PROVIDER BULLETIN
#11-2013

TO: Participating hospitals in Pennsylvania and Delaware

FROM: Daniel Brown
Director, Provider Reimbursement Analysis Administration

DATE: August 1, 2013

SUBJECT: Billing and Reimbursement Updates for Multiple Surgical Procedures and Miscellaneous Codes

We are sending this bulletin to notify you of the following billing changes that will be effective for dates of service on or after September 1, 2013.

Multiple Surgical Procedures

Currently, when multiple outpatient surgical procedures are performed on the same date of service, the same revenue code should be used for each procedure for secondary procedures to be reimbursed at 50 percent of the contracted rate. When providers bill with different revenue codes, there is no additional reimbursement.

Effective for dates of service on or after September 1, 2013, when multiple outpatient surgical procedures are performed during the same date of service, providers may now 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

We encourage you to share this information with appropriate members of your staff.

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

Provider Business Edit — Miscellaneous Codes

Effective for dates of service on or after September 1, 2013, the Provider Business Edit (PBE) for Miscellaneous Codes will no longer be in effect. The Miscellaneous HCPCS edit was created to prevent first-pass payment for services reported with unlisted procedure codes for laboratory and radiology services. Unlisted procedure codes may be reported for seldom used procedures, newly approved services, or procedures performed using emerging technology where a specific CPT® or HCPCS code does not exist. When reporting an unlisted laboratory or radiological code, providers were previously instructed to submit a paper claim with the medical record attached, in order to validate the need for the unlisted code.

Effective for dates of service on or after September 1, 2013, providers can begin electronically submitting claims for services reported with unlisted procedure codes for laboratory and radiology services. However, providers should only use unlisted codes when absolutely necessary. If there is a more specific code to represent the service, then providers should report that specific code. Providers should only report an unlisted service code when there is no appropriate CPT or HCPCS specific code for that service. AmeriHealth may still request medical records to ensure that the use of an unlisted procedure code is warranted.

If you have any questions about these billing changes, please contact your Network Coordinator.

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