CareFirst

Family of health care plans

PROVIDER MANUAL

CareFirst
Family of health care plans

Chapter 9: Policies and Procedures

Medical Policy and Technology Assessment

Medical Policies and Medical Policy Operating Procedures

The CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) evidence-based medical policies and medical policy operating procedures can be found in the Medical Policy Reference Manual. This manual is an informational database, which, along with other documentation, is used to assist CareFirst in reaching decisions on matters of medical policy and related member coverage. These policies and procedures are not intended to certify or authorize coverage availability and do not serve as an explanation of benefits or a contract.

Member coverage will vary by contract and line of business. Benefits will only be available upon the satisfaction of all terms and conditions of coverage. Some benefits may be excluded from individual coverage contracts.

Medical policies and medical policy operating procedures are not intended to replace or substitute for the independent medical judgment of a practitioner or other health professional for the treatment of an individual. Medical technology is constantly changing, and CareFirst reserves the right to review and update its medical policy periodically and as necessary.

For specific reporting codes and instructions, refer to the appropriate and current coding manual, such as:

- The Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS Level II codes)
- The International Classification of Diseases (ICD)
- The American Medical Association's Current Procedural Terminology (CPT®) (HCPCS Level I codes).

The Medical Policy Reference Manual is organized according to specialty, and in some cases, subspecialty, as follows:

- 00 Introduction
- 01 Durable Medical Equipment
- 02 Medicine
- 03 Mental Health
- 04 OB/GYN/Reproduction
- 05 Prescription Drug
- 06 Radiology/Imaging
- 07 Surgery
- 08 Rehabilitation/Therapy
- 09 Anesthesia
- 10 Administrative
- 11 Laboratory/Pathology
- 99 Archived Policies and Procedures

The introduction to the Medical Policy Reference Manual should be referenced prior to reviewing the medical policies and procedures. This section describes the medical policy process, format of documents, and definitions and interpretive guidelines of key terms such as medical necessity, cosmetic and experimental/investigational.

The medical policies and procedures located in the Medical Policy Reference Manual provide guidelines for most local lines of business. Many national accounts, processed through the National Account Service Company (NASCO) system, and members with federal employee program benefits, may defer to policies developed by the Blue Cross and Blue Shield Association. Therefore, there may be differences in medical policy and technology assessment determinations depending on the member contract. Benefits and coverage determinations should be verified prior to providing services.

Technology Assessments

A technology assessment is a process in which current or new/emerging technologies are thoroughly researched, evaluated and formulated, as appropriate, into evidence-based CareFirst medical policy. Technologies include drugs, devices, procedures and techniques. CareFirst has adopted the criteria of the BlueCross and BlueShield Association Technology Evaluation Center (TEC) for use in determining a technology's appropriateness for coverage. These criteria, along with an explanation of how they are applied, can be found in the introduction of the Medical Policy Reference Manual under Definitions and Interpretive Guidelines.

Technology assessments are presented with supportive data to the CareFirst technology assessment committee (TAC) on a regular basis. TAC is comprised of members of the healthcare policy department, CareFirst medical directors and specialty consultants, as appropriate. Determinations of the status of the technology (i.e., whether the technology is experimental/investigational) are made by consensus of the TAC. TAC determinations are effective on the first day of the month following the meeting.

Claims Adjudication Edits

Overview

Claim adjudication policies and associated edits are based on thorough reviews of a variety of sources including, but not limited to:

- CareFirst medical policy
- American Medical Association (AMA) guidelines
- CMS policies
- Professional specialty organizations (e.g., American College of Surgeons (ACS), American Academy of Orthopedic Surgeons, American Society of Anesthesiology)
- State and/or federal mandates
- Member benefit contracts
- Provider contracts
- Current healthcare trends
- Medical and technological advances
- Specialty expert consultants

ClaimsXten®

Our policies and clinical rules are developed through a compilation of information from a variety of sources. The clinical rules we use are designed to verify the coding accuracy on professional (non-institutional) claims. CareFirst utilizes Change Healthcare ClaimsXten software as part of the overall editing process for claims. The ClaimsXten software is updated quarterly and provides a means for our claims systems to recognize new and/or revised CPT and HCPCS codes, including any reclassifications of existing CPT codes. Providers are notified of key changes through BlueLink or newsflash updates at carefirst.com/providernews. We recommend that providers regularly access and review these policy statements to keep current with changes and updates.

Use of CPT, HCPCS or ICD-10 codes represent nationally recognized and published clinical coding systems of definitions and clinical rationales. These codes are used in claims processing to fully communicate and

accurately identify the services being rendered by the healthcare provider. Each is a Health Insurance Portability and Accountability Act compliant code set.

Professional services and procedures are identified by the appropriate and current CPT or HCPCS reporting code. The descriptor of the code is used to fully communicate and accurately identify the services provided to the member. ICD-10 diagnosis codes are utilized to indicate the appropriate patient diagnoses for which these procedures or services were provided.

Claims are filed utilizing these reporting codes and are reviewed to determine eligibility for reimbursement. If services are determined by CareFirst to be incidental, mutually exclusive, integral to or included in other services rendered or part of a global allowance, they are not eligible for separate reimbursement. Participating providers may not balance bill members for these services.

Claims are adjudicated first based on member benefits and subsequently based on claim editing policies. Claims may also be manually reviewed throughout the adjudication process. If needed, our clinical staff will review all medical documentation from you and determine if further review from a medical director is necessary.

Claims are edited for:

General Edit	Description	Professional	Facility
Global period	Payments for services associated with a surgical procedure are included in a single payment for services that fall within the specified date range (global surgical package).	X	
Payment/non-payment modifiers	Identifies claim lines with invalid modifier to procedure code combination.	X	
Age edit	The service reported was inappropriate for patient's age.	X	X
Age code replacement	Edits claims where the procedure code is not appropriate for the patient's age and is replaced with a more appropriate procedure code.	X	
Gender conflict	The service reported was inappropriate for patient's gender.	X	X
Gender code replacement	Edits claims where the procedure code is not appropriate for the patient's gender and is replaced with a more appropriate code.	X	X

General Edit	Description	Professional	Facility
Frequency Validation	Edits claims when a procedure code contains terminology that does not warrant multiple submissions of that procedure code for a single date of service.	X	
Duplicate procedures/similar service	Edits based on the maximum times a procedure code can be performed per date of service. Represents the total number of times it is clinically possible or clinically reasonable to perform the procedure code.	X	X
Multi code re-bundling	Occurs when two or more procedure codes are used to report a service when a single, more comprehensive procedure code exists that more accurately represents the service performed.	X	
Incidental procedures	An incidental procedure is carried out at the same time as a more complex primary procedure and/or clinically integral to the successful outcome of the primary procedure. When procedures that are considered incidental are reported with related primary procedure(s) on the same date of service, they are not eligible for reimbursement.	X	X
Integral/included in procedures	Procedures that are considered integral or included in occur in a variety of circumstances including, but not limited to, services that are part of an overall episode of care, or multiple surgery situations, when one or more procedures are considered to be an integral part of the major procedure or service.	X	X

General Edit	Description	Professional	Facility
Mutually exclusive procedures	Mutually exclusive procedures include those that may differ in technique or approach but lead to the same outcome. Procedures that represent overlapping services are considered mutually exclusive. In addition, reporting an initial and subsequent service on the same day is considered mutually exclusive. Procedures reported together on the same anatomic site with terms such as open/closed, partial/total, unilateral/bilateral, simple/complex, single/multiple, limited/complete and superficial/deep usually result in mutually exclusive edits. In these instances, if both procedures accomplish the same result, the procedure with the higher relative value unit (RVU) will usually be eligible for reimbursement. The higher valued procedure is likely to be the more clinically intense procedure, but the RVU will determine which procedure/service is reimbursed.	X	X
Assistant surgeon	Is a physician who actively assists the operating surgeon. An assistant may be necessary because of the complex nature of the procedure(s) or the patient's condition. The assistant surgeon is usually trained in the same specialty.	X	
Assistant-at-surgery	May be a physician assistant or nurse practitioner acting under the direct supervision of a physician, where the physician acts as the surgeon and the assistant-at-surgery as an assistant.	X	

General Edit	Description	Professional	Facility
Co-surgeon	Occurs when two surgeons, usually of different specialties, work together as a primary surgeon performing distinct part(s) of a procedure. Each surgeon participating in the surgical procedure(s) must file a separate claim and append CPT Modifier-62 to the specific procedure code(s) for reporting the service each provided. CareFirst policy is to reimburse each surgeon at 50% of the allowed amount for the procedure after all other edits (i.e., multiple surgery reduction, incidental, mutually exclusive, etc.) have been applied.	X	
Cosmetic procedures	Operative procedures performed with the primary intent to improve appearance. Service or supply provided with the intent of improving appearance, not restoring bodily function or correcting deformity resulting from disease, trauma or previous therapeutic intervention.	X	X
Experimental/investigational procedures	Services or supplies that are in the development stage and are in the process of human or animal testing. Services or supplies that do not meet all five of the criteria listed below adopted by the BlueCross BlueShield Association Technology Evaluation Center (TEC) are deemed to be experimental/investigational: ■ The technology* must have final approval from the appropriate government regulatory bodies; and ■ The scientific evidence must permit conclusions	X	X

General Edit	Description	Professional	Facility
	concerning the effect of the technology on health outcome; and ■ The technology must improve the net health outcomes; and ■ The technology must be beneficial as any established alternatives; and ■ The improvement must be attainable outside the investigational settings. *Technology includes drugs, devices, processes, systems or techniques. Refer to Medical Policy Reference Manual for more detail.		
Unlisted procedures	Services or procedures performed by physicians or other qualified healthcare professionals that are not found in CPT/HCPCS. Both CPT and HCPCS have specific numbers designated for unlisted procedures.	X	
Same day visit	Evaluation and Management (E/M) services which are rendered on the same date of service as a procedure that has a global period.	X	
Add-on codes without base	Procedures designated as add-on (or listed separately in addition to the codes for the primary procedure for CPT) are only reported in addition to the specific code for the primary (or parent) procedure. These add-on codes are not eligible for separate reimbursement when reported as stand-alone codes or, in some instances, when the primary	X	X

General Edit	Description	Professional	Facility
	procedure is not covered. Add-on codes are not subject to multiple procedure fee reduction as the RVU's assigned to these add-on procedure codes have already been reduced to reflect their secondary procedure status.		
Obstetrics package	Includes antepartum care, delivery services and postpartum care. Claim lines are evaluated to determine if the antepartum care, delivery services and postpartum care are reported during the average length of time of a typical pregnancy, which is between 280-322 days.	X	
Female/male only diagnosis(es)	Identifies diagnoses that are inconsistent with the patient's gender.	X	X
Frequency x-walk	Evaluates procedure codes with "single" or "unilateral" in the description that have been submitted more than once per date of service and recommends replacement for all occurrences of single/unilateral with appropriate multiple or bilateral code.	X	
Diagnosis age valid	Identifies diagnoses that are inconsistent with the member's age.	X	X
New patient	A new patient is one who has not received services from the same physician or group in the same specialty in the past three years. An established patient E/M visit must be reported if the patient is seen, for any reason, by the same physician or member of the group, within a three-year timeframe.	X	

General Edit	Description	Professional	Facility
	This also applies to physicians who are on-call for or covering for another physician. In this case, the patient's E/M service is classified as it would be for the physician who is not available. The covering physician should report the appropriate level E/M service according to the three-year timeframe as described above. If a new patient E/M is reported more than once by the same provider/group within the three-year timeframe, the code will automatically be replaced with the appropriate established E/M code.		
Lifetime event	This rule identifies claim lines that contain a procedure code that has been submitted more than once or twice across dates of service because it has been identified as a procedure that can only be performed once or twice in a lifetime, for the same member. Once audited for the maximum number of times the procedure can be performed, any additional submissions of the procedure are then not recommended for reimbursement.	X	
Medically unlikely edits	A medically unlikely edit is defined as the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service.	X	X
Pay percent multiple radiology	Recommends an adjustment in the pay percent when multiple diagnostic imaging services within the same radiology family are submitted on the same date for certain radiology procedures. In	X	

General Edit	Description	Professional	Facility
	addition, it also identifies claim lines with certain procedures that are subject to payment reduction when computed tomography (CT) equipment does not meet the National Electrical Manufacturers Association Standard XR-29-2013 and are required to be submitted with modifier CT. The CT reduction would then be applied on top of any other reduction over and above other reductions.		
Pay percent multiple cardiology	Recommends an adjustment in the pay percent when multiple cardiology procedures are submitted on the same date for certain procedures. These procedures are defined on CMS Medicare Physician Fee Schedule Database (MPFSDB), with a value of 6.	X	
Pay percent multiple ophthalmology	Recommends an adjustment in the pay percent when multiple ophthalmology procedures are submitted on the same date or service for certain procedures. These procedures are defined on CMS MPFSDB, with a value of 7.	X	
Pay percent professional therapy	Recommends an adjustment in the pay percent when multiple therapy procedures are submitted on the same date of service for certain procedures. When multiple therapy procedures are rendered in an office or non-institutional setting, these procedures are defined on CMS MPFSDB, with a value of 5.	X	

Requests for Clinical Information

In order to accurately adjudicate claims and administer member benefits, it is sometimes necessary to request medical records. The following is a list of some of the claims categories from which CareFirst may routinely require submission of clinical information, either before a service has been rendered, or before or after adjudication of a claim. Some of these specific modifiers are discussed in more detail throughout this manual. These categories include:

- Procedures or services that require prior authorization.
- Procedures or services involving determination of medical necessity, including but not limited to those outlined in medical policies.
- Procedures or services that are or may be considered experimental/investigational.
- Claims involving review of medical records.
- Claims involving pre-existing condition issues.
- Procedures or services related to case management or coordination of care.
- Procedures or services reported with unlisted, not otherwise classified or miscellaneous codes.
- Procedures or services reported with CPT Modifiers 22, 62, 66 and 78.
- Quality of care and/or quality improvement activities (e.g., data collection as required by accrediting agencies, such as National Committee of Quality Assurance/Healthcare Effectiveness Data and Information Set®/Quality Rating System).
- Claims involving coordination of benefits.
- Claims being appealed.
- Claims being investigated for fraud and abuse or potential inappropriate billing practices.
- Claims that are being investigated for fraud or potential misinformation provided by a member during the application process.

This list is not intended to limit the ability of CareFirst to request clinical records. There may be additional individual circumstances when these records may be requested. By contract, these records are to be provided without charge.

Place of Service Code Assignments

Information about Place of Service Code Assignments can be found by going to carefirst.com/providerguides. Select “See More” on the medical accordion. Click the Place of Service Code Assignments PDF.

Basic Claim Adjudication Policy Concepts

The following represent key coding methodologies, claims adjudication policies and reimbursement guidelines.

Note: These claim adjudication and associated reimbursement policies are applicable to local CareFirst lines of business. Adjudication edits/policies may differ for claims processed on the national processing system (NASCO) depending on the account’s home plan and FEP.

Unbundled Procedures

Procedure unbundling occurs when two or more procedure codes are used to report a service when a single, more comprehensive procedure code exists that more accurately represents the service provided. Unbundled services are not separately reimbursed. If the more comprehensive code is not included on the claim, the unbundled services will be re-bundled into the comprehensive code; if it is a covered benefit, the more comprehensive service will be eligible for reimbursement. Always report the most comprehensive code(s) available to describe the services provided.

Incidental Procedures

An incidental procedure is carried out at the same time as a more complex primary procedure and/or is clinically integral to the successful outcome of the primary procedure. When procedures that are considered incidental are reported with related primary procedure(s) on the same date of service, they are not eligible for reimbursement.

Integral/Included in Procedures

Procedures that are considered integral or included in occur in a variety of circumstances including, but not limited to, services that are a part of an overall episode of care, or multiple surgery situations, when one or more procedures are considered to be an integral part of the major procedure or service. Separate procedures should not be reported when they are carried out as an integral component of a total service or procedure. Integral or included in procedures are not eligible for reimbursement.

Providers should refer to CPT guidelines for reporting separate procedures when they are not a component of a total service. CPT Modifier-59 should be appended to the separate procedure code to indicate that it is a distinct, independent procedure and not related to the primary procedure.

Mutually Exclusive Procedures

Mutually exclusive procedures include those that may differ in technique or approach but lead to the same outcome. In some circumstances, the combination of procedures may be anatomically impossible.

Procedures that represent overlapping services are considered mutually exclusive. In addition, reporting an initial and subsequent service on the same day is considered mutually exclusive. Procedures reported together on the same anatomic site with terms such as open/closed, partial/total, unilateral/bilateral, simple/complex, single/multiple, limited/complete and superficial/ deep usually result in mutually exclusive edits. In these instances, if both procedures accomplish the same result, the procedure with the higher RVU will usually be eligible for reimbursement. The higher valued procedure is likely to be the more clinically intense procedure, but the RVU will determine which procedure/service is reimbursed.

Global Allowances

Reimbursement for certain services is based on a global allowance. Services considered to be directly included in a global allowance are considered integral to that allowance and are not eligible for separate reimbursement.

Add-On Procedures

Procedure codes designated as add-on (or listed separately in addition to the code for primary procedure for CPT), are only reported in addition to the specific code for the primary (or parent) procedure. These add-on codes are not eligible for separate reimbursement when reported as stand-alone codes or, in some instances, when the primary procedure is not covered.

Add-on codes are not subject to multiple procedure fee reductions as the RVUs assigned already been reduced to reflect their secondary procedure status.

If several procedures are performed during the same session by the same physician and the primary (or parent) code needs to be distinguished as a distinct procedure (i.e., CPT Modifier-59 is appended to the

primary code), then CPT Modifier-59 must also be appended to any add-on codes related to the parent code.

Duplicate Services and Multiple Reviews

Paying more than one provider for the same procedure or service represents duplicate procedure reimbursement. This includes, but is not limited to, multiple interpretations or reviews of diagnostic tests such as laboratory, radiology, and electrocardiographic tests reported with CPT Modifier-26 (professional component) or -59 (distinct procedural service).

CareFirst will reimburse only once for a service or procedure. Duplicate procedures, services and reviews, whether reported on the same or different claims, are not eligible for reimbursement.

Unlisted Procedures

In the Federal Register, CMS establishes and publishes RVUs for most CPT and some HCPCS Level II codes. RVUs are a weighted score used to determine the fee scales for procedures and services performed by professional providers. These RVUs are used to determine allowances for reimbursement. CMS, however, does not assign RVUs to all procedure codes. Some codes are unlisted (no specific definition) and no RVU is assigned. Therefore, the unlisted code has no established allowance.

Unlisted CPT and HCPCS codes should only be reported when there is not an established code to describe the service or procedure provided.

Submissions of claims containing an unlisted code are reviewed by our Medical Review Department. A reimbursement allowance is established based on this review using a variety of factors including, but not limited to, evaluating comparable procedures with an established RVU. To be considered for reimbursement, an unlisted CPT or HCPCS code must be submitted with a complete description of the service or procedure provided. Any applicable records or reports must be submitted with the claim.

All applicable reimbursement policies will apply (i.e., incidental procedures, multiple procedures, bilateral procedures, global periods) in relation to claims submitted with unlisted codes.

All modifiers will be considered invalid with unlisted codes. Do not report modifiers with any unlisted procedure codes.

Fragmented Billing

Reporting services provided on the same date of service on multiple CMS 1500 claim submissions is considered fragmented billing. This practice may lead to incorrect reimbursement of services, including delays in claims processing or retractions of overpaid claims. Historical claims auditing is performed to ensure that all services or procedures performed on the same date are edited together. Therefore, services or procedures performed by a provider on the same date must be reported together on the same claim whether submitted electronically or on a paper form.

Modifier Reimbursement Guidelines

CareFirst accepts all valid CPT and HCPCS modifiers. A modifier enables the provider to indicate that a service or procedure performed has been altered in some way but that the standard definition and associated reporting code remains unchanged. Modifiers may be used to indicate that:

- A service or procedure was provided more than once
- A service or procedure was performed on a specific anatomical site
- A service or procedure has both a professional and technical component
- A bilateral procedure was performed

- A service or procedure was performed by more than one provider and/or in more than one location
- A service was significant and separately identifiable from other services or procedures

Up to four modifiers may be reported per claim line. CareFirst claims systems are capable of adjudicating multiple modifiers. Modifiers that may affect reimbursement should be listed first.

Services reported with an invalid modifier-to-procedure code combination will be denied. Claims must be resubmitted with the correct modifier (or without the invalid modifier) in order to ensure appropriate claim adjudication.

Modifiers may or may not affect reimbursement. Certain modifiers are for informational purposes only and assist in the correct application of benefits.

The following CPT Modifiers may affect reimbursement:

-22	-54	-77
-24	-55	-78
-25	-56	-79
-26	-57	-80
-50	-59	-81
-51	-62	-82
-52	-66	-91
-53	-76	

The following HCPCS Modifiers may affect reimbursement:

RT	TA-T9	TC	GC
LT	LC	AA	QK
E1-E4	LD	AD	QX
FA-F9	RC	AS	QY

The following are examples of modifiers that are used for informational purposes and not affect reimbursement:

-23	-33	-90
-32	-63	-99

The following CPT Modifiers do not affect reimbursement:

-47	-63
P1-P6	-92

The following are examples of modifiers that may affect how member benefits are determined and reimbursed:

BR	BP	Kl	UE
BU	KA	K2	QE
Kl	KH	K3	QF
KJ	KM	K4	QG
KR	KN	NR	QH
LL	KS	NU	GO
MS	KX	RA	GP
RR	KO	RB	

CareFirst follows the CMS guidelines when determining if particular diagnostic or therapeutic tests and procedures can be reported as a global (total) service or if they can also be reported as either a technical or professional component of the service. It is important to report these services according to the following guidelines:

- Report the procedure as a global (total) service, without a modifier. If you own the equipment, administer the test and provide the interpretation.
- Report the procedure as a technical component (along with HCPCS Modifier-TC), if you only perform the technical portion of the procedure.
- Report the procedure as a professional component (along with CPT Modifier-26), if you only perform the interpretation and/or supervision portion of the procedure.

In instances where one provider is reporting the technical component and another is reporting the professional component, both providers should submit separate claims with the same procedure code(s), the appropriate modifier and the same date of service. As noted above, services reported with an invalid modifier-to-procedure code will be denied and must be resubmitted.

Submissions of claims containing the following CPT modifiers are reviewed by our Medical Review Department and should be submitted with the pertinent medical records (i.e., complete operative record, office notes, etc.) in order to be appropriately and expeditiously adjudicated. Documentation should clearly support the intent of the modifier and demonstrate the reason for its submission.

- CPT Modifier-22: Not valid with E/M codes. Pertinent medical records that clearly demonstrate the reason that the procedure/service requires "substantial additional work" compared with that of the reported procedure must accompany the claim. This modifier should be reported only when the work performed is clearly out of the ordinary for the particular procedure. While not required, it is often helpful for the provider to attach a separate letter to the medical records that outlines why the procedure or service was particularly unusual.
- CPT Modifier-62: Only valid with surgery procedure codes. Operative records that clearly demonstrate that each surgeon performed distinct and separate parts of a procedure must be available if requested. Each surgeon submits a separate claim for the operative session. CPT Modifier-62 should be appended only to procedures performed by the two surgeons. Do not use in lieu of CPT Modifier-66 or CPT Modifiers-80, -81, -82 or HCPCS Modifier-AS.
- CPT Modifier-66: Only valid with surgery procedure codes. Operative records that clearly demonstrate that each surgeon performed components of a procedure in a team fashion must accompany the claim.
- CPT Modifier-78: Only valid with surgery procedure codes. Operative records that clearly demonstrate a related procedure had to be carried out during the post-operative period must accompany the claim.

Global Surgical, Anesthesia and Maternity Reimbursement Guidelines

Surgical procedures described in CPT (see CPT surgical package definition in the CPT manual) usually include, at a minimum, the following components, in addition to the surgery itself:

- Local infiltration, select blocks or topical anesthesia
- After the decision for surgery is made, one E/M visit on the day before or on the day of surgery (including history and physical exam)
- The surgical procedure/intraoperative care
- Immediate post-operative care
- Interacting with the patient's significant other and other care providers
- Writing post-operative orders
- Assessing the patient in the post-anesthesia care area
- Usual post-operative follow-up care

Separate benefits are provided for moderate (conscious) sedation whether rendered by the physician performing the diagnostic or therapeutic service the sedation supports or by another physician. Moderate sedation codes are not used to report administration of medications for pain control, minimal sedation (anxiolysis), deep sedation or monitored anesthesia care. Refer to medical policy operating procedures 9.01.001A, 9.01.003A, 9.01.004A, 9.01.007A in our Medical Policy Reference Manual.

Combining the above services and reporting them under a single fee as a surgical package, is referred to as global billing. In the event that only a component of the surgical package is provided, follow CPT guidelines for reporting the following split care CPT Modifiers-54, -55 and -56.

Depending on the nature of the procedure, member or provider contract or specific policies, certain services may include additional components in the global allowance, such as for maternity or anesthesia services. Examples of services that are reimbursed with a global allowance can be found in the following references:

- Maternity services that are and are not included in the global allowance.
  - Refer to global maternity services, 4.01.006A in our Medical Policy Reference Manual.
- Surgical services and related global periods.
  - Refer to global surgical procedure rules, 10.01.009A in our Medical Policy Reference Manual.
- Anesthesia services that are/are not included in the global anesthesia allowance.
  - Refer to anesthesia services, 9.01.001A in our Medical Policy Reference Manual.
- Procedures containing the term “one or more sessions” in the description.
  - When reporting services where the procedure code indicates “one or more sessions,” the CPT code should be reported only one time for the entire defined treatment period, regardless of the number of sessions necessary to complete the treatment. While the defined treatment period is determined by the physician and varies depending on the patient, diagnosis and often the location of treatment, these services may be reported only once during the global post-operative period assigned to the specific code.
  - Refer to CPT guidelines listed in the table below:

CPT Guidelines	
CPT Modifier-52	Reduced Services: Valid only when a service or procedure is partially reduced or eliminated at the discretion of the rendering physician or other qualified healthcare professional. The CareFirst reimbursement policy is to allow a 50% reduction for procedures billed with Modifier-52.
CPT Modifier-53	Discontinued Procedure: Under certain circumstances a rendering provider may terminate a surgical or diagnostic procedure due to circumstances that threaten the wellbeing of the patient. The CareFirst reimbursement policy is to allow a 50% reduction for the surgical or diagnostic procedure billed with Modifier-53.
CPT Modifier-54	Surgical Care Only: When one rendering provider (or use physician or other qualified healthcare professional) performs a surgical procedure and another provides preoperative and/or postoperative care, surgical services

	are identified by appending Modifier-54. The CareFirst reimbursement policy is to allow 80% reduction for the surgical care only.
CPT Modifier-55	Postoperative Care Only: When one rendering provider (or use physician or other qualified healthcare professional) performs postoperative management and another has performed the surgical procedure, append Modifier-55 to the postoperative care.
CPT Modifier-56	Preoperative Care Only: When one rendering provider (or use physician or other qualified healthcare professional) performs the preoperative care and evaluation and another performs the surgical procedure, the preoperative component should be appended with Modifier-56.

Note: CPT Modifiers -58, -76, -77, -78 and -79 identify procedures performed during the global surgical period. Follow CPT reporting guidelines for these modifiers.

Note: CPT Modifier-24 identifies an unrelated E/M service provided during the global post-operative period. Follow CPT reporting guidelines for this modifier.

Bilateral Procedures Reimbursement Guidelines

Bilateral procedures are defined as surgeries rendered by the same provider, during the same operative session, on paired anatomical organs or tissues.

Bilateral procedures are typically reimbursed at 150% of the allowance of the unilateral procedure (i.e., 100% for one side, and 50% for the other side). For bilateral secondary surgical procedures, bilateral surgical adjudication edits are applied first and then multiple surgical edits are applied. The primary bilateral procedure is reimbursed at 150% (100% for the first side, and 50% for the second side). The second bilateral procedure is reimbursed at 100% (50% for the first side and 50% for the second side).

Policy Guidelines for Reporting Bilateral Procedures

Bilateral procedures are reimbursed based on either CPT coding guidelines or the CMS list of procedure codes that are eligible for CPT Modifier-50. When CPT Modifier-50 is valid, the appropriate code for the bilateral procedure should be reported on one line with the CPT-50 Modifier appended and a frequency of one in the unit field. If a claim for a bilateral procedure is not submitted this way, the claim will be returned with a request to resubmit it properly. Claims submitted with a procedure that is invalid with CPT Modifier-50 will be returned with a request to resubmit a corrected claim.

When reporting bilateral primary and secondary procedures, CPT Modifier-50 should be reported in the first modifier position. CPT Modifier-51 may be reported in the second modifier position.

HCPCS Level II Modifiers -RT (right side) and -LT (left side) are used when a procedure is performed either on one side of the body rather than both sides or when CPT Modifier-50 is not valid for a procedure code but the procedure is performed on both sides of paired organs. When -RT and -LT Modifiers are both used for the same procedure, report the procedure code on two lines with the -RT and -LT appended to each code.

If the description of the procedure code contains the phrase bilateral, it is eligible for reimbursement only once on a single date of service. Report the single procedure code with a frequency of one in the unit field.

If the description of the procedure code contains the phrase unilateral/bilateral, it is eligible for reimbursement only once on a single date of service. If the code includes unilateral/bilateral in the description, it is not appropriate to report the code with CPT Modifier-50. The fee schedule allowance is the same regardless of whether it is performed on one side or both sides. Report the single procedure code with a frequency of one in the unit field.

If the description of the procedure code specifies unilateral and there is another code that specifies bilateral for the same procedure, the bilateral code will replace the unilateral codes when they are reported more than once for the same date of service. Code replacements will also occur when one procedure code specifies a single procedure and a second procedure code specifies multiple procedures. Do not report CPT Modifier-50 in this circumstance. Always report the most comprehensive code for the procedure(s) performed.

Certain procedures may only be reported a specified number of times on a single date of service. Once the maximum number is reached, all additional submissions of the procedure code will not be eligible for reimbursement.

Multiple Surgical and Diagnostic Procedures Reimbursement Guidelines

General Guidelines

Multiple surgical and select diagnostic procedures (including endoscopic and colonoscopy procedures) are edited to ensure appropriate reimbursement for the benefit.

Covered procedures performed during the same operative session, through only one route of access and/or on the same body system and that are clinically integral to the primary procedure, are usually considered incidental, integral to/included in or mutually exclusive to the primary procedure. The primary procedure is reimbursed at 100% of the allowed benefit. Incidental, integral to/included in or mutually exclusive procedures are not eligible for reimbursement.

Covered procedures performed during the same operative session that are not clinically integral to the primary procedure (i.e., those performed at different sites or through separate incisions) are usually eligible for separate reimbursement. The most clinically intense procedure is reimbursed at 100% of the allowed benefit and the second and subsequent procedure(s) at 50% of the allowed benefit.

Multiple procedures not considered to be integral to the primary procedure should be reported with the CPT Modifer-51 appended to the second and subsequent procedure codes.

Some surgical, diagnostic or therapeutic procedures may appear to be integral to, included in, mutually exclusive or duplicates of other procedures performed during the same encounter or session by the same provider. In order to distinguish these procedures as distinctly different (i.e., different operative site or procedure, separate incision, etc.), CPT Modifier-59 should be appended to these select procedures. Follow CPT guidelines for reporting CPT Modifier-59.

As one factor in determining a fee schedule allowance, CareFirst typically uses the fully implemented non-facility total RVU (as published annually in the CMS national physician fee schedule) for all places of service. In addition to including the provider work and malpractice factor, this RVU also includes a robust PE component. The use of this RVU is particularly significant when multiple procedures are performed during the same session by the same provider, as its value determines the ranking of these procedures (i.e., what is considered the primary procedure, and how any subsequent/secondary procedures are ranked.)

CareFirst utilizes the transitioned non-facility total RVU (Column P in the link below) as published by CMS.

For additional information on this methodology, visit the CMS website to view the Physician Fee Schedule.

Note: Effective with claims processed on and after January 1, 2013, CareFirst will utilize the non-facility total RVU (Column L) now that the transition period has been completed.

Multiple Endoscopic Procedures Through the Same Scope

When an endoscopic procedure is considered to be a component of a more comprehensive endoscopic procedure, the more clinically comprehensive procedure is usually eligible for reimbursement.

Multiple Endoscopic and Open Surgical Procedures

Endoscopic and open surgical procedures performed in the same anatomic area are not usually eligible for separate reimbursement. If an open surgical procedure and an endoscopic procedure accomplish the same result, the more clinically intense procedure is usually reimbursed. The comparable procedure is considered mutually exclusive and is not eligible for reimbursement.

If a number of endoscopic-assisted, open surgical procedures are performed on the same anatomic area during the same operative session, these procedures are usually eligible for separate reimbursement based on the additional time, skill and physician resources required when two approaches are used for a surgical procedure.

Serial Surgery Reimbursement Guidelines

Separate or additional reimbursement is not made each time a procedure is performed in stages or for procedures identified as “one or more sessions” in the code definition. Global surgical rules apply.

Multiple Provider Participation in Surgical Procedures

Certain procedures may require the participation of more than one provider in order to accomplish the desired outcome. Policies and reporting guidelines for these situations are as follows:

Surgical Assistant or Assistant-at-Surgery

Assistants-at-surgery are distinct from team and co-surgery, as described below. For information on this topic refer to Medical Policy Reference Manual operating procedure 10.01.00 8A, Surgical Assistants.

The American College of Surgeons (ACS), a professional specialty organization, is the primary source for determining reimbursement for assistant-at-surgery designations of “always” or “never.” The ACS utilizes clinical guidelines (instead of statistical measures) to determine the appropriateness of assistants-at-surgery. A variety of sources, including expert clinical consultants, specialty organizations (e.g., American Academy of Orthopedic Surgeons and CMS) are used to determine reimbursement for assistant-at-surgery ACS designations of sometimes.

CPT Modifiers -80, -81 or -82 are reported for the services of a Doctor of Medicine or Doctor of Osteopathic Medicine. HCPCS Modifier-AS is reported for the services of the non-physician assistant (i.e., physician assistant, nurse practitioner, nurse midwife, or registered nurse first assistant).

CPT Modifiers -80, -81, -82 and HCPCS Modifier-AS are currently reimbursed at 16% of the allowance for the procedure(s) for which assistant services are eligible for reimbursement.

All applicable reimbursement policies will apply to an assistant-at-surgery the same as they would apply to the primary surgeon (e.g., incidental procedures, multiple procedures, bilateral procedures, global periods).

Team Surgery

The term “team surgery” describes highly complex procedures requiring the skills of several physicians with different specialties and specially trained personnel. Examples of these circumstances include procedures performed during organ transplantation or re-implantation of limbs, extremities or digits. In these instances, the surgeons are not acting as an assistant-at-surgery, but rather as team surgeons.

To report as team surgeons, each surgeon participating in the surgical procedure(s) must file a separate claim and append CPT Modifier-66 to the specific procedure code(s) used for reporting the services provided.

Submissions of claims containing CPT Modifier-66 are reviewed by our medical review department and should include the complete record in order to be appropriately adjudicated. The unique surgical services and level of involvement of each surgeon should be documented in a single operative report that is signed by all participants.

If a surgeon functions as both a team surgeon and an assistant-at-surgery for different portions of the total operative procedure, then CPT Modifier-66 should be appended to the procedure applicable to team surgery, and CPT Modifier -80, -81 or -82, as appropriate, should be appended to the procedure(s) in which the surgeon acted as an assistant.

The percentage of allowed benefit apportioned to each of the team surgeons will be determined based on several factors, including but not limited to:

- The complexity of the individual surgical services performed
- The amount of involvement in the operating room
- The amount of pre- and post-operative care required
- Whether the procedures performed are related, incidental or unrelated to each other

All applicable reimbursement policies will apply (i.e., incidental procedures, multiple procedures, bilateral procedures, global periods) in relation to claims submitted with CPT Modifier-66.

Co-Surgeon

The term “co-surgery” describes circumstances in which two or more surgeons work together as primary surgeons performing distinct parts of a procedure. In these instances, the surgeons are not acting as an assistant-at-surgery, but rather as a co-surgeon.

To report as co-surgeons, each surgeon participating in the surgical procedure(s) must file a separate claim and append CPT Modifier-62 to the specific procedure code(s) used for reporting the services each provided.

Our policy reimburses each surgeon at 50% of the allowed amount for the procedure after all other edits (i.e., multiple surgery reductions, incidental, mutually exclusive, etc.) have been applied.

Providers will need to send in the appropriate clinical documentation for claim lines that contain Modifier-62 and any other modifier on the same line that would potentially impact reimbursement. If an additional modifier, such as Modifier-22 or -78 is appended to a procedure also containing Modifier-62, then the appropriate clinical documentation will be reviewed to determine an appropriate reimbursement.

If a surgeon functions as both a co-surgeon and an assistant-at-surgery for different portions of the total operative procedure, then CPT Modifier-62 should be appended to the procedure(s) applicable to co-surgery, and CPT Modifier-80, -81 or -82, as appropriate, should be appended to the procedure in which the surgeon acted as an assistant.

If additional procedures (including each additional procedures) are performed during the same operative session by one of the surgeons, the additional procedure code(s) should be reported by that surgeon only, without CPT Modifier-62 appended.

All applicable reimbursement policies will apply (e.g., incidental procedures, multiple procedures, bilateral procedures, global periods) in relation to claims submitted with CPT Modifier-62.

General and Specialty Related Claim Adjudication Policies and Reimbursement Guidelines

Consultations

Consultation services should be reported using the appropriate consultation E/M codes (office/outpatient, inpatient) according to CPT reporting guidelines and as follows:

- Consultation services are reimbursed according to the terms of the member's benefit contract and applicable claims adjudication policies. A consultation occurs when the attending physician or other appropriate source asks for the advice or opinion of another physician for the evaluation and/or management of the patient's specific problem. The need for a consultation must meet medical necessity criteria and be documented in the referring physician's medical record.
- A physician consultant may initiate diagnostic and/or therapeutic services as part of or during the consultation process. The request for a consultation from the attending physician or other appropriate source and the reason for the consultation must be documented in the patient's medical record. The consultant's opinion/recommendation and any services that were ordered or performed must also be documented in the medical record and communicated to the requesting provider.
- If the attending physician requests a second or follow-up office or outpatient consultation, an office/outpatient consultation E/M visit may be reported a second time, as there is no follow-up consultation code for this setting.
- A consultation initiated by the patient and/or family and not requested by a physician should not be reported using consultation codes. Report these services using the setting specific non-consultation E/M codes, as appropriate.

A consultation code is not eligible for reimbursement when an attending physician requests that the second (consulting) physician take over care of the patient. If the attending physician decides to transfer care of the patient to the consultant after the consultation, the consultant may not continue to report a consultation visit. The consultant should report the appropriate non-consultation E/M codes. (See CPT E/M services guidelines.)

Concurrent Care

Reimbursement may be made for multiple providers caring for a patient during an episode of care, according to the terms of the member's benefit contract and applicable claims adjudication policies. This includes providers of multiple specialties caring for a patient in an inpatient setting on the same date of service. The need for multiple provider participation in the patient's care must meet medical necessity criteria and be documented in the medical record (see also consultations above and CPT E/M services guidelines regarding concurrent care and transfer of care).

Standby Services

Standby services are not eligible for reimbursement (see medical policy operating procedure, 10.01.004A, Standby Services), except for attendance at delivery when requested by the obstetrician (10.01.002A, Attendance at Delivery). Refer to the Medical Policy Reference Manual for both policies.

Evaluation and Management (E/M) services

Benefits are available for E/M services according to the terms of the member's benefit contract and applicable claims adjudication policies. Incidental, integral to/included in, mutually exclusive and global services editing policies apply to all E/M services.

E/M services are reported for the appropriate level of service in accordance with CPT guidelines and must be supported in the medical record according to the CareFirst Medical Record Documentation Standards, located in Operating Procedure 10.01.013A, in our Medical Policy Reference Manual.

CPT Modifier-25

In many instances, E/M services are considered included in or mutually exclusive to other procedures and services reported on the same date and are therefore not eligible for separate reimbursement.

CPT Modifier-25 is used to describe a significant, separately identifiable E/M service by the same physician on the same day of a procedure or other service. CPT Modifier-25 is only valid with E/M codes.

Reporting with a CPT Modifier-25 does not require a different diagnosis as the procedure or other service, but documentation in the medical record must support that a significant, separately identifiable E/M service was provided. To be eligible for reimbursement for CPT Modifier-25, the key components of the E/M service (e.g., history, physical, decision-making, or as outlined in CPT) must be performed and documented in the medical record.

New Patient Visit Frequency

According to CPT guidelines, a new patient is one who has not had services from the same physician or group in the same specialty in the past three years. An established patient E/M visit must be reported if the patient is seen, for any reason, by the same physician or member of the group, within the three-year timeframe. This also applies to physicians who are on-call for or covering for another physician. In this case, the patient's E/M service is classified as it would be for the physician who is not available. The covering physician should report the appropriate level E/M service according to the three-year timeframe as described above. Refer to CPT reporting guidelines for further instructions.

If a new patient E/M code is reported more than once by the same provider/group within the three-year timeframe, the code will automatically be replaced with a corresponding established E/M code.

Preventive Services

Preventive services, also known as health maintenance exams, include preventive physical examinations, related X-ray, laboratory or other diagnostic tests, and risk factor reduction counseling. Most CareFirst member contracts include a benefit for these preventive examinations, many of which are limited to once per benefit year/annually. Preventive services (CPT 99381-99397) should only be reported when providing the complete health maintenance exam and related tests and immunizations. Routine, age-specific immunizations are reported separately (see Reimbursement for Injectables, Vaccines and Administration later on in this chapter). Providers must report the appropriate E/M codes (i.e., CPT 99201-99215) for other encounters such as preoperative or pre-diagnostic procedure evaluations.

For additional information, refer to the CareFirst Preventive Services Guidelines.

Preventive Services Under the ACA

As part of the ACA, certain preventive services for children and adults must be covered at no cost to the member when using in-network providers.

As a reminder, providers should use the proper diagnosis screening code and CPT code in order to be reimbursed.

Multiple E/M Services on the Same Date

Multiple E/M services reported by the same provider on the same date of service are usually considered mutually exclusive. The most clinically intense service is usually reimbursed.

There are times that a patient may be present for a health maintenance/preventive medicine service visit and a condition or symptom is identified that requires significant additional effort to address and treat. If the treatment of the condition or symptom requires the performance of the key components of a problem-oriented service, then the appropriate level E/M code may need to be reported in addition to the preventive care visit code. CPT Modifier-25 must be appended to the E/M code to indicate that a significant separately identifiable E/M service was provided in addition to the preventive service.

CareFirst considers significant additional effort as encompassing all of the following:

- Additional time is required to diagnose and treat the presenting problem; and
- The physician develops and initiates a treatment program for the identified condition by the end of the office visit.

If a physician monitors a chronic condition (e.g., hypertension, diabetes) at the time of the preventive medicine visit and the condition does not require a significant change in the plan of care, then CareFirst considers this monitoring to be part of the comprehensive system review and assessment. Likewise, if a patient requires problem-focused care (e.g., for a sore throat or viral illness) or needs to be referred to a specialist, this is considered to be included in preventive medicine evaluation and management and is not considered significant additional effort. In both these instances it would not be appropriate to report an E/M service in addition to the preventive visit.

Counseling Services

Follow CPT guidelines when reporting preventive counseling services (i.e., CPT codes 99401-99429). Since these guidelines indicate that these codes are used for persons without a specific illness, it is inappropriate to report these codes for services such as preoperative counseling.

Care Plan Oversight

CareFirst provides a benefit for care plan oversight services (CPT codes 99374-99380) for one physician who provides a supervisory role in the care of a member receiving complex case or disease management services. These services are reported in accordance with CPT guidelines and may be reported in addition to direct patient care E/M services as appropriate.

Advance Planning

CareFirst provides a benefit for advance care planning (CPT 99497, 99498). These codes are used to report the face-to-face service between a physician or other qualified healthcare professional and a patient, family member or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. Refer to CPT guidelines for reporting CPT 99497 and 99498 separately if performed on the same day as another E/M service.

Chronic Care Coordination Services

CareFirst provides a benefit for complex chronic care coordination services (CPT 99487–99490). These services are reported in accordance with CPT guidelines (e.g., time spent per calendar month, etc.) and may be reported in addition to direct patient care E/M services as appropriate, as outlined in the CPT code book. Attention should be given to the services that may not be separately reported during the month for which chronic care coordination services are reported, also as outlined in the CPT code book.

Transitional Care Management Services

CareFirst provides a benefit for transitional care management services (CPT 99495-99496). These services are reported in accordance with CPT guidelines (e.g., calendar days between discharge and a face-to-face visit, who may report these services, etc.) and may be reported in addition to direct patient care E/M services as appropriate, as outlined in the CPT code book. Attention should be given to the services that may not be separately reported during the timeframes during which transitional care management services are reported, also as outlined in the CPT code book.

Online/Internet and Telephone Services

CareFirst does not provide benefits for non-face-to-face services via telephone or internet (CPT 99441-99443, 99444, 98966-98968, 98969), or Inter-professional Telephone/Internet Consultations (CPT 99446-99449). All these services are considered integral to/included in all other services, whether reported alone or in addition to other services or procedures. Integral to/included in services are not eligible for reimbursement.

Telemedicine

Telemedicine services refers to the use of a combination of interactive audio, video or other electronic media used by a licensed healthcare provider for the purpose of diagnosis, consultation or treatment consistent with the provider's scope of practice. Use of e-mail, online questionnaires or fax is not considered a telemedicine service.

Services for diagnosis, consultation or treatment provided through telemedicine must meet all the requirements of a face-to-face consultation or contact between a healthcare provider and a patient for services appropriately provided through telemedicine services. Diagnostic consultative and treatment telemedicine services should be reported with the appropriate category I CPT code and the HCPCS Modifier-GT (via interactive audio and video telecommunication systems) or CPT Modifier-95 (synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system).

CareFirst provides benefits for telemedicine services under certain circumstances. Refer to medical policy 2.01.072, Telemedicine (Unified Communications), in the Medical Policy Reference Manual.

The Maryland Preserve Telehealth Access Act

Effective July 1, 2021, the Maryland Preserve Telehealth Access Act expands the telehealth definition to include audio-only calls, which result in the appropriate delivery of a billable, covered healthcare service. All professional provider types are included in this mandate, but not all procedures. If a provider offers audio-only calls, they will be paid at the same rate as an in-person office visit, where applicable. This mandate expires June 30, 2023, and is applicable to patients enrolled in a fully insured Maryland benefit plan.

Refer to the chart below for additional details. Providers should check their patient's benefits to confirm their plan includes coverage for audio-only telehealth calls.

Coverage type	Codes/Payment	Specialties Covered
MD fully insured	Effective July 1, 2021, **do not use any of the six codes listed below** for other jurisdictions. Please use the appropriate E&M codes to be paid at in-person rates. Follow guidance online for place of service and modifiers, and add CPT® code 99056 at $0.	All specialties
DC fully insured	6 codes paid at $20 99441, 99442, 99443, 98966, 98967 or 98968	All specialties
VA fully insured	6 codes paid at $20 99441, 99442, 99443, 98966, 98967 or 98968	Limited specialties: primary care providers, internal medicine, OB/GYN, family practice, and pediatrics
MD, DC and VA non-risk (self-insured ASO)	6 codes paid at $20 99441, 99442, 99443, 98966, 98967 or 98968	Limited specialties: primary care providers, internal medicine, OB/GYN, family practice, and pediatrics

E/M Services During the Global Period

E/M services reported on the same date as zero-day global period procedures are edited as follows:

- Initial/new patients: The E/M service is eligible for reimbursement in addition to the procedure.
- Follow-up/established patients: Only the procedure is eligible for reimbursement unless CPT Modifier-25 is appended to the visit code to indicate that a significant, separately identifiable E/M service was provided at the time of the procedure.

The global period is 10 days post-operative for minor procedures and 90 days post-operative for major procedures. E/M services for new or established patients who have a 10- or 90-day global period are not eligible for reimbursement.

An exception to this is when CPT Modifier-57 (see below) or CPT Modifier-25 is appended to the visit code to indicate that a significant, separately identifiable E/M service was provided in conjunction with the procedure. The E/M service is then eligible for separate reimbursement.

CPT Modifier-24 identifies an unrelated E/M service provided during the global post-operative period. Follow CPT reporting guidelines for this modifier.

See “Collecting Copayments/Coinsurance During Global Surgical Periods” later in this chapter.

CPT Modifier-57

When an E/M visit results in the initial decision to perform surgery for a major procedure, CPT Modifier-57 should be appended to the E/M service code. The E/M service is then eligible for separate reimbursement. Refer to CPT reporting guidelines for more information.

CPT Modifier-57 is not eligible for reimbursement in the following circumstances:

- When reported with non-E/M codes
- When E/M visit codes is used for the preoperative history and physical exam prior to the surgical procedure

E/M Services in Conjunction with Immunizations

If immunization(s) and administration of the drug(s) are reported together, both are eligible for separate reimbursement. Covered E/M services are also eligible for separate reimbursement at the same visit as the immunization, with the exception of CPT code 99211. If a significant, separately identifiable CPT code 99211 is rendered at the time of the immunization/injection, CPT Modifier-25 should be appended.

Prolonged Services

Prolonged physician service codes (CPT codes 99354-99359) may be reported when there is patient contact beyond the usual E/M service in either the inpatient or outpatient setting.

Several of these are add-on codes and must be reported in addition to other E/M codes. They are not valid when reported with any other procedure or service. See CPT guidelines when reporting CPT 99358-99359 as these may be reported on a different date from the E/M visit under certain circumstances.

Prolonged service codes are not eligible for reimbursement in combination with the following:

- Emergency services (CPT 99281-99288)
- Observation services (CPT 99217-99220)
- Observation or inpatient services (CPT 99234-99236)
- Critical care services (CPT 99291-99292)

Prolonged services are not eligible for reimbursement for time spent by a non-physician incidental to the physician's service (e.g., office staff discussing dietary concerns with a patient).

Follow CPT reporting guidelines when reporting prolonged services, including base codes with which they may be reported. Because these are time-based codes, documentation in the medical record must clearly reflect exact times spent on base and prolonged services in order to verify appropriate use of these codes.

Intensity of Service Auditing

CareFirst will not automatically reassign or reduce the code level of E/M codes for covered services, except in the case of replacing a new patient visit code with an established patient visit code, in accordance with CPT guidelines. We will evaluate and reduce or reassign code levels if it is determined through review of clinical information that the reported code(s) is not reflective of the service rendered.

Billing for Services Rendered to Patients

Except for very limited circumstances (e.g., physician assistants or registered nurses administering injections), providers may only report and submit claims for services rendered to patients that the practitioner individually and personally provides. CareFirst contracts with participating providers to perform services for an agreed upon fee. It is that provider, and only that provider, who can submit a claim and receive reimbursement.

As outlined in the CareFirst medical record documentation standards policy, 10.01.013A, in the Medical Policy Reference Manual, participating providers must accurately and completely document the medically

necessary services they perform in the appropriate medical record and sign the document(s) attesting that they performed the service.

Attending physicians and other qualified healthcare professionals who supervise and teach residents or students are allowed to submit claims for those services the resident or student in training provides, only if the supervising provider also interacts with the patient/family, examines the patient (if applicable) and personally documents their patient encounter in the medical record. Services rendered by residents, associates, graduate students or others in training (in any discipline, specialty or occupation) are not eligible for reimbursement unless these requirements are met.

Reporting Medication Administration

In all instances, providers should only report the actual services provided to the patient, including medications administered in any setting. CareFirst will only reimburse providers for the amount of the medication administered. Providers should schedule patients to minimize any waste and utilize medications efficiently. If a specific dose of medication is drawn from a multi-dose vial, only the amount of medication administered to the patient is to be reported—not the total amount of the drug in the vial.

Reimbursement for Injectables, Vaccines and Administration

Covered vaccines and injectables are reimbursed and administered according to an established fee schedule. Newly recommended vaccines are eligible for reimbursement as of the effective date of a recommendation made by any of the following:

- The U.S. Preventive Services Task Force
- The American Academy of Pediatrics
- The Advisory Committee on Immunization Practices

Benefits for vaccinations and immunizations are contractually determined. Providers should ensure that benefits are available prior to rendering these services.

Additional information is available in the Medical Policy Reference Manual and the CareFirst Preventive Services Guidelines.

For information regarding procurement of office administered medications, refer to the Medication section of this manual.

The D.C. Minor Consent for Vaccinations Amendment Act of 2020

CareFirst has implemented the D.C. Minor Consent for Vaccinations Amendment Act of 2020 (the Act). This legislation allows minors, 11 years of age or older, to receive a vaccine, if the minor is capable of meeting the informed consent standard and the vaccination is recommended by the United States Advisory Committee on Immunization Practices (ACIP) and provided in accordance with the United States Advisory Committee on Immunization Practices' recommended vaccinations schedule.

The Act applies to all age-appropriate vaccines including COVID-19. Vaccine(s) given under the Act must be administered in Washington, D.C.

Providers are not required to administer vaccines to minors without parental consent. However, should the elect to do so, the Act requires that providers notify CareFirst as well as seek reimbursement directly from the insurer for vaccinations given without parental consent, pursuant to the Act.

To support the Act, CareFirst developed the following process so we can suppress the EOB statement normally sent to the parent/guardian.

To ensure proper reimbursement and suppression of the corresponding EOB for vaccines administered under this Act, providers must complete both the D.C. Minor Consent Notification Form and the appropriate paper claim form.

Note: Claims for vaccines administered under this Act should not be sent electronically and must be sent on one of the paper forms below:

- Professional claims – please use the current version of the CMS-1500 form (version 02/12) on original red-ink-on-white-paper.
- Institutional claims – please use the current version of the UB-04 form on original red-in-on-white-paper.

Providers must submit both the completed notification form and correct paper claim form by mail to the following address:

CareFirst BlueCross BlueShield
Privacy Office
P.O. Box 14858
Lexington, KY 40512

Please note: Providers must follow this process exactly as outlined or CareFirst will not be able to suppress the EOB.

Refer to the Frequently Asked Questions and instructions for the paper claim form process for more information.

Collecting Copayments/Coinsurance During Global Surgical Periods

- If an E/M service/visit is allowed, regardless if rendered before, during or after a global surgical period, a claim should be submitted, and the applicable copayment or coinsurance may be collected.
- If an E/M service/visit is disallowed and/or bundled into the global surgical allowance, a claim should not be submitted, and a copayment or coinsurance may not be collected

It is not appropriate to collect a copayment/coinsurance from a member and not submit a claim for a service/visit. See also medical policy operating procedure 10.01.009A, Global Surgical Care Rules, in the Medical Policy Reference Manual.

Special Services

Services rendered during off-hours, on weekends, on holidays, on an emergency basis and for hospital mandated on call (CPT 99026-99060) are considered incidental or mutually exclusive to other services. Incidental and mutually exclusive services are not eligible for reimbursement.

Exception

CPT 99050 and 99051 are eligible for separate reimbursement for after-hours service or service on holidays, when required by law. After-hours service is defined as medical office services rendered in the office after 6 p.m. and before 8 a.m. weekdays, weekends, and national holidays.

Do **NOT** use CPT code 99050 or 99051 if the patient has an appointment during business hours but is not seen until later because the office is behind. These codes must be reported in addition to an associated basic service(s) (e.g., Evaluation and Management, Psychotherapy) and are not reimbursable as stand-alone procedures.

Additionally, if the associated basic service(s) is denied, no additional reimbursement is made for the adjunct services. CPT 99050 and 99051 are not eligible for separate reimbursement for services rendered at an urgent care center or by a specialist.

Cerumen Removal

Removal impacted cerumen (ear wax) using irrigation/lavage unilateral, CPT code 69209 (effective January 1, 2016), has been established to report the removal of impacted cerumen by irrigation and/or lavage. Several exclusionary and instructional notes were added to the CPT guidelines to ensure appropriate reporting of CPT codes 69209 and 69210 are unilateral.

A new code was warranted to differentiate between direct and indirect approaches of removing impacted cerumen performed or supervised by physicians or other qualified healthcare professionals. Impacted cerumen is typically extremely hard and dry and accompanied by pain and itching and can lead to hearing loss. CPT 69210 only captures the direct method of earwax removal utilizing instrumentation such as curettes, hooks, forceps and suction.

Another less invasive method uses a continuous low pressure flow of liquid (i.e., saline water) to gently loosen impacted cerumen and flush it out with or without the use of a cerumen softening agent (i.e., cerumenolytic) that may be administered days prior to the procedure or at the time of the procedure. CPT 69209 enables the irrigation or lavage method of impacted cerumen removal to be separately reported and not mistakenly reported with CPT 69210.

CPT codes 69209 and 69210 should not be reported together when both services are provided on the same day on the same ear. Only one code (CPT 69209 or 69210) may be reported for the primary service (most intensive time or skilled procedure) provided on that day on the same ear. Two instructional parenthetical notes have been added following CPT 69209 and 69210 to exclude them from being reported together. If either one of the cerumen removal procedures is done on both ears, Modifier-50 should be appended as indicated in the new parenthetical note added following CPT codes 69209 and 69210. The E/M codes should be reported when non-impacted cerumen is removed according to the section category defined by the site of service (e.g., office or other outpatient, hospital care, nursing facility services) as instructed in the parenthetical notes following CPT 69209 and 69210.

Critical Care Services

CPT describes reporting guidelines for the time-based, critical care services codes (CPT 99291-99292) that are consistent with CareFirst policy. These guidelines also define procedures and services that are considered incidental to critical care. Examples of additional procedures that CareFirst considers to be incidental to critical care are as follows:

- Venipuncture, under age 3 (CPT 36400, 36405, 36406)
- Venipuncture (CPT 36415)
- Insertion of needle/catheter (CPT 36000)
- Transfusion procedures (CPT 36430)
- Intravenous fluid administration (i.e., CPT 96360–96379)
- Incidental services and procedures are not eligible for reimbursement

Handling and Conveyance

Handling and conveyance (CPT 99000–99002) are considered integral to most procedures and services including, but not limited to E/M, surgery and surgical pathology. Integral services are not eligible for reimbursement.

Hot and Cold Packs

Hot and cold packs (CPT 97010) are considered incidental or mutually exclusive to most services, including but not limited to chiropractic manipulation, therapeutic exercise, therapeutic activity, manual therapy, massage and whirlpool therapy. Incidental or mutually exclusive services are not eligible for reimbursement.

Supervision, Interpretation and/or Guidance for Diagnostic Tests

Interpretation of diagnostic studies, including but not limited to, laboratory, radiology, and electrocardiographic tests are considered incidental or integral to all E/M services and other services that include evaluation components. Incidental or integral services are not eligible for reimbursement.

Specialty physicians (e.g., radiologists, cardiologists, pathologists) that perform the final interpretation and separate, distinctly identifiable, signed, written report (per CPT guidelines) of a diagnostic service may be eligible to receive reimbursement when the procedure is reported with CPT Modifier-26.

CPT codes reported for supervision and interpretation and radiologic guidance (e.g., fluoroscopic, ultrasound or mammographic) are eligible for reimbursement to the extent that the associated procedure code is recognized and eligible for reimbursement, and provided that the associated procedure code does not include supervision and interpretation or radiologic guidance services. For each procedure (e.g., review of x-ray or biopsy analysis or ultrasound guidance), only one qualified provider/healthcare professional shall be reimbursed.

Reimbursing more than one provider for the same service represents duplicate procedure payment. Duplicate services are not eligible for reimbursement. (See also “Duplicate services and multiple reviews” listed earlier in this chapter.)

Introduction of Intravenous Needles/Catheters

Introduction of a catheter/needle (CPT 36000) is considered incidental to all anesthesia services, select radiology procedures, critical care E/M services and all procedures that typically require the patient to have a peripheral IV line. Incidental procedures are not eligible for reimbursement.

Hydration, Infusions and Injections

Follow CPT guidelines when reporting hydration, injection and infusion services alone or in conjunction with other infusion/injection procedures and/or chemotherapy. Because a number of factors determine correct code assignment (e.g., reason for encounter, indications for additional procedures, sequencing of initial, subsequent and concurrent procedures, inclusive services and time) it is imperative the medical record documentation be accurate and clearly identify all of these pertinent issues to ensure reporting is accurate. Incidental and/or mutually exclusive editing will apply when certain inappropriate code combinations are reported together.

Select intravenous fluids, needles, tubing and other associated supplies are considered incidental to the administration of infusion/injection procedures. Incidental procedures are not eligible for separate reimbursement.

Routine injections (CPT 96372) are usually eligible for separate reimbursement when reported with office E/M services. If a physician is not present, they should report (exception CPT 99211. Follow CPT guidelines when reporting injection procedures. Injections are considered incidental when reported with services such as anesthesia, emergency and inpatient E/M, surgery, select radiology and select therapeutic and diagnostic procedures. Incidental procedures are not eligible for reimbursement.

Hydration, infusion and injection procedures provided in inpatient and/or outpatient centers are typically provided by personnel in those settings and reported on claims for those facilities. It is not appropriate,

therefore, for the professional provider to report those services unless that provider personally performs the service.

Pulse Oximetry

Non-invasive pulse oximetry determinations (CPT 94760–94762) are considered incidental when reported with E/M services, anesthesia and other procedures. Incidental procedures are not eligible for reimbursement. These codes are only eligible for reimbursement when they are reported as stand-alone procedures (i.e., when no other services are provided to the patient on the same date).

Vital Capacity Measurements

This procedure (CPT 94150) is considered incidental to all other procedures. Incidental procedures are not eligible for reimbursement. This code is only eligible for reimbursement when it is reported as a stand-alone procedure (i.e., when no other services are provided to the patient on the same date).

Supplies and Equipment

CareFirst follows the CMS guidelines regarding what is included in the PE for each procedure code. A portion of a procedure code's RVU and associated reimbursement allowance is PE.

The PE portion includes medical and/or surgical supplies and equipment commonly furnished in a practice and are usually part of the surgical, medical, anesthesiology, radiology or laboratory procedure or service. This includes, but is not limited to:

- Syringes, biopsy and hypodermic needles (A4206–A4209, A4212–A4215)
- IV catheters and tubing (A4223)
- Gowns/gloves/masks/drapes (A4927–A4930)
- Scalpels/blades
- Sutures/steri-strips
- Bandages/dressings/tape (A4450–A4452, A6216–A6221)
- Alcohol/betadine/hydrogen peroxide (A4244–A4248)
- Sterile water/saline (A4216–A4218)
- Thermometers (A4931–A4932)
- Trays and kits (A4550)
- Oximetry and EKG monitors
- Blood pressure cuffs (A4660–A4670)

Additional charges for routine supplies and equipment used for a procedure, service or office visit and reported with CPT 99070, HCPCS code A4649 and any other code that describes these supplies or equipment, are considered incidental to all services and procedures. This is applicable whether or not the supply is reported with other procedures/services or is reported alone. Incidental services are not eligible for reimbursement and members may not be balance-billed for them.

Note: Supplies and equipment used while treating a patient in an institutional or outpatient facility should not be reported by the professional provider, as these supplies are reported on the facility claim.

Miscellaneous Services

The following are considered incidental to all services:

- Educational supplies (CPT 99071)
- Medical testimony (CPT 99075)
- Physician educational services (CPT 99078)
- Special reports (CPT 99080)
- Unusual travel (CPT 99082)
- Telephone calls (CPT 99441–99443)
- Collection/interpretation/analysis of data stored in computers (CPT 99090–99091)

CareFirst member contracts do not provide benefits for these services, and these services are not eligible for reimbursement.

Venipuncture

Venipuncture procedures (CPT 36400–36410) which require a physician's skill are eligible for separate reimbursement when reported with laboratory tests from the CPT 8xxxx series. Please note these procedures are not to be used for routine venipuncture. In addition, separate procedure rules apply.

Routine venipuncture procedures (CPT 36415) are considered incidental to all laboratory services. Incidental procedures are not eligible for reimbursement. If billed with an office visit, venipuncture procedures may be eligible for separate reimbursement.

If a routine venipuncture (as noted above) laboratory test from the CPT 8xxxx series and an E/M service are reported on the same claim, same date of service and from the same provider, the venipuncture will be considered incidental to the laboratory test.

Visual Acuity Testing

Visual acuity screening (CPT 99173) is considered incidental to new and established office or other outpatient E/M services. Incidental procedures are not eligible for reimbursement. However, this procedure is eligible for separate reimbursement when reported with a new or established preventive medicine E/M service.

Medical/Clinical Photography

Photographs taken for any purpose are considered the same as medical documentation for a patient. As with written or typed documentation, photography, regardless of the individual performing the photography, is considered to be an integral part of any service, procedure or episode of care. Integral services are not eligible for separate reimbursement.

Emergency Medicine

Emergency medicine E/M services (CPT 99281-99285) are provided in a hospital-based emergency department (see CPT reporting guidelines).

Many procedures are performed on patients during the emergency care encounter and are provided by personnel employed by the hospital (e.g., nurses, respiratory therapists, phlebotomists, technicians). Procedures performed by hospital personnel are included in the facility charge and should not be reported on the professional claim unless personally provided by the emergency physician or other qualified provider.

Services personally rendered by other physicians (consultants) are reported separately by those providers.

Procedures including, but not limited to the following, are considered incidental or mutually exclusive to emergency medicine E/M services:

- Inhalation treatment (CPT 94640)
- Ventilation management (CPT 94002–94004)
- Ear or pulse oximetry (CPT 94760–94762)
- Sedation (see operating procedure 9.01.003A in the Medical Policy Reference Manual)
- Physician direction of Emergency Medical Systems (EMS) (CPT 99288)
- Interpretation of diagnostic studies

Certain procedures when personally performed by the emergency physician are usually eligible for separate reimbursement and include:

- Wound repair (CPT 12001-14350)*
- Endotracheal intubation (CPT31500)
- Insertion of central venous catheter (CPT 36555-36571)*

*Global surgical rules apply. This means that E/M services are not eligible for separate reimbursement when provided with procedures for which the E/M is considered part of the surgical package. CPT Modifier-25 may be required if there is a significant, separately identifiable E/M service provided on the same date as certain procedures (see "E/M Services During the Global Periods" earlier in this chapter). Emergency physicians who perform surgical procedures should report these with CPT Modifier-54, as appropriate, since they typically provide the surgical component, not the pre-or post-operative component of the surgical package.

Physician direction of EMS (CPT 99288) when reported alone is not eligible for reimbursement.

Hearing Aids

Hearing aid benefits are defined by the member's contract. When reporting these services to CareFirst, follow the guidelines below:

- The description of the CPT/HCPCS procedure code specifies Monaural/Binaural and is eligible for reimbursement only once on a single date of service.
- Because these codes indicate Monaural/Binaural in the description, it is not appropriate to report the code with CPT modifier 50 or with Category II modifiers RT/LT.
- The fee schedule allowance for Monaural is set to allow for one, and Binaural is set to allow for two.
- Claims for CPT codes 92590–92595 and HCPCS codes V5010–V5298 should only be submitted with a frequency of one.

Note: Any of the hearing aid codes should only be reported with a frequency of **one** in the unit's field.

Surgery/Orthopedics

Anesthesia by Operating Surgeon

Administration of anesthesia by the surgeon, assistant surgeon, nursing staff or any other provider within the same clinical practice (same tax ID number) during a procedure is considered included in the allowance for the surgical procedure. This includes any method

of anesthesia (e.g., general anesthesia, moderate (conscious) sedation, local or regional anesthesia, nerve blocks). Included in procedures are not eligible for reimbursement.

Fracture Care, Strapping/Casting

Follow CPT guidelines when reporting fracture care and casting/strapping. Fracture care provided by multiple providers on various days, is subject to historical claims auditing.

Certain casting supplies (HCPCS A4580, A4590) are eligible for separate reimbursement when reported with fracture care and casting and strapping procedures.

Gender Reassignment and Transgender Services

Gender reassignment and transgender services are often defined by the member contract. For additional information on this topic, including authorization requirements, refer to medical policy 7.01.123 Gender Reassignment Services and 7.01.017 Cosmetic and Reconstructive Surgery with Attached Companion Table in the Medical Policy Reference Manual.

Lesion Removals and Biopsies

Covered, non-cosmetic lesion removals are eligible for separate reimbursement according to the terms of the member contract and applicable medical policies. Follow CPT guidelines for reporting excision, destruction and shaving of benign and malignant lesions. Multiple lesion removal procedures reported together with the same CPT code are usually considered duplicates or mutually exclusive to each other. CPT Modifier-59 should be appended to lesion removals subsequent to the primary procedure to indicate that they were distinct procedures (i.e., separate sites, separate lesions). Multiple procedure editing rules apply.

Lesion Excision and Wound Closures

Follow CPT guidelines for reporting single and multiple wound closures. When intermediate, complex or reconstructive closures are reported with lesion excisions, both procedures may be eligible for separate reimbursement. Simple wound repair procedures (CPT 12001) are considered incidental to excision of lesions in the same anatomic site. Incidental procedures are not eligible for separate reimbursement.

Surgical Trays

As discussed in the supplies and equipment section of this guide, a portion of the RVU is PE. This also includes trays necessary for surgical procedures performed in the office setting. Therefore, additional charges for trays (HCPCS code A4550) used for a surgical procedure or during an office visit are considered incidental to all services and procedures. Incidental procedures are not eligible for reimbursement.

Nasal Sinus Endoscopy/Debridement

Nasal sinus endoscopy (CPT 31237, separate procedure) is eligible for separate reimbursement when performed as postoperative care following functional endoscopic sinus surgical procedures that have a zero-day global period or after a ten-day global period. Endoscopic surgical sinus cavity debridement is not eligible for separate reimbursement when performed as a postoperative treatment related to major surgeries (septoplasty) within a 90-day global period. When the patient is being followed postoperatively for both a zero or 10-day global and a major (90-day global) procedure, append CPT Modifier-79 to CPT 31237 to indicate that the debridement is unrelated to the major procedure. In addition, ensure that medical record documentation and associated ICD-10 diagnosis codes accurately describe for which procedure(s) the endoscopic sinus debridement is being performed. It should be noted that many nasal surgery codes are considered unilateral. Append CPT Modifier-50 as appropriate when a procedure is performed bilaterally. As always, separate procedure rules apply, according to CPT guidelines.

Medicine/Oncology

Allergy Testing/Immunotherapy

Allergy services and procedures benefits are often defined by the member contract. For additional information on this topic, refer to medical policy 2.01.023, Allergy Testing, medical policy 2.01.017, Allergy Immunotherapy and other applicable policies in the Medical Policy Reference Manual.

Chemotherapy (Office, Inpatient and Outpatient Settings)

Chemotherapy procedures (CPT 96401–96549) are considered independent from E/M services. E/M services, when reported with chemotherapy, are not eligible for reimbursement unless CPT Modifier-25 is appended to the E/M code to indicate that a significant, separately identifiable E/M service was performed in addition to the chemotherapy.

Follow CPT guidelines when reporting chemotherapy services alone or in conjunction with other infusion and injection procedures. Because a number of factors determine correct code assignments (e.g., reason for encounter, indications for additional procedures, sequencing of initial, subsequent and concurrent procedures, inclusive services, time), the medical record documentation must be accurate and clearly identify all of these pertinent issues so reporting is accurate. Incidental and/or mutually exclusive editing will apply when certain inappropriate code combinations are reported together.

Select intravenous fluids, needles, tubing and other associated supplies are considered incidental to the administration of chemotherapy. Incidental procedures are not eligible for separate reimbursement.

Medically necessary, non-experimental/investigational chemotherapeutic agents and other drugs are usually eligible for separate reimbursement when reported with the appropriate HCPCS code. Chemotherapy procedures provided in inpatient and/or outpatient centers are typically provided by personnel in those settings and reported on claims for those centers. The professional provider (physician) should not report those services unless that provider personally performs the service.

Nutrition Therapy and Counseling

Follow CPT guidelines for reporting nutritional therapy services. For instance, non-physicians should report these services using CPT codes 97802-97804. Providers are instructed to report these services with an appropriate E/M code.

Sleep Disorders

CareFirst provides benefits for the diagnosis and management of sleep disorders, including oral appliances. Most sleep disorder services can be provided in the home setting. Refer to medical policy 2.01.018, Sleep Disorders in the Medical Policy Reference Manual for details and authorization requirements.

Genito-Urinary

Erectile Dysfunction

Refer to medical policy 2.01.025, Erectile Dysfunction, in the Medical Policy Reference Manual.

Pediatrics/Neonatology

Normal Newborn

Benefits for newborn care are defined by the member contract. Follow CPT guidelines when reporting all aspects of newborn care. For further information, refer to medical policy 10.01.006, Care of the Normal Newborn in the Medical Policy Reference Manual.

Neonatal and Pediatric Intensive Care Services

Follow CPT guidelines for reporting pediatric critical care transport (CPT 99466–99467 and 99485–99486), inpatient neonatal and pediatric critical care (CPT 99468–99476) and initial and continuing intensive care services (CPT 99477– 99480).

Note: These represent 24-hour global services (except pediatric critical care transport) and may only be reported once per day, per patient. These guidelines also define procedures and services that are considered incidental to CPT 99468–99480.

Incidental services are not eligible for separate reimbursement.

Obstetrics and Gynecology

Lactation Consultations

Lactation consultation refers to the educational services provided to women who plan to breastfeed but encounter difficulties due to anatomic variations, complications and feeding problems with newborns. Refer to medical policy 4.01.010, Lactation Consultations in the Medical Policy Reference Manual.

Maternity Services

Maternity benefits are defined by the member contract. Follow CPT guidelines for reporting maternity services, including reporting non-global services (e.g., separate antepartum, delivery and/or postpartum care). Refer to medical policy 4.01.006A, Global Maternity Care in the Medical Policy Reference Manual.

Multiple births

Refer to medical policy operating procedure 4.01.006A, Global Maternity Care in the Medical Policy Reference Manual.

Contraceptive Devices

Family planning services are defined by the member contract. Established patient E/M services reported with insertions and removals of intra-uterine devices (CPT 58300-58301) are considered to be included in the surgical package for the procedure and are not eligible for separate reimbursement unless the E/M service is a significant, separately identifiable service. In that case, CPT Modifier-25 should be appended to the E/M service.

Diaphragm/cervical cap fitting (CPT 57170) is considered incidental to all established patient E/M services. Incidental procedures are not eligible for reimbursement.

Radiology/Imaging

Mammography

Mammography benefits are defined by the member contract. Depending on the member contract and related CareFirst Preventive Services Guidelines, both a screening and/or diagnostic mammogram may be eligible for reimbursement on the same date of service. In this case, the procedure with the higher RVU will be reimbursed at 100% of the allowed benefit, and the procedure with the lesser RVU will be reimbursed at 50% of the allowed benefit.

Digital Breast Tomosynthesis

CPT codes 77061, 77062 and 77063 were established to report diagnostic and screening breast tomosynthesis, unilateral and bilateral procedure. The digital breast tomosynthesis images, and if acquired, the conventional mammography images, are utilized for interpretation for screening and diagnostic mammograms. The addition of digital breast tomosynthesis to conventional mammography has been shown to be more sensitive and specific for breast cancer screening.

Instructional parenthetical notes have been added to ensure appropriate reporting of breast tomosynthesis imaging procedures. Report CPT 77061 and 77062 (diagnostic breast tomosynthesis) in conjunction with CPT 77055 and 77056 (conventional diagnostic mammography). Report CPT 77063 (bilateral screening breast tomosynthesis) in conjunction with CPT 77057 (conventional bilateral screening mammography).

Exclusionary parenthetical notes have been added to further clarify the reporting of breast tomosynthesis imaging procedures. Do **not** report add-on CPT code 77063 (screening breast tomosynthesis) in conjunction with CPT codes 77055 and 77056 (conventional diagnostic mammography) or CPT 76376 or 76377 (three-dimensional reconstruction). Do **not** report CPT 77061 and 77062 (diagnostic breast tomosynthesis) in conjunction with CPT 77057 (conventional screening mammography) or CPT 76376 or 76377 (three- dimensional reconstruction).

Diagnostic Ultrasound with Ultrasound Guidance Procedures

- Limited diagnostic ultrasound procedures reported with ultrasound guidance procedures.
  - When a limited diagnostic ultrasound (CPT 76705) and an ultrasonic guidance procedure (CPT 76942) are reported on the same date, our claims system assumes that both were performed during the same session in the same anatomic area. Based on CPT guidelines, an ultrasound guidance procedure includes imaging protocols that are comparable to the limited diagnostic ultrasound. Therefore, when these two procedures are reported together on the same date, the limited ultrasound is considered mutually exclusive to the ultrasound guidance. Mutually exclusive services are not eligible for separate reimbursement. The procedure with the higher RVU value is eligible for reimbursement.
- Diagnostic ultrasound procedures reported with ultrasound guidance procedures.
  - When an ultrasound guidance procedure (CPT 76942) and an ultrasound procedure (CPT 76536) are reported on the same date, our claims system assumes that both were performed during the same session in the same anatomic area. Based on CPT guidelines, an ultrasound guidance procedure includes imaging protocols that are comparable to the ultrasound procedure. Therefore, when these two procedures are reported together on the same date, the ultrasound procedure is considered mutually exclusive to the ultrasound guidance.
  - Mutually exclusive services are not eligible for separate reimbursement. The procedure with the higher RVU value is eligible for reimbursement.

- Ultrasound guidance procedures reported with ultrasound guidance procedures.
  - When multiple ultrasound guidance procedures (CPT 76930 and CPT 76942) are reported on the same date, our claims system assumes that both were performed during the same session in the same anatomic area and for similar clinical indications. When these procedures are reported together on the same date, the code with the lower RVU value will be considered mutually exclusive to the code with the higher RVU value. Mutually exclusive services are not eligible for separate reimbursement. The procedure with the higher RVU value is eligible for reimbursement.

In each of these scenarios there may be particular clinical circumstances in which the procedures are performed on separate anatomic sites, and/ or there may be distinct clinical indications for each study. In these circumstances, it will be necessary to append the appropriate modifier(s) to the code(s) to indicate such. Documentation in the medical record must support the reason for multiple reporting of these procedures.

Invasive and Non-Invasive Diagnostic Tests and Procedures

Many of these tests and procedures (e.g., cardiac catheterizations, electrophysiological studies, imaging studies) can be reported several ways depending on ownership of equipment, place of service, who is performing the service and who is supervising and/or interpreting the results of the test. Providers must report these services appropriately in order for the claim to be properly adjudicated. Refer to the “Modifier Reimbursement Guidelines” section under the Basic Claim Adjudication Policy Concepts unit earlier in this chapter, regarding reporting global and/or components of these services. (See also “Duplicate Services and Multiple Reviews” listed earlier in this chapter.)