



Claims Editing, Coding and Reimbursement Guidelines

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changes to the procedure codes, changes in technology, and in the standards of medical and surgical practice.

Medically Unlikely Edits (MUEs) were implemented by CMS as of January 1, 2007 and are effective as of October 1, 2008. These edits are based on codes that would not likely be performed in more than certain quantities as defined by CMS.

Separate Procedures are CPT® procedure codes that include a designation “separate procedure”. The codes that are deemed “separate procedures” will not be considered for payment when billed with a code for the total procedure of which it is considered a component. The inclusion of “separate procedure” within the procedure code description is used to describe a procedure that should not be reported in addition to a total procedure or service. If a procedure that is described as a “separate procedure” is performed independently and not related to another procedure or service, such as in a separate session, separate site, or different organ system, it may be considered for payment. The addition of appropriate modifiers, diagnosis codes, and operative reports may indicate that the “separate procedure” has been performed as an independent procedure. If the information included with the claim is not sufficient to make a determination, a request for complete notes will be made.

Examples of services screened and adjudicated per the standards above include, but are not limited to, the following in combinations:

- Evaluation and management services billed with dialysis, audiology, allergy and immunology services
- Denial of payment for other procedures which are included in Evaluation and Management procedures as defined by AMA billing standards and/or CMS guidelines
- Exploratory surgery billed with more extensive surgical procedures
- Separate components of surgical services when a more comprehensive code is available
- Evaluation and management services billed with injections or immunizations
- Pathology Services
- Radiological Services
- Respiratory Services
- Urological Services
- Consultation Services

Notes and an appended modifier if needed are required for separate payment consideration for all prospective claims reimbursement edits. Please see the

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“Reconsiderations” section of this manual for further instruction on how to submit documentation for further review.

Services denied based on NCCI edits or MUE edits cannot be billed to Neighborhood Health Plan of RI members. These denials are based on incorrect coding and cannot be billed to the member.

Auditing- Retrospective Review

Records are reviewed to ensure all charges billed are supported and note requirements are met.

- Audits may be performed pre or post payment
- Audits may be performed on site or requested via regular mail and/or a Remittance Advice (explanation of benefits)
- The frequency of audits vary from quarterly, semi-annually to annually
- For retrospective audits, a pre-determined sample size based on claims submission volume will be requested and reviewed
- Any on site audit will be scheduled at least thirty days prior to the review
- Results will be communicated, in writing, within thirty days post review

Typically, auditing methods are post payment and performed on a historical basis. Generally, historical claims audits will not exceed one year from the original payment date. Some exceptions include:

- Fraud and Abuse Investigations – up to six year retrospective review
- Retroactive Membership and/or Termination
- Coordination of Benefits exceptions
- Third party liability activity
- Any claims activity resulting from legal activity not otherwise defined.

Neighborhood Health Plan of RI uses the 1997 Documentation Guidelines for Evaluation and Management Services standards when performing reviews on professional services.

Fraud and Abuse- Definitions and Detection

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As a payer of health care claims, Neighborhood Health Plan of RI has actively implemented programs in fraud and abuse detection and reporting. The Rhode Island Department of Human Services requires that health plans engage in identifying potential fraud and abuse.

A. Fraud is defined as the “intentional deception or misrepresentation that the individual makes, knowing it to be false or does not believe it to be true and the individual makes knowing that the deception could result in some unauthorized benefit to himself/herself or other person” (Section 14002.4B) .

B. Any provider or provider agent that does not provide care that is consistent with professionally accepted standards could be prosecuted for fraud. The following are the most common examples and forms of fraud:

- Billing for services that were not provided – such as billing for “no shows”
- Misrepresenting the diagnosis to justify the services, care, or equipment provided to the member – by indicating the member has a more serious condition than established in the exam, the provider or the member receive services that are not medically necessary or consistent with accepted standards of care
- Altering claims forms to receive a higher level of payment – billing companies may alter the claim form if they receive a commission based on the amount the carrier pays
- Soliciting, offering, or receiving a kickback for referral of patients in exchange for other services – hospitals and labs have paid physicians a percentage of their lab charges back to the physician as a kickback or waiver of deductibles or co-payments as an incentive
- Concealing ownership of related companies (i.e., the physician also owns the MRI service)
- Deliberate duplicate billing to Medicare, Medicaid, or another insurer in order to get paid twice
- Unbundled or exploded charges in which the provider bills for the component parts of a procedure instead of using the comprehensive code that describes the complete and total procedure – this is seen where the lab panel is billed as the individual tests or a surgical procedure is billed as all the components
- Providing Certificates of Medical Necessity for members that do not meet criteria or for members not known to the provider
- Falsifying plans of treatment or medical records in order to justify payment

- Misrepresenting the services provided or the person receiving the care – using another members coverage to pay for the services for another member or up-coding the procedure and providing a lower level of care
- Billing for non-covered benefits by using a different diagnoses – routine foot care provided for members without diabetes or systemic disease that meet the criteria for medically necessary podiatric service
- Billing services provided on one date over a period of days – billing for the removal of multiple skin lesion over a period of visits instead of on the date they were all removed
- Gang visit billing at a skilled nursing facility or other group domicile for members that did not receive any care
- Excessive charges for services or supplies –charging exorbitant fees for supplies or surgical trays or billing for sample drugs
- Claims for services that are not medically necessary – this includes not providing the documentation in the medical record that would support the level of care billed

C. Abuse is defined as incidents or practices by providers or their agents, which although not usually considered fraudulent, are inconsistent with accepted sound medical, business or fiscal practices that directly or indirectly create unnecessary costs. When a provider is notified of an abusive billing practice, and fails to make corrections, intent is then implied and the prosecution is for fraud.

D. Abuse can take many forms and is not limited to the following areas:

- Over-utilization of medical or health care services – 20 visits to the physical therapist without any measurable clinical improvement
- Claims for services that are not medically reasonable or necessary – weekly visits for blood pressure checks for a patient with medically treated and stable hypertension
- Billing for services not actually rendered – in order to receive higher capitation payments, the provider up-codes the encounters
- Underutilization of services – physicians who are capitated for services may not withhold medically necessary services
- Solicitation for payment for covered services outside of co-payment amounts

Coding Standards

Professional and Facility Procedural Coding

Valid procedural coding is required to process professional and facility services. Failure to furnish valid coding may result in payment delays or claim rejection. Codes must be in effect for the date of service.

Professional Coding

CPT Codes	All professional services require valid CPT coding for the date and nature of service.
HCPCS Level II Codes	All pharmacy, DME, and ambulance services require a valid HCPC code for the date and nature of service.

Facility Coding

Revenue Codes	All facility services require a valid four digit revenue code for the date and nature of service.
CPT Codes	All outpatient facility services require a corresponding valid CPT coding for the date and nature of service. Some exceptions may be made where no CPT code exists, such as recovery room charges or pharmaceutical charges.
HCPCS Level II Codes	All pharmacy, DME, nursing, home therapy and other applicable charges require a valid HCPC code for the date and nature of service.
DRG Codes	When contractually reimbursed

Revenue codes must crosswalk with any corresponding CPT or HCPC code billed. Neighborhood Health Plan of RI will accept pharmacy, supply, and device charges billed by revenue code only. An invoice may be required; please refer to any individual contractual language.

Diagnosis Coding

Claims submitted to Neighborhood Health Plan of RI will not be processed without a diagnosis code. The following guidelines from CMS bulletin B-03-046 should be followed by all providers in assigning an ICD-9-CM code:

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- Assign an ICD-9-CM code that provides the **highest degree of accuracy and completeness**. In the context of ICD-9-CM coding, the “highest degree of specificity” refers to assigning the most precise ICD-9-CM code that most fully explains the narrative description of the symptom or diagnosis. Concerning the level of specificity, ICD-9-CM codes contain 3, 4, or 5 digits. If a 3-digit code has a 4-digit code that further describes it, then the 3-digit code is not acceptable for claim submission. If a 4-digit code has a 5-digit code that further describes it, then the 4-digit code is not acceptable for claim submission.
- Diagnoses documented as “probable,” “suspected,” “questionable,” and “rule-out” or “working diagnosis” should not be coded as though they exist in the outpatient or office setting. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit such as signs, symptoms, abnormal test results, exposure to communicable disease, or other reason for the visit. In an inpatient setting, these diagnosis codes may be indicated as the reason for admission.
- Information for laboratories includes the following “Include the ICD-9-CM diagnosis code, as furnished by the physician/practitioner”. And “If a diagnosis or narrative diagnosis is not submitted by the physician/practitioner, laboratories must request this information from the physician/practitioner who ordered the service.”

On the CMS form 1500, providers shall enter the diagnosis code reference number (1, 2, 3, or 4) from the item 21 to relate the date of service and procedures performed to the primary diagnosis listed. Only reference one diagnosis indicator in item 24E, per line of service from the valid diagnosis codes in item 21.

Providers who are submitting claims with improper diagnosis codes may be subject to internal audit. Coders must use the ICD-9-CM coding book that is effective for the date the service was provided. The updated codes are published in the Federal Register in the Spring of each year.

Facility Bill Types

Valid bill types are required to process facility claims. Failure to furnish a valid bill type for the submission may result in processing delays or claim rejection. Some common bill types are listed below:

Inpatient Bill Types

- 111 Inpatient Hospital
- 112 Interim Inpatient Bill (Initial Claim)
- 113 Interim Inpatient Bill (Continuing Claim)

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- 114 Interim Inpatient Bill (Last Claim)
- 115 Inpatient Late Charges
- 117 Replacement Inpatient Claim (corrected claim)

Outpatient Bill Types

- 131 Outpatient Hospital
- 135 Outpatient Late Charge
- 137 Replacement Outpatient Claim (corrected claim)
- 141 Outpatient Hospital- same as 131

Home Health Care Bill Types

- 331 Outpatient Home Health Care
- 332 Outpatient Home Health Care- Interim (Initial Claim)
- 333 Outpatient Home Health Care- Interim (Continuing Claim)
- 334 Outpatient Home Health Care- Interim (Last Claim)

Ambulatory Surgical Center Bill Types

- 831 Outpatient Ambulatory Surgical Center
- 835 Outpatient Ambulatory Surgical Center Late Charges
- 837 Outpatient Ambulatory Surgical Center (replacement/corrected claim)

Evaluation and Management Services

Multiple Evaluation and Management Codes for the Same Date of Service

Payment is only allowed for one Evaluation and Management code per provider office, per date of service. A discharge from the hospital (99238 or 99239) can be billed and paid on the same day as a nursing facility admission code when they are billed by the same provider as long as the provider was not the surgical attending. This payment rule is an exception to the MCM guideline against billing for two Evaluation and Management services by the same provider on the same date for the same patient. For example, if the patient is discharged by a surgeon and admitted to a nursing facility (SNF, ICF, or LTCF) by that surgeon, there is no additional payment. These services fall under

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the global period for the surgery. In some cases, the surgeon discharges the patient from the hospital and the PCP admits the patient to the nursing facility. Both services are then payable as they are rendered by different providers.

New Versus Established Patient Guidelines

The Medicare and Physicians Current Procedural Terminology (CPT®) guidelines are used to determine the new or established patient status. A “new patient” is defined a patient who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years. In the instance where a physician is on call or covering for another physician, the patient’s encounter will be classified as it would have been by the physician who is not available. If no face-to-face encounter has previously occurred between the physician and the patient, then the patient may be coded as a new patient the first time a face-to-face encounter does occur. An interpretation of a diagnostic test, reading of an x-ray or EKG, etc., in the absence of a face-to-face encounter does not affect the new patient designation.

Preventative Medicine

Preventative service codes are used to report the routine evaluation and management of well infants, children, and adults. In general, the codes identify those visits that are scheduled by or for the patient for annual or periodic history and physical examinations.

- Coding is new versus established patient
- Coding is patient age sensitive
- Routine infant and childhood checks include routine assessment of growth and development, present health status, motor abilities, coordination skills, diet, sleep, and exercise habits, history and examination appropriate to the patient’s age and development status.
- Laboratory, radiology services, and immunizations are not typically included in the preventative codes and may be separately itemized on the claim.
- In some circumstances, a provider may discover or evaluate an illness or condition normally handled by a sick visit. Only one visit per day is payable.

Consultations

AMA CPT® and Medicare Carriers Manual (MCM) section 15506 guidelines are utilized to differentiate consultations from office visits or other outpatient services. There are four key elements in the MCM section 15506. Section (A) Consultation versus Visit is used to determine whether a visit can be considered a consultation. **All criteria must be met to use a consultation code:**

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- Specifically, a consultation is distinguished from a visit because it is provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.
- A request for a consultation from an appropriate source and the need for consultation must be documented in the patient's medical record. If the request is made verbally, the consulting physician records in the medical record – "I was asked to see Ms. Smith at the request of Dr. Gray."
- After the consultation is provided, the consultant prepares a written report of his/her findings, which is provided to the referring physician.
- If counseling/coordination of care constitutes more than 50 percent of the face-to-face encounter between the physician and the patient, consultations may be billed for time.

Consultations Followed by Treatment (MCM 15506 (B) – Pay for an initial consultation if all the criteria for a consultation are satisfied. Payment may be made regardless of treatment initiation unless a transfer of care occurs.

- A transfer of care occurs when the referring physician transfers the responsibility for the patient's complete care to the receiving physician at the time of referral, and the receiving physician documents approval of care in advance. The receiving physician would report a new or established patient visit depending on the situation (a new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past 3 years) and setting (e.g., office or inpatient).
- Physician consultant may initiate diagnostic and/or therapeutic services at an initial or subsequent visit. Subsequent visits (not performed to complete the initial consultation) to manage a portion or all of the patient's condition should be reported as established patient office visit or subsequent hospital care depending on the setting. MCM 15506 (C)
Consultations Requested by Members of the Same Group – Pay for a consultation if one physician in a group practice requests a consultation from another physician in the same group practice as long as all the requirements for use of the CPT® consultation codes are met. See §§15506A and 15501.H.
- Non-physician practitioners, e.g., nurse practitioners, certified nurse midwives or physician assistants, may request a consultation. They may also perform other medically necessary services, e.g., consultations when the performance is within the scope of practice for that type of non-physician practitioner in the State in which they practice. Applicable collaboration and general supervision rules apply as well as billing rules.

- Documentation for Consultation – A request for a consultation from an appropriate source and the need for consultation must be documented in the patient’s medical record. A written report must be furnished to the requesting physician.
- In an emergency department or an inpatient or outpatient setting in which the medical record is shared between the referring physician and the consultant, the request may be documented as part of a plan written in the requesting physician’s progress note, an order in the medical director, or a specific written request for the consultation. In these settings, the report may consist of an appropriate entry in the common medical record. In an office setting, the documentation requirement may be met by a specific written request for the consultation from the requesting physician or if the consultant’s records show a specific reference to the request. In this setting, the consultation report is a separate document communicated to the requesting physician. If the provider/consultant sees the patient in the emergency department and then decides to admit the patient, the provider has to decide whether to charge for the consultation or an admission code. The provider cannot charge for both.

In reviewing the medical record to determine whether a consult has been provided, the following conditions would rule out the charge for a consultation:

- No order in the record for a consultation – did the requesting physician ask for an opinion or advice regarding a patient’s specific problem
- No written report of a consultation back to the requesting physician
- A standing order in the medical record for consultations

A consultation that is requested by the patient and or the patient’s family is not coded as an initial consultation, but may be reported using a code for a new or established patient visit as determined by the patient’s history with the practice and the site of service provided.

Eliminated from CPT 2006 are the follow up consultation codes and the confirmatory consultation codes. Only initial inpatient consults and office/outpatient consultations are included in CPT 2006. The following guidelines will assist in the payment of the consultation codes:

- Only one inpatient consult 99251-99255 is allowed per physician per admission.
- Only one initial inpatient consult may be coded per nursing facility admission. Time interval is not considered.

- Subsequent inpatient visits by the consulting physician should be billed as follow up hospital visits 99231-99233 or subsequent nursing facility codes 99307-99310.

Confirmatory consults were also deleted from CPT 2006 and CPT guidelines call for the provider to bill the service based on the place of service and the type of service.

Neighborhood Health Plan of RI may disallow payment for “compound” procedures which are normally included in E&M consult code range from 99241 through 99255 and are not identified as “in addition to” by AMA CPT® documentation.

Specialty Services

Allergy Testing and Immunotherapy

Allergy testing consists of the selective evaluation and performance of cutaneous or mucous membrane tests. Immunotherapy consists of the injection of allergenic extracts which are prepared by the allergist. Key coding and reimbursement points include:

- Separate coding for injection only codes 95115 through 95117 and coding for the preparation of the antigens 95144 through 95170 should be used.
- The preparation of single dose vials is discouraged as it unnecessarily increases the costs for the care. Medical record documentation must support the need for single dose vials.
- The fee schedule amounts for the antigen codes are for a single dose. The provider should indicate the number of doses provided in the multi-dose vial.
- Codes 95115 through 95199 include all the professional services necessary for allergen immunotherapy. The physician can bill for an office visit if the service is medically necessary and separately identifiable from other immunotherapy services that date. The office visit with a 25 modifier can be submitted.

Chemotherapy

Chemotherapy is the parenteral administration of anti-neoplastic drugs for the treatment of cancer diagnosis and auto-immune conditions. Chemotherapy also includes biologic

response modifiers and monoclonal antibody agents. Key coding and reimbursement points include:

- The 2008 CPT® guidelines for drug administration changed the categories of drug administration and the use of the codes. The guidelines were developed in partnership with CMS. The guidelines developed by the AMA and CMS are developed around three separate areas of administration:
 - Infusions for hydration
 - Non-chemotherapy therapeutic or diagnostic injections/infusions
 - Chemotherapy administration
- All the infusion codes for hydration, injections, and chemotherapy require direct physician supervision. If the physician is not present, the ancillary staff, RN, or LPN cannot bill for these services. The physician must be physically present, review and affirm the treatment plan, and supervise the non-physician clinical staff.
- The following services and supplies are included in the infusion and injection codes and are not separately billable:
 - Use of local anesthetic
 - IV access
 - Access to an indwelling IV, subcutaneous catheter or port
 - Flush at the conclusion of infusion
 - Standard tubing, syringes, and supplies
 - Preparation of the chemotherapy agents
- Flushing of a port is considered bundled into another service, either an Evaluation and Management services or administration of the drug. The flushing of a port is only payable if it is the only service billed. The patient would have to present to the physician's office just for port flushing.
- Hydration is the administration IV fluids necessary for the treatment of dehydration or required in the treatment protocol and administered prior to the administration of the chemotherapy drug. The following are reimbursement rules for hydration therapy:
 - Payment for hydration therapy is bundled into the payment for chemotherapy drug administration when the infusions are administered at the same time.

- The fluids used to administer or prepare the chemotherapy drugs is considered incidental hydration and is not separately reportable. Hydration is only payable when sequential or as a separate and medically necessary service.
 - If the hydration service is performed sequentially or as a separate procedure, the code should be modified with a 59 to indicate the special circumstances.
 - The actual solutions administered for hydration are billed with the appropriate J code.
- Therapeutic, prophylactic, and diagnostic injections and infusions exclude the administration of chemotherapy agents.
 - Pushes are infusions that last for 15 minutes or less. Infusions are considered to be any infusion greater than 15 minutes. The times in the medical record are required to be exact and not approximate or rounded to nearest 5- minute increments.
 - The medications administered to the cancer patient to treat or prevent nausea or anemia are not considered part of the chemotherapy but a separate therapeutic injection.
 - The physician may report the infusion code for “each additional hour” only if the infusion is greater than 30 minutes beyond the hour increment.
 - If the patient is having more than one or multiple injections, infusions or combinations, the physician should bill for one initial service unless the treatment protocol requires two separate IV sites to be used. The initial service code describes the primary reason for the patient encounter and may not be the “first service” provided to the patient.
 - The following services and supplies are included in the chemotherapy codes and are not separately billable:
 - Use of local anesthetic
 - IV access
 - Access to an indwelling IV, subcutaneous catheter or port
 - Flush at the conclusion of infusion
 - Standard tubing, syringes, and supplies
 - Preparation of the chemotherapy agents

- The complex chemotherapy codes require the direct supervision of the patient by the physician, require highly trained personnel to administer and support the patient care, including frequent monitoring of the patient's condition.
- The initial therapy will be the primary reason for the patient encounter and when multiple infusions are administered, only the initial code is reported unless two lines – IV sites – are required. The order of the administration of the drugs will not always reflect the order of the initial service and concurrent or subsequent injections or infusions.
- The chemotherapy codes are organized by type of injection or infusion. The add-on codes are tied to codes but unlike other section of the 2006 CPT®, the codes may be added on to multiple levels of codes.
- Evaluation and management services provided on the same day as chemotherapy or non-chemotherapy injections and infusions are covered if medically necessary and separately identifiable from the other services. The E/M services must be billed with a modifier 25 and do not require a separate diagnosis.
- 99211 should not be billed with a diagnostic or therapeutic injection or infusion.
- Oral anti-nausea drugs are covered as a treatment modality as part of the patient's chemotherapy treatment. The following conditions must be met for these oral anti-nausea drugs to be covered:
 - The drug must be FDA approved for the use as an anti-emetic.
 - The oral anti-emetic must be administered by the treating physician or in accordance to a written order from the physician as part of the patient's chemotherapy treatment plan.
 - The oral anti-emetic must be administered and initiated not more than two hours prior to the administration of chemotherapy and cannot exceed a period of 48 hours from that time.
 - The oral anti-emetic must be used as a full therapeutic replacement for any anti-emetic drugs that would have been infused at the time of the chemotherapy treatment.
 - More than one anti-emetic drug can be billed during the chemotherapy treatment.

Critical Care Services

Critical care encompasses treatment for any patient who is suffering from a life-threatening condition. CMS describes a critical illness or injury as one that “acutely impairs one or more vital organ systems such that the patient’s survival is jeopardized.” Documentation is required to support the personal management by the patient’s physician including notation of time. Key coding and reimbursement points include:

- Critical care includes the care of critically ill and unstable patient who require constant physician attention, whether the patient is in the course of a medical emergency or not.
- Both CMS and the AMA say that the critical illness or injury results in a high probability of imminent or life threatening deterioration in the patient’s condition.
- While critical care is usually given in the coronary care unit, intensive care unit, respiratory care unit, or emergency department, payment may be made for critical care services in any location as long as the care meets the definition of critical care.
- The typical place of service codes are 21 and 23.
- Constant attendance or constant attention is a prerequisite for care to be considered critical care.
- The duration of critical care time is the time the physician spent working on the critically ill patient.

The following are activities that can be included in the critical care time:

- Review of medical data – lab, x-ray, or other diagnostic tests
- Discussion of the patient’s care with other medical staff in the unit or at the nurse’s station
- Obtaining medical history and discussion of treatment options with the family members if the patient is unable to contribute. The conversation must have a direct contribution to medical decision- making. Other family discussions that include the routine updating of the family of the patient’s condition or emotional support are not considered critical care.

- The time spent with the critically ill patient and the services rendered should be recorded in the patient's medical record to support the claim for critical care services. Even if the time is not continuous, the physician should list the number of minutes with a detail of what he or she was doing and spell what happened during the patient encounter.
- Procedures included in the description of critical care service codes are not reimbursed separately when provided by the physician billing critical care are:
 - Gastric intubation
 - Pulse oximetry
 - Temporary transcutaneous pacing
 - Ventilator management and settings
 - Vascular access procedures
 - Review of ECGs, blood pressures, and hematologic data
 - Blood draws for specimen
 - Blood gases
 - Chest x-ray review
 - Interpretation of cardiac output measurement
 - Family medical psychotherapy
- In teaching facilities, time spent teaching or supervising residents is not considered critical care. Critical care services billed by a physician cannot include any delegated care by other health care professionals or residents.
- Only one physician can bill for any given hour of critical care, even if more than one physician is in attendance. A physician can only bill for 99291 once per date for the first 30-74 minutes of critical care.
- Critical care code 99292 is used to report each additional 30-minute interval beyond 74 minutes.
- Total Duration of Critical Care Time Codes:
 - Less than 30 minutes 99232 or 99233
 - 30 to 74 minutes 99291
 - 75 to 104 minutes 99291 x 1 and 99292 x 1
 - 105 to 134 minutes 99291 x 1 and 99292 x 2
 - 135 to 164 minutes 99291 x 1 and 99292 x 3
 - 165 to 194 minutes 99291 x 1 and 99292 x 4

- If critical care is provided in the emergency department physician and critical care services are billed; no other emergency department or outpatient evaluation and management codes will be reimbursed for that visit.
- If critical care services are billed by the surgeon, the modifier should indicate that either the condition was unrelated to the original surgical problem (modifier 24) or the patient's condition required a separately identifiable E/M service on the day of service (modifier 25) that was beyond the usual postoperative care associated with the procedure. This includes critical care services in both trauma and burn cases.

Emergency Department Services, Evaluation and Management Codes

Emergency Department Services codes 99281 to 99285 are used to report evaluation and management services provided in the emergency department. These codes will only be allowed for place of service 23, Emergency Department, Hospital. Medicare, along with the AMA, defines an emergency department as an organized hospital based facility, open 24 hours a day, whose purpose is to provide unscheduled, episodic, immediate services. 99281 to 99285 are not to be used for any other setting but the emergency department. While urgent care centers and other ambulatory facilities may provide emergent or urgent care, the place of service is not 23, Emergency Department, Hospital. Evaluation and management codes appropriate to the setting and level of services should be used to bill for the patient's care. In most instances, urgent care facilities are classified as place of service 20. Key coding and reimbursement points include:

- Only one emergency department E & M code can be billed per emergency room visit.
- The code range applies to new and established patients.
- If an emergency department E & M code is billed with a consult code by the same physician, for the same visit, the emergency department E & M code is not separately reimbursed
- If a hospital admission (observation or inpatient) E & M code is billed by the same physician, for the same visit, all other E & M codes billed are not separately reimbursed.
- If an emergency department E & M code is billed with a critical care service, multiple diagnoses must be billed on the claim to be considered for separate payment. Modifier 25 may be billed on the emergency Evaluation and Management code.

Hospital Inpatient Services

Hospital inpatient services are typically visits during the course of an inpatient hospital stay. The following services are considered inclusive in the initial and subsequent hospital visits:

- Hospital admission includes all evaluation and management services on the same day including emergency visits, office visits, and nursing facility visits.
- Only one visit per day per provider is reimbursable
- Multiple visits on the same day from providers with different specialties may be considered
- Post surgical visits billed by the physician performing the surgery are considered inclusive in the surgical procedure fee allowance
- Post surgical visits not related to surgery will be considered for separate payment

Laboratory and Pathology-Biopsy Services

A biopsy is a payable service if the biopsy was performed independently of, unrelated to, or as a distinct procedure from other services provided at the same surgical session. A biopsy is a removal of a small piece of tissue for microscopic examination and /or culture. Biopsies are obtained by shaving the lesion, punching a piece of tissue out, or excisional removal. Key coding and reimbursement points include:

- If a biopsy is performed during a surgical excisional procedure and the removed tissue is sent for pathology or culture, the excised tissue is considered a routine part of the excisional procedure and as such is not billable. Biopsies cannot be billed if they are part of the lesion removal.
- Multiple biopsies from the same lesion are coded as a single biopsy.
- If the surgical note indicates that the entire lesion was removed, then the procedure is not coded as a biopsy but as an excision.
- Modifier 59 is used to indicate that a procedure or service was distinct or independent from other services performed on the same day. If an excision was performed from one site and a biopsy taken from another lesion, then a modifier 59 is added to the biopsy code along with any relevant anatomical modifiers.

- The medical record should document the distinct anatomical location and description of the biopsy(ies), how the tissue was obtained, and a copy of the pathology or culture report to validate medical necessity.

Inpatient Neonatal and Pediatric Critical Care Services

Critical care encompasses treatment for any patient who is suffering from a life-threatening condition. CMS describes a critical illness or injury as one that “acutely impairs one or more vital organ systems such that the patient’s survival is jeopardized.” Documentation is required to support the personal management by the patient’s physician including notation of time. The inpatient neonate and pediatric critical care services are reported for infants and children from under 28 days to 24 months of age. Key coding and reimbursement points include:

- Constant attendance or constant attention is a prerequisite for care to be considered critical care. The duration of critical care time is the time the physician spent working on the critically ill patient. The following are activities that can be included in the critical care time:
 - Review of medical data – lab, x-ray, or other diagnostic tests
 - Discussion of the patient’s care with other medical staff in the unit or at the nurse’s station
 - Obtaining medical history and discussion of treatment options with the family members if the patient is unable to contribute. The conversation must have a direct contribution to medical decision-making. Other family discussions that include the routine updating of the family of the patient’s condition or emotional support are not considered critical care.
- The Inpatient Neonatal and Pediatric Critical Care Services are divided into two age groupings:
 - Under 28 days
 - 29 days to 24 months
- Services that are bundled into the critical care services according to CPT are include the following:
 - Umbilical venous and umbilical arterial catheters
 - Other arterial catheters, including central or peripheral catheterization

- Vascular access procedures
 - Vascular punctures
 - Oral or nasogastric tube placement
 - Endotracheal intubation
 - Lumbar puncture
 - Suprapubic bladder aspiration
 - Bladder catheterization
 - Ventilatory management
 - Continuous positive airway pressure (CPAP)
 - Surfactant administration
 - Intravascular fluid administration
 - Transfusion of blood components
 - Invasive or noninvasive electronic monitoring of vital signs, bedside pulmonary function testing
 - Monitoring or interpretation of blood gases or oxygen concentration
- Any other services performed that are not on the above list may be reported separately.

Mammography Screening

Screening mammography is a benefit for Neighborhood Health Plan of RI members. Screening mammographies are radiological procedures for early detection of breast cancer. Key coding and reimbursement points include:

- Billable primary diagnosis codes are V76.11 “Special screening for malignant neoplasm, screening mammogram for high-risk patients” and V76.12 “Special screening for malignant neoplasm, other screening mammogram.”
- When submitting a claim for a screening mammography and a diagnostic mammography for the same patient on the same day, attach modifier GG to the diagnostic mammography.
- 77051 - Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images, diagnostic mammography. (List separately in addition to code for primary diagnostic procedure, 77055, 77056, G0204, G0206).
- 77052 - Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or

without digitization of film radiographic images, screening mammography. (List separately in addition to code for primary screening procedure, 77057 or G0202).

.Other key coding and reimbursement points include:

- To bill the technical component only, use modifier TC. To bill the professional component only, use modifier 26.
- When billing a global fee, no modifier is needed.
- If more than one modifier is necessary (i.e., for HPSA), place the mammography modifier in position 1 and the other modifier in position 2.

Documentation in the progress notes must reflect medical necessity and be available on request.

Observation Status Evaluation and Management Services

Patients designated as observation status are being observed to determine if they should be admitted to the hospital, sent home, or transferred to another level of care. Key coding and reimbursement points include:

- Only the physician who admits the patient to observation status can report the initial observation evaluation and management (E/M) code.
- The Initial Observation Care for New and Established Patient codes 99218-99220 are used to denote that the attending physician admitting the patient to observation status has done the following:
 - Accessed and established a care plan
 - Supervised the care plan
 - And performed periodic reassessments
 - Dated and timed admitting orders along with progress notes and nursing notes
- All the attending physician's E/M services provided on the date of the patient's admission to observation are included in the E/M code. The guidelines for the initial observation care can be found in your CPT® book. All the codes call for a detailed or comprehensive history and comprehensive exam. The Medical Decision Making component is a key component in determining the actual code level.

- In reviewing the observation notes, a comprehensive history includes family and social history and a comprehensive exam includes a full system review.
- If the patient is admitted to observation from the office or another department of the hospital, any services that were provided in addition to the observation stay services are considered to be a part of the initial observation care when performed on the same date of service by the same provider.
- If the patient is admitted on the same date as the initial observation stay date, the physician can only bill for the initial hospital visit. CMS payment for the initial hospital visit includes all services provided to the patient on the date of admission.
- When the patient is changed from observation to inpatient status on the same date of service, the physician cannot bill for a discharge management code, 99217 or an outpatient visit for the care in the observation unit.
- If the patient requires observation care during the postoperative period, the global surgical fee includes payment for observation care related to the surgical procedure. The observation status would only be payable if the care was justified with modifiers 24, 25, or 57 and the medical record supported the observation stay.
- Any physician, other than the admitting physician to observation status, should use the appropriate outpatient/office or consultation codes to bill for services to the patient while on observation status.
- If the patient is admitted and discharged from observation status on the same date, the appropriate coding section include codes 99234-99236, Observation or Inpatient Care Services (Including Admission and Discharge Services). There are some additional guidelines not included in the CPT® book for these codes:
 - The observation stays must be for a minimum of eight hours but less than 24 hours
 - The billing physician must be present and personally providing the services
 - The admitting and discharge notes must be written by the billing physician
- If the patient is discharged on the second day, the discharge day services are coded with the observation care discharge code. No observation discharge code is allowed if the patient is admitted to observation status for less than 8 hours.

- In those instances where the patient is initially admitted to observation status, stays day 2 and is discharged on day 3, the second day services are billed using the subsequent office/outpatient visit codes. The hospital inpatient codes are not applicable as the patient is not an inpatient.

Obstetrical Guidelines

When routine maternity care is rendered by the same physician (or another physician in the same practice) for antepartum, delivery, and/or postnatal care, a global obstetrical care code should be used. Key coding and reimbursement points include:

- Routine care is generally defined as:
 - Initial and subsequent history
 - Physical examination
 - Recording of weight
 - Blood pressure checks
 - Monitoring of fetal heart tones
 - Routine chemical urinalysis
 - Routine visits
 - Management of uncomplicated labor and delivery services, including admission
 - Post partum hospital and office visits following vaginal and cesarean delivery
 - Any high risk visits or visits for an unrelated diagnosis must be billed with supporting diagnosis codes for separate reimbursement to be considered.
 - Obstetrical care is considered included in the obstetrical package from the date that the obstetrical medical record is established.

Ophthalmology

A comprehensive eye examination is rendered when a general evaluation of the complete visual system is made. The components of a comprehensive ophthalmology examination may be provided in one visit or on the subsequent day. The date of service that is submitted on the claim is the date that all the components are completed and documented. Key coding and reimbursement points include:

- Procedures included in a comprehensive level exam include those performed under an intermediate level exam plus:

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- Dilated ophthalmoscopy
 - Motor evaluation
 - Biomicroscopy, if indicated
 - Examination with cycloplegia or mydriasis (dilated ophthalmology), if indicated
 - Tonometry, if indicated
 - A comprehensive examination always includes initiation of diagnostic and treatment programs as indicated
- When performing a comprehensive eye examination, it is important that the following exam elements are documented in the patient's records:
 - History
 - General medical observation
 - External and ophthalmoscopic exam
 - Confrontation visual fields
 - Basic sensorimotor exam
- The coding for the comprehensive eye exam can be submitted using the general ocular medical examination CPT codes (CPT codes 92002-92014).
- Other non routine exams can be billed using the evaluation and management (E/M) services CPT codes (CPT codes 99201-99350).
- When E/M CPT codes are submitted, documentation in the patient's medical record must substantiate the medical necessity for and performance of the submitted level of care.
- Medical diagnostic evaluation is included in visual field testing and should not be reported separately.
- Denial of commercial and senior visual field testing (e.g. 92225 - 92284), unilateral procedures, when reported with a -50 (bilateral) modifier.
- Codes 92225 92284 are considered unilateral.
- Valid modifiers include modifiers 22,26,32,51,52,53,55,56,57,58.
- Valid post-operative modifiers include modifiers 59, 76, 77, 78, 79, 90, 99.

Pediatric Critical Care Transport

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The pediatric critical care patient transport codes are used to report the direct face-to face care and physical attendance by a physician during the inter-facility transport of a critically injured or ill pediatric patient of 24 months of age or less. Key coding and reimbursement points include:

- The Pediatric Critical Care Patient Transport Codes are found in the Evaluation and Management section of the current CPT® manual. These codes are to be used when the physician attendance of the pediatric patient exceeds 30 minutes. If less than 30 minutes, the physician should select a more appropriate Evaluation and Management code.
- Critical care services delivered by a physician, face-to-face, during an inter-facility transport of critically ill or critically injured pediatric patient, 24 months of age or less; first 30-74 minutes of hands on care during transport are reported with 99466. This is a primary code. Each additional 30 minutes should be reported with the add-on code 99467.
- These codes are time related and the actual times of care and service will be documented in the medical record including the ambulance/air transport records. The times should correlate.
- The following codes are considered components of the Pediatric Critical Care Transport and are not to be reported separately. Any other services that are not included in this list may be billed separately.
 - Routine monitoring evaluations (e.g., Heart rate, respiratory rate, blood pressure and pulse oximetry) – Vital signs and cardiac monitoring.
 - Interpretation of cardiac output measurements
 - The interpretation of chest x-rays
 - The interpretation of pulse oximetry -fifth vital sign
 - The interpretation of blood gases and information data stored in computers, such as ECGs, blood pressures, or hematological data
 - Gastric intubation
 - Temporary cardiac transcutaneous pacing
 - Ventilator management
 - Vascular access procedures

Physical Therapy Time Limits and Service Guidelines

The 15-minute increment physical therapy timed codes were redefined by CMS. The following guidelines exclude pre-delivered and post-delivery services from the

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reimbursable periods. Under CMS Program Memo AB-00-04, new guidelines were established for billing the 15-minute units of physical therapy. Medicare guidelines state that a single 15-minute unit of physical therapy is equal or greater than 8 minutes but less than 23 minutes. Physical Therapists should not bill for any services of less than 8 minutes. CMS established the following parameters to aid in billing multiple units of physical therapy services:

- 2 units are greater to or equal to 23 minutes but less than 38 minutes
- 3 units are greater to or equal to 38 minutes but less than 53 minutes
- 4 units are greater to or equal to 53 minutes but less than 68 minutes
- 5 units are greater to or equal to 68 minutes but less than 83 minutes
- 6 units are greater to or equal to 83 minutes but less than 98 minutes
- 7 units are greater to or equal to 98 minutes but less than 113 minutes
- 8 units are greater to or equal to 113 minutes but less than 128 minutes

When more than one physical therapy service is billed in a calendar day, the total number of units billed is based on the total treatment time.

- For example, if the therapist delivers 7 minutes of 97035 (Ultrasound), 5 minutes of 97140 (massage) and 10 minutes of 97110 (therapeutic exercise), the total time is 22 minutes. When billed, only 1 unit of 97110 is submitted. This was the service that took the greatest amount of time. The physical therapy record will document the other modalities that were provided.

- If the therapist delivers 15 minutes of 97036 (Hubbard tank) and 10 minutes of 97140 (massage), when billed 1 unit of 97036 and 1 unit of 97140 would be submitted as there was greater than 23 minutes. Total units billed are based on total time.

The timing of each unit excludes any other pre or post treatment services. The patient should be timed from when the actual therapies or services begin. Waiting, exercise, rest periods, bathroom breaks, and clothing changes are excluded from the calculation of the unit minutes. Medical record documentation by the physical therapist should indicate the beginning and ending times of each modality and the outcomes of each treatment. As in all physical therapy service, the patient's condition along with the need for services that can only be provided by a licensed Physical Therapist are key determinants of medical necessity.

- Non-skilled personnel can perform services such as heat or ice packs, assistive walking or repetitive exercises. In those instances, these services are considered part of the treatment of the patient and not skilled in nature nor separately billable.

- The physical therapy plan of care must include the diagnosis and anticipated goals of therapy and **must be recertified every 30 days**. The Plan of Care must have the following documented in the patient's record:
 - The patient's significant past history
 - Patient's diagnosis that requires physical therapy
 - Related physician orders
 - Therapy goals and potential for achievement
 - Any contraindications
 - Patient's awareness and understanding of diagnosis, prognosis, treatment goals, and
 - The summary of treatment provided and results achieved during previous periods of therapy, if appropriate.

Other coding and reimbursement points include:

- CMS requires the continued use of the GP modifier for Physical Therapy, GO modifier for Occupational Therapy, and GN for Speech Therapy.
- 97010 (application of modality to one or more areas; hot or cold packs) is bundled by Medicare whether they are billed alone or in conjunction with another therapy code. With supporting documentation, this code may be reimbursable when billed **alone**.

Physician Stand By Services

Additional payment is allowed for procedures billed in addition to physician standby services. The AMA CPT® description for physician standby services states this service should be reported with 99360. This code should not be reported with 99464 but may be reported in addition to 99460 and 99465 as appropriate. Key coding and reimbursement points include:

- Code is billable for one patient only
- Full thirty minute time increments are required for reimbursement
- One unit is equivalent to a full thirty minutes
- If less than thirty minutes, code is not reportable
- The time requirement represents total duration per day
- If a surgical procedure is performed by the stand by physician on the same day, the standby service is inclusive in the surgical reimbursement

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Prolonged Services

Prolonged physician services are payable, under Medicare guidelines, when the duration and content of the direct face-to-face contact with the patient encounter has exceeded the “typical time” set by CPT by 30 minutes. Emergency Department Services codes 99281 to 99285 do not have an average time listed in their code descriptions and cannot have “prolonged services” in addition to the emergency visit. Medicare and other payers will pay for prolonged face-to-face services between the patient and the physician in addition to the E&M service for that day. The medical record documentation must demonstrate the E&M level of service, and the duration and content of the prolonged services. Prolonged physician services codes are add on codes and must be billed with one of the following E&M codes:

- 99201-99205, 99212-99251, or 99241-99245.

Vaccine Billing Guidelines

For children under the age of 18.9 years of age enrolled with Neighborhood Health Plan of RI, vaccines are typically reimbursed directly to providers by the State of Rhode Island. A provider is entitled to reimbursement of an administrative charge for each vaccine administered from Neighborhood Health Plan of RI. For Neighborhood Health Plan of RI’s adult population, a provider is typically entitled to both the vaccine and administration reimbursement. The following details appropriate billing for vaccine charges:

Intramuscular Administration Codes	Oral/Nasal Administration codes
90471 (first vaccine)	90473 (first vaccine)
90472 (each subsequent)	90474 (each subsequent)
90465 (first vaccine) < age 8	90467 (first vaccine) < age 8
90466 (each subsequent) < age 8	90468 (each subsequent) < age 8

Usage Guidelines:

1. Codes are not interchangeable. If providers are going to use the 90471-90474 series of codes, it is a NHPRI recommendation that they only use these codes per billed claim. The same standard applies if they are choosing to use the 90465-90468 for the young patients.

Ex. Provider should not bill 90471 and 90465 on the same claim as they are essentially the same code. These codes are considered bundled and one will be denied.

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2. If provider administers both intramuscular and oral vaccines during the same visit, they must use the appropriate administration codes to reflect the type of substance given.

Ex. Provider gives member 90669 (pneumonia injection), 90680 (rotavirus oral), 90700 (Dtap injection) & 90710 (mmrv injection). We would expect to see the following administration code combinations if using the 90471-90474 series of codes:

90471 with 1 unit (for the first vaccine)
90472 with 2 units (for the last two injections)
90474 with 1 unit (for the oral vaccine)

OR

90473 with 1 unit (for the nasal vaccine)
90472 with 3 units (for all injections)

If using the 90465-90468 codes for their patients under 8:

90465 with 1 unit (for the first vaccine)
~~9046~~ 90466 with 2 units (for the last two injections)
90468 with 1 unit (for the oral vaccine)

OR

~~9047~~ 90467 with 1 unit (for the nasal vaccine)
~~9046~~ 90466 with 3 units (for all injections)

REMINDER: ALL VACCINE ADMINISTRATION CODES MUST BE BILLED WITH A CORRESPONDING VACCINE CODE OR THE SERVICE WILL DENY.

A provider who has paid for a vaccination out of pocket is entitled to submit the charge with an invoice to Neighborhood Health Plan of RI for consideration.

Venipuncture

Venipuncture (CPT 36415 or 36416) is not paid separately when billed with anesthesia or lab tests because they are considered incidental to the primary procedure performed. In addition, multiple occurrences of 36415 or 36416 in the same session, when reimbursable, are paid as a single procedure. It is standard practice of major carriers to

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deny blood collection on pathology and anesthesia claims. Multiple occurrences of 36415 or 36416 are denied with pathology as the tests are usually performed on a single blood draw. A provider is entitled to reimbursement if the collection is performed and sent to an outside laboratory for processing.

Materials and Handling Charges

Neighborhood Health Plan of RI will deny payment for 99000 and 99001 material and handling for all procedures billed (including procedures billed in addition to surgery). This service is not separately reimbursable.

Billable Medical Supplies

All medical supplies should be billed with the appropriate CPT® or HCPC® code. If the supply is considered a miscellaneous supply, the claim must be billed on paper with a miscellaneous supply code and an invoice attached for review. CPT® Code 99070 (Supplies and Materials) is generally not reimbursed unless dictated by contractual reimbursement.

Special Services, Procedures and Reports (Codes 99000-99091)

Under Medicare and most Medicaid programs, “special service” codes are considered bundled and while these are covered services, they are not separately payable. Managed care contracts and private payers may consider these codes payable based on contract or medical necessity. The Special Services, Procedures, and Reports codes 99000- 99091 are always billed in conjunction with the basic service provided for the patient.

- 99000 – 99002: Handling and conveyance charges are routinely bundled by Medicare and most Medicaid programs. Routine handling charges are not payable when a specimen is referred from one lab to another or when a physician’s lab transfers a specimen to a reference laboratory as these charges are considered part of the office visit. These charges are not covered by Neighborhood Health Plan of RI.
- 99024: Postoperative follow up visit, included in global service is a bundled service as the postoperative visits are a component of the surgical global package. This code is not separately reimbursable by Neighborhood Health Plan of RI when billed as part of surgical care.

- 99026-99027 Hospital mandated on call services both in house and out-of-hospital are not usually reimbursable by Medicare, Medicaid, or commercial payers.
- 99050 – 99058 After hours reimbursement (These codes are only reimbursable under specific contractual agreements).
- 99070 The development of the HCPCs has eliminated the payment and use of this code. Neighborhood Health Plan of RI does not typically reimburse this code.
- 99071 Educational supplies, such as books, tapes, pamphlets proved by the physician are bundled into the office visit or other service under Medicare and most Medicaid programs. Neighborhood Health Plan of RI does not reimburse this code.
- 99075 and 99080 Medical testimony and special reports are not covered benefits under Medicare or most Medicaid plans. It is usually billed for workers' compensation or litigation related services where the applicant or defendant's attorney pays for the services. Neighborhood Health Plan of RI does not reimburse this code.
- 99078 Physician educational services rendered to patients in a group setting such as cardiac rehabilitation, diabetic, prenatal, and obesity instruction may be covered if under specific contractual agreement and/or benefit package.
- 99082 Unusual travel, transport and escort of patient is used to report the physician services for accompanying a patient by an unusual method of transport such as by helicopter. If the physician does not travel with the patient, this code should not be used. Neighborhood Health Plan of RI does not reimburse this code.
- 99090 - 99091 Analysis of clinical data stored in computers (eg, ECGs, blood pressures, hematologic data) and provider collection and interpretation of computerized data stored or transmitted by the patient or caregiver. These services are bundled by Medicare. 99091, using AMA guidelines, should be reported no more than once per month, is considered bundled if billed on the same day as the patient receives Evaluation and Management services or within 30 days of billing for care plan oversight services 99374-99380. Neighborhood Health Plan of RI does not reimburse these codes.

Billing for Unlisted Procedure Codes

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Services billed with unlisted procedure codes or a “not otherwise classified” code require supporting documentation prior to consideration of payment. Most sections of the CPT® code book contain codes for billing procedures and services that are not otherwise classified or described within the codes.

- Unlisted procedures should only be billed when no other code is appropriate. Providers should bill with the closest or most similar unlisted code.
- The medical report that accompanies the claim should include the following:
 - Nature and extent of the procedure performed
 - Medical necessity of the procedure performed
 - Total time, effort, and equipment needed
 - Complexity of the symptoms, final diagnosis, physical findings, concurrent problems, and follow-up care

Surgical Services

Decision for Surgery

Preoperative visits starting with the day before the day of surgery are included in the global surgery payment for major procedures and the day of surgery for minor surgeries.

- Under the National Correct Coding Initiative (NCCI) edits, evaluation and management codes are included in the global surgical package
- If the decision to perform surgery is made at the time of the consultation or other E&M service during the preoperative period, modifier 57 should be used to indicate the decision for surgery. Modifier 57 indicates that the physician provided an evaluation and management service during the preoperative period for a major procedure that resulted in the initial decision for surgery. Modifier 57 can only be added to an E/M code and the ophthalmology codes 92012 and 92014.
- The decision for surgery must be clearly documented within the medical record, hospital or office record. When billing with modifier 57, medical notes may be required to review for payment.
- Under Medicare policy, minor procedures are services with a 0 or 10 day postoperative period. These are either minor surgical procedures or endoscopies.
- Major surgeries are those procedures with a 90-day postoperative period.

- Modifier 25 would be used to indicate decision for surgery when a minor procedure is performed (0 or 10 day global period.)

ECG Interpretation and Report with Surgery

Unless another supporting diagnosis or procedure can be found to support that the EKG was not related to anesthesia, separate payment will not be allowed for ECG interpretation and report when administered by the same physician when billed with surgical procedures. CMS considers anesthesia as part of the global surgical package when performed by the same physician.

Exploratory Surgery

Separate payment is not allowed for exploratory surgical procedures when billed in addition to a more significant primary abdominal surgical procedure(s). Exploratory surgery is considered incidental to the primary procedure. Exploration of intra-abdominal organs and structures for systemic examination, which results in surgery, is not payable according to Medicare standards.

Immunosuppressive Therapy During A Global Period

The global surgical package for renal transplantation does not include immunosuppressive therapy management. Immunosuppressive therapy is a critical management focus in the postoperative period following renal transplant. While the global surgical period for the transplant is 90 days, the Medicare fee schedule does not include the immunosuppressive care.

- Immunosuppressive care is billed with the appropriate Evaluation and Management service and based on the physician's work performed.
- The Evaluation and Management services should be billed with modifier 24 to indicate that the services performed were unrelated to the surgical procedure.
- The attending surgeon should indicate in the medical record that the visit is for immunosuppressive therapy
- Claims payment will be made based on the contracted amount for the Evaluation and Management Service

For patients whose transplant cases are being administered by Neighborhood Health Plan of RI's contracted transplant vendor, these services may be contractually inclusive in a global case rate.

IV Infusion with Surgery

Separate payment is not allowed for IV infusion/anesthesia codes administered by the same physician when billed with surgical procedures where CMS considers anesthesia part of the global surgical package. Direct physician supervision of IV infusion conflicts with an actual surgical procedure being performed that does require full supervision.

Lesion Excision Surgery

The excision of a lesion includes the full thickness (through the dermis) removal of the lesion, including all margins, and a simple (non-layered closure) repair. A lesion is an abnormal change in the skin or organ due to either injury or disease. Lesions are classified as either benign or malignant.

- The diagnosis submitted on the claim should be coded to the highest level of specificity.
- The medical record should document the following information regarding the excision procedure(s):
 - Lesion location – codes are selected based on the anatomic location of the lesion. If more than one lesion is removed from the same body area, a modifier 59 is used to identify the separate site. The medical record should identify the precise location either in written terms or in an anatomic diagram.
 - Full or partial thickness excision.
 - Measurements of the lesion and margin sizes prior to the excision. The tissues will shrink and not match the parameters in the pathology report. It is important to remember that the tissue will shrink after excision and the excision size may not be accurately reflected in the pathology report.
 - The type of repair or closure used to close the excision should also be documented.

- Both vaginal delivery – Twin A (first born) 59400 and Twin B 59409-51
- Both cesarean delivery – Only one cesarean section surgical procedure is done; 59510 is billed once
- One birth vaginal and one birth cesarean - 59510 (primary procedure) for cesarean delivery and 59409-51 for vaginal delivery
- If more than twins are delivered, each additional baby is coded by method of delivery with the appropriate modifier.
- Medical complications including hypertension, toxemia, hyperemesis gravidarium, congenital and genetic defects, cardiac or neurological abnormalities should be documented in the record and coded appropriately. The additional measures and care will be identified using E & M codes with a 25 modifier.

Once in a Lifetime Procedures

There are some procedure codes by their description can be performed only once for a patient. For example, removal of the nose can only be done once. Claims for these services are either pended for additional information if flagged or denied if the procedure is located in the patient's history and has previously been billed and paid.

- Claims submitted for any of these once-in-a-lifetime procedures a second time for the same patient must include a full explanation and medical justification to avoid being denied.
- If the patient has the same procedure billed by the same or a different provider in the claim history, the new claim will be denied. The provider may appeal and send in the full explanation and medical justification for reconsideration.
- The codes selected for once-in-a-lifetime review are derived from review of the Physician's Current Procedural Terminology – 4th Edition [CPT-4] published by the American Medical Association.

Patient Visit on Same Day as Surgery

After the decision to operate is made, visits to the patient beginning with the day before surgery for major procedures and the day of surgery for minor surgeries are included in the global surgery fee.

- Medicare’s global surgical billing policy requires that a single fee be billed for all necessary services normally furnished by the surgeon before, during, and after a procedure.
- Minor procedures and endoscopies have either a 0 or 10 global period.
- Major surgeries are those procedure codes identified in the Medicare Physician Fee Schedule Data Base with a 90-day postoperative period.
- Patient visits on the day before or same day of surgery are included in the global package regardless of whether they take place in the office or in a facility setting.
- Services not included in the global surgery policy would include visits unrelated to the diagnosis for which the surgical procedure is being performed or treatment for an underlying condition or an added course of treatment which would not be considered a normal part of recovery from surgery.
- The use of modifier 25 on evaluation and management services for minor surgeries and a separate diagnosis would identify these services as outside the global package or decision for surgery.
- The use of modifier 57 on evaluation and management services and a separate diagnosis would identify services as outside the global package for major surgery or decision for surgery.
- In those cases where there is no indication that the services are unrelated to the surgical package or diagnosis, a request for the visit notes will be required to determine the appropriateness of the billing.
- A separate note that meets the requirements for the E&M service must be documented in the medical record.

Surgical Global Fee Period

The Surgical Global Fee Period is defined as a single reimbursement fee for a surgical procedure and all routine pre and post operative care. Global services include:

- The preoperative visit the day before or the day of surgery
- The surgical procedures (s)

- Local, topical, or other anesthesia when administered by the surgeon
- Associated biopsies performed on the same day
- Routine intra operative care performed during the assigned global period (Medicare Global Surgical Period)
- Treatment of complications not requiring a return to the operating room
- Routine post-operative care during the assigned global period.
- Any unrelated service rendered during the global period must be billed with the appropriate modifier and supporting diagnosis to be considered for payment.
- Operative notes must clearly document the separate service to be considered for reimbursement.

Venous with Colonoscopy

Separate payment is not allowed for venous procedures when billed with colonoscopic, sigmoidoscopic, or endoscopic procedures because these are considered components of or incidental to the actual service performed. This endoscopic bundling procedure is industry standard.

Venous with Endoscopy

Separate payment is not allowed for venous procedures when billed with endoscopic procedures as these are considered a component or incidental to the actual service performed. This endoscopic bundling procedure is industry standard.

Venous with Sigmoidoscopy

Separate payment is not allowed for venous procedures when billed with sigmoidoscopy procedures because these are considered components of or incidental to the actual service performed. This sigmoidoscopy bundling procedure is industry standard.

Modifiers

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Ambulance Origin and Destination Modifiers

Each line of an ambulance claim must use two single alphabetical modifiers to identify both the point of origin of the pick up and the destination of the patient.

- Each ambulance trip for a patient must be coded on a separate claim unless the second trip is within the same zip code as the first.
- Origin and destination modifiers are single digit modifiers. The first single digit indicates the origin of the trip and the second single digit modifier indicates the destination of the patient.
- The HCPC code for the transportation should have origin and destination modifiers on all lines of the claim.
- The following table lists the current origin and destination modifiers:

D	Diagnostic or therapeutic site other than "P" or "H" (includes free-standing facilities)
E	Residential, domiciliary, custodial facility (includes nonparticipating facilities).
G	Hospital-based dialysis facility (hospital or hospital-related).
H	Hospital (includes OPD or ER)
I	Site of Transfer (e.g., airport or helicopter pad) between modes of ambulance transfer.
J	Non hospital-based dialysis facility (free standing).
N	Skilled Nursing Facility (Medicare participating only).
P	Physician's office.
R	Residence
S	Scene of accident or acute event.
X	Intermediate stop at physician's office on the way to the hospital(destination only).
- Claims without origin and destination modifiers will be denied for further modifier information.

Assistants at Surgery, Modifiers 80, 81, 82 and AS

An assistant at surgery is a physician or an approved non-physician practitioner who actively assists the physician in charge of the case in performing a surgical procedure. The presence of an assistant at surgery must be medically necessary and appropriate for

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the surgical procedure. Neighborhood Health Plan of RI currently accepts the following modifiers that were developed to report assistant surgeon services. The differences between the modifiers are important in the correct reimbursement of the provider.

- Modifier 80 – is an assistant surgeon who fully assists in the surgery
- Modifier 81 – is for minimal assistance and indicates that the surgeon did not assist for the entire surgery but for a limited amount of time
- Modifier 82 – was developed to be used only at teaching hospitals. It identifies that the teaching facility does not have a teaching program that is related to the medical specialty required by the surgical procedure or there is no qualified resident available, or the surgeon does not use residents or interns during the surgery.
- Modifier AS – the assistant at the surgery was a non-physician provider such as a PA, NPP, or clinical nurse specialist licensed in that state to act as an assistant at surgery.
 - Two assistant surgeons may be required for certain procedures. Each surgeon should bill with an assistant surgeon modifier. If the procedure performed is approved by the AMA for multiple assistant surgeon reimbursement, payment will be considered.

Co-Surgeons, Modifier 62

Two surgeons may be required to perform a surgical procedure due to the complexity of the procedure or the patient's medical status. Modifier 62 is used to indicate that two providers are billing for the same procedure on the same patient.

- All procedures performed by co-surgeons must have appropriate documentation to establish the medical necessity for two surgeons. In most instances, payment for an assistant surgeon is not allowed unless clear and compelling medical documentation can support the medical necessity.
- When two surgeons are either authorized or approved for claim payment, each surgeon is paid 62.5% of the total global surgical fee under Neighborhood Health Plan of RI payment guidelines.
- Services billed with Modifier 62 (co-surgeons) may require notes.

Level II (HCPCS/National) Modifiers

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Level II National HCPCS modifiers were developed to expand the information provided by CPT codes by the AMA and CMS. The modifiers are in the form of two characters, numbers, letters or a combination of numbers and letters and are used to provide additional information regarding the anatomical location of procedures or services.

The following details the anatomical modifiers listed in the current CMS procedure code manual:

- E1 Upper left, eyelid
- E2 Lower left, eyelid
- E3 Upper right, eyelid
- E4 Lower right, eyelid
- F1 Left hand, second digit
- F2 Left hand, third digit
- F3 Left hand, fourth digit
- F4 Left hand, fifth digit
- F5 Right hand, thumb
- F6 Right hand, second digit
- F7 Right hand, third digit
- F8 Right hand, fourth digit
- F9 Right hand, fifth digit
- FA Left hand, thumb
- LC Left circumflex coronary artery (Hospitals use with codes 92980-92984, 92995, 92996)
- LD Left anterior descending coronary artery (Hospitals use with codes 92980-92984, 92995, 92996)
- LT Left side (used to identify procedures performed on the left side of the body)
- OM Ambulance service provided under arrangement by a provider of services
- UN Ambulance service furnished directly by a provider of services
- RC Right coronary artery (Hospitals used with codes 92980-92984, 92995, 92996)
- RT Right side (used to identify procedures performed on the right side of the body)
- T1 Left foot, second digit
- T2 Left foot, third digit
- T3 Left foot, fourth digit
- T4 Left foot, fifth digit
- T5 Right foot, great toe
- T6 Right foot, second digit
- T7 Right foot, third digit

- T8 Right foot, fourth digit
- T9 Right foot, fifth digit
- TA Left foot, great toe

Multiple Surgical Modifiers 50, 51 ad 59

Modifiers 50, 51, and 59 are used when billing multiple surgical services performed during the same operative session. As these modifiers alter fee schedule reimbursement rates, proper billing is critical.

- Modifier 50 (bilateral procedure) should be used on bilateral surgical procedures only (10000 – 69999 and some codes in the 9xxxx range) and a quantity of one should be billed.
- If the CPT code billed does not allow for bilateral billing, the charge will be denied for incorrect modifier.
- Modifier 51 (multiple surgical services) should be used when more than one surgical service are billed for the same date of service. The most significant procedure should be listed first and does not need the modifier, and all other surgical lines (except add-on codes, such as 69990, or those exempt from modifier 59, such as 17004) will need modifier 51 listed in order for the claim to be paid. **Providers must determine which service is more extensive and considered the primary procedure.**
- NHPRI currently reimburses the first procedure at 100% of fee schedule, the second at 50%, and the third, fourth, and fifth at 25%. The sixth procedure and greater are considered global.
- Modifier 59 (significant, separately identifiable service) should only be used to identify multiple surgical services that cannot be billed with modifier 51. Notes may be requested to support separate payment.
- Multiple surgical services billed without appropriate modifiers will be denied for missing/invalid modifiers. Modifiers are also required when requesting separate reimbursement for procedures that have been denied or are considered global to another procedure.

Return to the Operating Room, Modifier 78

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Modifier 78 is used on surgical codes to indicate that another procedure was performed during the postoperative period of the initial surgery. The surgery is usually for the treatment of a complication related to the initial surgery and required the use of the operating room. Services billed with Modifier 78 may require notes.

- Modifier 78 is used for billing for a complication of the initial surgery that requires a return to the operating room.
- Services that do not require a return to the operating room cannot be billed with this modifier.
- The surgeon treating the complication is the same as performed the initial surgery.
- The physician must bill the procedure code that best describes the surgical procedures performed.
- The initial procedure code should not be billed unless the exact identical procedure is performed again.
- An operating room is defined as a specifically equipped and staffed place of service for the sole purpose of performing procedures. The term “operating room” includes the cardiac catheterization suite, a laser suite, or an endoscopy suite in addition to the formal operating suites within a hospital or ASC.
- The only time a procedure would be reimbursed for treatment of a complication outside the operating room is when the patient’s condition was so critical that transport to the operating room would have been detrimental to the patient’s care. Medical records are required to substantiate medical necessity.
- A new postoperative period does not begin when the procedure performed to treat the complication is performed.
- When a procedure with a 000 global period is performed to treat complications, CMS will pay for the entire full value of the procedure.
- CMS will make no payment to the surgeon for iatrogenic complications: those caused by the physician during the original surgery.
- Full payment is allowed for the treatment of complications by another physician or surgeon. These services will not be billed with a 78 modifier.

Separately Identifiable Services, Modifier 25

Significant separately identifiable Evaluation and Management services that are performed by the same physician on the same day as a procedure or other service should be indicated by the addition of the modifier 25 to the Evaluation and Management code.

- Modifier 25 can only be added to an Evaluation and Management (E&M) code.
- Medicare’s minor surgical payment policy allows for payment of an Evaluation and Management service on the same day as a minor surgical procedure if it is “separate and identifiable.” (Section 15501.1 of the Medicare Carriers Manual). The services billed under the Evaluation and Management codes need to be above and beyond the usual preoperative and postoperative care associated with the procedure.
- The patient’s medical record must substantiate the need for the E&M service and all components of history, examination, medical decision making, counseling and coordination of care, and nature of the presenting problem intrinsic to the level of the code will be included in the medical documentation.

Notes may be requested to confirm documentation of a “separate and identifiable service” performed.

Surgical Modifiers 54, 55 and 56

Modifiers 54, 55, and 56 are used when only a part of the global surgical package is performed by the physician or provider. Failure to indicate the portion of the surgical package performed by the physician results in an overpayment and billing for services that were not rendered.

- Modifier 54 – surgical care only indicates that the physician performed only the intra-operative portion of the surgical procedure.
- Modifier 55 – postoperative management only indicates that the physician performed only the postoperative care and management after another physician performed the surgery.
- Modifier 56 – preoperative management only indicates that the physician only provided the preoperative evaluation and management services of the global surgical package.

- These modifiers should be billed for procedures with a 90-day global period and not for procedures with zero or 10-day global periods.
- The percentages paid for these modifiers are set by contract or Neighborhood Health Plan of RI standard modifier allowances.
- If the physician providing most of the postoperative care is a part of the same group or a covering physician, the modifier 54 cannot be used by the surgeon or physician with the postoperative care 55 billed by a member of the same group.
- When using Modifier 54, there must be a notation in the record agreeing to the transfer of the postoperative care to another physician or provider.
- Modifier 55 is added to the surgery code only after the initial postoperative visit is completed by the physician providing the postoperative care.
- Modifier 55 is used only after the patient has been discharged from the hospital. If another physician sees the patient after surgery, the physician (not the surgeon) will bill using the hospital care codes.
- Modifier 56 is used in rare instances and only on surgical codes.

Team Surgery, Modifier 66

A team surgery is a complex procedure performed by more than two surgeons of different specialties. When a team of surgeons is required to perform a procedure, each of the surgeons should bill for the same procedure code using Modifier 66. Modifier 66 is used when two or more surgeons of different specialties are submitting claims with the same procedure codes.

- Medical necessity must be established in the documentation and should be sent as an attachment to the claim.
- Neighborhood Health Plan of RI applies the CMS predetermined lists of complex procedures that may require a team approach.
- If there is an assistant surgeon billed in addition to the team, a compelling medical reason needs to be documented in order to substantiate the payment for the assistant services.

- The 22 modifier description was significantly revised in the 2008 CPT® codes with clearly defined documentation requirements.
- This modifier is attached to the primary procedure.
- The documentation guidelines include that the reason for the additional work:
 - Increased intensity
 - Increased time
 - Increased technical difficulty
 - Severity of the patient’s condition
 - Physical and mental effort required
- Neighborhood Health Plan of RI typically reimburses an additional 20% of a provider’s contractual reimbursement for modifier 22 if notes support the modifier.
- This modifier is typically used on surgical procedures
- Notes are required in order to make any financial determination.
- The anatomical modifiers can be used with the NCCI-associated edits with an indicator of “1”.
- The anatomical modifiers are used when there are separate patient encounters, separate anatomic sites, or separate specimens.
- Modifier 59 is required if the procedure is considered bundled with another service on the same date. Notes may also be required for review.

Modifier Grid

The CPT® and HCPC® coding systems are comprised of two digit modifier codes which indicate that a service or a procedure has been modified by some special circumstance. At Neighborhood Health Plan of RI, some modifiers do not impact pricing while others require pre-payment review. Detailed below is a listing of modifiers accepted by Neighborhood Health Plan of RI. This grid also details any change in reimbursement.

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Modifier	Description	Pricing Impact?	recommended % allowed of procedure code
21	Prolonged E & M	Yes	120% requires review of notes
22	Unusual Procedure	Yes	120% requires review of notes
23	Unusual Anesthesia	Yes	120% requires review of notes
24	Unrelated Evaluation	No	100%
25	Significant, Separately Identifiable Evaluation	No	100%
26	Professional Component	Yes	Varies per code range
27	Multiple Outpatient Hospital E/M Encounters on the same date	No	100%
32	Mandated Services	No	100%
47	Anesthesia by Surgeon	No	100%
50	Gen TST; Neuro NN Neo MECP2	No	100%
50	Bilateral Procedure	Yes	50%
51	Multiple Procedures	Yes	50%
52	Reduced Services	Yes	15%
53	Discontinued Procedure	Yes	20%
54	Surgical Care Only	Yes	69%**
55	Postoperative Care Only	Yes	21%**
56	Pre-OP Management	Yes	10%**
57	Decision for Surgery	No	100%
58	Staged or Related Procedure	Yes	69%
59	Distinct Procedural Service	No	100%
62	Two Surgeons	Yes	62%
63	Procedure Performed on Infants	Yes	100%
66	Surgical Team	No	62%

73	Discontinued Out-Patient Procedure Prior to Anesthesia Administration	Yes	50%
74	Discontinued Out-Patient Procedure After Anesthesia Administration	No	100%
76	Repeat Procedure by Same Physician	No	100%
77	Repeat Procedure by Another Physician	No	100%
78	Return to Operating RM for Related Procedure	Yes	69%**
79	Unrelated Proc/Svs by Same Physician	No	100%
80	Assistant Surgeon	Yes	20%
81	Minimum Assistant Surgeon	Yes	15%
82	Assistant Surgeon when qualified resident surgeon	Yes	20%
90	Outside Lab	No	100%
92	Alternative Laboratory Platform Testing	No	100%
91	Repeat Clinical Diagnostic Test	No	100%
99	Multiple Modifiers	No	100%
0A	Gen TST; Neoplasia BRCA 1	No	100%
0B	Gen TST; Neoplasia BRCA 2	No	100%
0C	Gen TST; Neoplasia Neurofibromin	No	100%
0D	Gen TST; Neoplasia Merlin	No	100%
0E	Gen TST; Neoplasia c-RET	No	100%
0F	Gen TST; Neoplasia VHL	No	100%
0G	Gen TST; Neoplasia SDHD	No	100%
0H	Gen TST; Neoplasia SDHB	No	100%
0I	Gen TST; Neoplasia Her-2/NEU	No	100%
0J	Gen TST; Neoplasia MLH1	No	100%
0K	Gen TST; Neoplasia MSH2	No	100%
0L	Gen TST; Neoplasia APC	No	100%
0M	Gen TST; Neoplasia RB	No	100%
1Z	Gen TST; Neoplasia SLD TUMOR; UNSPEC	No	100%
2A	Gen TST; Neoplasia AML1 ALSO ETO	No	100%
2B	Gen TST; Neoplasia BCR ALSO ABL	No	100%
2C	Gen TST; Neoplasia CGF1	No	100%
2D	Gen TST; Neoplasia CBF BETA	No	100%
2E	Gen TST; Neoplasia MML	No	100%

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2F	Gen TST; Neoplasia PML/RAR ALPHA	No	100%
2G	Gen TST; Neoplasia TEL	No	100%
2H	Gen TST; Neoplasia BC1-2	No	100%
2I	Gen TST; Neoplasia BC1-1	No	100%
2J	Gen TST; Neoplasia C-MYC	No	100%
2K	Gen TST; Neoplasia IGH	No	100%
2Z	Gen TST; Neoplasia LYMP/HEMAT UNSPEC	No	100%
3A	Gen TST; NN Neoplasia Factor V	No	100%
3B	Gen TST; NN Neoplasia FACC	No	100%
3C	Gen TST; NN Neoplasia FACD	No	100%
3D	Gen TST; NN Neoplasia BETA GLOBIN	No	100%
3E	Gen TST; NN Neoplasia ALPHA GLOBIN	No	100%
3F	Gen TST; NN Neoplasia MTHFR	No	100%
3G	Gen TST; NN Neoplasia PROTHOMBIN	No	100%
3H	Gen TST; NN Neoplasia FACTOR VIII	No	100%
3I	Gen TST; NN Neoplasia Factor IX	No	100%
3J	Gen TST; NN Neoplasia HEM/OAG UNSPC	No	100%
3Z	Gen TST; NN Neoplasia BETA GLOBIN	No	100%
4A	Gen TST; Blood Typing HLA-A	No	100%
4B	Gen TST; Blood Typing HLA-B	No	100%
4C	Gen TST; Blood Typing HLA-C	No	100%
4D	Gen TST; Blood Typing HLA-D	No	100%
4E	Gen TST; Blood Typing HLA-DR	No	100%
4F	Gen TST; Blood Typing HLA-DQ	No	100%
4G	Gen TST; Blood Typing HLA-DP	No	100%
4H	Gen TST; Blood Typing KELL	No	100%
4Z	Gen TST; Blood Typing UNSPEC	No	100%
5A	Gen TST; Neuro NN Neo ASPRTCYLASE	No	100%
5B	Gen TST; Neuro NN Neo FMR-1	No	100%
5C	Gen TST; Neuro NN Neo FRATAXIN	No	100%
5D	Gen TST; Neuro NN Neo HUNTINGTON	No	100%
5E	Gen TST; Neuro NN Neo GABRA	No	100%
5F	Gen TST; Neuro NN Neo CONNEXIN-26	No	100%
5G	Gen TST; Neuro NN Neo CONNEXIN-32	No	100%
5H	Gen TST; Neuro NN Neo SNRPN	No	100%
5I	Gen TST; Neuro NN Neo ATAXIN-1	No	100%
5J	Gen TST; Neuro NN Neo ATAXIN-2	No	100%
5K	Gen TST; Neuro NN Neo ATAXIN-3	No	100%

5L	Gen TST; Neuro NN Neo CACNA1A	No	100%
5M	Gen TST; Neuro NN Neo ATAXIN-7	No	100%
5N	Gen TST; Neuro NN Neo PMP-22	No	100%
5Z	Gen TST; Neuro NN Neo UNSPEC	No	100%
6A	Gen TST; Musc NN NEO DYSTROPHIN	No	100%
6B	Gen TST; Musc NN NEO CMPK	No	100%
6C	Gen TST; Musc NN NEO ZNF-9	No	100%
6D	Gen TST; Musc NN NEO SMN	No	100%
6Z	Gen TST; Musc NN NEO MUSC UNSPEC	No	100%
7A	Gen TST; MTBOL OTHR APOLIPOPROTEIN E	No	100%
7B	Gen TST; MTBOL OTHR SPHNGMYLN PHOSP	No	100%
7C	Gen TST; MTBOL ACID BETA GLUCOSIDASE	No	100%
7D	Gen TST; MTBOL HFE	No	100%
7E	Gen TST; METABOLIC UNSPEC	No	100%
7Z	Gen TST; MTBOL OTHR APOLIPOPROTEIN E	No	100%
8A	Gen TST; MTBOL TRNS CFTR	No	100%
8Z	Gen TST; METABOLIC TRANSPORT UNSPEC	No	100%
9A	Gen TST; MTBOL PARM TPMT	No	100%
9L	Gen TST; MTBOL PARM UNSPEC	No	100%
9M	Gen TST; DYSMORPHOLOGY FGFR1	No	100%
9N	Gen TST; DYSMORPHOLOGY FGFR2	No	100%
9O	Gen TST; DYSMORPHOLOGY FGFR3	No	100%
9P	Gen TST; DYSMORPHOLOGY TWIST	No	100%
9Q	Gen TST; DYSMORPHOLOGY CATCH-22	No	100%
9Z	Gen TST; DYSMORPHOLOGY UNSPEC	No	100%
A1	Dressing for One Wound	No	100%
A2	Dressing for Two Wounds	No	100%
A3	Dressing for Three Wounds	No	100%
A4	Dressing for Four Wounds	No	100%
A5	Dressing for Five Wounds	No	100%
A6	Dressing for Six Wounds	No	100%
A7	Dressing for Seven Wounds	No	100%
A8	Dressing for Eight Wounds	No	100%
A9	Dressing for 9 or more wounds	No	100%
AA	Anesthesia Performed Personally	No	100%
AD	Medical Supervision by a Physician. more than four anesth procedures	No	100%
AE	Registered Dietician	No	100%

AF	Specialty Physician	No	100%
AG	Primary Physician	No	100%
AH	Clinical Psychologist	No	100%
AJ	Clinical Social Worker	No	100%
AK	Non- Participating Physician	Yes	100%
AM	Physician ; Team Member Service	No	100%
AP	Determination of Refractive State	No	100%
AQ	Physician Service Unlisted HPSA	No	100%
AR	Physician provider services in a physician scarcity area	No	100%
AS	Physician Assistant; Nurse Practitioner	No	100%
AT	Acute Treatment	No	100%
AU	Item Furnished in Conjunction with a urological, ostomy, trach supply	No	100%
AV	Item Furnished in Conjunction with a prosthetic device	No	100%
AW	Item Furnished in Conjunction with a surgical dressing	No	100%
AX	Item Furnished in Conjunction with parenteral enteral nutrition services	No	100%
BA	Item Furnished in Conjunction with dialysis services	No	100%
BL	Spec Acquisition Blood Products	No	100%
BO	Orally Administered Nutrition; Not by feeding tube	No	100%
BP	The Beneficiary has been informed of the purchase and rental options and has elected to purchase the item.	No	100%
BR	The Beneficiary has been informed of the purchase and rental options and has elected to rent the item.	No	100%
BU	The Beneficiary has been informed of the purchase and rental options and after 30 days has not informed the supplier of his/her decision	No	100%
CA	Procedure payable only in an inpatient setting when performed emergency on an outpatient who expires prior to admission.	No	100%
CB	Service ordered by a renal dialysis facility (RDF) physician as part of the ESRD beneficiary's dialysis benefit, is not part of the composite rate, and is separately reimbursable.	No	100%
CC	Procedure code change	No	100%

CD	AMCC test has been ordered by an ESRD facility or MCP physician that is part of the composite rate and is not separately billable.	No	100%
CE	AMCC test has been ordered by an ESRD facility or MCP physician that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity.	No	100%
CF	AMCC test that has been ordered by an ESRD facility or MCP physician that is not part of the composite rate and is separately billable.	No	100%
CG	Innovator drug dispensed	No	100%
CR	Catastrophe/Disaster related	No	100%
DD	AMB; Diag- Ther to Diag-Ther	No	100%
DE	AMB; Diag- Ther to Nursing Home	No	100%
DG	AMB; Diag- Ther to Hosp Dialysis	No	100%
DH	AMB; Diag- Ther to Hospital	No	100%
DI	AMB; Diag- Ther to Site of Transfer	No	100%
DJ	AMB; Diag- Ther to NN HSP Dialysis	No	100%
DN	AMB; Diag- Ther to SNF	No	100%
DP	AMB; Diag- Ther to Physician Office	No	100%
DR	AMB; Diag- Ther to Residence	No	100%
DX	AMB; Diag- Ther to Hosp with Stop at DR	No	100%
E1	Upper Left; Eyelid	No	100%
E2	Lower Left; Eyelid	No	100%
E3	Upper Right; Eyelid	No	100%
E4	Lower Right; Eyelid	No	100%
EA	Erythropoetic Stimulating Agent, Anemia due to Chemotherapy	No	100%
EB	Erythropoetic Stimulating Agent, Anemia due to Radiotherapy	No	100%
EC	Erythropoetic Stimulating Agent, Anemia not due to Radiotherapy or Chemotherapy	No	100%
ED	Multiple Purpose Modifier	No	100%
EE	Multiple Purpose Modifier	No	100%
EG	AMB; NH to Hosp Dialysis	No	100%
EH	AMB; NH to Hospital	No	100%
EI	AMB; NH to Site of Transfer	No	100%
EJ	Multiple Purpose Modifier	No	100%

EM	Emergency Reserve Supply (for ESRD Beneficiaries)	No	100%
EP	Multiple Purpose Modifier	No	100%
ER	AMB; NH to Residence	No	100%
ES	PET; Equivocal_PSTV; EXT ISCHEMIA	No	100%
ET	Emergency Service	No	100%
EX	AMB; NH to Hsp with stop at DR	No	100%
EY	No Physician or Other Licensed Health Care provider order for this service	No	100%
F1	Left Hand; Second Digit	No	100%
F2	Left Hand; Third Digit	No	100%
F3	Left Hand; Fourth Digit	No	100%
F4	Left Hand; Fifth Digit	No	100%
F5	Right Hand, Thumb	No	100%
F6	Right Hand, Second Digit	No	100%
F7	Right Hand, Third Digit	No	100%
F8	Right Hand, Fourth Digit	No	100%
F9	Right Hand, Fifth Digit	No	100%
FA	Left Hand, Thumb	No	100%
FB	Item Provided w/o Cost to Provider	No	100%
FC	Partial Credit Received for Replaced Device	No	100%
FP	Service Provided as Part of Medicaid Family Planning Program	No	100%
G1	Most Recent Urr Reading of Less Than 60	No	100%
G2	Most Recent Urr Reading of 60 to 64.9	No	100%
G3	Most Recent Urr Reading of 65 to 69.9	No	100%
G4	Most Recent Urr Reading of 70 to 74.9	No	100%
G5	Most Recent Urr Reading of 75 or greater	No	100%
G6	ESRD Patient for Whom Less than Six Dialysis sessions have been provided a month	No	100%
G7	Pregnancy resulted from rape or incest	No	100%
G8	Monitored Anesthesia Care	No	100%
G9	Monitored Anesthesia Care	No	100%
GA	Waiver of Liability Statement on File	No	100%
GB	Claim being resubmitted for payment because it is no longer covered global payment demonstration	No	100%
GC	This service has been performed in part by a resident under the direction of a teaching physician	No	100%
GD	Multiple Purpose Modifier	No	100%

GE	Multiple Purpose Modifier	No	100%
GF	Non- Physician (e.g., NP, CRNA, CNS, PA services) in a critical access hospital.	No	100%
GG	Performance and Payment of a Screening Mammogram and Diagnostic Mammogram on the same patient, same day	No	100%
GH	Diagnostic Mammogram converted from screen mammogram on the same day	No	100%
GI	Ambulance; Hospital Dialysis to Site of Transfer/Ambulances	No	100%
GJ	"OPT OUT" Physician or Practitioner emergency or urgent service	No	100%
GK	Actual item/service ordered by physician, item associated	No	100%
GL	Medically Unnecessary upgrade provided by physician	No	100%
GM	Multiple Patients on ambulance trip	No	100%
GN	Services delivered under an outpatient speech language pathology plan of care	No	100%
GO	Services delivered under an outpatient occupational therapy plan of care	No	100%
GP	Services delivered under an outpatient physical therapy plan of care	No	100%
GQ	Via asynchronous telecommunications system	No	100%
GR	Multiple Purpose Modifier	No	100%
GR	Ambulance; hospital based dialysis to residence	No	100%
GS	Dosage EPO/Darbepoietin Alfa- reduced	No	100%
GT	Via interactive audio and video telecommunication systems	No	100%
GV	Attending physician not employed or paid under arrangement by the patient's hospice provider	No	100%
GW	Service not related to the hospice patient's condition	No	100%
GX	Ambulance; Hospital Dialysis to Hosp with stop at doctors	No	100%
GY	Item or service statutorily excluded or does not meet the definition of a Medicare benefit	No	100%
GZ	Item or service expected to be denied as not reasonable or necessary	No	100%
H9	Court ordered	No	100%
HA	Child/Adolescent Program	No	100%

HB	Adult Program; not geriatric	No	100%
HC	Adult Program; geriatric	No	100%
HD	Pregnant/Parenting women's program	No	100%
HE	Mental Health Program	No	100%
HF	Substance Abuse program	No	100%
HG	Opioid addiction treatment program	No	100%
HH	Multiple Purpose Modifier** for all providers except AMB, should be configured to deny MNHLT	No	100%
HH	Ambulance; hospital to hospital	No	100%
HI	Integrated mental health and mental retardation/developmental disabilities program	No	100%
HJ	Employee Assistance program	No	100%
HK	Specialized mental health programs for high-risk populations	No	100%
HL	Intern	No	100%
HM	Less than bachelor degree level	No	100%
HN	Bachelors degree level	No	100%
HO	Masters degree level	No	100%
HP	Doctoral level	No	100%
HQ	Group setting	No	100%
HR	Family/Couple with client present	No	100%
HS	Family/Couple without client present	No	100%
HT	Multi-Disciplinary Team	No	100%
HU	Funded by child welfare agency	No	100%
HV	Funded by state addictions agency	No	100%
HW	Funded by state mental health agency	No	100%
HX	Funded by county/local agency	No	100%
HY	Funded by juvenile justice agency	No	100%
HZ	Funded by criminal justice agency	No	100%
ID	Ambulance; site of trans to diag-ther	No	100%
IE	Ambulance; site of trans to NH	No	100%
IG	Ambulance; site of trans to hospital dialysis	No	100%
IH	Ambulance; site of trans to hospital	No	100%
II	Ambulance; site of trans to site of trans	No	100%
IJ	Ambulance; site of trans to nn hosp dialysis	No	100%
IN	Ambulance; site of trans to SNF	No	100%
IP	Ambulance; site of trans to doctor office	No	100%
IR	Ambulance; site of trans to residence	No	100%

IX	Ambulance; site of trans to hosp w stop at doctor	No	100%
J1	Competitive acquisition prog no-pay submission for a prescription number	No	100%
J2	Competitive acquisition prog restocking	No	100%
J3	Competitive acquisition prog drug not available	No	100%
JA	Administered intravenously	No	100%
JB	Administered subcutaneously	No	100%
JD	Ambulance; NN hosp dialysis to Diag- Ther	No	100%
JE	Ambulance; NN hosp dialysis to nh	No	100%
JG	Ambulance; NN hosp dialysis to hosp dialysis	No	100%
JH	Ambulance; NN hosp dialysis to hospital	No	100%
JI	Ambulance; NN hosp dialysis to site of trans	No	100%
JJ	Ambulance; NN hosp dialysis to nn hosp dialysis	No	100%
JN	Ambulance; NN hosp dialysis to SNF	No	100%
JP	Ambulance; NN hosp dialysis to dr office	No	100%
JR	Ambulance; NN hosp dialysis to residence	No	100%
JW	Drug amount discarded/not administered	No	100%
JX	Ambulance; NN hosp dialysis to hsp w stop at doctors	No	100%
K0	Lower extremity prosthesis functional level 0	No	100%
K1	Lower extremity prosthesis functional level 1	No	100%
K2	Lower extremity prosthesis functional level 2	No	100%
K3	Lower extremity prosthesis functional level 3	No	100%
K4	Lower extremity prosthesis functional level 4	No	100%
KA	Add on Option/Accessory for wheelchair	No	100%
KB	Beneficiary requested upgrade for abn; more than four modifiers identified on claim	No	100%
KC	Replacement of special power wheelchair interface.	No	100%
KD	Drug or biological infused through DME	No	100%
KF	Item designated by FDA as class III device	No	100%
KG	DMEPOS item subject to DMEPOS competitive bidding program number 1	No	100%
KH	DMEPOS item; Initial claim, purchase of first month rental	No	100%
KI	DMEPOS item; second or third month rental	No	100%
KJ	DMEPOS item; parenteral enteral nutrition pump or capped rental, months four to fifteen	No	100%
KL	DMEPOS item delivered via mail	No	100%
KM	Replacement of facial prosthesis including new impression/moulage	No	100%

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KN	Replacement of facial prosthesis using previous master model	No	100%
KO	Single drug unit dose formulation	No	100%
KP	First drug of multiple drug unit dose formulation	No	100%
KQ	Second or subsequent drug of a multiple drug unit dose formulation	No	100%
KR	Rental item; Billing for partial month	Yes	10%
KS	Glucose monitor supply for diabetic beneficiary not treated with insulin	No	100%
KT	Beneficiary resides in a competitive bidding area and travels to a non-competitive bidding area and receives item from a non-contract supplier	No	100%
KU	DMEPOS item subject to DMEPOS competitive bidding program number 3	No	100%
KV	DMEPOS item subject to DMEPOS competitive bidding program that is furnished as part of a professional service	No	100%
KW	DMEPOS item subject to DMEPOS competitive bidding program number 4	No	100%
KX	Specific required documentation on file	No	100%
KY	DMEPOS item subject to DMEPOS competitive bidding program number 5	No	100%
KZ	New coverage not implemented by managed care	No	100%
LC	Left circumflex coronary artery	No	100%
LD	Left anterior descending coronary artery	No	100%
LL	Lease/Rental	Yes	10%
LR	Laboratory round trip	No	100%
LS	FDA monitored intraocular lens implant	No	100%
LT	Left side	No	100%
M2	Medicare Secondary Payer (MSP)	No	100%
MS	Six-Month maintenance and servicing fee	No	100%
ND	Ambulance; SNF to diag-ther	No	100%
NE	Multiple Purpose Modifier	No	100%
NG	Ambulance; SNF to hospital dialysis	No	100%
NH	Ambulance; SNF to hospital	No	100%
NI	Ambulance; SNF to site of trans	No	100%
NJ	Ambulance; SNF to non hosp dialysis	No	100%
NN	Multiple Purpose Modifier	No	100%
NP	Multiple Purpose Modifier	No	100%

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NR	New when rented	Yes	10%
NS	PET; negative-positive; ext ischemia	No	100%
NU	New equipment	No	100%
NX	Ambulance; SNF to hosp w stop at doctor	No	100%
P1	Normal healthy patient	No	100%
P2	Patient w/mild systemic disease	No	100%
P3	Patient w/severe system disease	No	100%
P4	Pat w/severe syst dis const threat life	No	100%
P5	Moribund patient no survival w/operation	No	100%
P6	Decl brain-dead pat organs to be removed	No	100%
PD	Ambulance; doctor office to diag-ther	No	100%
PE	Multiple Purpose Modifier	No	100%
PE	Ambulance; doctor office to residential,domiciliary,cust facility	No	100%
PG	Ambulance; doctor office to hosp dialysis	No	100%
PH	Ambulance; doctor office to hospital	No	100%
PI	Ambulance; doctor office to site of trans	No	100%
PJ	Ambulance; doctor office to non hosp dialysis	No	100%
PL	Progressive addition lenses	No	100%
PN	Multiple Purpose Modifier	No	100%
PP	Multiple Purpose Modifier	No	100%
PR	Ambulance; doctor office to residence	No	100%
PS	PET; pstv; nt ext isch-pstv ext ishemia	No	100%
PX	Ambulance; doctor office to hosp w stop at doctor	No	100%
Q0	Investigational clinical service provided in a clinical research study that is in a approved clinical research study	No	100%
Q1	Routine clinical service provided in a clinical research study that is in an approved clinical research study	No	100%
Q2	CMS/ORD demonstration project procedure	No	100%
Q3	Live kidney donor surgery and related services	No	100%
Q4	Service for ordering/referring physician qualifies as a service exception	No	100%
Q5	Service furnished by locum tenens physician	No	100%
Q6	Service furnished by substitute physician	No	100%
Q7	One Class A finding	No	100%
Q8	Two Class B findings	No	100%
Q9	One Class B and two class C findings	No	100%
QA	FDA investigational device exemption	No	100%

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QC	Single channel monitoring	No	100%
QD	Recording and storage in solid state memory by digital recorder	No	100%
QE	Prescribed amount of oxygen is less than one liter per minute	No	100%
QF	Prescribed amount of oxygen exceeds 4 liters per minute	No	100%
QG	Prescribed amount of oxygen is greater than four liters per minute	No	100%
QH	Oxygen conserving device is being used with an oxygen delivery system	No	100%
QJ	Service/items provided to a prisoner or patient in state or local custody	No	100%
QK	Medical direction of two, three or four concurrent anesthesia procedures	No	100%
QL	Patient pronounced dead after ambulance called	No	100%
QM	Ambulance service provided under arrangement by provider of services	No	100%
QN	Ambulance service furnished directly by provider of service	No	100%
QP	Documentation on file showing that the lab tests ordered individually or ordered as a cpt recognized panel	No	100%
QR	Item/Service provided Medicare spec study	No	100%
QS	Monitored Anesthesia Care	No	100%
QT	Recording and storage on tape by an analog tape recorder	No	100%
QV	Item/Service provided as routine care	No	100%
QW	CLIA waived test	No	100%
QX	CRNA service: with medical direction by physician	No	100%
QY	Medical direction of one CRNA by anesthesiologist	No	100%
QZ	CRNA service: without medical direction by physician	No	100%
RC	Right coronary artery	No	100%
RD	Multiple Purpose Modifier	No	100%
RD	Ambulance; residence to diag or ther site	No	100%
RE	Ambulance; residence to nh	No	100%
RG	Residence to hospital-based dialysis facility	No	100%
RH	Residence to hospital	No	100%
RI	Residence to site of trans	No	100%

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RJ	Residence to non hospital-based dialysis facility	No	100%
RN	Ambulance; residence to SNF	No	100%
RP	Residence to physician's office	No	100%
RR	Rental item	Yes	10%
RT	Right Side	No	100%
RX	Ambulance; residence to hospital w stop at doctor	No	100%
SA	Nurse practitioner rendering service in collaboration with a physician	No	100%
SB	Nurse midwife	No	100%
SC	Medically necessary service or supply	No	100%
SD	Scene of accident or acute event to diagnostic or therapeutic site	No	100%
SE	Scene of accident or acute event to residential,domiciliary,custodial facility	No	100%
SF	Second opinion ordered by a professional review organization	No	100%
SG	ASC facility	No	100%
SH	Multiple Purpose Modifier	No	100%
SI	Ambulance; scene of accident to site of trans	No	100%
SI	Scene of accident or acute event to site of transfer (airport or helicopter pad).	No	100%
SJ	Scene of accident or acute event to non hospital based dialysis clinic.	No	100%
SK	Member pf high-risk population	No	100%
SL	State supplied vaccine	No	100%
SM	Second surgical opinion	No	100%
SN	Scene of accident or acute event to SNF	No	100%
SP	Multiple Purpose Modifier	No	100%
SP	Ambulance; accident/incident to doctors office	No	100%
SQ	Item ordered by home health	No	100%
SS	Multiple Purpose Modifier	No	100%
ST	Related to trauma or injury	No	100%
SU	Procedure performed in physician's office	No	100%
SV	Pharmaceuticals delivered to patient's home but not utilized	No	100%
SW	Services provided by a certified diabetic educator	No	100%
SX	Ambulance; scene of accident to hospital w stop at doctor	No	100%

SY	Persons who are in close contact with members of high-risk population (use only with codes for immunization)	No	100%
T1	Left foot, second digit	No	100%
T2	Left foot; third digit	No	100%
T3	Left foot; fourth digit	No	100%
T4	Left foot; fifth digit	No	100%
T5	Right foot; Great toe	No	100%
T6	Right foot; Second digit	No	100%
T7	Right foot; third digit	No	100%
T8	Right foot; fourth digit	No	100%
T9	Right foot; fifth digit	No	100%
TA	Left foot, great toe	No	100%
TC	Technical Component	Yes	Varies per code range
TD	RN	No	100%
TE	LPN/LVN	No	100%
TF	Intermediate level of care	No	100%
TG	Complex/High level of care	No	100%
TH	Obstetrical treatment/services/ prenatal	No	100%
TJ	Program group; child and/or adolescent	No	100%
TK	Extra patient or passenger; non ambulance	No	100%
TL	Early intervention/individualized family services plan (IFSP)	No	100%
TM	Individualized education program (IEP)	No	100%
TN	Rural/Outside providers customary service area	No	100%
TP	Medical transport, unloaded vehicle	No	100%
TQ	Basic life support (BLS) transport by a volunteer ambulance provider	No	100%
TR	School based individual education program (IEP) services provided outside the public school district	No	100%
TS	Follow up service	No	100%
TT	Individualized service provided to more than one patient in the same setting	No	100%
TU	Special payment rate; overtime	No	100%
TV	Special payment rate; holiday/weekends	No	100%
TW	Back up equipment	No	100%
U1	Medicaid level of care 1, as defined by each state	No	100%
U2	Medicaid level of care 2, as defined by each state	No	100%

U3	Medicaid level of care 3, as defined by each state	No	100%
U4	Medicaid level of care 4, as defined by each state	No	100%
U5	Medicaid level of care 5, as defined by each state	No	100%
U6	Medicaid level of care 6, as defined by each state	No	100%
U7	Medicaid level of care 7, as defined by each state	No	100%
U8	Medicaid level of care 8, as defined by each state	No	100%
U9	Medicaid level of care 9, as defined by each state	No	100%
UA	Medicaid level of care 10, as defined by each state	No	100%
UB	Medicaid level of care 11, as defined by each state	No	100%
UC	Medicaid level of care 12, as defined by each state	No	100%
UD	Medicaid level of care 13, as defined by each state	No	100%
UE	Used durable medical equipment	No	100%
UF	Services provided; morning	No	100%
UF	Services provided; afternoon	No	100%
UH	Services provided; evening	No	100%
UJ	Services provided; night	No	100%
UK	Svs on behalf client collat	No	100%
UN	Two Patients Served	No	100%
UP	Three Patients Served	No	100%
UQ	Four Patients Served	No	100%
UR	Five Patients Served	No	100%
US	Six or More Patients Served	No	100%
VP	Aphakic patient	No	100%

Neighborhood Health Plan of RI Reconsideration Process

- Claims editing software will screen all billed services for any applicable reimbursement policies outlined in this guideline, and deny any transaction(s) with the appropriate denial reason code. Denials are communicated via a provider's remittance advice.
- Providers may request reconsideration of separate reimbursement for any charge denied by editing software.
- A provider is required to resubmit the claim, with any applicable revisions (including appended modifiers) and complete notes attached, for reconsideration of any denial rendered. Providers have 180 to 365 days (depending on individual contractual terms) from the date of the original denial to resubmit for further consideration.
- Please allow 30 days for a reconsideration to be processed.
- Provider will receive written acknowledgement of any reconsideration received via remittance advice and/or individual letter.
- If a reconsidered claim denial is upheld, the provider may pursue the matter through the Neighborhood Health Plan of RI appeals process.

Please submit all reconsideration requests, with supporting documentation to:

Neighborhood Health Plan of RI
299 Promenade Street
Providence, RI 02908
Attention: Claims Quality and Audit
Fax: (401) 459-6188

References

Neighborhood Health Plan of RI adapts multiple reimbursement guidelines from various industry standard resources. These include, but are not limited to;

- The Center for Medicare and Medicaid Services (CMS)
- The American Medical Association (AMA)
- The American College of Obstetricians and Gynecologists (ACOG)
- The National Uniform Billing Committee (NUBC)
- The Federal Register
- Specialty Physician Publications
- American Academy of Professional Coders (AAPC) publications
- Annual CPT, HCPC and ICD-9 coding publications

Websites

- www.cms.gov
- www.ama-assn.org
- www.acog.org
- www.cms.hhs.gov/physicians/cciedits/
- www.ntis.gov.
- www.cms.hhs.gov/medlearn/icd9code.asp.
- www.cms.hhs.gov/NationalCorrectCodInitEd/

For complete information regarding these guidelines, please refer to the most current version of CPT® Assistant.

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Reimbursement Reference Manual

All information in this document is deemed reliable as of October 2009 and will be updated as needed. Reimbursement may be additionally affected by benefit coverage as mandated by the State of Rhode Island.