<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy</td>
<td>16</td>
</tr>
<tr>
<td>Prescription Drug Formulary</td>
<td>16</td>
</tr>
<tr>
<td>Specialty Pharmaceutical Benefit</td>
<td>17</td>
</tr>
<tr>
<td>Pharmacy Program Coordination</td>
<td>18</td>
</tr>
<tr>
<td>Formulary Decision-Making Process</td>
<td>19</td>
</tr>
<tr>
<td>Medication Prior Authorization</td>
<td>19</td>
</tr>
<tr>
<td>Practitioner Appeals Process</td>
<td>20</td>
</tr>
<tr>
<td>Appealing a Denial of Coverage</td>
<td>20</td>
</tr>
<tr>
<td>Expedited Reviews</td>
<td>20</td>
</tr>
<tr>
<td>Product Descriptions</td>
<td>21</td>
</tr>
<tr>
<td>Provider Coordinators</td>
<td>23</td>
</tr>
<tr>
<td>Provider Coordinator Service Area</td>
<td>24</td>
</tr>
<tr>
<td>Referrals</td>
<td>25</td>
</tr>
<tr>
<td>Out-of-Plan Referrals</td>
<td>25</td>
</tr>
<tr>
<td>Prior Authorization</td>
<td>25</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>26</td>
</tr>
<tr>
<td>Prior Authorization</td>
<td>27</td>
</tr>
</tbody>
</table>
Welcome to Quartz. We are pleased to have you in our network of providers and look forward to a long, mutually satisfying relationship.

Quartz is a third-party administrator (TPA) that offers a wide range of high-quality administrative services to manage health benefit programs for employer groups.

As providers, you can expect highly-rated service, maintaining good patient outcomes is our overarching goal, supported by clinical practice guidelines, health management programs and timely and efficient claims processing. We encourage providers contact us with any questions or comments at Quartz.CustomerService@quartzbenefits.com.

This Provider Manual is designed to provide guidance that may help providers prepare claims to smoothly move through the process for payment. Please review this manual carefully and follow the policies and procedures so that we can provide you with efficient claims processing.

Covered services may vary between group health plan participants. Some may participate in health management programs, wellness programs, disease management programs, pharmacy benefits management and more.

If you have questions after reviewing this Manual, please contact us through MyPlanTools or by calling Quartz Customer Service at – (800) 805-0693.
Access Standards

Primary Care Practitioner Standards are –

- **Emergent Care** – Symptomatic, not interfering with daily function, such as minor pain, indigestion, rash, sore throat; follow-up care; and life or limb threatening illness or injury. *Standard = to be seen immediately*

- **Urgent Care** – Sudden onset of symptoms, not life or limb threatening that includes minor injuries, high fever, nausea, ear infections, etc. *Standard = to be seen within 48 hours*

- **Routine / Preventive Care** – preventive care such as annual check-ups and screens. *Standard = to be seen within 30 calendar days*

Our Behavioral Health Appointment Standards are –

- **Emergent Care** – Life-threatening emergency care. *Standard = to be seen immediately*

- **Non-life-threatening emergency** – *Standard = to be seen within six hours*

- **Urgent Care** – *Standard = to be seen within 48 hours*

- **Routine Care** – *Standard = to be seen within 10 working days*
Claims

Quartz uses an imaging and workflow system to –

- Eliminate the possibility of misdirected claims;
- Retrieve claims and other documentation electronically; and
- Reduce processing errors through the electronic transfer of claims information.

Quartz is committed to meeting the standard goal of processing claims within 30 days of receipt. We thank you in advance for helping us process your claims efficiently and accurately by using the following procedures –

Medical Claims
When submitting medical claims, please remember the following –

- Submit within your contractual filing limit.
- Use red CMS 1500 02 / 12 or UB-04 forms, making sure all information is clear and precise.
- Information should be lined up appropriately on the form when printed so nothing touches the lines on the form. Printing should not be light and characters should be clear and well-formed. This facilitates the imaging process.
- Whenever possible, do not send photocopies or claims on onion-skin or colored paper.
- Use current and appropriate CPT-4 procedure codes, ICD-10 diagnosis codes, HCPCS codes, and revenue codes.
- Include a description when miscellaneous codes are used.
- Indicate the DRG in the appropriate box for all inpatient claims when using the UB form.
- Attach the primary carrier’s explanation of benefits form (EOB), if applicable.
- If services were provided because of an accident, check the accident box and indicate the date of the accident.

Medicare Claims
Upon receipt of payment from Medicare for the claim, submit the following to Quartz –

- A copy of the Medicare claim as filed with Medicare showing the Quartz participant number;
- The Explanation of Medicare Benefits (EOMB) form and
- The Medicare Remittance Advice.

Quartz will coordinate benefits when applicable, per the terms of the group health plan.

Dental Claims
When submitting dental claims to Quartz, please remember the following –

- Submit only claims for Oral Surgery, Temporomandibular Disorders (TMJ / TMD) (when required) and Accident Claims to Quartz.
- Submit all other claims to the participant’s dental carrier.
- Submit within your contractual filing limit.
- Use the American Dental Association (ADA) Claim form.
- Use current and appropriate ADA procedure codes.
- If there is coverage for temporomandibular joint disorder (TMJ / TMD), submit this diagnosis code on the claim.
- Whenever possible, do not send photocopies, claims on onion-skin or colored paper.
- Indicate “Pre-treatment Estimate” on the envelope, when applicable.
- Attach the primary carriers’ explanation of benefits form (EOB), if applicable.
- If services were provided because of an accident, check the accident box and indicate the date of the accident.

Claim Submission Guidelines
To expedite processing and to ensure that all types of claims are processed accurately, Quartz requests that you do the following –

- Include the participant’s current person code in the subscriber number field.
- Indicate the current alpha-numeric group number.
- Put all dates of service on one claim form not to exceed six lines, when submitting a 1500 form.
Submit only one provider of service per claim.

Therapy services must have individual dates of service; date ranges cannot be used.

Include the appropriate National Provider Identification (NPI) number.

Indicate facility where services were rendered.

Do not write on the claim form with red ink or dark highlighter.

If a highlighter must be used, use yellow and send the original claim.

If a copy must be sent, make the copy and then highlight with yellow.

Be sure the ribbon on your printer produces legible information on the claim form.

Information should be lined up appropriately on the form when printed so nothing touches the lines on the form. Printing should not be light and characters should be clear and well-formed. This facilitates the imaging process.

Where to Submit Claims
Quartz®
P.O.Box 490
Sauk City, WI 53583

Questions on the claim submission process should be directed to –
Quartz Customer Service – (800) 805-0693, prompt 2
For the hearing impaired – TDD / TTY: 711 or toll free 800.877.8973

Hours are 8:00 a.m. to 5:00 p.m., Monday through Friday, Central Time.

When to Submit Claims
Submit the claim with the appropriate referral / certification number or other written statements within the timely filing limit required in the provider contract.

Failure to submit claims within the contract filing limit may result in non-payment.

Electronic Claims Submission (EDI)
EDI, also known as Electronic Claims Submission, allows medical providers to send and receive health care claims information. For more information regarding EDI claim submission/electronic claim payment/Remittance advice (835) please go to our website at:

Authorization Agreement For Electronic Health Care Claim Payment / Advice (835)

If you have questions regarding this process, contact one of the Quartz EDI Analysts for more information. Please email edi@quartzbenefits.com

Electronic Funds Transfer (EFT) is available for you to receive your claim payments electronically. This will allow you to receive payments sooner and will eliminate paper checks being sent through the mail. Payments will be electronically deposited into your checking account weekly. This will include a tracing number that will tie back to your Electronic Remittance Advice to allow for easy posting of payments, If you have questions regarding this process please contact your Provider Coordinator, If you are interested in signing up for EFT the forms can be found within the Quartz website at https://quartzaso.com/practitioners
Coding Policies and Procedures
As a general rule, Quartz follows the American Medical Association coding guidelines as the authoritative source for correct coding applications. As a secondary resource, Quartz will reference industry standards, including a review of Medicare and Medicaid guidelines.

Please refer to Appendix A.

Remittance Advice
The remittance advice (“Remit”) is the information Quartz sends to the provider to explain how submitted claims were processed.

The following is a breakdown of the various fields appearing on the Remit –

1) Provider ID number assigned by Quartz
2) Provider Name Provider that rendered the service.
3) Service Dates or date of service.
4) Service Code or procedure code / DRG.
5) Charged Amt. or amount billed per procedure.
6) Allowed Amt. or amount allowed per procedure.
7) Deductible billable to the patient.
8) Co-pay amount billable to the patient.
9) Coinsurance amount billable to the patient
10) Not Covered or all non-covered charges, but does not always mean the amounts can be billed to the patient.
11) Reserve or contractual agreement of withhold amount.
12) Code – Quartz-assigned code to explain group health plan procedure denials.
14) Individual Claim information will show
   a) Check Number
   b) Check Date
   c) Claim Number assigned by Quartz – this number is helpful when calling about a claim
   d) Patient’s ID Number
   e) Date of Birth
   f) Patient’s Group Name and Number
   g) Patient’s Account Number

If there are questions or problems with a Remit, please contact Quartz Customer Service at (800) 805-0693 using prompt 2 for providers.

Quartz contracted providers cannot attempt to recover from the patient the difference between charges and reimbursement, except for copayments, deductibles, and coinsurance, and services that are excluded under the patient’s health plan. When charges are not covered, the remittance advice message will state whether the patient may or may not be billed by you. The amount not covered can be either the discount amount, charges that exceed the health plan allowable, or a charge that the health plan does not cover.

The patient may be billed for only the “Copayment / Deductible Amount,” Coinsurance and “Non-Covered Charges.” For example, charges described as “patient met or exceeded number of visits or procedures” may be billed to the patient.

The Patient may NOT be billed for any of the following –

- “Charges Exceeding Maximum Allowance”
- “Reserve Amounts”
- Procedures that are in the not-covered column which have a line description stating “participant may not be billed”
- Procedures that need further review by the provider, such as a duplicate or incorrect code
- Services requiring a Referral or Prior Authorization but are lacking the Referral or Prior Authorization
Recourement
Quartz’s most common method of claim payment correction is the recourement process. This means that any amount owed to the group health plan administered by Quartz will be offset from future payments. All recouements will be listed individually and at the end of the remittance advice and will be listed as a negative amount. If an amount is due and there are no claims payments due to a provider during a weekly payment cycle, an outstanding liability report will print out showing the amount that is still owed.

Example –
A claim was submitted to Quartz and was paid in the amount of $39.43. Quartz then receives notice that the participant terminated coverage. In this case, the full amount of the payment will need to be recouped from subsequent remittance advices until the amount is repaid.

- The claim is reprocessed and notification that the participant was terminated is sent to the provider on the first payment cycle after the date the claim was reprocessed. On this remittance advice, there was no payment due to the provider for any other claims.
- The amount owed on the reprocessed claim will show individually and on the last page of the remittance advice.
- On the following payment cycle, the check to the provider contained claims payments totaling $216.00; however, since there is $39.43 listed as an outstanding liability, the check is written for $176.57. This clears the outstanding liability. Detail of each claim payment amount and the negative amount is included on the remittance advice.

Subrogation
The subrogation provision of the self-funded plans administered by Quartz and its provider contracts entitles an plan sponsor to recover from a responsible third party when they pay benefits on behalf of a participant. Participants and providers must cooperate to assist Quartz in protecting the plan sponsor’s subrogation rights.

The provider is expected to advise Quartz of the existence of a potential third party when submitting a claim.

Subrogation vendors may contact the provider for needed information.
Confidentiality

As required by HIPAA, Quartz has developed policies and procedures to protect the confidentiality of participant information. A Privacy and Security Committee sets standards for Quartz employees and some external parties, such as Quartz’s subcontractors.

The duties of the Privacy and Security Committee include –

- Overseeing Quartz’s compliance with HIPAA as a business associate
- Developing strategies to promote the prevention, detection and correction of privacy or security incidents
- Ensuring Quartz has policies and procedures relating to the use and disclosure of confidential information

The following is a brief summary of how Quartz uses, discloses and protects participant information.

General Policy
Quartz may only use or disclose participant information to the extent permitted in the service agreement and/or business associate agreement with a Covered Entity or as otherwise permitted or required by law. Quartz’s policies and procedures are designed to safeguard the confidentiality of individually identifiable participant information including both Protected Health Information ("PHI") and Personally Identifiable Information ("PII"). When we receive a request for confidential information, we will release the minimum amount of information necessary to respond to the request as described below.

Release of Protected Health Information without Authorization
Subject to the general policy above, Quartz may generally disclose protected health information without a participant’s written or verbal authorization for payment and health care operations. “Health care operations and payment” include –

- Payment of practitioners and providers
- Measurement and improvement of care and services
- Preventive health and disease management programs
- Investigation of complaints and appeals
- Other purposes needed to administer benefits

Additionally, Quartz may disclose protected health information pursuant to a valid court order or subpoena, or as otherwise required by law.

Release of Protected Health Information Requiring Authorization
For purposes other than payment and health care operations, the participant must sign an authorization before Quartz will disclose protected health information. In certain limited circumstances, Quartz will accept a verbal authorization for a one-time release of protected health information. Examples of disclosures that require an authorization include –

- Release of information to an attorney
- Data requested for an auto insurance claim
- Release of information that could result in another company contacting the participant for marketing purposes
- Release of certain information to an employer, a family member or a friend
- Release of information to a personal representative

Participant Access to Medical Records
Quartz does not maintain original medical records. We advise participants to contact their health care practitioner or provider to obtain medical records. The participant has the right to access protected health information maintained by Quartz. The participant also has the right to request amendment of such information and to place limitations on the disclosure of such information.

Disclosure of Information to Self-Insured Health Plans
Quartz provides certain types of protected health information to the self-insured health plans as part of the plan administration process. The type of information disclosed depends upon the contract between Quartz and the self-insured health plan. Both Quartz and the self-insured health plan must meet HIPAA requirements. HIPAA requires that self-insured health plans also protect protected health information from inappropriate disclosure and prohibits them from using such information for employment-related decisions or to administer any other employer-sponsored benefit plan.

Treatment Setting
Quartz is committed to ensuring the confidentiality of information in all settings. We expect our credentialed practitioners and providers to implement confidentiality policies and procedures that address the disclosure of medical information, patient access to medical information, and the storage, protection and destruction of protected health information. Quartz reviews practitioner confidentiality processes during pre-contractual site visits for primary care physician and for some specialists.
Coverage

Durable Medical Equipment (DME) and Medical Supplies

Durable Medical Equipment and medical supplies must be obtained from Quartz participating DME providers unless the participant has out of network benefits. Each patient’s DME benefits are specific to their health plan designed by their plan sponsor. To verify each patient’s DME coverage, please log in to the MyPlanTools secure portal under the Summary Plan Description. If further assistance is needed please contact Quartz Customer Service at (800)805-0693.

DME and medical supplies generally must be medically necessary and a covered item or service to qualify for coverage.

Covered DME and medical supplies are reimbursed at the provider’s contractual rate. Most items are subject to a –

1. Maximum dollar allowance;
2. Maximum length of rental; and/or
3. Copayment, coinsurance or deductible amount.

Prior Authorization

Prior Authorization is required for some DME and medical supplies. If Prior Authorization is not obtained, there will not be coverage. Please log in to the MyPlanTools secure portal under the patient’s Summary Plan Description to verify if a Prior Authorization is required. If further assistance is needed, you may contact Quartz Customer Service at (800)805-0693. If required, you may be asked to submit written documentation to Medical Management (see Utilization Management Section) for review and determination of medical necessity prior to providing the equipment or supply to participant.

Examples of Coverage Exclusions* –

- Equipment and appliances that are not prescribed for the treatment of illness or injury
- Repairs and replacement of DME
- Elastic support stockings (unless they are medically necessary), foot pads and bunion covers
- Orthopedic shoes unless they are part of a brace or for care of diabetes
- Items for activities of daily living, such as shower chairs, grab bars, toilet seats, etc.
- Convenience items

* Exclusions apply depending on the participant’s Plan Document and Summary Plan Description.

In general, supplies and equipment that are not primarily intended for medical use (e.g., air conditioners, exercise bicycles, and filter vacuum cleaners) will likely not be covered. Call Quartz Customer Service with any questions.

Home Health Care

Home Health Care may be covered when the participant requires skilled nursing care that cannot be provided by a family member or other person and, if not provided, would require the participant to be hospitalized or placed in a skilled nursing facility. Generally, in order for home health care services to be reimbursed, the attending physician must submit a treatment plan, prior to initiating the care, and must obtain Prior Authorization from the Medical Management Department. Participants must use Quartz participating providers for home health care services unless the participant has out of network benefits. All Quartz providers are state licensed or Medicare certified.

You can verify the self-insured plan and coverage a participant has by calling Quartz Customer Service. One home care visit consists of up to four consecutive hours in a 24-hour period.

Home Infusion Therapy

The self-funded plans administered by Quartz may encourage the use of home infusion therapy services rather than inpatient administration whenever medically appropriate. Patients with conditions such as osteomyelitis, Crohn’s Disease and cancer may be able to receive treatment at home due to advances in home infusion therapy. This safe and cost-effective therapy can mean an earlier hospital discharge, or even eliminate hospitalization. Some examples of appropriate situations are –

- Anti-Infectives including Anti-Virals and Anti-Fungals (both long-term and short-term)
- Total Parenteral Nutrition (TPN)
- Blood Products
- Cardiovascular / Inotropics
- Hydration
- Chemotherapy
- Immune Globulin
- Pain Management
- Anti-Coagulants
Home infusion providers are usually able to initiate service within a few hours of the request. Some patients do not require inpatient services before initiating service. Please verify the patient’s coverage regarding Home Infusion by logging into the MyPlanTools secure portal and consult the patient’s Summary Plan Description. If Prior Authorization is necessary before initiating home infusion services, authorization may be requested by the PCP, his / her designated staff, the referred-to specialist or other appropriate medical personnel. However, in circumstances when Prior Authorization is not possible, therapy can be initiated with a Quartz participating Home Infusion provider. Please contact Quartz the next business day following initiation of therapy. If further assistance is needed please contact Quartz Customer Service at (800) 805-0693.

**Behavioral Health and Chemical**

**Dependency Benefits**

Behavioral Health and AODA Services must be provided by a participating behavioral health professional unless the participant has out of network benefits. All services more intense than outpatient (inpatient, residential, PHP, etc.) must be Prior Authorized except for emergency admissions. Emergency admissions require notification within three business days of the admission. For verification of the patient’s Behavioral Health coverage please log in to the MyPlanTools secure portal under the patient’s Summary Plan Description. The patient’s plan sponsor may choose UW Health – Behavioral Health Care Management for assistance in accessing behavioral health services.

If applicable, patients requiring AODA services will be managed by – UW Health Behavioral Health Care Management.

**Service Limitations – Behavioral Health and AODA Benefits**

Service limitations vary by self-funded plan. Benefits along with only medically necessary care may be combined for outpatient, inpatient and transitional care. Health plans may exclude coverage for behavioral / conduct disorders, learning disabilities, and developmental delay and court-ordered treatment that does not otherwise qualify for coverage.

Examples of common non-covered services may include* –

- Hypnotherapy
- Marriage counseling
- Biofeedback

Please contact Quartz Customer Service with questions about coverage. Questions about the management process may be directed to the appropriate medical management staff –

**UW Health – Behavioral Health Care Management**

Toll-Free (800) 683-2300

Local (608) 233-3575

*Exclusions apply depending on the participant’s Plan Document and Summary Plan Description.

**Skilled Nursing Facility (SNF)**

The self-funded plans administered by Quartz may encourage the use of skilled nursing and rehabilitation as part of the medical management process. Please note that self-funded plans may exclude coverage for custodial, maintenance or long term care.

**Coverage**

Coverage may apply only when skilled nursing or skilled rehabilitation services are required on a daily basis. Skilled nursing care means care that can only be performed by or under the supervision of licensed nursing personnel. Skilled rehabilitation services include such services as physical therapy performed by or under the supervision of a professional therapist. SNF admissions may require Prior Authorization.

Examples of Coverage Exclusions for care that is* –

- Essentially domiciliary or custodial,
- Available to the insured without charge, or
- Paid for under a governmental health care program other than Medical Assistance

*Exclusions apply depending on the participant’s Plan Document and Summary Plan Description.

Coverage for skilled nursing care provided in a licensed skilled nursing facility varies by self-funded plan. Call Quartz Customer Service for specific coverage information.

**Hearing Aid Coverage**

The self-funded plans administered by Quartz must provide coverage for hearing aids in accordance with federally mandated coverage requirements. At a minimum, coverage is allowed for one standard model hearing aid, as determined by Quartz, per ear once every 36 months. Hearing aids must be obtained from a participating Quartz provider. Hearing aid providers must submit both the appropriate code along with the manufacturer and model on the claim for appropriate
coverage determination. The standard model list is updated annually.

Covered Hearing Aids
Please go to: quartzaso.com/hearing-aid-list to view list.

Emergency Room

Definition of “Emergency”
Emergency is defined as –

1. Serious jeopardy to the person’s health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child;
2. Serious impairment of the person’s bodily functions;
3. Serious dysfunction of one or more of the person’s body organs or parts.

Procedure
Generally, a participant is able to receive emergency care from a Quartz network hospital. However, if a participant is unable to reach a network hospital, he/she should go to the nearest hospital emergency room for treatment.

Follow-up Treatment
All follow up treatment should be performed by a participating provider, unless the participant has out of network benefits.

Emergency Transfer
The attending physician should refer the participant to a participating provider hospital if an emergency transfer is required.
Health Management Programs

Quartz offers the self-funded plan sponsor the option to purchase Health Management Programs to measure and improve the health status and quality of life of their participants. Services are available for the following –

- Asthma
- Diabetes

The UW Health Quality Care Coordinators, on behalf of Quartz, communicate with practitioners and participants throughout the year regarding evidence-based clinical guidelines, recommended labs and screenings, and self-management tools / resources.

Quartz’s Health Management Programs are confidential and participation in the programs is voluntary. If purchased, each program provides a variety of services for at-risk participants with chronic conditions. The goal is to promote participant self-management and offer resources and support to assist the primary care practitioner in managing their patients’ conditions.

Participant resources and services may include –

- An informational brochure about the condition, along with a list of national and local organizations to contact for additional information
- Reminders about necessary screenings and exams, recommended frequency of practitioner visits
- Annual influenza vaccine reminder
- Ongoing educational mailings regarding helpful condition-related health information
- Information about the connection between chronic conditions and key associated co-morbid disorders and when to seek medical assistance
- Special attention is also given to emotional wellness for each program.
- Screening for complex case management or telephonic health coaching to participants following an inpatient stay or ED visits.
- Condition-specific magazine subscription (diabetes program only)

Practitioner resources and services include –

- Clinical Practice Guidelines – Each CPG is developed by an interdisciplinary group of recognized local leaders and is based on a nationally recognized evidence based recommended guideline. You can obtain a copy of the guidelines by calling (800) 805-0693.
- Practitioner-specific notification of participants seen in the ED or hospitalized with a condition-specific diagnosis.
- Periodic reminders regarding missing labs or tests for their patients.
- To enroll / remove a participant from a health management program, please contact the UW Health, Health Services department at (866) 884-4601.

Health Coaching

Quartz offers the self-funded plan sponsor the option to purchase telephonic health coaching. If purchased, health coaching is offered to participants identified via claims (post hospitalization), or following completion of a health risk assessment (HRA) and / or biometric screening event or through self/practitioner referrals.

Health Coaching involves –

- Three to six brief confidential telephone discussions with a coach to work together to identify strengths, create a plan, and develop action steps / tasks to reach goals; as well as explore potential resistance about making a behavior change and identifying ways to overcome the barriers
- A process by which individuals choose the areas they would like to work on such as – eating habits, increasing physical activity, tobacco cessation, lowering stress, or medication adherence
Preventive and Wellness Services
Quartz offers the self-funded plan sponsor the option to purchase targeted preventive and wellness services. Quartz provides reminders to participants on a variety of preventive health topics. Reminders are sent to participants who qualify based on gender, age, claims, laboratory results, and/or pharmacy indicators. The services for which regular reminders are sent are –

<table>
<thead>
<tr>
<th>Service or Measure</th>
<th>Contact protocols</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunization – Childhood</td>
<td>10, 19 months, 12 years</td>
</tr>
<tr>
<td>Health Milestones – reminders of age and gender-appropriate services</td>
<td>Female – age 18, 40 and 50 Male – age 50</td>
</tr>
<tr>
<td>Influenza</td>
<td>Annually</td>
</tr>
<tr>
<td>Diabetes lab &amp; screening</td>
<td>Goal of two HbA1c / year, microalbumin urine, eye exam</td>
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Shared Decision-Making
Shared decision-making is the collaboration between patients and their practitioner to come to an agreement about a healthcare decision. It is especially useful when there is no clear “best” treatment option.

Medical Records

Importance of Medical Records
The medical record communicates the participant’s current and past health status, past medical treatments and treatment plans for future health care. Therefore, the medical record may reflect all services provided by the primary care practitioner, specialty care providers, ancillary services, diagnostic tests, and therapeutic services that the participant receives and may be billed. Sometimes medical records need to be reviewed by Quartz to determine claims payment or coverage. The content and quality of information documented in the medical record is important in facilitating communication, continuity and coordination of care and promoting efficiency and effectiveness of treatment. It is important that the participant’s medical record be available to the practitioner at the time of the participant’s appointment. The confidentiality of the medical record information must be assured.
MyPlanTools
MyPlanTools is a secure, on-line tool that can be used by Quartz providers to perform administrative tasks, including reviewing –

- Patient Eligibility
- Participant Demographics
- Creating and Viewing authorizations
- Viewing Remittance Advices
- Claim status and denial descriptions
- Summary of Benefits & Coverage
- Plan Document and Summary Plan Description
- Practitioner Look Up

MyPlanTools also offers the ability to email Quartz Customer Service, through the Tools portion, within Ask An Expert and receive a response within 24 hours. MyPlanTools is not meant to replace the services offered by Quartz Customer Service. Should you need to contact Customer Service, please call (800) 805-0693, Monday through Friday, 8:00 a.m.-5:00 p.m.

Access within MyPlanTools
After you have returned the Access Request Form, your Provider Coordinator will contact you to determine who the administrator account person will be. This person will be provided access to –

- View Eligibility, Claims and Benefits
- If needed – Prior Authorization and Remittance

Additionally –

- Add Users within your facility to allow access to:
  - View Eligibility, Claims and Benefits
  - Prior Authorization and Remittance
- Behavioral Health Authorizations
- If you need assistance, on-site training can be provided.

Forgotten Password / Username
If you have forgotten your password for MyPlanTools, simply click on the MyPlanTools login of Quartz’s website and enter your user name and choose “Forgot your password”. You will be prompted to enter your user name again choose “Email Password”. A new password will be emailed to you immediately.
New Medical Technology Evaluation
The health care industry changes rapidly. The medical community develops new medical treatments and procedures on a daily basis. The process of reviewing and assessing new medical technologies as well as new applications of existing technologies is utilized in providing safe, effective care to participants.

Requesting a New Medical Technology Evaluation
If you believe that a new technology or a new application of an existing technology is medically necessary for the treatment of a participant, either you or the participant may contact Quartz to initiate the preliminary medical review and obtain information about the process. Self-funded plans administered by Quartz benefit plans generally do not cover experimental or investigational treatments.

After you request a review and submit medical information supporting the request, the medical management staff, in conjunction with the medical director, will initiate a thorough investigation. In addition to reviewing the information submitted, Quartz will research additional in-house and external resources, and consult with experts in the specific medical field as needed.

Evaluation Factors
When evaluating new treatments and procedures for determination of coverage, the medical director takes into account –

- The technology must have final approval from the appropriate government regulatory bodies
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
- The technology must improve the net health outcome.
- The technology must be as beneficial as any established alternatives.
- The improvement must be attainable outside investigational settings

After conducting the review, the medical director determines if the service or treatment is experimental and / or investigational as defined by the self-funded plan’s Plan Document and Summary Plan Description or if it is medically necessary, and is not otherwise excluded from coverage.

After the review is complete, the medical director will determine if a medical policy will need to be developed or if an existing policy will require revision. Participants have the right to appeal a coverage decision if they disagree and are encouraged to contact Quartz Customer Service with any questions or concerns at (800) 805-0693.
Pharmacy

If your patient’s plan sponsor has not purchased Pharmacy Benefit Management services through Quartz, much of the information contained in this section does not apply. Ask the participant to provide their Prescription Drug Card. If the participant does not have pharmacy benefits through Quartz, there will be no information for Rx BIN, RxPCN or Rx Group on the ID card. Some Quartz participants may have their own PBM vendor and will have a separate ID card listing those benefits.

However, if the participant’s card does list Rx BIM, Rx PCM and Rx Group, then the information in this section does apply.

The following information is provided to help you understand the prescription drug benefit, address concerns you may have regarding medication coverage, answer benefit-related questions from participants, and work within the Quartz system to provide appropriate care for your patients.

Prescription Drug Formulary

The purpose of a formulary is to promote use of safe, efficient, and cost-effective medications. A formulary is an important tool to help the health plan meet its goal of providing coverage for safe and effective medications in an affordable manner.

The Prescription Drug Formulary is made up of a list of preferred medications, a list of non-preferred medications and a list of restricted medications. Preferred medications are cost-effective drugs covered by the health plan. Non-preferred medications are those that have suitable alternatives on the formulary, or those that are considered less effective or less safe for most patients. Preferred or non-preferred medications may be restricted, which means that an approved prior authorization is necessary before coverage is granted. The prescription drug benefits cover the FDA-approved generic equivalent when it becomes available. For exceptions to this benefit, refer to the prior authorization section.

Additionally, some medications may be benefit exclusions; these are specifically excluded from coverage under the health plan. For some participants, benefit exclusions consist of cosmetic treatments, weight modification medications, infertility and sexual dysfunction medications, over-the-counter medication, medical food, and nutritional supplements.

Some medications that are administered in the clinic or a practitioners’ office require review and an approved prior authorization from the Pharmacy Program prior to medication administration in the clinic. These medications are noted on the formulary listing under Medical Benefit Medications.

How is the Formulary Developed?
The Pharmacy & Therapeutics (P&T) Committee is responsible for creating and maintaining the prescription drug formulary and provides this on behalf of Quartz. This committee is made up of physicians and pharmacists who care for participants in our community. The P&T Committee meets monthly to review medications and determine their formulary status. The committee considers a variety of factors, such as safety, side effects, drug interactions, how well the drug works, dosing schedule and dose form, appropriate uses, and cost-effectiveness. In making these decisions, the committee obtains up-to-date information from a variety of sources, including published clinical trials, data submitted to the FDA for drug approval, and recommendations from local or national treatment guidelines. Additionally, the committee solicits input from local practitioners who are experts in the use of the drug class under review.

The formulary is subject to change at any time. There may be copayment differences between the various self-funded plans administered by Quartz. Some plans may not include coverage for all the drugs listed on the formulary. Questions about drug benefits or medications listed on the formulary can be directed to Quartz Customer Service.

To obtain a copy of your patient’s current drug formulary, go to MyPlanTools. The formulary is also available at via Surescripts for electronic prescribing systems that connect to the Surescripts hub.

Pharmacy Benefit Basics

In order to meet the wide-ranging needs of the marketplace, Quartz has developed a variety of pharmacy benefit options for plan sponsors to consider. The plan sponsor self-funding the health plan makes the final decision as to what pharmacy benefit its employees will have. Understanding a few basics about each type of pharmacy benefit will help you with some of the questions that your patients may have.

Some of the common features of the Quartz drug benefits are described below. To determine an individual patient’s coverage, have them refer to their Plan Document and Summary Plan Description to determine which coverage is included with their pharmacy benefit.

Deductibles – A deductible is the amount paid out of pocket before the plan pays for covered services. The drug benefit may have a deductible that combines costs for both...
Pharmacy

pharmacy and medical services, or it may only count pharmacy costs. In either case, 100% of the covered drug costs are paid until the deductible is met. Once the deductible is met, the participant pays nothing for covered prescriptions until the end of the benefit year.

With deductible requirements, it is important that the participant has their pharmacy submit claims online to Quartz even though they will be paying 100% until the deductible is met. This is important because the participant will get a lower negotiated price and the amount the participant pays will be applied toward the deductible amount as tracked in our system.

Participant cost share – Once the deductible has been met, (if there is one) the drug benefit provides benefits for covered drugs for the rest of the coverage period. The participant’s share of the cost for each claim may be a copayment or it may be a co-insurance. This amount is paid by the participant to the pharmacy. The self-funded plan administered by Quartz pays the rest of the cost of the drug.

Fixed dollar co-payments are usually based on the type of drug. Typical copay tiers for self-funded plans are as follows –

<table>
<thead>
<tr>
<th>Copay Tier</th>
<th>Preferred Generics</th>
<th>Preferred Brands</th>
<th>Non-preferred Brands or Generics</th>
<th>Specialty Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<tr>
<td>4</td>
<td></td>
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</tbody>
</table>

Each tier may have a different copay amount. For example, a common pharmacy benefit sold by Quartz may look like –

- Tier 1 copay of $10
- Tier 2 copay of $35
- Tier 3 copay of $60
- Tier 4 copay of $100

Copayment amounts for each tier will vary among participants depending on the benefit plan.

The tier of a medication can be determined by reviewing the formulary. Please note that patients with the Tier 3 benefit cannot have a third tier copayment reduced to a second tier copayment. Copayment tiers are fixed based on preferred status and brand / generic status and are not adjusted based on individual circumstances.

Coinsurance is the percentage of the total cost of the drug that a participant is required to pay. Coinsurance may vary. Since the prices of drugs can change, the cost share for that drug may also change from time to time. When the participant receives the prescription medication, the pharmacy staff will inform them of the amount of cost share.

Out of Pocket Limits – The prescription benefit may include an out of pocket limit. This is a limit on the share of the cost of covered services during a coverage period. The limit on the benefit may combine out of pocket costs for both pharmacy and medical services. Alternatively, it may only count the pharmacy costs.

There are typically individual and family out of pocket limits. Meeting the individual limit may result in zero out-of-pocket for that individual for the rest of the coverage period. Meeting the family out-of-pocket limit will result in zero out of pocket for the entire covered family for the rest of the coverage period.

So, if the benefit includes a deductible, cost share and out-of-pocket limit, there could be three phases during a coverage period –

Deductible ➔ Cost Share ➔ Out-of-Pocket Limit

Coverage of Drugs – Not all drugs are covered by the health plan. Some are covered only under specific circumstances. Categories of non-covered drugs are described below.

Exclusions – Some drugs or groups of drugs may be excluded from coverage under the self-funded plans administered by Quartz.

Restrictions – Restricted drugs are those that require Prior Authorization or Step Therapy before you can receive coverage. Restricted drugs may be preferred or non-preferred. Restrictions are noted on the formulary.

Non-preferred drugs – Some of the self-funded plans administered by Quartz provide coverage for non-preferred drugs at higher copays or at the coinsurance amount. Other benefits do not provide coverage for non-preferred drugs without prior authorization.

Specialty Pharmaceutical Benefit

Some plan sponsors may have purchased a Specialty Pharmaceutical Benefit; this benefit requires the use of the Specialty Pharmaceuticals Program for certain medications. Medications included in the Specialty Pharmaceutical Program are denoted with an “SP” on the formulary listing. Medications included in the Specialty Pharmaceutical Benefit are required to be filled by a pharmacy in the Quartz...
Pharmacy

Specialty Pharmaceutical Program and additional specific requirements for each program may apply.

Quantity Limits

- Maximum Days Supply – 30 days
- Individually Packaged Items – limited to two packages per copayment (Examples: two insulin vials, two inhalers, two ophthalmic bottles)
- Certain medications have specific quantity limits as noted in Appendix A on the formulary listing.

Pharmacy Program Coordination

The UW Health Pharmacy Benefit Management Program manages the Quartz Pharmacy Program. The program staff develops and coordinates medication use policy and drug information for Quartz. In addition, the staff provides the P&T Committee with scientific support, drug use evaluation services, medication use policy analysis, physician profiling, physician education and assistance with disease management programs and outcomes research.

Review of Drugs

All new FDA approved medications, including new molecular entities and new dosage forms that are not specifically excluded from coverage are reviewed by staff within 90 days of release to the market.

- A coverage decision will be made by the P&T committee within 180 days of release to the market –
- Other medications not newly approved and marketed or with new FDA indications will be reviewed at the discretion of the P&T Committee Chairperson
- Practitioner request for a review
- P&T committee member request for a review

If a review is not possible or desirable within 90 days of market approval or a new drug of indication, the P&T Committee will be apprised of the situation and clinical justification of the delay in the review will be presented.

Drugs or drug classes not meeting the criteria for a review trigger will be reviewed by the Quartz P&T Committee at the discretion of the Pharmacy Program Director or the P&T Committee Chairperson.

Prioritization of the timing of drug reviews is based on a variety of factors. Factors considered in determining the timing of a review by the P&T Committee include –

- Presence or absence of safety signals, depth and duration of available safety data
- Depth and duration of available efficacy data, presence of head-to-head comparisons with existing products
- Relevance of the indication(s) the population of participants on plans administered by Quartz
- Volume of prior authorization requests or volume of non-formulary utilization
- Opportunities to improve the cost-effectiveness of care
- Practitioner or P&T committee member request

Pharmacy program staff monitor a variety of information sources on an ongoing basis to identify triggers for P&T review. Sources of information may include FDA email updates for approvals and safety warnings, review of table of contents for top medical journals, and a variety of daily health news email services, interaction with practitioners, HCPCS and CPT published lists.

When a possible opportunity is identified, pharmacy program staff discusses the relevance and determine if the criteria for a review has been met. Based on this assessment, the timing of review is established.

Reviews are assembled by clinical pharmacists from the UW Health Pharmacy Benefit Management Program and consist of a three-stage process. Stage one incorporates biomedical evidence from clinical research, FDA documents and expert opinion to determine the efficacy, safety, compliance implications and cost effectiveness of the medication. Stage two involves comparing the drug product being reviewed to existing medications to determine whether it offers a different or better treatment modality. Stage three returns to the scientific literature and physician expertise to determine the reviewed product’s place in therapy.

Based on the review, the staff recommends an appropriate formulary status and restriction status for the drug, as well as any applicable prior authorization criteria. The P&T Committee meets monthly to review staff recommendations. Based on committee consensus, formulary and restriction status is assigned (preferred or non-preferred, restricted or non-restricted.)

Factors and Ratings of Factors used to analyze drug products –

1. Efficacy / effectiveness – Has the drug been proven to be effective in clinical trials? Do the medical experts and the FDA view the new medication as an improvement?
2. **Safety and side effects profile** – What is the difference in toxicity and tolerability compared to alternatives?

3. **Pharmacokinetics** – Are there advantages / disadvantages to specific patient populations (e.g., patients with kidney failure or liver disease)?

4. **Monitoring parameters** – Does the drug have special monitoring parameters (e.g., blood tests)?

5. **Compliance issues** – Does the dosing frequency or duration of therapy offer advantages in compliance over existing therapies?

6. **Indications / therapeutic need** – Does another covered medication deliver similar benefits?

7. **Cost** – What is the incremental cost versus the incremental benefit of this drug compared to alternative therapy?

The factors weighted most heavily in drug evaluations are efficacy and safety. Cost is considered in terms of the value a product provides from outcomes or when two or more products have similar efficacy and safety profiles or when the benefits provided by the drug are small relative to the cost. When reviewing cost as a factor in the decision, a long-term perspective will be taken for the cost analysis (three to five years). Using a longer term perspective accounts for anticipated changes to the marketplace (new entrants, utilization shifts) as well as pricing (generic availability, more aggressive pricing due to additional competition) and results in a more stable formulary for participants and providers.

The P&T Committee evaluates the quality of drug products. The following examples illustrate the way different factors are used in determining where a drug is placed on the formulary.

- Drugs that are less costly and provide better outcomes than current therapies are added.
- Drugs that are more costly and are not better than current products are not added.
- Drugs that are less costly and are not better than alternative therapies require deeper analysis. In some cases, when the drug is only slightly less effective than alternatives, the consequences of treatment failure are not serious, and the cost difference is significant, patient, provider and the plan sponsor cost become considerations.
- Drugs that are more costly and provide better outcomes than current medications require deeper analysis. In some cases, when the drug provides only slightly better outcomes that are not considered significant in terms of a patient’s overall treatment results, and the drug is significantly more expensive than alternatives, patient, provider and plan sponsor cost become considerations.

### Formulary Decision-Making Process

**Medication Prior Authorization**

Generally, self-funded plans administered by Quartz require the submission and approval of a Medication Prior Authorization Request form before coverage is granted for all restricted medications, regardless of formulary status. Participants with a closed formulary benefit also require an approved prior authorization for coverage of non-preferred medications. In addition, certain clinic administered medications require an approved prior authorization before administration in the clinic is covered.

The Medication Prior Authorization Request form can be obtained through Quartz Customer Service or via MyPlanTools. Prior Authorization criteria for each restricted medication can be verified by logging into the MyPlanTools secure portal and looking under the group’s benefits. For medications where an equivalent generic is available and the brand name is medically necessary, a prior authorization approval is required. Specific criteria for generic availability includes a prior trial of the generic product and depending upon the product requested, may also include a trial with a therapeutic equivalent preferred alternative before coverage for the brand name medication is approved.

Completed forms can be faxed to (888) 450-4711 or returned to the address indicated on the form. The information provided will be reviewed by a clinical pharmacist, and a decision will be made based on criteria developed by the P&T Committee. Notification of the coverage decision will be provided to both the requesting practitioner and the participant. If you would like to discuss the specifics of a medication request decision with a pharmacist or have general questions about the prior authorization criteria, you may call (888) 450-4884.
Practitioner Appeals Process

Quartz is committed to a fair and thorough process for reviewing self-funded group health benefits to make medical management decisions. Quartz invites practitioners to discuss such decisions with the medical director, if necessary, for fair decision-making.

Appealing a Denial of Coverage

If applying plan benefits as listed in the Plan Document and Summary Plan Description denies coverage of a service or supply on behalf of the plan, the participant and practitioner will receive written notification that clearly indicates the reason for the denial, including information about the appeal process. As a practitioner, you may contact the medical director to discuss any medical management determinations. A physician reviewer or medical director is available to you Monday-Friday during normal business hours. Practitioners have the right to appeal on behalf of a participant when an adverse benefit determination is rendered in an expedited review. For non-expedited appeals, the participant must sign an appointment of authorized representative form, appointing the practitioner as the participant’s authorized representative. This form can be found on Quartz’s public website.

Expedited Reviews

An expedited review process is available when a delay in decision-making might seriously jeopardize the life or health status of a participant. We provide a decision no later than 72 hours after the request is received. A participant, or practitioner acting on behalf of a participant, may request an expedited appeal. Expedited reviews will be granted for requests concerning –

- Preauthorization of treatment for urgent clinical situations (patient has high potential for deterioration to an emergent condition within 48 hours);
- Admissions, concurrent review and continued inpatient stays;
- Potential interruptions of active course of treatment

For non-expedited reviews, if an adverse benefit determination is appealed the following timeline generally applies –

- Appeal requests are to be filed within 180 days of an adverse benefit determination. Pre-service appeals will be completed within a thirty (30) day time frame. Post-service appeals will be completed within a sixty (60) day time frame.
- Once the appeal is reviewed, the Appeals Specialist will compose a letter and provide attachments, as appropriate to the participant and/or his/her authorized representative that will contain the decision with the specific reason for the decision, in easily understandable language. This is sent within the notification period depending on if the appeal is pre- or post-service.

Self-insured group health plans may utilize separate services for Appeals. For further information regarding the formal appeals process, please verify by logging into the MyPlanTools secure portal under the patient’s Summary Plan Description. If further assistance is needed, please call Quartz Customer Service at (800) 805-0693.

UW Health Pharmacy Benefit Management Program (888) 450-4884

If the participant does not receive pharmacy benefits from Quartz, contact the participant’s plan sponsor.
Product Descriptions

Quartz offers an Exclusive Provider Organization (EPO) plan option to plan sponsors interested in self-funding their employee health benefits. An EPO Plan provides a choice of providers within a selected network of high quality providers under which participants must use the doctors and hospitals within the Quartz Network. For groups who select the EPO, there is no coverage for care received from a non-network provider, except in an emergency situation. Additionally, Quartz will offer a Point of Service (POS) product that provides in and out of network benefits. Please refer to MyPlanTools, to verify benefits and cost sharing requirements.

Understanding the Participant Identification Card

All participants receive two individualized Participant Identification Cards that are described below.

First Panel of ID Card

<table>
<thead>
<tr>
<th>Network:</th>
<th>Group Logo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant Name:</td>
<td>Participant #</td>
</tr>
<tr>
<td>Dependent Name:</td>
<td>Dependent #:</td>
</tr>
</tbody>
</table>

Second Panel of ID Card

<table>
<thead>
<tr>
<th>Dependent Name:</th>
<th>Dependent #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP: Clinic Name</td>
<td></td>
</tr>
<tr>
<td>Provider Name</td>
<td></td>
</tr>
</tbody>
</table>

See your Summary of Benefits and Coverage for complete benefit information

Third Panel of ID Card

**Benefit Information:** Can be found within MyChart at QuartzASO.com.

**Provider Network:** Please use Find a Doctor at QuartzASO.com

**Prior Authorization Information:** The provider, patient or family member must call the Customer Service (telephone number listed below) to receive certification of certain Cost Management Services. **Participants Send Medical Claims to:**

Quartz ASO, PO Box 490, Sauk City, WI 53583-1374

**Important Telephone Numbers:**

- Quartz Customer Service: (800) 805-0693
- 24 Hour Pharmacy: (800) 555-1572
- Cost Management (Vendor Name): 888-888-8888

Pharmacies may use: BIN # 003585 Rx PCN # ASPROD1 Rx Group # UTYXX

Quartz is a third party administrator for employers who self-fund employee health benefits.
The Participant Identification Card (ID card) includes the following enrollment-related information –

**Your Network** – The ID card will indicate which network to use to search for providers in Find A Doctor.

**Participant Name** – Full name of the participant.

**Date Printed** – This is the date the ID card was printed. It helps the participant identify his / her most current benefits.

**Participant Number** – The participant number is a unique number assigned to each individual participant.

**Group Number** – The group number identifies the plan sponsor and is usually the same for all employees and their dependents within that plan sponsor. In a few instances, employees of the same employer and/or plan sponsor will have different group numbers due to different locations and / or please contact Quartz Customer Service with questions regarding participant benefits.

**Participant Name** – Each participant / dependent is listed under “participant name,” along with each individual participant’s PCP name, clinic name and telephone number.

**Person Code** – Each participant / dependent is identified by a person code. The person code is the last two digits of the participant’s identification number. The subscriber will always have person code “00.” Please include the appropriate person code whenever you contact Quartz regarding a specific participant.

**Primary Care Physician (PCP)** – The clinic and Primary Care Physician (PCP) selected by each participant is listed along with the clinic phone number. Some participant identification cards may list only the clinic name and clinic phone number. Each participant shown on a card may have a different PCP.

**Please Note** – This information will not be listed for PPO participants or participants with a non-contracted PCP.

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**IMPORTANT!** The third panel of the ID card includes important information for both participants and providers. In particular, the Prior Authorization Information is very important. The provider, patient or family member must call Cost Management to receive certification of certain Cost Management Services. This call must be made at least three days in advance of services being rendered or within 72 hours after a Medical Emergency. Failure to follow this procedure may reduce reimbursement in the form of a penalty or a denial of payment.

Please contact Quartz Customer Service with questions regarding participant benefits.
Provider Coordinators

Quartz has dedicated Provider Coordinators to service your clinic / facility needs. You can reach your Provider Coordinator by calling (877) 849-1029 and entering the correct extension listed on the map. Your Provider Coordinator will be assigned based on the county in which your primary facility or business office is located.

Provider Office Changes

Quartz requests timely notification of significant changes within your organization so that we can provide accurate claims processing, notification to providers and participants and continuity of care processes. You can complete a change form at Quartzaso.com and choose the Practitioners link to the Self-Help Forms. Please notify Quartz as soon as possible of any changes, such as –

- New practitioner within your facility
- New facility location
- Terminated practitioner
- Terminated location
- Change Form

Adding a new practitioner or notification that a practitioner is leaving?

Notify Quartz when a new practitioner joins your clinic. You can complete the New Practitioner Form at quartzaso.com. If credentialing is required, it will proceed as per the requirements.

In the event that a practitioner leaves your clinic, please notify Quartz with the Termination Practitioner Form. If the practitioner is relocating to a location within Quartz’s service area, the practitioner may need to follow continuity of care guidelines. Continuity of care guidelines are available upon request.

Adding a new location and / or a location is closing? Notify Quartz when a new a new facility or location is added by completing the New Location Form. Notification of the facility must be received before participants may receive services at the new location.

In the event that a clinic or facility is no longer available to our participants, please notify Quartz with the Termination Location Form.

Change form - This form should be used when changes occur such as:

- practitioner changing name,
- specialty, degree / credentials

All forms are submitted electronically through our web site.
Provider Coordinators

For assistance, call 800.362.3309 or:

- Cali - 608.881.8232
- Kathy - 608.643.1442
- Season - 608.643.1497
- Tammy - 608.643.1524

Effective January 1, 2017
Referrals

Self-funded plans administered by Quartz may not require written approval prior to accessing specialty care from an in-plan specialist (unless specified in your provider contract). However, please note that some medical services, supplies and equipment, and generally all out-of-plan requests, require Prior Authorization (see section below on Prior Authorization).

For patients with self-funded health plans, prior authorization guidelines are specific to that patient’s health benefit plan. Always verify if prior authorization is required by logging in to the MyPlanTools secure portal under the patient’s Summary Plan Description. If further assistance is needed please contact Quartz Customer Service at (800) 805-0693.

Out-of-Plan Referrals

When the PCP or treating provider recommends services from a practitioner or provider who is not part of the Quartz provider network, the provider generally must complete a Prior Authorization Request Form. This request must be submitted to and approved by Quartz on behalf of the plan before a non-participating provider renders care.

Please note – approval to obtain services from a non-participating practitioner or provider will be granted only when such services are medically necessary and not available from a plan practitioner or provider.

Prior Authorization

Some medical procedures, (such as clinic administered medications- see Pharmacy Section), supplies and equipment may require Prior Authorization. The provider requesting the service must obtain approval from Quartz on behalf of the plan before services are provided by submitting the Prior Authorization Request Form with supporting medical documentation. For a list of services requiring Prior Authorization, please review the Prior Authorization List under the patient’s Summary Plan Description within the MyPlanTools portal for verification.

Please Note: Denied authorization liability is determined by the patient’s health plan sponsor.

If the patient’s self-funded plan sponsor has purchased Quartz Medical Management and you have specific questions about Prior Authorization or would like to submit a written Prior Authorization Request Form, please log on to the MyPlanTools portal under the patient’s name or contact Quartz Customer Service at 800-805-0693 for assistance.
Utilization Management

Medical and Behavioral Health Management

The health care industry recognizes that one way to offer efficient care is to provide appropriate preventive and medical care from the outset. The goal of utilization management (UM) is to help guide medical care efficiently and economically. If these services are purchased by the health plan, Quartz uses a variety of processes to evaluate the utilization and quality of health care services provided to participants.

Medical Management and Behavioral Health Management options for participants with self-funded health plans are determined by the plan sponsor. Always verify availability of these options by logging into the MyPlanTools secure portal under participant’s Summary of Benefits.

If more assistance is required please contact Quartz Customer Service at (800)805-0693

Participants may be managed by –

- Medical Management:
- Pharmacy Benefit Management
- Behavioral Health Care Management

Should the group choose Medical Management offered through Quartz, all the UM programs are supported by qualified health professionals who are supported by physicians whose education, training and experience are commensurate with the UM reviews they conduct.

In an effort to assess the clinical appropriateness of hospital and other services, the medical management staff utilizes clinically-based decision support criteria. Medical Management uses evidence-based criteria, such as InterQual and Milliman Care Guidelines for inpatient care. Decisions are also made based on policies and procedures.

The InterQual criteria are a set of clinical practice benchmarks for treating common conditions. They describe an efficient treatment for a given condition and the typical progress that can be expected. Physicians, nurses and other health care professionals developed the guidelines based on the actual practices of clinical care throughout the United States. These guidelines are typically used in planning inpatient care, projecting the length of stay, and monitoring care a patient may require. The physicians and other medical experts in our community review them annually and modify them as necessary to meet individual needs and the local delivery system.

Other care guidelines or criteria utilized are –

- UW Health - Behavioral Health Care Management:
- Mihalik Group Medical Necessity Manual for Behavioral Health, American Society of Addiction Medicine criteria and other national, state and locally established standards of practice.
- UW Health Medical Policies
- The Participant’s Plan Document and Summary Plan Description

The guideline-based system eliminates reviewer subjectivity, guides decisions about clinical appropriateness that support cost-effective, appropriate level of care decisions, and ensures quality of care and service.

The medical management teams have full disclosure capabilities of the care guidelines and can provide a specific set of criteria to you upon request. You may request the guideline criteria by contacting the appropriate medical management team.

The guideline / criteria are evidence-based and in line with how health care providers across the United States are practicing. They are supported by the latest publications regarding medical management and are not considered financially-derived utilization controls. Quartz monitors the UM decision-making processes on behalf of plans to ensure appropriate utilization and prevent inappropriate denials. In addition, the Utilization Management / Technology Assessment Committee (UM / TAC) consists of network physicians who oversee UM activities including assessments of new technology and new applications of existing technology.

Quartz, and the self-funded plans it administers, do not provide financial incentives based on utilization management denials / decisions. All UM decision making is based solely on appropriateness of care a practitioner. You may contact the medical director to discuss any medical determinations. A physician reviewer or medical director is available to you to discuss any UM decision, Monday- Friday, eight hours a day, during normal business hours (8 a.m. to 5 p.m.), at the numbers noted below.

Medical Management and Behavioral Health Management staff are available Monday through Friday 8:00 a.m. – 5:00 p.m. on business days to receive and return calls regarding medical / behavioral health management issues. After normal business hours, calls are answered by an answering machine or service and are returned the next business day. Staff members identify themselves by name, title and
Utilization Management

organization when receiving or returning calls relating to medical / behavioral health management issues. A toll-free number is also available to accept and address any concerns. Medical Management and Behavioral Health Management staff are available Monday through Friday 8:00 a.m. – 5:00 p.m. on business days to receive and return calls regarding medical / behavioral health management issues. After normal business hours, calls are answered by an answering machine or service and are returned the next business day. Staff members identify themselves by name, title and organization when receiving or returning calls relating to medical / behavioral health management issues. Always refer to the MyPlanTools secure portal under the patient’s Summary Plan Description to verify patient’s medical management information.

Hospital Admissions Policy
When arranging for an elective hospital admission, remember that all participants must be admitted to a participating hospital. Exceptions are emergencies. If a participating hospital cannot provide the needed services, the admitting physician should obtain written prior authorization for an out-of-plan admission from the appropriate medical management department.

Notification Requirements
The self-funded plan may require notification of participant inpatient hospital admissions. This requirement applies when the self-funded plan administered by Quartz is considered the primary or the secondary coverage. Notifications can be made via our toll-free numbers or the number listed on the back of the participant’s ID card –

Prior Authorization
Generally, self-funded plans administered by Quartz require all elective or planned inpatient admissions must be prior authorized, at least 24 hours in advance, by the admitting physician. Cases are reviewed for prior day surgery admissions, out-of-plan admissions, procedures that could be performed on an outpatient basis, benefit coverage, and general admissions that may not meet criteria for inpatient status. The UM team also identifies cases for long-term care management (Inpatient and outpatient rehabilitation, Long Term Acute Care and Skilled Nursing Facility admissions) and assigns an initial length of stay. Failure to have elective / planned hospitalizations prior authorized may result in costs assessed as provider liability to the admitting physician / provider and penalties to the participant.

Outpatient Procedures
Many procedures and surgeries are appropriate for the outpatient / ambulatory setting. Quartz on behalf of the plan uses a list of procedures / surgeries that, under normal circumstances, can be safely performed in an outpatient setting, thereby avoiding admission to the hospital.

Participants may be required to obtain Prior Authorization for certain outpatient procedures or surgeries. Please go to MyPlanTools, contact the medical management team, view the Prior Authorization List or call Quartz Customer Service if you have a question about prior authorization requirements.

Concurrent Review
Generally, all hospital admissions must be reported by the hospital to Quartz or the appropriate medical management team within 24 hours of admission or the first business day after admission. Medical information regarding any emergent / urgent admissions and elective / planned admissions that are continued beyond the initial length of stay assigned must be communicated to the medical management staff.

Length of Stay
Length of stay (LOS) assignments are projections / guidelines rather than rigid authorization limits. Although it is anticipated that many or most patients will be discharged within the LOS time frame, longer stays may be authorized based on medical necessity. Generally, inpatient days will be authorized whenever standard intensity and severity criteria for medical necessity exist. At times, attending physician input may be needed in order to make decisions regarding LOS authorizations.

Retrospective Review
Medical record reviews occur retrospectively on selected cases in order to –

- Review for medical necessity for inpatient days not reviewed concurrently
- Validate the accuracy of concurrent information
- Reconsider the medical necessity during the appeal process
- Perform clinical quality studies
- Verify claim payment

Case Management
Quartz offers the self-funded plan sponsor the option to purchase case management services. If purchased, Quartz provides Complex Case Management services which involves providing assistance to participants who have experienced a critical event or have multiple chronic conditions that required the extensive use of resources. The Registered
Nurse and Social Service Case Managers help participants navigate the health system, coordinate care with the care team, provide education, connect to community resources and offer advance care planning. Benefits are subject to plan terms.

The goals of case management are to help participants regain optimum health or improved functional capability in the appropriate setting and in a cost-effective manner. It involves comprehensive assessment of the participant’s condition, determination of available benefits and resources, and development and implementation of a case management plan with performance goals, monitoring and follow-up.

Providers are encouraged to refer participants for case management services if they feel their patients will benefit from case management services by contacting the Patient Resources Department at (608) 821-4819 or within UW Health, enter a consult order to complex case management. Participants can also self-refer by calling Patient Resources.
Quartz Contact Information

<table>
<thead>
<tr>
<th>Who to Contact</th>
<th>Quartz hours of operation are 7 a.m. to 5 p.m., Monday through Friday.</th>
</tr>
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### Who to Contact

<table>
<thead>
<tr>
<th>Customer Service</th>
<th>(800) 805-0693</th>
<th>(608) 644-3440</th>
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**Hearing impaired Wisconsin Relay line**

- 711 or (800) 877-8973

<table>
<thead>
<tr>
<th>General Information</th>
<th>Fax (608) 643-5230</th>
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**Web site:** quartzaso.com

**Email:** Quartz.CustomerService@quartzbenefits.com

**Claims Submission Address and Correspondence:**

- Quartz
- P.O. Box 490
- Sauk City, WI 53583-1374
<table>
<thead>
<tr>
<th>Policy Name</th>
<th>Last Update</th>
</tr>
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<tbody>
<tr>
<td>General Coding Applications ....................................................................</td>
<td>April 2015</td>
</tr>
<tr>
<td>Adaptive Behavioral Treatment ..................................................................</td>
<td>March 2017</td>
</tr>
<tr>
<td>Add-on Codes .........................................................................................</td>
<td>April 2015</td>
</tr>
<tr>
<td>Anesthesia Care ......................................................................................</td>
<td>April 2015</td>
</tr>
<tr>
<td>Global Surgery .......................................................................................</td>
<td>April 2015</td>
</tr>
<tr>
<td>Multiple Procedure Discounting ................................................................</td>
<td>April 2015</td>
</tr>
<tr>
<td>Unlisted Procedures ................................................................................</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier 22 – Increased Procedural Services ........................................</td>
<td>March 2017</td>
</tr>
<tr>
<td>Modifier 23 – Unusual Anesthesia ................................................................</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier 25 – Significant, Separately Identifiable E&amp;M ..........................</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier 50 – Bilateral Procedures ....................................................</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier RT/LT – Bilateral Procedures ................................................</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier 51 – Multiple Procedures .....................................................</td>
<td>April 2015</td>
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<tr>
<td>Modifier 52 – Reduced Services ................................................................</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier 53 – Discontinued Procedure ................................................</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier 54 – Surgical Care Only .......................................................</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier 55 – Post Operative Management Only .......................................</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier 56 – Pre Operative Management Only .........................................</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier 57 - Decision For Surgery ..................................................</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier 58 – Staged or Related Procedure or Service ............................</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier 62 – Two Surgeons, Co-Surgery ...............................................</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier 63 – Procedure Performed on Infant Less Than 4kgs ...................</td>
<td>April 2015</td>
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<tr>
<td>Modifier 66 – Surgical Team ....................................................................</td>
<td>April 2015</td>
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<tr>
<td>Modifier 73 – Discontinued Out-Patient Hospital/ASC Prior to Anesthesia ..</td>
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<tr>
<td>Modifier 74 – Discontinued Out-Patient Hospital/ASC After Anesthesia ......</td>
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</tr>
<tr>
<td>Modifier 76 – Repeat Procedure or Service by Same Physicians ................</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier 77 – Repeat Procedure by Another Physician ............................</td>
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General Coding Applications Policy and Procedure

Last Revision/Review Date: 4/1/2015

Organization and Associated Product Lines

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Purpose

The General Coding Applications Policy and Procedure is designed to provide Unity Health Plan members, providers and staff with organizational standards for compliant coding and proper claims adjudication process. Coding related policies are intended to provide consistent methodologies for code interpretation that follow industry standards. Reimbursement applications will comply with provider contract terms and at times, may reference industry standards and CMS guidance, NCCI and/or other coding resources. Providers are responsible for submitting accurate claim data to support the services being reported. Providers are encouraged to reference specific terms in the Provider Manual in the event that contractual reimbursement terms may be impacted.

Common Definitions

- AMA – American Medical Association
- APC - Ambulatory Payment Classifications
- APG – Ambulatory Patient Group
- ASC – Ambulatory Surgical Centers
- CMS -Centers for Medicare and Medicaid Services
- CPT4 - Current Procedural Terminology – Published by the American Medical Association
- DME – Durable Medical Equipment
- DRG -Diagnosis Related Group
- HCPCS - Healthcare Common Procedure Coding System
- ICD - International Classifications of Diseases: Developed by the World Health Organization and maintained by the US Government
- MS-DRG – Medicare Severity Diagnosis-Related Group
- NCCI - National Correct Coding Initiatives
- OPPS – Outpatient Prospective Payment Systems
- PHI – Protected Health Information
- RVU - Relative Value Units

Policy

Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity’s general policy is structured based on the AMA coding directives. Medicare and Medicare policies will serve as a secondary resource for compliant claims adjudication.
• Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.

• On an annual basis, procedure codes, modifiers and diagnostic codes will be reviewed and policies will be updated accordingly. As periodic updates are released, an evaluation will occur for appropriate updates. Unity’s Benefits Coordination Committee will implement updated policies.

• In cases that involve unusual and extraordinary circumstances, medical records may be requested and as needed, Unity’s Medical Director will provide guidance for complex cases.

• New and revised policies will be the responsibility of the Claim Coding and Compliance Manager, with input and final approval by Provider Relations, Quality Audit and Operations.

• Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits.

• Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.

**Coding Interpretation and Applications**

Unity is committed to providing clear, concise communication with its members and providers. The following standards serve as a base line for claims adjudication and policy interpretation. While Unity strives for consistent interpretation of coding guidelines there may be occasions that require additional supporting interpretation guidance to serve as a secondary resource.

**Ambulatory Payment Classifications**

• Proper CPT and HCPCS code assignment are applied to outpatient facility services utilizing the APC assignment to guide reimbursement as structured by CMS.

**Diagnostic Related Group**

• Proper DRG assignment and associated reimbursement for inpatient services will follow the Medicare Severity Diagnosis-Related Group system. This will allow for consistent reporting and outcomes analysis published by the federal government DRG system.

**International Classification of Diseases**

• The International Classifications of Diseases (ICD), will be Unity’s primary source to interpret diagnostic code applications. Developed by the World Health Organization and maintained by the US Government includes interpretation of diagnostic codes.

**Modifiers**

• Unity will follow the American Medical Association CPT4 guidance to establish the foundation for accurate interpretation and decisions about proper claims processing. Occasionally, other resources, including HCPCS and CMS guidelines will be referenced to further define a policy. These policies will apply to CMS 1500 and UB04 forms for claims processing.

**Procedural**

• Unity will follow the American Medical Association CPT4 guidance to establish the foundation for accurate interpretation and decisions about proper claims processing. Occasionally, other resources, including HCPCS and CMS guidelines will be referenced to further define a policy. These policies will apply to CMS 1500 and UB04 forms for claims processing.
Reimbursement Applications
Unity reimbursement policies are designed to accurately process claims based on the services reported by the provider. This policy will serve as a general guideline and may not incorporate every situation related to reimbursement. Unity will process claims according to industry standards and will adhere to contractual obligations. Reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported. Specific reimbursement rates and methodologies are based the provider contract type (fee for services, percentage of billed, etc.). Modified services (such as bilateral procedures) will follow industry standards and contract methods. Unity may modify this and will publish this information as deemed appropriate. For specific reimbursement rates, please refer to the specific Policy and Procedure documents.

Unity’s General Coding Policy contains an associated claims edit system that analyzes data on each claim and checks for errors or questionable coding relationships.

The claims edit system reviews each line of the claim for coding issues to ensure compliance with relevant CPT and CMS coding guidelines including unbundling, rejection of duplicate claims, rebundles/transfers, detection of mutually exclusive services, new patient visit auditing, patient diagnosis correlated with procedure appropriateness, validation of procedure modifiers, detection of multiple procedure reductions, place of service editing, surgical assistant appropriateness, flagging of maximum frequency-per-day, age appropriateness of procedures and diagnoses, and sex-specific procedures and diagnoses versus patient sex.

Quality Assurance
The Claims Coding and Compliance Manager, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

Enforcement
Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate care and billing.

Review, Revision and Distribution
This policy will be provided to all Operations, Provider Relations and Audit staff and Unity Leadership. The documents will be maintained in the Provider Manual (publication on website).

Approval of new and revised policies will be assigned to the following individuals:

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations
Individual coding policies will be reviewed and updated annually based on procedure and modifier coding updates published by the AMA. A review of CMS regulatory guidance will also be reviewed and any related policies will be updated.

**Document Logistics & Revision History**

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<td>10-11-2013</td>
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<td>06-01-2014</td>
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<td>3</td>
<td>04-1-2015</td>
<td>Revision</td>
<td>Manager, Claims Coding and Compliance Manager</td>
<td>04-1-2015</td>
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**NOTE:**
Purpose:
Quartz Health Solutions (Quartz) coverage for the diagnosis and treatment of Autism Spectrum Disorders (ASD) follows the 2009 Wisconsin Act 28 and Wisconsin Office of the Commissioner of Insurance (OCI) Rule. The Adaptive Behavior Treatment & Assessment Policy and Procedure is designed to address organizational standards for compliant coding and proper claims adjudication process. Reimbursement applications will comply with provider contract terms and at times, may reference industry standards and CMS guidance, NCCI and/or other coding resources. Providers are responsible for submitting accurate claim data to support the services being reported. Providers are encouraged to reference specific terms in the Provider Manual in the event that contractual reimbursement terms may be impacted.

Common Definitions
- ABA – Adaptive Behavioral Treatment
- AMA – American Medical Association
- ASD - Autism Spectrum Disorders
- CMS -Centers for Medicare and Medicaid Services
- CPT4 - Current Procedural Terminology– Published by the American Medical Association
- HCPCS - Healthcare Common Procedure Coding System
- ICD - International Classifications of Diseases: Developed by the World Health Organization and maintained by the US Government
- NCCI - National Correct Coding Initiatives
- OCI – Office of the Commissioner of Insurance
- PHI – Protected Health Information
- RVU - Relative Value Units
- SIU – Special Investigation Unit

Policy:
Quartz is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Quartz’s general policy is structured based on the AMA coding directives. Medicare and Medicaid policies will serve as a secondary resource for compliant claims adjudication.
- Quartz will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be
communicated in advance to the provider via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.

- On an annual basis, procedure codes, modifiers and diagnostic codes will be reviewed and policies will be updated accordingly. As periodic updates are released, an evaluation will occur for appropriate updates. Quartz’s Benefits Edits and Standards Committee will implement updated policies.
- In cases that involve unusual and extraordinary circumstances, medical records may be requested and as needed, Quartz’s Medical Director will provide guidance for complex cases.
- New and revised policies will be the responsibility of the Manager, Special Investigation Unit, with input and final approval by Coding Policy and Procedure Oversight Committee.
- Quartz policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits.
- Policies and Procedures that contain reimbursement policies are constantly evolving and Quartz reserves the right to review and update these policies periodically.

**Coding Interpretation and Applications**

Quartz is committed to providing clear, concise communication with its members and providers. The following standards serve as a base line for claims adjudication and policy interpretation. While Quartz strives for consistent interpretation of coding guidelines there may be occasions that require additional supporting interpretation guidance to serve as a secondary resource.

1. All entries in the medical records must be legible and complete which includes sufficient information to identify the patient; support the diagnosis/condition; justify the care, treatment, and services; document the course and results of care, treatment, and services; and promote continuity of care among providers. All entries in the medical records must be dated and authenticated, in written or electronic form by the person responsible for providing or evaluating the service provided.

2. Compliant coding applications require the service(s) to be reported with the CPT and/or HCPCS code(s) that most accurately describe the service being provided. In addition, the AMA has developed Category III codes for adaptive behavior assessment and treatment to patients of any age with autism spectrum disorders (ASDs) or other diagnoses or conditions (e.g., development disabilities) which are recognized and accepted by Quartz.

3. All claims must be reported with the applicable ICD10 diagnosis code(s) reporting services based on the highest level of specificity and complying with ICD10 coding guidelines.

4. Providers are required to include a modifier with the procedure code to indicate the type of treatment (comprehensive or focused). Each claim line requires one of the following modifiers. Claim lines that do not contain a modifier will be considered focused treatment.
   - TG Modifier – Comprehensive treatment
   - TF Modifier – Focused treatment

**Reimbursement Applications**

1. Quartz reimbursement policies are designed to accurately process claims based on the services reported by the provider. This policy will serve as a general guideline and may not incorporate every situation related to reimbursement.

2. Quartz will process claims according to industry standards and will adhere to contractual obligations. Reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported.

3. Specific reimbursement rates and methodologies are based the provider contract type (fee for services, percentage of billed, etc.).
4. Quartz requires that ABA treatment be reported by physicians or qualified health care professionals that are licensed and/or credentialed professionals. Covered services require face-to-face observation of the member to be considered for reimbursement.

5. Reimbursement of covered therapy services will be limited for time based services, to no more than 8 hours of therapy per date of service. Therapy services reported greater than 8 hours per date of service will be denied for excessive units and will be subject for post pay audit review.

6. Quartz’s General Coding Policy contains an associated claims edit system that analyzes data on each claim and checks for errors or questionable coding relationships. The claims edit system reviews each line of the claim for coding issues to ensure compliance with relevant CPT and CMS coding guidelines including unbundling, rejection of duplicate claims, rebundle/transfers, detection of mutually exclusive services, new patient visit auditing, patient diagnosis correlated with procedure appropriateness, validation of procedure modifiers, detection of multiple procedure reductions, place of service editing, surgical assistant appropriateness, flagging of maximum frequency-per-day, age appropriateness of procedures and diagnoses, and sex-specific procedures and diagnoses versus patient sex.

Quality Assurance
The Manager of SIU, in conjunction with Operations, Audit and Provider Relations Leadership will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Quartz website.

Enforcement
Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Quartz is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate care and billing.

Review, Revision and Distribution
This policy and any material revisions to this policy require the approval of the following Quartz Oversight Committee Members:

- Assistant Vice President, Operations
- Director, Provider Relations
- Director, Internal Audit
- Manager, Special Investigation Unit
- Manager, Health Informatics, Provider Relations

This document will be updated periodically to reflect changing business and technology requirements or at least annually, whichever is sooner. All change requests should be directed to the document owner.

Document Logistics & Revision History
Document Owner: Manager, Special Investigation Unit
Document Location: Adaptive Behavioral Treatment.doc
Next Review: March 1, 2018
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Only keep the initial creation, last revision and last approval dates. Previous versions must be archived for 10 years.
Add-on Codes
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Organization and Associated Product Lines

Organization:
- Unity Health Plans Insurance Corporation

Product Lines:
- ☑ All lines
- ☐ HMO
- ☐ PPO
- ☐ POS
- ☐ UWA
- ☐ Medicare Supplement
- ☐ Medicaid
- ☐ Individual Exchange
- ☐ Individual Non-Exchange

Purpose
The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for add-on procedure codes.

As defined by the AMA, some listed procedures are commonly carried out in addition to the primary procedure performed. These additional or supplemental procedures are designated as add-on codes with + symbol and they are listed in Appendix D of the CPT4 code book. Add-on codes can be readily identified by specific descriptor nomenclature that includes phrases such as “each additional” or “(List separately in addition to primary procedure).”

Common Definitions
- AMA – American Medical Association
- ASC – Ambulatory Surgery Center
- CMS – Centers For Medicare and Medicaid Services
- PPO – Preferred Provider Option
- POC – Percent of Charge

Policy
Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications for add-on procedures. Unity follows AMA coding directives as the authoritative source for correct coding applications for add-on procedures. As a secondary resource, Unity will reference industry standards, including a review of CMS Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider and facility community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.
Coding Interpretation and Applications

The add-on coding guidelines allow professionals to separately identify a service that is performed in certain situations as an additional service or a supplemental service. The add-on code concept applies only to add-on procedures or services performed by the same physician. Add-on codes describe additional intra-service work associated with the primary procedure, e.g., additional digit(s), lesion(s), neurorrhaphy(s), vertebral segment(s), tendon(s), joint(s). Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code.

Reimbursement Applications

Add-on codes describe additional intra-service work associated with a primary service/procedure and are considered for payment when they are reported in addition to the primary service/procedure.

When the primary procedure is not allowed for payment, the add-on procedure(s) will also not be allowed for payment. Add-on codes should never be reported as stand-alone codes. Add-on codes will not be allowed when they are reported alone.

Add-on codes are exempt from the multiple procedure concept (see modifier 51 and multiple discounting policies).

PPO contracted facilities will follow reimbursement procedures as established by the preferred provider network vendor. BadgerCare providers are required to follow the Health Care Portal, Medicaid online handbook and the Forward Health provider updates for additional Medicaid guidelines. In all cases, reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported.

Facilities reporting inpatient, outpatient and ASCs must report with the appropriate revenue and DRG code when applicable.

Unity Add-on policy contains associated claim editing software that identifies the appropriateness of billing Add-on procedures. Incorrect reporting of Add-on procedures will result in a denial.

Quality Assurance

The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

Enforcement

Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers and facilities are accurately submitting claims. On occasion, this policy may require providers and facilities to submit supporting documentation of the services reported to substantiate the reporting of add-on procedures.
Add-on Codes
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Review, Revision and Distribution
This policy will be provided to all Operations, Providers Relations and Audit staff and Unity Leadership. The documents will be maintained in the Provider Manual and (publication on website).

Approval of new and revised policies will be assigned to the following individuals;
- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

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NOTE:
Anesthesia Care
Policy and Procedure
Last Revision/Review Date: 4/1/2015

**Organization and Associated Product Lines**

- **Organization:**
  - Unity Health Plans Insurance Corporation

- **Product Lines:**
  - All lines
  - HMO
  - PPO
  - POS
  - UWA
  - Medicare
  - Medicaid
  - Individual
  - Exchange
  - Non-Exchange

**Purpose**

The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for services described by AMA CPT4 codes in the 00100 – 01999 range for anesthesia care services.

As defined by the CPT4 anesthesia guidelines, the reporting of anesthesia care services is appropriate by or under the responsible supervision of a physician. Anesthesia care services may include but are not limited to general, regional, supplementation of local anesthesia, or other supportive services in order to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedure.

**Common Definitions**

- AMA – American Medical Association
- ASA – American Society of Anesthesiologist
- CMS – Centers For Medicare and Medicaid Services
- CPT4 – Current Procedural Terminology – Published by the American Medical Association
- NCCI – National Correct Coding Initiative

**Policy**

Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications for anesthesia care. Unity follows AMA coding directives as the authoritative source for correct coding applications for anesthesia care. As a secondary resource, Unity will reference industry standards, including a review of Medicare and Medicaid policies and ASA instructions;

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider and facility contractual obligations. Any change to a policy that impacts claim submission guidelines, claims processing and reimbursement will be communicated in advance to the provider and facility community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.
Coding Interpretation and Applications

Unity follows the AMA definition of the anesthesia care package and includes the following services in the payment for anesthesia care services:

- The usual preoperative and postoperative visits;
- The anesthesia care during the procedure;
- The administration of fluids and/or blood;
- The usual monitoring services (e.g., ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry)

The following services are not included in the AMA defined anesthesia care package and may be separately reported with appropriate modifier application:

- Unusual forms of monitoring (e.g., intra-arterial, central venous, and Swan-Ganz)
- Other significant, separately identifiable services

Reimbursement Applications

The anesthesia care services policy applies to professional services. The base units allowed for each individual procedure code is consistent with the ASA base units assignments. Time units are based on when the provider of anesthesia services begins to prepare the patient for anesthesia care in the operating room or in the equivalent area, and ends when the individual is no longer in personal attendance and is no longer providing anesthesia services. Anesthesia time can be counted in blocks of time if there is an interruption in anesthesia, as long as the time counted is for continuous anesthesia services. Unity allows one unit of time for each 15 minute increment of anesthesia time. Unity will round up to allow one full time unit when the actual anesthesia time exceeds one minute of a single 15 minute time unit. Providers that submit actual minutes of administered anesthesia time will be converted to 15 minutes increments per unit of service.

 Significant, separately identifiable services may be reported by the anesthesia practitioner during a single anesthetic administration. Unity follows the CMS guidance in the (NCCI) edits manual on the appropriate reporting of these services and modifier application by the anesthesia practitioner. Clinical documentation should support the modified CPT code.

Providers should refer to the Unity policies titled Modifier AA-Anesthesia Performed Personally, Modifier AD, QK, QY-Medical Supervision Direction, Modifier QX, QZ-CRNA With/Without Medical Direction, and Modifier P1-P6-Anesthesia Physical Status for appropriate modifier application for anesthesia services and reimbursement related to these modifiers.

PPO contracted providers will follow reimbursement procedures as established by the preferred provider network vendor. BadgerCare providers are required to follow the Health Care Portal, Medicaid online handbook and the Forward Health provider updates for additional Medicaid guidelines. In all cases, reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported.

Unity anesthesia care package policy contains associated claim editing software that identifies the appropriateness of anesthesia care with other services. Incorrect reporting of anesthesia care and bundled services will result in a denial.
Quality Assurance
The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

Enforcement
Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of anesthesia care and associated significant, separately identifiable services.

Review, Revision and Distribution
This policy will be provided to Unity Leadership, Operations, Provider Relations and Audit staff. The documents will be maintained in the Provider Manual and (publication on website).

Approval of new and revised policies will be assigned to the following individuals;
- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

Document Logistics & Revision History

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NOTE:
Purpose

The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for services reported with an AMA CPT-4 code assigned a global surgery period.

The global surgery period for a service includes the pre-procedure, intra-procedure, and post-procedure work furnished by a surgeon. The three global surgery periods are described as 0 days post-operative period (endoscopies and some minor procedures), 10-day post-operative period (other minor procedures), and 90-day post-operative period (major procedures). The global surgery period concept applies to surgeons practicing in any setting, including inpatient hospital, outpatient hospital, ambulatory surgical center, and physician’s office.

Common Definitions

- AMA – American Medical Association
- CMS – Centers For Medicare and Medicaid Services
- CPT-4 – Current Procedural Terminology – Published by the American Medical Association

Policy

Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications for global surgery. Unity follows AMA coding directives as the authoritative source for correct coding applications for global surgery. As a secondary resource, Unity will reference industry standards, including a review of Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established facility contractual obligations. Any change to a policy that impacts claim submission guidelines, claims processing and reimbursement will be communicated in advance to the provider and facility community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.
Coding Interpretation and Applications

Unity follows the CMS definition of the global surgery package and includes the following services in the global surgery payment:

- Pre-operative visits after the decision is made to operate beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures;
- Intra-operative services that are normally a usual and necessary part of a surgical procedure;
- All additional medical or surgical services required of the surgeon during the post-operative period of the surgery because of complications which do not require additional trips to the operative room;
- Follow-up visits during the post-operative period of the surgery that are related to recovery from the surgery;
- Postsurgical pain management by the surgeon;
- Selected supplies; and
- Miscellaneous services 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, naso-gastric and rectal tubes, and changes and removal of tracheostomy tubes.

The following services are not included in the global surgery payment and may be separately billed:

- Initial consultation or evaluation of the problem by the surgeon to determine the need for a major surgical procedure;
- Services of other physicians related to the surgery, except where the surgeon and the other physician(s) agree on the transfer of care;
- Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery;
- Treatment for the underlying condition or any added course of treatment which is not part of normal recovery from surgery;
- Diagnostic tests and procedures, including diagnostic radiological procedures;
- Clearly distinct surgical procedures that occur during the post-operative period which are not re-operations or treatment for complications;
- Treatment for post-operative complications which require a return trip to the operative room.
- If a less extensive procedure fails, and a more extensive procedure is required; the second procedure may be separately reported;
- Immunosuppressive therapy for organ transplants; and
- Critical Care services (CPT 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician.

The Medicare physician fee schedule relative value file lists the global period applicable to surgical procedures. For a complete list of global periods, please refer to: [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU14A.html?DLPage=1&DLSort=0&DLSortDir=descending](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU14A.html?DLPage=1&DLSort=0&DLSortDir=descending).

Reimbursement Applications

The global surgery policy applies to professional services. Services related to the pre-procedure, intra-procedure, and post-procedure work for the surgical service will be denied as included in the global surgery payment.

Unity follows CMS guidance on appropriate modifier usage to report services not included in the global surgery package. Clinical documentation should support the modified CPT code. For those cases where more than one physician may furnish services included in the global surgical package, providers should refer to the Unity policies titled Modifier 54-Surgical Care Only, Modifier 55-Post Operative Management Only, and Modifier 56-Pre Operative Management Only.

PPO contracted providers will follow reimbursement procedures as established by the preferred provider network vendor. BadgerCare providers are required to follow the Health Care Portal, Medicaid online handbook and the Forward Health provider updates for additional Medicaid guidelines. In all cases, reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported.

Unity Global Surgery Policy contains associated claim editing software that identifies the appropriateness of billing global surgery, pre-intra and postoperative periods, in addition to correct modifiers when appropriate. Incorrect reporting of global surgery will result in a denial.

Quality Assurance

The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

Enforcement

Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that facilities are accurately submitting claims. On occasion, this policy may require facilities to submit supporting documentation of the services reported to substantiate the reporting of global surgery.

Review, Revision and Distribution

This policy will be provided to all Unity Leadership, Operations, Provider Relations and Audit staff. The documents will be maintained in the Provider Manual and (publication on website).

Approval of new and revised policies will be assigned to the following individuals;

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations
Global Surgery
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Document Logistics & Revision History

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<th>Revision or Review Date</th>
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NOTE:
Purpose

The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for multiple procedures performed in the outpatient facility setting.

When multiple procedures are performed during the same operative session, multiple discounting rules apply and only one of the procedures will be considered as the primary procedure. Unity will determine the appropriate multiple procedure ranking from the highest valued procedure to the lowest valued procedure, utilizing CMS APC weight values. The reduction applies to those services that are subject to the reduction as defined by the OPPS status indicator.

Common Definitions

- AMA – American Medical Association
- APC – Ambulatory Payment Classification
- ASC – Ambulatory Surgery Center
- CMS – Centers For Medicare and Medicaid Services
- OPPS – Hospital Outpatient Prospective Payment System
- PPO – Preferred Provider Option
- POC – Percent of Charge

Policy

Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications for multiple procedures. Unity follows AMA coding directives as the authoritative source for correct coding applications for surgical procedures. As a secondary resource, Unity will reference industry standards, including a review of Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established facility contractual obligations.
Multiple Procedure Discounting
Policy and Procedure
Last Revision/Review Date: 4/1/2015

- Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider and facility community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.

**Coding Interpretation and Applications**

Multiple surgeries are distinct surgical procedures performed on the same patient during the same operative session. Procedures that include multiple within the description of the code are inclusive of a multiple descriptor and therefore, not subject to discounts.

Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure(s) and do not apply to add-on codes.

As defined by CMS OPPS status indicator “T”, multiple procedure discounting applies to services provided in a facility setting. Multiple procedures provided in an ASC will be subject to multiple discounts based on the approved CMS ASC covered surgical procedure listing. For professional services, please refer to modifier 51 policy and procedures. These policies are subject to the terms of the facility/provider contract.

**Reimbursement Applications**

Multiple surgery discounting applies when at least 2 or more codes are eligible for the standard multiple surgical calculations when performed during the same operative session. Secondary surgical procedures are eligible for reimbursement, but at a lower allowance and can be distinguished from other procedures that might be components of, or incidental to, a primary surgical service performed.

Reimbursement will be considered at 100% of the allowed for the primary procedure and 50% for subsequent procedures, subject to the facility contract terms. Unity will take steps to identify and rank multiple procedures in order of their values and apply the appropriate multiple reductions.

Unity contracted facilities that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms and multiple discounting applies. PPO contracted facilities will follow reimbursement procedures as established by the preferred provider network vendor. BadgerCare providers are required to follow the Health Care Portal, Medicaid online handbook and the Forward Health provider updates for additional Medicaid guidelines. In all cases, reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported.

Facilities reporting inpatient, outpatient and ASCs must report with the appropriate revenue and DRG code when applicable.

Unity multiple discounting in the facility setting policy contains associated claim editing software that identifies the appropriateness of billing multiple procedures. Incorrect reporting of multiple procedures will result in a denial.

**Quality Assurance**

The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify...
established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

**Enforcement**

Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that facilities are accurately submitting claims. On occasion, this policy may require facilities to submit supporting documentation of the services reported to substantiate the reporting of multiple procedures.

**Review, Revision and Distribution**

This policy will be provided to all Operations, Providers Relations and Audit staff and Unity Leadership. The documents will be maintained in the Provider Manual and (publication on website). Approval of new and revised policies will be assigned to the following individuals:

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

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**NOTE:**
Unlisted Procedures and Services
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Purpose
The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for services reported with AMA CPT4 codes reported for unlisted procedures and services.

Unlisted codes are used to report a procedure or service performed by a healthcare professional where there is not a specific CPT code available. The unlisted procedure code and service numbers for each section of the CPT manual are identified in the guidelines for the specific section.

Unlisted procedures and services are appropriate in any setting, including inpatient hospital, outpatient hospital, ambulatory surgical center, and physician’s office.

Common Definitions
- AMA – American Medical Association
- CMS – Centers For Medicare and Medicaid Services
- CPT4 – Current Procedural Terminology – Published by the American Medical Association

Policy
Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications for unlisted procedures and services. Unity follows AMA coding directives as the authoritative source for correct coding applications for unlisted procedures and services. As a secondary resource, Unity will reference industry standards, including a review of Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established facility contractual obligations. Any change to a policy that impacts claim submission guidelines, claims processing and reimbursement will be communicated in advance to the provider and facility community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.
Coding Interpretation and Applications

Unity follows the AMA guidelines for reporting an unlisted procedure or service. The CPT4 code reported should accurately reflect the procedure or service performed. Appropriate code selection should not be based on a code that is similar to the description for the procedure or service. If a code is not available that accurately describes the service rendered, an unlisted code should be submitted. Reporting of unlisted procedure codes should be infrequent and used as a last resort when other codes are not available.

Submission of an unlisted procedure or service code should include a concise description of the specific service provided.

Reimbursement Applications

Unlisted procedure codes are not assigned relative value units (RVUs) by CMS for payment purposes as each of these codes may be reported for varying services. Reimbursement is generally based on review of submitted medical records. Unity may request the clinical documentation of the reported unlisted CPT4 code or service prior to determination of reimbursement for the service.

Unity contracted facilities that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms. PPO contracted facilities will follow reimbursement procedures as established by the preferred provider network vendor. BadgerCare providers are required to follow the Health Care Portal, Medicaid online handbook and the Forward Health provider updates for additional Medicaid guidelines. In all cases, reimbursement will be based on the reasonableness and necessary charges for the patient's condition reported.

Unity unlisted procedures and services policy contains associated claim editing software that identifies the appropriateness of billing unlisted procedures and services. Reporting of unlisted procedures and services without a description of the service will result in a denial.

Facilities reporting inpatient, outpatient and ASC's must report with the appropriate revenue and DRG code when applicable.

Quality Assurance

The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

Enforcement

Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that facilities are accurately submitting claims. On occasion, this policy may require facilities to submit supporting documentation of the services reported to substantiate the reporting of unlisted procedures.
Unlisted Procedures and Services
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Review, Revision and Distribution
This policy will be provided to all Unity Leadership, Operations, Provider Relations and Audit staff.

The documents will be maintained in the Provider Manual and (publication on website). Approval of new and revised policies will be assigned to the following individuals;

- Director, Business Services
- Director, Provider Relations
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- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

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NOTE:
Modifier 22 – Increased Procedural Services
Policy and Procedure
Last Revision/Review Date: 4/1/2017

**Organization and Associated Product Lines**

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**Purpose**

The purpose of this policy and procedure is to document and communicate Quartz Health Plans Insurance Corporation’s coding and reimbursement policy for increased procedural services that are reported with CPT4 modifier 22.

As defined by the AMA CPT4 coding instructions, when the work to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual CPT4 code. Circumstances that may require the reporting of modifier 22 include the following:

- Increased intensity
- Increased time
- Technical difficulty of procedure
- Severity of patient’s condition
- Physical and mental effort required

In all cases, medical record documentation must justify the substantial additional work and the reason for the additional work.

**Common Definitions**

- AMA – American Medical Association
- CMS - Centers for Medicare and Medicaid Services
- CPT4 - Current Procedural Terminology – Published by the American Medical Association
- E&M – Evaluation and Management
- SIU – Special Investigation Unit

**Policy**

Quartz is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Quartz follows AMA coding directives as the authoritative source for correct coding applications for unusual procedural services. As a secondary resource, Quartz will reference industry standards, including a review of Medicare and Medicaid policies.
Modifier 22 – Increased Procedural Services
Policy and Procedure
Last Revision/Review Date: 4/1/2017

- Quartz policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Quartz reserves the right to review and update these policies periodically.
- Quartz will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.

**Coding Interpretation and Applications**

Modifier 22 should be used only when additional work factors requiring the physician’s technical skill involve significantly increased physician work, time, and complexity than when the procedure is normally performed. The increased procedure may be surgical or non-surgical, however, the use of this modifier excludes E&M services.

Circumstances that may be considered appropriate to utilize modifier 22 is reserved to identify those services that are significantly more complex than described within the CPT4 code. Examples may include, but are not limited to;

- Significant time, unusually lengthy procedure
- Significant adhesions requiring extra time and work
- Significant anatomic anomalies which would require extra work
- Complications relating to morbid obesity
- Extensive trauma
- Difficult surgical approach, technique
- Excessive blood loss, hemorrhaging

Sufficient documentation to support the modified claim should include an adequate definition or description of the nature, extent and need for the procedure, time, effort, and equipment necessary to provide the service. The operative note should include a clear description of the procedure, as well as identify additional diagnoses, pre-existing conditions, or any unexpected findings or complicating factors that contribute to the extra time and effort spent performing the procedure.

Quartz follows the Medicare Claims Processing Manual Chapter 12 guidelines on appropriate use of Modifier 22 which defines which services are appropriate for modifier 22 and requires; a) a concise statement about how the service differs from the usual, and b) an operative report with the claim. Quartz will require this documentation through an appealed case to determine if the services warrant additional reimbursement. Modifier 22 should only be reported with procedure codes that have a global period of 0, 10, or 90 days.

It is not appropriate to append modifier 22 in the following cases;

- When another code adequately describes the service performed
- Evaluation and management services
- Unlisted procedure codes
- Increased post operative recovery time
- Surgical techniques that do not justify increased work or resources (eg, robotic surgical techniques, laparoscopic techniques)
Modifier 22 – Increased Procedural Services
Policy and Procedure
Last Revision/Review Date: 4/1/2017

The modifier 22 policy applies to professional services and is subject to the terms of the provider contract.

Reimbursement Applications
Quartz reimbursement policies are designed to accurately process claims based on the services reported by the provider. This policy will serve as a general guideline and may not incorporate every situation related to reimbursement. Quartz will process claims according to industry standards and will adhere to contractual obligations. Reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported.

Quartz contracted providers that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms. PPO contracted providers will follow reimbursement procedures as established by the preferred provider network vendor. BadgerCare providers are required to follow the Health Care Portal, Medicaid online handbook and the Forward Health provider updates for additional Medicaid guidelines. In all cases, reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported.

In cases that the provider of service is requesting consideration for additional reimbursement, such as those cases that are deemed difficult or time-intensive above and beyond the typical procedure, the provider may request an appeal requesting a review of additional information related to the case. It is expected that the procedure must be unusually difficult in relation to other procedures of the same type. Supporting documentation may be required and should reflect the unusual circumstances of the procedure.

In certain circumstances, the reporting of modifier 22 for unusual procedural services may result in additional reimbursement for the provider through Quartz appeal process. Providers that routinely demonstrate that documentation supports the reporting of modifier 22 with supporting documentation, may be moved to a post payment reviews.

Quartz modifier 22 policy contains associated claim editing software that identifies the appropriateness of billing modifier 22. Incorrect reporting of modifier 22 will result in a payment reduction or denial.

Quality Assurance
Quality outcome measurements on the use of modifier 22, unusual procedural services will be conducted through periodic claim checks. The Manager, Special Investigation Unit (SIU), in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Quartz website.

Enforcement
Enforcement of coding policies will be conducted through periodic claim checks and requests for documentation. These periodic reviews will ensure that Quartz is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of increased procedural services. In these cases, providers should provide a concise statement that explains the nature of the unusual service, with pertinent, supporting portions of the operative note highlighted.
Modifier 22 – Increased Procedural Services
Policy and Procedure
Last Revision/Review Date: 4/1/2017

Review, Revision and Distribution
This policy will be provided to Quartz Leadership, Operations, Providers Relations and Audit staff. The documents will be maintained in the Provider Manual and (publication on website

Approval of new and revised policies will be assigned to the following individuals;
- Assistant Vice President, Operations
- Director, Provider Relations
- Director, Internal Audit
- Manager, Special Investigation Unit
- Manager, Health Informatics, Provider Relations

Document Logistics & Revision History

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NOTE:
Modifier 23 – Unusual Anesthesia Policy and Procedure

Last Revision/Review Date: 4/1/2015

Organization and Associated Product Lines

Organization:
- Unity Health Plans Insurance Corporation

Product Lines:
- [x] All lines
- [ ] HMO
- [ ] PPO
- [ ] POS
- [ ] UWA
- [ ] Medicare
- [x] Medicaid
- [ ] Individual
- [x] Exchange
- [ ] Individual Non-Exchange

Purpose
The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for unusual anesthesia services.

As defined by the AMA CPT4 coding instructions; occasionally, a procedure which requires either no anesthesia or local anesthesia must be done under general anesthesia. In these unusual circumstances, modifier 23 should be added to the procedure code of the basic service.

Common Definitions
- AMA - American Medical Association
- CMS - Centers for Medicare and Medicaid Services
- CPT4 - Current Procedural Terminology– Published by the American Medical Association

Policy
Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications. As a secondary resource, Unity will reference industry standards, including a review of Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.

Coding Interpretation and Applications
Modifier 23 should be used on basic anesthesia service procedure codes (00100-01999). This modifier would be used when general anesthesia is administered in situations that typically would not require this level of anesthesia, or in situations in which local anesthesia might have been required, but would not be sufficient under the circumstances.
It would not be appropriate to report this modifier with procedure codes that include the term “without anesthesia” in the description or with procedure codes that are normally performed under general anesthesia.

Modifier 23 should be sequenced as the second modifier. The modifier indicating the service was personally performed, medically directed, or medically supervised should be reported in the first modifier position. Please refer to the Unity policies titled Modifier AA – Anesthesia Personally Performed, Modifiers AD, QK, QY – Medical Supervision Direction, and Modifier QX, QZ – CRNA Services.

**Reimbursement Applications**

Modifier 23 is an informational modifier and does not affect the reimbursement for the reported anesthesia code. Clinical documentation may be requested for services reported with modifier 23 to support the medical necessity for general anesthesia. In all cases, reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported.

**Quality Assurance**

Quality outcome measurements on the use of modifier 23, Unusual Anesthesia, will be conducted through periodic claim checks. The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

**Enforcement**

Enforcement of coding policies will be conducted through periodic claim checks and requests for documentation. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of unusual anesthesia services.

**Review, Revision and Distribution**

This policy will be provided to all Unity Leadership, Operations, Provider Relations and Audit staff. The documents will be maintained in the Provider Manual (publication on website). Any change to the policy that impacts claim submission guidelines or claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments, and/or provider manual updates.

Approval of new and revised policies will be assigned to the following individuals;

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations
# Modifier 23 – Unusual Anesthesia Policy and Procedure

Last Revision/Review Date: 4/1/2015

## Document Logistics & Revision History

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**NOTE:**
**Modifier 25 – Significant, Separately Identifiable E&M Policy and Procedure**

**Last Revision/Review Date: 4/1/2015**

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**Organization and Associated Product Lines**

**Organization:**
- Unity Health Plans Insurance Corporation

**Product Lines:**
- [x] All lines
- [ ] HMO
- [ ] PPO
- [ ] POS
- [ ] UWA
- [ ] Medicare
- [ ] Medicaid
- [ ] Individual Exchange
- [ ] Individual Non-Exchange

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**Purpose**

The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for significant, separately identifiable evaluation and management (E&M) services by the same physician or other qualified health care professional on the same day of the procedure or other service.

As defined by the AMA CPT4 coding instructions; it may be necessary to indicate that on the day a procedure or service identified by a CPT4 code was performed, the patient’s condition required a significant, separately identifiable E&M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. This circumstance may be reported by adding modifier 25 to the appropriate level of E&M service.

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**Common Definitions**

- AMA – American Medical Association
- CMS - Centers for Medicare and Medicaid Services
- CPT4 - Current Procedural Terminology – Published by the American Medical Association
- E&M – Evaluation and Management

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**Policy**

Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications. As a secondary resource, Unity will reference industry standards, including a review of Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.
Coding Interpretation and Applications

Modifier 25 should be used with the appropriate level of E&M service code 99201-99499 or Ophthalmology E&M service code 92002-92014. The E&M service may be prompted by the symptom or condition for which the procedure and/or service was provided. Modifier 25 may be appended to E&M services reported with minor surgical procedures (global period of 000 or 010 days) or procedures not covered by global surgery rules. It is not appropriate to use modifier 25 to report an E&M service that resulted in a decision to perform a major surgical (global period of 90 days) procedure. Providers should refer to Unity Modifier 57 policy for E&M services resulting in the decision for the major surgery.

Per the guidelines in the CPT manual, it is appropriate to append modifier 25 to a significant, separately identifiable E&M service performed during the same session as a preventive medicine visit.

The medical record documentation of the E&M service should support the clearly distinct and significantly identifiable E&M service rendered. Modifier 25 should be sequenced as the first modifier.

Modifier 25 policy applies to professional services and facility outpatient/ASC services.

Reimbursement Applications

E&M services reported with modifier 25 are considered for reimbursement when the clinical documentation supports the significant, separately identifiable service. Unity follows CMS guidance in the Medicare Claims Processing Manual, Chapter 12, 30.6.6 and does not permit the use of modifier 25 to generate payment for multiple E&M services by the same physician for the same or related problem on the same date of service. Unity may request medical records to review the appropriateness of the 25 modifier and may deny claim lines if the documentation does not support application of modifier 25.

Unity modifier 25 policy contains associated claim editing software that identifies the appropriateness of billing modifier 25. Incorrect reporting of modifier 25 will result in a denial.

Quality Assurance

Quality outcome measurements on the use of modifier 25, Significant, Separately Identifiable E&M, will be conducted through periodic claim checks. The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

Enforcement

Enforcement of coding policies will be conducted through periodic claim checks and requests for documentation. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of significant, separately identifiable E&M services.
Modifier 25 – Significant, Separately Identifiable E&M Policy and Procedure
Last Revision/Review Date: 4/1/2015

Review, Revision and Distribution
This policy will be provided to all Unity Leadership, Operations, Provider Relations and Audit staff. The documents will be maintained in the Provider Manual (publication on website). Any change to the policy that impacts claim submission guidelines or claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments, and/or provider manual updates.

Approval of new and revised policies will be assigned to the following individuals;
- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

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NOTE:
Organization and Associated Product Lines

Organization:

- Unity Health Plans Insurance Corporation

Product Lines:

- All lines
- HMO
- PPO
- POS
- UWA
- Medicare
- Medicaid
- Individual
- Exchange
- Individual
- Non-Exchange

Purpose

The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for bilateral procedures.

As illustrated by AMA CPT4 coding instructions, unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate CPT4 5 digit code. In most cases, these are unilateral procedure that can be performed on both sides of the body during the same session by the same individual physician or health care professional. CPT4 or HCPCS codes with bilateral in their description should not be reported with the bilateral modifier 50, as the code is inclusive of the bilateral procedure.

Common Definitions

- 50 – Bilateral Procedure
- 52 – Reduced Services
- AMA – American Medical Association
- CMS -Centers for Medicare and Medicaid Services
- CPT4 - Current Procedural Terminology– Published by the American Medical Association
- HCPCS – Healthcare Common Procedure Coding System

Policy

Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications for unilateral and bilateral procedures. As a secondary resource, Unity will reference industry standards, including a review of Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.
Coding Interpretation and Applications

Bilateral surgeries are procedures performed on both sides of the body during the same operative session. Procedures that are reported using a unilateral code should be reported as a single line item with one unit of service. Modifier 50 should be appended to the 5 digit CPT code to report that a bilateral procedure was performed. Unity follows CMS guidance and allows modifier 50 to be reported with CPT4 codes that have a status indicator of “1” in the Medicare Physician Fee Schedule Database. For a complete list of status indicators, please refer to www.cms.gov/regulations-and-guidance/Guidance/transmittals/downloads/R2549CP.pdf.

CPT codes that include bilateral within the description of the code are intended to represent a bilateral service; therefore, modifier 50 should not be appended to the procedure code.

For those cases that have codes available to report bilateral and not a unilateral service, it is acceptable to report the bilateral procedure code and append the -52 modifier (reduced services) when the procedure is performed unilaterally.

Additional multiple procedures reported during the same session as a bilateral service will be subject to the multiple surgery guidelines.

The modifier 50 policy applies to professional services and facility outpatient/ASC services.

Reimbursement Applications

Modifier 50 identifies procedures that are performed as a bilateral service. The procedure should be billed on one line with modifier 50 and one unit of service. Providers must report the full fee for both services. Reimbursement will be allowed at 150%, subject to the provider contract terms.

CPT codes that include bilateral within the code description will be paid according to the Unity fee schedule and provider contract terms. When these services are reported as a reduced service (modifier 52) to reflect unilateral, the approved fee schedule will be reduced by 50% of the allowed contracted rate.

Unity contracted facilities that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms and multiple discounting applies. PPO contracted facilities will follow reimbursement procedures as established by the preferred provider network vendor. BadgerCare providers are required to follow the Health Care Portal, Medicaid online handbook and the Forward Health provider updates for additional Medicaid guidelines. In all cases, reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported.

Facilities reporting inpatient, outpatient and ASCs must report with the appropriate revenue and DRG code when applicable.

Unity’s modifier 50 policy contains associated claim editing software that identifies the appropriateness of reporting modifier 50. Incorrect reporting of modifier 50 will result in a payment reduction or denial.

Quality Assurance

Quality outcome measurements on the use of modifier 50, Bilateral Procedure coding policies will be conducted through periodic claim checks.
The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

**Enforcement**

Enforcement of coding policies will be conducted through periodic claim checks and requests for documentation. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of bilateral procedures.

**Review, Revision and Distribution**

This policy will be provided to all Unity Leadership, Operations, Providers Relations and Audit staff. The documents will be maintained in the Provider Manual and (publication on website)

Approval of new and revised policies will be assigned to the following individuals;

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

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Purpose

The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for multiple procedures.

When multiple procedures, other than Evaluation and Management services, physical medicine and rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedures(s) or service(s) may be identified by appending modifier -51 to the additional procedure or service code(s).

Modifier -51 should not be appended to add-on codes as defined by the AMA. Unity also recognizes that CPT4 includes a listing of procedures that are typically performed with another procedure but may be a stand-alone procedure and not always performed with other specified procedures. Modifier -51 should not be reported with these procedures. For example the following CPT4 code does not require modifier -51 to be reported;

17004 - Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettent) premalignant lesions (eg, actinic keratoses), 15 or more lesions.

The AMA also published a CPT Assistant article in December 2013, regarding the application of modifier 51 to CMT codes (98940-98943). Per AMA guidance, modifier 51 should not be appended to the CMT codes. These are separate and distinct procedures and the use of modifier 51 does not apply. CMT claims submitted with modifier 51 will be denied.

Common Definitions

- 50 – Bilateral Procedure
- 51 – Multiple Procedures
- AMA – American Medical Association
- CMT – Chiropractic Manipulative Treatment
- CPT4 - Current Procedural Terminology– Published by the American Medical Association

Policy

Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications for multiple procedures.
Modifier 51 – Multiple Procedures
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Unity follows AMA coding directives as the authoritative source for correct coding applications for surgical procedures. As a secondary resource, Unity will reference industry standards, including a review of Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.

**Coding Interpretation and Applications**

Multiple surgeries are distinct surgical procedures performed by a provider on the same patient during the same operative session. Modifier -51 should be appended to the 5 digit CPT4 code to report that multiple procedure(s) were performed.

CPT4 codes that include multiple within the description of the code are inclusive of a multiple descriptor and therefore, modifier -51 should not be reported.

When multiple surgical procedures are performed during a single anesthetic administration, only the anesthesia code with the highest base unit value is reported. (The time reported is the combined total for all procedures). Add-on anesthesia codes are an exception to this application. They are listed in addition to the code for the primary procedures. Please refer to the Anesthesia Policy and Procedure.

The modifier 51 policy applies to professional services and is subject to the terms of the provider contract.

**Reimbursement Applications**

Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure(s). Modifier -51 is not applied to add-on codes.

Multiple surgery reimbursement applies when, at least 2 or more codes are eligible for the standard multiple surgical calculations when reported as performed during the same operative session. These secondary surgical procedures are eligible for reimbursement, but at a lower allowance and can be distinguished from other procedures that might be components of, or incidental to, a primary surgical service performed.

For those procedures that CMS has designated multiple payment adjustments, Unity will follow CMS guidance. Reimbursement will be allowed at 100% for the primary procedure and 50% for subsequent procedures, subject to the provider contract terms. Contracted providers that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms and modifier -51 rules will apply. Reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported.

Providers must bill the same day multiple surgeries on the same claim at their full fee to allow appropriate claims to be adjudicated. List the most resource-intense procedure first, and append modifier 51 to the second and any subsequent procedures.
By appending modifier -51, the provider is stating that the same procedure was performed on different sites. In the event that the provider does not report modifier -51, Unity will take steps to identify and rank multiple procedures in order of their values and apply the appropriate multiple reductions.

When different physicians, operating under the same anesthesia but using different surgical fields or separate organ system, perform multiple surgical procedures on the same day, each surgeon is allowed 100% of their respective primary surgery, based on contractual obligations. Multiple surgery guidelines are followed for each surgeon when additional procedures are performed.

In cases that require extensive multiple surgeries (greater than 6 multiple surgeries), Unity may request supporting documentation from the providers and these services will be considered on an individual basis.

Bilateral procedures reported with modifier -50 will be subject to multiple surgery guidelines.

Facilities reporting inpatient, outpatient and ASCs must report with the appropriate revenue and/or HCPCS code, and DRG code when applicable.

Unity contracted providers that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms and multiple discounting applies. PPO contracted providers will follow reimbursement procedures as established by the preferred provider network vendor. BadgerCare providers are required to follow the Health Care Portal, Medicaid online handbook and the Forward Health provider updates for additional Medicaid guidelines. In all cases, reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported.

Unity modifier 51 policy contains associated claim editing software that identifies the appropriateness of reporting modifier 51. Incorrect reporting modifier 51 will result in a denial.

**Quality Assurance**

The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

**Enforcement**

Enforcement of coding policies will be conducted through periodic claim audits. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of multiple procedures.

**Review, Revision and Distribution**

This policy will be provided to all Unity Leadership, Operations, Providers Relations and Audit staff. The documents will be maintained in the Provider Manual and (publication on website).
Modifier 51 – Multiple Procedures
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Approval of new and revised policies will be assigned to the following individuals:

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

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NOTE:
Modifier 52 – Reduced Service
Policy and Procedure
Last Revision/Review Date: 4/1/2015

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Purpose
The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for reduced services. Under certain circumstances a service or procedure is partially reduced or eliminated. Under these circumstances the service provided can be identified by its usual procedure code and the addition of modifier 52, signifying that the service has been reduced. This modifier provides a means of reporting reduced services without disturbing the identification of the basic service.

As noted in the CPT4 instructions, hospital outpatient and Ambulatory Surgery Centers reporting of a previously scheduled procedure/service that is partially reduced or cancelled, as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia should be billed with modifiers 73 or 74.

Common Definitions
- 52 – Reduced Services, Service or Procedure
- 53 – Discontinued Procedure, Surgical or Diagnostic
- 73 – Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia
- 74 – Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) procedure After the Administration of Anesthesia
- AMA – American Medical Association
- CPT4 - Current Procedural Terminology– Published by the American Medical Association

Policy
Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications for reduced and discontinued procedures. As a secondary resource, Unity will reference industry standard, including a review of Medicare and Medicare policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.

**Coding Interpretation and Applications**

A reduced service or procedure occurs when the intended service or procedure was partially reduced or eliminated at the discretion of the physician or other qualified health care professional. These services should be reported with modifier 52 appended to the 5 digit CPT4 code for the scheduled service or procedure.

Providers should not use modifier 52 when a procedure has been terminated. The modifier 52 policy applies to professional services and facility outpatient/ASC services.

**Reimbursement Applications**

Modifier 52 identifies the service or procedure was not performed as fully described by the five digit CPT4 code and therefore, the value of the service is also reduced. Providers are encouraged to report the reason for the reduced service in the electronic documentation field on the claim form, Item 19 if reporting on paper. Reimbursement will be allowed at 50%, subject to the provider contract terms. Reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported. Contracted providers that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms and modifier 52 payment rules will apply.

Facilities reporting inpatient, outpatient and ASCs must report with the appropriate revenue and DRG code when applicable.

Unity modifier 52 policy contains associated claim editing software that identifies the appropriateness of reporting modifier 52. Incorrect reporting of modifier 52 will result in a denial.

**Quality Assurance**

The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

**Enforcement**

Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of reduced services.

**Review, Revision and Distribution**

This policy will be provided to all Unity Leadership, Operations, Providers Relations and Audit staff. The documents will be maintained in the Provider Manual and (publication on website).
Approval of new and revised policies will be assigned to the following individuals:

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

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<td>6-1-2014</td>
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<td>4-1-2015</td>
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**NOTE:**
Modifier 53 – Discontinued Procedure
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Organization and Associated Product Lines

Organization:  
- Unity Health Plans Insurance Corporation

Product Lines:  
- All lines  □ HMO  □ PPO  □ POS  □ UWA
- Medicare  □ Medicaid  □ Individual Exchange  □ Individual Non-Exchange

Purpose
The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for discontinued procedures. Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the 5 digit CPT4 code for the discontinued procedure.

This modifier is not used to report the elective cancellation of a procedure prior to the patient’s anesthesia induction and/or surgical preparation in the operating suite.

Common Definitions
- 53 – Discontinued Procedure
- 73 – Discontinued Out-Patient Hospital/ASC Procedure Prior Administration of Anesthesia
- 74 – Discontinued Out-Patient Hospital/ASC Procedure After Administration of Anesthesia
- AMA – American Medical Association
- ASC – Ambulatory Surgery Center
- CPT4 - Current Procedural Terminology—Published by the American Medical Association

Policy
Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications for discontinued procedures. As a secondary resource, Unity will reference industry standard, including a review of Medicare and Medicare policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.
Coding Interpretation and Applications
Under certain circumstances, a surgical or diagnostic procedure is terminated at the physician or other health care profession’s direction. Under these circumstances the procedure provided should be identified by the 5 digit CPT4 code and the addition of modifier 53 signifying that the procedure was started but discontinued.

For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well being of the patient prior to or after administration of anesthesia, modifier 73 and modifier 74 are reported.

It would not be appropriate to report modifier 53 in the following situations;

- Elective cancellation of a procedure prior to the patient’s anesthesia induction and/or surgical preparation in the operating suite.
- When a laparoscopic or endoscopic procedure is converted to an open procedure or when a procedure is changed or converted to a more extensive procedure.
- Do not report modifier 53 with Evaluation and Management services.
- Do not report modifier 53 with time based procedure codes, such as critical care or psychotherapy.

The modifier 53 policy applies to professional services only.

Reimbursement Applications
Providers should report their full fee for the surgery or diagnostic procedure to allow appropriate claims to be adjudicated. Reimbursement for the discontinued surgery or diagnostic services will be at 50% of the primary surgery fee or diagnostic service fee, subject to provider contract terms. Reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported. Contracted providers that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms and modifier 53 payment rules will apply.

Providers may be asked to provide Unity with supporting documentation to explain the reason for the discontinued service. Documentation should include the time when the procedure was started and why the procedure was discontinued, state the percentage of the procedure that was performed.

Facilities reporting inpatient, outpatient and ASCs must report with the appropriate revenue and DRG code when applicable.

Unity modifier 53 policy contains associated claim editing software that identifies the appropriateness of reporting modifier 53. Incorrect reporting of modifier 53 will result in a denial.

Quality Assurance
Quality outcome measurements on the use of modifier 53, Discontinued Procedure coding policies will be conducted through periodic claim checks. The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.
Enforcement

Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of discontinued procedures.

Review, Revision and Distribution

This policy will be provided to all Unity Leadership, Operations, Providers Relations and Audit staff. The documents will be maintained in the Provider Manual and (publication on website).

Approval of new and revised policies will be assigned to the following individuals;

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analyst, Client Relations

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NOTE:
Modifier 54 – Surgical Care Only
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Organization and Associated Product Lines

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Purpose
The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for surgical care only. As illustrated by AMA CPT4 coding instructions, when one physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, the surgical service may be identified by adding modifier 54 to the 5 digit CPT4 code.

When physicians agree on the transfer of care during the global period, services will be distinguished by the use of the appropriate modifier. Under this type of arrangement, the postoperative management is reported with modifier 55. The same 5 digit CPT4 code must be used when reporting modifier 54 and 55. Preoperative management is reported with modifier 56 and the appropriate evaluation and management code.

Surgical care only includes intra-operative services that are normally a usual and necessary part of a surgical case. Unity’s interpretation of global surgery is consistent with CMS and industry standards. Please see Global Surgery Policy and Procedure for details of the global surgery policy.

Common Definitions
- 54 – Surgical Care Only
- 55 – Post Operative Management Only
- AMA – American Medical Association
- CMS - Centers for Medicare and Medicaid Services
- CPT4 - Current Procedural Terminology – Published by the American Medical Association

Policy
Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications for global surgery and surgical care only. As a secondary resource, Unity will reference industry standards, including a review of Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
• Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.

Coding Interpretation and Applications
When components of a global surgical procedure are furnished by different providers, correct coding guidelines dictate that each provider report only the service they performed identifying that service with the appropriate modifier. Modifier 54 indicates that the surgeon is billing the surgical care only and is relinquishing all or part of the postoperative care to another physician. Modifier 54 does not apply to assistant at surgery. This modifier applies to professional services.

Reimbursement Applications
When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed what would have been paid if a single global code was reported.

Providers should report their full fee for the surgery to allow appropriate claims to be adjudicated. Reimbursement for the intra-operative portion of the surgery will be allowed at 70%, subject to provider contract terms. Reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported. Contracted providers that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms and modifier 54 payment rules will apply.

The date of service is the date of surgery. Physicians must keep copies of the written transfer agreement in the patient’s medical record.

Facilities reporting inpatient, outpatient and ASCs must report with the appropriate revenue and DRG code when applicable.

Unity modifier 54 policy contains associated claim editing software that identifies the appropriateness of reporting modifier 54. Incorrect reporting of modifier 54 will result in a denial.

Quality Assurance
Quality outcome measurements on the use of modifier 54, Surgical Care Only coding policies will be conducted through periodic claim checks. The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

Enforcement
Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of global surgery and surgical care only.
Review, Revision and Distribution

This policy will be provided to all Unity Leadership, Operations, Providers Relations and Audit staff. The documents will be maintained in the Provider Manual and (publication on website).

Approval of new and revised policies will be assigned to the following individuals:

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

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NOTE:
Modifier 55 – Post Operative Management Only
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Organization and Associated Product Lines

Organization:
- Unity Health Plans Insurance Corporation

Product Lines:
- All lines
- HMO
- PPO
- POS
- UWA
- Medicare
- Medicaid
- Individual Exchange
- Individual Non-Exchange

Purpose
The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for post operative management only.

When one physician or other qualified health care professional performs the postoperative management and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the 5 digit CPT4 code.

In the event that the surgeon provides the surgery and only a portion of the post discharge post operative care, modifier 55 is appropriate. The same 5 digit CPT4 code must be used when reporting modifier 54 and 55.

Common Definitions
- 52 – Reduced Service
- 54 – Surgical Care Only
- 55 – Post Operative Management Only
- AMA – American Medical Association
- ASC – Ambulatory Surgery Center
- CPT4 - Current Procedural Terminology– Published by the American Medical Association

Policy
Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications for post operative management. As a secondary resource, Unity will reference industry standards, including a review of Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.
Coding Interpretation and Applications

When components of a global surgical procedure are furnished by different providers, correct coding guidelines dictate that each provider report only the service they performed identifying that service with the appropriate modifier. Modifier 55 indicates that the physician or other qualified health care professional performed the postoperative management and another performed the surgical procedure.

Other factors to consider when reporting split surgical care;
- When different physicians in a group practice participate in the care of the patient, the group practice bills for the entire global package. The physician who performs the surgery is reported as the performing physicians.
- When the transfer of care occurs immediately after surgery with inpatient care provided, the receiving physician should bill subsequent hospital care codes.
- When two different physicians share in the postoperative care, each bills for their portion-reporting modifier 55 and indicating the assumed and relinquished dates on the claim.
- Append Modifier 55 to the procedure code that describes the surgical procedure performed that has a 10 or 90 day postoperative period.
- The date of service is the date of surgery. Indicate the date of care assumption and relinquished on the claim form.

It is inappropriate to report modifier 55 in the following situations;
- Modifier 55 should not be appended to E&M codes.
- Modifier 55 is not reported for the assistant surgery services.
- Modifier 55 is not appropriate for ASC services.
- Modifier 52 (Reduced Services) should not be reported when furnishing only part of the postoperative care.

The modifier 55 policy applies to professional services.

Reimbursement Applications

When one physician performs the postoperative management and another physician performs the surgical procedure, the postoperative component is identified by appending modifier 55.

Reimbursement for the postoperative portion of the surgery will be allowed at 20%, subject to provider contract terms. Contracted providers that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms and modifier 55 rules will apply.

Facilities reporting inpatient, outpatient and ASCs must report with the appropriate revenue and DRG code when applicable.

Unity modifier 55 policy contains associated claim editing software that identifies the appropriateness of reporting modifier 55. Incorrect reporting of modifier 55 will result in a denial.

Quality Assurance

Quality outcome measurements on the use of modifier 55, Post Operative Management will be conducted through periodic claim checks.
The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

**Enforcement**

Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of global surgery and postoperative management only.

**Review, Revision and Distribution**

This policy will be provided to all Operations, Providers Relations and Audit staff and Unity Leadership. The documents will be maintained in the Provider Manual and (publication on website).

Approval of new and revised policies will be assigned to the following individuals:

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

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**NOTE:**
Purpose

The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for preoperative management only.

When one physician or other qualified health care professional performed the preoperative care and evaluation and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the 5 digit CPT4 code.

In the event that the surgeon provides the surgery and the postoperative management is relinquished to another provider, modifier 55 is appropriate. The same 5 digit CPT4 code must be used when reporting modifier 54 and 55.

Common Definitions

- 54 – Surgical Care Only
- 55 – Post Operative Management Only
- 56 – Pre Operative Management Only
- 57 – Decision For Surgery
- AMA – American Medical Association
- ASC – Ambulatory Surgery Center
- CPT4 - Current Procedural Terminology – Published by the American Medical Association

Policy

Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications for global surgery and preoperative management only. As a secondary resource, Unity will reference industry standards, including a review of Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations.
• Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.

**Coding Interpretation and Applications**

When components of a global surgical procedure are furnished by different providers, correct coding guidelines indicate that each provider report only the service they performed by identifying that service with the appropriate modifier.

An evaluation and management service that resulted in the initial decision to perform the surgery is not considered part of the global surgery and should be identified by appending modifier 57 to the 5 digit CPT4 code.

If an unmodified surgical code is reported and global payment made, claims submitted with modifier 56 will be denied as inclusive or redundant to the global surgical payment. The modifier 56 policy applies to professional services.

**Reimbursement Applications**

When one physician performs the preoperative care and evaluation service and another physician performs the surgical procedure, the preoperative component is identified by appending modifier 56.

Append Modifier 56 to the procedure code that describes the surgical procedure performed that has a 10 or 90 day postoperative period.

Reimbursement for the preoperative portion of the surgery will be allowed at 10%, subject to provider contract terms. Reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported. Contracted providers that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms and modifier 56 rules will apply.

Facilities reporting inpatient, outpatient and ASCs must report with the appropriate revenue and DRG code when applicable.

Unity modifier 56 policy contains associated claim editing software that identifies the appropriateness of reporting modifier 56. Incorrect reporting of modifier 56 will result in a denial.

**Quality Assurance**

Quality outcome measurements on the use of modifier 56, Pre Operative Management Only policies will be conducted through periodic claim checks. The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.
Modifier 56 – Pre Operative Management Only
Policy and Procedure

Last Revision/Review Date: 4/1/2015

Enforcement

Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of global surgery and preoperative management only.

Review, Revision and Distribution

This policy will be provided to all Unity Leadership, Operations, Providers Relations and Audit staff. The documents will be maintained in the Provider Manual and (publication on website).

Approval of new and revised policies will be assigned to the following individuals:

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

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NOTE:
Purpose
The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for evaluation and management (E&M) services resulting in the initial decision to perform a major surgical procedure. CMS defines a major surgical procedure as a procedure that has a global period of 90 days. The global period includes the day before the surgery, the day of the surgery and the 90 days immediately following the day of surgery.

As defined by the AMA CPT4 coding instructions, an E&M service that resulted in the initial decision to perform the major surgery may be identified by adding the modifier 57 to the appropriate level of E&M service.

Common Definitions
- AMA – American Medical Association
- CMS - Centers for Medicare and Medicaid Services
- CPT4 - Current Procedural Terminology – Published by the American Medical Association
- E&M – Evaluation and Management
- NCCI – National Correct Coding Initiative

Policy
Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications. As a secondary resource, Unity will reference industry standards, including a review of Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.
Modifier 57 – Decision for Surgery
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Coding Interpretation and Applications
Modifier 57 should be used with the appropriate level of E&M service code 99201-99499 or Ophthalmology E&M service code 92002-92014. Unity follows the CMS global surgery rules for reporting E&M services with procedures. These rules state that E&M services on the day before major surgery or on the day of major surgery that result in the initial decision to perform the surgery are not included in the global surgery payment and may be separately billed.

The medical record documentation of the E&M service should support the visit resulted in the provider’s decision to perform the major surgical service.

Modifier 57 policy applies to professional services performed in inpatient hospital, outpatient hospital, Ambulatory Surgical Center, and physician’s office setting.

Reimbursement Applications
E&M services that occurred on the day of or on the day before a major procedure and resulted in the initial decision to perform the major surgical procedure are considered for reimbursement when reported with modifier 57. Unity follows CMS guidance in the NCCI policy manual, Chapter 1 – General Correct Coding Policies and does not permit the use of modifier 57 on other preoperative E&M services by the same physician, on the same date of service, after the decision is made to operate, as these are included in the global payment for the procedure. Unity may request medical records to review the appropriateness of the 57 modifier and may deny claim lines if the documentation does not support application of modifier 57.

Unity modifier 57 policy contains associated claim editing software that identifies the appropriateness of billing modifier 57. Incorrect reporting of modifier 57 will result in a denial.

Quality Assurance
Quality outcome measurements on the use of modifier 57, Decision for Surgery, will be conducted through periodic claim audits. The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

Enforcement
Enforcement of coding policies will be conducted through periodic claim checks and requests for documentation. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting the E&M service which resulted in the initial decision to perform the surgery.

Review, Revision and Distribution
This policy will be provided to all Unity Leadership, Operations, Provider Relations and Audit staff. The documents will be maintained in the Provider Manual (publication on website). Any change to the policy that impacts claim submission guidelines or claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments, and/or provider manual updates.
Approval of new and revised policies will be assigned to the following individuals:

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

**Document Logistics & Revision History**

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NOTE:
 Modifier 58 – Staged or Related Procedure or Service During Postoperative Period
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Organization and Associated Product Lines

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Purpose

The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for staged or related procedure or service during the postoperative period.

As described by AMA CPT4 procedural coding instructions, it may be necessary to indicate that the performance of a procedure or service during the postoperative period was; (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. For treatment of a problem that requires a return to the operating/procedure room (e.g. unanticipated clinical condition), modifier 78 may be appropriate.

Common Definitions

- 51 – Multiple Procedures
- 58 – Staged or Related Procedure
- 78 – Unplanned Return to Operating/Procedure Room
- AMA – American Medical Association
- CPT4 - Current Procedural Terminology – Published by the American Medical Association

Policy

Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications for staged or related procedure or service during the postoperative period. As a secondary resource, Unity will reference industry standards, including a review of Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations.
Modifier 58 – Staged or Related Procedure or Service During Postoperative Period
Policy and Procedure

Last Revision/Review Date: 4/1/2015

- Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.

Coding Interpretation and Applications

Staged or related procedures or services by the same physician or other qualified health care professional during the postoperative period of a surgical procedure is reported by appending modifier 58 to the 5 digit CPT4 code.

Medical record documentation should support each stage of the surgery and the plan to return to the operating room for additional procedures to manage or treat the complexity of the disease process. The global period concept restarts when the subsequent procedures are performed.

It is not appropriate to report Modifier 58 under the following circumstances;

- Modifier 58 is not used if reporting the treatment of a complication from the original surgery – requiring a return trip to the operating room. Modifier 78 is more appropriate in this situation.
- The descriptor of the CPT4 code includes reference to multiple sessions.
- Staged procedures do not apply to claims for assistant at surgery.
- The procedure provided is unrelated to the original procedure during the postoperative period.

The modifier 58 policy applies to professional services and facility outpatient/ASC services.

Reimbursement Applications

Providers should report each procedure in full charge when reporting modifier 58, to allow appropriate claims to be adjudicated. Reimbursement for the primary procedure will be allowed at 100%, subject to the provider contract terms. Reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported. Contracted providers that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms and modifier 58 payment rules will apply.

When more than one procedure is performed during the first and subsequent operative sessions, multiple guidelines apply and modifier 51 should be reported. Reimbursement for these services will follow the Modifier 51 Policy and Procedure and are subject to reductions and specific contract terms.

A new postoperative period begins when the next procedure in the staged procedure series is reported.

Facilities reporting inpatient, outpatient and ASCs must report with the appropriate revenue and DRG code when applicable.

Quality Assurance

Quality outcome measurements on the use of modifier 58, Staged or Related Procedure or Service coding policies will be conducted through periodic claim checks. The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary.
Modifier 58 – Staged or Related Procedure or Service During Postoperative Period
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

**Enforcement**

Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of stated or related procedure(s) or service(s).

**Review, Revision and Distribution**

This policy will be provided to all Unity Leadership, Operations, Providers Relations and Audit staff. The documents will be maintained in the Provider Manual and (publication on website).

Approval of new and revised policies will be assigned to the following individuals:

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

**Document Logistics & Revision History**

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**NOTE:**
Purpose

The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for distinct, independent procedures or services.

As defined by the AMA, under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-Evaluation and Management (E&M) services performed on the same day. Modifier 59, XE, XP, XS, and XU are used to identify procedures/services, other than E&M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual or a different individual. However, when another already established modifier is appropriate it should be used rather than modifier 59, XE, XP, XS, or XU. Only when there is not a more descriptive modifier available, and the use of one of these modifiers best explains the circumstances, should these modifiers be used.

To support the use of modifier 59, XE, XP, XS, or XU, medical documentation is vital and essential to support medical necessity.

Common Definitions

- 25 – Significant, Separately Identifiable Evaluation and Management Service
- 59 – Distinct Procedural Service
- XE - Separate Encounter
- XP - Separate Practitioner
- XS – Separate Structure
- XU – Unusual non-overlapping service
- AMA – American Medical Association
- CPT4 - Current Procedural Terminology – Published by the American Medical Association
- E&M – Evaluation and Management
- CMS NCCI – National Correct Coding Initiative
Modifier 59, XE, XP, XS, and XU – Distinct Procedural Service
Policy and Procedure

Last Revision/Review Date: 8/26/2016

Policy
Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications for distinct procedural services. As a secondary resource, Unity will reference industry standards, including a review of Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.

Coding Interpretation and Applications
Modifier 59, XE, XP, XS, or XU is appended to the 5 digit CPT4 code to define a distinct separate procedure or service. These designated procedures or services are typically carried out as an integral component of a more extensive procedure and are considered to be unrelated or distinct from other services performed. Often the service requires performance of multiple necessary “elements” to complete the total procedure.

As a foundation to determine the acceptability of modifier 59, XE, XP, XS, or XU, Unity will reference the code combinations as published by CMS NCCI edits. These modifiers should be appended to the secondary, additional, or lesser service. Documentation should indicate two separate distinct procedures performed on the same day by the same physician or a separate physician. They should only be used if no other modifier more appropriately describes the relationship of the two or more procedure codes.

It is inappropriate to use modifier 59, XE, XP, XS, or XU under the following circumstances:
- Do not report XS when performed along with another procedure in an anatomically related region through the same skin incision or orifice.
- Modifier 59, XE, XP, XS, or XU should not be appended to an E&M service. To report a separate and distinct E&M service with a non-E&M service performed on the same day, see modifier 25.
- Modifier 59, XE, XP, XS, or XU should not be reported when the code designation indicates “separate procedure”.
- Do not report modifier 59, XE, XP, XS, or XU when CMS NCCI code combination directs otherwise.
- Do not report modifier 59, XE, XP, XS, or XU when documentation does not support the separate and distinct status.
- Do not report the X modifiers when also reporting modifier 59.

The modifier 59, XE, XP, XS, and XU policy applies to professional services and facility outpatient/ASC services.

Reimbursement Applications
Reporting modifier 59, XE, XP, XS, or XU is important to the adjudication of the claim as it may allow payment when reported correctly and will not be subject to procedure unbundling edit rules. Unity accepts these modifiers for claims processing but not always to determine reimbursement. Unity reserves the right to request
medical records to review the appropriate nature of these modifiers and may deny claim lines if not appropriately reported.

Multiple and bilateral surgery guidelines also apply when reporting modifier 59, XE, XP, XS, or XU. Facilities such as hospital inpatient and hospital outpatient must report with the appropriate revenue and DRG code when applicable.

The Unity modifier 59, XE, XP, XS, and XU policy contains associated claim editing software that identifies the appropriateness of reporting modifier 59, XE, XP, XS, or XU. Incorrect reporting of these modifiers will result in a denial.

**Quality Assurance**

The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

**Enforcement**

Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of distinct procedural services.

**Review, Revision and Distribution**

This policy will be provided to all Unity Leadership, Operations, Providers Relations and Audit staff. The documents will be maintained in the Provider Manual and (publication on website)

Approval of new and revised policies will be assigned to the following individuals;

- Assistant Vice President, Operations
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Healthcare Informatics Provider Relations

**Document Logistics & Revision History**

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## Modifier 59, XE, XP, XS, and XU – Distinct Procedural Service

**Policy and Procedure**  
*Last Revision/Review Date: 8/26/2016*

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**NOTE:**
Modifier 62 – Two Surgeons, Co-Surgery
Policy and Procedure
Last Revision/Review Date: 4/1/2015

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Purpose
The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for two surgeons, co-surgery.

As defined by the AMA CPT4 manual, when two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the 5 digit CPT4 code. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) including add-on procedures(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or 82 appended, as appropriate.

Co-surgeons share responsibility for a surgical procedure, each serving as a primary surgeon for separate portions of the surgery. It is common for the co-surgeons to be of different specialties.

Common Definitions
- 51 – Multiple Procedure
- 62 – Two Surgeons, Co-Surgery
- 80 – Assistant Surgeon
- 82 – Assistant Surgeon When Qualified Resident Surgeon Is Not Available.
- AMA – American Medical Association
- CPT4 - Current Procedural Terminology– Published by the American Medical Association

Policy
Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications for surgical procedures. As a secondary resource, Unity will reference industry standard, including a review of Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
 Modifier 62 – Two Surgeons, Co-Surgery
 Policy and Procedure
 Last Revision/Review Date: 4/1/2015

- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.

**Coding Interpretation and Applications**

When determining if a co-surgery claim is payable, Unity considers the following requirements in the adjudication claim process;

- Type of surgical procedure performed. Unity follows industry standard guidance when determining co-surgery designations for each code. The use of status indicators are based on input from the American College of Surgeons (ACS).
- Type of provider performing the service to determine if the claim is payable. Modifier 62 requires the services be performed by a licensed physician.

Each surgeon must dictate an operative note (listing the other surgeon as co-surgeon), describing their distinct part of the procedure. Documentation must support medical necessity for co-surgeons. The modifier 62 policy applies to professional services.

**Reimbursement Applications**

Providers should report their full fee for co-surgeries to allow appropriate claims to be adjudicated. Reimbursement for co-surgeons will be paid at 62.5% of the allowed amount for each surgeon subject to the provider contract terms. Reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported. Contracted providers that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms and modifier 62 payment rules will apply.

Co-surgeries are subject to the multiple surgery policies and modifier 51 procedure guidelines apply. Services reported with an unlisted CPT4 code will be pended and may require supporting documentation to determine reimbursement.

Facilities reporting inpatient, outpatient and ASCs must report with the appropriate revenue and DRG code when applicable.

Unity modifier 62 policy contains associated claim editing software that identifies the appropriateness of reporting modifier 62. Incorrect reporting of modifier 62 will result in a denial.

**Quality Assurance**

Quality outcome measurements on the use of modifier 62, Two Surgeons, Co-Surgery coding policies will be conducted through periodic claim checks. The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.
Modifier 59, XE, XP, XS, and XU – Distinct Procedural Service
Policy and Procedure
Last Revision/Review Date: 8/26/2016

Organization and Associated Product Lines

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Purpose
The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for distinct, independent procedures or services.

As defined by the AMA, under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-Evaluation and Management (E&M) services performed on the same day. Modifier 59, XE, XP, XS, and XU are used to identify procedures/services, other than E&M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual or a different individual. However, when another already established modifier is appropriate it should be used rather than modifier 59, XE, XP, XS, or XU. Only when there is not a more descriptive modifier available, and the use of one of these modifiers best explains the circumstances, should these modifiers be used.

To support the use of modifier 59, XE, XP, XS, or XU, medical documentation is vital and essential to support medical necessity.

Common Definitions
- 25 – Significant, Separately Identifiable Evaluation and Management Service
- 59 – Distinct Procedural Service
- XE - Separate Encounter
- XP - Separate Practitioner
- XS – Separate Structure
- XU – Unusual non-overlapping service
- AMA – American Medical Association
- CPT4 - Current Procedural Terminology – Published by the American Medical Association
- E&M – Evaluation and Management
- CMS NCCI – National Correct Coding Initiative
Modifier 59, XE, XP, XS, and XU – Distinct Procedural Service
Policy and Procedure
Last Revision/Review Date: 8/26/2016

Policy
Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications for distinct procedural services. As a secondary resource, Unity will reference industry standards, including a review of Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.

Coding Interpretation and Applications
Modifier 59, XE, XP, XS, or XU is appended to the 5 digit CPT4 code to define a distinct separate procedure or service. These designated procedures or services are typically carried out as an integral component of a more extensive procedure and are considered to be unrelated or distinct from other services performed. Often the service requires performance of multiple necessary “elements” to complete the total procedure.

As a foundation to determine the acceptability of modifier 59, XE, XP, XS, or XU, Unity will reference the code combinations as published by CMS NCCI edits. These modifiers should be appended to the secondary, additional, or lesser service. Documentation should indicate two separate distinct procedures performed on the same day by the same physician or a separate physician. They should only be used if no other modifier more appropriately describes the relationship of the two or more procedure codes.

It is inappropriate to use modifier 59, XE, XP, XS, or XU under the following circumstances:

- Do not report XS when performed along with another procedure in an anatomically related region through the same skin incision or orifice.
- Modifier 59, XE, XP, XS, or XU should not be appended to an E&M service. To report a separate and distinct E&M service with a non-E&M service performed on the same day, see modifier 25.
- Modifier 59, XE, XP, XS, or XU should not be reported when the code designation indicates “separate procedure”.
- Do not report modifier 59, XE, XP, XS, or XU when CMS NCCI code combination directs otherwise.
- Do not report modifier 59, XE, XP, XS, or XU when documentation does not support the separate and distinct status.
- Do not report the X modifiers when also reporting modifier 59.

The modifier 59, XE, XP, XS, and XU policy applies to professional services and facility outpatient/ASC services.

Reimbursement Applications
Reporting modifier 59, XE, XP, XS, or XU is important to the adjudication of the claim as it may allow payment when reported correctly and will not be subject to procedure unbundling edit rules. Unity accepts these modifiers for claims processing but not always to determine reimbursement. Unity reserves the right to request
Modifier 59, XE, XP, XS, and XU – Distinct Procedural Service Policy and Procedure

Last Revision/Review Date: 8/26/2016

Medical records to review the appropriate nature of these modifiers and may deny claim lines if not appropriately reported.

Multiple and bilateral surgery guidelines also apply when reporting modifier 59, XE, XP, XS, or XU. Facilities such as hospital inpatient and hospital outpatient must report with the appropriate revenue and DRG code when applicable.

The Unity modifier 59, XE, XP, XS, and XU policy contains associated claim editing software that identifies the appropriateness of reporting modifier 59, XE, XP, XS, or XU. Incorrect reporting of these modifiers will result in a denial.

Quality Assurance
The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

Enforcement
Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of distinct procedural services.

Review, Revision and Distribution
This policy will be provided to all Unity Leadership, Operations, Providers Relations and Audit staff. The documents will be maintained in the Provider Manual and (publication on website)

Approval of new and revised policies will be assigned to the following individuals:

- Assistant Vice President, Operations
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Healthcare Informatics Provider Relations

Document Logistics & Revision History

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Modifier 59, XE, XP, XS, and XU – Distinct Procedural Service
Policy and Procedure
Last Revision/Review Date: 8/26/2016

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NOTE:
Enforcement

Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of co-surgery.

Review, Revision and Distribution

This policy will be provided to all Unity Leadership, Operations, Providers Relations and Audit staff. The documents will be maintained in the Provider Manual and (publication on website)

Approval of new and revised policies will be assigned to the following individuals;
- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

Document Logistics & Revision History

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NOTE:
Purpose
The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for procedures performed on neonates and infants up to a present body weight of 4 kilograms. Additional work on small infants may involve significantly increased complexity by physicians or other qualified health care professionals. In these circumstances, the CPT4 code may be reported by adding modifier 63.

As defined by the AMA CPT4 coding instructions, this modifier may only be appended to procedures/services listed in the 20005-69990 code series. Modifier 63 should not be appended to any CPT4 codes listed in the E&M services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine section.

Common Definitions
- AMA – American Medical Association
- CMS - Centers for Medicare and Medicaid Services
- CPT4 - Current Procedural Terminology – Published by the American Medical Association
- E&M – Evaluation and Management
- kg - Kilograms

Policy
Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications for procedures performed on infants less than 4 kg. As a secondary resource, Unity will reference industry standards, including a review of CMS Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.
Coding Interpretation and Applications

Modifier 63 should be used when additional work is involved in the surgical procedure(s) performed on small infants. Modifier 63 reflects the increased complexity and physician work commonly associated with neonates and infants up to a present body weight of 4 kg.

Thorough medical record documentation must substantiate the reporting of modifier 63, including the additional work performed and the reason for the additional work.

Do not report modifier 63 when a CPT4 code exists that adequately describes the service(s) performed.

The modifier 63 policy applies to professional services and is subject to the terms of the provider contract.

Reimbursement Applications

In certain circumstances, the reporting of modifier 63 for additional work performed on neonates and infants up to a present body weight of 4 kg. may result in additional reimbursement for the provider. An increase of 20% of the allowable fee schedule will be considered for the difficult nature of these procedure(s).

Multiple surgery reductions apply if more than one procedure is performed during the same operative session.

Unity contracted providers that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms and multiple discounting applies. PPO contracted providers will follow reimbursement procedures as established by the preferred provider network vendor. BadgerCare providers are required to follow the Health Care Portal, Medicaid online handbook and the Forward Health provider updates for additional Medicaid guidelines. In all cases, reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported.

Quality Assurance

Quality outcome measurements on the use of modifier 63, procedures performed on infants less than 4 kg will be conducted through periodic claim checks. The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

Enforcement

Enforcement of coding policies will be conducted through periodic claim checks and requests for documentation. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of infant procedures.

Review, Revision and Distribution

This policy will be provided to all Unity Leadership, Operations, Providers Relations and Audit staff. The documents will be maintained in the Provider Manual and (publication on website).
Approval of new and revised policies will be assigned to the following individuals:

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

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**NOTE:**
Modifier 66 – Surgical Team
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Organization and Associated Product Lines

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Purpose
The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for team surgery.

Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians or other qualified health care professionals, often of different specialties, plus other highly skilled, specialty trained personnel, various types of complex equipment) are carried out under the “surgical team” concept. Such circumstances may be identified by each participating provider with the addition of modifier 66 to the basic procedure 5 digit CPT4 code for reporting the services.

Common Definitions

- 51 – Multiple Procedures
- 66 – Surgical Team
- AMA – American Medical Association
- CMS -Centers for Medicare and Medicaid Services
- CPT4 - Current Procedural Terminology– Published by the American Medical Association

Policy
Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications for surgical team procedures. As a secondary resource, Unity will reference industry standards, including a review of Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.
Coding Interpretation and Applications

Surgical Team refers to more than two surgeons with different skills and specialties working together to carry out various portions of a complicated surgical procedure during the same operative session on the same date of service for the same patient. Each surgical team member should submit the same procedure code(s) with modifier 66 indicating that a team of surgeons was required for the procedure.

To support the medical necessity of the team surgery concept, each surgeon should include details on their specific involvement in the total procedure.

Global surgery rules apply to each of the physicians participating in a team surgery. If an assistant is utilized, individual consideration will be used to determine if the assistant surgeon will be covered, as assistants are not typically required when a team of surgeons is utilized. The modifier 66 policy applies to professional services.

Reimbursement Applications

Unity follows CMS guidance for those procedures identified as approved for team surgery. Each provider is reimbursed at 100% of the allowance for their procedures, subject to provider contract terms. Reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported. Contracted providers that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms and modifier 66 payment rules will apply.

Multiple surgery guidelines do apply during team surgeries and modifier 51 should be appended to the 5 digit code when performing multiple surgeries.

Providers must provide sufficient documentation to establish that a team was medically necessary. All claims for team surgeons must contain sufficient information to support the complexity of the procedure.

Facilities reporting inpatient, outpatient and ASCs must report with the appropriate revenue and DRG code when applicable.

Unity modifier 66 policy contains associated claim editing software that identifies the appropriateness of reporting modifier 66. Incorrect reporting of modifier 66 will result in a denial.

Quality Assurance

Quality outcome measurements on the use of modifier 66, Surgical Team coding policies will be conducted through periodic claim checks. The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

Enforcement

Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of surgical team concept.
Modifier 66 – Surgical Team Policy and Procedure
Last Revision/Review Date: 4/1/2015

Review, Revision and Distribution
This policy will be provided to all Operations, Providers Relations and Audit staff and Unity Leadership. The documents will be maintained in the Provider Manual and (publication on website).

Approval of new and revised policies will be assigned to the following individuals:

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

Document Logistics & Revision History
Document Owner: Manager, Claim Coding and Compliance
Document Location: Claims: Coding Policies and Procedures

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NOTE:
Purpose
The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for discontinued hospital outpatient and ASC procedures prior to the administration of anesthesia.

As defined by AMA CPT4 coding instructions, due to extenuating circumstances or those that threaten the well being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for, but cancelled can be reported with modifier 73 appended to the 5 digit CPT4 code.

The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician services of discontinued services, see modifier 53.

Common Definitions
- 53 - Discontinued Procedure
- 73 - Discontinued Out-Patient Hospital/ASC Procedure Prior Administration of Anesthesia
- AMA – American Medical Association
- ASC – Ambulatory Surgery Center
- CMS -Centers for Medicare and Medicaid Services
- CPT4 - Current Procedural Terminology– Published by the American Medical Association
- OPPS – Outpatient Prospective Payment System

Policy
Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications for discontinued out-patient hospital/ASC procedures prior to the administration of anesthesia. As a secondary resource, Unity will reference industry standard, including a review of Medicare and Medicare policies.
Modifier 73 – Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to Administration of Anesthesia Policy and Procedure

Last Revision/Review Date: 4/1/2015

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.

**Coding Interpretation and Applications**

Modifier 73 is used by the facility to indicate that a surgical or diagnostic procedure requiring anesthesia was termed due to extenuating circumstances or to circumstances that threatened the well being of the patient. This determination was made after the patient had been prepared for the procedure (including procedural pre-medications when provided), and been taken to the room where the procedure was to be performed, but prior to the administration of anesthesia. As defined by CMS, for purposes of billing for services furnished in the hospital outpatient department, anesthesia is defined to include local, regional block(s) moderate sedation, and deep sedation/analgesia and general anesthesia.

It is not appropriate to report modifier 73 under the following circumstances:
- Elective cancellation of a procedure.
- Discontinued radiological procedures that do not require anesthesia.
- Do not report modifier 73 when the surgeon cancels or postpones the schedule surgery because of a patient complaint, such as a cold or flu symptoms.
- Thorough documentation is critical when reporting modifier 73. Documentation must list why and when the physician canceled the procedure.

The modifier 73 policy applies to facility outpatient/ASC services and is subject to the terms of the provider contract.

**Reimbursement Applications**

Unity follows CMS OPPS guidelines and allows 50% of the payment amount for cases in which the procedure is discontinued after the patient was prepared for the procedure and taken to the room where the procedure was to be performed. Reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported. Contracted providers that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms and modifier 73 rules will apply.

If the procedure is discontinued after the patient has received anesthesia or after the procedure was started (eg, scope inserted, intubation started, incision made) payment will be allowed at full amount subject to contract terms, for the discontinued procedure. Please refer to Policy and Procedure Modifier 74.

Unity modifier 73 policy contains associated claim editing software that identifies the appropriateness of reporting modifier 73. Incorrect reporting of modifier 73 will result in a denial.
Quality Assurance
Quality outcome measurements on the use of modifier 73, Discontinued Procedure Prior to the administration of anesthesia will be conducted through periodic claim checks. The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

Facilities reporting inpatient, outpatient and ASCs must report with the appropriate revenue and DRG code when applicable.

Enforcement
Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of discontinued outpatient procedures.

Review, Revision and Distribution
This policy will be provided to all Unity Leadership, Operations, Providers Relations and Audit staff. The documents will be maintained in the Provider Manual and (publication on website).

Approval of new and revised policies will be assigned to the following individuals:
- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

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Modifier 74 – Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia
Policy and Procedure

Last Revision/Review Date: 4/1/2015

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Purpose
The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for discontinued outpatient hospital/ASC procedures after administration of anesthesia.

As defined by AMA CPT4 coding instructions, due to extenuating circumstances or those that threaten the well being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia or after the procedure was started (incision made, intubation started, scope inserted, etc). Under these circumstances, the procedure started but terminated can be reported with modifier 74 appended to the 5 digit CPT4 code.

The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For discontinued physician services, see modifier 53.

Common Definitions
- 53 – Discontinued Procedure
- 73 – Discontinued Out-Patient Hospital/ASC Procedure Prior Administration of Anesthesia
- 74 – Discontinued Out-Patient Hospital/ASC Procedure After Administration of Anesthesia
- AMA – American Medical Association
- ASC – Ambulatory Surgery Center
- CPT4 - Current Procedural Terminology – Published by the American Medical Association

Policy
Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications for discontinued out-patient hospital/ASC procedures after the administration of anesthesia. As a secondary resource, Unity will reference industry standard, including a review of Medicare and Medicaid policies.
Modifier 74 – Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia

Policy and Procedure

Last Revision/Review Date: 4/1/2015

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.

**Coding Interpretation and Applications**

Modifier 74 is used by the facility to indicate that a surgical or diagnostic procedure requiring anesthesia was termed due to extenuating circumstances or to circumstances that threatened the well being of the patient. This determination was made after the administration of anesthesia or after the procedure was started (incision was made, patient was intubated, scope inserted). For purposes of billing for services furnished in the hospital outpatient department, anesthesia is defined to include local, regional block(s) moderate sedation, and deep sedation/analgesia and general anesthesia.

It is not appropriate to report Modifier 74 under the following circumstances;

- Elective cancellation or postponement of a procedure based on the physician or patient’s choice.
- This modifier is not appropriate when the termination of the procedure occurs prior to the beginning of the procedure or the administration of anesthesia. See Modifier 73.
- Do not report Modifier 74 when the surgeon cancels or postpones the schedule surgery because of a patient complaint, such as a cold or flu symptoms.

The modifier 74 policy applies to facility outpatient/ASC services.

**Reimbursement Applications**

Unity will consider full payment, subject to contract terms, when the procedure is discontinued after the patient has received anesthesia or after the procedure was stared (eg, scope inserted, intubation started, incision made). Reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported. Contracted providers that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms and modifier 74 rules will apply.

When one or more of the procedure(s) planned are completed, the completed procedure(s) is reported as usual. Other procedures that were planned, and not started, should not be reported.

Thorough documentation is critical when reporting modifier 74. Documentation must list why and when the physician canceled the procedure. In addition, documentation should clearly explain the intended surgical procedure and the actual services performed and supplies provided.

**Quality Assurance**

Quality outcome measurements on the use of modifier 74, Discontinued Procedure After Administration of Anesthesia will be conducted through periodic claim checks. The Manager, Claim Coding and Compliance Manager, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies
Modifier 74 – Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia Policy and Procedure

Last Revision/Review Date: 4/1/2015

identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

Facilities reporting inpatient, outpatient and ASCs must report with the appropriate revenue and DRG code when applicable.

**Enforcement**

Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of discontinued outpatient procedures.

**Review, Revision and Distribution**

This policy will be provided to all Unity Leadership, Operations, Providers Relations and Audit staff. The documents will be maintained in the Provider Manual and (publication on website).

Approval of new and revised policies will be assigned to the following individuals:

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

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**NOTE:**
Purpose
The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for repeat procedures or services performed on the same date of service.

As defined by the AMA CPT4 coding instructions; it may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. In this circumstance, modifier 76 should be added to the repeated procedure or service. If the repeated service is performed by another physician or other qualified health care professional, modifier 77 should be added to the repeated procedure or service.

Definitions
• AMA – American Medical Association
• CMS – Centers for Medicare and Medicaid Services
• CPT4 - Current Procedural Terminology – Published by the American Medical Association
• E&M – Evaluation and Management
• NCCI – National Correct Coding Initiative

Policy
Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications. As a secondary resource, Unity will reference industry standards, including a review of Medicare and Medicaid policies.

• Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
• Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.
**Coding Interpretation and Applications**
Modifier 76 or modifier 77 should be applied to indicate a procedure or service code was repeated on the same date of service. Modifier 76 is appropriate when the repeated procedure or service was performed by the same provider. Modifier 77 is appropriate when the repeated procedure or service was performed by a different provider. Each service should be reported on a separate line with a quantity of one, and modifier 76 or 77 appended to the subsequent procedure code. Per CPT guidelines, modifiers 76 and 77 should not be appended to an E&M service code.

The medical record should include appropriate documentation for each procedure or service performed.

The modifier 76 and 77 policy applies to professional services performed in inpatient hospital, outpatient hospital, Ambulatory Surgical Center, and physician’s office setting.

**Reimbursement Applications**
Repeat procedures or services performed on the same date of service are considered for reimbursement when reported with modifier 76 or 77. Unity follows CMS guidance in the NCCI policy manual, Chapter 1 – General Correct Coding Policies and does not allow modifiers 76 or 77 to bypass NCCI edits.

The Unity modifier 76 and modifier 77 policy contains associated claim editing software that identifies the appropriateness of billing modifier 76 and 77. Incorrect reporting of modifier 76 or 77 will result in a denial.

**Quality Assurance**
Quality outcome measurements on the use of modifier 76 and 77, Repeat Procedure or Service, will be conducted through periodic claim audits. The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

**Enforcement**
Enforcement of coding policies will be conducted through periodic claim checks and requests for documentation. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of repeat procedures.

**Review, Revision and Distribution**
This policy will be provided to all Unity Leadership, Operations, Provider Relations and Audit staff. The documents will be maintained in the Provider Manual (publication on website). Any change to the policy that impacts claim submission guidelines or claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments, and/or provider manual updates.
Approval of new and revised policies will be assigned to the following individuals:

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

### Document Logistics & Revision History

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Note:
**Modifier 78 – Unplanned Return to Operating or Procedure Room**

**Policy and Procedure**

*Last Revision/Review Date: 4/1/2015*

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**Organization and Associated Product Lines**

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**Purpose**

The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for unplanned return to operating room or procedure room by the same physician following the initial procedure for a related procedure during the postoperative period. As directed by AMA CPT4 guidelines, it may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76).

The unplanned surgery involves a separate operative session followed by the original surgery and may include complications such as excessive bleeding, post surgery hemorrhage or infection.

**Common Definitions**

- 58 – Staged or Related Procedure or Service During Postoperative Period
- 76 – Repeat Procedure or Service
- 78 – Unplanned Return to Operating/Procedure Room
- AMA – American Medical Association
- ASC – Ambulatory Surgery Center
- CMS -Centers for Medicare and Medicaid Services
- CPT4 - Current Procedural Terminology – Published by the American Medical Association
- OPPS – Outpatient Prospective Payment System

**Policy**

Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications for unplanned return trips to the operating/procedure room. As a secondary resource, Unity will reference industry standard, including a review of Medicare and Medicare policies.
Modifier 78 – Unplanned Return to Operating or Procedure Room
Policy and Procedure
Last Revision/Review Date: 4/1/2015

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.

**Coding Interpretation and Applications**

Modifier 78 is used for an unplanned return trip to the operating room for a related surgical procedure during the postoperative period of the initial major surgery. The term operating room is defined as a place of service specifically equipped and staffed for the sole purpose of performing surgical procedures.

As defined by CMS, this may include a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient’s room, a minor treatment room, a recovery room, or an intensive care unit unless the patient’s condition was so critical there would be insufficient time for transportation to an operating room.

- Modifier 78 is used for surgical treatment that is an unintended outcome of the previous procedure and should not be confused with modifier 58, which involves subsequent planned procedures.
- Do not use modifier 78 on codes that do not have a global surgery indicator.
- Do not use modifier 78 when the surgery is unrelated to the original procedure.
- Procedures is performed in a setting other than the approved locations should not be reported with modifier 78.

The modifier 78 policy applies to professional services and facility outpatient/ASC services.

**Reimbursement Applications**

The pre and postoperative care is included in the allowance for the prior surgical procedure, therefore, reimbursement for the procedure reported with modifier 78 will be allowed based on the intra-operative portion of the surgery. A new postoperative period does not begin when reporting modifier 78.

Providers should report their full fee for the procedure to allow appropriate claims to be adjudicated. Reimbursement will be 70% of the allowed contracted rate. Reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported. Contracted providers that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms and modifier 78 rules will apply.

Facilities reporting inpatient, outpatient and ASCs must report with the appropriate revenue and DRG code when applicable.

Unity modifier 78 policy contains associated claim editing software that identifies the appropriateness of reporting modifier 78. Incorrect reporting of modifier 78 will result in a denial.
Modifier 78 – Unplanned Return to Operating or Procedure Room
Policy and Procedure
Last Revision/Review Date: 4/1/2015

**Quality Assurance**

Quality outcome measurements on the use of modifier 78, Unplanned Return to Operating or Procedure Room coding policies will be conducted through periodic claim checks. The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

**Enforcement**

Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of unplanned return visit to the operating or procedure room.

**Review, Revision and Distribution**

This policy will be provided to all Unity Leadership, Operations, Providers Relations and Audit staff. The documents will be maintained in the Provider Manual and (publication on website).

Approval of new and revised policies will be assigned to the following individuals;

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

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**NOTE:**
Modifier 79 Unrelated Procedure/Service During Post-Op Period

Policy and Procedure

Last Revision/Review Date: 4/1/2015

Organization and Associated Product Lines

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Purpose

The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for an unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period.

As defined by the AMA CPT4 coding instructions; the individual provider may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79.

Definitions

- AMA – American Medical Association
- CMS - Centers for Medicare and Medicaid Services
- CPT4 - Current Procedural Terminology – Published by the American Medical Association
- NCCI – National Correct Coding Initiative

Policy

Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications. As a secondary resource, Unity will reference industry standards, including a review of Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.
Coding Interpretation and Applications
Modifier 79 should be applied to indicate an unrelated procedure or service code was performed by the same provider during the post-operative period of another service or procedure. Modifier 79 is appropriate for use on surgical codes, except those with XXX global period as identified on the Medicare Physician Fee Schedule.

The medical record should include appropriate documentation for each procedure or service performed.

The modifier 79 policy applies to professional services performed in inpatient hospital, outpatient hospital, Ambulatory Surgical Center, and physician’s office setting.

Reimbursement Applications
Unrelated procedures or services performed by the same physician or other qualified health care professional during the postoperative period are considered for reimbursement when reported with modifier 79. Unity follows CMS guidance in the NCCI policy manual, Chapter 1 – General Correct Coding Policies and does recognize modifier 79 as a global surgery modifier.

The Unity modifier 79 policy contains associated claim editing software that identifies the appropriateness of billing modifier 79. Incorrect reporting of modifier 79 will result in a denial.

Quality Assurance
Quality outcome measurements on the use of modifier 79, Unrelated Procedure or Service during the Post-Op Period, will be conducted through periodic claim audits. The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

Enforcement
Enforcement of coding policies will be conducted through periodic claim checks and requests for documentation. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of repeat procedures.

Review, Revision and Distribution
This policy will be provided to all Unity Leadership, Operations, Provider Relations and Audit staff. The documents will be maintained in the Provider Manual (publication on website). Any change to the policy that impacts claim submission guidelines or claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments, and/or provider manual updates.
Modifier 79 Unrelated Procedure/Service During Post-Op Period
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Approval of new and revised policies will be assigned to the following individuals:
- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

**Document Logistics & Revision History**
Document Owner: Manager, Claim Coding and Compliance Manager
Document Location: Claims: Coding Policies and Procedures

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Note:
Purpose

The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for assistant surgeons.

An assistant surgeon is a physician who actively assists the primary surgeon in a surgical procedure. Surgical assistants should report their services by appending modifier 80 to the surgical code. Modifier 80 should be appended to the same 5 digit CPT4 code reported by the primary surgeon. By reporting modifier 80, the physician is stating that they were providing full assistance during the surgery. The AMA and CMS have additional modifiers (81, 82 and AS) to report assistant surgery based on the unique situation.

- 80 – Assistant Surgeon
- 81 - Minimum Assistant Surgeon
- 82 – Assistant Surgeon When Qualified Resident Surgeon Is Not Available.
- AS – Non-Physician Providing Assistance in Surgery
- AMA – American Medical Association
- CMS – Center for Medicare and Medicaid Services
- CPT4 - Current Procedural Terminology – Published by the American Medical Association

Policy

Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications for surgical procedures. As a secondary resource, Unity will reference industry standard, including a review of Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.
Coding Interpretation and Applications

As defined by the AMA and CMS, the use of modifier 80, represents that the provider of service is a licensed physician and is qualified to perform the surgical service(s) reported.

Modifier 80 should be appended to the 5 digit CPT4 surgical code when the assistant surgeon was involved with the entire case.

When determining if an assistant surgery claim is payable, Unity considers the following requirements in the adjudication claim process;

- Type of surgical procedure performed. Unity follows industry standard guidance when determining assistant surgeon designations for each code. The use of status indicators are based on input from the American College of Surgeons (ACS).
- Type of provider performing the service to determine if the claim is payable. Modifier 80 requires the services be performed by a licensed physician. Non-physicians assisting in surgical cases should reference the AS Modifier Policy and Procedure in the Provider Manual.
- First assists that include registered nurses or certified surgical technicians should not bill separately, as payment is included in the prospective payment system to the facility.
- Medical necessity for use of the assistant surgeon must be well documented in the operative report and include the distinct services provided by both the primary surgeon and the assistant surgeon.

The modifier 80 policy applies to professional services.

Reimbursement Applications

Providers should report their full fee for assistant surgeries to allow appropriate claims to be adjudicated. Reimbursement for assistant surgery provided by a physician will be 16% of the primary surgery fee, subject to provider contract terms. Reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported. Contracted providers that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms and modifier 80 payment rules will apply.

In addition;

- Only one assistant surgeon is eligible for reimbursement per covered surgical procedure when the service is appropriate and qualifies for an assistant.
- Assistant surgeon services are subject to the multiple surgery policies and procedure guidelines, if applicable.
- Services reported with an unlisted CPT4 code will be pended and supporting documentation will be requested to determine reimbursement.

Unity modifier 80 policy contains associated claim editing software that identifies the appropriateness of reporting modifier 80. Incorrect reporting of modifier 80 will result in a denial.

Quality Assurance

The quality outcome measurements on the use of modifier 80, Assistant Surgeon coding policies will be conducted through periodic claim checks.
Modifier 80 – Assistant Surgeon Policy and Procedure

Last Revision/Review Date: 4-1-2015

The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

**Enforcement**

Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of assistant surgeons.

**Review, Revision and Distribution**

This policy will be provided to all Unity Leadership, Operations, Provider Relations and Audit staff. The documents will be maintained in the Provider Manual and (publication on website)

Approval of new and revised policies will be assigned to the following individuals;

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

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**NOTE:**
Modifier 81 – Minimum Assistant Surgeon
Policy and Procedure
Last Revision/Review Date: 4/1/2015

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Purpose
The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for minimum assistant surgeon.

A Minimum Assistant Surgeon is a physician who actively assists the primary surgeon in a limited portion of the surgical procedure. Minimum Surgical Assistants should report their services by appending modifier 81 to the same 5 digit CPT4 code reported by the primary surgeon. By reporting modifier 81, the physician is stating that they were providing minimal assistance during the surgery. This modifier is not intended for use by non-physicians assisting at surgery. The AMA and CMS have additional modifiers (80, 82 and AS) to report assistant surgery based on the circumstance of the case.

- 80 – Assistant Surgeon
- 81 - Minimum Assistant Surgeon
- 82 – Assistant Surgeon When Qualified Resident Surgeon Is Not Available.
- AS – Non-Physician Providing Assistance in Surgery
- AMA – American Medical Association
- CMS – Center for Medicare and Medicaid Services
- CPT4 - Current Procedural Terminology—Published by the American Medical Association

Policy
Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications for surgical procedures. As a secondary resource, Unity will reference industry standard, including a review of Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.
Coding Interpretation and Applications

Modifier 81 is used to indicate the assisting physician provided either limited or minimal surgical assistance to the primary surgeon during a procedure. These services are typically defined as; physician assistance needed during only a portion of the entire procedure; or a clinical situation requiring more than one physician assistant during a surgical procedure.

As defined by the AMA and CMS, the use of modifier 81 represents that the provider of service is a licensed physician and is qualified to perform the surgical service(s) reported.

Modifier 81 should be appended with the 5 digit CPT4 surgical code when the assistant surgeon was providing minimal assistance during the entire case.

Medical necessity for use of the assistant surgeon must be well documented in the operative report and include a description of the distinct services provided by both the primary surgeon and the minimal assistant surgeon.

When determining if a minimal assistant surgery claim is payable, Unity considers the following requirements in the adjudication claim process;

- Type of surgical procedure performed. Unity follows industry standard guidance when determining minimal assistant surgeon designations for each code. The use of status indicators are based on input from the American College of Surgeons (ACS).
- Type of provider performing the service to determine if the claim is payable. Modifier 81 requires the services be performed by a licensed physician. Non-physicians assisting in surgical cases should reference the AS Modifier Policy and Procedure in the Provider Manual.
- First assists that include registered nurses or certified surgical technicians should not bill separately, as payment is included in the prospective payment system to the facility.

The modifier 81 policy applies to professional services.

Reimbursement Applications

Providers should report their full fee for assistant surgeries to allow appropriate claims to be adjudicated. Reimbursement for minimum assistant surgery provided by a physician will be 16% of the primary surgery fee, subject to provider contract terms. Reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported. Contracted providers that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms and modifier 81 payment rules will apply.

In addition;

- Minimal assistant surgeon services are subject to the multiple surgery policies and procedure guidelines, if applicable.
- Services reported with an unlisted CPT4 code will be pended and supporting documentation will be requested to determine reimbursement.

Unity modifier 81 policy contains associated claim editing software that identifies the appropriateness of reporting modifier 81. Incorrect reporting of modifier 81 will result in a denial.
Quality Assurance

Quality outcome measurements on the use of modifier 81, Minimum Assistant Surgeon coding policies will be conducted through periodic claim checks. The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

Enforcement

Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of minimum assistant surgeon.

Review, Revision and Distribution

This policy will be provided to all Unity Leadership, Operations, Provider Relations and Audit staff. The documents will be maintained in the Provider Manual and (publication on website).

Approval of new and revised policies will be assigned to the following individuals:

- Director, Business Services
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- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

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NOTE:
Purpose

The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for assistant surgeons when a qualified resident surgeon is not available.

In approved teaching facilities, qualified resident surgeons may perform as assistant surgeons. An assistant surgeon is a physician who actively assists the primary surgeon in a surgical procedure. Per the AMA CPT4 guidelines, appending modifier 82 to the surgical procedure code is only appropriate when a qualified resident surgeon is not available to assist.

Modifier 82 should be appended to the same 5 digit CPT4 surgical code reported by the primary surgeon when the assistant surgeon is performing cases and the qualified resident surgeon is not available. This modifier is not intended to report cases performed by non-physicians. The AMA and CMS have additional modifiers (80, 81, and AS) to report assistant surgery based on the unique situation.

- 80 – Assistant Surgeon
- 81 - Minimum Assistant Surgeon
- 82 – Assistant Surgeon When Qualified Resident Surgeon Is Not Available.
- AS – Non-Physician Providing Assistance in Surgery
- AMA – American Medical Association
- CMS – Center for Medicare and Medicaid Services
- CPT4 - Current Procedural Terminology– Published by the American Medical Association

Policy

Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications for surgical procedures. As a secondary resource, Unity will reference industry standard, including a review of Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
Modifier 82 – Assistant Surgeon (When Qualified Resident Surgeon Not Available)
Policy and Procedure
Last Revision/Review Date: 4-1-2015

- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.

**Coding Interpretation and Applications**
Modifier 82 is used to report cases when the assistant at surgery was provided by a licensed provider and there was not a qualified resident available. As defined by the AMA and CMS, the use of modifier 82, represents that the provider of service is a licensed physician and is qualified to perform the surgical service(s) reported.

These 5 digit CPT4 surgical code should be reported with modifier 82 when the assistant surgeon was involved with the case and there was not a qualified resident surgeon available.

Medical necessity for use of the assistant surgeon must be well documented in the operative report and include the distinct services provided by both the primary surgeon and the assistant surgeon.

When determining if an assistant surgery claim is payable in cases that would require a resident surgeon, Unity considers the following requirements in the adjudication claim process;
- Type of surgical procedure performed. Unity follows industry standard guidance when determining assistant surgeon designations for each code. The use of status indicators are based on input from the American College of Surgeons (ACS).
- Type of provider performing the service to determine if the claim is payable. Modifier 82 requires the services be performed by a licensed physician when a qualified resident surgeon is not available.
- First assists that include registered nurses or certified surgical technicians should not bill separately, as payment is included in the prospective payment system to the facility.
- Documentation must include information relating to the unavailability of a qualified resident in this situation.

The modifier 82 policy applies to professional services.

**Reimbursement Applications**
Providers should report their full fee for assistant surgeries to allow appropriate claims to be adjudicated. Reimbursement for assistant surgery provided by a physician will be 16% of the primary surgery fee, subject to provider contract terms. Reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported. Contracted providers that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms and modifier 82 payment rules will apply.

In addition;
- Assistant surgeon services are subject to the multiple surgery policies and procedure guidelines, if applicable.
- Services reported with an unlisted CPT4 code will be pended and supporting documentation will be requested to determine reimbursement.
- Only one assistant surgeon is eligible for reimbursement per covered surgical procedure.
Unity modifier 82 policy contains associated claim editing software that identifies the appropriateness of reporting modifier 82. Incorrect reporting of modifier 82 will result in a denial.

**Quality Assurance**

The quality outcome measurements on the use of modifier 82, Assistant Surgeon When Qualified Resident Not Available coding policies will be conducted through periodic claim checks. The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

**Enforcement**

Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of assistant surgeon, when qualified resident unavailable.

**Review, Revision and Distribution**

This policy will be provided to all Unity Leadership, Operations, Provider Relations and Audit staff. The documents will be maintained in the Provider Manual and (publication on website)

Approval of new and revised policies will be assigned to the following individuals;

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

**Document Logistics & Revision History**

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**NOTE:**

- Policy and Procedure Form Version 1 – 4-1-2015
- Confidential
Modifier 91– Repeat Clinical Diagnostic Laboratory Test
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Organization and Associated Product Lines

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Purpose
The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for repeat clinical diagnostic laboratory tests.

In the course of the treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure code number and the addition of modifier 91.

As defined by AMA CPT4 guidelines, this modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

Common Definitions
- 91 – Repeat Clinical Diagnostic Laboratory Test
- AMA – American Medical Association
- CPT4 - Current Procedural Terminology– Published by the American Medical Association

Policy
Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications for clinical diagnostic laboratory tests. As a secondary resource, Unity will reference industry standard, including a review of Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.
Coding Interpretation and Applications

The correct application of Modifier 91 can help reduce denials and inappropriate appeals when billing duplicate CPT codes or a single CPT code with multiple units of service. Modifier 91 provides further explanation on why duplicate tests are ordered and performed on the same day for the same patient.

This modifier is added only when additional test results are to be obtained subsequent to the initial administration or performance of the test(s) on the same day. It is not used when laboratory tests or studies are simply rerun because of specimen or equipment error or malfunction.

It is inappropriate to report modifier 91 in the following situations;
- When a laboratory test is rerun to confirm the results of the previous test
- Due to testing problems with the specimen and/or equipment
- When the procedure code, or another procedure code describes a series of tests
- For any reason when a normal one-time result is required
- Tests that require serial measurements, meaning a certain test has to be done several times to compare measurements.

The modifier 91 policy applies to professional services and facility outpatient/ASC services.

Reimbursement Applications

When properly reported, modifier 91 will help eliminate denials and payment will be considered at the full allowed amount, subject to provider contract terms. Reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported. Contracted providers that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms and modifier 91 payment rules will apply.

Services with multiple units should be billed on one line with the appropriate units and modifier indicated.

Facilities reporting inpatient, outpatient and ASCs must report with the appropriate revenue and DRG code when applicable.

Quality Assurance

Quality outcome measurements on the use of modifier 91 will be conducted through periodic claim checks. The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

Enforcement

Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of repeat clinical diagnostic tests.
Modifier 91– Repeat Clinical Diagnostic Laboratory Test
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Review, Revision and Distribution

This policy will be provided to all Unity Leadership, Operations, Provider Relations and Audit staff. The documents will be maintained in the Provider Manual (publication on website).

Approval of new and revised policies will be assigned to the following individuals:

- Director, Business Services
- Director, Provider Relations
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NOTE:
Modifier AA – Anesthesia Services Performed Personally By Anesthesiologists
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Organization and Associated Product Lines

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Purpose
The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for Anesthesia Services Performed Personally by Anesthesiologists, modifier AA.

Services involving the administration of anesthesia are reported by using the anesthesia 5 digit CPT4 code and, if applicable, the appropriate service and physical status modifier(s). Modifier AA is used for reporting physician services and is not used if the provider of service is a CRNA. Guidelines surrounding the medical direction and medical supervision of CRNA’s can be found in Policies and Procedures Modifier AD, QK, QY, QX and QZ.

Common Definitions
- AA – Anesthesia Services Performed Personally By The Anesthesiologists
- AD – Medically Supervised By a Physician, More Than Four Concurrent Anesthesia Procedures
- QK – Medical Direction By a Physician, Two, Three or Four Concurrent Anesthesia Procedures
- QY – Medical Direction of One CRNA/AA (Anesthesiologist’s Assistant) By An Anesthesiologist
- QX – CRNA/AA (Anesthesiologist Assistant) Service With Medical Direction By a Physician
- QZ – CRNA/AA (Anesthesiologist Assistant) Service Without Medical Direction By a Physician
- AMA – American Medical Association
- ASA – American Society of Anesthesiologists
- CPT4 - Current Procedural Terminology– Published by the American Medical Association
- CRNA – Certified Registered Nurse Anesthetist

Policy
Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications for anesthesia procedures. As a secondary resource, Unity will reference industry standard, including ASA and a review of Medicare and Medicare policies.
Modifier AA – Anesthesia Services Performed Personally By Anesthesiologists
Policy and Procedure
Last Revision/Review Date: 4/1/2015

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.

Coding Interpretation and Applications
Anesthesia care includes the usual preoperative and postoperative visits. The following components are considered an integral part of the global service for general anesthesia and should not be reported separately;

- Pre-anesthesia evaluation
- Post operative visits
- Anesthetic or analgesic administration
- Routine, non-invasive monitoring, including: blood pressure monitoring, EKG, ECG monitoring, arterial blood gases, oximetry, carbon dioxide determination, pulmonary function tests, mass spectrometry, intubation
- Intra-operative administration of drugs, IV fluids, blood, etc
- Set up, maintenance and supervision of intravenous patient-controlled analgesia (PCA) pump
- Pharmacological or physical activation requiring physician attendance during EEG recording

Unusual forms of monitoring (e.g., intra-arterial, central venous, and Swan-Ganz) are not included in the routine anesthesia care policy.

The reporting of anesthesia services is appropriate by or under the responsibility supervision of a physician. These services may include but are not limited to general, regional, supplementation of local anesthesia, or other supportive services in order to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedure.

The modifier AA policy applies to professional services, is considered a payment modifier and should be reported in the first modifier field on the claim form.

Reimbursement Applications
Unity reimbursement methodology for anesthesia services is determined by a combination of base units, time units, conversion factor, modifiers and additional indicators; such as qualifying circumstances. Providers should report their full fee for the anesthesia service. Reimbursement will be allowed at 100%, subject to provider contract terms and will be based on the reasonableness and necessary charges for the patient’s condition reported. Contracted providers that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms.

The base units allowed for each individual procedure code is consistent with the ASA base units assignments.
Time units are based on when the provider of anesthesia services begins to prepare the patient for anesthesia care in the operating room or in the equivalent area, and ends when the individual is no longer in personal attendance and is no longer providing anesthesia services. Anesthesia time can be counted in blocks of time if there is an interruption in anesthesia, as long as the time counted is for continuous anesthesia services. Unity allows one unit of time for each 15 minute increment of anesthesia time. Providers that submit actual minutes of administered anesthesia time will be converted to 15 minutes increments per unit of service.

When multiple surgical procedures are performed during a single anesthetic administration, the anesthesia code representing the most complex procedure is reported. The time reported is the combined total for all procedures. Add-on anesthesia codes are listed in addition to the code for the primary procedure.

Anesthesia codes reported with modifier P3, P4 or P5 are eligible for additional unit(s) of reimbursement.

Facilities reporting inpatient, outpatient and ASCs must report with the appropriate revenue and DRG code when applicable.

Unity modifier AA policy contains associated claim editing software that identifies the appropriateness of billing modifier AA. Incorrect reporting of modifier AA will result in a denial.

**Quality Assurance**

Quality outcome measurements on the use of modifier AA, Anesthesia Services Performed Personally by Anesthesiologists coding policies will be conducted through periodic claim checks. The Manager, Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

**Enforcement**

Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of anesthesia procedures.

**Review, Revision and Distribution**

This policy will be provided to all Operations, Providers Relations and Audit staff and Unity Leadership. The documents will be maintained in the Provider Manual and (publication on website).

Approval of new and revised policies will be assigned to the following individuals;

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations
Modifier AA – Anesthesia Services Performed Personally By Anesthesiologists
Policy and Procedure
Last Revision/Review Date: 4/1/2015

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**NOTE:**

Policy and Procedure Form Version 1 – 4-1-2015
Modifier AD, QK, QY – Medical Supervision, Direction Services By a Physician
Policy and Procedure
Last Revision/Review Date: 4/1/2015

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Purpose

The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for medical supervision and medical direction by a physician. These modifiers are not reported by the CRNAs. Please refer to Policy and Procedure QX and QZ Modifiers for CRNA reported services.

As defined by the ASA, medical direction requires the anesthesiologist to be immediately available if he/she is in physical proximity that allows the anesthesiologist to return to re-establish direct contact with the patient to meet medical needs and address any urgent or emergent clinical problems. These responsibilities may also be met through coordination among anesthesiologist of the same group or department. The medically directing provider must perform the following services to meet the medical direction status;

- Perform a pre-anesthetic examination and evaluation;
- Prescribe the anesthesia plan;
- Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;
- Ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
- Monitor the course of anesthesia administration at frequent intervals;
- Remain physically present and available for immediate diagnosis and treatment of emergencies, and;
- Provide indicated post-anesthesia care.

Medical supervision occurs when the physician is not able to meet all of the requirements defined under medical direction, performs a task that is not permitted while medically directing, or is involved in more than four concurrent cases.

In accordance with the AMA coding guidelines, services involving the administration of anesthesia are reported by the use of the anesthesia 5 digit CPT4 code. Medically directed and medically supervised anesthesia procedure should be billed using the appropriate modifiers to describe the case.
Modifier AD, QK, QY – Medical Supervision, Direction Services By a Physician

Policy and Procedure

Last Revision/Review Date: 4/1/2015

Common Definitions

- AA – Anesthesiologist’s Assistant
- AD – Medically Supervised By a Physician, more Than Four Concurrent Anesthesia Procedures
- P3 – A patient with severe systemic disease
- P4 – A patient with severe systemic disease that is a constant threat to life
- P5 – A moribund patient who is not expected to survive without the operation
- QK – Medical Direction By a Physician of 2, 3 or 4 Concurrent Anesthesia Procedures
- QX –CRNA Service; With Medical Direction By a Physician
- QY – Medical Direction of One CRNA/AA (Anesthesiologist’s Assistant) By an Anesthesiologist
- QZ – CRNA Service; Without Medical Direction By a Physician
- AMA – American Medical Association
- ASA – American Society of Anesthesiologists
- CPT4 - Current Procedural Terminology– Published by the American Medical Association
- CRNA – Certified Registered Nurse Anesthetist

Policy

Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications for medically supervised and directed anesthesia procedures. As a secondary resource, Unity will reference the ASA guide, industry standards, including a review of Medicare and Medicare policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.

Coding Interpretation and Applications

The reporting of anesthesia services is appropriate by or under the medical supervision or medical direction of a physician. These services may include but are not limited to general, regional, supplementation of local anesthesia, or other supportive services in order to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedure.

Anesthesia care includes the usual preoperative and postoperative visits. The following components are considered an integral part of the global service for general anesthesia and should not be reported separately;

- Pre-anesthesia evaluation
- Postoperative visits
- Anesthetic or analgesic administration
- Routine, non-invasive monitoring, including; blood pressure monitoring, EKG, ECG monitoring, arterial blood gases, oximetry, carbon dioxide determination, pulmonary function tests, mass spectrometry, intubation
• Intra-operative administration of drugs, IV fluids, blood, etc
• Set up, maintenance and supervision of intravenous patient-controlled analgesia (PCA) pump
• Pharmacological or physical activation requiring physician attendance during EEG recording

Unusual forms of monitoring (e.g., intra-arterial, central venous, and Swan-Ganz) are not included in the routine anesthesia care policy.

Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room (or in an equivalent area) and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision.

The modifier AD, QK and QY policy applies to professional services. Modifiers AD, QX and QZ are payment modifiers and should be sequenced before any applicable informational modifiers.

Reimbursement Applications

Global reimbursement for the anesthesia service provided includes all procedures integral to the successful administration of anesthesia from the initial pre-anesthesia evaluation through the time when the anesthesiologist is no longer in personal attendance. Total reimbursement for anesthesia services provided by a MD and a non-MD will not exceed what would have been allowed had anesthesia been provided by one MD.

Unity reimbursement policy for medically supervised and medically directed anesthesia cases will be considered as follows, subject to provider contract terms;

AD – Medical supervision by a physician: more than 4 concurrent anesthesia procedures.
• Unity allows 3 base units per procedure when the anesthesiologist is involved in furnishing more than four procedures concurrently or is performing other services while directing the concurrent procedures. No additional units are allowed for time, physical status and/or qualifying circumstances. An additional time unit may be recognized if the anesthesiologist can document that he or she was present at the time of induction.
QK – Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individual.
• Unity will allow 50% of the amount that would have been allowed if personally performed by an anesthesiologists or non-supervised CRNA.
QY – Medical direction of one CRNA or AA by an anesthesiologist.
• Unity will allow 50% of the amount that would have been allowed if personally performed by an anesthesiologist or non-supervised CRNA.

Reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported. Contracted providers that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms.

When multiple surgical procedures are performed during a single anesthetic administration, the anesthesia code representing the most complex procedure is reported. The time reported is the combined total for all procedures. Add-on anesthesia codes are listed in addition to the code for the primary procedure.
Anesthesia codes reported with modifier P3, P4 or P5 are eligible for additional unit(s) of reimbursement. Please refer to Policy and Procedure P, Physical Status Indicator.

Unity modifier AD, QX and QZ policy contains associated claim editing software that identifies the appropriateness of billing these modifiers. Incorrect reporting of modifiers AD, QX and QZ will result in a denial.

**Quality Assurance**

Quality outcome measurements on the use of modifiers AD, QK, QY, Medically Supervised and Medically Directed Anesthesia coding policies will be conducted through periodic claim checks. The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

**Enforcement**

Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of medically supervised and medically directed anesthesia procedures.

**Review, Revision and Distribution**

This policy will be provided to all Operations, Providers Relations and Audit staff and Unity Leadership. The documents will be maintained in the Provider Manual and (publication on website).

Approval of new and revised policies will be assigned to the following individuals:

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
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## Modifier AD, QK, QY – Medical Supervision, Direction Services By a Physician

### Policy and Procedure

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**NOTE:**
Purpose

The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for services provided by a CSW, Clinical Social Worker.

Clinical social work is a state-regulated profession and the provider of service must be legally authorized to perform services based on state requirements.

In accordance with the AMA coding guidelines and licensure, CSW should report their services with the appropriate 5 digit CPT4 code and append modifier AJ.

Common Definitions

- AJ – Clinical Social Worker
- AMA – American Medical Association
- ASA – American Society of Anesthesiologists
- CPT4 – Current Procedural Terminology– Published by the American Medical Association
- CSW – Clinical Social Worker

Policy

Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications for clinical social worker services. As a secondary resource, Unity will reference industry standards, including a review of Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.
Coding Interpretation and Applications
Reimbursement is based on CPT services rendered by clinical practitioners licensed at the independent practice level. The reporting of services for clinical social workers should be reported with the appropriate 5 digit CPT code selected from the psychiatric/psychotherapy codes, excluding those codes that include evaluation and management services. Modifier AJ should be appended to further define the service(s) as those provided by a CSW. The modifier AJ policy applies to professional services. Modifier AJ should be sequenced after any applicable payment modifiers.

Reimbursement Applications
CSW’s should report their full fee for the services provided. Reimbursement will be subject to provider contract terms. Reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported. Contracted providers that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms and modifier AJ rules will apply.

Facilities reporting inpatient, outpatient and ASCs must report with the appropriate revenue and DRG code when applicable.

Unity modifier AJ policy contains associated claim editing software that identifies the appropriateness of billing modifier AJ. Incorrect reporting of modifier AJ will result in a denial.

Quality Assurance
Quality outcome measurements on the use of modifier AJ, Clinical Social Worker will be conducted through periodic claim checks. The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

Enforcement
Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of clinical social worker services.

Review, Revision and Distribution
This policy will be provided to all Unity Leadership, Operations, Provider Relations and Audit staff. The documents will be maintained in the Provider Manual and (publication on website).

Approval of new and revised policies will be assigned to the following individuals;

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations
Modifier AJ – Clinical Social Worker  
Policy and Procedure  
Last Revision/Review Date: 4/1/2015

**Document Logistics & Revision History**

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<th>Revision or Review Date</th>
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**NOTE:**

Policy and Procedure  
Form Version 1 – 4-1-2015  
Confidential
Organization and Associated Product Lines

Organization:
- Unity Health Plans Insurance Corporation

Product Lines:
- All lines
- HMO
- PPO
- POS
- UWA
- Medicare
- Medicaid
- Individual Exchange
- Individual Non-Exchange

Purpose
The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for non-physician assistant surgeons.

Modifier AS is a HCPCS Level II modifier that is recognized and accepted by most major insurance plans, including Unity. Modifier AS is used to report assistant surgery provided by a qualified assistant other than an MD/DO. Non-physician providers or advanced practice providers (APP) must have training and experience in the type of surgical procedure being performed as required by state licensure.

The non-physician assistant at surgery must be present for the entire surgical procedure and perform operational assistance under the direct supervision of the operating physician(s). The assistant at surgery must be involved in the actual performance of the procedure, not simply in ancillary services.

Non-physician surgical assistants should report their services by appending modifier AS to the same 5 digit CPT4 surgical code as reported by the primary surgeon. This modifier is valid for use by non-physician practitioners (NPP) when billing under their own provider name and provider identification number.

- 80 – Assistant Surgeon
- 81 – Minimum Assistant Surgeon
- 82 – Assistant Surgeon When Qualified Resident Surgeon Is Not Available
- AS – Non-Physician Providing Assistance in Surgery
- AMA – American Medical Association
- APP – Advanced Practice Providers
- CPT4 - Current Procedural Terminology– Published by the American Medical Association
- DO – Doctor of Osteopathic Medicine
- MD – Medical Doctor

Policy
Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications.
Modifier AS – Non-Physician Assistant Surgeon
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Unity follows AMA coding directives as the authoritative source for correct coding applications for surgical procedures. As a secondary resource, Unity will reference industry standard, including a review of Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.

**Coding Interpretation and Applications**

The use of modifier AS, represents that the provider of service is a licensed non-MD/DO and is qualified to perform the surgical service(s) reported.

These 5 digit CPT4 surgical code should be reported with modifier AS when the non-physician assistant surgeon was involved with the entire case. Modifier AS is a payment modifier and should be sequenced before any applicable informational modifiers.

When determining if an assistant surgery claim is payable, Unity considers the following requirements in the adjudication claim process;

- Type of surgical procedure performed. Unity follows industry standard guidance when determining assistant surgeon designations for each code. The use of status indicators are based on input from the American College of Surgeons (ACS).
- Type of provider performing the service to determine if the claim is payable. Modifier AS requires the services be performed by a licensed non-physician. AS should not be reported by an MD/DO.
- First assists that include registered nurses or certified surgical technicians should not bill separately, as payment is included in the prospective payment system to the facility.
- Medical necessity for use of the non-physician assistant surgeon must be well documented in the operative report and include the distinct services provided by both the primary surgeon and the non-physician assistant surgeon.

The modifier AS policy applies to professional services.

**Reimbursement Applications**

When a non-physician actively assists a physician in performing a surgical procedure and furnishes more than just ancillary services, the non-physician services are eligible for payment as assistant at surgery services. Only one assistant surgeon is eligible for reimbursement per covered surgical procedure.

Providers should report their full fee for assistant surgeries to allow appropriate claims to be adjudicated. Reimbursement for assistant surgery provided by a physician will be 10% of the primary surgery fee, subject to provider contract terms. Reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported. Contracted providers that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms and modifier AS payment rules will apply.
Modifier AS – Non-Physician Assistant Surgeon Policy and Procedure

In addition;

- Non-physician services are subject to the multiple surgery policies and procedure guidelines, if applicable.
- Services reported with an unlisted CPT4 code will be pended and supporting documentation may be requested to determine reimbursement.

Facilities reporting inpatient, outpatient and ASCs must report with the appropriate revenue and DRG code when applicable.

Unity modifier AS policy contains associated claim editing software that identifies the appropriateness of billing modifier AS. Incorrect reporting of modifier AS will result in a denial.

**Quality Assurance**

Quality outcome measurements on the use of modifier AS, Non-Physician Assistant Surgeon coding policies will be conducted through periodic claim checks. The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

**Enforcement**

Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of non-physician assistant surgeon.

**Review, Revision and Distribution**

This policy will be provided to all Unity Leadership, Operations, Providers Relations and Audit staff. The documents will be maintained in the Provider Manual and (publication on website).

Approval of new and revised policies will be assigned to the following individuals:

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

**Document Logistics & Revision History**

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Modifier AS – Non-Physician Assistant Surgeon
Policy and Procedure
Last Revision/Review Date: 4/1/2015

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NOTE:
Purpose
The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for acute therapy for chiropractic manipulative treatment.

As defined by the HCPCS Level II; Modifier AT is used to report Acute Treatment (this modifier should be used when reporting service 98940, 98941, 98942). Medical record documentation must adequately support the services provided.

Common Definitions
- AMA – American Medical Association
- CMS - Centers for Medicare and Medicaid Services
- CPT4 - Current Procedural Terminology– Published by the American Medical Association
- HCPCS – Healthcare Common Procedure Coding System

Policy
Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications. As a secondary resource, Unity will reference industry standards, including a review of Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.

Coding Interpretation and Applications
Acute treatment is used to report active/corrective treatment of the spine by hand or hand held device with the thrust or force of the device be manually controlled.
As defined by CMS, the following definitions apply when determining the type of chiropractic treatment being rendered:

- **Acute Condition**: A patient’s condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical exam. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient’s condition.

- **Chronic Condition**: A patient’s condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition), but where the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy.

- **Maintenance Therapy**: Chiropractic maintenance therapy is defined as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. Modifier AT is not used when the service is for maintenance therapy.

The AMA also published a CPT Assistant article in December 2013, regarding the application of modifier 51 to CMT codes (98940-98943). Per AMA guidance, modifier 51 should not be appended to the CMT codes. These are separate and distinct procedures and the use of modifier 51 does not apply. CMT claims submitted with modifier 51 will be denied.

**Reimbursement Applications**

Modifier AT is used to report acute chiropractic treatment and should be appended to the following codes when appropriate:

- 98940: Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
- 98941: Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
- 98942: Chiropractic manipulative treatment (CMT); spinal, 5 regions

Effective August 1, 2014, procedure codes 98940, 98941 and 98942 that are reported without the AT modifier will be considered maintenance chiropractic therapy codes and will be denied as not medically necessary.

BadgerCare providers are required to follow the Forward Health Portal, Medicaid online handbook and the Forward Health provider updates for additional Medicaid guidelines. In all cases, reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported.

**Quality Assurance**

Quality outcome measurements on the use of modifier AT, Acute Treatment will be conducted through periodic claim audits. The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.


Enforcement

Enforcement of coding policies will be conducted through periodic claim checks and requests for documentation. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of acute chiropractic treatment services.

Review, Revision and Distribution

This policy will be provided to all Operations, Providers Relations and Audit staff and Unity Leadership. The documents will be maintained in the Provider Manual and (publication on website).

Approval of new and revised policies will be assigned to the following individuals;

- Director, Business Services
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- Manager, Claim Coding and Compliance
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NOTE:
Modifier P – Anesthesia Physical Status
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Organizations and Associated Product Lines

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Purpose

The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation's coding and reimbursement policy for anesthesia physical status indicators, reported with various levels of the HCPCS Level II P modifiers.

As defined by the AMA and ASA, services involving the administration of anesthesia are reported by the use of the anesthesia 5 digit CPT4 code. The addition of a physical modifier (P1, P2, P3, P4, P5, P6) further defines the patient’s health status and to distinguish among various levels of complexity of the anesthesia service provided.

Common Definitions

- P1 – A normal health patient
- P2 – A patient with mild systemic disease
- P3 – A patient with severe systemic disease
- P4 – A patient with severe systemic disease that is a constant threat to life
- P5 – A moribund patient who is not expected to survive without the operation
- P6 – A declared brain-dead patient whose organs are being removed for donor purposes
- AMA – American Medical Association
- ASA – American Society of Anesthesiologists
- CPT4 – Current Procedural Terminology – Published by the American Medical Association
- HCPCS – Healthcare Common Procedure Coding System

Policy

Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications for physical status anesthesia qualifiers. As a secondary resource, Unity will reference industry standard, including the ASA Guide and a review of Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations.
Modifier P – Anesthesia Physical Status
Policy and Procedure
Last Revision/Review Date: 4/1/2015

- Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.

**Coding Interpretation and Applications**

The reporting of anesthesia services is appropriate by or under the responsible supervision of a physician. These services may include but are not limited to general, regional, supplementation of local anesthesia, or other supportive services in order to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedure.

These services include the usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services (eg, ECG, temperature, blood pressure, oximetry, capnography and mass spectrometry). Unusual forms of monitoring (eg, intra-arterial, central venous, and Swan-Ganz) are not included.

Anesthesia time is defined as the period during which the anesthesiologist is present with the patient. The anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room (or in an equivalent area) and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision. Time for anesthesia procedures should be reported in time units based on standard 15 minute intervals. Each 15 minute block will allow for one time unit. Claims that are submitted with actual anesthesia minutes will be converted to the standard 15 minute blocks, rounding minutes up to the nearest 15 minute block.

The physical status P modifiers policy applies to professional services and is considered informational; therefore, the physical status P modifiers should not be sequenced before any applicable payment modifiers.

**Reimbursement Applications**

The following modifiers may be reported with the single anesthesia code when reporting the patient’s physical status. Additional base unit(s) are reportable when indicated.

- P1 – A normal health patient – 0 Base Unit Value
- P2 – A patient with mild systemic disease – 0 Base Unit Value
- P3 – A patient with severe systemic disease – 1 Base Unit Value
- P4 – A patient with severe systemic disease that is a constant threat to life – 2 Base Unit Value
- P5 – A moribund patient who is not expected to survive without the operation – 3 Base Unit Value
- P6 – A declared brain-dead patient whose organs are removed for donor purposes – 0 Base Unit Value

When multiple surgical procedures are performed during a single anesthetic administration, the anesthesia code representing the most complex procedure is reported. The time reported is the combined total time for all procedures. Add-on anesthesia codes are listed in addition to the code for the primary procedure.

Reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported. Contracted providers that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms.
Facilities reporting inpatient, outpatient and ASCs must report with the appropriate revenue and DRG code when applicable.

**Quality Assurance**

Quality outcome measurements on the use of P modifiers will be conducted through periodic claim checks. The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

**Enforcement**

Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of physical status modifiers.

**Review, Revision and Distribution**

This policy will be provided to all Operations, Providers Relations and Audit staff and Unity Leadership. The documents will be maintained in the Provider Manual and (publication on website).

Approval of new and revised policies will be assigned to the following individuals:

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

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**NOTE:**
**Organization and Associated Product Lines**

**Organization:**
- Unity Health Plans Insurance Corporation

**Product Lines:**
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- ☐ HMO
- ☐ PPO
- ☐ POS
- ☐ UWA
- ☐ Medicare Supplement
- ☐ Medicaid
- ☐ Individual Exchange
- ☐ Individual Non-Exchange

**Purpose**

The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for prescribed oxygen.

Oxygen therapy is available in a variety of systems to meet the patient’s medical requirements and mobility needs. HCPCS Level II modifiers QE, QF, and QG provide additional information to the claim regarding the quantity of prescribed oxygen.

**Common Definitions**

- QE – Prescribed Amount of Oxygen, Less Than 1 LPM
- QF – Prescribed Amount of Oxygen, Exceeds 4 LPM and Portable Oxygen Prescribed
- QG – Prescribed Amount of Oxygen, Greater Than 4 LPM
- AMA – American Medical Association
- CPT4 - Current Procedural Terminology– Published by the American Medical Association
- HCPCS – Healthcare Common Procedure Coding System
- LPM – Liters Per Minute

**Policy**

Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications for prescribed oxygen. As a secondary resource, Unity will reference industry standards, including a review of Medicare and Medicare policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.
Coding Interpretation and Applications
The appropriate 5 digit HCPCS code should be reported, indicating the oxygen and related respiratory equipment provided. The selected code should identify if the equipment is purchased or rented. As defined in the HCPCS DME manual, compressed gaseous oxygen systems include the following: container, contents, regulator, flow-meter, humidifier, nebulizer, cannual or mask, and tubing.

Modifiers QE, QF or QG should be appended to the HCPCS code to further define the amount of prescribed oxygen. Medical record documentation, including the physicians and pharmacy orders should support the medical necessity for the oxygen therapy. Modifiers QE, QF, and QG should be sequenced after any applicable payment modifiers.

The modifier QE, QF, QG policy applies to DME services.

Reimbursement Applications
Unity reimbursement policy for medically necessary, prescribed oxygen is subject to provider contract terms. Providers should bill their full fee to allow for appropriate claims adjudication. Reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported.

Contracted providers that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms.

Unity modifier QE, QF, QG policy contains associated claim editing software that identifies the appropriateness of billing modifier QE, QF, or QG. Incorrect reporting of modifier QE, QF, or QG will result in a denial.

Quality Assurance
Quality outcome measurements on the use of modifiers QE, QF and QG, Prescribed Amount of Oxygen coding policies will be conducted through periodic claim checks. The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

Enforcement
Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of prescribed oxygen.

Review, Revision and Distribution
This policy will be provided to all Unity Leadership, Operations, Provider Relations and Audit staff. The documents will be maintained in the Provider Manual and (publication on website).
Modifier QE, QF, QG– Prescribed Amount of Oxygen
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Approval of new and revised policies will be assigned to the following individuals:

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

**Document Logistics & Revision History**

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**NOTE:**
Modifier RT/LT – Bilateral Procedure
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Organization and Associated Product Lines

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Purpose
The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for bilateral procedures that are reported with HCPCS modifiers RT, right side (used to identify procedures performed on the right side of the body) and LT, left side (used to identify procedures performed on the left side of the body).

HCPCS modifiers RT and LT are used to report services rendered on identical anatomic sites during the same session. These modifiers are reported when modifier 50, bilateral procedure rules do not apply.

Common Definitions
- 50 – Bilateral Procedure
- AMA – American Medical Association
- CMS -Centers for Medicare and Medicaid Services
- CPT4 - Current Procedural Terminology– Published by the American Medical Association
- HCPCS – Healthcare Common Procedure Coding System
- LT – Left Side
- RT – Right Side

Policy
Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications for unilateral and bilateral procedures. As a secondary resource, Unity will reference industry standards, including a review of CMS Medicare and Medicaid policies.

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.
Coding Interpretation and Applications

When reporting bilateral procedures, providers should refer to the Policy and Procedure that provides detailed information on the use of modifier 50. However, there are certain circumstances that modifier 50 may not be applicable; therefore, modifiers RT and LT may be appropriate. Unity follows CMS guidance for bilateral procedures reported with RT/LT. This policy applies to CPT4 codes that have a status indicator of “3” in the Medicare Physician Fee Schedule Database. For a complete list of status indicators, please refer to: www.cms.gov/regulations-and-guidance/Guidance/transmittals/downloads/R2549CP.pdf.

As defined by CMS, 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.

It is not appropriate to use these modifiers if the CPT4 descriptor identifies the procedure as bilateral.

Additional multiple procedures reported during the same session as a bilateral service will be subject to the multiple surgery guidelines. Reimbursement applications for modifier 50 will be applied primary and multiple reductions (modifier 51) will be applied secondary.

The use of modifiers RT and LT applies to professional services and facility outpatient/ASC services. These are considered location modifiers and are always sequenced last on the claim format.

Reimbursement Applications

UHP recognizes that there are additional approved modifiers to report bilateral services under certain circumstances, including RT and LT modifiers. When services are reported on two separate line items using RT and LT to reflect the appropriate anatomic location for the same procedure, these claims will be reimbursed 100% of the fee schedule.

Unity contracted providers and facilities that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms. PPO contracted providers and facilities will follow reimbursement procedures as established by the preferred provider network vendor. BadgerCare providers are required to follow the Health Care Portal, Medicaid online handbook and the Forward Health provider updates for additional Medicaid guidelines. In all cases, reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported.

Facilities reporting inpatient, outpatient and ASCs must report with the appropriate revenue and DRG code when applicable.

Unity modifier RT and LT policy contains associated claim editing software that identifies the appropriateness of billing modifiers RT and LT. Incorrect reporting of modifier RT and LT will result in a denial.

Quality Assurance

Quality outcome measurements on the use of modifier RT and LT, Bilateral Procedures coding policies will be conducted through periodic claim checks. The Manager, Claims Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary.
Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

**Enforcement**

Enforcement of coding policies will be conducted through periodic claim checks and requests for documentation. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of unilateral and bilateral procedures.

**Review, Revision and Distribution**

This policy will be provided to all Operations, Providers Relations and Audit staff and Unity Leadership. The documents will be maintained in the Provider Manual and (publication on website).

Approval of new and revised policies will be assigned to the following individuals;

- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager Claim Coding and Compliance
- Manager Financial Analysis, Provider Relations

**Document Logistics & Revision History**

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**NOTE:**
Modifier QX and QZ – CRNA Service; With and Without Medical Direction By a Physician
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Organization and Associated Product Lines

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**Purpose**
The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for CRNA services with and without medical direction by a physician.

A Certified Registered Nurse Anesthetist (CRNA) is an advanced practice nurse who is an anesthesia specialist and may administer anesthesia independently or under physician medical direction or supervision.

The HCPCS Level II modifiers QX and QZ differentiate with and without medical direction of a physician for the CRNA services.

**Common Definitions**
- AA – Anesthesiologist’s Assistant
- P3 – A patient with severe systemic disease
- P4 – A patient with severe systemic disease that is a constant threat to life
- P5 – A moribund patient who is not expected to survive without the operation
- QX – CRNA/AA Service With Medical Direction By a Physician
- QZ – CRNA/AA Service Without Medical Direction By a Physician
- AMA – American Medical Association
- ASA – American Society of Anesthesiologists
- CPT4 - Current Procedural Terminology– Published by the American Medical Association
- CRNA – Certified Registered Nurse Anesthetist
- HCPCS – Healthcare Common Procedure Coding System

**Policy**
Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications for CRNA/AA services. As a secondary resource, Unity will reference the ASA guide, industry standards, including a review of Medicare and Medicare policies.
Modifier QX and QZ—CRNA Service; With and Without Medical Direction By a Physician
Policy and Procedure
Last Revision/Review Date: 4/1/2015

- Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.
- Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.

**Coding Interpretation and Applications**

As defined by the ASA, in order to report medical direction, the physician must medically direct qualified providers in two, three or four concurrent cases and perform the following:
- Perform a pre-anesthetic examination and evaluation;
- Prescribe the anesthesia plan;
- Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergency;
- Ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist,
- Monitors the course of anesthesia administration at frequent intervals;
- Remains physically present and available for immediate diagnosis and treatment of emergencies; and
- Provides indicated post-anesthesia care.

Anesthesia time begins when the anesthesiologist/CRNA begins to prepare the patient for the induction of anesthesia in the operating room (or in an equivalent area) and ends when the anesthesiologist/CRNA is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision.

The modifier QX and QZ policy applies to professional services.

**Reimbursement Applications**

When submitting claims for CRNA services, the provider of service should clearly identify if the anesthesia services were provided with or without medical direction by the physician as this will impact the allowed amount of the claim. Providers should bill their full fee amount to allow for appropriate claim adjudication. Reimbursement will be based on the reasonableness and necessary charges for the patient’s condition reported.

Modifier QX defines CRNA services that were performed with medical direction by the physician. Payment is limited to 50% of the amount that would have been allowed if personally performed by an anesthesiologist or non-supervised CRNA, subject to the provider contract terms.

Modifier QZ has no affect on payment and the allowed amount is what would have been allowed if personally performed by an anesthesiologist, subject to the provider contract terms.

Contracted providers that are based on a percentage of charge (POC) will have their rates adjusted to the agreed upon reimbursement terms. When multiple surgical procedures are performed during a single anesthetic administration, the anesthesia code representing the most complex procedure is reported.
Modifier QX and QZ—CRNA Service; With and Without Medical Direction By a Physician
Policy and Procedure
Last Revision/Review Date: 4/1/2015

The time reported is the combined total for all procedures. Add-on anesthesia codes are listed in addition to the code for the primary procedure.

Anesthesia codes reported with modifier P3, P4 or P5 are eligible for additional unit(s) of reimbursement. Please refer to Policy and Procedure P, Physical Status Indicator.

Quality Assurance

Quality outcome measurements on the use of modifiers QX and QZ-CRNA Service; With and Without Medical Direction By a Physician coding policies will be conducted through periodic claim checks. The Claims Coding and Compliance Manager, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

Enforcement

Enforcement of coding policies will be conducted through periodic claim checks. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of CRNA services.

Review, Revision and Distribution

This policy will be provided to all Operations, Providers Relations and Audit staff and Unity Leadership. The documents will be maintained in the Provider Manual and (publication on website).

Approval of new and revised policies will be assigned to the following individuals;
- Director, Business Services
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Financial Analysis, Provider Relations

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Purpose

The purpose of this policy and procedure is to document and communicate Unity Health Plans Insurance Corporation’s coding and reimbursement policy for Habilitative services.

As defined by the HCPCS Level II; Modifier SZ is used to report Habilitative Services and to distinguish between Habilitative verses Rehabilitative Services. Medical record documentation must adequately support the services provided.

Habilitation services are defined as health care services that help a person acquire, keep or improve, partially or fully, and at different points in life, skills related to communication and activities of daily living. These services address the competencies and abilities needed for optimal functioning in interaction with their environments. Habilitative services include physical therapy, occupational therapy, speech-language pathology, audiology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Rehabilitation services refer to health care services that help a person keep, restore or improve skills and functioning for daily living and skills related to communication that have been lost or impaired because a person was sick, injured or disabled. These services include physical therapy, occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Common Definitions

- ACA – Affordable Care Act
- AMA – American Medical Association
- CMS -Centers for Medicare and Medicaid Services
- CPT4 - Current Procedural Terminology– Published by the American Medical Association
- HCPCS – Healthcare Common Procedure Coding System

Policy

Unity is committed to servicing their members in a compliant and cost effective manner, with the primary objective to provide uniformity and consistency in the interpretation of compliance and accurate coding applications. Unity follows AMA coding directives as the authoritative source for correct coding applications. As a secondary resource, Unity will reference industry standards, including a review of Medicare and Medicaid policies.
Unity policy is subject to federal and state law to the extent applicable, as well as the terms and limitations of the member’s benefits. Policies and Procedures that contain reimbursement policies are constantly evolving and Unity reserves the right to review and update these policies periodically.

Unity will identify and comply with established provider contractual obligations. Any changes to a policy that impact claims submission guidelines, claims processing and reimbursement will be communicated in advance to the provider community via direct communication (newsletter and/or letter), contract amendments and/or provider manual updates.

**Coding Interpretation and Applications**

In compliance with the Affordable Care Act (ACA), Unity Health Insurance will apply separate and distinct benefit limits for Habilitative and Rehabilitative services for individual and small group coverage.

Effective with dates of service on and after January 1, 2017, the appropriate use of the modifier SZ is required when billing Habilitative services to Unity. Appending modifier SZ to the corresponding CPT code on the claim form will ensure that benefits are applied correctly.

**Reimbursement Applications**

Modifier SZ does not impact reimbursement to a claim, rather allows for the appropriate benefits to be applied. The modifier SZ policy applies to professional services and facility outpatient/ASC services.

**Quality Assurance**

Quality outcome measurements on the use of modifier SZ, Habilitative Services will be conducted through periodic claim audits. The Manager, Claim Coding and Compliance, in conjunction with Audit and Provider Relations will periodically review claim payment trends to confirm adherence to best coding practices and modify established guidelines when necessary. Any deficiencies identified and/or recommendations for change in policy will be communicated through updated policies published on the Unity website.

**Enforcement**

Enforcement of coding policies will be conducted through periodic claim checks and requests for documentation. These periodic reviews will ensure that Unity is accurately and properly processing claims according to the coding policies set forth and also that providers are accurately submitting claims. On occasion, this policy may require providers to submit supporting documentation of the services reported to substantiate the reporting of habilitative services.

**Review, Revision and Distribution**

This policy will be provided to all Operations, Providers Relations and Audit staff and Unity Leadership. The documents will be maintained in the Provider Manual and (publication on website).

Approval of new and revised policies will be assigned to the following individuals:

- Assistant Vice President, Operations
- Director, Provider Relations
- Director, Internal Audit
- Manager, Claim Coding and Compliance
- Manager, Healthcare Informatics, Provider Relations
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Document Owner: Manager, Claim Coding and Compliance Manager  
Document Location: Claims: Coding Policies and Procedures

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