Section 11: Billing Requirements

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

Effective January 1, 2017, charges submitted with expired CPT codes will be denied immediately. Note that there is no longer a grace period for changing CPT codes.

11.0 Incident to Billing

PacificSource credentialing standards follow the guidelines of the National Committee on Quality Assurance (NCQA). The PacificSource and delegate credentialing process includes meticulous verification of the education, experience, judgment, competence, and licensure of all healthcare providers.

PacificSource allows "incident to" billing for caregivers who are not eligible to be credentialed by PacificSource or a delegated credentialing entity. This provides practices the opportunity to fully utilize their staff appropriately. PacificSource does NOT allow "incident to" billing for practitioners who are eligible for credentialing.

Effective June 1, 2018, in order for a service to be considered for payment under the "incident to" billing policy, the modifier SA must be appended to the CPT code. Only claims with the required SA modifier, will be considered eligible for "incident to" billing.

In limited situations, PacificSource allows for exceptions to the credentialing and modifier SA requirements. Examples of these exceptions are:

- In the event that another policy exists that conflicts with this policy and allows exception to this rule, precedence will be given first to the rules of that policy. For example, PacificSource does allow for licensed behavioral health professionals who are eligible for credentialing to bill under the "incident to" status if the services being rendered are part of an applied behavior analysis (ABA). These services are exempt from the modifier SA requirement.
- The CPT/HCPCS code being billed is inherently considered a collaborative care service, such as G0511 and G0512 for Care Coordination Services or G0502, G0503, G0504, and G0507 for Behavioral Health Integration Services. These codes are exempt from the modifier SA requirement. PacificSource will follow CMS Guidelines in the use and payment of these types of services.

In order to provide care that will be billed to PacificSource using "incident to" status, the caregiver must be ineligible to be credentialed by PacificSource or its delegated credentialing entity. In addition, if the caregiver's profession is licensable in the state where services are provided (e.g., nursing, social work), then the caregiver must hold an active license and be providing services within the scope of that license. If the caregiver's profession is not licensable in the state where services are provided (e.g., medical assistants, community health workers), then the caregiver must be working under the license and within the scope of practice of the licensed clinician under whom services are being billed. PacificSource requires strict adherence to the following guidelines, and these criteria must be met in order for services to be billed as "incident to."

PacificSource allows "incident to" billing only if the following criteria met:

1. The patient must be established in the practice.
2. The services must be provided under the direct supervision of the physician or credentialed, qualified non-physician practitioner.
3. The supervising provider must actively participate in the continuation of the patient's course of care, with periodic face-to-face encounters. Care may not be transferred to a non-credentialed provider.
4. The original supervising provider, or similarly qualified substitute supervising provider, must be present in the office suite at the time of service delivery and available to provide any necessary assistance.
5. The patient must have a covered condition that was initially diagnosed by the supervising provider.
6. The services must be medically necessary and an integral part of the patient's care.
7. Services must be rendered in a physician's office or clinic (not in an institutional setting).
8. Services rendered under the "incident to" billing policy must be billed under the credentialed, supervising provider.
9. PacificSource will adhere to CPT Billing Guidelines in the payment of services billed under the "incident to" billing policy.
10. The caregiver billing under the supervising provider must be an employee of the practice (i.e., a W-2 employee).

11.1 Osteopathic Manipulation Treatment

Osteopathic Manipulative Treatment CPT Codes 98925–98929

It is PacificSource policy not to allow an evaluation & management service (E&M) on the same date of service as osteopathic manipulative treatment (OMT). Consistent with

CPT coding guidelines, E&M services may only be reported if the work provided is above and beyond what is associated with preservice and postservice manipulative treatment.

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

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

If a second diagnosis represents a new condition, and requires significant evaluation and management of a separate body system, an E&M code may be reported. Modifier -25 must be attached to the E&M code. PacificSource reserves the right to determine, by chart note evaluation, whether or not an E&M service is warranted.

If a second diagnosis represents a brief recheck of an ongoing, but unrelated condition, an E&M service will be processed to provider write-off.

If a second diagnosis represents the same body system and/or condition, an E&M service will be processed to provider write-off.

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

11.2 Global Period

"Global period" is defined as the period of time when services must be included in the surgical allowance. PacificSource uses the number of days indicated in the "Global Period" column of the Federal Register as the standard.

PacificSource considers the following services to be included in the global surgical package. These services are not separately reimbursable when billed by the same physician or by another physician within the same Provider Group (same Tax ID number).

Services include:

- Preoperative E&M services after the decision to perform surgery is made, one day prior to major surgery, and on the same day a major or minor surgery is performed;
- Intraoperative services that are a usual and necessary part of the surgical procedure;
- Anesthesia provided by the surgeon (including local infiltration, digital block or topical anesthesia);
- Supplies;
- Normal, uncomplicated follow-up care for the period indicated in the Federal Register Global Period; and
- All additional medical or surgical post-operative services required of the surgeon during the post-operative period due to complications that do not require additional trips to the operating room.

PacificSource considers the following services to be not included in the global surgical package:

- Preoperative services not encompassed in the global period;
- Evaluation and management services unrelated to the primary procedure;
- Services required to stabilize the patient for the primary procedure;
- Procedures required during the immediate preoperative period that are usually not part of the basic surgical procedure (for example, bronchoscopy prior to chest surgery); and
- Treatment by the original physician for a related post-operative complication that requires a return trip to the operating room.

11.3 Obstetric and Gynecology Care Billing Guidelines

11.3.1 Global OB Care

The global maternity allowance is a complete, one-time billing which includes all professional services for routine antepartum care, delivery services, and postpartum care. The fee is reimbursed for all of the member's obstetric care to one provider. If the member is seen four or more times prior to delivery for prenatal care and the provider performs the delivery, the provider must bill the Global OB code, beginning with the date of the initial prenatal visit. Global maternity billing ends with release of care within 42 days after delivery. Global OB care should be billed after the delivery date.

Services Included in Global Maternity Care

- Routine prenatal visits until delivery, after the first three antepartum visits
- Recording of weight, blood pressures and fetal heart tones
- Admission to the hospital including history and physical
- Inpatient Evaluation and Management (E/M) service provided within 24 hours of delivery

- Management of uncomplicated labor
- Vaginal or cesarean section delivery
- Delivery of placenta (see "Billable Services Outside of Global Maternity Care" for examples of when delivery of the placenta may be reimbursed).
- Administration/induction of intravenous oxytocin
- Insertion of cervical dilator on same date as delivery
- Repair of first or second degree lacerations
- Simple removal of cerclage (not under anesthesia)
- Uncomplicated inpatient visits following delivery
- Routine outpatient E/M services provided within 42 days following delivery
- Postpartum care after vaginal or cesarean section delivery

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

59400 Routine obstetrical care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care

59510 Routine obstetric care including antepartum care, cesarean delivery and postpartum care

59610 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery

59618 Routine obstetric care including antepartum care, cesarean delivery and postpartum care, following attempted vaginal delivery after previous cesarean delivery

11.3.2 Partial Services

Nonglobal OB care, or partial services, refers to maternity care not managed by a single provider or group practice. Billing for nonglobal OB care may occur if a member transfers care or is referred to another provider during her pregnancy, a provider from another practice performs the delivery or antepartum care (see the E/M visit info under "Billable Services Outside of Global Maternity Care"), a member terminates or miscarries her pregnancy, or if the member changes insurers during her pregnancy.

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

For Antepartum Care Only

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

Additional evaluation and management visits during the antepartum period must be billed with modifier -25 to support an evaluation and management service for a medical condition unrelated to the pregnancy. As always, you may bill for ultrasound, amniocentesis, special screening tests for genetic disorders (preauthorization is required for many genetic tests, please refer to the preauthorization list), visits for unrelated conditions, or additional frequent visits due to high risk conditions. You will be reimbursed according to contract benefits.

For Postpartum Care Only

59430

Delivery only

59409 Vaginal delivery only (with or without episiotomy and/or forceps).

59514 Cesarean delivery only

59612 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)

59620 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery

Delivery and Postpartum Care Only

59410 Vaginal delivery only (with or without episiotomy and/or forceps), including postpartum care

59515 Cesarean delivery only; including postpartum care

59614 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps), including postpartum care

59622 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care

Billable Services Outside of Global Maternity Care

- The first three antepartum visits
- Services during the antepartum and postpartum period unrelated to maternity or not in the global period
- Maternal or fetal echography
- Amniocentesis, any method

- Amnioinfusion
- Chorionic villus sampling
- Fetal contraction stress test, and fetal non stress test.
- Delivery of the placenta, CPT 59414, is considered integral to a vaginal or cesarean section delivery, this code may be billed if the member delivers vaginally before admission with subsequent delivery of the placenta, or if the placenta is delivered by a provider other than the delivering physician.
- Evaluation and Management (E/M) visits:
  - Additional E/M visits for high risk or complications > 13 antepartum visits
  - E/M visits for conditions unrelated to pregnancy - The diagnosis should clearly identify that the condition is unrelated to pregnancy for the services provided (e.g., appendicitis, bronchitis, cholecystectomy).
  - Maternal Fetal Medicine Specialists seen in addition to the member's regular provider (if the specialist is in the same practice, then use of mod 25 will indicate a significant and separate E/M service).
  - E/M with an OB ultrasound procedure – E/M CPT codes submitted with modifier 25 may be reimbursed with an OB ultrasound on the same date of service. Mod 26 (professional component) is not reimbursed when performed by the same or other health care professional on the same date of service.

11.3.3 Multiple Births

Multiple births should be billed with the appropriate CPTs depending on the delivery method per newborn:

Vaginal delivery CPTs:

- First newborn 59400, 59409, 59410, 59610, 59612, or 59614
- Subsequent newborn(s): 59409 or 59612

Cesarean delivery CPTs:

- First Newborn: 59510, 59514, 59515, 59618, 59620, or 59622
- Subsequent newborns: 59514 or 59620

Claim reimbursement: 100% allowance for the delivery method with the highest RVU, and subsequent newborns per the multiple procedure reduction rules and the member's contracted benefit rate.

Midwife Reimbursement

Eligible Certified Nurse Midwives (CNM) will receive reimbursement of services when rendered within the scope of their license.

- Lay midwives, direct-entry midwives, certified midwives (CM), certified professional midwives (CPMs), and doulas will deny in the system as these are ineligible providers.
- Time, services, and medications, are not separately reimbursed as they are part of the global fees.
- Supplies are reimbursed up to $150.00 when billed with the following codes:
  - CPT **99070**: Supplies Provided By Physician Over & Above Those Included In The Service (documentation may be required)
  - HCPC **S8415**: Supplies for home delivery of infant
- If the CNM is unable to perform delivery (another provider delivers), the CNM should only bill for antepartum care.

Increased Procedural Services/Modifier 22

Additional reimbursement may be considered for obstetrical services when the work required to provide a service is substantially greater than typically required, designated by appending modifier 22 (mod 22) to a CPT procedure code. Documentation must support the reason for the additional work (i.e., increased intensity, time, technical difficulty of the procedure, severity of the patient's condition, physical and mental effort required). Mod 22 may not be appended to an E/M code (2013 Professional Edition/CPT manual). Clinical records should be submitted with the claim whenever mod 22 is utilized.

One example of an allowed use of mod 22 for obstetrical services:

> Laceration repairs: 3rd and 4th degree laceration repairs may be billed in addition to the delivery or global OB CPTs by appending modifier 22 to the global OB, delivery only, or delivery plus postpartum care CPTs. The allowable is based on the delivery component alone.

Prolonged Services

Prolonged services, CPT codes 99354 to 99357 for services beyond the usual service provided in an inpatient or outpatient setting, and Prolonged Service without direct patient contact, CPT codes 99358 and 99359 non face-to-face services, are not reimbursed for maternity care services.

Noncovered Service Billed with Global or Nonglobal CPT Codes

Travel time billed by the practitioner is not reimbursed.

Assistant Surgeon

Assistant surgeon fees are reimbursed only with an appropriate modifier for eligible providers using nonglobal cesarean section CPT codes (59514, 59620).

Delivery in Nonhospital Settings

Reimbursement for home delivery, birthing centers, or any nonhospital facility setting is subject to the terms of the PacificSource group and provider contracts, provider eligibility for reimbursement, and provider and facility credentialing

11.3.4 Annual Gynecological Exams

Routine gynecological exams are allowed once each calendar year (or once each benefit year, if plan year).

Any laboratory tests performed are subject to gynecological laboratory benefit. These include:

- Weight and blood pressure check
- Laboratory tests:
  - Occult blood
  - Urinalysis
  - Complete blood count
  - Pap smear
  - Mammography
  - Lab fees CPT 36415, 99000

Any laboratory tests performed, in absence of diagnosis, which are not listed above are subject to the standard preventive laboratory benefits and maximums.

A referral to a women's health care provider is not required for the annual gynecological exam and medically necessary follow-up visits resulting from that examination when performed within ninety (90) days of the annual gynecological exam.

Screening and counseling for sexually transmitted infections, including HIV, and for interpersonal and domestic violence, when provided during a gynecological exam, will be covered at no cost to the member.

This applies to services with participating providers and is effective for PacificSource nongrandfathered group policies and Oregon and Idaho individual policies as they renew (or are effective) on or after August 1, 2012. This is effective for all Montana individual policies effective July 1, 2012, regardless of effective or renewal date.

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

11.3.5 Screening Papanicolaou Smear HCPCS Code Q0091

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

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

11.4 Emergency Services

PacificSource provides coverage without preauthorization for emergency medical conditions. This could include claims within a pre-existing (waiting) exclusion period and/or services not ordinarily covered on the plan.

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

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

See below for current contract definition of an Emergency Service.

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

"Emergency Services" shall mean those covered services that are medically necessary to treat emergency conditions.

11.4.1 Emergency Room Claims not Approved

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

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

11.4.2 Emergency and After-hours Codes Defined

(including but not limited to)

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

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

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

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

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

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

To account for the complexity and acute nature of the conditions being seen, the basic emergency room CPT already has a higher level of reimbursement built in as compared to a routine office visit CPT. The emergency room provider is working his or her regular schedule, and therefore additional reimbursement for a late shift is not appropriate.

The basic facility charge billed with revenue code 450 includes the cost of maintaining a 24-hour facility, which would include staffing of medical providers and support staff.

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

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

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

Criteria:

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

PacificSource Policy: PacificSource will review any claim with this code to see if the situation falls under our emergency definition (see section 11.4). If so, the claim will be released for payment. If not, the charge will be processed as provider write-off unless supporting documentation is included.

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

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

11.5 Surgery

11.5.1 Bilateral Procedures

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

If a procedure is not identified by CPT terminology as an inherently bilateral (unilateral or bilateral) procedure, the procedure should be reported with modifier 50. Bilateral procedures should be billed as a separate charge line for each procedure, using a modifier on the second line. However, bilateral procedures may be billed on one line. Please see the examples below.

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

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

Example 2: Billed as one line (two services).

CPT	Modifier	Description	$ Charges	Units
31238-50		Nasal/sinus endoscopy, surgical, with control epistaxis	$1,000.00 units	1

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

11.5.2 Multiple Procedures

Multiple surgeries are separate procedures performed during the same operative session or on the same day, for which separate billing is allowed. Please be aware that this applies to both professional and hospital/facility charges:

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

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

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

Idaho and Montana
PacificSource uses the following payment structure for multiple procedure claims.

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

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

11.5.3 Multiple and Bilateral Surgical Procedures Performed in the Same Operative Session

Selected bilateral eligible services may also be subject to multiple procedure reductions when billed alone or with other multiple procedure reduction codes. When two or more procedure codes subject to reductions are performed on the same date of service and are subject to reduction as defined in the Federal register, only one of the procedure codes will be considered as the primary procedure, and all the remaining procedures will be considered secondary. The procedure with the highest CMS-based Relative Value Unit or contracted allowance, after the bilateral adjustment, as appropriate, will be considered the primary procedure.

Note: The bilateral procedure is not always the primary procedure. Assistant surgeon fees will be subject to multiple procedure reductions.

Idaho and Montana Examples

First bilateral procedure equals 150 percent of the fee schedule allowance or your billed charge, whichever is less.

Second bilateral procedure equals 75 percent of the fee schedule allowance (150% reduced by half) or your billed charge, whichever is less.

Please note: If the bilateral procedures are billed on two separate lines on the claim, the reduction will be split evenly between both lines.

- When billing two bilateral procedures:
  - Primary bilateral = 150 percent of the fee schedule allowance for the procedure
  - Secondary bilateral = 75 percent of the fee schedule allowance for the procedure; 150 percent X 50 percent = 75 percent
- When billing a primary, nonbilateral procedure and a secondary bilateral procedure:
  - Primary procedure = 100 percent of the fee schedule allowance for the procedure
  - Secondary bilateral procedure = 75 percent of the fee schedule allowance for the procedure; 150 percent X 50 percent = 75 percent
- When billing a primary bilateral procedure and a secondary procedure:
  - Primary bilateral = 150 percent of the fee schedule allowance for the procedure
  - Secondary procedure = 50 percent of the fee schedule allowance for the procedure

Procedure	Billed	Contract allowed	Modifier	Considered allowed
31255-50	$4,000.00	$2,100.00	X 150%	$3,150.00
31276-51	$1,100.00	$975.00	X 50%	$487.50
31267-51	$1,100.00	$975.00	X 50%	$487.50

For this example, the primary procedure is 31255-50 and allowed at 150 percent of the fee schedule allowance or billed charges, whichever is less. All remaining procedures are allowed at 50 percent of the fee schedule allowance.

Procedure	Billed	Contract allowed	Modifier	Considered allowed
30140-51, 50	$1,200.00	$500.00	150% X 50%	$375.00
30520	$2,950.00	$2,500.00	Primary @ 100%	$2,500.00
31200-51	$975.00	$900.00	X 50%	$ 450.00

For this example, the primary procedure is 30520 and allowed at 100 percent of the fee schedule allowance. The secondary procedure is 30140-50 and allowed at 150 percent X 50 percent resulting in a reimbursement of 75 percent of the fee schedule allowance. The third procedure, 31200, is allowed at 50 percent of the fee schedule allowance.

Oregon Examples

First bilateral procedure equals 150 percent of the fee schedule allowance or your billed charge, whichever is less.

Second bilateral procedure equals 50 percent of the fee schedule allowance (25% X 2) or your billed charge, whichever is less.

Please note: If the bilateral procedures are billed on two separate lines on the claim, the reduction will be split evenly between both lines.

- When billing two bilateral procedures:
  - Primary bilateral = 150 percent of the fee schedule allowance for the procedure
  - Secondary bilateral = 25 percent of the fee schedule allowance for the procedure; 25 percent X 2 = 50 percent
- When billing a primary, nonbilateral procedure and a secondary bilateral procedure:
  - Primary procedure = 100 percent of the fee schedule allowance for the procedure
  - Secondary bilateral procedure = 75 percent of the fee schedule allowance for the procedure; 150 percent X 50 percent = 75 percent
- When billing a primary bilateral procedure and a secondary procedure:
  - Primary bilateral = 150 percent of the fee schedule allowance for the procedure
  - Secondary procedure = 25 percent of the fee schedule allowance for the procedure

Procedure	Billed	Contract allowed	Modifier	Considered allowed
31255-50	$4,000.00	$2,100.00	X 150%	$3,150.00
31276-51	$1,100.00	$975.00	X 25%	$243.75
31267-51	$1,100.00	$975.00	X 25%	$243.75

For this example, the primary procedure is 31255-50 and allowed at 150 percent of the fee schedule allowance or billed charges, whichever is less. All remaining procedures are allowed at 25 percent of the fee schedule allowance.

Procedure	Billed	Contract allowed	Modifier	Considered allowed
30140-51, 50	$1,200.00	$500.00	150% X 50%	$375.00
30520	$2,950.00	$2,500.00	Primary @ 100%	$2,500.00
29881-51	$975.00	$900.00	X 25%	$ 225.00

For this example, the primary procedure is 30520 and allowed at 100 percent of the fee schedule allowance. The secondary procedure is 30140-50 and allowed at 150 percent X 50 percent resulting in a reimbursement of 75 percent of the fee schedule allowance. The third procedure, 29881, is allowed at 25 percent of the fee schedule allowance.

11.5.4 Ambulatory Surgery Center Billing Guidelines

Idaho and Montana

The ASC fee schedule is modeled after the Outpatient Prospective Payment System (OPPS). ASC rules for modifier 50/51 application are different from CPT standard.

When submitting a claim for multiple procedures, submit the primary procedure as the first procedure code. Use modifier 51 in the first modifier position and subsequent procedures including exempt and add on codes. If modifier 51 is missing on secondary and subsequent procedures that should be stepped down, PacificSource may deny the claim as billed in error and request a correction or a modifier 51 to be appended to indicate multiple procedures.

Pleas note: PacificSource requires the use of Modifier SG to expedite processing.

Procedure	Billed	Contract allowed	Modifier	Considered allowed
31255-SG-RT	$1,500	$1,100.00	0%	$1,100.00
31255-51-SG-LT	$1,500	$1,100.00	X 50%	$550.00
30520-51-SG	$1,000	$900.00	X 50%	$450.00
30140-51-SG-RT	$600	$450.00	X 50%	$225.00
30140-51-SG-LT	$600	$450.00	X 50%	$225.00

For this example, the primary procedure is 31255-RT and allowed at 100% of the fee schedule allowance, or billed charges, whichever is less. All remaining procedures are allowed at 50 percent of the fee schedule allowance.

Please see section 11.7 for complete information of ASC Payment Guidelines.

Oregon

When submitting a claim for multiple procedures, submit the primary procedure as the first procedure code. Use modifier 51 in the first modifier position and subsequent procedures including exempt and add on codes. If modifier 51 is missing on secondary and subsequent procedures that should be stepped down, PacificSource may deny the claim as billed in error and request a correction or a modifier 51 to be appended to indicate multiple procedures.

Please note: PacificSource requires the use of Modifier SG to expedite processing.

Procedure	Billed	Contract Allowed	Modifier	Considered Allowed
31255-RT	$1,500.00	$1,100.00	100%	$1,100.00
31255-51-LT	$1,500.00	$1,100.00	X 50%	$550.00
30520-51	$1,000.00	$900.00	X 25%	$225.00
30140-51-RT	$600.00	$450.00	X 25%	$112.50
30140-51-LT	$600.00	$450.00	X 25%	$112.50

For this example, the primary procedure is 31255-RT and allowed at 100% of the fee schedule allowance, or billed charges, whichever is less. The second procedure is allowed at 50 percent of the fee schedule allowance, or billed charges, whichever is less. The remaining procedures are allowed at 25 percent of the fee schedule allowance or billed charges, whichever is less.

Please note: For ASCS claims, PacificSource does not recognize Add-on Codes and procedures not subject to the MPR guidelines. All procedures are eligible for MPR.

Please see section 11.7 for complete information of ASC Payment Guidelines.

11.5.5 Surgical Assistant Guidelines

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

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

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

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

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

Modifier AS—Nonphysician Assistant (PA, RN, CRNFA, CST, CNM)

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

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

Please note: Certified Nurse First Assist, Certified First Assist (CFS), Certified Surgical Technicians, Surgical Assistants, and Registered Nurse cannot bill independently. These providers must bill under the overseeing doctor's tax identification number (see section 4.1).

11.5.6 Office Surgery Suites and Fees

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

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

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

RBRVS surgical relative value unit	% of PacificSource surgical allowance
00.01 through 02.09	Billed
02.10 through 08.75	40%*
08.76 through 14.60	30%*
14.61 and greater RVUs	25%*

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

The surgical suite allowance includes usage of room, lights, cautery, dressings, sutures, sterile tray, optical or other equipment, and any services of an assistant (e.g., MD, RN, PA). If any of these supplies are billed separately, it will be processed to provider write-off. Surgical Suite reimbursement will only be allowed if there is a dedicated room or space in which surgical procedures are performed. Service done in an exam room or area that is utilized for dual purposes will not be considered a surgical suite and will be denied.

Colonoscopy

Screening colonoscopies: Colonoscopy screenings will be covered at 100 percent for ages 50-75 when billed by a participating provider.

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

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

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

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

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

11.5.7 Payment Rules for Multiple Scope Procedures

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

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

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

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

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

Examples of Scope Procedure Families

45378 Base procedure
45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45391, 45392

Examples of Laparoscopy Families

49320 Base procedure
38570, 49321, 49322, 49323, 58550, 58660, 58661, 58662, 58663, 58670, 58671, 58672, 58673

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

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

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

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

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

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

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

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

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

Please note: Multiple Scope payment rules are exempt for Idaho and Montana providers. Idaho and Montana utilize multiple surgery guidelines of 100/50/50 for multiple scope services.

11.6 Evaluation and Management (E&M) Billing Guidelines

11.6.1 Preventive Visits and E&M Billed Together

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

PacificSource's Policy for Modifier 25

If the provider provides both a service or procedure and an evaluation and management (E&M) on the same day, it must be significant, separate, and identifiable. Documentation must support both services and show that the E&M was above and beyond the service or procedure provided.

When preventive care codes 99381-99387 or 99391-99397 are billed with office visit codes 99201-99203 or 99211-99213 (with modifier 25 on the office visit code) chart notes are not needed; both codes will be allowed. For all other preventive care & office visit code combinations (or these combinations billed without modifier 25), chart notes are required for consideration of both codes.

When the original claim is received with both preventive services and office visit charges:

- The system will stop the claim for review to allow the adjudicator to determine if chart notes are attached to the claim.
- If there are no chart notes submitted, the charges for the medical office visit will be considered provider write-off. If notes are attached, the notes will be reviewed and, based on the content, a determination will be made whether or not the office visit is appropriate.
- Claims received as rebills with notes will be forwarded to a Claims Research Analyst.

Examples

Examples of when both charges would not be appropriate:

- A patient who has a history of hypertension is scheduled for a routine physical. You make brief mention of the hypertension and refill the patient's prescription.
- During an annual gynecological exam, a patient mentions that she is having hot flashes, and you order blood work to check hormone level.
- A child is seen for a well-child checkup and you note that he has an ear infection and prescribe antibiotics.
- Examples of when both charges would be appropriate:
- A patient is scheduled for a routine physical with a history of hypertension, and upon examination, you discover that the patient's blood pressure is extremely high. The patient says he is having lightheadedness and ringing in the ears. You take measures to reduce the blood pressure and counsel the patient on how to monitor the condition.
- During an annual gynecological exam, you find a lump in a patient's breast and order additional blood work and radiological procedures. You also take additional time to go over treatment options with the patient.

Prolonged Physician Service

If chart notes are not submitted for Prolonged Services, the claim will be processed as provider write-off with the explanation code stating that supporting documentation is required.

PacificSource will reimburse for prolonged physician services with direct face-to-face patient contact that require a minimum of 30 minutes beyond the usual service. "Prolonged services" are limited to include the procedure codes 99354 through 99357.

- Prolonged services charges must be billed with an E/M code in which time is a factor in determining the level of service.
- Prolonged service charges are not reportable with nontime based procedures codes such as surgery or maternity. Other noncovered services include, but are not limited to:
  - Neuropsychological and behavioral testing
  - Intubation
  - Bronchoscopy
  - CPR
  - Infusion/chemo administration
  - Anytime spent performing and documenting separately reportable services
- The time for usual service refers to the typical/average time units associated with the companion evaluation and management (E/M) service.
- Prolonged services cannot be billed if separately reportable services were performed.
- Office visits that consist of 50% or more counseling and exceed the usual time for the E/M must first be billed to the highest level in the given E/M group (new patient, established patient) before the prolonged service can be billed. In this circumstance, time is the deciding factor in choosing the appropriate E/M code.

- Physicians may count only the duration of direct face–to-face contact between the physician and patient, whether the service was continuous or not.
- For inpatient settings, the physician cannot bill prolonged services for the time spent waiting for lab results, reviewing charts, etc.
- Services rendered during the prolonged portion of the visit must be coverable on the member's policy. For example, services for obesity, lifestyle and/or dietary counseling would not be covered unless the member's plan allows for it.
- CPT 99358 and 99359 will not be allowed if the time is spent in medical team conferences, on-line medical evaluations, care plan oversight services, anticoagulation management, or other non-face-to-face services that have more specific codes and no time limit in the CPT code set.

The following is a threshold table from the CMS website that shows the total number of usual face-to-face time (in minutes) and the amount of time needed before prolonged charges can be added:

Threshold Time (in minutes) for Prolonged Visit Codes 99354 and/or 99355 Billed with Office/OP and Consultation Codes:

CPT	Typical time	To bill 99354	To bill 99354 and 99355
99201	10	40	85
99202	20	50	95
99203	30	60	105
99204	45	75	120
99205	60	90	135
99212	10	40	85
99213	15	45	90
99214	25	55	100
99215	40	70	115
99241	20	50	95
99242	30	60	105
99243	45	75	120
99244	60	90	135
99245	75	105	150
99324	20	50	95
99325	30	60	105
99326	45	75	120
99327	60	90	135
99328	75	105	150
99334	15	45	90
99335	25	55	100
99336	40	70	115
99337	60	90	135
99347	15	45	90
99348	25	55	100
99349	40	70	115
99350	60	90	135

If chart notes are not submitted for Prolonged Services, the claim will be processed as provider write-off with the explanation code stating that supporting documentation is required.

11.6.2 Appropriate Use of CPT Code 99211

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

- The service must be for evaluation and management (E&M).
- The patient must be established, not new (see section 11.6.4).
- The service must be separated from other services performed on the same day.
- The provider-patient encounter must be face-to-face, not via telephone.

Code 99211 will be accepted only when documentation shows that services meet the minimum requirements for an E&M visit. For example, if the patient receives only a blood pressure check or has blood drawn, 99211 would not be appropriate. All E&M office visits follow the member's office visit benefit; therefore, if another CPT code more accurately describes the service, that code should be reported instead of 99211.

11.6.3 Anticoagulant Management Codes

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

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

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

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

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

11.6.4 Distinction Between New and Established Patients

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

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

11.7 Ambulatory Surgery Center (ASC) Payment Guidelines

When contracting directly with an Ambulatory Surgery Center (ASC), PacificSource contracts using various payment methodologies. Please refer to your provider agreement for specifics.

For codes that do not have an ASC allowed amount published by CMS, PacificSource will establish such values for its maximum rate determination.

The SG modifier must be used to bill services provided in an ASC.

11.7.1 Services included in the ASC Facility Payment:

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

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

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

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

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

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

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

to determine the suitability of an ASC setting. Other diagnostic and therapeutic tests directly connected to the procedure are included in the facility payment.

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

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

Unless otherwise noted in your agreement, PacificSource will not pay for services or supplies specifically outlined by CMS as included in the Case Rate, or in which CMS has deemed nonreimbursable. These can be found on the CMS Web page at cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html. Refer to your specific payment schedule outlined in your agreement. Procedures that have an "N1" payment indicator listed in Addendum AA will not be reimbursable. Services and supplies outlined in Addendum EE, "Surgical Procedure to be Excluded from Payment," will be reimbursed if prior approved by PacificSource.

11.7.2 Services not Included in the ASC Facility Payment

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

11.8 Ultrasound: Same-day Billing of Transvaginal and Standard

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

11.9 Never Events Policy

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

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

11.9.1 Surgical Events

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

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

11.9.2 Product or Device Events

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

- Patient death or serious disability associated with the use of contaminated drugs, devices, or biologicals provided by the healthcare facility

- Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended
- Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility

11.9.3 Case Management Events

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

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

11.9.4 Environmental Events

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

- Patient death or serious disability associated with an electric shock or elective cardioversion while being cared for in a healthcare facility
- Incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
- Patient death or serious disability associated with a fall while being cared for in a healthcare facility
- Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility
- Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility

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

11.10 Modifiers

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

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

25—Significant, Separately Identifiable E&M Service by the Same Physician on the Same Day of the Procedure or Other Service: Used by provider to indicate that on the same date of service, the provider performed two significant, separately identifiable services that are not "unbundled".

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

81—Minimum Assistant Surgeon (MD, DMD, DDS, DO): The allowance for modifier 81 is ten percent of the surgery CPT allowance. This modifier is used when the doctor performed minimal assistance.

82—Assistant Surgeon: This modifier is used when a qualified resident surgeon is not available. This is a rare occurrence. The fee allowance is automatically reduced to 20% of the surgical fee allowance as billed by the primary surgeon.

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

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

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

Modifier AS—Non-physician Assistant (PA, RN, CRNFA, CST, CNM): The allowance for modifier AS is ten percent of the surgery CPT allowance.

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

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

SU—Procedure performed in physician's office (to denote use of facility and equipment)

CMS has defined four new HCPCS modifiers to selectively identify subsets of Distinct Procedural Services (-59 modifier) as follows (effective January 1, 2015):

XE—Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter

XS—Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure

XP—Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner

XU—Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

11.11 Place of Service Codes for Professional Claims

Listed below are place of service codes. These codes should be used on professional claims to specify the entity where services were rendered. Place of service descriptions are available on the CMS website at cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Website-POS-database.pdf. If you would like to comment on a code or description, please email your request to posinfo@cms.hhs.gov.

Place of service code(s)	Place of service name	Facility (F) or nonfacility (NF)
01	Pharmacy	NF
02	Unassigned	
03	School	NF
04	Homeless Shelter	NF
05	Indian Health Services Free-standing Facility	NF
06	Indian Health Services Provider-based Facility	NF
07	Tribal 638 Free-standing Facility	NF
08	Tribal 638 Provider-based Facility	NF
09	Prison/Correctional Facility	NF
10	Unassigned	
11	Office	NF
12	Home	NF
13	Assisted Living Facility	NF
14	Group Home	NF
15	Mobile Unit	NF
16	Temporary Lodging	
17	Walk-in Retail Health Clinic	
18	Unassigned	
19	Off Campus-Outpatient Hospital	
20	Urgent Care Facility	NF
21	Inpatient Hospital	F
22	Outpatient Hospital	F
23	Emergency Room—Hospital	F
24	Ambulatory Surgical Center	F
25	Birthing Center	NF
26	Military Treatment Facility	F
27-30	Unassigned	
31	Skilled Nursing Facility	F
32	Nursing Facility	NF
33	Custodial Care Facility	NF
34	Hospice	F
35-40	Unassigned	
41	Ambulance—Land	F
42	Ambulance—Air or Water	F
43-48	Unassigned	
49	Independent Clinic	NF

Place of service code(s)	Place of service name	Facility (F) or nonfacility (NF)
50	Federally Qualified Health Center	NF
51	Inpatient Psychiatric Facility	F
52	Psychiatric Facility-Partial Hospitalization	F
53	Community Mental Health Center	F
54	Intermediate Care Facility/ Mentally Retarded	NF
55	Residential Substance Abuse Treatment Facility	NF
56	Psychiatric Residential Treatment Center	F
57	Nonresidential Substance Abuse Treatment Facility	NF
58-59	Unassigned	NF
60	Mass Immunization Center	
61	Comprehensive Inpatient Rehabilitation Facility	F
62	Comprehensive Outpatient Rehabilitation Facility	F
63-64	Unassigned	
65	End-Stage Renal Disease Treatment Facility	NF
66-70	Unassigned	
71	Public Health Clinic	NF
72	Rural Health Clinic	NF
73-80	Unassigned	
81	Independent Laboratory	NF
82-98	Unassigned	
99	Other Place of Service	NF

11.12 Routine Venipuncture and/or Collection of Specimens

Venipuncture or phlebotomy is the puncture of a vein with a needle or an IV catheter to withdraw blood. Venipuncture is the most common method used to obtain blood samples for blood or serum lab procedures, and is sometimes referred to as a "blood draw." The work of obtaining the specimen sample is an essential part of performing the test. Reimbursement for the venipuncture is included in the reimbursement for the lab test procedure code.

Collection of capillary blood specimen or a venous blood from an existing line or by venipuncture that does not require a physician's skill or a cutdown is considered "routine venipuncture."

Professional and Clinical Laboratory Services

Venipuncture is the most common method used to obtain blood samples for blood or serum lab procedures. The work of obtaining the specimen sample is an essential part of performing the test. Reimbursement for the venipuncture is included in the reimbursement for the lab test procedure code.

Venipuncture is only eligible to be billed once, even when multiple specimens are drawn or when multiple sites are accessed in order to obtain adequate specimen size for the desired test(s).

PacificSource does not allow separate reimbursement for venipuncture when billed in conjunction with the blood or serum lab procedure performed on the same day and billed by the same provider will be denied as a subset to the lab test procedure.

If some of the blood and/or serum lab procedures are performed by provider and others are sent to an outside lab, venipuncture is not eligible for separate reimbursement.

The use of modifier 59 with venipuncture when blood/serum lab tests are also billed is not a valid use of the modifier. The venipuncture is not a separate procedure in this situation.

PacificSource does allow separate reimbursement for venipuncture when the only other lab services billed for that date by that provider are for specimens not obtained by venipuncture (e.g., urinalysis).

Collection of a capillary blood specimen is designated as a status B code (bundled and never separately reimbursed) on the Physician Fee Schedule RBRVU file. PacificSource clinical edits will deny a collection of a capillary blood specimen whether it is billed with another code or as the sole service for that date. This edit is not eligible for a modifier bypass.

Inpatient Hospital Services

A maximum of one collection fee (any procedure code) is allowed per specimen type (venous blood, arterial blood) per date of service, per CMS policy. Specimen collections out of an existing line (arterial line, CVP line, port, etc.) are not separately reimbursable.

11.13 Lab Handling Codes

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

Lab Handling Codes

- 36415—Collection of venous blood by venipuncture.
- Our claims editing system may deny as unbundled when billed with any E&M, lab or other procedure codes.
- 36416—Collection of capillary blood specimen.
- Our claims editing system may deny as unbundled when billed with any E&M, lab or other procedure codes.
- 99000—Handling and/or conveyance of specimen for transfer from physician's office to a lab.*
- 99001—Handling and/or conveyance of specimen for transfer from the patient in other than a physicians office to a laboratory.*
- 99002—Handling, conveyance, and/or any other service in connection with implementation of an order involving devices (e.g., designing, fitting, packaging, handling, delivering, or mailing) when devices such as orthotics, protectives, or prosthetics are fabricated by an outside laboratory or shop but which items have been designed, and are to be fitted and adjusted by the attending physician.*

**These codes (99000, 99001, and 99002) will deny as unbundled when billed with an E&M code.*

11.14 Clinical Lab Services

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

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

80047–80076	80100–80103	80150–80299
80400–80440	80500–80502	81000–81099
82000–83018	83020–83887	83915–84163
84202–84999	85002–85055	85130–85385
85397–85557	85597–85999	86000–86063
86140–86243	86277–86318	86329–86332
86336–86480	86485–86580	86590–86849
87001–87158	87164–87206	87209–87999

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

11.15 Editing Software for Facility and Professional Claims

11.15.1 Professional Claims

PacificSource Health Plans has used the OPTUM iCES Professional Editing application as the clinical editing solution for professional medical claims for many years. Using claims editing software helps to promote correct coding and standardized editing of the claims we receive on behalf of our members. The coding guidelines contained in the knowledge base are well researched, clearly defined and documented in support of transparency requirements. We apply these guidelines to both participating and nonparticipating professional providers. Edits made to claims are considered to be a provider adjustment and not billable to the member.

11.15.2 Facility Claims

Edits will be applied to both participating and nonparticipating facilities. All claims edited for correct coding will be considered to be a facility adjustment and not billable to the member.

11.15.3 Sample Edit Criteria

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

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

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

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

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

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

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

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

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

11.15.4 Other Generalized Edits

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

Hospital High-Dollar Audits: PacificSource contracts with an outside vendor for our high-dollar hospital audits (claims over $20,000). Once the audit is complete, the claim will be reprocessed based on the audited amount and contracted allowance.

11.16 Vision—Routine vs. Medical

PacificSource offers routine vision benefits, including hardware, as an endorsement to Group policies. Vision endorsements contain maximum dollar benefits and time limitations. Refer to plan documents for specific benefit limitations.

The following diagnosis codes are always paid as vision benefits, never as medical:

ICD-10	Description
H5200	Hypermetropia, unspecified eye
H5201	Hypermetropia, right eye
H5202	Hypermetropia, left eye
H5203	Hypermetropia, bilateral
H521	Myopia
H5210	Myopia, unspecified eye
H5211	Myopia, right eye
H5212	Myopia, left eye
H5213	Myopia, bilateral
H52201	Unspecified astigmatism, right eye
H52202	Unspecified astigmatism, left eye
H52203	Unspecified astigmatism, bilateral
H52209	Unspecified astigmatism, unspecified eye
H52211	Irregular astigmatism, right eye
H52212	Irregular astigmatism, left eye
H52213	Irregular astigmatism, bilateral
H52219	Irregular astigmatism, unspecified eye
H52221	Regular astigmatism, right eye
H52222	Regular astigmatism, left eye
H52223	Regular astigmatism, bilateral
H52229	Regular astigmatism, unspecified eye
H5231	Anisometropia
H5232	Aniseikonia
H524	Presbyopia
H52511	Internal ophthalmoplegia (complete) (total), right eye
H52512	Internal ophthalmoplegia (complete) (total), left eye
H52513	Internal ophthalmoplegia (complete) (total), bilateral
H52519	Internal ophthalmoplegia (complete) (total), unspecified eye
H52521	Paresis of accommodation, right eye
H52522	Paresis of accommodation, left eye
H52523	Paresis of accommodation, bilateral
H52529	Paresis of accommodation, unspecified eye
H52531	Spasm of accommodation, right eye
H52532	Spasm of accommodation, left eye
H52533	Spasm of accommodation, bilateral
H52539	Spasm of accommodation, unspecified eye
H526	Other disorders of refraction
H527	Unspecified disorder of refraction
Z0100	Encounter for examination of eyes and vision without abnormal findings
Z0101	Encounter for examination of eyes and vision with abnormal findings
Z460	Encounter for fitting and adjustment of spectacles and contact lenses

For detailed information regarding a member's vision benefits, refer to their Benefit Summary. There are many different plans (calendar year, plan year, dollar limits, rolling accumulators, etc.).