rules:

• Vaginal Deliveries — Vaginal deliveries involved in multiple births should be billed with Modifier 51. Multiple procedure guidelines will apply. (Please see Multiple and Bilateral Surgery reimbursement policy for more information.)

• Cesarean Deliveries — Cesarean deliveries involved in multiple births should be billed with Modifier 22. (Please see Modifier 22 reimbursement policy for more information.) Multiple procedure guidelines will not apply.

## Multiple Radiology Payment Reduction

*IntegraNet* allows professional and facility reimbursement for multiple diagnostic imaging procedures unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. Multiple diagnostic imaging procedures will be subject to a multiple procedure payment reduction when services are performed by the same provider or provider group on the same date of service during the same member encounter. CT scan services are not subject to a multiple procedure payment reduction.

The global, Professional Component and Technical Component of diagnostic imaging procedures will reimburse at 100% of the contracted/negotiated rate for each Professional Component and Technical Component service with the highest allowance. Reimbursement of subsequent procedures is based on:

- 95% of the Professional Component.

- 50% of the Technical Component.

A reduced allowance for the second and subsequent procedures will not apply when multiple imaging procedures are reported with modifier 59 or X{EPSU} to indicate the procedure was done on the same day but not during the same session.

A single imaging procedure is subject to the multiple imaging reductions when submitted with multiple units.

## New Patient Billing

*IntegraNet* will only reimburse ***one*** Initial Visit CPT/ HCPCS Code during the same patient encounter for Annual Routine Physical service( 99381-99387) and Same Day New Patient E/M 99202-99205. However, when appropriate IntegraNet will allow i.e. a separate reimbursement for an established patient visit (99212-99215).

## Nurse Practitioner and Physician Assistant Services

*IntegraNet* allows reimbursement for services provided by Nurse Practitioner (NP) and Physician Assistant (PA) providers. Unless provider, state, federal or CMS contracts and/or requirements indicate otherwise, reimbursement is based upon all of the following:

- Service is considered a physician’s service

- Service is within the scope of practice

- A payment reduction consistent with CMS reimbursement

Services furnished by the NP or PA should be submitted with their own NPI.

## Portable Mobile Handheld Radiology Services

*IntegraNet* allows reimbursement for portable/mobile radiology services when furnished in a residence used as the patient's home and if ordered by a physician and performed by qualified portable radiology suppliers unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise. Portable/mobile radiology studies should not be performed for reasons of convenience. Reimbursement is based on the applicable fee schedule or contracted/negotiated rate for the radiological service, and transportation and setup components with the use of applicable modifiers. *IntegraNet* allows preventive screenings performed by portable/mobile radiology studies for routine purposes.

**Note:** Portable radiology suppliers must be licensed or registered to perform services as required by applicable laws.

## Transportation and Setup

*IntegraNet* allows reimbursement for transportation and setup of portable radiology equipment when transported to the member's residence. Transportation costs are payable when the portable X-ray equipment used was actually transported to the location where the X-ray was taken. Reimbursement for the setup cost of portable radiology equipment is separately reimbursable.

Reimbursement for transportation is based on a single payment for each particular location regardless of the number of members receiving radiological services. For services provided to more than one member, the transportation cost is divided by the total number of members receiving services at that location. If more than one member receives portable radiology services, providers must bill according to the Related Coding section. No modifier is required when only one member is served.

## Nonreimbursable

*IntegraNet* does not allow reimbursement for transportation costs of equipment stored for use as needed at any location qualifying as a member's residence.

If the diagnostic X-rays are not covered, payment will not be made for the transportation and setup fee.

## Handheld Radiology

The use of handheld radiology instruments is allowed. Reimbursement will be part of the physician's professional service, and no additional charge will be paid. The technical components for handheld radiology are not separately reimbursable.

**Preadmission Services for Inpatient Stays**

*IntegraNet* allows reimbursement for applicable services for a covered member prior to admission to an inpatient hospital (referred to as the payment window) unless provider, state, federal or CMS contracts and/or requirements indicate otherwise, based on CMS guidance as follows:

 For admitting hospitals, preadmission services are included in the inpatient reimbursement for the three days prior to and including the day of the member's admission and, therefore, are not separately reimbursable expenses. This includes any entity wholly owned or wholly operated by the admitting hospital or by another entity under arrangements with the admitting hospital.

 For the following other hospitals and units, preadmission services are included in the inpatient reimbursement within one-day prior to and including the day of the member's admission and, therefore, are not separately reimbursable expenses:

- o Psychiatric hospitals and units
- o Inpatient rehabilitation facilities and units
- o Long-term care hospitals
- o Children's hospitals
- o Cancer hospitals

 For critical access hospitals, preadmission services are not subject to either the three-day or one-day payment window and, therefore, are separately reimbursable expenses from the inpatient stay reimbursement.

 The three-day or one-day payment window does not apply to preadmission services included in the rural health clinic or federally qualified health center all-inclusive rate.

**Preadmission services**

Preadmission services are included in the inpatient reimbursement and consist of all diagnostic outpatient services and admission-related outpatient nondiagnostic services.

A hospital may attest to specific nondiagnostic services as being unrelated by adding a condition code 51 to the outpatient nondiagnostic service to be billed separately. Providers should append Modifier PD to diagnostic and nondiagnostic services that are subject to the preadmission payment window.

**Outside payment window**

*IntegraNet* does not consider the following services to be included in the payment window prior to an inpatient stay for preadmission services:

- Ambulance services
- Maintenance renal dialysis services
- Donor post-kidney transplant complication services
- Services provided by:
    - Skilled nursing facilities
    - Home health agencies
    - Hospices
- Unrelated diagnostic services and nondiagnostic services (e.g., not directly related to the inpatient stay)

**Note:** These services may be considered for separate outpatient reimbursement.

**Preventive Medicine and Sick Visits on the Same Day**

*IntegraNet* allows reimbursement for preventive medicine and sick visits on the same day, unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. Reimbursement is based on the fee schedule or contracted/negotiated rate for the preventive medicine and the allowed sick visit under the following conditions:

• Modifier 25 must be billed with the applicable evaluation and management code for the allowed sick visit — If Modifier 25 is not billed appropriately, the sick visit will be denied.

• Appropriate diagnosis codes must be billed for respective visits.

Federally qualified health centers and rural health centers reimbursed other than through *IntegraNet*'s fee schedule or state encounter rates are not subject to this policy.

**Professional Anesthesia Services**

*IntegraNet* allows reimbursement of anesthesia services rendered by professional providers for covered members unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. Reimbursement is based upon:

 The reimbursement formula for the allowance and time increments in accordance with CMS.

 Proper use of applicable modifiers.

Providers must report anesthesia services in minutes. Anesthesia claims submitted with an indicator other than minutes may be rejected or denied. Start and stop times must be documented in the member's medical record. Anesthesia time starts with the preparation of the member for administration of anesthesia and stops when the anesthesia provider is no longer in personal and continuous attendance. The reimbursement formula for anesthesia allowance is based on CMS guidelines.

**Anesthesia Modifiers**

Anesthesia modifiers are appended to the applicable procedure code to indicate the specific anesthesia service or who performed the service. Modifiers identifying who performed the anesthesia service must be billed in the primary modifier field to receive appropriate reimbursement. For additional or reduced payment for modifiers, *IntegraNet* will default to the following CMS guidelines. Claims submitted for anesthesiology services without the appropriate modifier will be denied. Please review below for reimbursement information for specific anesthesia modifiers.

**Multiple Anesthesia Procedures**

*IntegraNet* allows reimbursement for professional anesthesia services during multiple procedures. Reimbursement is based on the anesthesia procedure with the highest base unit value and the overall time of all anesthesia procedures.

**Obstetrical Anesthesia**

*IntegraNet* allows reimbursement for professional neuraxial epidural anesthesia services provided in conjunction with labor and delivery for up to 300 minutes by either the delivering physician or a qualified provider other than the delivering physician based on the time the provider is physically present with the member. Providers must submit additional documentation upon dispute for consideration of reimbursement of time more than 300 minutes. Reimbursement is based on one of the following:

 For the delivering physician — based on a flat rate or fee schedule using the surgical CPT pain management codes for epidural analgesia

 For a qualified provider other than the delivering physician — based on:

- The allowance calculation
- The inclusion of catheter insertion and anesthesia administration

**Services Provided in Conjunction with Anesthesia**

*IntegraNet* allows separate reimbursement for the following services provided in conjunction with the anesthesia procedure or as a separate service. Reimbursement is based on the applicable fee schedule or contracted/negotiated rate with no reporting of time.

 Swan-Ganz catheter insertion

 Central venous pressure line insertion

 Intra-arterial lines

 Emergency intubation (must be provided in conjunction with the anesthesia procedure to be considered for reimbursement)

 Critical care visits

 Transesophageal echocardiography

**Nonreimbursable**

*IntegraNet* does not reimburse for:

 Use of patient status modifiers or qualifying circumstances codes denoting additional complexity levels.

 Anesthesia consultations on the same date as surgery or the day prior to surgery, if part of the preoperative assessment.

 Anesthesia services performed for noncovered procedures, including services considered not medically necessary, experimental and/or investigational.

 Anesthesia services by the provider performing the basic procedure, except for a delivering physician providing continuous epidural analgesia.

 Local anesthesia considered incidental to the surgical procedure.

 Standby anesthesia services.

**Reimbursement for Reduced and Discontinued Services**

*IntegraNet* allows reimbursement to professional providers and facilities for reduced or discontinued services when appended with the appropriate modifier unless provider,

state, federal or CMS contracts and/or requirements indicate otherwise. The following modifiers can be appended for reduced and discontinued services, if applicable:

 Modifier 52: indicates surgical procedures for which services performed are partially reduced or eliminated; reimbursement is reduced to 50 percent of the applicable fee schedule or contracted/negotiated rate; do not report Modifier 52 on evaluation and management (E&M) and consultation codes

 Modifier 53: indicates the physician elected to terminate a surgical or diagnostic procedure due to extenuating circumstances or that threatened the well-being of the patient; reimbursement is reduced to 50 percent of the applicable fee schedule or contracted/negotiated rate; Modifier 53 is not applicable for facility billing and is not valid when billed with E&M or time-based codes

 Modifier 73: indicates the physician cancelled the surgical or diagnostic procedure prior to administration of anesthesia and/or surgical preparation of the patient; reimbursement is reduced to 50 percent of the applicable fee schedule or contracted/negotiated rate; Modifier 73 is not applicable for professional provider billing

 Modifier 74: indicates a procedure was stopped after the administration of anesthesia or after the procedure was started; reimbursement is 100 percent of the applicable fee schedule or contracted/negotiated rate; Modifier 74 is not applicable for professional provider billing

If the reduced or discontinued procedure is performed with an assistant surgeon or in conjunction with multiple surgeries, assistant surgeon and/or multiple procedure rules and fee reductions apply. We reserve the right to perform post-payment review of claims submitted with Modifiers 52, 53, 73 and 74.

**Eligible Billed Charges**

Eligible charges mean charges billed by the provider subject to conditions and requirements which make the service eligible for reimbursement. *IntegraNet* allows reimbursement of eligible charges unless provider, federal or CMS contracts and/or requirements indicate otherwise. Eligibility for reimbursement of the billed service is dependent upon application of the following conditions and requirements:

• Member program eligibility

• Provider program eligibility

• Benefit coverage

• Authorization requirements

• Provider manual guidelines

• *IntegraNet* administrative policies

• *IntegraNet* clinical policies

• *IntegraNet* reimbursement policies

• Code editing logic

The allowed amount reimbursed for the eligible charge is based on the applicable fee schedule or contracted/negotiated rate after application of coinsurance, copayments, deductibles, and coordination of benefits.

*IntegraNet* will not reimburse providers for:

• Items the provider receives free of charge.

• Items the provider provides to the member free of charge.

In absence of clear language or specific reference to eligible charges in provider contracts, the use of the following terms will default to eligible charges as stated within this policy:

• Billed charges

• Covered charges

• Billed charges for covered services

• Allowed charges

• Percent of charge

**Claims with Charge Discrepancies**

*IntegraNet* does not allow reimbursement for claims submitted with an itemized statement where there is a discrepancy unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. Itemized claims with discrepancies or claims submitted that are not itemized and contain a discrepancy between the line item and the total amount billed will be denied and returned to the provider as an unclean claim. The provider will be required to resubmit a corrected claim for reimbursement.

**Reimbursement for Items Under Warranty**

*IntegraNet* does not allow reimbursement for repair or replacement of rented or purchased items during the warranty period designated by the applicable manufacturer unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

**Items include:**

 Durable medical equipment.

 Supplies.

 Prosthetics.

 Orthotics.

**The manufacturer and/or distributor is responsible for:**

 Repairing the item or providing an acceptable replacement item.

 All fees associated with shipment of the defective item.

 All fees associated with delivery of the repaired item.

In circumstances in which *IntegraNet* has reimbursed the provider for repair or replacement of an item during the warranty period, *IntegraNet* is entitled to recoup fees from the manufacturer and/or distributor holding the warranty. Providers are required to supply members with information concerning the manufacturer's warranty for all items dispensed to members.

 *IntegraNet* will consider reimbursement for replacement of the item through another manufacturer, after review, only in circumstances in which both the member and member's provider deem the manufacturer's replacement of the applicable item unacceptable. The design, materials, measurements, fabrications, testing, fitting, and training in the use of another manufacturer's replacement item are included in the reimbursement of the item and are not separately reimbursable expenses.

 If the manufacturer offers an acceptable reduced-price replacement, but either the member prefers another replacement at full price or a provider did not utilize the reduced-price offer, *IntegraNet* allows reimbursement only up to the cost of the reduced-price item under the prudent buyer rule.

 If the manufacturer offers an acceptable replacement, but imposes a charge or pro rata payment, *IntegraNet* allows reimbursement for the partial payment imposed by the manufacturer, subject to approval.

## Reimbursement of Sanctioned and Opt-Out Providers

*IntegraNet* does not allow reimbursement to providers who are excluded or debarred from participation in state and federal healthcare programs. *IntegraNet* also does not allow reimbursement to providers who have rendered services to members enrolled in any Medicare program if such provider has opted out from participation in Medicare. Services that are rendered by such a provider who is sanctioned or has opted out of participation in Medicare may only be reimbursed in urgent or emergent situations. Claims received for services other than emergency services submitted by sanctioned or opt-out providers as provided herein will be denied.

*IntegraNet* will allow reimbursement to a sanctioned or opt-out provider for emergency items or services only if the claim is accompanied by a sworn statement of the person furnishing the items or services specifying:

• The nature of the emergency.

• Why the items or services could not have been furnished by a provider eligible to furnish or order such items or services.

Modifier GJ is required on claims for emergency or urgent care services when rendered by an opt-out provider.

**Note:** Payment may not be made for services furnished by an opt-out physician or practitioner who has signed a private contract with a Medicare beneficiary for emergency or urgent care items.

*IntegraNet* screens providers through all applicable state and federal exclusion lists.

## Robotic Assisted Surgery

*IntegraNet* does not allow separate or additional reimbursement for the use of robotic surgical systems unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. Robotic surgical systems refer to robotic technology integral or optional in a surgical procedure. This policy applies to both professional and facility providers.

Robotic technique is considered included in the primary surgical procedure, and reimbursement will be based on the payment for the primary surgical procedure(s), regardless of any instruments, supplies, techniques, or approaches used in a procedure, or increase in operating room use.

**Note:** S2900- Surgical technique requiring use of robotic surgical system (list separately in addition to code for primary procedure). This code is not separately reimbursable.

## Scope of Practice

*IntegraNet* allows reimbursement for the performance of covered services that are within the provider's scope of practice under state law in accordance with CMS guidelines unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

The provider shall:

 Satisfy state and federal requirements for the performance of such service or procedure.

 Be licensed to perform the particular service or procedure by the state where the patient encounter occurs.

 Perform the service and procedure legally authorized to provide under his/her professional scope of license.

Services provided outside of a practitioner's scope of practice are not covered or reimbursable.

Nonparticipating Medicare providers will be reimbursed according to CMS guidelines.

## Reimbursement of Services with Obsolete Codes

*IntegraNet* does not allow reimbursement for services billed with obsolete codes, in compliance with industry standard coding practices according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Billing with obsolete codes is not HIPAA-compliant.

Claims submitted for services using obsolete codes will be denied. Providers must resubmit claims with applicable new or replacement codes to have services considered for reimbursement. Resubmitted claims are subject to claims timely filing guidelines.

## Split-Care Surgical Modifiers

*IntegraNet* allows reimbursement of surgical codes appended with split-care modifiers unless provider, federal or CMS contracts and/or requirements indicate otherwise. Reimbursement is based on a percentage of the fee schedule or contracted/negotiated rate for the surgical procedure. The percentage is determined by which modifier is appended to the procedure code:

• Modifier 54 (surgical care only): 80%

• Modifier 55 (postoperative management only): 20%

• Separate reimbursement for Modifier 56 not allowed

The global surgical package consists of preoperative services, surgical procedures and postoperative services. Total reimbursement for a global surgical package is the same regardless of how the billing is split between the different physicians involved in the member's care. When more than one physician performs services that are included in the global surgical package, the total amount reimbursed for all physicians may not be higher than what would have been paid if a single physician provided all services.

Correct coding guidelines require that the same surgical procedure code (with the appropriate modifier) be used by each physician to identify the services provided when the components of a global surgical package are performed by different physicians.

Claims received with split-care modifiers after a global surgical claim have been paid will be denied.

When an assistant surgeon is used and/or multiple procedures are performed, assistant surgeon and/or multiple procedure rules and fee reductions apply.

**Sterilization**

*IntegraNet* allows reimbursement of sterilization procedures performed for the purpose of rendering a member permanently incapable of reproducing unless provider, federal or CMS contracts and/or requirements indicate otherwise. Reimbursement is based on the applicable fee schedule or contracted/negotiated rate.

*IntegraNet* considers reimbursement of sterilization procedures based on the following guideline — The sterilization is a necessary part of the treatment of an illness or injury.

An informed consent form does not have to be submitted with claims.

A valid consent form must be properly executed and include all required signatures:

• Member or member's authorized representative

• Interpreter, if applicable

• Person obtaining the member's consent

• Physician performing the sterilization procedure

If a sterilization procedure is performed in conjunction with a delivery, then multiple surgery guidelines apply (refer to the *IntegraNet* Multiple and Bilateral Surgery policy).

**Sexually Transmitted Infections Testing — Professional**

*IntegraNet* allows reimbursement of sexually transmitted infection (STI) tests unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise. *IntegraNet* considers certain STI testing CPT codes to be part of a laboratory panel grouping. When *IntegraNet* receives a claim with two or more single tests laboratory procedure codes reported, we will bundle those two or more single test into the comprehensive laboratory procedure code listed below.

Applicable single STI CPT codes:

 87491 Chlamydia trachomatis

 87591 Neisseria gonorrhoeae

 87661 Trichomonas vaginalis

Applicable comprehensive code:

 87801 Comprehensive multiple organism code

*IntegraNet* will reimburse the more comprehensive, multiple organism code for infectious agent detection by nucleic acid; amplified probe technique, CPT code 87801 when two or more single test CPT codes are billed separately by the same provider on the same date of service. Reimbursement will be made based on a single unit of CPT code 87801 regardless of the units billed for a single code. No modifiers will override the bundle edit.

Note: The provider is required to bill for the applicable single STI CPT codes, as rendered. The comprehensive CPT code will be reimbursed as indicated above.

**Transportation Services: Ambulance and Non-Emergent Transport**

*IntegraNet* allows reimbursement for transport to and from covered services or other services mandated by contract, unless provider, state, federal, or CMS contracts and/or requirements indicated otherwise. Reimbursement is based on the guidelines in this policy.

*IntegraNet* allows reimbursement for ambulance transport, and the services and supplies associated with the transportation, to the nearest facility equipped to treat the member.

**Reimbursable**

Ambulance services reimbursement is based on the ambulance base rate per trip, in accordance with the appropriate level of care provided to the member. Claims for transportation services must be billed with origin and destination modifiers, or the claim may be denied.

Providers should refer to their provider manual, and state and federal guidelines for details on transportation submission requirements.

Services included in the ambulance base rate:

- Ambulance equipment and supplies:
    - o Disposable/first aid supplies
    - o Reusable devices/equipment
    - o Oxygen
    - o Intravenous (IV) drugs
- Ambulance personnel services

Services separately reimbursed from the ambulance base:

- Mileage

Non-Emergency Medical Transport (NEMT) to and from covered services reimbursement is based on the appropriate mode of transportation. Claims for NEMT services must be billed with origin and destination modifiers, or the claim may be denied.

Services reimbursed for NEMT:

- Medical transport base rate

 Additional appropriately licensed medical personnel as needed for member's health status

 Mileage

 Unusual waiting time

 Parking and/or toll fees

**Nonreimbursable**

*IntegraNet* does not allow reimbursement of the following for ambulance or medical transport services:

 Mileage when the transport service has been denied or is not covered

 A member who is not available (no-show)

 Additional rates for night, weekend, and/or holiday calls

 Mileage in transit to pick up or drop off the member (unloaded mileage)

 Mileage for additional passengers

 Mileage for extra attendant for additional passengers

 Transport for a member's or caregiver's convenience

 Transport available free of charge

 Transportation vendor/supplier lodging or meals

 Vehicle maintenance or gas

*IntegraNet* does not allow reimbursement of the following for ambulance only services:

 Ambulance transports other than medical care

 Ambulance Base Rate when no transportation is provided (treatment without transport)

 Where another means of transportation could be used without endangering the member's health

 For separate reimbursement for services/items included in the base ambulance rate

 For a higher level of care when a lower level is more appropriate

 For both basic and advanced life support when ALS services are provided

 For services provided by the Emergency Medical Technician (EMT) in addition to ALS or BLS base rates

 For services provided on the ambulance by hospital staff

 Additional ground and/or air ambulance providers who respond but do not transport the member

 Transport from the member's home to a facility other than a hospital, skilled nursing facility, dialysis facility, or nursing home

 Transport from a facility other than a hospital, skilled nursing facility, dialysis facility, or nursing home to the member's home

 Transport of persons other than the member and a medically required attendant who do not require medical attention

 Transport for a member pronounced dead prior to the ground and/or air ambulance being contacted

 Mileage beyond the nearest appropriate facility (excessive mileage)

| **Related Coding** Modifier | Description | Comments |
|---|---|---|
| D | Diagnostic or therapeutic site/free standing facility other than P or H | Origin and destination modifier |
| E | Residential, domiciliary, custodial facility | Origin and destination modifier |
| G | Hospital-based dialysis facility (hospital or hospital associated) | Origin and destination modifier |
| H | Hospital (inpatient or outpatient) | Origin and destination modifier |
| I | Site of transfer between two types of ambulance | Origin and destination modifier |
| J | Nonhospital based dialysis | Origin and destination modifier |
| N | Skilled Nursing Facility (SNF), including swing bed | Origin and destination modifier |
| P | Physician's office, including HMO nonhospital facility, clinic, etc. | Origin and destination modifier |

| | | |
|---|---|---|
| R | Private residence | Origin and destination modifier |
| S | Scene of accident or acute event | Origin and destination modifier |
| X | Intermediate stop at the physician's office en route to hospital (included HMO nonhospital facility, clinic, etc.) | Destination modifier |
| GM | Multiple members on one trip | Additional to origin and destination modifiers |
| QL | The member died after the ambulance was called | Origin and destination modifiers not required with this modifier |
| QM | The provider arranged for transportation services | Additional to origin and destination modifiers |
| QN | The provider furnished the transportation services | Additional to origin and destination modifiers |
| TK | Multiple carry trips | Additional to origin and destination modifiers |
| TQ | Life support transport by a volunteer ambulance provider | Additional to origin and destination modifiers |

**Unlisted, Unspecified or Miscellaneous Codes**

*IntegraNet* allows reimbursement for unlisted, unspecified or miscellaneous codes in accordance with specified guidelines unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. Unlisted, unspecified or miscellaneous codes should only be used when an established code does not exist to describe the diagnosis, service, procedure or item rendered.

Reimbursement is based on review of the unlisted, unspecified, or miscellaneous codes on an individual claim basis. Claims submitted with unlisted, unspecified, or miscellaneous codes must contain the following information and/or documentation for consideration during review:

 A written description, office notes or operative report describing the procedure or service performed

 An invoice and written description of items and supplies

 The corresponding National Drug Code number for an unlisted drug code

## Multiple and Bilateral Surgery: Professional and Facility Reimbursement

*IntegraNet* allows reimbursement to professional providers and facilities for multiple and bilateral surgery unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. Reimbursement is based on multiple and bilateral procedure rules in accordance with contracts and/or state guidelines for applicable surgical procedures performed on the same day by the same provider to the same patient.

### Multiple Surgery

Professional provider claims for applicable surgical procedures must be billed with Modifier 51 to denote a multiple procedure. Facility claims should not be billed with Modifier 51. However, the following reductions apply to both physician and facility claims. Reimbursement is the total of:

• 100 percent of the fee schedule or contracted/negotiated rate for the highest valued procedure.

• 50 percent for the secondary through fifth procedures.

• 50 percent for the sixth and additional procedures, only if determined to be medically necessary through clinical review.

*IntegraNet* does not apply multiple procedure reduction reimbursement to Modifier-51 exempt (also known as MS-exempt) or add-on procedure codes since the fee allowance and/or relative value is already reduced for the procedure itself.

A single surgery procedure is subject to a multiple procedure reduction when submitted with multiple units.

### Bilateral Surgery

Professional provider and facility claims with applicable surgical procedures must be billed with Modifier 50 to denote a bilateral procedure. It is inappropriate to use Modifier LT or RT to identify bilateral procedures. Reimbursement is 150 percent of the fee schedule or contracted/negotiated rate of the procedure.

For procedure codes containing bilateral or unilateral or bilateral in their description, no modifier is used, and reimbursement is based on 100 percent of the fee schedule or contracted/negotiated rate for the procedure.

Claims with applicable surgical procedures billed without the correct modifier to denote a multiple or bilateral procedure may be denied. In the instance when more than one bilateral procedure or multiple and bilateral procedures are performed during the same operative session, multiple procedure reductions apply.

## Preventable Adverse Events

*IntegraNet* does not reimburse for Preventable Adverse Events (PAEs) unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. PAEs are defined as the following:

 Hospital-acquired conditions and health care-acquired conditions (both referred to in this document as Health Care Acquired Conditions)

 Other Provider Preventable Conditions

Health Care Acquired Conditions (HCAC)

*IntegraNet* requires the identification of HCACs (see Exhibit C) through the submission of a Present on Admission (POA) indicator (see Exhibit A) for all diagnoses on inpatient facility claims as identified by CMS. If the POA indicator identifies an HCAC, the reimbursement for the episode of care may be reduced or denied.

POA indicators are required for all inpatient primary and secondary diagnoses. Failure to include the POA indicator with the primary and secondary diagnosis codes may result in the claim being denied or rejected. The POA indicator is not required on the admitting diagnosis. Unless noted in Exhibit B, this requirement applies to all facilities.

Reimbursement will not be reduced or denied if a condition defined as HCAC for a member existed prior to the initiation of treatment for that member by that provider. If an HCAC is caused by one facility (primary), payment will not be denied to the secondary facility that treated the HCAC.

*IntegraNet* reserves the right to request additional records to support documentation submitted for reimbursement.

**Note:** Claims may be subject to clinical review for appropriate reimbursement consideration.

## Other Provider Preventable Conditions (OPPC)

For professional providers and facilities, procedures identified as an OPPC and all related services will be rejected or denied. OPPCs are defined by CMS contracts and/or requirements and categorized as:

| Description | Modifiers | ICD-10 Diagnosis |
|---|---|---|

| | | |
|---|---|---|
| Surgical or invasive procedure on the wrong body part | PA | Y65.53 |
| Surgical or invasive procedure on the wrong patient | PB | Y65.52 |
| Wrong surgery or invasive procedure on patient | PC | Y65.51 |

Providers should use the appropriate codes to report OPPCs. Erroneous surgical events occurring during an inpatient stay should be reflected on Type of Bill 0110 (no-pay claim) along with all services or procedures related to the surgery. All other inpatient procedures and services should be submitted on a separate claim.

A condition defined as an OPPC for a particular member existing prior to the initiation of treatment for that member by that provider will not impact that provider's reimbursement.

**NOTE:** The PC modifier is defined as "Wrong Surgery on a Patient." It should not be used to represent the Professional Component of a service. Claims that incorrectly use this modifier may be denied. Claims must be resubmitted as a corrected claim and indicate the appropriate coding for the service(s) rendered.

**Claims Submission — Required Information for Professional Providers**

Professional providers of healthcare services are required, unless otherwise stipulated in their contract, to submit an original CMS-1500 Health Insurance Claim Form to *IntegraNet* for payment of healthcare services.

Providers must submit a properly completed CMS-1500 for services performed or items/devices provided. If the required information is not submitted, the claim is not considered a clean claim, and *IntegraNet* will deny payment without being liable for interest or penalties. The CMS-1500 claim form must include the following information, if applicable:

 Patient information (name, address including ZIP code, date of birth, gender, relationship to insured, and medical condition as related to employment or an accident)

 Insured's information (member ID number, name, address including ZIP code, policy, group or Federal Employees' Compensation Act number, name of insurance plan or program, and name of other health benefit plan)

 Coordination of benefits/other insured's information (name, policy or group number, and name of insurance plan or program)

 Name of referring physician or source

 Indication of outside laboratory

 ICD-9 diagnosis code(s), including fourth and fifth digit when required or ICD-10 diagnosis code(s) depending upon the dates of service

Note: Do not report ICD-10-CM codes for claims with dates of service prior to implementation of ICD-10-CM, on either the old or revised version of the CMS-1500 claim form.

 Clinical Laboratory Improvement Act certification number

 Date(s) of service(s) rendered

 Place of service

 Procedures, services, or supplies (description of services rendered using CPT-4 codes/HCPCS codes and appropriate modifiers)

 Charge(s) for service(s) rendered

 Day(s) or unit(s) related to service(s) rendered

 Total charges and amount paid by patient

 Federal TIN

 Name and address of facility where services were rendered and the NPI of the service facility, if applicable

 NPI:

    o Individual servicing provider's NPI must be reported as the rendering provider ID, if applicable

    o When billing is from a group, the group's NPI must be reported as the billing provider, if applicable

 Other non-NPI ID number of the referring, ordering or supervising provider

 Billing provider information (name, address including ZIP code, telephone number)

 Indication of signature on file — a handwritten or computer generated signature for the provider of service or his/her representative — and date the form was signed

 National Drug Code(s) (NDC) to include the NDC number, unit price, quantity and composite measure per drug

*IntegraNet* cannot accept claims with alterations to billing information. Altered claims will be returned to the provider with an explanation of the reason for the return.

Although *IntegraNet* prefers the submission of claims electronically through the electronic data interchange (EDI), *IntegraNet* will accept paper claims. A paper claim must be submitted on an original claim form with drop out red ink, computer-printed or typed, and in a large, dark font in order to be read by optical character reading technology. All claims must be legible. If any field on the claim is illegible, the claim will be rejected or denied.