# CLAIMS PAYMENT POLICIES AND NOTICES

The purpose of this document is to advice all providers of the claim payment policies followed by ProMed Health Care Administrators and its capacity as a Management Services Organization (MSO) for its contracted IPA's. To administer and adjudicate claims the most current year "CPT Plus" manual for coding standards and formats is utilized.

## CPT Standardization and Format

Standard CPT Guidelines are followed by ProMed Health Care Administrators in the 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.

CPT Plus utilizes a color-coded format for the identification of:
- 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. ProMed Health Care Administrators 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. ProMed Health Care Administrators 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

• Eligibility Status

• Submission of Invoice

All standard elements are 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.

## 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 bill 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.

### Coding

Codes must be submitted using the appropriate codes as published in the AMA's CPT Level I, HCPCS Levels II and III, ICD-9-CM and Revenue codes.

## Fee Schedule

• Senior Members: Unless otherwise stated per contract, reimbursement for Senior Members is based on the current Medicare Fee Schedule for the appropriate geographical area. If there is not a Medicare allowable for the service, the service is paid at 40% of billed charges unless contract has specific language.

• Commercial and POS Members: Unless otherwise stated per contract, reimbursement for Commercial Members is based on 125% of the current Medicare Fee Schedule for the appropriate geographical area. If there is not a Medicare allowable for the service, the service is paid at 40% of billed charges unless contract has specific language.

• For Medicare Fee Schedule, DMEPOS Fee Schedule and related information go to: http://www.cms.gov/Medicare/Medicare.html

• Medi-Cal Members: Unless otherwise stated per contract, reimbursement is based on the current Medi-Cal Fee Schedule for the appropriate geographical area. For Medi-Cal Fee Schedule and related information go to: http://www.medi-cal.ca.gov/default.asp. If there is not a Medi-Cal allowable for the service, the service is paid at 12% of billed charges unless contract has specific language.

• Assistant Surgeon Reimbursement: Unless otherwise stated per contract, the fee schedule amount equals 16% of the amount otherwise applicable for the global surgery.

**Global Period**

Procedures with defined global periods are reimbursed according to Medicare guidelines. Components of a global surgical package include:

• Preoperative Visits: visits after the decision is made to operate beginning with the day before the day of the surgery for major procedures and the day of surgery for minor procedures;

• Intra-Operative Services: services that are normally a usual necessary part of a surgical procedure;

• Complications Following Surgery: all additional medical or surgical ser ices required of the surgeon during the postoperative period of the surgery because of the complications which do not require additional trips to the operating room;

• Postoperative Visits: follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery;

• Postsurgical Pain Management: by the surgeon;

• Supplies: except those identified as exclusions; and

• Miscellaneous Services: items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes drains, casts, and splints; insertion irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

## Modifiers

Industry standard modifiers as published by the American Medical Association are acceptable for billing. The Correct Coding Initiative (CCI) guidelines for claims payment 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.
ProMed Health Care Administrators accepts 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.

The above information represents the standard claims processing policies approved and utilized by ProMed Health Care Administrators to administer claims for its contracted IPA's. Please refer to you contract for any negotiated modifications to these policies.