Claims Payment Policies and Notices

The purpose of this document is to advise all providers of the claim payment policies followed by PrimeCare Medical Network, Inc. ("PMNI") and NAMM California, its capacity as a Management Services Organization (MSO) for its contracted IPA's.

Medicare Guidelines

Commercial and Medicare Claims payment process is in accordance with Medicare guidelines as indicated below and paid according to current Medicare Fee Schedule, unless otherwise specified in provider's contract.

- Center for Medicare & Medicaid Services (CMS) guidance, including but not limited to Medicare Provider Reimbursement Manual (PRM) – relating to charge and cost reporting guidelines. Internet-only manuals (IOM) relating to Medicare coverage, benefits, coding, billing and payment, CMS Transmittals, MLN Matters Articles, frequently asked questions, Medicare contractors, National Correct Coding Initiative (NCCI), Medically unlikely Edits (MUE), National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).
- National benchmarks & industry standards
- National Uniform Billing Committee (NUBC) Guidelines
- American Medical Association (AMA) / Current Procedural Terminology (CPT®)
- Healthcare Common Procedure Coding System (HCPCS)
- International Classification of Disease, 9th edition/Revision (ICD-9) code sets
- Diagnosis Related Group (DRG)
- National Drug Codes (NDC)
- National Health Care Billing Audit Guidelines
- Charge Master Guidelines as they relate to and define services billed.
- UB-04 Data Specifications Manual ICD-9-CM Official Guidelines for Coding and Report
- Uniform Billing (UB) Editor
- American Society of Anesthesiologists (ASA) relative values for the basic coding, regarding Provider, Vendor and Facility claims.

This policy applies to all Heath Care Services billed on either a CMS 1500 / UB04 form, 837p/837i or future claim form.

Definitions:

NCCI – National Correct Coding Initiative comprised of three types of edits: NCCI Procedure to Procedure (PTP), Medically Unlikely Edits (MUE) & Add-on Code Edits.

PTP – (Procedure to Procedure) Identification of services not appropriately billed together. If a provider reports the two codes of an edit pair for the same beneficiary on the same date of service, the column one code is eligible for payment but the column two codes is denied unless a clinically appropriate NCCI – associated modifier is billed.

Modifiers – NAMM recognizes the following NCCI designated modifiers as it relates to Medicare PTP edits:

27	LM	F3	RC	T4		
58	E1	F4	RI	T5		
59	E2	F5	TA	T6		
78	E3	F6	T1	T7		
79	E4	F7	T2	T8		
91	FA	F8	T3	T9		

Modifiers offer specific information and should be used appropriately

MUE – A unit of service edit applied to both HCPCS and CPT codes and defines the maximum units of service that a single provider/supplier would report under most circumstances for an individual one singe date of service.

Medically Unlikely Edits (MUE) – these are units-of-service edits for practitioners, ambulatory surgical centers, outpatient hospital services, and durable medical equipment. This component defines for each HCPCS/CPT code the number of units of service that is unlikely to be correct.

Add-on Code Edits – consist of a listing of HCPCS and CPT add-on codes with their respective primary codes. An add-on code is eligible for payment if and only if one of its primary codes is also eligible for payment.

ME Edits – Many procedure codes cannot be reported together because they are mutually exclusive of each other. Mutually exclusive procedures cannot reasonably be performed at the same anatomic site or same patient encounter.

Charges – Medicare Provider Reimbursement Manual, section 2202.4 states:

- Charges refer to the regular rates established b the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient. All patients' charges used in the development of apportionment rations should be recorded at the gross value; i.e., charges before the application of allowances and discounts deductions.

Routine Services – Medicate Provider Reimbursement Manual, Section 2202.6 states:

- "Inpatient routine services in a hospital or skilled nursing facility generally are those services included in the daily service charge – sometimes referred to as the "room and board" charge. Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made."

Routine Medical/Surgical Supplies – Considered to be packaged into the procedure or room charge and should not be separately billable to NAMM. These items are customarily used during the course of treatment as needed, are stocked at the nursing station or in floor bulk stock and generally available to all patients receiving supplies in that location and are not tracked individually. (e.g., alcohol preps, applicators, band – aids, Maalox, aspirin and other non legend drugs ordinarily kept on hand, suppositories and tongue depressors, gloves, paper masks, chux/linen savers, cotton balls).

Routine Nursing Services – All general nursing services, including administration of oxygen and related medications, monitoring patients, hand feeding, incontinency care, tray service, enemas, and other bedside nursing services.

Routine Laboratory Services – Routine specimen collections

Routine Pharmacy Services – Flush and Irrigation supplies

Ancillary Services – Medicare Provider Reimbursement Manual, Section 2202.8 states:

- Ancillary services in a hospital or SNF include laboratory, radiology, drugs, delivery room (including maternity labor room), operation room; (including post anesthesia and post operative recovery rooms), and therapy services (physical, speech, occupational). Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge.

Capital Equipment & Monitors/Pumps – Equipment commonly available to patients in a particular setting or ordinarily furnished during the course of a procedure is considered routine and not billed separately. Supplies used in conjunction with the equipment are also considered routine. The cost of the equipment should be incorporated into the charge for the procedure.

Dietary Services – Dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as prescription items by a physician.

Patient Convenience Items – Items that do not meaningfully contribute to the treatment of patient's illness or injury or the functioning of a malformed body member.

Supplies – Items which are utilized by individual recipients but which are reusable and expected to be available in an institution providing a skilled level of care: e.g., ice bags, bedrails, canes, crutches, walkers, wheelchairs, IV poles and pumps, traction equipment and other durable medical equipment.

Criteria for Billing Services:

- Must be medically necessary and furnished at the direction of a physician. Documentation in the patients' medical records must be provided.
- Must be covered in accordance with current Medicare regulations and guidelines.
- Uses of non-FDA-approved procedure/drug/services are considered investigational and are non-covered services.

Billed Charges – Represent allowable charges for billable items that are in accordance with all regulatory agencies or coding references listed above. Routine and non-chargeable items shall be eliminated from the itemized statement.

CPT Standardization and Format

Standard CPT Guidelines are followed by PMNI and NAMM California in processing of all claims. CPT Plus has educational sections for identifying coding fundamentals and CPT coding and billing issues and is revised on an annual basis.

Administration and adjudication of claims is performed in the most current year of CPT Plus.

CPT Plus utilizes a color coded format for the identification of the following:

- Separate procedure
- Unlisted codes
- Non-specific codes
- Correct Coding Initiative (CCI) to identify services included in primary procedure

CPT Plus identifies codes added or deleted each year. PMNI and NAMM California allows a 3 month grace period each year (first quarter) for the transition of codes new to CPT, or deleted from previous year. Once the grace period has expired, claims with expired codes will be rejected for accurate coding.

CPT guidelines provide clear criteria for the Evaluation and Management codes, setting standards for providers and supporting documentation needed when billing E&M codes. PMNI and NAMM California may request additional "relevant" records to support higher levels of care than those services authorized.

Administration of Immunizations and Injectable Medication

Administration of immunizations and injectable medication are not separately payable services unless clearly specified in the individual contract. If the service is provided during the course of a routine office visit, the visit will be compensated by either monthly capitation payments or contracted fee schedule.

Coordination with Other Payers

Benefits will be coordinated with other carriers when we are notified the enrollee has other insurance. Please refer to your individual contract for information on Coordination of Benefits (COB).

Other Billing and Payment Criteria

Services provided to any enrollee must meet the contractual requirements, or a denial may be issued. These requirements include, but are not limited to:

- Referral or prior authorization
- Submission of invoice

All standard elements as required to process a claim (see section on claim submission found in the downstream provider notification).

All payments and co-payments are subject to the benefit information as defined by the enrollee's employer group specific benefit plan. Claims payment is always dependent on member eligibility status for date of service.

Should provider bill less than agreed upon contractual amounts or based on PMNI's Usual and Customary payment schedules; payment will be made in the amount of the provider's allowable billed charge.

Format and Coding

Anesthesia:

- Anesthesia is processed following the ASA guidelines. One (1) unit is equal to 15 minutes up to four (4) hours. After four (4) hours, one (1) unit is equal to 10 minutes. Obstetrical anesthesia units are equal to 15 minutes regardless of the duration.

Claim Forms:

- Hospital and Facility vendors are required to bill on a UB04 claim form. Professional providers are required to ill on a CMS Form 1500. Claims from ambulatory surgery centers may be submitted on a UB04 or on a CMS Form 1500 if appropriate modifier is used (SG or TC). Electronic claims are accepted via the HIPAA standard format via the contracted clearinghouse.

Coding:

- Codes must be submitted using the appropriate codes as published in the AMA's CPT Level I, HCPCS Levels II and III, ICD-10CM and Revenue codes.

Fee Schedules:

- Unless otherwise stated per contract, reimbursement is based on the current Medicare Fee Schedule for the appropriate geographical area. For Medicare Fee Schedule and related information go to http://www.medicarenhic.com/cal_prov/fee_sched.shtml or http://cms.hhs.gov/providers/pufdownload/#dme for DMEPOS Fee Schedule.
- Provider contracts specifying reimbursement at AWP are paid utilizing the Medicare Fee Schedule plus 5%.
- If there is not a Medicare allowable for the service, the service is paid at 60% of billed charges unless contract has specific language.

Global Period:

- Services rendered within the pre and post global period are included in the global rate. Procedure specific global periods are published in the Federal Register (http://www.gpoaccess.gov/fr/index.html). The standards listed in the AMA's CPT Surgery section are followed for surgical global packages.

Modifiers:

- Industry standard modifiers as published by the American Medical Association are acceptable for billing. The Correct Coding Initiate (CCI) guidelines for claims payments and use of modifiers are utilized when adjudicating claims.
- CPT defines the standard, acceptable modifiers to be used for professional claims.
- HCPCS also includes acceptable modifiers for services not defined by CPT.
- PMNI and NAMM California accept all modifiers published by CPT and HCPCS.

Multiple Procedures:

- Multiple surgeries performed by the same physician on the same patient during the same operative session are reimbursed at 100% of the contracted rate for the highest valued procedure, 50% of the contracted rate for the secondary procedure and 25% of the contracted rate for all tertiary procedures.

Unbundling and Up Coding:

- CCI edits are followed for identification of unbundled and up coded services. PMNI and NAMM California uses Claim Editing System (CES) software to evaluate claims for unbundling and up coding.
- For more information on the proprietary CES software, you may visit the website at http://www.optum.com/health-plans/operations/payment-integrity/pre-payment.html

The above information represents the standard claim processing policies approved and used by PMNI and utilized by NAMM California to administer claims for its contracted IPA's. Please refer to your contract for any negotiated modification to these policies.