Facility Guidelines

We follow specific guidelines for billing and payment for facilities that are outlined in this section.

To the extent the terms of this administrative manual are inconsistent with the terms of the participating agreement, the terms of the agreement prevail.

Pre-authorization, eligibility and benefits
Please verify the patient's eligibility and benefits. Services in this section may require pre-authorization for medical necessity. Pre-authorization requirements can be found in the Pre-authorization section of our website.

Audits
We may audit any claim for appropriate coding, payment per contract and payment per Medical and Reimbursement policy. We will request any combination of invoice, medical records or itemized bill to support audit. All documentation requested must be provided within the time frame specified in the audit letter.

Inpatient hospital guidelines
An inpatient hospital is a facility, which primarily provides diagnostic, therapeutic (both surgical and non-surgical) and rehabilitation services by or under the supervision of physicians, to patients admitted for a variety of medical conditions.

Inpatient hospital claims are submitted electronically on an ANSI 837I (Institutional) format and exclude all professional components and air ambulance. Inpatient hospital claims must include the appropriate room and board revenue codes. Professional components, including pathology, radiology, anesthesia, emergency, etc., should be submitted electronically on an ANSI 837P (Professional) format.

An outpatient facility is that portion of a hospital which provides the following to sick or injured persons who do not require hospitalization.

- Rehabilitation services
- Diagnostic, therapeutic (both surgical and non-surgical) services
- May perform laboratory tests that are billed by the hospital
- May provide services in an emergency room or outpatient clinic
- May offer ambulatory surgical procedures and/or medical supplies

Billing inpatient versus outpatient stays
We use MCG at careguidelines.com to determine appropriate level of care. Inpatient hospital claims must include the appropriate room and board revenue codes. The total units billed on the room and board revenue codes should match the length of stay as calculated as discharge date less admit date plus one.

Observation
Hospital observation is intended to allow a physician an opportunity to monitor and observe a patient and make a decision about on-going care. We reimburse for up to 48 hours of
observation, if clinically appropriate, per the outpatient reimbursement terms. Observation stays beyond 48 hours may be rebilled by the provider as an inpatient stay and will process per inpatient guidelines. Applicable pre-authorization and notification requirements will apply.

If inpatient level of care is not met, reimbursement will be made for up to 48 hours per outpatient reimbursement terms. Covered charges, generally billed under revenue code 0760 or 0762 will be for the number of hours a patient is in observation, up to 48 hours. Charges for any twenty-four (24) hour period of observation cannot exceed the Hospital/Providers usual semi-private room rate.

Revenue code 0760 is not accepted for use to identify observation room charges.

We use MCG to determine appropriate level of care. In addition, we follow Centers for Medicare & Medicaid Services (CMS) guidelines regarding proper documentation of observation stays, including the Medicare Outpatient Observation Notice (MOON), form CMS-10611 for Medicare members receiving outpatient observation care for more than 24 hours. All hospitals, including critical access hospitals, are required to provide this notice. You can find the notice and accompanying instructions at cms.gov/Medicare/Medicare-General-Information/BNI/.

Hospital-based physician services
To the extent your hospital and/or provider agreement does not address hospital-based physician services, the following guidelines will apply:

- Professional fees for covered services rendered to members by hospital-based physicians during a covered inpatient hospital stay, are not included in the hospital Maximum Allowable.
- Professional services should be submitted in an electronic ANSI 837P (Professional) format.

Pre-admission services
Pre-admission services are considered:

- Outpatient hospital services rendered two calendar days prior to an inpatient admission
- Diagnostic services (including clinical diagnostic laboratory tests) provided to a patient by the hospital and/or provider, or by an entity wholly owned or wholly operated by the hospital and/or provider (or by another entity under arrangements with the hospital and/or provider), within two days prior to and including the date of the patient's admission are deemed to be inpatient hospital services and included in the inpatient payment.

Hospital readmission review (group and Individual plans)
All hospital readmissions for the same, similar or related condition which occur within 48 hours of the original discharge from hospital/facility or as defined in the Hospital Provider Contract is considered a continuation of initial treatment.
The two Diagnosis Related Group (DRG) hospital claims (identified using the assigned provider identifier) will be consolidated into one, combining all necessary codes, billed charges and the length of stay. The maximum allowable for Covered Services will be recalculated per the reimbursement terms of the hospital/facility contract so that reimbursement is for a single, per case reimbursement.

This policy applies to the following but not limited to:

- Emergent readmissions
- Psychiatric readmissions
- Clinically related readmissions

This policy does not apply to the following:

- Readmission for unrelated condition
- Transfer from one acute care hospital to another
- Patient discharged from the hospital against medical advice
- Readmission for the medical treatment of rehabilitation care
- Readmission for cancer chemotherapy or transfusion for chronic anemia

For additional information view the Inpatient Hospital Readmissions (Administrative #111) reimbursement policy on our provider website: Library>Policies and Guidelines>Reimbursement Policy.

Hospital readmission review (Medicare Advantage Plans)

Our policy aligns with CMS and includes readmission to the same hospital (using the assigned provider identifier) within 30 days of the initial admission. Hospital stays are subject to clinical review to determine if the readmission is related to or similar to the initial admission.

Readmissions occurring:

- On the same day (or within 24 hours) will be processed as a single claim
- Within 2-30 days will be subject to clinical reviews. If the clinical review indicates that the readmission is for the same or similar condition, it may be considered a continuation of the initial admission for the purposes of reimbursement.

When we receive Diagnosis Related Group (DRG) claims for both an initial and subsequent hospital stay, we combine the subsequent hospital stay with the initial claim within our system. When this occurs, we will send you a notification reflecting these changes and additional payment, if applicable.

This applies to, but is not limited to:

- Emergent readmissions
- Psychiatric readmissions
- Clinically related readmission
- Planned readmission or leave of absence
This policy does not apply to the following:

- Readmission for unrelated condition
- Transfer from one acute care hospital to another
- Readmission for the medical treatment of rehabilitation care
- Patient discharged from the hospital against medical advice
- Readmission for cancer chemotherapy, transfusion for chronic anemia or similar repetitive treatments

For additional information view the Inpatient Hospital Readmissions (Medicare Administrative #111) reimbursement policy on our provider website: Library>Policies and Guidelines> Reimbursement Policy.

Submission of maternity/newborn claims
Separate claims must be submitted for the mother and newborn services. Claims that reflect both maternity and newborn charges on the same claim form will be returned to the hospital and/or provider for correct billing.

Interim billing
Interim bills will not be accepted. To properly adjudicate an inpatient claim, the patient must be discharged.

Late charges
Late submissions in general are not accepted. Late charges are defined as Type of Bill (TOB) code 115 and are not reimbursable. The hospital and/or provider must submit a corrected billing of the entire claim with TOB code 117 to receive reimbursement for charges not included when the original bill was submitted.

Hospital corrected billings and/or adjustments
Corrected claims must be submitted using TOB code 117. All claims must contain all pertinent information including all applicable International Classification of Diseases (ICD) diagnosis and procedure codes, present on admission (POA) flags and discharge status. Charges included on previously submitted claims, whether billed as interim or complete claims, must be included on the corrected claim. Itemizations or records may be requested to re-adjudicate the corrected claim.

Grouper use
To determine the Diagnosis Related Group (DRG) for an inpatient stay, we use the grouper version in effect on the date of admission. The Grouper used for reimbursement purposes is the DRG Grouper version as defined in the Inpatient Reimbursement Schedule found in your hospital and/or provider agreement and shall also be based on the date of admission.

Ungroupable DRGs
Ungroupable DRGs are defined as the following:

- MS DRG 998 and 999
- AP DRG 469 and 470
• MS DRG version 24 or lower: 469 and 470

**Member deductible and coinsurance calculation**  
Member deductible, copayment and coinsurance amounts will be calculated based on the billed charges or maximum allowable, whichever is less.

**DRG methodology**  
The following charges and fees are included in the DRG reimbursement:

- Late discharge  
- Observational/outpatient  
- Diagnostic laboratory services  
- Emergency or after-hours admission  
- Admission or utilization review paperwork  
- Discharge (take home) prescription drugs  
- Emergency room, if the patient is admitted  
- Medical transportation (excluding air ambulance)  
- Room and board, including services and supplies  
- Pre-admission services two days prior to admission and one day post discharge

In general, for hospitals reimbursed using DRG methodology, most inpatient claims will be processed using DRG methodology. Some types of services and situations are excluded from this methodology, such as:

- Transfer patients  
- Other circumstances specified in the provider contracts  
- Hospitalization during the time insurance becomes effective with us

Note: Any exceptions will be specified in a hospital's current payment attachment(s).

**Medicare post-acute transfer policy**  
It is important to follow the CMS requirements to report the correct discharge status when transitioning to another hospital, nursing facility, home health, hospice, inpatient rehabilitation facility, long-term care hospital or psychiatric hospital. We will audit and, if applicable, adjust claims based on the appropriate discharge status indicator.

The CMS policy is outlined in the MLN Matters article Fiscal Year (FY) 2006 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes (MM4046) at [cms.gov/Outreachand-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM4046.pdf](http://www.cms.gov/Outreachand-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM4046.pdf).

**Facility pre-authorization requirements**  
Please note facility pre-authorization is required for:

- Rehabilitation  
- Detoxification
• Skilled nursing facility (SNF)
• Long-term acute care facility (LTAC)
• Intensive outpatient for mental health and chemical dependency
• Partial hospitalization for mental health and chemical dependency
• Residential treatment for mental health and chemical dependency
• All elective inpatient admissions, including behavioral health (effective May 1, 2019)

Admission and discharge notification requirements
Notification of admission should occur within 24 hours of admission to assist with coordination of care and reduce 30-day readmission. These require notification be received within 24 hours after the actual weekday admission (or by 5:00 p.m. local time on the next business day, if 24-hour notification would require notification on a weekend. Facilities that submit patient data, including admission and discharge data, via electronic record submission/EDIE are no longer required to submit notification of inpatient admissions in another format.

Admission notification includes:

• All inpatient hospice admissions
• Chemical dependency detoxification
• All unplanned acute care admissions
• All planned and elective acute care admissions
• All admissions that follow an outpatient surgery
• All admissions that follow outpatient observation
• Intensive outpatient admissions for chemical dependency
• All newborns who are admitted to the neonatal intensive care unit
• All newborns who remain hospitalized after the mother is discharged

Admission and discharge notification, must be made via fax to 1 (800) 453-4341 or by providing us with access to the information via an electronic medical record application. For Medicare lines of business, if the admission notification is not completed, we will review post-payment.

• Admission notification by the facility for non-Medicare lines of business is required even if a pre-authorization was completed by the physician or other health care professional and a pre-authorization approval is on file with us.
• Receipt of an admission notification does not guarantee or authorize payment. Payment of covered services is contingent upon coverage within our individual member's benefit plan, the facility being eligible for payment, any claim processing requirements, and the facility's participation agreement with us.
• Admission notifications must contain the following details regarding the admission:
  o Member/patient's full name, date of birth and member number
  o Facility name and TIN or NPI
  o Actual admission date and anticipated discharge date
  o Admitting/attending physician full name and TIN or NPI
  o Description for admitting diagnosis or valid ICD diagnosis code
Discharge Notifications must also contain the following on related to patient discharge:
  
  - Member/patient's full name, date of birth and member number
  - Primary diagnosis
  - Discharge disposition
  - Date of actual discharge
  - Facility name and TIN or NPI

**Notification timeframe reimbursement**

There may be exceptions to obtaining pre-authorization. The six situations listed below may apply as part of our Extenuating Circumstances Policy Criteria:

1. Member presented with an incorrect member card or member number.
2. Natural disaster prevented the provider or facility from securing a pre-authorization or providing hospital admission notification.
3. Member is unable to communicate (e.g., unconscious) their medical insurance coverage. Neither family nor other support present can provide coverage information.
4. Compelling evidence the provider or facility attempted to obtain pre-authorization or provide hospital admission notification. The evidence shall support the provider or facility followed our policy and that the required information was entered correctly by the provider office or facility into the appropriate system. *Note:* A copy of the faxed preauthorization request showing the information was entered correctly or a copy of the provider's or facility's fax cover sheet for hospital admission notifications indicating the member health plan information and a fax confirmation from the fax machine showing the fax was successfully sent to the appropriate health plan fax number will be considered compelling evidence.
5. A surgery which requires pre-authorization occurs in an urgent/emergent situation. Services are subject to review post-service for medical necessity.
6. A participating provider or facility is unable to anticipate the need for a pre-authorization before or while performing a service or surgery.

**Inpatient medical concurrent review**

We no longer perform facility concurrent review for our commercial lines of business, including our Federal Employee Program (FEP) and Administrative Services Only (ASO) groups. For urgent and emergent admissions, facilities will be required to send us records upon request but not within 24 hours of the inpatient notification. Concurrent review on extracorporeal membrane oxygenation (ECMO) for the treatment of cardiac and respiratory failure in adults will continue.

We require facilities to provide documentation when requested for extended length of stays and assist us with discharge and care coordination to reduce readmissions.

Please note for all facilities:

- Clinical records are no longer required, unless requested.
- All reviews are based on MCG Goal Length of Stay national/industry standards.
- Continued notification of inpatient admissions within 24 hours or one business day of the admission is still required.
It is our intent to conduct post service reviews for medical necessity when such reviews are not conducted concurrently. Documentation for review via records requests may continue, as needed, for care coordination or upon receipt of the claim(s). If a claim does not meet MCG guidelines for the inpatient stay, it will be denied. Facilities should rebill Medicare Advantage claims using Type of Bill 0127, following CMS guidelines. Commercial claims can be rebilled with Type of Bill 0127 or 0137, whichever is appropriate. For more information, view the:


See the Medical management section of the Administrative Manual for more information about concurrent review.

**Payment implications for failure to pre-authorize services**

Failure to secure approval for services subject to pre-authorization requirements will result in an administrative denial, claim non-payment and facility liability. Our members must be held harmless and cannot be balance billed.

Please note the following:

- Facility claims for services that require pre-authorization will be reimbursed based upon the member’s contract only when the pre-authorization has been completed and approved. Facilities should verify the services have been approved.
- Admissions for services that require pre-authorization will be administratively denied if there is no approved pre-authorization. Administrative denials are a provider/facility write-off and cannot be charged to the member.
- When scheduling a service that requires pre-authorization, facilities should develop a method with the professional provider to ensure the pre-authorization request has been performed. The pre-authorization request submitted should designate the facility where the treatment will occur to ensure proper reconciliation with related inpatient claims.
- We will not accept retrospective requests for pre-authorization. If a member receives services that require pre-authorization and services are either started or completed before pre-authorization is obtained, the requestor will be advised that the service required pre-authorization and it was not obtained. Facility claims will be administratively denied and cannot be charged to the member.
- If a service that requires pre-authorization needs to occur during an inpatient admission and that need could not be foreseen prior to admission, the facility/provider can request pre-authorization for the service while the member is inpatient (before the service occurs). If pre-authorization does not occur during the stay, services are subject to review post-service for medical necessity.
Other facility guidelines

Level of Care
When a member’s procedure or service is performed in a place other than the site of service approved by the health plan during the pre-authorization process, the member will not be liable for the charges and they will become a facility write-off.

Hospital Acquired Conditions and Never Events
We follow our Hospital Acquired Conditions and Never Events reimbursement policy. We also encourage the use of a Surgical Safety Checklist at http://www.who.int/patientsafety/safesurgery/checklist/en.

Medical management
Services and supplies that are eligible for reimbursement must be medically necessary, as defined in the medical policies.

Examples of medical management responsibilities may include, but are not limited to, the following:

- Preadmission review to determine whether a scheduled inpatient admission is medically necessary
- Admission review to determine whether an unscheduled inpatient admission or an admission not subject to preadmission review is medically necessary
- Concurrent review to determine whether a continued inpatient admission is medically necessary, including the management of patient care by suggesting alternative sites and methods of care
- Length-of-stay review to assign the number of inpatient days appropriate for an inpatient stay
- Retrospective review to determine whether services and supplies were medically necessary including the assignment of appropriate diagnostic and procedure codes
- Case management to coordinate the care for patients whose medical needs are extensive and usually longer term, when applicable
- Review of the hospital's health care practices and utilization patterns
- Utilization guidelines to determine appropriate rendering of health-care services
- Collaboration with us on clinical guidelines/pathways and disease management programs
- Post-payment review for appropriate level of care when concurrent management has not occurred.
- Our on-site reviewers will have access from the provider, and appropriate personnel, to chart documents to assure the above. Concurrent reviewers will have access to charts and patients as needed on the nursing floors. Retrospective and quality reviewers will have access to chart documents in the provider's medical records department. Our reviewers will make best efforts to work with the provider and to audit policies
- Quality improvement activities that support credentialing, re-credentialing, clinical and service studies and other medical management functions
Outpatient hospital guidelines
Claims for all outpatient services, as defined below, must be submitted electronically in an ANSI 837I claim format using current CPT coding. Professional services that are billed in an ANSI 837P format are not affected. All claims must be submitted electronically.

- One procedure typically equals one unit of services (except: laboratory, radiology, mental health and physical therapy services).
- Claims that include a service that has a CPT code, but one is not listed, will be returned to the hospital for resubmission using the required code.
- Services will be subject to identical requirements for all outpatient providers (e.g., National Correct Coding Initiative (NCCI) at cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/NationalCorrectCodInitEd/ and correct coding editor (CCE)
- Reimbursement is based upon a maximum allowable fee schedule (if submitted charges are less than the fee schedule, we will reimburse at the charged amounts).
- Claims for the same date of service for the same patient must be submitted as one claim, similar to inpatient claims. We will not accept interim bills for outpatient services, except monthly billing for rehabilitative services.

High-technology services
We will work with hospitals to identify high-technology services and supplies performed in an outpatient setting to establish appropriate billing protocols and standards for reimbursement.

Emergency room services
Most contracts include an emergency room copayment that may be collected at the time services are rendered. This copayment is waived in certain circumstances, such as when the patient is admitted to inpatient care directly from the emergency room. All services provided in the emergency room in conjunction with an inpatient hospital stay should be included on the inpatient hospital claim.

Rehabilitation services
Services for rehabilitative care, when it is medically necessary to restore and improve function previously normal but lost due to illness or injury are covered. If a child was covered from birth on one of our health plans, rehabilitation services for congenital anomalies may be covered.

Inpatient and outpatient rehabilitation services (physical, speech or occupational therapy) are eligible for reimbursement up to a specific dollar amount per condition. Some member contracts may require pre-authorization. The hospital must be approved for these services to receive reimbursement.

The following services or items are not covered:

- Gym or swim therapy
- Non-medical self-help
- Custodial care, maintenance
- Recreational, education or vocational therapy
- Chemical dependency rehabilitative treatment
- Learning disabilities (e.g., attention deficit disorders or development delay)
- Hippotherapy (Aqua and/or hippotherapy may be covered under some contracts if specific criteria are met.)

Note: Include the referring physician's name on all claims.

Pre-admission outpatient services
Claims processing system edits are in place to capture claims for outpatient services that are provided two days before a related inpatient admission and within one day after hospital discharge. Auditing is performed on a post payment basis.

Claims for outpatient diagnostic and non-diagnostic services billed within the two-day pre-admission and one-day post-discharge time frame will be re-processed by our auditors and denied because the charges are included in reimbursement for the inpatient stay. The patient is not responsible for the charge. The provider will be notified that this is a write off and not billed to the patient on the payment voucher.

Outpatient reimbursement guidelines
Outpatient surgery is reimbursed based on rate classifications. Procedures that have not been classified may be paid using a discount of billed charges (if the procedure qualifies for reimbursement).

Refer to your agreement for specific details regarding outpatient reimbursement that may differ from the above-mentioned process.

Note: Outpatient prescription drugs are covered under a separate prescription drug benefit.

Multiple surgical procedures
The procedure with the highest fee will be paid to the maximum allowable rate for surgeries that involve more than one procedure. The second procedure will be paid at 50% of the maximum allowable rate. There will be no additional reimbursement for the third and subsequent procedures. Outpatient services will be subject to identical requirements for all outpatient providers (e.g., National Correct Coding Initiative (NCCI) at cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/NationalCorrectCodInitEd/ and correct coding editor (CCE).

Non-reimbursable revenue codes
Unless otherwise specified in the contract:
- Clinic charges 0510-0529 are non-reimbursable.
- Revenue code 0761 must be appropriately billed. As directed in the UB-04 Editor, bill revenue code 0761 for actual use of a treatment room in which a specific procedure has been performed or a treatment rendered. Do not bill evaluation & management (E&M) CPT codes with revenue code 0761.
- E&M codes billed with revenue codes that include, but are not limited to: 0280, 0480, 0760, 0762-0769 and 0960-0989 are not reimbursable.
Freestanding ambulatory surgery centers
Freestanding ambulatory surgery centers (ASC) provide an alternative setting for surgical procedures that would otherwise be performed in a hospital on an outpatient basis.

ASCs:
- In most cases, are freestanding facilities
- Some may be co-located with a hospital, physician office or clinic
- Must meet the state's criteria for licensure when sharing a location
- Must have a registered nurse on duty at all times when patients are in the facility

Facility accreditation
Before reimbursement can be approved, or contracted for facility fees, a freestanding ASC must be credentialed. The freestanding ASC must have:
- A current passing state quality review survey
- A current onsite quality assessment completed by us, or
- A current passing quality review from the Centers for Medicare & Medicaid Services (CMS)

CMS or state surveys cannot be more than three years old and may be submitted upon recredentialing.

Reimbursement
A fee schedule is used for these claims. Fees for multiple procedures are calculated as follows:
- The code with the highest fees is reimbursed at 100%.
- The subsequent codes are reimbursed at 50% of the fee.
- Any code not subject to cuts is removed from consideration before reductions are applied.
- For any single procedure code, reimbursement is never more than the charged amount.

Unlisted codes (defined by CPT as a code used for services or procedures that do not have a specific code) that are covered CPT Category III Codes, may be reimbursed at percentage of charges or as outlined in the provider agreement.

ASCs are not reimbursed for:
- Procedures usually performed in an inpatient or outpatient hospital setting
- Minor surgeries customarily performed in a physician's office and for which use of a facility is generally considered part of the physician's office overhead. (e.g., where the Relative Value Unit (RVU) assigned includes a consideration for overhead)

Billing guidelines
- Include Modifier SG on all surgical codes.
- Facility charges should be submitted on an ANSI 837P.
- Use '24' or other designated appropriate place of service code for a freestanding ASC.
• All line items must be submitted on one claim. Do not bill separate procedures on multiple claim forms.

ASC facility fee services
Unless otherwise specified in the contract, the maximum allowable is intended to include, but not limited to the following:

• Intraocular lenses for insertion during or after cataract surgery
• Administrative functions such as scheduling or cleaning, utilities and rent
• Anesthetic and any materials, disposable or re-useable, needed to administer anesthesia
• Implants, including but not limited to the following: screws, plates, anchors, pins, and wires
• Nursing, technical staff, orderlies and others involved in patient care connected to the procedure, intravenous therapy, and other related services
• Use of facility, including operating room, recovery and/or short stay rooms, prep areas, and use of waiting rooms and lounges created for patients and relatives
• Diagnostic testing such as urinalysis, blood hemoglobin or hematocrit, pre-operative chest x-ray, and therapeutic items and services directly related to the procedure/service
• Drugs (including take home), biologicals (blood), surgical dressings, supplies, splints, casts, appliances, non-custom braces, disposable infusion pain control pump, and equipment related to the provision of care

Services not included in the ASC facility fee
Unless otherwise specified in the contract, these items should be billed separately from the facility fee with appropriate Healthcare Common Procedure Coding System (HCPCS) or CPT coding.

• Ambulance services
• Custom braces (e.g., leg, arm, back and neck)
• Services furnished by an independent laboratory
• Physician or other individually contracted provider services, including anesthesia
• The sale, lease or rental of durable medical equipment to ASC patients for use in their homes
• Prosthetic devices defined as those items that are permanent replacements to existing body parts, including artificial legs, arms and eyes. Invoices are to be submitted upon request. Shipping and handling are not separately reimbursed.

Physician charges
The physician charge is the fee for performing the surgery and related diagnostic and therapeutic services. This includes the administration or the supervision of the administration of local anesthesia or IV sedation. The professional fees are billed separately by the performing physician. The facility and performing physician codes must be the same.
Hospice
Hospice services provide medical, nursing, and emotional care when a cure is no longer possible. Hospice care is provided by a coordinated team of professionals and may include a:

- Nurse
- Physician
- Therapist
- Social worker
- Home health aid
- Bereavement counselor

Hospice services may need pre-authorization for medical necessity.

Submitting claims
- Submit claims electronically in an ANSI 837I claim format and submit it once every month.
- Include all charges for each month on one claim. Do not overlap calendar months or years.

Billing guidelines
Current revenue codes and the services they include are listed below. The revenue codes are subject to change.

0651 - Routine home care (per diem) includes:
- Dietary counseling
- Medical equipment and supplies
- 24-hour on-call medical management
- Grief counseling with patient and family
- Physical, occupational and speech therapy
- All visits by nurses, chaplains, MSW's and HHA volunteers
- All medicine pertaining to terminal illness, including pain management

0652 - Continuous home care (per hour)
- The patient needs at least 8 hours of skilled nursing care at home
- The caregiver cannot cope or when patient needs intensive short-term care

0655 - Inpatient respite care (per diem)
- The patient is in a SNF

0656 - Inpatient hospice care (per diem)
- The patient is hospitalized for pain control

0659 - Other hospice care
- Use this code for in-home respite care (per hour)

Hourly non-skilled care provided to patient when respite is needed for the caregiver.
Services not Included in hospice care
The following services are not included. They should be billed separately by the performing provider:

- Surgery
- Tube Feedings
- Physician services
- Blood transfusions
- Ambulance services
- Diagnostic radiology
- Drugs not related to the terminal illness
- Chemotherapy and radiation (other than when used for pain control)
- IV's and intravenous medications necessary for pain or symptom management

Treatment plans
Treatment plans and progress notes may be requested for selected patients. We reserve the right to review past records and claims submissions. The fully documented treatment plans must include:

- Physician prescription or referral
- Appropriate and legible chart note documentation

The treatment plan should describe in detail the specific hospice services to be provided to the patient. Progress reports and/or notes which support the following status of the patient:

- The diagnosis or diagnoses must support the level of care provided.
- Medical necessity of the care provided must be demonstrated and may be subject to review.
- Procedures performed must be within the scope of license as defined by either the Revised Code of Washington, Washington Administrative Code or the governing Quality Assurance Commission.

Skilled nursing facilities
Skilled nursing facilities (SNF) care for individuals requiring rehabilitative services and/or the daily attention of nurses. SNF care is for patients that no longer need all of the medical support provided by a hospital but need more skilled care than they would have at home or in a nursing home.

SNFs may be referred to as transitional care units, extended care facilities, nursing homes or sub-acute facilities.

Admissions require pre-authorization to determine medical necessity, treatment plan, length of stay, as well as requiring ongoing concurrent reviews. It is the responsibility of the SNF to ensure that a pre-authorization is in place and completed upon admission.
Physician Certification and Recertification requirements
According to the Washington Administrative Code (WAC) 388-97-1260 at apps.leg.wa.gov/WAC/default.aspx?cite=388-97-1260, the skilled nursing facility must ensure that the resident is seen by a physician, whenever necessary. In addition except as specified in the Revised Code of Washington (RCW) 74.42.200 at apps.leg.wa.gov/RCW/default.aspx?cite=74.42.200, a physician must personally approve in writing a recommendation that an individual be admitted to a skilled nursing facility.

The skilled nursing facility must also ensure that except as specified in RCW 74.42.200, the medical care of each resident is:

- Supervised by a physician
- When the attending physician is unavailable, another physician supervises the medical care of the residents
- Physician services are provided 24 hours per day, in case of emergency.

The physician must:

- Write, sign and date the progress notes at each visit, including all orders
- Review the resident's total program of care, including medications and treatments, at each federally required visit in Medicare and Medicare/Medicaid certified facilities.

Quality Rating
All our network SNF providers with Medicare contracts are expected to participate in and comply with CMS reporting and health inspection regulations. CMS calculates Health Inspections ratings and Quality Measures ratings for SNFs and posts them online on the Medicare Nursing Home Compare database.

The health inspections ratings contain information from the last three years of onsite inspections, including both standard surveys and any complaint surveys. This information is gathered by trained, objective inspectors who go onsite to the nursing home and follow a specific process to determine the extent to which a nursing home has met Medicaid and Medicare’s minimum quality requirements. The most recent survey findings are weighted more than the prior two years.

The Quality Measures ratings are determined by combining the values of eleven quality measures and have been derived from clinical data reported by the nursing home.

Each contracted provider’s quality rating will be evaluated based on data from Medicare’s Nursing Home Compare database, and the hybrid score will be calculated by multiplying the Health Inspections rating by three, adding the Quality Measures rating and dividing the sum by four.

Calculation: Health Inspection Score * 3 + Quality Measures Score / 4 = hybrid score

Medicare Advantage reimbursement rates will be based on the following quality rating categories and will be defined in your agreement:

December 1, 2019 - 16 - Facility Guidelines
regence.com Regence BlueShield Administrative Manual
• Category 1 includes the highest performing facilities (also known as excellent); those with a hybrid score equal to or greater than 4.5.
• Category 2 includes good facilities; those with a hybrid score between 3 and 4.4.
• Category 3 includes adequate facilities; those with hybrid score less than 3.

We will reassess the quality rating of each network facility annually, using the April Nursing Home Compare data. We will send notification of changes in reimbursement or network participation termination to be effective in September each year.

Notice of Medicare Non-Coverage (NOMNC) form
Our network SNF and home health providers with Medicare contracts are expected to deliver the NOMNC according to CMS guidelines at least two days before the last day of covered SNF or home health services for Medicare members. The NOMNC informs our members of the date they no longer meet criteria for SNF or home health care and describes their appeal rights.

We will request the clinical documentation to support continued SNF or home health care three to five days before the current authorization period ends. Based on our review, we will notify you of our determination as follows:

• If we determine that continued SNF or home health care is appropriate, we will send notification of the new authorized dates.
• If we determine that the patient no longer meets the criteria for SNF or home health coverage, we will prepare the patient-specific NOMNC and send it to you with our determination. It is your responsibility to deliver the NOMNC to the patient or his or her authorized representative at least two days prior to the last day of coverage.

Please follow these steps to ensure that the NOMNC is delivered in compliance with the requirements:

1. The SNF or home health agency discusses discharge with the patient and family or authorized representative informing them of the last covered day of services, and presents the NOMNC provided by Regence.

2. The patient or authorized representative signs page 2 of the NOMNC. If the patient is unable to sign and the SNF or home health agency is working with an authorized representative who is unable to be present that day, the SNF or home health agency may issue the NOMNC by telephone. For a telephonic notice to be valid, the documentation on the NOMNC must include all of the following:
   - The name of the staff person initiating the contact
   - The name of the representative contacted by phone
   - The date and time of the telephone contact
   - The telephone number called
   - A notation that full appeal rights were given to the representative
The date of the telephone conversation is the date of the receipt of the notice. The facility or agency must confirm the telephone contact by sending written notice to the authorized representative on that same date.

3. Copies of the completed NOMNC are:
   o Given to the patient or the authorized representative who signed the NOMNC
   o Placed in the patient’s medical record at the SNF or home health agency
   o Faxed to Regence at 1 (855) 240-6498 as soon as possible after the form is signed

NOMNCs can be issued early to accommodate a weekend or to provide a longer transition period. After delivery of the NOMNC, the patient may choose to appeal the decision. They must contact the Quality Improvement Organizations (QIO) to request a review no later than noon on the day before services are to end. The QIO appeal decision will generally be completed within 48 hours of the patient's request. Please be prepared to provide documentation to us quickly to assist the QIO review process.

**Provider responsibility for failure to deliver a valid NOMNC:** Medicare Advantage providers are responsible for the delivery of the NOMNC. **Effective January 1, 2020, if a QIO or Regence determines that you did not deliver a valid NOMNC to a beneficiary or that requested records were not returned by a stated deadline, you will be financially liable for continued services until two days after the beneficiary receives valid notice, or until the effective date of the valid notice, whichever is later.** You must supply all information, including medical records, requested for the QIO appeal to Regence.

**Home health**

Home health encompasses a broad spectrum of both health and social services delivered to the recovering, disabled or chronically ill person in the home environment. These services include:

- Nutritional services
- Medical social services
- Therapy services (e.g., physical, occupational, speech)
- Traditional professional nursing and home care aide services

Generally, home health is appropriate whenever a person needs assistance that cannot be easily or effectively provided only by a family member or friend on an ongoing basis, for a short or long period of time.

Home health care is subject to the following limitations:

- The patient's condition must be serious enough to require hospitalization in the absence of home health care.
- The patient must be homebound, which means that leaving the home could be harmful to him or her or would involve a considerable and taxing effort.

Please verify the patient's eligibility and benefits. Home health services may require pre-authorization for medical necessity. **Pre-authorization is required for Medicare Advantage**
patients’ subsequent episodes of treatment beginning with the 61st day of home health care. (Pre-authorization is not required for the 60 consecutive days of home health care.) Note: Effective January 1, 2020, an episode will be defined as a period of 30 consecutive days, not by the number of visits.

Billing guidelines
The following services can be performed by any of the following professionals, if they are employees of and billed by an approved home health agency:

- Certified aide
- Speech therapist
- Registered nurse
- Physical therapist
- Nutritionist/Dietician
- Master social worker
- Occupational therapist
- Licensed practical nurse

A written treatment plan and the signature of the attending physician must be on file at the home health agency.

A home health agency can submit claims for supplies and home medical equipment that are eligible for reimbursement. The treatment plan should describe in detail the specific services to be provided to the patient.

Claims Submission
All claims must be submitted electronically on an ANSI 837I (Institutional) claim format and include the revenue code and appropriate CPT/HCPCS code as indicated below.

<table>
<thead>
<tr>
<th>Revenue code</th>
<th>Procedure code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>551</td>
<td>CPT 99500-99507, 99511, 99512 and 99600</td>
<td>Skilled nursing visit</td>
</tr>
<tr>
<td>552</td>
<td>HCPCS S9123</td>
<td>Hourly skilled nursing services</td>
</tr>
<tr>
<td>552</td>
<td>HCPCS S9124</td>
<td>Hourly LPN care</td>
</tr>
<tr>
<td>571</td>
<td>HCPCS 99509</td>
<td>Home health aide visit</td>
</tr>
<tr>
<td>572</td>
<td>HCPCS S9122</td>
<td>Hourly home health aide or CNA care</td>
</tr>
<tr>
<td>561</td>
<td>HCPCS S9127</td>
<td>Medical social services per diem</td>
</tr>
<tr>
<td>421</td>
<td>HCPCS S9131</td>
<td>Physical therapy per diem</td>
</tr>
<tr>
<td>431</td>
<td>HCPCS S9129</td>
<td>Occupational therapy per diem</td>
</tr>
<tr>
<td>441</td>
<td>HCPCS S9128</td>
<td>Speech therapy per diem</td>
</tr>
<tr>
<td>581</td>
<td>HCPCS S9470</td>
<td>Nutritionist visit</td>
</tr>
<tr>
<td>691</td>
<td>CPT 99509</td>
<td>Palliative care home health aide visit</td>
</tr>
<tr>
<td>691</td>
<td>CPT 99510</td>
<td>Palliative care medical social services visit</td>
</tr>
</tbody>
</table>

Note: Reimbursement for supplies is included in the payment amounts listed in your Agreement. Supplies shall not be considered eligible for additional reimbursement.
Submitting claims

- CPT/HCPCS codes with descriptions reading “per hour” will be reimbursed as one unit of service per day.
- The date of service should be the date of drug administration - not the date of shipment.
- Include all charges for each month on one claim. Do not overlap calendar months or years.
- When billing for drugs use the National Drug Code (NDC) number and appropriate "J" code.
- There are certain infusion medications that require prior-authorization by us. Please refer to our drug formulary for the most current list.
- Retail drugs will not be reimbursed through the infusion therapy contract. Claims for retail drugs must be submitted through our pharmacy drug care program.

Treatment plans

Treatment plans and progress notes may be requested for selected patients. We reserve the right to review past records and claims submissions. We require fully documented treatment plans to include:

- Physician prescription or referral
- Appropriate and legible chart note documentation
- Progress reports and/or notes which support the status of the patient should include:
  - The diagnosis or diagnoses must support the level of care provided.
  - Medical necessity of the care provided must be demonstrated and may be subject to review.
  - Procedures performed must be within the scope of license as defined by either the Revised Code of Washington, Washington Administrative Code or the governing Quality Assurance Commission.

Pre-authorization

Pre-authorization requests should be submitted five to seven days before the subsequent episode begins. Requests should include the original Outcome and Assessment Information Set (OASIS) and the completed medication reconciliation form, both signed by the physician.

Medicare Advantage home health agencies

The Medicare Advantage home health program aligns reimbursement with quality for our Medicare Advantage home health agencies. The program is based on the CMS Quality of Patient Care Star Ratings in Medicare Home Health Compare. Medicare Home Health Compare is available at medicare.gov/homehealthcompare/search.html.

Quality ratings and reimbursement will be reviewed annually. Notification to agencies of changes to the percentage of Medicare allowable will be provided by October 1 each year for a January 1 effective date. Reimbursement rates will be based on an agency’s Quality of Patient Care Star Ratings for the period ending each July based on the previous calendar year’s data.
Payment continues to be based on a percentage of the current CMS Home Health Prospective Payment System (PPS) fee schedule.

<table>
<thead>
<tr>
<th>CMS Star Rating</th>
<th>Regence Quality Rating</th>
<th>%CMS Allowable</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.5 to 5 Stars</td>
<td>Excellent</td>
<td>105%</td>
</tr>
<tr>
<td>3.5 to 4 Stars</td>
<td>Good</td>
<td>85%</td>
</tr>
<tr>
<td>1.5 to 3 Stars</td>
<td>Adequate</td>
<td>75%</td>
</tr>
<tr>
<td>1 Star</td>
<td>Poor</td>
<td>70%</td>
</tr>
</tbody>
</table>

*Note:* If a home health agency has a Poor quality rating for two consecutive years, we will evaluate continued participation for the agency and may determine that terminating participation is appropriate.

**Notification requirements for Medicare Advantage home health agencies**

Home health agencies are required to provide written notification to Medicare patients before reducing or terminating an item and/or service and when home health services are ending.

In accordance with Medicare guidelines, home health agencies are responsible for issuing the following beneficiary rights and protections notices to Medicare patients when required:

- *Home Health Change of Care Notice (HHCCN)* Form CMS-10280
- *Advance Beneficiary Notice of Noncoverage (ABN)* Form CMS-R-131
- *Notice of Medicare Non-coverage (NOMNC)* Form CMS-10123 (See instructions under Skilled nursing facilities above)
- *Detailed Explanation of Non-coverage (DENC)* Form CMS-10124

These forms are available on the CMS website at: [cms.gov/Medicare/Medicare-General-Information/BNI](http://cms.gov/Medicare/Medicare-General-Information/BNI).

**Home infusion therapy**

Home infusion therapy allows patients to receive vital fluids and medications without the inconvenience or costs of a hospital visit. These services may be provided by any agency that is dually licensed as a pharmacy and a home health agency.

Home Infusion Therapy services are not allowable for days when a patient is in an inpatient facility.

Infusion services and/or administrative drugs may require pre-authorization. The patient must have a written prescription and plan of care. The provider should always sign changes in infusion therapy, including the dose and frequency of medication.

**Wastage policy**

Medicine mixed and delivered to the patient but not used must be billed by using the J code with modifier JW and the National Drug Code (NDC) number.
Per diem rate includes
- Lab draws
- Setup and disposal
- Administrative overhead
- Clinical pharmacy services
- Delivery of medication and supplies
- Pharmacy compounding and dispensing fees
- Intravenous solutions, diluents and compounding ingredients
- Equipment (e.g., IV pumps, poles), ancillary medical supplies (e.g., syringes, tubing) and nursing supplies (e.g., catheter care kits, catheter-flushing solutions, dressings)

Nursing services include:
- Pharmacokinetic dosing
- Compounding of medication
- Patient/caregiver educational activities
- Monitoring for potential drug interaction
- Pharmacy assessment and clinical monitoring
- Review and interpretation of patient test results
- Medication profile set-up and drug utilization review
- Comprehensive knowledge of vascular access systems
- Development and implementation of pharmaceutical care plans
- Home visit by a health care professional in a single 24-hour period
- Recommendation of dosage or medication changes based on clinical findings
- Coordination of care with physicians, nurses, the patient and his or her family, other providers and caregivers
- Patient discharge services, including communication with other medical professionals and closing of the medical record
- Sterile procedures including intravenous admixtures, clean room upkeep, vertical and horizontal laminar flow hood certification and all other biomedical procedures necessary for a safe environment

Growth hormones
All growth hormones must be pre-authorized, and a contracted growth hormone provider must render all services.

Durable medical equipment and prosthetic devices
Durable medical equipment (DME) can enhance the quality of life for those in need of services by providing durable medical equipment and supplies. Rehabilitation products are a necessity for anyone who has been involved in any minor or serious injury or condition such as a stroke. For those whose injuries are less severe, DME needs may include items such as crutches, canes and walkers.

DME refers to equipment that is:
- Able to withstand repeated use
• Appropriate for use in the home
• Primarily and customarily used to serve a medical purpose
• Not generally useful to a person in the absence of illness or injury

The provider agrees to provide medical equipment, orthotic devices, prosthetic appliances and other medically necessary supplies to Regence’s members who submit a physician’s prescription to secure such equipment or supplies. Such medical equipment and supplies shall be immediately available in the provider’s warehouse. Items not routinely available shall be delivered to the patient as rapidly as possible, not to exceed two calendar days unless delayed by the manufacturer. The provider shall obtain pre-authorization from Regence prior to providing certain medical equipment in accordance with Regence’s published policy as amended from time to time.

The provider also agrees to the following additional responsibilities:

• Accept orders for medical equipment, related products and services on a 24-hour basis.
• Provide free delivery and installation of medical equipment and related products ordered for or furnished to patients.
• If requested by Regence, perform in-service training for Regence’s employees on the medical equipment and related products and supplies.
• Maintain an adequate inventory of medical equipment and related products and supplies including economical models that meet the patient’s needs and quality standards.
• Provide installation by people properly trained and qualified to do so.
• Ensure that all equipment has been maintained to manufacturer’s specifications and standards and that records are available to confirm this.
• Meet or exceed all applicable standards in the Joint Commission Accreditation Manual for Home Care.

The provider agrees that the maintenance, replacement or repair of medical equipment and other items and supplies shall be available as follows:

• If a patient’s life is threatened by a sudden equipment malfunction, emergency services are available 24 hours a day, seven days a week.
• If the performance and intended use of the equipment is affected by a sudden malfunction, services for repair or replacement are available 24 hours a day, seven days a week.
• If the performance and intended use of the equipment is not affected by a sudden malfunction, services for assessment, repair or replacement (when applicable) are available within five business days.
• Emergency backup systems for electrical equipment are provided either through a manual means or a self-contained battery integral to the equipment.
• The medical equipment, items and supplies are safe, sanitary and working as intended for use in the patient’s home. The provider will complete a written assessment at the time of delivery and ensure that the medical equipment, items or supplies are appropriate for use within the patient’s home.
The provider shall provide education appropriate to the medical equipment, items and/or supplies provided and shall document ongoing education of the patient, family members and care givers, including but not limited to the following:

- Written instructions in terms the patient and family can reasonably understand, which includes but is not limited to the care, storage, handling and therapeutic use of the medical equipment, items and supplies
- Written instructions regarding when and how to contact the provider for maintenance and/or repair
- Documentation of the patient’s and/or patient’s family’s receipt and understanding of the above required education and their demonstrated ability to operate the equipment safely and appropriately
- Verbal and written instructions regarding emergency procedures
- Provide at a minimum, a one-year warranty for purchased medical equipment, orthotic devices and prosthetic appliances (this does not supersede or replace any manufacturer’s warranty)

The provider shall be responsible for servicing, at no additional charge, all rented medical equipment. The provider shall provide warranty services for purchased medical equipment, orthotic devices and prosthetic appliances limited to the manufacturer’s warranty. Repairs and replacements covered by warranties are not eligible for reimbursement. Any maintenance or repair performed on the medical equipment shall not be billed to Regence unless pre-approved by Regence.

Least costly items and services: The provider shall provide or arrange for the provision of the least costly items and services appropriate to the member’s needs and safety. Exceptions must be discussed and approved by Regence and the patient prior to delivery of the item or service.

Dispensing codes
Dispensing codes are not eligible for separate reimbursement.

Oxygen equipment rental-only reimbursement
Our DME exhibits specify that life-sustaining oxygen equipment is eligible for reimbursement based on rental periods only. Reimbursement exceeding the rental allowable rate is not provided for equipment purchased by the member.

If the member purchases the equipment, DME providers should obtain a member consent form signed by the member that specifies that neither the DME provider nor the Company is financially responsible in excess of one month's rental allowable amount.

For more information, refer to our reimbursement policy Durable Medical Equipment Purchase and Rental Limitations (Administrative #131).
**Oxygen and Oxygen Equipment**

The fee schedule amount for oxygen system rentals is a monthly allowance and will include all equipment, oxygen, accessories, supplies, maintenance and repairs. The provider will include the appropriate modifier identifying the amount of oxygen prescribed.

We reserve the right to determine if an item should be rented or purchased on an individual item basis according to the medical recommendations of physicians and the determination of our appropriate employees or agents who may review such recommendations.

**Sales tax**

In compliance with Washington state Senate Bill (SB) 6273 at [http://apps.leg.wa.gov/billinfo/summary.aspx?year=2010&bill=6273](http://apps.leg.wa.gov/billinfo/summary.aspx?year=2010&bill=6273), our payment to providers for eligible prescribed durable medical equipment or mobility enhancing equipment claims includes the sales tax or use a tax calculation.

Please note the following billing information:

- A separate line item should appear on claims for the sales tax or tax calculation.
- Use HCPCS S9999 *Sales tax* when submitting claims. The tax should be based on the equipment's allowable amount listed in our fee schedules.

Our payment to the provider will include the tax in the payment. Providers must then remit the tax to the Department of Revenue.

**Rental/purchase guidelines**

**Rental**

- Rental is paid up to the purchase price
- Use Modifier RR with HCPCS codes to indicate rental
- Repairs required on rented equipment are not separately reimbursable
- One unit of service equals one month's rental, with the exception of HCPCS B4034, B4035, B4036, E0277, E0935, and E2402 where one unit of service equals one day's rental

**Purchase**

- Use Modifier NU if purchasing new DME equipment
- Use Modifier UE if purchasing used DME equipment
- The outstanding dollars are paid toward the purchase price

We will only reimburse up to the purchase price regardless of when the decision to purchase is made.

**Additional modifiers**

When appropriate, use the following modifiers when billing for DME services. If more than one modifier is used, place the modifier in the first position or directly after the procedure and/or HCPCS code.
• Modifier AW Items furnished in conjunction with surgical dressings
• Modifier KM Replacement of facial prosthesis including new impression/moulage
• Modifier KN Replacement of facial prosthesis using previous master model

Shipping and handling
Shipping and handling charges are not eligible for separate reimbursement.

Repairs and modifications
If the purchased equipment is not covered by the manufacturer's warranty, we allow one month's rental fee for loaner equipment while the equipment is being repaired or serviced.

All claims for repairs and servicing are subject to review and approval to ensure charges do not exceed the purchase price.

Replacement
If an item needs to be replaced, the referring physician must submit a new prescription and the supplier must indicate the condition of the present equipment on the prescription. Claims for replacement are subject to our review and approval.

Customization
When it is necessary for a manufacturer, factory or supplier to create an item to fit a specific patient, it is considered a custom item. Custom items must be purchased rather than rented and medical necessity criteria must be met.

Back-up DME
Back-up DME items are not eligible for separate reimbursement.

Deluxe products/upgrades
The patient may choose to upgrade from a standard product. We will only reimburse up to the allowable amount for the standard product.

It is the responsibility of the provider to inform the patient that there are standard products available that meet medical necessity. The patient must sign a waiver indicating that he or she has been informed of his or her responsibility for any outstanding balance prior to ordering the product or before the product is delivered. If the patient does not sign a waiver, the outstanding balance will be a provider write-off.

Providers should use HCPCS S1001 Deluxe item, patient aware (list in addition to code for basic item) when billing for the cost in excess of the standard product. The signed waiver must accompany the bill and be on file if a health care service requests the waiver at a future date.

Pre-authorization
Pre-authorization may be required. View our pre-authorizations lists, forms and submission information.
Orthoses
Custom-made, functional orthotics are covered when they are medically necessary to treat a condition of the foot, ankle or leg. Prefabricated, supportive, accommodative and digital orthotics are not covered on most of our products.

Billing guidelines
- Indicate the units of service
- Use HCPCS codes to bill for the orthoses

Note: Reimbursement for HCPCS orthotic codes include the cost of orthoses, cast impression and materials.

Fitting or adjustment
Adjustment and/or fitting of orthoses and prosthetics is not covered. This service is included in the cost of the device.

Repair and/or replacement
The repair and/or replacement of an orthotic or prosthetic device may be allowed, based on the patient's benefit. Please use the appropriate HCPCS or CPT code when submitting a claim for repair or replacement.

Prosthetic Devices
For purposes of this document, the definition of prosthetic devices (other than dental) is: A device which replaces all or part of an internal body organ (including contiguous tissue) or replaces all or part of the function of a permanently inoperative or malfunctioning internal body organ.

A prescription must be on file and the prescribing physician's name must be submitted on the claim. Pre-authorization may be required.

DME documentation requirements for Medicare Advantage Plans
Providers must follow CMS criteria for durable medical equipment (DME) for our Medicare Advantage Plan members. This includes using appropriate Certificates of Medical Necessity (CMN) or other forms.

Criteria, documentation requirements, CMN forms and instructions for completing the forms are available in chapter 4 of the Supplier Manual at https://www.noridianmedicare.com/eula.php?t=dme/news/manual/chapter4.html from Noridian Administrative Services, LLC. Noridian has also made several documentation checklists at https://www.noridianmedicare.com/dme/coverage/checklists.html, available for various DME, to help ensure compliance with the requirements.

Ambulance
Our standard member contracts state that, the service of a licensed ambulance company will be provided, when medically necessary and if other means of transportation would endanger the patient's health. The purpose of the transportation cannot be for personal or convenience
reasons. Ambulance services are provided when the ambulance is used to transport the patient, to the nearest accredited hospital where adequate facilities for treatment are available.

Levels of Ambulance Services
- Cabulance is used when the patient is medically stable and does not require the use of a stretcher.
- Air ambulance service is medically necessary when the use ground ambulance would endanger the patient's health.
- Basic Life Support means non-invasive emergency medical services and provides transportation by stretcher, plus equipment and staff.
- Advanced Life Support means invasive emergency medical services with specialized life-sustaining equipment and (usually) radiotelephone contact with a physician or hospital.

Air Ambulance Services
Claims for air transportation are reimbursed according to the patient's benefits as described in the member contract. Medical necessity must be established. It is not covered when done for convenience. Transportation must be to the nearest hospital equipped to provide the necessary treatment.

Transportation by air is considered medically necessary when:
- There are multiple orthopedic fractures.
- There is a high potential for rapid medical decliner.
- The patient's condition is considered life threatening.
- The point of pick-up is inaccessible by land vehicles.
- There are great distances or other factors involved in transporting the patient to the nearest appropriate medical services.
- Other factors include but are not limited to; the time of day and imminent danger of limb loss if other modes of transportation are used.

Note: Air transport is not considered medically necessary for routine medical visits or for returning home or to another hospital when services can be provided at the present hospital.

Cabulance Services
Cabulance services are available for non-emergent transport of medically stable patients who cannot otherwise use private transportation without endangering their safety. Eligible services include:
- Medically stable patients via wheelchair with portable oxygen, a non-active IV, hep lock, Foley catheter or NG tube.
- A patient who is non-ambulatory, medically stable and requires movement by wheelchair or the patient is ambulatory but requires assistance to transfer.

Typical uses
- Transfer to a medical facility for special treatment
• The purpose of transportation is not for personal or convenience reasons.
• From a hospital or skilled nursing facility to home when other transportation is not medically feasible.
• When transportation is medically necessary, if other means of transportation would endanger the patient's health.

Billing guidelines

Proper Use of 'V' Codes
Ambulance claims should be billed using valid ICD 'V' diagnosis codes in the second position when it is necessary and appropriate. The 'V' codes are used to define the external cause of morbidity and cannot be billed as the primary diagnosis.

Example: For injuries incurred from a driver in a motor vehicle accident, the symptom ICD-10 S62.90xA Unspecified Fracture of unspecified wrist and hand, initial encounter for closed fracture would be listed as the primary diagnosis. ICD-10 V48.5xxA Car driver injured in noncollision transport accident in traffic, initial encounter would be listed as secondary.

Use the appropriate 'V' code that best represents the accident type. This allows us to identify the responsible party and process the claim without delay.

Name and Address of Facility Where Services Were Rendered
Include the "From" location and the "To" location.

• If the "From" or "To" location is not a hospital or care facility, enter the street address.
• If the "From" or "To" location is a hospital or care facility, enter the name of the facility only. Do not enter the address.

This information should be entered in the narrative field of the electronic claim format.

Services Not Typically Covered
The following is a list of examples of services not normally covered. This list is not a complete list of plan exclusions or a determination of medical necessity:

• Charges for the return and pickup of staff
• Ambulance calls where the patient is not transported to a medical facility
• Ground ambulance transportation for patients during an inpatient hospital stay initiated in a DRG payment methodology (e.g., a patient is transported to another facility for a MRI because there was no MRI equipment available at the DRG hospital where the patient is currently hospitalized). Contact your provider consultant for a list of DRG hospitals.
• Transportation to a clinic or provider's office
• Transportation for personal or convenience reasons including but not limited to:
  • Moving the patient closer to home
  • Moving the patient to receive treatment from his or her provider (i.e., if the provider does not have admitting privileges at the first hospital)
Note: When in the course of transporting a patient to a hospital, the ambulance stops at the provider's office, the claim will be reviewed for medical necessity.

**Urgent Care Clinics**

Urgent care is a category of walk-in clinics focused on the delivery of ambulatory care in a dedicated medical facility outside of a traditional emergency room. Urgent care centers primarily treat injuries or illnesses requiring immediate care, but not serious enough to require an emergency room visit. Urgent care clinics are distinguished from similar ambulatory health care centers, such as emergency rooms and convenient care clinics, by the scope of conditions treated and available facilities on-site.

Urgent care clinics can only submit professional claims electronically via an ANSI ASC X12N 837P Health Care Claim Transaction using the Place of Service Code 20 (POS -20).

**Qualifying Criteria for categorization as an Urgent Care Clinic**

**Availability and capability**

- The facility accepts walk-in patients of all ages for a broad spectrum of illness, injury and disease.
  - Hours: During weekdays and evenings and at least one weekend day.
  - Appointments: Not needed.
- The facility has access to rapid diagnostic testing (including labs and radiology), on-site injectable medications for emergent needs, and transfer or admission arrangements with local hospitals.

**Building and equipment**

- The facility has at least one exam room and separate waiting area.
- The following equipment is available (and the staff are trained to use this equipment):
  - Automated external defibrillator (AED) or standard defibrillator
  - Oxygen and emergency breathing equipment
  - Drug cart with some emergency medications

**Staffing**

- A licensed physician (MD/DO) has been designated as the facility’s medical director and is responsible for overall clinical quality.
- All medical care is provided under the direction or supervision of a physician who accepts responsibility for that care.
- Any paraprofessionals who assist in providing care (e.g., RN) are appropriately licensed.
- Licensed providers are able to:
  - Perform pulse oximetry, cardiac monitoring, and advanced cardiac life support in an emergency, while 911 is called.
  - Obtain and read an EKG and X-ray.
  - Administer oral, intramuscular, and intravenous medication and fluids.
  - Perform minor procedures (e.g., suturing, cyst removal, incision, drainage, splinting)

**Licensure and compliance**
• The facility is licensed by the state in which it is located, if the state requires such licensure.
• The facility complies with applicable federal, state, and local laws and regulations.

If your clinic meets the criteria above and is interested in being designated as an Urgent Care Clinic, please contact your provider consultant.

Retail Clinics
Retail Clinics, sometimes referred to as convenient care clinics, are a category of walk-in clinics focused on the delivery of ambulatory care in a retail setting, such as a supermarket or pharmacy location outside of a traditional dedicated medical facility. Retail Clinics provide convenient access to care for preventive health services. Retail Clinics also provide care for minor illnesses and injuries for which immediate care is desired but not medically required and that are not serious enough to require an urgent care or emergency room visit. Retail Clinics are distinguished from similar ambulatory health care centers, such as urgent care and emergency rooms, by the scope of conditions treated and available services on-site.

Retail Clinics should only submit professional claims electronically via an ANSI ASC X12N 837P Health Care Claim Transaction using the Place of Service Code 17 (POS 17).

Qualifying Criteria for categorization as a Retail Clinic
Availability and capability
• The clinic accepts walk-in patients for minor illness, injury and disease. Age ranges may vary by clinic (e.g. 18 months or older).
  o Hours: During weekdays and evenings and at least one weekend day
  o Appointments: Not needed
• The clinic has access to Point of Care “CLIA” waived lab testing, the ability to send out for lab services and write prescriptions for medications routinely within the scope of services provided.

Building and equipment
• The clinic has at least one exam room and a separate waiting area.

Staffing
• A licensed physician (MD/DO) provides oversight or supervision of a Retail Clinic and is responsible for insuring clinic Policy and Procedures are in place with a dedicated team of medical professionals.
• An advance practice provider (ARNP, PA) provides treatment of patient in the Retail Clinic and is responsible for following the Policies and Procedures while providing the best care within those guidelines.
• Any paraprofessionals who assist in providing care (e.g., medical assistants) are appropriately licensed.
• Licensed providers are able to:
  o Obtain samples from venipuncture and/or non-venipuncture lab tests
  o Perform point of care testing, such as rapid strep, urinalysis and conjunctivitis testing
- Administer immunizations including travel vaccinations, following a pre-travel health evaluation
- Write prescriptions for medications to treat minor illnesses and injuries that fall within the Retail Clinic scope of service

Licensure and compliance
- The clinic is licensed by the state in which it is located, if the state requires such licensure.
- The clinic complies with applicable federal, state and local laws and regulations.
- Joint Commission Accreditation is preferred.

If your clinic meets the criteria above and is interested in being designated as a Retail Clinic, please contact your provider consultant.

Behavioral Health
Contracting Service Requirements
The following Contracting Service Requirements and should assist behavioral health facilities in understanding our minimum requirements for each level of service in the delivery of mental health and chemical dependency services.

Notes:
- The assumption for all levels of care is that the facility is licensed for that level in the state where services are rendered.
- It is understood that all treatment will be developed to meet the member’s individual needs. Guidelines regarding the frequency and types of therapy sessions are suggested minimal expectations.

Mental Health, Inpatient (MHIP) level of care
- Psychosocial assessment completed within 24 hrs of admit
- Psychiatric evaluation and History and Physical completed within 24 hours of admit
- Psychiatric visits need to occur daily or at least 5 out of 7 days per week
- 24-hour nursing staff on site (RN or LPN/LVN)
- Chemical Dependency evaluation within first 48 hours, including UA
- Discharge planning and development of treatment plan begins within 24 hours
- Individual Therapy twice weekly
- Group Therapy at least once daily
- Family Therapy once weekly, twice weekly for children only. Family therapy for children and adolescents is scheduled within 24 hours of admission
- Seven (7) day post hospital follow up appointment is scheduled before discharge

Mental Health, Residential Treatment Center (MHRTC) level of Care
- Must stay overnight and be involved in structured activities 8 hours a day, 5 days per week
- All therapy must be provided by or supervised by a licensed clinician
• Psychiatric evaluation within 48 hours of admit by psychiatrist or Advanced Practice Nurse
• Chemical Dependency assessment within 48 hours of admit, including UA
• Psychiatric visits need to occur at least once per week
• 24-hour nursing staff on site (RN or LPN/LVN)
• Discharge planning and development of treatment plan begins within 72 hours
• Individual Therapy at least weekly
• Group Therapy at least once daily
• Family Therapy once weekly, twice weekly for children only. Family therapy for children and adolescents is scheduled within 24 hours of admission
• Designated physician medical director
• Availability of a medical physician for history and physicals and ongoing medical problems
• Availability of psychiatrist for evaluation as needed
• School provided on site for children
• Seven (7) day post hospital follow up appointment is scheduled before discharge

Mental Health Partial Hospitalization Program (MHPHP) level of care
• Minimum of 12-20 hours per week
• Services greater than 5 days per week must demonstrate clinical need
• Psychosocial assessment within 24 hours of admit
• Psychiatric evaluation completed within 48 hours of admit by psychiatrist or Advanced Practice Nurse, unless stepping down
• Chemical Dependency assessment within 48 hours of admit
• Psychiatric visits need to occur at least once weekly
• Individual Therapy at least weekly
• Group Therapy at least once daily
• Family Therapy once weekly, twice weekly for children only. Family therapy for children and adolescents is scheduled within 24 hours of admission
• Discharge planning and development of treatment plan begins within 72 hours
• Designated physician medical director
• Availability of a medical physician for history and physicals and ongoing medical problems

Mental Health Intensive Outpatient Program (MHIOP) level of care
• All treatment provided by state licensed or state certified professionals (or supervised by)
• Services occur at least 2 hours per day, 3 days per week (6 hours minimum per week, 9 hours maximum)
• Psychiatric evaluation completed at the beginning of treatment, unless member is stepping down
• Family therapy component required for children and adolescents
• Discharge planning and development of treatment plan begins within 72 hours
Chemical Dependency, Inpatient or Detoxification (CDIP) level of care
- Psychosocial assessment and CD assessment within the first 24 hours
- Medical evaluation (including relevant labs) and History and Physical within first 24 hours
- Physician visits 7 days per week including med management for withdrawal symptoms
- 24-hour nursing staff on site (RN or LPN/LVN)
- Discharge planning and development of treatment plan begins within 24 hours

Chemical Dependency, Inpatient Rehabilitation (CDIP Rehab) level of care
- Authorization occurs when the member has: significant co-morbid psychiatric condition that needs to be monitored, significant medical condition that needs to be monitored, in addition to significant withdrawal symptoms. The degree of supervision needed is higher than CDRTC level of care
- Must stay overnight and be involved in structured activities 8 hours a day, 5 days per week
- 24-hour nursing staff on site (RN or LPN/LVN)
- Medical evaluation (including relevant labs) and History and Physical within first 48 hours, unless stepping down
- Availability of psychiatrist for evaluation as needed
- All treatment provided by state licensed or state certified professionals (or supervised by)
- Individual Therapy at least weekly
- Group Therapy daily
- Family Therapy once weekly
- Seven (7) day post hospital follow up appointment is scheduled before discharge

Chemical Dependency, Residential Treatment Center (CD RTC) level of care
- Must stay overnight and be involved in structured activities 8 hours a day, 5 days per week
- 24-hour nursing staff on site (RN or LPN/LVN)
- Medical evaluation (including relevant labs) and History and Physical within first 48 hours, unless stepping down
- Availability of psychiatrist or Advanced Practice Nurse for evaluation as needed- this is not required
- School completed on site for children
- All treatment provided by state licensed or state certified professionals (or supervised by)
- Facility must be licensed as a Residential facility in the state treatment is delivered
- Individual Therapy at least weekly
- Group Therapy daily
- Family Therapy once weekly, twice weekly for children only. Family therapy for children and adolescents is scheduled within 24 hours of admission
- Seven (7) day post hospital follow up appointment is scheduled before discharge
Chemical Dependency Partial Hospitalization Program (CDPHP) level of care
- All treatment provided by state licensed or state certified professionals (or supervised by)
- Services provided minimum of 3 hours a day, 5 days per week
- Services greater than 5 days per week must demonstrate clinical need
- Psychosocial assessment and Chemical Dependency assessment within 48 hours of admit
- Availability of psychiatrist or Advanced Practice Nurse for evaluation if needed
- Random drug screens throughout treatment as needed
- Individual Therapy at least weekly
- Group Therapy at least once daily
- Family Therapy once weekly, twice weekly for children only. Family therapy for children and adolescents is scheduled within 24 hours of admission

Chemical Dependency Intensive Outpatient Program (CDIOP) level of care
- All treatment provided (or supervised) by state licensed or state certified professionals
- Services occur at least 3 hours per day, 3 days per week (9 hours minimum per week)
- Chemical Dependency evaluation completed at the beginning of treatment, unless member is stepping down