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## Overview

The purpose of this section is to describe the specific billing and Preapproval/Precertification requirements for services rendered in the hospital setting and to supplement the claims submission information in the *Administrative Procedures* section.

Many of the services in this section of the manual require Preapproval/Precertification. For a list of current Preapproval/Precertification requirements, go to *www.amerihealthnj.com*. Select the "Providers" tab and then *Policies*. These requirements are subject to change. Any additional requirements specific to a certain type of service are listed under that service category.

## General billing guidelines

### Electronic billing (837P or 837I)

#### *National Association of Insurance Commissioners (NAIC) codes*

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate payer ID document at *www.amerihealthnj.com/html/providers/claims_billing/edi.html* for a complete list of the NAIC-assigned codes.

Providers must file claims within 180 days of the last date of service of the course of treatment.

When billing through Electronic Data Interchange (EDI), claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth through your own computer system. Claims are submitted in batches and may be sent daily or weekly, depending on your claims volume. If you submit claims electronically, you will receive a 277 Claims Acknowledgement (277CA). The error description on the 277CA will aid you in correcting and resending files to ensure an expedited remittance.

For electronic submission instructions, please refer to the appropriate *HIPAA Transaction Standard Companion Guide* at *www.highmark.com/edi-amerihealth/resources/index.shtml*. If you have questions about an electronic claim submission, please contact Highmark EDI Operations at 1-800-992-0246.

### Paper billing

If you must submit a claim on paper, you will need to use the CMS-1500 or UB-04 claim form, as specified in the remainder of this section based on the type of service you provide.

## Inpatient Services

The purpose of this section is to communicate specific billing requirements and reimbursement policies for inpatient hospital services. Hospitals will be reimbursed for inpatient services according to the terms of their Hospital, Ancillary Facility, or Ancillary Provider Agreement (Agreement). To the extent that any of the requirements or policies in this section conflict with the Agreement, the terms of the Agreement shall govern.

**Interim billing.** Inpatient claims submitted with bill types 112 (Interim – first claim), 113 (Interim – continuing claim), and 114 (Interim – last claim) and/or a discharge status indicating that the Member is still inpatient will be rejected on the 277CA. You will be advised to submit the bill when the Member is discharged. Long-term care hospitals, physical rehabilitation hospitals, and skilled nursing facilities are excluded from this directive and may continue to bill with a patient status of 30.

## Inpatient claims

### *Preapproval/Precertification*

Preapproval/Precertification is required for certain services prior to services being performed, including elective inpatient admissions. For detailed information on Preapproval/Precertification, please refer to the *Clinical Services – Utilization Management* section of this manual.

### *Inpatient day*

An inpatient day is an admission period that begins at midnight on the day of admission and ends 24 hours later. The midnight-to-midnight method is to be used in reporting inpatient days even if the hospital uses a different definition for other purposes. Any part of an inpatient day, including the day of admission, counts as an inpatient day. The day of discharge is not counted as an inpatient day.

### *Inpatient services*

Inpatient services are Covered Services that are diagnostic, therapeutic, or surgical and pursuant to an admission. Reimbursement for inpatient services includes, but is not limited to:

- ancillary services
- anesthesia care
- appliances and equipment
- diagnostic services
- medication and supplies
- nursing care
- radiology
- recovery room services
- room and board
- surgical procedures (including implantable devices, blood, and blood products)
- therapeutic items (drugs and biologicals)

The reimbursement rates for inpatient acute admissions are inclusive of all services provided to the Member during the admission. The rate of payment is determined by the effective date of a Member's inpatient admission and applies for the length of the admission; therefore, any rate change under the contract during the Member's stay will not apply.

### *Outpatient services included in reimbursement for inpatient services*

- **Outpatient services rendered during an inpatient admission.** The AmeriHealth hospital inpatient reimbursement includes payment for all services provided (1) during the inpatient stay, (2) on the day of the admission, and (3) on the day of discharge. There is no additional payment for services billed on an outpatient basis. If a hospital submits a separate claim for outpatient services that were, or should have been, reported on the Member's inpatient claim, the outpatient claim is subject to retrospective review through a Provider audit.

- **Outpatient services rendered prior to an inpatient admission (preadmission).** Outpatient procedures, such as preadmission services and other services related to the admission, can be before the date of the inpatient admission, but they are not separately reimbursable. Charges for outpatient services not related to the admission may be billed separately. Preadmission services include:
  - **Preoperative examinations.** Services billed with a diagnosis code for preoperative examinations are not separately reimbursable.
  - **Preadmission diagnostic services.** The AmeriHealth acute care hospital inpatient reimbursement includes payment for preadmission diagnostic services. Diagnostic services provided to a Member within three days prior to and including the date of the Member's admission are deemed to be inpatient services and included in the inpatient payment. For example, if a Member is admitted on a Wednesday, outpatient services provided by the hospital on Sunday, Monday, Tuesday, or Wednesday are included in the inpatient reimbursement.

    Diagnostic services include the following revenue/procedure codes*:

    - 0254: Drugs incident to other diagnostic services
    - 0255: Drugs incident to radiology
    - 030X: Laboratory
    - 031X: Laboratory pathological
    - 032X: Radiology diagnostic
    - 0341, 0343: Nuclear medicine, diagnostic/diagnostic radiopharmaceutical
    - 035X: Computed tomography (CT) scan
    - 0371: Anesthesia incident to radiology
    - 0372: Anesthesia incident to other diagnostic services
    - 040X: Other imaging services
    - 046X: Pulmonary function
    - 0471: Audiology diagnostic
    - 0482: Cardiology, stress test
    - 0483: Cardiology, echocardiology
    - 053X: Osteopathic services
    - 061X: Magnetic resonance technology (MRT)
    - 062X: Medical/surgical supplies, incident to radiology or other diagnostic services
    - 073X: Electrocardiogram (EKG/ECG)
    - 074X: Electroencephalogram (EEG)
    - 0918: Testing, behavioral health
    - 092X: Other diagnostic services

    ** The list of diagnostic services may be revised periodically to reflect current revenue and/or procedure codes.*

– **Other preadmission services.** Non-diagnostic outpatient services that are related to a Member's hospital admission during the three days immediately preceding and including the date of the Member's admission are deemed to be inpatient services and are included in the inpatient payment. Non-diagnostic services are defined as being related to the admission when there is a match between the principal diagnosis codes (first three digits) assigned for both the preadmission services and the inpatient stay.

### *Inpatient stays*

Reimbursement for an inpatient stay is displayed on two or more separate payment lines, as shown below.

| Claim ID | Claim line | Rev code | Units of service | Charges | Contracted rate | Reimbursement |
|---|---|---|---|---|---|---|
| 0011 | 1 | 171 | 1 | $3,000 | $47 per diem | $884.00 |
| 0011 | 2 | 174 | 1 | $6,000 | $3,489 per diem | $1,768.00 |
| 0011 | 3 | 300 | 5 | $1,000 | – | $294.67 |
| 0011 | 4 | 636 | 10 | $2,000 | – | $589.33 |
| **Total:** | | | | **$12,000** | **$3,536.00** | **$3,536.00** |

### *Inpatient hospice care*

Reimbursement is made directly to the contracted hospice agency for the provision of inpatient hospice care. The contracted hospice agency is responsible for reimbursing the hospital for the provision of general inpatient hospice care.

### *Present on admission (POA) indicator*

All acute care hospitals are required to follow instructions from the Centers for Medicare & Medicaid Services (CMS) regarding the identification of the POA indicator for all diagnosis codes for inpatient claims. Acute care hospitals are required to bill claims with applicable ICD-10 diagnosis and procedure codes — including applicable POA indicator — that apply as of the date of the hospital admission. Claims submitted without a valid POA indicator will be rejected.

Consistent with the CMS requirements for POA indicators, the following facility types are exempt:

- critical access hospitals
- long-term care hospitals
- cancer hospitals
- children's inpatient facilities
- inpatient rehabilitation facilities
- psychiatric hospitals

### *Member enrollment during an admission*

AmeriHealth payment responsibility varies depending on the Member's coverage, as summarized below:

- **Commercial HMO and PPO Members.** AmeriHealth is required to cover the admission from the Member's enrollment date in an AmeriHealth plan. If a Member enrolls in a Commercial plan from another Commercial HMO plan, the previous plan should cover the Member's entire admission.

- **Medicare Advantage Members.** For Members in a Medicare Advantage plan of one of our Affiliates, Original Medicare covers the Member through to the discharge date.

If the Member's benefits plan or regulations conflict with these provisions, actual payments may vary.

### *Member termination during an admission*

AmeriHealth payment responsibility varies depending on Member coverage and Provider payment methodology, as summarized below:

| Payment methodology | Line of business | |
|---|---|---|
| | Commercial HMO | Commercial PPO |
| Per diem | Pays to the discharge date | Pays to the last covered day |
| Per case | Pays the entire case rate | Pays the entire case rate |
| Percent of charge | Pays to the discharge date | Pays to the last covered day |

If the Member's benefits plan or regulations conflict with these provisions, actual payments may vary.

## Maternity admissions

Reimbursement for maternity admissions is inclusive of the mother and newborn days while the mother is inpatient. Neonatal intensive care unit (NICU) and transitional nursery days are paid separately regardless of mother's status as inpatient.

- **Normal delivery claims.** When billing newborn baby charges (e.g., revenue code 0170, 0171, 0172, or 0179) the maternity charges for mother and baby must be submitted as separate claims — one for the mom and one for the baby. Providers will receive two separate Provider Remittances.
- **Detained baby claims.** If the baby remains hospitalized after the mother is discharged (i.e., detained baby), a new admission with its own Preapproval/Precertification is required. The detained baby's admission date is the same date as the mother's discharge date. A separate claim for the detained baby's admission is required.

## Per case reimbursed admissions only

All inpatient days that are reimbursed under a diagnosis-related group (DRG) and/or per-case payment rate are subject to Medical Necessity review, which may include concurrent review and/or retrospective review. Admissions that have been Preapproved/Precertified will not be retrospectively denied for Medical Necessity unless the Preapproval/Precertification was based on erroneous information or misinformation provided by the hospital.

### *Readmissions*

Readmissions are subject to the Inpatient Hospital Readmission policy, which applies to hospitals and health systems paid per case or per admission for inpatient hospital stays. For additional information on readmissions, please refer to our medical policies at *www.amerihealth.com/medpolicy*.

### *Ungroupable or invalid DRG*

Claims that are ungroupable or group to an invalid DRG will be denied payment. Claims may be resubmitted by the hospital with corrected data.

### *Version DRG versus rate effective date*

Unless otherwise specified in the contract, the grouper version used will be based on the contracted version in effect on the date of admission. For all hospitals, the CMS Pricer adjustment factor applied to the DRG pricing will be based on the date of admission.

### *Per-diem reimbursed admissions only*

All inpatient days that are reimbursed under a per diem payment rate are subject to a concurrent review of Medical Necessity. In the event the hospital fails to provide timely medical information necessary for concurrent review as requested by AmeriHealth, inpatient days not reviewed concurrently will be reviewed retrospectively for Medical Necessity. Admissions that have been concurrently reviewed will not be retrospectively denied for Medical Necessity unless the concurrent review was based on erroneous information or misinformation provided by the hospital.

### *Revenue code groupings*

Per diem reimbursement shall be based on bed-type in accordance with the following crosswalk. To the extent that any of the revenue codes listed on the following page conflict with the Agreement, the terms of the Agreement shall govern.

| Group | Revenue codes |
|---|---|
| Medical/surgical | 0110, 0111, 0112, 0117, 0120, 0121, 0122, 0127, 0130-0132, 0134, 0137, 0140-0142, 0150-0152, 0157, 0206, 0214 |
| Medical/surgical/pediatric | 0113, 0123, 0133, 0143, 0153 |
| Intensive care | 0200-0203, 0207-0213, 0219 |
| Sub-acute | 0159, 0190-0194, 0199 |
| Maternity/NICU | 0170-0174, 0179 |
| General rehab (non-behavioral health) | 0118, 0128, 0138, 0148, 0158 |
| Behavioral health | 0114, 0116, 0118, 0124, 0126, 0128, 0134, 0136, 0138, 0144, 0146, 0148, 0154, 0156, 0158, 0204 |

*Note:* When billing for inpatient services that are reimbursed per diem, acute care hospitals and skilled nursing facilities should bill the revenue code applicable to the bed level the patient occupies while hospitalized. If the bed level revenue code billed differs from what was authorized, we will reimburse according to the bed level billed, not to exceed the bed level revenue code authorized.

## Outpatient Services

The purpose of this section is to communicate specific billing requirements and reimbursement policies for outpatient hospital services. All services are reimbursed in accordance with AmeriHealth's medical policies, which can be found at *www.amerihealth.com/medpolicy*.

Hospitals will be reimbursed for outpatient services according to the terms of their Agreement and medical policies. To the extent any of the below requirements or policies conflict with the Agreement, the terms of the Agreement shall govern.

## Cardiology

The technical components for outpatient cardiology services are paid at the hospital's contracted outpatient rate, with the exception of the following EKG procedure codes: 93000, 93005. These procedure codes are paid as a global reimbursement for technical and professional service components for HMO Members, and the hospital is responsible for reimbursing the Physician for their professional services.

## Diabetic education

Outpatient diabetic education is a covered benefit for eligible Members who have been diagnosed as having diabetes mellitus and have a written Physician order to attend an outpatient diabetic education program. In order for a participating hospital's program to be eligible as an approved outpatient diabetic education program in the AmeriHealth network, the program must be certified by the American Diabetes Association (ADA) and specifically referenced in the Agreement.

When billing for diabetic education, use revenue code 0942, include an appropriate HCPCS/CPT® code, the number of units, and a diabetic diagnosis on the UB-04 claim form. For billing and reimbursement purposes, one unit is equal to one visit (individual or group session).

## Emergency services

Reimbursement rates for Emergency services are inclusive of all services provided to the Member during the visit, including the professional component of laboratory and radiology for all managed care Benefits Programs. Fee schedule payments for Comprehensive Major Medical (CMM) Members apply only for facility services.

### *How to bill for Emergency services*

Emergency visits should be reported with revenue codes 0450, 0451, 0452, 0456, or 0459. Whenever one of the revenue codes in the 045X series is present, the UB-04 admitting diagnosis and the Member's reason for the visit are required fields for outpatient claims. Please report one diagnosis code describing the Member's stated reason for seeking care. Emergency room/department (ER) claims that do not have the required information completed will not be processed.

### *Critical care*

Critical care in the ER is to be billed with procedure code 99291 (i.e., critical care). Please note that procedure code 99292 is not separately reimbursable. When ER level-of-service procedure codes are billed with 99291, the claim will be paid at the lower level of service.

### *Follow-up care*

Routine (non-emergent) follow-up care provided in the ER setting by a Participating Provider is not a covered benefit and is not eligible for a separate ER visit payment. Claims billed for routine (nonemergent) follow-up care provided in the ER setting that contain a routine follow-up diagnosis code will be automatically denied.

### *Inpatient admissions*

If the ER visit results in an inpatient admission, the date the Physician wrote the order becomes the date of admission. The ER charges should be included on the inpatient claim, and no separate ER claim should be filed.

### *Surgical services*

If an ER visit includes surgery performed in a fully equipped and staffed operating room, the facility will receive the fee schedule reimbursement for both the ER visit and the surgery. In this circumstance, the surgery should be billed using an appropriate surgery revenue code with the applicable HCPCS/CPT code.

When surgical services are performed in the ER and *not* a fully equipped operating room, the surgical services are included in the reimbursement for the ER visit. In this circumstance, the surgery should be billed using an appropriate ER revenue code with the applicable HCPCS/CPT code.

Reimbursement for ER services when billed with surgical services

| Services billed together | Services reimbursed* | Revenue code requirements |
|---|---|---|
| Surgical services performed in the operating room and Emergency services performed in the ER | Both ER services and surgical services are reimbursed | Surgical services reported with 36x, 481, 49x, or 790; ER services reported with 45x |
| Surgical services and Emergency services performed in the ER | ER services are reimbursed | Surgical services reported with 45x; ER services reported with 45x |

**Fee schedule reimbursement for these services includes all services provided during the visit, including the professional component of laboratory and radiology.*

### *Observation services*

If an ER visit includes observation services, observation services may be eligible for separate reimbursement at the hospital's contracted rate. Please refer to the main *Observation services* section for more information.

### *Multiple therapies*

**Facility outpatient therapy claims.** When multiple physical, occupational, and speech therapy services are reported by the same Provider, for the same member, on the same date of service, claims will be processed as follows:

- The procedure code with the highest total allowance is eligible for reimbursement at 100 percent of the Provider's applicable contracted rate.
- Each subsequent procedure code is eligible for reimbursement at 50 percent of the Provider's applicable contracted rate.

In addition, multiple procedures may be submitted on one claim or on multiple claims. These claim payment policies for services designated as "Always Therapy" are based on the date of service regardless of the date the claim was submitted or received.

## Genetic/genomic tests, certain molecular analyses, and cytogenetic tests

Preapproval/Precertification for certain genetic/genomic tests is required through eviCore healthcare (eviCore) for all commercial Members.

Initiate Preapproval/Precertification for genetic/genomic tests in one of the following ways:

- **PEAR Practice Management (PM).** Select *eviCore* from the Transactions tab (under authorizations).
- **Telephone.** Call eviCore directly at 1-866-686-2649.

In addition, eviCore manages prepayment review for all genetic/genomic tests, along with certain molecular analyses and cytogenetic tests, for all Commercial Members.

For additional information on this utilization management program, please refer to our medical policy at *www.amerihealth.com/medpolicy*.

## Laboratory services

Members are required to obtain a Physician order for laboratory services.

### *Capitated laboratory services*

Laboratory services for HMO/POS Members are generally provided by the designated Provider under the Capitated Laboratory Program. A complete listing of the services included in this program can be found at *www.amerihealth.com/medpolicy*. Laboratory services that are excluded from capitation are paid at the hospital's contracted rate.

### *STAT laboratory services for HMO/POS Members*

If an HMO/POS Member receives STAT laboratory services from their capitated laboratory Provider, these services are included in the capitated laboratory payment and are not separately reimbursed. However, if the HMO/POS Member is not at their capitated site for STAT laboratory services, payment for the STAT testing will be reimbursed according to the hospital contracted rates. A Referral is not required for any STAT laboratory services. For additional information on STAT laboratory services, please refer to our medical policies at *www.amerihealth.com/medpolicy*.

## Observation services

Observation services are considered an outpatient service and involve the use of a bed and periodic monitoring by the facility's nursing or other ancillary staff in order to evaluate and treat an individual's condition or determine the need for a possible inpatient admission.

In accordance with your Agreement, the Observation Fee Schedule includes all implants, biologicals, equipment, supplies, drugs, and ancillary services provided to the beneficiary during the visit or procedure, including the professional components of laboratory and radiology.

When billed with outpatient surgical and/or Emergency services, observation services are reimbursed as follows:

- **Observation services billed with outpatient surgery.** Outpatient surgical services are reimbursed according to the Agreement; observation services are not separately reimbursed.
- **Observation services billed with an ER visit.** ER visits and observation services are both reimbursed according to the Agreement.
- **Observation services billed with an ER visit and outpatient surgery.** Outpatient surgical services and the ER visit are both reimbursed according to the Agreement; however, observation services are not separately reimbursed.

### *Medicare Outpatient Observation Notice*

CMS requires that all hospitals and critical access hospitals (CAH) provide the Medicare Outpatient Observation Notice (MOON) to beneficiaries in Original Medicare (fee-for-service) and Medicare Advantage enrollees of one of our Affiliates who receive observation services as an outpatient for more than 24 hours.

The hospital or CAH must issue the MOON no later than 36 hours after observation services as an outpatient begin. This also applies to beneficiaries in the following circumstances:

- beneficiaries who do not have Part B coverage (as noted on the MOON, observation stays are covered under Medicare Part B);
- beneficiaries who are subsequently admitted as an inpatient prior to the required delivery of the MOON;
- beneficiaries for whom Medicare is either the primary or secondary payor.

For further details on observation services, including billing requirements and reimbursement, please refer to our policy at *www.amerihealth.com/medpolicy*.

## Outpatient surgery

Outpatient surgery reimbursement represents an all-inclusive payment for all facility Covered Services provided during and related to the surgical procedure. The all-inclusive payment includes services/items provided in conjunction with surgical procedures but excludes certain implantable devices. Please refer to the *Outpatient implantable devices* section for more information.

All services related to the outpatient surgery should be billed on the same claim. Surgeries performed on multiple dates should be billed on separate claims for each surgical date of service and include all the services related to each surgery. Do not bill multiple surgical dates of service on the same claim.

Outpatient surgical procedures must be reported with a surgical revenue code. The surgical revenue codes are as follows: 0360, 0361, 0362, 0367, 0369, 0481, 0490, 0499, 0519, 0750, 0790. Only services listed on the Surgical Procedure Code list should be reported with one of the surgical revenue codes above. Surgical procedures listed on the surgical fee schedule are assigned a category, which determines the level of reimbursement. Surgical procedures not listed on the Outpatient Fee Schedule are individually reviewed for payment consideration when performed in a hospital outpatient setting.

### *Services included in reimbursement for outpatient surgery*

- **Outpatient services rendered prior to an outpatient surgical procedure.** Outpatient procedures, such as preadmission diagnostic services and other services related to the surgical procedure, can occur before the date of the surgical procedure but are not separately reimbursable.
- **Preoperative examinations.** Services billed with a diagnosis code for preoperative examinations are not separately reimbursable.
- **Preadmission diagnostic services.** Reimbursement for outpatient surgical procedures includes payment for preadmission diagnostic services. Diagnostic services provided to a Member within 30 days prior to and including the date of the Member's surgery are included in the surgical procedure payment.

  Diagnostic services include the following revenue/procedure codes*:

  – 0254: Drugs incident to other diagnostic services
  – 0255: Drugs incident to radiology
  – 030X: Laboratory
  – 031X: Laboratory pathological
  – 032X: Radiology diagnostic

- 0341, 0343: Nuclear medicine, diagnostic/diagnostic radiopharmaceutical
- 035X: Computed topography (CT) scan
- 0371: Anesthesia incident to radiology
- 0372: Anesthesia incident to other diagnostic services
- 040X: Other imaging services
- 046X: Pulmonary function
- 0471: Audiology diagnostic
- 0482: Cardiology, stress test
- 0483: Cardiology, echocardiology
- 053X: Osteopathic services
- 061X: Magnetic resonance technology (MRT)
- 062X: Medical/surgical supplies, incident to radiology or other diagnostic services
- 073X: Electrocardiogram (EKG/ECG)
- 074X: Electroencephalogram (EEG)
- 0918: Testing, behavioral health
- 092X: Other diagnostic services

**The list of diagnostic services may be revised periodically to reflect current revenue and/or procedure codes.*

- **Observation services.** When Outpatient surgical claims are paid according to the fee schedule, there is no additional reimbursement for observation room services. Please refer to the main *Observation services* section for more information.

### *Multiple surgical procedures*

When multiple outpatient surgical procedures are performed on the same claim, Providers may bill multiple outpatient surgical procedures with multiple surgical revenue codes. AmeriHealth will reimburse the primary procedure at 100 percent of the contracted rate and each eligible secondary procedure at 50 percent of the contracted rate. The primary service on each claim will be determined based on the highest-allowable contracted rate. When a claim has multiple procedures with the same highest-allowable contracted rate, the first listed procedure with the highest allowable will be reimbursed as primary, all other eligible procedures will be reimbursed as secondary.

**Example 1**

| Rev code | Procedure code | Contracted rate | Status | Reimbursement |
|---|---|---|---|---|
| 0360 | 23130 | $100 x 2.5 = $250 | Primary (highest allowable) | 100% of contracted rate |
| 0369 | 23156 | $50 x 2.5 = $125 | Secondary | 50% of contracted rate |

**Example 2**

| Rev code | Procedure code | Contracted rate | Status | Reimbursement |
|---|---|---|---|---|
| 0481 | 92937 | $200 x 2.0 = $400 | Primary (highest allowable) | 100% of contracted rate |
| 0481 | 92938 | $200 x 2.0 = $400 | Secondary | 50% of contracted rate |
| 0360 | 93505 | $80 x 2.5 = $200 | Secondary | 50% of contracted rate |

### *Incidental procedures*

Services identified as incidental procedures (IP) on the Outpatient Fee Schedule may or may not be eligible for reimbursement. When multiple surgical procedures are performed on the same date of service, procedures identified as IP are considered incidental to the primary procedure and are not eligible for additional reimbursement. However, payment for an IP is made when that procedure is the only surgical procedure performed or when it is the primary procedure for the episode of care.

**Example 1 (IP with additional surgical procedures)**

| Revenue code | Procedure code | IP | Reimbursement |
|---|---|---|---|
| 0361 | 24366 | N/A | 100% of contracted rate |
| 0361 | 24000 | IP | No reimbursement |
| 0361 | 28476 | N/A | 50% of contracted rate |

**Example 2 (IP as primary surgical procedures)**

| Revenue code | Procedure code | IP | Reimbursement |
|---|---|---|---|
| 0360 | 58672 | IP | 100% of contracted rate |

**Example 3 (IP as primary and secondary surgical procedures)**

| Revenue code | Procedure code | IP | Reimbursement |
|---|---|---|---|
| 0360 | 29836 | IP | 100% of contracted rate |
| 0360 | 29830 | IP | No reimbursement |

Members may not be balance-billed for any incidental procedure that is not reimbursed by AmeriHealth.

### *Surgical procedures not found on the Outpatient Fee Schedule*

Surgical procedures not listed on the Outpatient Fee Schedule are individually reviewed for payment consideration when performed in a hospital outpatient setting. AmeriHealth may also request medical records to help determine a reimbursement rate or to ensure that the procedure code reported accurately represents the surgery performed. If medical records are requested, AmeriHealth will make a determination regarding reimbursement once the documentation is received.

### *Variations before and after surgery*

Preapproval/Precertification by AmeriHealth is based on the code for the procedure planned, but the code assigned for billing after the procedure may be different. Assuming the codes are reasonably related, this is not a barrier for payment; however, an updated Preapproval/Precertification may be required.

### *Cancelled surgeries*

Currently, three types of outpatient cancelled surgery scenarios are eligible for reimbursement. In order for these claims to be processed correctly, certain coding and billing criteria must be met. Claims submitted that do not meet these criteria will be returned to the facility for correction. Please note the criteria for each of the following scenarios when coding and billing your claims

| | |
|---|---|
| Scenario 1: Patient receives preoperative services, but surgery is cancelled. | **Example:** The patient has preadmission testing for intended cataract surgery but subsequently develops a cold and the surgery is cancelled.<br>**Coding and billing requirements:**<br>• Report the principal diagnosis code, which is the reason for the surgery.<br>• Report the secondary diagnosis with the appropriate diagnosis code(s) indicating cancelled surgery.<br>• Report the HCPCS and/or CPT code(s) for the preoperative services, indicating procedures performed and the date(s) of service.<br>• Submit the claim through the standard channels — no medical record review is required.<br>**Reimbursement:** The hospital will be reimbursed for preoperative services according to its Agreement. |
| Scenario 2: Planned surgery is stopped before the entire procedure is completed. | **Example:** The patient has planned a laparoscopic adhesiolysis. Surgery proceeds as far as the insertion of the laparoscope when the patient develops an arrhythmia and the surgery is stopped.<br>**Coding and billing requirements:**<br>• Report the principal diagnosis code, which is the reason for the surgery.<br>• There is no need to use a diagnosis code indicating cancelled surgery.<br>• Code the procedure to the extent it was completed. In this example, the diagnostic laparoscopy code would be used to describe the insertion of the scope.<br>• Submit the claim through the standard channels — no medical record review is required.<br>**Reimbursement:** The hospital will be reimbursed to the extent that the procedure was performed (e.g., diagnostic laparoscopy) according to its Agreement. |

| | |
|---|---|
| Scenario 3: Patient was admitted to same day surgery/short procedure unit, but surgery was cancelled before it began. | **Example:** Some services related to the intended procedure have been rendered. For example, the patient is in the operating room. When anesthesia has been induced, the patient's blood pressure drops, and the procedure is cancelled.<br>**Coding and billing requirements:**<br>• Report the principal diagnosis code, which is the reason for the surgery.<br>• Report the secondary diagnosis with the appropriate code indicating cancelled surgery.<br>• Report the HCPCS and/or CPT code for the intended procedure with the correct revenue code for outpatient surgery.<br>• Submit the claim to your Provider Partnership Associate with medical records for the encounter and the reasons for the cancellation. Claims submitted without this required information will not be considered for payment.<br>**Reimbursement:** The hospital/facility may be reimbursed for surgical procedures cancelled for reasons beyond the hospital's control. The hospital may be reimbursed at the minor surgery rate (surgical category M) for fee schedule claims or 50% of the contracted rate for all other claims. The procedure will not be reimbursed if the cancellation is due to administrative reasons (e.g., equipment failure, staffing problems). |

## Outpatient implantable devices

If the hospital is contracted under the hospital Outpatient Surgery Fee Schedule, specific implantable devices are eligible for additional reimbursement. These select approved implantable devices, listed and updated periodically through Provider bulletins, may be reimbursed separately at the hospital's invoice cost.

### *How to bill implantable devices*

Submit the claim electronically through standard channels. Bill the implant using revenue code 0275 or 0278, as appropriate. Charges must also be assigned to implants. These devices will be reimbursed separately at the Provider's cost, as documented on the manufacturer's invoice (shipping and sales tax excluded). The implant revenue code and charges must be billed on the initial claim submission. They will not be added when the request for implant reimbursement is submitted.

After the base claim is paid, submit the following documentation to your Provider Partnership Associate:

- operative report
- implant record
- implant manufacturer's invoice (not purchase order)

Send all documentation listed above to:

AmeriHealth New Jersey
259 Prospect Plains Road, Building M
Cranbury, NJ 08512

*Note:* The purchase order is not acceptable in lieu of the manufacturer's invoice. It may be submitted in addition to the manufacturer's invoice to clarify a date discrepancy. Also, a

manufacturer's invoice received with handwritten amounts will not be considered acceptable documentation.

Generally, we will not accept an invoice with a date greater than the date of surgery as applicable documentation. However, it may be your hospital's billing practice to request a device with a purchase order, receive the device and use it during surgery, and then be billed by the manufacturer after the actual surgery date. If this is the case, include both the invoice and purchase order for documentation, and specify that this is your hospital's practice.

For certain implants that are purchased on consignment or ordered in bulk (e.g., drug-eluting stents), a representative copy of the manufacturer's invoice that reflects the cost per unit, units per order (e.g., pack, case, box), and model number and/or clear description of the implantable device will be considered acceptable documentation. We will also require that the patient-specific serial number of the implantable device be recorded in the implant record.

To facilitate processing, include a cover sheet that contains a summary of the required information, including:

- Member name
- Member ID number
- Member claim number
- implant type
- invoice amount

### *Implant record*

The implant record is required to verify the model and serial number of the implantable device. This information can be found on the implant labels that are attached to the implant record. The facility should place these labels on the operative report, purchase order, or on one of the following:

- cardiac catheterization report
- implantable device registration form
- intra-operative nursing record
- medical device or issue tracking form
- operative notes
- progress notes

You may submit one of these forms in lieu of the implant record as long as they include the implant label, indicating the implant's model and serial number, and a brief description of the device. With the exception of radioactive seeds, implantable devices include implant labels from the manufacturer.

Implant requests received without all required documentation will not be considered for reimbursement.

Please note that originally submitted requests for implant payments will be processed in accordance with the timely filing provisions of your Agreement.

### *Reimbursement exceptions*

The following are examples of circumstances where implantable devices are not eligible for reimbursement:

- The base surgery claim has been denied or has not yet been paid.
- The type of device is not specified on approved listing.
- There is insufficient documentation.
- AmeriHealth is not the primary payor.

## Radiation therapy

Preapproval/Precertification for nonemergent outpatient radiation therapy services is required through eviCore for all commercial HMO and PPO Members and Members in a Medicare Advantage plan of one of our Affiliates. Preapproval/Precertification is not required when radiation therapy is rendered in the inpatient hospital setting.

Initiate Preapproval/Precertification for nonemergent outpatient radiation therapy in one of the following ways:

- **PEAR PM.** Select *eviCore* from the Transactions tab (under authorizations).
- **Telephone.** Call eviCore directly at 1-866-686-2649.

For additional information on nonemergent outpatient radiation therapy services, please refer to our medical policies at *www.amerihealth.com/medpolicy*.

## Radiology services

Radiology services are reimbursed in accordance with the AmeriHealth medical policies, which are available at *www.amerihealth.com/medpolicy*. Members are required to obtain a Physician order and/or a Referral to receive radiology services. Additionally, there are certain high-technology diagnostic services that require Preapproval/Precertification, and AmeriHealth has delegated this responsibility to Carelon Medical Benefits Management (Carelon).

For additional information on high-technology diagnostic services, please refer to our medical policies at *www.amerihealth.com/medpolicy*.

### *Capitated services*

Radiology services for HMO/POS Members are generally provided by the designated Participating Provider under the Capitated Diagnostic Radiology Program. A complete listing of the services included in this program can be found at *www.amerihealth.com/medpolicy*. Radiology services that are excluded from capitation are paid at the hospital's contracted rate.

### *Interventional radiology*

Interventional radiology (IR) involves procedures with both a surgical and radiological component. In addition to the radiology service, claims should also be submitted with the appropriate surgical procedure. The surgical procedure code is reimbursed and includes the radiology services.

## Short-term rehabilitation therapy services

Short-term rehabilitation therapy services are reimbursed in accordance with the AmeriHealth medical policies, which can be found at *www.amerihealth.com/medpolicy*. Payment will be made directly to the facility according to the hospital's contracted rates.

### *Capitated services*

Physical therapy and occupational therapy services for HMO/POS Members are generally provided by the designated Participating Provider under the Capitated Outpatient Short-Term Rehab Program. A complete listing of the services included in this program can be found at *www.amerihealth.com/medpolicy*. Therapy services that are excluded from capitation are paid at the hospital's contracted rate.

### Sleep study (neurology)

In order for a participating hospital's sleep study program to be eligible as an approved sleep study program for the AmeriHealth network, the program must be accredited by the Joint Commission or the American Association of Sleep Medicine, as specifically referred to in your Agreement. For hospital billing, sleep study is part of the neurology fee schedule.

## Additional billing information

### Revenue codes requiring HCPCS/CPT codes

When billing one of the revenue codes listed below, a corresponding HCPCS/CPT code must be reported on the claim line.

| Revenue code series | Revenue codes |
|---|---|
| 02xx | 0250-0256, 0258-0261, 0269, 0274-0275, 0278, 0280, 0289-0294, 0299 |
| 03xx | 0300-0312, 0314, 0319-0324, 0329-0333, 0335, 0339-0344, 0349-0352, 0359-0362, 0367, 0369, 0374, 0380-0387, 0389-0381, 0399 |
| 04xx | 0400-0404, 0409-0410, 0412-0413, 0419-0424, 0429-0434, 0439-0444, 0449-0452, 0456, 0459-0460, 0469-0472, 0479-0483, 0489-0490, 0499 |
| 05xx | 0510-0517, 0519, 0530-0531, 0539 |
| 06xx | 0610-0612, 0614-0616, 0618-0619, 0621-0623, 0631-0637 |
| 07xx | 0700, 0720-0723, 0729-0732, 0739-0740, 0750, 0760-0762, 0769, 0771, 0790 |
| 08xx | 0820-0825, 0829-0835, 0839-0845, 0849-0855, 0859-0861, 0880-0881, 0889, 0891, 0892 |
| 09xx | 0901, 0903, 0914-0918, 0920-0925, 0929, 0940-0949, 0951-0952 |

### *Surgical revenue code requirements*

Surgical revenue codes have additional requirements. Only procedures identified on the Surgical Procedure Code list should be reported with surgery revenue codes. Please refer to the current Surgical Procedure List, which is updated and distributed each quarter, when determining whether or not a procedure is eligible to be reported with a surgical revenue code for billing.

### Not separately payable (NSP) procedures

When multiple procedures are billed, no additional payment is made to hospitals for procedures identified as NSP on the Outpatient Fee Schedule. Services identified as NSP are an inherent part of another procedure and therefore are considered packaged services/items for which no separate payment is made. Members may not be balance-billed for any NSP procedure that is not reimbursed by AmeriHealth.

## Enhanced Claim Editor Program

Claims received by AmeriHealth are subject to a claim editing process during prepayment review.* The Enhanced Claim Editing Program is one of many programs in place dedicated to ensuring claims are billed accurately and in accordance with industry standard coding principles. The program includes Automated Edits and Coding Validator reviews:

- **Automated Edits** are systematic edits automatically applied based on coding rules
- **Coding Validator** reviews are denials based on a thorough review of the claim coding by a Registered Nurse who is also a Certified Professional Coder (CPC) against pertinent information billed on the claim and the claims in the member's history.

The Enhanced Claim Editing Program supports our commitment to ensure compliance with correct coding principles as endorsed by national and regional industry sources, including but not limited to:

- Centers for Medicare & Medicaid Services (CMS) standards such as:
  - National Coverage Determinations (NCDs)
  - Local Coverage Determinations (LCDs)
  - Medicare Claims Processing Manual
  - Durable Medical Equipment Regional Carries (DMERC) Manual
  - CMS HCPCS LEVEL II Manual coding guidelines
- American Medical Association (AMA) Current Procedural Terminology (CPT®) coding guidelines
- ICD-10-CM Official Guidelines for Coding and Reporting
- Food and Drug Administration (FDA)
- Nationally recognized specialty societies such as:
  - National Comprehensive Cancer Network (NCCN)
  - American College of Obstetricians and Gynecologists (ACOG):
  - U.S. Preventive Services Task Force (USPSTF)

Please be advised that as guidelines from these sources are updated, our claim edits will be reviewed, and additional claim edits will be implemented as applicable.

**Self-funded groups have the option to not participate in the enhanced claim edits; therefore, your outcomes may vary by health plan.*

### *Areas of focus*

AmeriHealth's correct coding principles focus on the following areas, but are not limited to:

- International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) coding and reporting guidelines including:
  - "Code Also" and "Code First" instructional notes
  - Principle/first listed and secondary only diagnosis codes
  - Inappropriate use of unspecified codes
- National bundling guidelines including:
  - CMS National Correct Coding Initiative (NCCI) edits and NCCI Policy Manual guidelines

  - AMA unbundling guidelines
  - Global surgery guidelines
- Modifier Usage including:
  - Appropriate reporting of modifiers including but not limited to: 59, GN, GO, GP, LT, RT, TC, XE, XP, XS, XU, etc.
  - CMS modifier requirements for durable medical equipment (DME) and prosthetics and orthotics (P&O)
  - Reporting of an override modifier on procedures subject to NCCI edits with a modifier override allowed
- Add-On codes
- Medically Unlikely Edits (MUE)
- Injectable drugs and biological agents including:
  - Consistency of diagnosis codes with FDA-approved labeling indications and approved off-label indications
  - Reporting diagnosis codes in accordance with ICD-10-CM coding guidelines
  - Dosage and frequency of administration appropriate for reported diagnosis

## Identifying Automated Edits vs. Coding Validator reviews

Automated Edits are systematic edits automatically applied based on coding rules, whereas Coding Validator reviews are denials based on a thorough review of the claim coding by a Registered Nurse who is also a Certified Professional Coder (CPC) against pertinent information billed on the claim and the claims in the Member's history.

If your claim was affected by the Enhanced Claim editor, the edit explanation will be displayed on your electronic remittance report (835) and/or paper Provider Explanation of Benefits (EOB) or Facility Remittance. Unique alpha-numeric codes and messages have been created that begin with E8.

A Coding Validator edit claim line will contain an E819X denial, all other E8XXX codes/messages are Automated Edits. You can also find the E8XXX codes/messages within PEAR PM using the Claim Search transaction. From the Claim Details screen, if there is an E8XXX code, a Claim Editor link will appear. This link will show further detail in the Rationale and Description. This is an additional indication that the edit is related to Coding Validation and is not an Automated Edit. Only E8XXX codes/messages are part of the Enhanced Claim Editor program. All other codes/messages are unrelated to the program.

## Denial Dispute Processes

To request a claim review of a Coding Validator edit or dispute a denial from an Automated edit, please follow the appropriate process for the applicable edit as described below.

### *Request for Coding Validator claim review*

While you may use PEAR PM to view detailed information on a Coding Validator E819X denial, clinical information needs to be submitted to dispute the denial. The clinical information should include all applicable medical records, notes, and tests along with a cover letter explaining the reason for the dispute.

To facilitate a review, submit the documents listed above via:

- Email: *claimcodingvalidation@amerihealth.com*
- Mail:

  AmeriHealth
  Claim Coding Validation
  1901 Market Street
  Philadelphia, PA 19103

### *Request for an Automated Edit claim review*

For all other E8XXX edits related to Automated Edits, Providers should submit a Claim Investigation through the Claim Search transaction in PEAR PM to ask questions or request an adjustment. Please provide any additional information including reference claim numbers or corrections submitted to support your request for reconsideration for approval.

## Coding discrepancies

Any coding discrepancies should be reported using PEAR PM. For finalized claims, Providers will be offered an option to submit a Claim Investigation within the Claim Search transaction. The transaction allows Providers to submit an adjustment for an individual claim (excluding the ability to submit late charges). Additional details on rejected claims can be obtained via the Claim Editor link in the Claim Search transaction. Up to 18 months of historical data will be available to you.

## Billing requirements for Providers contracted under Ambulatory Payment Classification (APC)

The billing requirements for products reimbursed under APCs are consistent with the Integrated Outpatient Code Editor (IOCE). The IOCE identifies billing errors and indicates what actions to take to rectify a claim and performs the calculations to determine composite rate payments where applicable. All claims submitted will be processed through the IOCE, so any errors will need to be addressed and resolved for the claim to pass through the IOCE and be available for adjudication.

### *Implantable items*

The Outpatient Implantable Device Reimbursement does not apply to APC reimbursement. The reimbursement for implantable items is included in the appropriate surgical procedure and is not paid separately. Please follow CMS billing requirements for modifiers and code combinations for implants.

## National Drug Code (NDC) submission

The FDA guidelines for NDC submission for co-packaged products listed as kits and multi-level packaged products are as follows:

- For co-packaged products listed as kits and multi-level packaged products, Providers should report the NDC on the outermost package. Only the outermost NDC is reported by firms as part of their product listing submission to the FDA and included in the NDC directory. Only NDCs included in the NDC directory will be considered valid NDCs for claims submission.

## Billing for Physician and advanced practice nurse services

Physician and advanced practice nurse services may not be billed by a facility using a UB-04 claim form or 837I transaction. These services must be billed by the Physician or advanced practice nurse using his or her National Provider Identifier on a CMS-1500 claim form or through an 837P transaction.

## Professional office-based services in an outpatient setting

When a professional Participating Provider performs a service that is considered an office-based service (e.g., office visit, outpatient consultation, professional interpretation and report) in an office-based setting (e.g., clinic, treatment room) located in a hospital facility or hospital Affiliate-owned site, the facility is not eligible to receive reimbursement for these services or for any services included in the payment to the professional Participating Provider. However, according to their Agreement, the facility is eligible to receive reimbursement for any ancillary Covered Services (e.g., laboratory test, radiologic study) related to the office visit or consultation. For additional information about these services, please refer to our medical policies at *www.amerihealth.com/medpolicy*.

## Coordination of Benefits/Other Party Liability

All claims should clearly indicate if the claim is the result of an accident, such as a motor vehicle accident, or related to employment. Refer to the *General Information* section of this manual for more details. The claim should be submitted to the appropriate primary insurance carrier and should include all services rendered during the admission or date of service.

To ensure that timely filing standards are met, these types of claims should also be submitted to AmeriHealth with the appropriate indicator, in the event that the primary insurer denies responsibility for the claim.