Facility Guidelines

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

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

For purposes of clarification, payment for inpatient services (whether priced as a diagnosis-related group, per diem or other methodology) shall be based on the reimbursement schedule in effect as of the relevant member's date of admission irrespective of contract amendments that take effect during the term of that member's inpatient admission. Any amendments to compensation amount shall be applied to services rendered to members admitted after such amendment's effective date.

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

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

Medical policies
We maintain our own medical policies for most services and procedures while following MCG for inpatient and tertiary services. This includes services and care received in inpatient hospitals, skilled nursing facilities, long-term acute care hospitals and facilities, inpatient rehabilitation centers, residential treatment facilities, partial hospitalization and intensive outpatient behavioral health services.

Hospital guidelines

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

- Rehabilitation services
- Diagnostic, therapeutic (both surgical and no-surgical) services
- May perform laboratory tests that are billed by the hospital
- May provide services in an emergency room or outpatient clinic
- May offer ambulatory surgical center (ASC) procedures and/or medical supplies

Site of service (outpatient to ASC)
Some services require pre-authorization for the site of service. Pre-authorization requirements are published in the Pre-authorization section of our provider website, **regence.com**. Providers can check whether services require pre-authorization and then request pre-authorization using Availity's Electronic Authorization application at **availity.com**.

For additional site of service information, see our commercial and Medicare Advantage *Surgical Site of Service – Hospital Outpatient* (Utilization Management #19) medical policies on our provider website, **regence.com**: Policies & Guidelines>Medical Policy.

Inpatient hospital

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

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

Billing inpatient versus outpatient stays

We use MCG at **mcg.com** to determine appropriate level of care, and we use American Society of Addiction Medicine (ASAM) guidelines for substance use disorder treatment. Inpatient hospital claims must include the appropriate room and board revenue codes. The total units billed on the room and board revenue codes should match the length of stay as calculated as discharge date less admission date plus one.

Observation

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

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

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

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

Hospital-based physician services

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

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

Pre-admission services

Pre-admission services are considered:

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

Hospital readmission review (group and Individual plans)

All hospital readmissions for the same, similar or related condition which occur within 72 hours of discharge from hospital/facility or as defined in the Hospital Provider Contract is considered a continuation of initial treatment.

The two Diagnosis Related Group (DRG) hospital claims (identified using the assigned provider identifier) will be consolidated into one, combining all necessary codes, billed charges and the length of stay. The maximum allowable for Covered Services will be recalculated per the reimbursement terms of the hospital/facility contract so that reimbursement is for a single, per case reimbursement.

This policy applies to the following but not limited to:

- Emergent readmissions
- Clinically related readmissions

This policy does not apply to the following:

- Transplants
- Medical treatment for cancer
- Psychiatric and substance abuse
- Readmission for unrelated condition
- Transfer from one inpatient stay at an acute care hospital to an inpatient stay at another acute care hospital
- Patient discharged from the hospital against medical advice
- Readmission for the medical treatment of rehabilitation care
- Readmission for cancer chemotherapy or transfusion for chronic anemia

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

Hospital readmission review (Medicare Advantage Plans)

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

- On the same day (or within 24 hours) will be processed as a single claim

- Within 2-30 days will be subject to clinical reviews. If the clinical review indicates that the readmission is for the same or similar condition, it may be considered a continuation of the initial admission for the purposes of reimbursement.

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

This applies to, but is not limited to:

- Emergent readmissions
- Clinically related readmission
- Planned readmission or leave of absence

This policy does not apply to the following:

- Transplants
- Medical treatment for cancer
- Psychiatric and substance abuse
- Readmission for unrelated condition
- Transfer from one inpatient stay at an acute care hospital to an inpatient stay at another acute care hospital
- Readmission for the medical treatment of rehabilitation care
- Patient discharged from the hospital against medical advice
- Readmission for cancer chemotherapy, transfusion for chronic anemia or similar repetitive treatments

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

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

<u>Interim billing</u>
Interim bills will not be accepted. To properly adjudicate an inpatient claim, the patient must be discharged. Notification of admission and ongoing stay are required.

<u>Claims that span multiple years</u>
CMS coding guidelines require institutional claims that span from one calendar year to another to be split into separate claims by year. This allows proper processing of all items on the claim. CMS' general guidance is:

FL 6. Statement covers period (from - through)

- These fields cannot exceed eight positions in either "from" or "through" portion, allowing for separations (non-numeric characters) in the third and sixth positions.
- The "from" date must be a valid date that is not later than the "through" date.

- The “through” date must be a valid date that is not later than the current date.

Facility claims (ANSI 837I claims) that span from one calendar year to the next (e.g., December 28, 2022, to January 3, 2023) will be denied automatically if they are submitted on the same claim. The following claim types are exceptions that do not need to be split:

- Home health prospective payment system (PPS) claims
- Outpatient hospital observation or emergency room visits
- Facility inpatient claims

Late charges

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

Hospital-corrected billings and/or adjustments

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

Grouper use

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

Ungroupable DRGs

Ungroupable DRGs are defined as the following:

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

Member deductible and coinsurance calculation

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

DRG methodology

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

- Late discharge
- Observational/outpatient
- Diagnostic laboratory services
- Emergency or after-hours admission
- Admission or utilization review paperwork
- Discharge (take home) prescription drugs
- Emergency room, if the patient is admitted

- Medical transportation (excluding air ambulance)
- Room and board, including services and supplies
- Pre-admission services two days prior to admission and one day post discharge

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

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

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

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

The CMS policy is outlined in the MLN Matters article Fiscal Year (FY) 2006 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes (MM4046) at **cms.gov/Regulations-and-Guidance/Guidance/Transmittals/ Downloads/R692CP.pdf**.

Facility pre-authorization requirements

Pre-authorization applies but is not limited to the following:

- Inpatient rehabilitation facilities
- Detoxification
- Acute care hospitals
- Skilled nursing facilities (SNF)
- Long-term acute care hospitals and facilities (LTAC)
- Intensive outpatient for mental health and substance use
- Partial hospitalization for mental health and substance use
- Residential treatment for mental health and substance use
- All elective inpatient admissions, including behavioral health

Admission and discharge notification requirements
Notification of admission must occur within 24 hours of admission–regardless of the day of week or holiday status–to assist with coordination of care and reduce 30-day readmission. Failure to notify of admission will result in an administrative denial, claim non-payment and facility liability. Facilities that submit patient data, including admission and discharge data, via electronic record submission are not required to submit notification of inpatient admissions in another format.

Admission notification requirements apply but are not limited to the following:

- All inpatient hospice admissions
- Substance use detoxification
- All unplanned acute care admissions

- All planned and elective acute care admissions
- All admissions that follow an outpatient surgery
- All admissions that follow outpatient observation
- Intensive outpatient admissions for substance use
- All newborns who are admitted to a pediatric intensive care unit (PICU) or neonatal intensive care unit (NICU)
- All newborns who remain hospitalized after the mother is discharged

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

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

<u>Payment implications for failure to pre-authorize services</u>

Failure to secure approval for services subject to pre-authorization requirements will result in an administrative denial, claim non-payment and facility liability. Our members must be held harmless and cannot be balance billed. The complete list of payment implications is available in the Pre-authorization section of provider website.

<u>Notification timeframe reimbursement</u>
There may be exceptions to obtaining pre-authorization. The six situations listed below may apply as part of our Extenuating Circumstances Policy Criteria:

1. Member presented with an incorrect member card or member number.
2. Natural disaster prevented the provider or facility from securing a pre-authorization or providing hospital admission notification.
3. Member is unable to communicate (e.g., unconscious) their medical insurance coverage. Neither family nor other support present can provide coverage information.
4. Compelling evidence the provider or facility attempted to obtain pre-authorization or provide hospital admission notification. The evidence shall support the provider or facility

followed our policy and that the required information was entered correctly by the provider office or facility into the appropriate system. **Note**: A copy of the faxed preauthorization request showing the information was entered correctly or a copy of the provider's or facility's fax cover sheet for hospital admission notifications indicating the member health plan information and a fax confirmation from the fax machine showing the fax was successfully sent to the appropriate health plan fax number will be considered compelling evidence

5. A surgery which requires pre-authorization occurs in an urgent/emergent situation. Services are subject to review post-service for medical necessity.
6. A participating provider or facility is unable to anticipate the need for a pre-authorization before or while performing a service or surgery.

Inpatient concurrent review

All hospital and behavioral health admissions are subject to concurrent review. Upon receipt of the admission notification, we will respond with an acknowledgment that includes the date clinical information will be due. Facilities are required to send us medical records upon request.

Failure to submit clinical records will result in an administrative denial, claim non-payment and facility liability. Facilities that provide electronic medical record (EMR) clinical access do not need to submit records if complete clinical documentation is available for access on the requested date.

Discharge planning for members with long length of stay

Our care management team provides discharge planning support for members with long length of stays. We engage high-risk members in an acute inpatient setting. This care management process includes assisting the member with discharge planning, transition of care management and performing medical necessity reviews.

We require facilities to provide documentation, such as a treatment plan, when requested for extended length of stays and assist us with discharge and care coordination to reduce readmissions. Providers must provide records when requested and within the required timeframe.

All clinical reviews are based on medical necessity criteria.

We may also conduct post-service reviews for medical necessity when reviews are not conducted concurrently. Documentation for review via records requests may continue, as needed, for care coordination or upon receipt of the claim(s). If a claim does not meet the guidelines for the inpatient stay, it will be denied. Facilities should rebill Medicare Advantage claims using Type of Bill 0127, following CMS guidelines. Commercial claims can be rebilled with Type of Bill 0127 or 0137, whichever is appropriate. For more information, view the:

- Medicare Benefit Policy Manual (Chapter 6): **cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf**
- MLN Matters Number MM8820: **cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1412OTN.pdf**

Other facility guidelines

Preventable Adverse Events

We follow our *Preventable Adverse Events* (Administrative #106) reimbursement policy. We also encourage the use of the World Health Organization's *Surgical Safety Checklist* at **who.int/teams/integrated-health-services/patient-safety/research/safe-surgery/tool-and-resources**.

Reimbursement of Room and Board

We follow our *Reimbursement of Facility Room and Board* (Facility #103) reimbursement policy.

Medical management

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

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

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

Outpatient hospital guidelines

Claims for all outpatient services, as defined below, must be submitted electronically in an ANSI 837I claim format using current CPT coding. Professional services that are billed in an ANSI 837P format are not affected. All claims must be submitted electronically.

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

High-technology services

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

Emergency room services

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

Rehabilitation services

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

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

The following services or items are not covered:

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

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

Pre-admission outpatient services

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

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

Outpatient reimbursement guidelines

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

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

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

Multiple surgical procedures

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

Non-reimbursable revenue codes

Unless otherwise specified in the contract:

- Clinic charges 0510-0529 are non-reimbursable.
- Revenue code 0761 must be appropriately billed. As directed in the UB-04 Editor, bill revenue code 0761 for actual use of a treatment room in which a specific procedure has been performed or a treatment rendered. Do not bill evaluation & management (E&M) CPT codes with revenue code 0761.
- E&M codes billed with revenue codes that include, but are not limited to: 0280, 0480, 0760, 0762-0769 and 0960-0989 are not reimbursable.

Freestanding ambulatory surgery centers

Freestanding ambulatory surgery centers (ASC) provide an alternative setting for surgical procedures that would otherwise be performed in a hospital on an outpatient basis.

ASCs:

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

Facility accreditation

Before reimbursement can be approved, or contracted for facility fees, a freestanding ASC must be credentialed. The freestanding ASC must have:

- A current passing state quality review survey
- A current onsite quality assessment completed by us, or
- A current passing quality review from the Centers for Medicare & Medicaid Services (CMS)

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

Reimbursement

A fee schedule is used for these claims. Fees for multiple procedures are calculated as follows:

- The code with the highest fees is reimbursed at 100%.
- The subsequent codes are reimbursed at 50% of the fee.
- Any code not subject to cuts is removed from consideration before reductions are applied.
- For any single procedure code, reimbursement is never more than the charged amount.

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

ASCs are not reimbursed for:

- Procedures usually performed in an inpatient or outpatient hospital setting
- Minor surgeries customarily performed in a physician's office and for which use of a facility is generally considered part of the physician's office overhead. (e.g., where the Relative Value Unit (RVU) assigned includes a consideration for overhead)

Billing guidelines

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

ASC facility fee services

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

- Intraocular lenses for insertion during or after cataract surgery
- Administrative functions such as scheduling or cleaning, utilities and rent
- Anesthetic and any materials, disposable or re-useable, needed to administer anesthesia
- Implants, including but not limited to the following: screws, plates, anchors, pins, and wires

- Nursing, technical staff, orderlies and others involved in patient care connected to the procedure, intravenous therapy, and other related services
- Use of facility, including operating room, recovery and/or short stay rooms, prep areas, and use of waiting rooms and lounges created for patients and relatives
- Diagnostic testing such as urinalysis, blood hemoglobin or hematocrit, pre-operative chest x-ray, and therapeutic items and services directly related to the procedure/service
- Drugs (including take home), biologicals (blood), surgical dressings, supplies, splints, casts, appliances, non-custom braces, disposable infusion pain control pump, and equipment related to the provision of care

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

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

<u>Physician charges</u>
The physician charge is the fee for performing the surgery and related diagnostic and therapeutic services. This includes the administration or the supervision of the administration of local anesthesia or IV sedation. The professional fees are billed separately by the performing physician. The facility and performing physician codes must be the same.

<u>Submitting claims</u>
- ASCs cannot append a modifier 50 when billing bilaterally. ASCs must bill bilateral procedures on two separate lines with an RT and LT modifier.
- When billing multiple procedures, each procedure will need to be billed on a separate line with a unit of 1 in order for the system to calculate correctly.

Hospice
Hospice services provide medical, nursing, and emotional care when a cure is no longer possible. Hospice care is provided by a coordinated team of professionals and may include a:

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

Hospice services may need pre-authorization for medical necessity.

Services not included in hospice care

The following services are not included. They should be billed separately by the performing provider:

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

Treatment plans

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

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

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

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

Submitting claims

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

Revenue code	Procedure code	Description
0650	S9126	Routine home care, in home, 1-7 hours (61+ days)
0651	S9126, Q5001	Routine home care, in home, 1-7 hours (1-60 days)
0652	S9125, S9126, Q5001	Continuous home care, 8-24 hours
0655	Q5003-Q5008	Respite care, Inpatient
0656	Q5003-Q5008	General inpatient hospice care
0663	S9125	Respite care, in home

Skilled nursing facilities

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

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

Admissions require pre-authorization to determine medical necessity, treatment plan, length of stay, as well as requiring ongoing concurrent reviews. It is the responsibility of the SNF to ensure that a pre-authorization is in place and completed upon admission. View the Pre-authorization section of our provider website.

Physician certification and recertification requirements

According to the Washington Administrative Code (WAC) 388-97-1260 at **apps.leg.wa.gov/WAC/default.aspx?cite=388-97-1260**, the skilled nursing facility must ensure that the resident is seen by a physician, whenever necessary. In addition except as specified in the Revised Code of Washington (RCW) 74.42.200 at **apps.leg.wa.gov/RCW/default.aspx?cite=74.42.200**, a physician must personally approve in writing a recommendation that an individual be admitted to a skilled nursing facility.

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

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

The physician must:

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

Medicare Advantage SNFs

The Medicare Advantage SNF program aligns reimbursement with quality for our Medicare Advantage SNFs. The program is based on the CMS Quality of Patient Care Star Ratings in Medicare Home Health Compare. Medicare Compare is available at **medicare.gov/care-compare**.

Quality ratings and reimbursement will be reviewed annually. Notification to facilities of changes to the percentage of Medicare allowable will be provided by June 1 each year for an October 1 effective date. Reimbursement rates will be based on an agency’s Quality of Patient Care Star Ratings for the period ending each April based on the previous calendar year’s data. Payment continues to be based on a percentage of the current CMS Home Health Prospective Payment System (PPS) fee schedule, available at **cms.gov/medicare/medicare-fee-for-service-payment/snfpps**.

CMS Star Rating	Regence quality rating	% of CMS allowable
5 Stars	Excellent	90%
4 Stars	Good	85%
2-3 Stars	Adequate	80%
1 Star	Poor	75%
*If a provider is new and does not have any published Medicare Star data available or inadequate data (e.g., too few to score), Regence will utilize the Quality Rating of Adequate.		

Note: A SNF receives a "Poor" rating based on April Quality of Patient Care Star Ratings for two consecutive periods will receive a 90-day notice terminating their agreement effective September 30 of that year. If terminated, the facility is not eligible to reapply for participation in any of our networks for two years from the end of the network participation date.

We notify our participating providers of updates to the Medicare Advantage skilled nursing facility reimbursement schedule in the June issues of our provider newsletter, *The Connection*[SM], for an October 1 effective date. Subscribe to receive an email when new issues of our publications are available on our provider website.

Notice of Medicare Non-Coverage (NOMNC) form

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

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

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

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

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

2. The patient or authorized representative signs page 2 of the NOMNC. If the patient is unable to sign and the SNF or home health agency is working with an authorized

representative who is unable to be present that day, the SNF or home health agency may issue the NOMNC by telephone. For a telephonic notice to be valid, the documentation on the NOMNC must include all of the following:

- The name of the staff person initiating the contact
- The name of the representative contacted by phone
- The date and time of the telephone contact
- The telephone number called
- A notation that full appeal rights were given to the representative

The date of the telephone conversation is the date of the receipt of the notice. The facility or agency must confirm the telephone contact by sending written notice to the authorized representative on that same date.

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

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

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

Home health

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

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

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

Home health care is subject to the following limitations:

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

Please verify the patient's eligibility and benefits. Home health services may require pre-authorization for medical necessity; refer to the Pre-authorization section of our provider website.

Billing guidelines

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

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

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

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

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

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

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

Submitting claims

- CPT/HCPCS codes with descriptions reading “per hour” will be reimbursed as one unit of service per day.
- The date of service should be the date of drug administration—not the date of shipment.
- Include all charges for each month on one claim. Do not overlap calendar months or years.
- When billing for drugs use the National Drug Code (NDC) number and appropriate "J" code.
- There are certain infusion medications that require pre-authorization by us. Please refer to our drug formulary for the most current list.
- Charges for sales tax are not eligible for benefit consideration, except durable medical equipment defined by Washington state Senate Bill 6273 at **apps.leg.wa.gov/billinfo/summary.aspx?year=2010&bill=6273**.
- Retail drugs will not be reimbursed through the infusion therapy contract. Claims for retail drugs must be submitted through our pharmacy drug care program.

Treatment plans

Treatment plans and progress notes may be requested for selected patients. We reserve the right to review past records and claims submissions. We require fully documented treatment plans that may include but are not limited to:

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

Pre-authorization

Use the electronic authorization tool on Availity Essentials to see if a pre-authorization is required for a medical service or submit your request. Refer to the Pre-authorization section of our provider website for specific requirements. Generally, pre-authorization requests should be submitted five to seven days before the subsequent episode begins. Requests should include the original Outcome and Assessment Information Set (OASIS) and the completed medication reconciliation form, both signed by the physician.

Medicare Advantage home health agencies

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

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

If a provider location has a CMS Star Rating that falls between two levels, Regence will round up to the next Star Rating and reimburse at the respective provider quality rating and percentage of CMS allowable. For example, a 4.5 Quality of Patient Care Star Rating will be rounded to 5 Stars, considered as an "Excellent" quality rating and reimbursed at 105% of the CMS allowable.

CMS Star Rating	Regence quality rating	% of CMS allowable
5 Stars	Excellent	105%
4 Stars	Good	85%
2-3 Stars	Adequate	75%*
1 Star	Poor	70%
*If a provider is new and does not have any published Medicare Star data available or inadequate data (e.g., too few to score), Regence will utilize the Quality Rating of Adequate.		

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

We notify our participating providers of updates to the Medicare Advantage home health reimbursement schedule in the October issues of our provider newsletter, *The Connection*, for a January 1 effective date. Subscribe to receive an email when new issues of our publications are available on our provider website.

Notification requirements for Medicare Advantage home health agencies

In accordance with Medicare guidelines, home health agencies are required to submit a notice of admission (NOA) within five calendar days from the start of care date. There is a reduction in payment amount for late NOA submission. CMS instructions to submit the NOA can be located in the MLN Matters Article, *Replacing Home Health Requests for Anticipated Payment (RAPs) with a Notice of Admission (NOA) – Manual Instructions*, on the CMS website: **cms.gov/files/document/mm12256.pdf**.

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

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

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

These forms are available on the CMS website at: **cms.gov/Medicare/Medicare-General-Information/BNI**.

Home infusion therapy

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

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

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

<u>Wastage policy</u>
Medicine mixed and delivered to the patient but not used must be billed by using the J code with modifier JW and the National Drug Code (NDC) number.

<u>Per diem rate includes</u>

- Lab draws
- Setup and disposal
- Administrative overhead
- Clinical pharmacy services
- Delivery of medication and supplies
- Pharmacy compounding and dispensing fees
- Intravenous solutions, diluents and compounding ingredients
- Equipment (e.g., IV pumps, poles), ancillary medical supplies (e.g., syringes, tubing) and nursing supplies (e.g., catheter care kits, catheter-flushing solutions, dressings)

<u>Nursing services include:</u>

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

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

Durable medical equipment and prosthetic devices

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

DME refers to equipment that is:

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

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

The provider also agrees to the following additional responsibilities:

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

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

- If a patient's life is threatened by a sudden equipment malfunction, emergency services are available 24 hours a day, seven days a week.
- If the performance and intended use of the equipment is affected by a sudden malfunction, services for repair or replacement are available 24 hours a day, seven days a week.

- If the performance and intended use of the equipment is not affected by a sudden malfunction, services for assessment, repair or replacement (when applicable) are available within five business days.
- Emergency backup systems for electrical equipment are provided either through a manual means or a self-contained battery integral to the equipment.
- The medical equipment, items and supplies are safe, sanitary and working as intended for use in the patient's home. The provider will complete a written assessment at the time of delivery and ensure that the medical equipment, items or supplies are appropriate for use within the patient's home.

The provider shall provide education appropriate to the medical equipment, items and/or supplies provided and shall document ongoing education of the patient, family members and care givers, including but not limited to the following:

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

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

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

<u>Dispensing codes</u>
Dispensing codes are not eligible for separate reimbursement.

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

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

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

Oxygen and Oxygen Equipment

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

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

Sales tax

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

Please note the following billing information:

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

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

Rental/purchase guidelines

Rental

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

Purchase

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

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

Additional modifiers

When appropriate, use the following modifiers when billing for DME services. If more than one modifier is used, place the modifier in the first position or directly after the procedure and/or HCPCS code.

- Modifier AW *Items furnished in conjunction with surgical dressings*
- Modifier KM *Replacement of facial prosthesis including new impression/moulage*
- Modifier KN *Replacement of facial prosthesis using previous master model*

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

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

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

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

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

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

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

It is the responsibility of the provider to inform the patient that there are standard products available that meet medical necessity. The patient must sign a waiver indicating that he or she has been informed of his or her responsibility for any outstanding balance prior to ordering the product or before the product is delivered. If the patient does not sign a waiver, the outstanding balance will be a provider write-off. The provider should keep this waiver on file and submit it with their invoice if requested.

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

If a member is requesting a deluxe item that is medically necessary—such as a deluxe hearing aid—that exceeds the cost of the device, please bill as follows:

- Report the appropriate HCPCS code and standard charge for the least expensive device that meets the member’s medical needs and is considered medically necessary on the first line of the claim.
- Report code S1001 *Deluxe item, patient aware (list in addition to code for basic item)* and the balance between the base model considered medically necessary and the deluxe model on the second line of the claim.

- Before providing service, have the member sign a waiver indicating they are aware that the deluxe model is not covered by their insurance and that they will be liable for the difference in cost between the deluxe and standard charges.

Pre-authorization
Pre-authorization may be required. View our pre-authorizations lists, forms and submission information on our provider website.

Orthoses
Custom-made, functional orthotics are covered when they are medically necessary to treat a condition of the foot, ankle or leg. Prefabricated, supportive, accommodative and digital orthotics are not covered on most of our products.

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

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

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

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

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

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

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

Criteria, documentation requirements, CMN forms and instructions for completing the forms are available in chapter 4 of the Supplier Manual at **med.noridianmedicare.com/web/jddme/education/supplier-manual** from Noridian Heathcare Solutions. Noridian has also made several documentation checklists at **https://www.noridianmedicare.com/dme/coverage/checklists.html**, available for various DME, to help ensure compliance with the requirements.

We do not require the CMN to be submitted with the DME claim.

Sleep Centers
Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) are not eligible for reimbursement under the Sleep Center contract. If a Sleep Center is Medicare certified as a DME provider, they may be eligible for credentialing and contracting as a DME provider.

Ambulance

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

Levels of Ambulance Services

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

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

Transportation by air is considered medically necessary when:

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

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

Cabulance Services
Cabulance services are available for non-emergent transport of medically stable patients who cannot otherwise use private transportation without endangering their safety. Eligible services include:

- Medically stable patients via wheelchair with portable oxygen, a non-active IV, hep lock, Foley catheter or NG tube.

- A patient who is non-ambulatory, medically stable and requires movement by wheelchair or the patient is ambulatory but requires assistance to transfer.

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

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

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

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

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

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

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

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

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

Note: When in the course of transporting a patient to a hospital, the ambulance stops at the provider's office, the claim will be reviewed for medical necessity.

Urgent Care Clinics

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

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

<u>Qualifying Criteria for categorization as an Urgent Care Clinic</u>

Availability and capability

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

Building and equipment

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

Staffing

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

Licensure and compliance

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

If your clinic meets the criteria above and is interested in being designated as an Urgent Care Clinic, please update your information through the Self-Service Tool on our provider website: Quick Links>Self-Service Tool. You may also call our Provider Contact Center:

- For Uniform Medical Plan, call 1 (888) 894-3682
- For all other lines of business, call 1 (800) 253-0838

Retail Clinics

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

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

<u>Qualifying Criteria for categorization as a Retail Clinic</u>

Availability and capability

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

Building and equipment

- The clinic has at least one exam room and a separate waiting area.

Staffing

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

Licensure and compliance

- The clinic is licensed by the state in which it is located, if the state requires such licensure.

- The clinic complies with applicable federal, state and local laws and regulations.
- Joint Commission Accreditation is preferred.

If your clinic meets the criteria above and is interested in being designated as a Retail Clinic, please update your information through the Self-Service Tool on our provider website: Quick links>Self-Service Tool. You may also call our Provider Contact Center:

- For Uniform Medical Plan, call 1 (888) 894-3682
- For all other lines of business, call 1 (800) 253-0838

Behavioral Health

Behavioral health facilities must meet the contracting service requirements for each level of service in the delivery of mental health (including eating disorders) and substance use treatment. Facilities must be licensed for the level(s) of care they provide in the state where services are rendered. Medical necessity determinations are based on applicable criteria:

- **Level of Care Utilization System (LOCUS)**: Adult mental health levels of care
- **Children and Adolescent LOCUS (CALOCUS)**: Children and adolescents ages 6 to 18
- **Early Childhood Service Intensity Instrument (ECSII)**: Children younger than 6
- **American Society of Addiction Medicine (ASAM)**: Substance use disorder (SUD) levels of care, all ages
- **Our medical policies**: Applied behavior analysis (ABA) and transcranial magnetic stimulation (TMS) services

All treatment should be individualized to meet the member's needs.

Our medical policies are available on our provider website.

- **Commercial policies**: Policies & Guidelines>Medical Policy>Explore Commercial Policies>Continue to the Medical Policy Manual>Table of Contents>Behavioral Health.

- **Medicare Advantage policies**: Policies & Guidelines>Medical Policy>Explore Medicare Advantage Medical Policy>Continue to the Medicare Advantage Policy Manual>Table of Contents>Behavioral Health.