New Coding Integrity Reimbursement Guidelines

'Ohana Health Plan, Inc. is committed to continuously improving its claims review and payment processes.

Effective 02/26/2019, we will introduce new Coding Integrity Reimbursement Guidelines based on industry standards, coding rules published within the Medicare Claims Processing Manual, Current Procedural Terminology (CPT®) by the American Medical Association (AMA) and ICD-10-CM guidelines governed by Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS). These are the same rules used by most healthcare claims payers and enforced by the Centers for Medicare and Medicaid Services.

Additionally, to ensure claims process and pay accurately, 'Ohana Health Plans may deny a claim and request pertinent medical documentation from the provider or supplier who submitted the claim. The medical record request is coordinated with a third-party vendor. Providers should submit adequate medical record documentation that supports the claim (services) billed. Once medical records are received, medical review professionals will examine the documentation to determine if the claim is supported (or not supported) as submitted and pay (or deny) accordingly. Please note that the submission of medical records is not a guarantee of payment.

Determinations as to whether services are reasonable and necessary for an individual patient should be made on the same basis as all other such determinations: with reference to accepted standards of medical practice and the medical circumstances of the individual case.

The following table outlines the new coding guidelines.

Coding Policy	Description
Multiple Procedure Reduction for Radiology (Multi-Procedure Indicator 4-MPFS)	• When any provider with the same tax ID, for the same date of service performs two or more diagnostic imaging services from the same CMS-defined code family, the procedure with the highest RVU for the technical component (TC) is reimbursed at 100% and the technical component for all secondary procedures is reduced by 50%. • Likewise, the procedure with the highest RVU for the professional component is reimbursed at 100% and the professional component (PC) for all secondary procedures is reduced by 5%.
Multiple Procedure Reduction for Therapy Services	Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The MPPR applies to multiple units as well as multiple procedures.

(continued from: Multi-Procedure Indicator 5-MPFS)	• When more than one unit of an "Always Therapy" service is billed for the same date of service by the same provider, then the single unit with the highest allowed MPFS amount will pay at the full amount (100%) and all other units will pay with a 50% reduction on the practice expense portion of the allowed MPFS amount. • The reduction applies to a CMS-published list of "always therapy" services, including physical, occupational, and speech therapy services; regardless of setting and the type of provider or supplier that furnishes the services.
Multiple Procedure Reduction for Diagnostic Cardiovascular Services (Multi-Procedure Indicator 6-MPFS)	• For cardiovascular services, the procedure with the highest RVU price (MPFS) for the technical component (TC) is reimbursed at 100% and the technical component (TC) for all secondary procedures is reduced by 25%. • The MPPRs apply to TC-only services, and to the TC of global services. • This policy applies to diagnostic cardiovascular services billed by the same Tax ID and Specialty for the same date of service.
Multiple Procedure Reduction for Diagnostic Ophthalmology Services (Multiple-Procedure Indicator 7-MPFS)	• When providers with the same Tax ID and Specialty perform two or more CMS-defined diagnostic ophthalmology services on the same date of service, the procedure with the highest RVU price for the technical component is reimbursed at 100% under the Medicare Physician Fee Schedule (MPFS) and the technical component for all secondary procedures is reduced by 20%. • This policy applies to diagnostic ophthalmology services billed by the same Tax ID and Specialty for the same date of service.
Modifier Polices	**Anatomical Modifiers** • Claims may deny when a procedure defined as requiring an anatomical modifier is billed without an associated anatomical modifier. **Unrelated Procedure/Service by the Same Physician During the Postop Period, Modifier 79** • Claims may deny for procedures billed with modifier 79 when the same or different 0-, 10- or 90-day procedure code has not been billed on the same date of service. • Alternatively, XXXXX has been billed in the previous 10 days for a CPT code with a 10-day post-operative period, or in the previous 90 days for a code with a 90-day post-operative period by the same provider.
Diagnosis Code Guideline Policy	**ICD-10-CM Excludes 1 Notes Policy** • Claims may deny when reported with mutually exclusive code combinations according to the ICD-10-CM "Excludes 1 Notes" guideline policy.

	ICD-10-CM Laterality Policy "Laterality" (side of the body affected) is a coding convention added to relevant ICD-10 codes to increase specificity. Designated codes for conditions such as fractures, burns, ulcers, and certain neoplasms require documentation of the side/region of the body where the condition occurs. • Claims may deny when reported with incompatible ICD-10-CM Laterality policy for Diagnosis-to-Modifier comparison. • Claims may deny when reported and not meeting the ICD-10-CM Laterality policy for Diagnosis-to-Diagnosis comparison.
Maximum Units Policy: Surgical Pathology and Microscopic Examination	Diagnosis of malignancies and inflammatory conditions frequently requires numerous biopsies of a particular organ or suspicious site. CPT Code 88305 (Level IV – Surgical pathology, gross and microscopic examination) includes different types of biopsies. • To allow for multiple biopsies for investigation and diagnosis of certain disease entities, WellCare applies max units editing for CPT code 88305 based on gastrointestinal (GI) and prostate-related diagnoses.
Evaluation and Management Services Policies	**Multiple Inpatient Admission or Consultation Services** According to the AMA CPT Manual and our policy, an initial inpatient admission (CPT 99221-99223) is allowed once every seven days. • Claims may deny for the initial inpatient admission E&M if a provider from the same provider group and same specialty bills any other inpatient E&M visit, i.e. subsequent hospital care (CPT 99231-99233) or inpatient consultations(CPT 99251-99255) in the previous week. • Alternatively, the provider has billed a prior inpatient E&M visit, without an inpatient discharge service (CPT 99238-99239) in the interim. **Auditory Screening with Preventive Medicine Visits** • Claims may deny for audiology screening (CPT 92551, 92560, V5008) may be denied when a provider bills for auditory screening services at the same time as a preventive medicine visit (CPT 99381-99397) or wellness visit (CPT G0438-G0439), without appropriate modifier appended to the E&M service to identify a separately identifiable procedure. • Claims may deny when tympanometry/impedance testing (CPT 92567) is billed with a preventive medicine service (CPT 99381-99397) or wellness visit (CPT G0438-G0439) without appropriate modifier appended to the E&M service to identify a separately identifiable procedure; tympanometry/impedance testing will be considered part of the office visit.

	• In addition, when distinct service modifier 59 or modifier XE is not appended to auditory screening services and tympanometry/impedance testing, these services may be denied. **Observation Services** Based on reimbursement guidelines it is not appropriate for providers to bill inpatient Evaluation and Management (E/M) services while the patient is in an observation status. • Subsequently hospital care services (CPT 99221-99223 or 99231-99233) will be denied when billed for the same date of service as observation services (CPT G0378, 99218-99220 or 99224-99226) for Bill Type 0130-013Z (hospital outpatient).
Radiology Policy: Computed Tomography (CT) of the Abdomen and Pelvis	According to the American College of Radiology (ACR), the risk of developing cancer due to radiation exposure is greater for children than adults. Computed tomography (CT) of the abdomen/pelvis should not be the first diagnostic imaging study for the routine evaluation of abdominal pain in pediatric patients. • Claims for the abdominal or pelvic CT may be denied if abdominal pain is the only diagnosis reported for a patient under age 18. • Additionally, an appropriate medical necessity diagnosis should be included for CT of the abdomen/pelvis when the patient is under age 18 and if on the same day or in the previous 14 days a radiological exam, MRI or ultrasound of the abdomen/pelvis has not been performed/billed. • Associated CPT Procedure Codes: o Computed tomography (CT) of the pelvis (CPT 72192-72194) o Computed tomography (CT) of the abdomen (CPT 74150-74170) o Computed tomography (CT) of the abdomen and pelvis (CPT 74176-74178)
Radiology Policy: Intracranial and Extracranial Imaging (Duplex, CT, CTA, MRA, MRI) for Simple Syncope	According to the American College of Emergency Physicians, the American Heart Association and the American College of Cardiology Foundation, CT, CTA, MRA, MRI, should not be performed routinely for evaluation of syncope in the absence of related neurologic signs and symptoms. The likelihood of a central nervous system (CNS) cause of the event is extremely low, and patient outcomes are not improved with brain imaging studies. In addition, duplex scan of extracranial arteries, computed tomographic angiography (CTA) of the neck and magnetic resonance angiography (MRA) of the neck are not medically necessary for evaluation of syncope in patients with no suggestion of seizure and no report of other neurologic symptoms or signs.

	The American College of Emergency Physicians (ACEP) also indicates that it is not appropriate to perform screening with advanced imaging for syncope patients, however be guided by the patient's history and physical exam findings. A standard 12-lead electrocardiogram should be obtained first for patients with a diagnosis of syncope and collapse before performing advanced imaging procedures. • Claims may deny if the only reported diagnosis is syncope and collapse when any of the listed diagnostic head, brain, carotid artery or neck imaging procedures are billed. • Claims may be denied if an advanced imaging procedure is billed with a diagnosis of syncope and there is no history of a 12-lead EKG being performed/billed the same date or in the previous 90 days. • Associated CPT Procedure Codes o Computed tomography (CT) of the head or brain (CPT 70450, 70460, 70470) o Computed tomographic angiography (CTA) of the head (CPT 70496) o Magnetic resonance angiography (MRA) of the head (CPT 70544, 70545, 70546) o Magnetic resonance imaging (MRI) of the brain (CPT 70551, 70552, 70553) o Duplex scan of extracranial arteries (CPT 93880,93882) o Computed tomographic angiography (CTA) of the neck(CPT 70498) o Magnetic resonance angiography (MRA) of the neck(CPT 70547, 70548, 70549) o Electrocardiograms (CPT 93000-93005)
Radiology Policy: Intracranial and Extracranial Imaging (Duplex, CT, CTA, MRA, MRI) for Migraine	According to the American College of Radiology and the American Academy of Neurology, a CT of the head or brain, CTA of the head, MRA of the head or MRI of the brain should not be performed routinely for patients with a migraine in the absence of related neurologic signs and symptoms. The changes in the brain that happen during a migraine cannot be seen by the imaging studies since a migraine is caused by a complicated interaction between the brain and the blood vessels in the face and head. Head imaging in the form of CT scans, MRI or MRA is allowed only when the service is medically reasonable and necessary. • Claims may deny for a CT head or brain, CTA head, MRA head, MRI brain or CT follow-up when the only diagnosis on the claim is a migraine. • Associated CPT Procedure Codes: o CT Head or Brain: CPT 70450-70470, 76380 o CTA Head: CPT 70496 o MRA Head: CPT 70544-70546 o MRI Brain: CPT 70551-70553

	• Associated ICD10 Diagnoses codes o ICD-10 Diagnosis codes G43.009, G43.109, G43.709, G43.809, G43.829, G43.909 o ICD-10 migraine diagnosis codes indicating a "routine" or "uncomplicated" migraine (i.e. not intractable and without status)
Radiology Policy: Radiological Examination Chest	According to CMS policy and the American College of Radiology, a chest X-ray (CPT codes 71045, 71046) should not be performed for screening purposes in the absence of pertinent signs, symptoms or diseases. • Claims may deny the chest X-ray billed when the only diagnoses is one of the following routine screening diagnoses: o General medical exam (ICD-10 codes Z00.0-Z00.01, Z00.5, Z00.6, Z00.8) o Pre-admission/administrative exam (ICD-10 codes Z02.0-Z02.6, Z02.8-Z02.89, Z04.6) o Pre-operative exam (ICD-10 codes Z01.810-Z01.811, Z01.818)
Radiology Policy: Dual-Energy X-Ray Absorptiometry (DXA) Bone Density Screening	According to the American College of Radiology and the International Society for Clinical Densitometry, dual-energy X-ray absorptiometry (DXA) bone density screening (77080 or 77081) is not indicated for women under age 65 or men under age 70 without risk factors for osteoporosis. • Claims may deny when DXA bone density studies (CPT 77080 or 77081) are billed and the only diagnosis on the claim is osteoporosis screening (ICD-10 code Z13.820) for a woman who is under age 65 or for a man who is under age 70.
Revenue Code Policy: Revenue Code-HCPCS Code Links	Medicare accepts any National Uniform Billing Committee (NUBC) approved revenue codes. The Medicare Claims Processing Manual and the UB-04 Data Specifications Manual outlines requirements for billing outpatient claims including that (HCPCS) codes are required on outpatient claims (UB-04) with related revenue codes. • FL 42 - Revenue Code Required. The provider enters the appropriate revenue codes to identify specific accommodation and/or ancillary charges • FL 44 - HCPCS/Rates/HIPPS Rate Codes Required. When coding HCPCS for outpatient services, the provider enters the HCPCS code describing the procedure. Based on these reimbursement guidelines, claims may deny when the following revenue codes are billed without the appropriate HCPCS code: •0300-0319 (Laboratory/Pathology)

Place of Service Policy: Coding for Physician Services	According to CMS Medicare Claims Processing Manual, Place of Service codes (POS) are used to identify where i.e. physician office, inpatient hospital, a procedure or service is furnished to a patient. POS codes are required under the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For example, a claim from a physician provider with place of service 11 (Office) would be considered incorrectly coded when a claim from an outpatient facility (e.g. ambulatory surgical center, outpatient hospital) exists for the same member, same date of service and the same procedure or service. Therefore, physician provider claim would deny.
Anesthesia Policy: Anesthesia for Pain Management Injections	According to the American Society of Anesthesiologists and the International Spine Intervention Society, minor pain procedures such as epidural steroid injections, epidural blood patch, trigger point injections, sacroiliac joint injection, bursal injections, occipital nerve block and facet injections under most routine circumstances, require only local anesthesia. • Anesthesia and moderate sedation services billed with pain management services for a patient age 18 or older may deny unless a surgical procedure CPT code range 10021-69990 (other than pain management procedures) is also billed on the claim. • An exception will apply for anesthesia services billed with modifiers indicating severe systemic disease (Physical status modifiers P3, or P4, or monitored anesthesia care modifier G9). • Associated CPT Procedure Codes o Anesthesia and Moderate Sedation Services-CPTs 00300, 00400, 00600, 01935-01936, 01991-01992, 99152-99153, 99156-99157 o Pain Management Services- CPTs 20552, 20553, 27096, 62273, 62320-62323, 64405, 64479, 64480, 64483, 64484, 64490-64495, 0228T, 0229T, 0230T, 0231T, G0260
Neurology Policy: Nerve Conduction Studies (NCS) and Electromyography (EMG) for Radiculopathy	According to the American Association of Neuromuscular & Electro-Diagnostic Medicine and CMS Policy, nerve conduction studies and a needle electromyography (EMG) must both be performed in order to diagnose radiculopathy (pinched nerve in back or neck). • When the nerve conduction study or the needle EMG is performed on its own, the results can be misleading and important diagnoses may be missed. Claims may deny when a nerve conduction study is billed without a needle EMG, or a needle EMG is billed without a Nerve conduction study, and the only diagnosis is radiculopathy (ICD-10 codes M50.1-M50.23, M51.1-M51.27, M51.9, M53.80, M54.10-M54.18, M54.30-M54.42, and M79.2). • Associated CPT Procedure Codes o Nerve Conduction Studies-CPT 95907-95913 o Needle electromyography (EMG)- CPT 95885, 95886

Ultrasound (Obstetrics and Gynecology Policy: Detailed Fetal Anatomical Ultrasound with Evaluation	According to the Society of Maternal Fetal Medicine, a detailed fetal anatomical ultrasound (CPT codes 76811 or 76812) is not intended to be performed as routine for all pregnancies; rather it is performed for a known or suspected fetal anatomic abnormality, fetal growth disorder, genetic abnormality or increased risk for a fetal anatomic or genetic abnormality. • Therefore, WellCare may deny claims if a detailed fetal anatomic ultrasound is billed and the only diagnosis on the claim is for supervision of normal pregnancy (ICD-10 codes: Z33.1, Z34-Z34.93) or antenatal screening of mother (ICD-10 code Z36).

Above listing not intended to be all-inclusive.