Reimbursement Policies 2019

Reimbursement Policies

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Bundled Services

Decent considers payment for certain services to be already factored into the reimbursement for other services. Decent will not make a separate payment for the bundled service when conducted by the same provider in the same session.

Bundled Services The following services are not separately payable when billed on the same day with a service that they are identified as being bundled into.

- Codes identified with status code 'B' or 'T' in the National Physician Fee Schedule RVU file are always considered bundled
- Codes Identified with status code 'P' in the National Physician Fee Schedule RVU file are bundled into any service rendered outside the patient's home
- Routine Venipuncture is bundled into any other rendered service
- Cast supplies are bundled into custom foot orthotics
- CT guidance for insertion of radiation therapy fields is bundled into management of radiation therapy
- Continuous Intraoperative monitoring inside the OR is bundled into continuous Intraoperative monitoring outside the OR
- Diagnostic esophagogastroduodenoscopy (EGD) is bundled into laparoscopy, surgical, and gastric restrictive procedures
- Digital analysis of electroencephalogram (EEG) is bundled into monitoring for localization of cerebral seizure focus
- Electrical stimulator supplies are bundled into electrical stimulation modalities
- Electrodes are bundled with other services such as electrocardiograms (ECG), electroencephalograms (EEG), stress tests, sleep studies, electrical stimulation modalities, and acupuncture
- Electrodes and lead wires are bundled into electrical stimulator supplies
- Electrodes reported are bundled into conductive gel or paste
- Electroencephalograms and intraoperative neuromonitoring are bundled into electrocorticography
- Electromyography is bundled into intraoperative neuromonitoring
- Home infusion therapy professional pharmacy services, drug administration, equipment, and/or supplies are bundled into any per diem home infusion therapy (HIT) service
- Intravenous vascular introduction is bundled into injection and infusion services
- Major arthroscopic knee synovectomy is bundled into arthroscopic knee surgeries
- Needles are bundled into acupuncture services
- Open capsulectomy is bundled into delayed insertion of breast prosthesis
- Radiological supervision and interpretation of transcatheter therapy is bundled into injection of sclerosing solution
- Regional or local anesthesia is bundled when performed within a physician office
- Removal of impacted earwax is bundled with audiologic function testing
- Replacement soft interface material is bundled with continuous passive motion devices
- Needles and injection supplies are bundled with injection and infusion services
- Time based therapeutic behavioral services are bundled with per diem therapeutic behavioral services
- Therapeutic, prophylactic, and diagnostic injections and infusions are bundled with nuclear medicine testing
- Tissue markers are bundled with placement of breast localization device(s) and/or percutaneous placement of breast localization device(s)
- Ultrasonic guidance for needle placement is bundled with codes defined as including ultrasonic guidance

Coding Categories identified above include, but are not limited to, the below codes.

Code Description	Codes
Cast Supplies	A4580, A4590, S0395
Routine Venipuncture	36415
Custom Foot Orthotics	L3000, L3010, L3020, L3030
CT Guidance for insertion of Radiation Therapy Fields	77014
Management of Radiation Therapy	77280, 77285, 77290
Continuous Intraoperative Monitoring inside the OR	95940
Continuous Intraoperative Monitoring outside the OR	95941
Diagnostic Esophagogastroduodenoscopy (EGD)	43235
Laparoscopy, Surgical, and Gastric Restrictive Procedures	43770-43775
Digital Analysis of Electroencephalogram (EEG)	95957
Monitoring for Localization of Cerebral Seizure Focus	95950-95956
Electrical Stimulator Supplies	A4595
Electric Stimulation Modalities	97014, 97032
Electrodes	A4556
Electrocardiograms (ECG)	93000, 93227, 93228, 93005, 93229, 93010, 93268, 93025, 93270 93224, 93225, 93226,
Electrocorticograms	95829
Electroencephalograms (EEG)	95812, 95813, 95816, 95819, 95822, 95824, 95827, 95829, 95950, 95951, 95953, 95954, 95955, 95956, 95957, 95958, 95961, 95962
Electromyography	95860, 95861, 95867, 95868, 95870
Stress Tests with ECG	93015, 93016, 93017, 93018
Sleep Studies	95800-95807

Acupuncture	97810-97814
Lead Wires	A4557
Conductive Gel and Paste	A4558
Home Infusion Therapy Professional Pharmacy Services for Drug Administration	S9810
Home Infusion Therapy Equipment and Supplies	A4221, A4222, E0776, E0781
Per Diem Home Infusion Therapy Service	S5492-S5502, S9061, S9325-S9379, S9490-S9504, S9537-S9590
Intravenous Vascular Introduction	36000
Injection and Infusion Services	96360, 96365, 96374, 96375, 96376, 96405, 96406, 96409, 96413, 96416, 96440, 96446, 96450, 96542
Major Arthroscopic Knee Synovectomy	29876
Arthroscopic Knee Surgeries	29880-29883
Needles	A4215
Open Capsulectomy	19371
Delayed Insertion of Breast Prosthesis	19342
Radiological Supervision and Interpretation of Transcatheter Therapy	75894
Injection of Sclerosing Solution	36468, 36469, 36470, 36471, 45520, 46500
Regional or Local Anesthesia	J2001, J3490
Removal of Impacted Earwax	69210, G0268

Audiologic Function Testing	92551-92557, 92561-92588, 92596
Replacement Soft Interface Material	E1820
Continuous Passive Motion Devices	E0935-E0936
Injection Supplies	A4206-A4209, A4212, A4213, A4215-A4217, A4221-A4223, A4244-A4248, A4550, A4649, A4657, A4930
Time based Therapeutic Behavioral Services	H2019
Per Diem Therapeutic Behavioral Services	H2020
Therapeutic, Prophylactic, and Diagnostic Injections and Infusions	96365, 96369, 96372-96374, 96379
Nuclear Medicine Testing	78012-79999
Tissue Marker	A4648
Placement of Breast Localization Device(s) and/or Percutaneous Placement of Breast Localization Device(s)	19081-19101, 19281-19288
Ultrasonic Guidance for Needle Placement	76942
Codes defined as including Ultrasonic Guidance	10030, 19083, 19285, 20604, 20606, 20611, 27096, 32554-32557, 37760, 37761, 43232, 43237, 43242, 45341, 45342, 64479-64484, 64490-64495, 76975

Add-on Codes

Add-on codes are specific supplemental codes that describe services provided by a physician in addition to the primary service. Add-on codes are performed by the same physician during the same patient encounter.

Decent will only reimburse add-on codes if the correct primary code is billed and eligible for payment.

Add-on codes must be reported on the same claim as the primary code. The primary code must also be related and appropriately paired with the correct add-on code based on the CMS Add-on edit tables.

If an add-on code is billed with the incorrect primary code or without a primary code, it is not eligible for reimbursement. There is no modifier that can bypass a denial for an add-on code violation.

Clinical edits for the primary code can also affect the add-on codes. Per NCCI guidelines, if a clinical edit is applied to a primary code and prevents it from being paid, the add-on code will not be paid.

Decent follows CMS guidelines to determine primary / add-on code pairings.

Drug Testing

Drug testing describes measuring for the presence or quantity of a drug in a patient's system.

- Drug Test Codes Decent only reimburses for specific, multiple drug class CPT and HCPCS codes for presumptive and definitive drug tests, as outlined below. Decent considers all other drug testing codes to be unbundled and will not be reimbursed if billed.
- Definitive Testing Requirement Definitive drug testing services will be reimbursed only when conducted after a positive presumptive drug test.
- Quantity Limits Decent will reimburse up to one definitive or one presumptive drug test per date of service, limited to 20 reimbursable units total per plan year.
- Bundled Services The following services are not separately payable when billed on the same day as specific drug

testing services.

- Column chromatography/mass spectrometry is bundled into presumptive and definitive drug tests

Categories identified above include, but are not limited to, the below codes.

Code Description	Codes
Presumptive Drug Test	80305-80307, G0477-G0479
Definitive Drug Test	G0480-G0481, G0659
Column Chromatography/Mass Spectrometry	82541-82544
Unbundled Codes (not reimbursed)	80150-80203, 80320-80374

Non-Reimbursable Services

Decent does not reimburse for the procedures or categories of codes outlined in this policy. This list is not all-inclusive. Denials include non-covered services defined as exclusions in the member's evidence of coverage (EOC), payment included in the allowance of another service (i.e., global) and procedure codes submitted that are not eligible for payment.

- **Category II CPT Codes (XXXXF)** These codes are intended to facilitate data collection about quality of care. Use of these codes is optional, not required for correct coding, and may not be used as a substitute for Category I codes.
- **Category III CPT Codes (XXXXT)** Temporary codes for emerging technology, services and procedures. Services should be resubmitted with an unlisted code. Supporting documentation is required with the claim.
- **Non-Professional Component Codes with Professional Modifier** Decent does not reimburse codes identified by CMS as having no professional component (PC/TC Indicator of 3,4, or 9) when billed with a -26 modifier.
- **Separate Technical Component Services at Facility Place of Service** Decent does not reimburse technical component services billed separately from the facility claim when performed in a facility place of service.
- **PC/TC Indicator 5 Codes** Decent denies "Incident To" codes identified with a CMS PC/TC indicator 5 in the NPFS when reported in a facility place of service when billed by a physician. Modifiers -26 and TC cannot be used with these codes.
- **Measurement and Reporting Codes** Decent will not reimburse measurement codes (codes with RVU status indicator of 'M' or listed below as a measurement and reporting code).
- **Private Payer Codes (SXXXX)** Decent's standard policy is to not reimburse private payer codes.
- **OPPS Codes (CXXXX)** Decent's standard policy is to not reimburse OPPS codes when billed on a HCFA-1500 form.
- **Miscellaneous Non-Reimbursable Codes** Decent does not reimburse the below codes when billed on a HCFA-1500 form.
- **Obsolete and Unreliable Tests and Procedures** Decent does not reimburse obsolete and unreliable tests and procedures that are outdated and no longer the standard of care.

Coding Categories identified above include, but are not limited to, the below codes.

Code Description	Codes
3D Radiographic Procedures	76376, 76377
Placental Protein Test	84112

Hospital Mandated On-Call Service	99026, 99027
Prolonged Standby Service	99360
Physician Supervision of Hospice Services	99378
Sterile Water, Saline and/ or Dextrose	A4216, A4218
Permanent Implantable Contraceptive Intratubal Occlusion Device(s) and Delivery System	A4264
Gravlee Jet Washer	A4470
Vabra Aspirator	A4480
Surgical Supply; Miscellaneous	A4649
Implantable Radiation Dosimeter, each	A4650
Monitoring Feature/Device	A9279
DME Delivery, Set Up, and/or Dispensing Service	A9901
Blinded Procedure for Lumbar Stenosis	G0276
Trauma Response Team associated with Hospital Critical Care Services	G0390
Molecular Pathology Procedure	G0452
Inpatient Telehealth Pharmacologic Management	G0459
FQHC Visit Codes	G0466-G0470
Face-to-Face Behavioral Counseling for Obesity	G0473
Measurement and Reporting Codes	G3595-G9999
Specimen Handling	H0048, P9603, P9604
Heparin Lock Flush	J1642
Pharmacy Supply Fee	Q0511, Q0512
Obsolete or Unreliable Tests and Procedures	55725, 82024, 82150, 82495, 82930, 82965, 85345,85347, 85348, 86185, P2028, P2029, P2033, P2038,
Payment Policies – Non Reimbursable Services	30210, 38530, 43754, 43755, 51020, 51030,
Facility Place of Service	19,21,22,23,24,26,34,51,52,56,61

Surgical Techniques

Surgical techniques are methods that utilize supplemental devices or practices to conduct a surgical procedure.

Robotic Assisted Surgery

Decentdoesnot separatelyreimburseRoboticAssistedSurgery (HCPCSCodeS2900), asitisintegraltotheprimary surgicalprocedure.

Operating Microscope

Decent does not separately reimburse the use of an operating microscope (CPT Code 69990) during surgery, considering it integral to the primary surgical procedure.

Transfers

In cases where a patient is transferred during an inpatient stay to the home or another facility, Decent reimburses both the transferor and the transferee, subject to reimbursement adjustments.

For inpatient stays reimbursed using a DRG base rate, Decent reimburses the transferor the lesser of an adjusted per diem rate and the standard DRG rate. The per diem rate is calculated depending on the DRG assigned for stay for the

transferring facility and the type of facility or service to which the patient is transferred. The transfer information is determined from the patient discharge status code.

- **Transfers to Acute Care Facilities** The adjusted per diem rate is calculated by dividing the standard rate by the geometric mean length of stay for the assigned DRG. The date of admission is counted as as two days and each subsequent day counts as a single day for calculating the adjusted per diem payment. This payment is used for all DRGs where the patient is transferred to a short term general hospital for inpatient care or a Critical Access Hospital.

  The receiving provider is paid at the standard rate.

- **Transfers to Post-Acute Care Facilities** or Services The adjusted per diem rate is calculated by dividing the standard rate by the geometric mean length of stay for the assigned DRG. The date of admission is counted as as two days and each subsequent day counts as a single day for calculating the adjusted per diem payment. This payment applies to DRGs designated by CMS as post-acute DRGs when a patient is transferred to a skilled nursing facility, home care of organized home health service organization, an inpatient rehabilitation facility, a long term care hospital, a psychiatric hospital or psychiatric distinct unit of a hospital, or another type of institution not otherwise referenced in this document for inpatient care. Transfers to post-acute care facilities or services with an assigned DRG designated as a special pay DRG by CMS are subject to a blended transfer rate. This per diem rate is calculated using 50% of the standard DRG rate plus 50% of the adjusted per diem rate outlined above.

  The receiving provider is paid at the standard rate.

- Transfers from Stand-Alone Emergency Facilities In the event a member is transferred from a stand-alone emergency facility to an inpatient admission, the payment to the stand-alone facility is subject to reimbursement adjustments. For transfers within the same system, the outpatient visit is not separately reimbursable and is considered to be included in the payment for the inpatient admission. For transfers between unaffiliated facilities, the outpatient visit is subject to a 50% reduction in allowed amount. For the purposes of this policy, stand-alone emergency facilities are facilities that have limited or no inpatient beds, cannot provide trauma or intensive care treatment, and have limited surgical capabilities.

Coding Categories identified above include, but are not limited to, the below codes.

Codes	Patient Discharge Status Code Description
02 66	Discharged/ transferred to other short term general hospital for inpatient care. Discharged/transferred to a Critical Access Hospital.
03	Discharged/transferred to skilled nursing facility (SNF).
05 06	Discharged/transferred to another type of institution. Discharged/transferred to home care of organized home health services organization.
62 63	Discharged/transferred to an inpatient rehabilitation facility Discharged/transferred to a long term care hospitals.
65	Discharged/ Transferred to a psychiatric hospital or psychiatric distinct unit of a hospital

Evaluation and Management Services

Decent incorporates standards established by the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA) for our evaluation and management (E&M) services reimbursement policy. All services

should be coded to the appropriate level of care, as laid out in the CMS and AMA guidelines, and should be able to be substantiated by medical records.

- **Modifiers** Code modifiers used for E&M services billing should be appropriate for the services rendered and should be able to be supported by medical records. Decent may request medical records to ensure that included modifiers adhere to the standards outlined by the CMS and AMA.
- **Multiple Visits Per Day** Decent will reimburse one visit per billing group, per subspecialty, per day. If both preventive and problem-oriented services are billed, and the problem-oriented visit is billed with modifier 25, Decent will reimburse the higher-valued procedure at 100% of the otherwise allowable amount and the lower-valued procedure at 50% of the contracted rate. Minor problem-oriented visits and problem-oriented codes billed without modifier 25 will not be reimbursed. Other E&M Services will be paid at 100% when billed with modifier 25, unless addressed below.
- **Screening/Counseling/Nutrition Therapy/Prolonged Services/Overlapping E&M Services** If a screening, counseling, nutrition therapy, prolonged, or otherwise overlapping E&M service is coded with modifier 25 and billed on the same day as a preventive E&M service as defined in the coding section below, Decent will reimburse 50% of the otherwise allowable amount for the non-preventative service. Otherwise, these services are not separately payable when billed on the same day as preventive E&M services by the same provider.

  Examples of and exceptions to this policy are listed in the coding section below.

- **Bundled Services** The following services are not separately payable when billed on the same day as specific E&M services.
  - Annual wellness visits are bundled into preventative visits
  - Cervical or vaginal cytopathology is bundled into preventive or problem-oriented visits
  - Collection of blood from an Implantable venous access device or venous catheter is bundled into problem-oriented visits
  - Screening pap smears are bundled into preventative visits
  - Screening pelvic/breast/rectal examinations are bundled into preventative and problem-oriented visits
  - Interpretation and report of ECG is bundled into problem-oriented, inpatient, or ED visits
  - Interpretation and report of cardiovascular stress tests are bundled into ED visits
  - Interpretation of chest X-rays are bundled into ED and inpatient visits
  - Preventive medicine counseling is bundled into preventative visits
  - Removal of impacted earwax is bundled into any E&M visit
  - Pulse oximetry is bundled into any E&M visit
  - Health risk assessments are bundled into any E&M visit

E&M services are not separately payable when provided on the same day (or the day prior, for major surgical procedures) as a procedure with a global period, as defined by the CMS or Decent (for codes with global surgery indicator YYY). Exceptions to this policy are for significant and separately identifiable services, when billed with modifier 25, or for services resulting in a decision to perform a major surgery, when billed with modifier 57. For services billed with modifier 25, the lesser of the procedure or E&M rate is paid at 50% of the contracted rate.

E&M services provided within the global period are not considered separately payable unless unrelated to the original procedure and billed with modifier 24.

- **Consultation Codes** Decent will reimburse outpatient consultation E&M codes at the equivalent problem-oriented E&M visit rate, inpatient consultations at the equivalent inpatient visit E&M code, and emergency department consultations will be reimbursed at the equivalent Emergency department E&M code. For inpatient visits, the admitting physician must submit the visit with modifier 'AI' in order for the consulting physician to be reimbursed.

- **Non-Reimbursable Services** Decent does not reimburse the following services: Transitional care management, advance care planning, chronic care management services, prolonged services provided in an inpatient setting or by clinical staff, or services delivered via telephone or over the internet.
- Services During Global Periods

Coding Categories identified include, but are not limited to, the below codes.

Code Description	Codes
Preventive E&M Services	99381-99387,99391-99397, G0402
Problem-Oriented E&M Services	99201-99205,99211-99215
Emergency Department E&M Services	99281-99285
Observation E&M Services	99224-99226
Inpatient E&M Services	99221-99223,99231-99236
Annual Wellness Visits	G0438, G0439, G0402
Cervical or Vaginal Cytopathology	88141-88155, 88164-88167, 88174-88175
Collection of Blood from an Implantable Venous Access Device or Venous Catheter	36591, 36592
Screening Pap Smear	Q0091
Screening Pelvic and Clinical Breast Examination	G0101
Screening Rectal Exam	G0102
Interpretation and Report of ECG	93010, 93042
Interpretation and Report of Cardiovascular Stress Test	93018
Interpretation of Chest X-ray	71045, 71046
Preventive Medicine Counseling	99401-99404, 99411, 99412
Removal of Impacted Earwax	69209, 69210
Health Risk Assessment	96160, 96161
Screening Services	99172, G0442, 99173, G0444, 99408, 99409, 96110, G0396, G0397
Counseling Services	99406, 99407, 99411, 99412, G0245, G0246, G0296, G0443, G0445- G0447, G0473, H0005, S0257, S0265, T1006, T1027
Nutrition Therapy Services	G0270, G0271, S9470
Prolonged Services provided by a Physician in Outpatient Setting	99354, 99355
E&M Services overlapping with Preventative Services	99241-99245, 99251-99255, 99281-99285, G0245, G0246, S0285
Outpatient Consultation E&M Services	99241-99245
Inpatient Consultation E&M Services	99251-99255
Transitional Care Management	99495, 99496
Prolonged Services provided by Clinical Staff	99415, 99416
Prolonged Services provided in Inpatient Setting	99356, 99357
Chronic Care Management	99487-99490
Services delivered by Telephone or Internet	99441-99443, 98960-98969

Radiology

Decent reimburses for radiology services to treat or diagnose medical conditions subject to coverage, medical necessity, and policy restrictions.

- **Multiple Radiology Procedures** When multiple radiology procedures eligible for multiple procedure discounting (CPT/HCPCS code where the CMS NPFS Status Indicator is equal to 4) are performed on the same day by the same provider, Decent will apply a reduction to the technical and professional component reimbursement for the additional services. Decent will reimburse the technical component of the highest value procedure at 100% and the technical component of all subsequent procedures at 50%. Decent will reimburse the professional component of the highest value procedure at 100% and the professional component of all subsequent procedures at 95%.
- **PET Scans** Decent requires PET scans to be billed with a PI or a PS modifier to be considered reimbursable.
- **Contrast Media** Decent considers specific contrast media codes to be never separately reimbursable from the radiology procedure. Decent also considers some codes to only be reimbursable when provided in conjunction with an appropriate service.

Coding Categories identified above include, but are not limited to, the below codes.

Code Description	Codes
Contrast Media Never Separately Reimbursed	A9515, A9526, A9536, A9546, A9550, A9552, A9555, A9559, A9566, A9576, A9577, A9578, A9579, A9580, A9581, A9583, A9585, A9586, A9587, A9588, A9698, A9597, A9598, A9700, Q9951, Q9953, Q9954, Q9958, Q9959, Q9960, Q9961, Q9962, Q9963, Q9964, Q9965, Q9966, Q9967, Q9968
PET Scans	78608, 78811, 78812, 78813, 78814, 78815, 78816

Contrast Media Code	Procedure Codes
A9500	78451-78454, 78070-78072, 78605-78607, 78800-78804
A9502	78451-78454, 78070-78072, 78803
A9503	78300-78320
A9505	78451-78454, 78070-78072, 78800-78804, 78607
A9507	78800-78804
A9508	78075, 78800-78804
A9509	78000-78018, 78020, 78070-78072
A9510	78226, 78227
A9512	78012-78018, 78600-78607, 78610, 78481, 78483, 78261, 78290, 78291, 78070-78072, 78230-78232, 78730, 78740, 78630-78650, 78660, 78761
A9516	78012-78018, 78070-78072
A9521	78600-78607, 78610
A9524	78110-78111, 78122, 78600-78607, 78610, 78579-78598 78451-78454, 78800-78804, 78472-78473, 78481-78483
A9520	78195
A9528	78012-78018, 78803, 78012-78018, 78803, 78012-78018, 78803
A9537	78226, 78227
A9538	78300-78320, 78466-78469
A9539	78579-78598, 78761, 78700-78725, 78730, 78740, 78630-78650, 78600-78607, 78610, 78291, 78645, 78481, 78483, 78445, 78428
A9540	78579-78598, 78291, 78216, 78428, 78201, 78205, 78215, 78800, 78801, 78803
A9541	78201-78216, 78185, 78278, 78102-78104, 78264, 78265, 7826678258, 78262, 78740, 78730, 78195, 78291

A9542	78804
A9547	78805-78807, 78185, 78190-78191
A9548	78630, 78635,78645,78647, 78650, 78800
A9551	78700-78710, 78800-78804
A9553	78120-78122,78130-78135,78140,78190-78191,78707-78709,78725
A9554	78707-78709, 78725
A9556	78800-78807
A9557	78600-78607, 78610, 78579-78598
A9558	78579-78598,78472,78473,78494,78496,78278,78201-78206, 78445
A9560	78472, 78473, 78494, 78496, 78278, 78201-78206, 78445, 78457-78458, 78215, 78216, 78185
A9561	78300-78320
A9562	78700-78725
A9567	78579-78598
A9569	78805-78807
A9570	78805-78807, 78185
A9571	78190-78191
A9572	78075, 78800-78804, 78015-78018
A9582	78075, 78800-78804

Physician-Administered Drugs

Decent reimburses providers for physician-administered drugs subject to coverage, medical necessity, and policy restrictions.

NDC Billing Requirements: The following HCPCS codes require an NDC to be billed:

- J codes, including miscellaneous and unlisted drug codes
- Drug-related CPT codes, including miscellaneous and unlisted drug codes, immunizations, Synagis and Immune Globulin
- Drug-related Q codes, including miscellaneous and unlisted drug codes, and Contrast
- Drug-related S codes
- Drug-related A codes, including miscellaneous and unlisted drug codes, and Radiopharmaceuticals

Unit of Measure Billing Guidelines: In order to ensure consistent and correct processing of claims, the unit of measure must be correctly reported based on the below guidelines. These guidelines are adapted from the National Council for Prescription Drug Programs (NCPDP) Billing Unit Standard (BUS).

"UN" (unit) is used when the product is dispensed in discrete units. These products are not measured by volume or weight. The Billing Unit of "UN" is also used to address exceptions where "GM" and "ML" are not applicable. Examples of products defined as "UN" include but are not limited to:

- Tablets
- Capsules
- Suppositories
- Transdermal patches
- Non-filled syringes

- Tapes
- Blister packs
- Oral powder packets
- Powder filled vials for injection
- Kits
- Unit-of-use packages with a quantity less than one milliliter or gram should be billed as "one each". For example, ointment in packets of less than 1 gram or eye drops in droppettes that are less than 1 ml. This rule does not apply to injectable products.

"ML" (milliliter) is used when a product is measured by its liquid volume. Examples of products defined as "ML" include but are not limited to:

- Liquid non-injectable products of 1 ml or greater
- Liquid injectable products in vials/ampoules/syringes
- Reconstitutable non-injectable products at the final volume after reconstitution except when they are in powder packets
- Inhalers (when labeled as milliliters on the product)

"GM" (gram) is used when a product is measured by its weight. Examples of products defined as "GM" include but are not limited to:

- Creams (of 1 gram or greater)
- Ointments (of 1 gram or greater)
- Inhalers (when labeled as grams on the product)

"F2" (international unit) is used when billing products that are typically measured in international units. Examples of products defined as "F2" include but are not limited to:

- Antihemophilic Products

Convenience Kits: Point-of-use convenience kits are non-reimbursable. These kits typically contain injectable drugs as well as the medical supplies required to administer the injection. The components of these kits must be billed separately to be considered for reimbursement. The practice expense payment for a given procedure frequently already includes the payment for these supplies.

Durable Medical Equipment

Decent reimburses for Durable Medical Equipment (DME) subject to coverage, medical necessity, and health plan policy restrictions. Durable Medical Equipment must be able to withstand repeated use, used for a medical reason, generally not useful to someone who isn't sick or injured, appropriate for use within the home, and prescribed by a licensed physician or practitioner.

Rental DME Decent will reimburse rental DME until the total purchase price has been paid or 10 months of rental payments, whichever comes first. After the cap has been reached, the equipment is considered purchased. Oxygen equipment and DME defined as 'frequently serviced' by CMS is exempt from this cap.

Coding Categories identified above include, but are not limited to, the below codes.

Code	Modifier Description

NU	New Equipment
RR	Rental Equipment
UE	Used Equipment

Intraoperative Neuromonitoring

Decent reimburses for Intraoperative Neuromonitoring (IONM) subject to coverage, medical necessity, and policy restrictions. Physicians performing IONM can be in the operating suite or remote, but must be able to communicate in real-time with the surgeon.

- **Concurrent Monitoring** Decent will not reimburse IONM when a physician is monitoring more than 3 cases simultaneously.
- **Time Reporting** For continuous intraoperative monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, increments of less than 30 minutes should not be billed. For continuous intraoperative neurophysiology monitoring in the operating room with one on one monitoring requiring personal attendance, increments of less than 8 minutes should not be billed. The period of billable neuromonitoring includes intraoperative time only, which does not have to be continuous.
- **Billing** IONM must be performed by a licensed physician to be eligible for reimbursement when billed on a HCFA-1500 form.

In-Office Laboratory Testing & Procedures

The In-Office Laboratory Testing and Procedures List is a list of laboratory procedural/testing codes that Decent will reimburse its Network physicians to perform in their offices. This list represents procedures/tests that Decent Network physicians can perform in their offices that will be reimbursed by Decent at a rate similar to the CMS reimbursement for claims. All other lab procedures/tests must be performed by one of the participating laboratories in Decent's network or reimbursement to the physician's office is reduced to a level near the contractual allowable paid to our contracted laboratories.

In-Office Laboratory Testing and Procedures Code List

Code	Description
81000	Urinalysis, non-automated, with microscopy
81001	Urinalysis, automated, with microscopy
81002	Urinalysis, non-automated, without microscopy
81003	Urinalysis, automated, without microscopy
81025	Urine pregnancy test, by visual color comparison methods
82270	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided three cards or single triple card for consecutive collection)
82271	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; other sources
82272	Blood, occult, by peroxidase activity (eg, guaiac), qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening

82948	Glucose; blood, reagent strip
82962	Glucose, blood sugar by glucometer
83014	Helicobacter pylori, breath test analysis; drug administration
83026	Hemoglobin; by copper sulfate method, non-automated
83655	Lead
85013	Blood count; spun microhematocrit
85018	Blood count; hemoglobin (Hgb)
85651	Sedimentation rate, erythrocyte; non-automated
86403	Particle agglutination, screen, each antibody
86485 - 86580	Skin tests; various
88331	Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen Dermatologists
88332	Pathology consultation during surgery; each additional tissue block with frozen section(s) (List separately in addition to code for primary procedure) Dermatologists
89060	Crystal Identification by light microscopy with or without polarizing lens analysis; tissue or any body fluid (except urine)
89300	Semen analysis; presence and/or motility of sperm including Huhner test (post coital)
89310	Semen analysis; motility and count (not including Huhner test)
89320	Semen analysis; volume, count, motility and differential
89321	Semen analysis; sperm presence and motility of sperm, if performed morphologic criteria (eg, Kruger)
89322	Semen analysis; volume, count, motility, and differential using strict
82803	Gases, blood, any combination of pH, pCO2, pO2, CO2, HCO3 (including calculated O2 saturation)
85007	Blood count; automated differential WBC count blood smear, microscopic examination with manual differential WBC count
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)
85097	Bone marrow; smear interpretation only, with or without differential cell count
86077	Blood bank physician services; difficult cross-match and/or evaluation of irregular antibody(s), interpretation and written report
86078	Blood bank physician services; investigation of transfusion reaction, including suspicion of transmissible disease, interpretation and written report
86079	Blood bank physician services; authorization for deviation from standard blood banking procedures, with written report
86927 - 86999	Transfusion medicine
84146	Prolactin
84443	Thyroid stimulating hormone (TSH)
89322	Semen analysis; volume, count, motility, and differential using strict morphologic criteria (eg, Kruger)
83861	Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity Ophthalmologists
88172	Cytopathology, evaluation of fine needle aspirate; immediate cytohistological study to determine adequacy for diagnosis, first evaluation episode, each site Endocrinologists
88177	Cytopathology, evaluation of fine needle aspirate; immediate cytohistological study to determine adequacy for diagnosis, each separate additional evaluation episode, same site (List separately in addition to code for primary procedure) Endocrinologists

Code	**Description**
87070	Culture, bacterial; any other source but urine, blood or stool, with isolation and presumptive identification of isolates.
87081	Culture, bacterial, screening only, for single organisms

87177	Ova and parasites, direct smears, concentration and identification.
87210	Smear, wet mount with simple stain, for bacteria, fungi, ova, and/or parasites
87220	Tissue examination for fungi (e.g., KOH slide)
87804	Infectious agent antigen detection by immunoassay with direct optical observation; Influenza
87880	Infectious agent detection by immunoassay-streptococcus group A
88738	Hemoglobin (Hgb), quantitative, transcutaneous
89100	Duodenal intubation and aspiration; single specimen plus appropriate test
89105	Duodenal intubation and aspiration; collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube
89130 - 89141	Gastric intubation and aspiration; various
89350	Sputum, obtaining specimen, aerosol-induced technique
99195	Phlebotomy, therapeutic (separate procedure)
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count, For Stat Purposes Only
82247	Bilirubin, Total Pediatricians

Obstetrical Care Bundling

Maternity care includes antepartum care, delivery services, and postpartum care. This policy describes reimbursement for global obstetrical (OB) codes and itemization of maternity care services. In addition, the policy indicates what services are and are not separately reimbursable to other maternity services. Unless otherwise specified, for the purposes of this policy Same Group Physician and/or Other Health Care Professional includes all physicians and/or other healthcare professionals of the same group reporting the same federal tax identification number.

- **Global Obstetrical Care -** Global Obstetrical Care As defined by the American Medical Association (AMA), "the total obstetric package includes the provision of antepartum care, delivery, and postpartum care." When the Same Group Physician and/or Other Health Care Professional provides all components of the OB package, report the global OB package code.
- **Antepartum Care Only -** Accommodates for situations such as termination of a pregnancy, relocation of a patient or change to another physician. In these situations, all the routine antepartum care (usually 13 visits) or global (OB) care may not be provided by Same Group Physician and/or Other Health Care Professional.
- **Delivery Services Only** - Includes admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery.
- **Postpartum Care Only -** Includes the postpartum period to be six weeks following the date of the cesarean or vaginal delivery.
- **Delivery + Postpartum Care** - Sometimes a physician performs the delivery and postpartum care with minimal or no antepartum care. In these instances, the CPT book has codes for vaginal and cesarean section deliveries that encompass both of these services. The following are CPT defined delivery plus postpartum care codes:

Global Obstetric

59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care Global Obstetric
59510	Routine obstetric care including antepartum care, cesarean delivery and postpartum care Global Obstetric
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy,

	and/or forceps) and postpartum care, after previous cesarean delivery Global Obstetric
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery. Global Obstetric

Antepartum Care Only

59425	Antepartum care only; 4-6 visits Antepartum Care Only
59426	Antepartum care only; 7 or more visits Antepartum Care Only

Delivery Services Only

59409	Vaginal delivery only (with or without episiotomy and/or forceps) Delivery Services Only
59514	Cesarean delivery only Delivery Services Only
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps) Delivery Services Only
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, Delivery Services Only

Post-Partum Care Only

59430	Postpartum care only (separate procedure) Post-Partum Care Only
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care Delivery + Post-Partum
59515	Cesarean delivery only; including postpartum care Delivery + Post-Partum
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care Delivery + Post-Partum
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care. Delivery + Post-Partum

Services Included in the "Global Obstetrical" Care Package

- All routine prenatal visits until delivery (approximately 13 for uncomplicated cases)
- Initial and subsequent history and physical exams
- Recording of weight, blood pressures and fetal heart tones
- Routine chemical urinalysis 81000, 81002
- Admission to the hospital including history and physical
- Inpatient Evaluation and Management (E/M) service provided within 24 hours of delivery
- Management of uncomplicated labor
- Delivery of placenta 59414
- Administration/induction of intravenous oxytocin 96365 - 96367
- Insertion of cervical dilator on same date as delivery 59200
- Repair of first or second degree lacerations
- Simple removal of cerclage (not under anesthesia)
- Uncomplicated inpatient visits following delivery
- Routine outpatient E/M services provided within 6 weeks of delivery

Services Excluded from the "Global Obstetrical" Care Package The following services are excluded from the global OB package and may be reported separately if warranted:

Description Code(s)

- Initial E/M to diagnose pregnancy if antepartum record is not initiated at this confirmatory visit. This confirmatory visit would be supported in conjunction with the use of diagnosis code V72.42 (Pregnancy examination or test, positive result)
- Laboratory tests (excluding routine chemical urinalysis)
- Maternal or fetal echography procedures 76801 - 76828
- Amniocentesis, any method 59000, 59001
- Amnioinfusion 59070
- Chorionic villus sampling (CVS) 59015
- Fetal contraction stress test 59020
- Fetal non-stress test 59025
- External cephalic version 59412
- Insertion of cervical dilator more than 24 hours before delivery 59200
- E/M services for management of conditions unrelated to the pregnancy (e.g., bronchitis, asthma, urinary tract infection) during antepartum or postpartum care; the diagnosis should support these services.
- Additional E/M visits for complications or high risk monitoring resulting in greater than the typical 13 antepartum visits; per ACOG these E/M services should not be reported until after the patient delivers. Append modifier 25 to identify these visits as separately identifiable from routine antepartum visits.
- Inpatient E/M services provided more than 24 hours before delivery
- Management of surgical problems arising during pregnancy (e.g., appendicitis, ruptured uterus, cholecystectomy).

Services Included in the "Delivery Services Only" Care Package

- Admission to the hospital
- The admission history and physical examination
- Management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps, with or without vacuum extraction), or cesarean delivery, external and internal fetal monitoring provided by the attending physician
- Intravenous (IV) induction of labor via oxytocin 96365 - 96367
- Delivery of the placenta; any method
- Repair of first or second degree lacerations
- Cervical dilator 59200

High Risk/Complications A patient may be seen more than the typical 13 antepartum visits due to high risk or complications of pregnancy. These visits are not considered routine and can be reported in addition to the global obstetrical codes. The submission of these high risk or complication services is to occur at the time of delivery, because it is not until then that appropriate assessment for the number of antepartum visits can be made. Decent will separately reimburse for E/M services associated with high risk and/or complications when modifier 25 is appended to indicate it is significant and separate from the routine antepartum care and the claim is submitted with an appropriate high risk or complicated diagnosis code.

E/M Service with an Obstetrical (OB) Ultrasound Procedure Decent follows ACOG coding guidelines and considers an E/M service to be separately reimbursed in addition to an OB ultrasound procedures (CPT codes 76801-76817 and 76820- 76828) only if the

E/M service has modifier 25 appended to the E/M code. If the patient is having an OB ultrasound and an E/M visit on the same date of service, by the Same Individual Physician or Other Health Care Professional, per ACOG coding guidelines the E/M service may be reported in addition to the OB ultrasound if the visit is identified as distinct and separate from the ultrasound procedure. Per CPT guidelines, modifier 25 should be appended to the E/M service to identify the service as separate and distinct.

Multiple Gestation Decent's reimbursement for twin deliveries follows ACOG's coding guidelines for vaginal, cesarean section, or a combination of vaginal and cesarean section deliveries. See table below for appropriate code submission regarding delivery of twin births.

Delivery Type	Baby Code-Modifier
59400	Vaginal Baby A
59409-59	Vaginal Baby B
59610	VBAC Baby A
59612-59	VBAC Baby B
59510	Cesarean Delivery Baby A + Baby B
59518	Repeat Cesarean Delivery Baby A + Baby B
59409-51	Vaginal Delivery + Cesarean Delivery Baby A
59510	Vaginal Delivery + Cesarean Delivery Baby B
59612-51	VBAC + repeat Cesarean Delivery Baby A
59618	VBAC + repeat Cesarean Delivery Baby B

Assistant Surgeon

An assistant surgeon is considered medically necessary when the complexity of the operation necessitates the primary surgeon have additional skilled operative assistance from: 1) Another surgeon, 2) Licensed Physician Assistant, 3) Registered Nurse First Assistant. Decent provides coverage for assistant surgeons based on guidance from the Centers for Medicare and Medicaid Services (CMS).

An assistant surgeon is distinguished from an “assistant-in-surgery.” Generally, assistants-in-surgery are non-MD professionals such as nurses, operating room technicians, or other specially trained professionals, whose services are included in the primary surgeon’s, or the facility’s, reimbursement. These services are not separately reimbursed.

There may be times when a physician elects to utilize more than one assistant during the operative session. However, only one assistant per operative session will be reimbursed. Claims for services of an assistant surgeon should be filed with modifier 80, 81, 82 or AS. Use of modifiers is required for proper payment.

Decent follows criteria based on the CMS National Physician Fee Schedule Relative Value File (NPFS) status indicators. All codes in the NPFS with the status code indicator "2" for "Assistant Surgeons" are considered by Decent to be reimbursable for Assistant Surgeon services, as indicated by an Assistant Surgeon modifier (80, 81, 82, or AS).

Assistant Surgeons who are Physicians or non-Physicians should submit the identical procedure code(s) as the primary surgeon with one of the following modifiers to represent their service(s):

Assistant Modifier	Surgeon Description Modifiers	Type of Professional
80	Assistant Surgeon	Physician
81	Minimum Assistant Surgeon	Physician

82	Assistant Surgeon (when qualified resident surgeon not available) Physician AS PA (physician assistant), nurse practitioner, or clinical nurse specialist services for assistant at surgery non-Physician*
AS	PA (physician assistant), nurse practitioner, or clinical nurse specialist services for assistant at surgery non-Physician*
*Health care professionals acting as Assistant Surgeons should report their services under a surgeon's provider number.	

Reimbursement Decent's standard reimbursement for qualified Assistant Surgeon services are 16% of the primary surgeon's allowable amount when performed by a physician and 14% of the primary surgeon's allowable amount when performed by a non-Physician (as defined above). This percentage is based on CMS.

Co-Surgeons / Team Surgeons

The use of multiple surgeons for a single procedure is considered medically necessary when the nature and/ or complexity of the procedure necessitates contribution and expertise from more than one surgeon. Decent provides coverage for multiple surgeons based on guidance from the Centers for Medicare and Medicaid Services (CMS).

Decent follows criteria based on the CMS National Physician Fee Schedule Relative Value File (NPFS) status indicators. All codes in the NPFS with status code indicators "1" or "2" for "Co-Surgeons" are considered by Decent to be eligible for Co-Surgeon services as indicated by the co-surgeon modifier 62. All codes in the NPFS with the status code indicators "1" or "2" for "Team Surgeons" are considered by Decent to be eligible for Team Surgeon services as indicated by the team surgeon modifier 66. Use of modifiers is required for proper payment.

Co-Surgeon Modifier Description & Team Surgeon Type Modifiers of Professional

Code	Code Description
62	Two Surgeons Physician *
66	Team Surgeons Physician
* Physicians acting in the more limited capacity of an 'Assistant Surgeon' should bill with modifiers 80 or 82 and are not eligible for Co-Surgeon reimbursement	

- **Co-Surgeons**
  - Each co-surgeon should submit the same Current Procedural Terminology (CPT) code with modifier 62. Consistent with CMS guidelines, Decent will reimburse co-surgeon services at 62.5% of the allowable amount to each surgeon subject to additional multiple procedure reductions if applicable. The allowable amount is determined independently for each surgeon and is the amount that would be given to that surgeon performing the surgery without a co-surgeon.
- **Team Surgeons**
  - Each Team Surgeon should submit the same CPT code with modifier 66 along with written medical documentation describing the specific surgeon's involvement in the total procedure. Decent will review each submission with its appropriate medical documentation and will make reimbursement decisions on a case-by-case basis.

Anesthesia

Decent Insurance reimburses anesthesia based on the concepts of basic values, time unit values, and conversion factors. Basic values are defined by the ASA and time units are calculated on a 15 minute interval basis and rounded to the nearest decimal point (e.g. 32 minutes of anesthesia equals 2.1 time units). Conversion factors are either explicitly listed in provider contracts or based on CMS localities. Anesthesia time starts when the anesthesiologist begins to prepare the patient for induction and ends when the patient can safely be placed under postoperative supervision. The following formula is used to determine anesthesia reimbursement:

(Base Value + Time Units) x Conversion Factor = Reimbursement

The following modifiers should also be applied to distinguish when services are not directly performed by an anesthesiologist:

Type of Provider	Code	Description	Payment
Anesthesiologist	AA	Anesthesia services performed personally by an anesthesiologist	100% of fee schedule based on appropriate unit rate
	AD	Medical supervision for more than four concurrent anesthesia procedures is provided	Reimbursed at a rate equal to three base value units
	GC	Services performed in part by a resident under the direction of a teaching physician	Services are reimbursable at 100% of the allowable when billed by the teaching anesthesiologist. (Note: the teaching anesthesiologist must bill with the “AA” modifier in the first field and the “GC” certification modifier in the second field.)
	QK	Medical direction of two, three or four concurrent anesthetic procedures involving qualified individuals (e.g., CRNAs or residents)	Allows 50% of fee schedule payment based on the appropriate unit rate
	QY	Anesthesiologist medically directed one CRNA	Allows 50% of fee schedule payment based on the appropriate unit rate
CRNA	QZ	CRNA performed services without medical direction	100% of fee schedule based on appropriate unit rate
	QX	CRNA performed services under the medical direction of an anesthesiologist	Allows 50% of fee schedule payment based on the appropriate unit rate

Additional cases that require more specific pricing:

- Reimbursement for neuraxial/epidural labor is based on the actual time unit capped at the following minutes:
- Vaginal delivery codes are capped at a total of 225 minutes/15 time units - Cesarean section delivery codes are capped at a total of 270 minutes/18 time units

Hospital Based Clinics

Decent reimburses professional providers for covered services provided in a facility clinic setting when reported on a professional CMS 1500 form with a place of service office. This reimbursement includes both the professional services and the associated overhead. Decent will not separately reimburse a facility for facility clinic visits and services billed on a UB-04 when reported with

revenue codes 510-519, 520-529 and any successor codes.

The technical and overhead component of the facility clinic visit is included in the benefit paid to the professional provider for professional services, which encompasses but is not limited to E&M services in a clinic setting. The facility may not seek reimbursement for any technical or overhead component of the clinic charge from Decent or the member. The member is held harmless for these clinic overhead charges.

Code	Code Description and Guideline
510 - 519	Clinics Bill with appropriate CPT/HCPCS Codes; E&M codes will be denied.
520 - 529	Free Standing Clinics Bill with appropriate CPT/HCPCS codes; E&M codes will be denied.
960-969	Professional Fees - Clinics Bill with appropriate E&M codes
G0463	Hospital Outpatient clinic visit for assessment and management of a patient Not reimbursed

Bilateral Procedures

Bilateral procedures are procedures performed on both sides of the body during the same encounter or on the same day. Decent follows the bilateral procedure CMS standards in the NPFS (National Physician Fee Schedule) for adjustment of payment.

Bilateral services must be billed on a single line with modifier -50 appended. Modifier -50 is not applicable to procedures that are bilateral by definition or procedures with descriptions that include such terminology as "bilateral" or "unilateral." Do not use Modifiers RT and LT when modifier -50 applies.

Procedure Eligible for Bilateral Payment Adjustment

- **Status Indicator 1:** If the procedure is billed with the -50 bilateral modifier, a 150% payment adjustment applies.
- **Status Indicator 3:** Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures with CMS status indicator 1. If a procedure is reported with modifier -50, payment is based on 100% of the standard reimbursement for each side.

Procedures Ineligible for Bilateral Payment Adjustment

- **Status Indicator 2:** Payment for these services is already considered bilateral. If the procedure is submitted with modifier -50 or reported twice, payment is still 100% of the standard reimbursement.

Multiple Procedures

When multiple procedures are performed on the same day, by the same group, physician, or other healthcare professional, reduction in reimbursement for secondary and subsequent procedures will occur. Decent follows the multiple procedure CMS standards for reduction of payment. The use of modifier 51 appended to a code is not a factor in determining which codes are considered subject to multiple procedure reductions.

- **Surgical / Endoscopic Procedures (Status Indicators 2 & 3)** If a procedure is reported on the same day as another procedure with an indicator of 2 or 3, the procedures with the greatest reimbursable amount will be paid at 100% followed by 50% for all subsequent procedures. Payment is based on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.

- Special rules for multiple endoscopic procedures apply if an endoscopic procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in the Endobase field of the CMS NPFS Relative Value File. The multiple endoscopy rules are applied to a family before ranking the family with the other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with only its base procedure, the base procedure is not separately payable. Payment for the base procedure is included in the payment for the other endoscopy.

- **Cardiovascular Services (Status Indicator = 6)** For cardiovascular services, full payment is made for the service with the highest payment. Payment is made at 75 percent for subsequent services furnished by the same physician (or by multiple physicians in the same group practice, to the same patient on the same day). Reduction is taken only on the technical component, the professional component is paid at 100% for all procedures.

- **Ophthalmology Services (Status Indicator = 7)** For ophthalmology services, full payment is made for the service with the highest payment. Payment is made at 75 percent for subsequent services furnished by the same physician (or by multiple physicians in the same group practice, to the same patient on the same day). Reduction is taken only on the technical component, the professional component is paid at 100% for all procedures.

- **Global / Case Rate Adjustment** When a procedure requires a multiple procedure reduction but is billed as a global / case-rated procedure, Decent will apply an appropriate technical component reduction on a fixed 60% of the total payable amount. If a professional component payment reduction is appropriate, it is applied on a fixed 40% of the total payable amount.

Unlisted and Unspecified Procedures

Unlisted procedure codes are used when the services performed do not have specific codes assigned to them. When submitting claims with such unlisted or unspecified procedures, it is necessary to attach supporting documentation describing the services that were performed. Such documentation should include the following information:

- A clear description of the nature, extent, and need for the procedure or service;
- Whether the procedure was performed independently of other services provided, or if it was performed at the same surgical site or through the same surgical opening;
- Any extenuating circumstances which may have complicated the service or procedure;
- Time, effort, and equipment necessary to provide the service; and The number of times the service was provided.

When submitting documentation, designate the portion of the report that identifies the test or procedure associated with the unlisted procedure code.

Claims submitted with unlisted procedure codes and without supporting documentation will be denied. No additional reimbursement is provided for special techniques/equipment submitted with an unlisted procedure code. When performing two or more procedures that require the use of the same unlisted CPT code, the unlisted code should only be reported once to identify the services provided (excludes unlisted HCPCS codes; for example, DME/ unlisted drugs). Unlisted codes for DME, orthotics, and prosthetics require appropriate NU, RR or MS modifier in order to be considered for reimbursement. All other unlisted procedure codes appended with a modifier will be denied.

Required Documentation and Coding Guidelines

- Surgical procedures: all unlisted codes within the range of 10021–69990 Operative or procedure report
- Radiology/imaging procedures: all unlisted codes within the range of 70010–79999 Imaging report
- Laboratory and pathology procedures: all unlisted codes within the range of 80047–89398 Laboratory or pathology report
- Medical procedures: all unlisted codes within the range of 90281–99607 Office notes and reports
- Unlisted HCPCS procedure codes Operative or procedure report
- Unclassified drug codes NDC Number with full description/name and strength of the drug
- Unlisted HCPCS DME codes Provide narrative on the claim

Medically Unlikely, Mutually Exclusive, and Component Procedures

Decent reimburses providers for services that are medically appropriate and adhere to CMS standard coding conventions. Decent follows Medicare National Correct Coding Initiative (NCCI) standards for not reimbursing services that are mutually exclusive, medically unlikely, or component services reported alongside more comprehensive procedures.

Mutually Exclusive Procedures

Mutually exclusive procedures are codes that cannot reasonably be done at the same anatomic site, during the same patient encounter, or the coding combination represents two methods of performing the same service. An example of mutually exclusive procedures is the repair of an organ, performed by two different methods since only one method can be chosen to repair the organ. Mutually exclusive coding combinations are considered submitted in error and only one of the services will be reimbursed. The Medicare National Correct Coding Initiative (NCCI) has published procedure-to-procedure (PTP) claims edits that prevent inappropriate payment in these scenarios. Decent adopts these claims edits and will not reimburse providers for mutually exclusive procedures.

Medically Unlikely Procedures

Medically unlikely procedures are codes that are anatomically or clinically limited with regard to the number of times they may be performed on a single day. In addition to the PTP edits, NCCI has published medically unlikely claims edits (MUEs) that prevent payment for an inappropriate number or quantity of the same service on a given day. Decent adopts these claims edits and will not reimburse providers for services flagged as medically unlikely.

Comprehensive and Component Procedures

NCCI's PTP edits also address component and comprehensive procedures. Services that are integral to another service are component parts of the more comprehensive procedure. The PTP edits prevent payment for component services reported alongside comprehensive services. Decent adopts these claims edits and will not separately reimburse providers for component services if reported alongside comprehensive services.

Incident To Services

Decent does not recognize or allow incident-to billing. All practitioners must bill the services they provide under their own name and provider identification information.

Services Incidental to Admission

Services rendered prior to a related inpatient admission are considered incidental to such admission and are not separately reimbursablefromtheinpatientreimbursementrate.

Services that are incidental to an admission include, but are not limited to:

- Surgical daycare;
- Observation stay;
- Emergency room care;
- Diagnostic and/or testing services, including pre-admission testing.

Pre-admission services maybe subject to post-payment audits and retractions.

Inpatient Stays Reimbursed PerDiem

- Decent includes incidental services in the inpatient per diem reimbursement rate when they occur within one day prior to an inpatient admission. For example, an observation stay that converts to an inpatient admission before midnight of the same day is included in the inpatient per diem rate and is not separately reimbursed. On the other hand, an observation stay that converts to an inpatient admission after midnight of the observation day is not included in the perdiemrate and is separately reimbursed.
- Inpatient Stays Reimbursed via Case Rateor Diagnosis-Related Group (DRG) Decent includes incidental services in the inpatient case rate or DRG reimbursement rate when they occur within three days prior to an inpatient admission.

Observation Stays

An Observation Stay is an alternative to an inpatient admission that allows reasonable and necessary time to evaluate and render medically necessary services to a member whose diagnosis and treatment are not expected to exceed 24 hours but may extend to 48 hours, and the need for an inpatient admission can be determined within this specific period. Decent separately reimburses observation services performed in an Decent-contracted facility only under specific circumstances.

Observation stays that are discharged within the 48 hour time window do not require prior approval and can be billed as outpatient. - If an observation stay is to exceed 48 hours, follow prior authorization guidelines listed below in the inpatient admission section.

- **Inpatient Admission Following Observation Stay**
  - If an observation stay is within 48 hours and followed by an inpatient admission, the observation stay should be billed separately as an outpatient service and is not subject to prior authorization. The inpatient stay requires prior authorization and should be billed separately. - If an observation stay exceeds 48 hours, it should be billed as an inpatient stay and will be subject to prior authorization.
- **Emergency Department Services Preceding Observation Stay**
  - When emergency department services precede an observation stay, the emergency department services are incidental to the observation stay and therefore are not reimbursed separately.
- **Obstetrical Observation Stay - When an obstetrical patient is placed in observation status:**
  - The entire episode is considered an inpatient admission if delivery occurs prior to discharge. - The episode is considered an observation stay if delivery does not occur and the member is sent home. - Reimbursement includes diagnostic testing performed in conjunction with an obstetrical observation stay.
- **Decent** Does Not Reimburse: Observation stay is not considered an appropriate designation for the following,

and is therefore not reimbursed:

- Preparation for, or recovery from, diagnostic tests (e.g., fetal non-stress test, sleep studies)
- The routine recovery period following a surgical day care or an outpatient procedure
- Services routinely performed in the emergency department or outpatient department
- Observation care services submitted with routine pregnancy diagnoses
- Retaining a member for socioeconomic factors
- Custodial care

Surgical Supplies

This policy describes the reimbursement methodology for general surgical supplies associated with outpatient physician surgical services. Consistent with CMS, Decent does not reimburse providers for general surgical supplies.

- **Supply Code 99070** For reimbursement of covered medical and surgical supplies, an appropriate Level II HCPCS code must be submitted. The non-specific CPT code 99070 (supplies and materials, except spectacles, provided by the physician, hospital, ambulatory surgical center or other qualified healthcare professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)) is not reimbursable in any setting.
- **Surgical Tray Code A4550** CPT code A4550 will not be reimbursed separately. This code is considered to be part of a physician's practice expense and thus reimbursement of this code is included in the payment of other codes billed by the physician.

Emergent Admissions

Decent covers emergency services that are medically necessary to screen and stabilize members in a medical or behavioral health emergency. Members who believe they are having a medical or behavioral health emergency are encouraged to seek care at the nearest emergency facility. Neither a referral from the PCP nor prior authorization from Decent are required. In compliance with the Affordable Care Act (ACA), Decent covers out-of-network Emergency Health Services at an in-network equivalent benefit level.

An Emergent Admission is defined as an admission to the inpatient hospital level of care immediately subsequent to an Emergency Department (ED) Visit. An example of this may be a patient requiring emergency surgery (e.g. ruptured appendix, multiple trauma, etc.) who is taken to the operating room and admitted to the inpatient setting after discharge from the Recovery Room.

- A prior authorization is not required for an emergent admission.
- All emergent admissions are subject to retrospective review.
- Admitting hospitals are responsible for notifying Decent of an emergent/urgent inpatient admission within two business days following an emergent/urgent admission.
- Decent may elect to transfer the enrollee to a network facility as soon as medically appropriate. **If the enrollee chooses to stay at the non-network facility after the date that it is determined a transfer is medically appropriate, non-network benefits may be applied for the remainder of the inpatient stay.**
- Emergent admissions at in-network facilities must meet the threshold of medical necessity.
- Emergent admissions at out-of-network facilities must meet the higher threshold of medical necessity and emergency care of sufficient acuity and severity that would not allow the member to have received equivalent care at a later date in an in-network facility

- ED visit is inclusive of inpatient stay:
    - If the patient is admitted to the inpatient setting for a condition that the Plan agrees is medically necessary and is subsequent to an ED Visit, the ED visit is inclusive to the inpatient stay.
- Resubmission of a denied inpatient stay:
    - If an admission is denied upon concurrent or retrospective review as not meeting medical necessity criteria for admission to the inpatient setting, the provider may resubmit a claim at an alternate level of care or as an outpatient ER visit to allow payment of the ED visit portion.
- Itemized bills requested for partially denied inpatient stays:
    - If an emergent admission is determined to NOT meet medical necessity criteria for a portion of the stay, Decent will deny the claim with a request for an itemized bill to split and pay a portion of the claim.
- Claims denied if notification not provided:
    - If an emergent admission is not reviewed prior to claim submission, the claim will be denied with a request for medical records.

Readmissions

For all inpatient stays, Decent reserves the right to review readmissions for the same or related conditions within 30 days of discharge.

If Decent determines upon review that a readmission arose from premature discharge or is related to the initial admission or disease process, Decent will potentially rescind payment for either the readmission or the original stay, regardless of the medical necessity of the readmit.

Mid-level Providers

Decent follows guidelines established by CMS pertaining to mid-level providers. For the specialities listed in the table below, Decent's reimbursement is equal to the lesser of 80% of billed charges and 85% of the allowed amount for physicians.

Specialty

- Physician Assistant
- Nurse Practitioner
- Certified Clinical Nurse
- Nurse
- Midwife
- Certified Surgical Assistant

Never Events

An adverse event is defined as an injury caused by medical management rather than by the underlying disease or condition of the patient. A subcategory, Never Events, are medical errors that are particularly severe due to their preventability. Never Events include errors such as performing surgery on the wrong body part, leaving a foreign object inside a patient after surgery, or

discharging aninfant to the wrong person.

Decent will deny reimbursement to hospitals and providers for any costsincurred for treatment of Never Events. Decent has adapted guidance from the National Quality Forumon Serious Reportable Events (SRE), the CMS Medicare Hospital Acquired Conditions (HAC), and Presenton Admission (POA) indicator reporting.

Decent identifies,reviews, and monitors incidences of serious reportable adverse events andhospital acquired conditions to ensureproviders are rendering high quality care and appropriatereimbursement is rendered.

Decent will not reimburse professional or facility charges when:

- treatment or services rendered are directly related to the occurrence of the Never Event
- treatment or services rendered are related to the the correction or remediation of the Never Event
- treatment or services rendered are related to subsequent complications arising from the occurrence ofthe Never Event
- follow-up services or readmission for the Never Event are performed by the same provider or a provider owned by the same parent organization
- follow-up services or readmission for the Never Event are performed in the same facility

Any professional provider associated with a Never Event (surgeon, anesthesiologist, radiologist, etc.)is noteligiblefor reimbursement. Reimbursement is also not provided for any services in the operating orprocedure room where the incorrect surgery error occurs.

Providers are strictly prohibited from billing members for copayments, coinsurance, deductible charges.This includes attempts to balance bill members for events and post-event related services,which aredesignated as ineligiblefor payment.