ProviderNotification | pa health & wellness

Updated Payment Policies

December 20, 2019

PA Health & Wellness is implementing Payment & Clinical Policies that will guide how claims for certain services are adjudicated and paid. To ensure accurate reimbursement, the updated policies will provide the clinically-based rule content used to evaluate claims. This is in addition to all other reimbursement processes that PA Health & Wellness currently employs. The policies that dictate the coding and billing rules applied are based on industry standards and guidelines as published and defined in the Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), and public domain specialty society edits, unless specifically addressed in the fee-for-service provider manual published by the State of Pennsylvania or regulations.

The effective date of the change(s) for each policy is posted within the document. These policies apply to all PA Health & Wellness products, unless otherwise noted.

The policies documents can be found on the PA Health & Wellness web site via the link below:

PAHealthWellness.com

Policy Number	Policy Name	Policy Description	Line of Business (LOB)	Adoption Date
PA.CC.PP.007	Maximum Units	The purpose of this policy is to define payment criteria for the maximum units of service billed on a claim to be used by the Health Plan in making payment decisions and administering benefits.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.008	Cerumen Removal	The purpose of this policy is to define separate payment criteria for removal of impacted cerumen to be used by the Health Plan in making payment decisions and administering benefits.	Medicare, Medicaid	18-Dec-19

PA.CC.PP.009	Unlisted Procedure Codes	Outlines the parameters and documentation requirements necessary when an unlisted or unspecified procedure code is utilized.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.010	E/M Bundling with Labs and Radiology	The purpose of this policy is to define payment criteria for those physician services included in the payment for E/M services to be used by the Health Plan in making payment decisions and administering benefits.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.011	Coding Overview	The purpose of this policy is to serve as a reference guide for general coding and claims editing information.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.012	Intravenous Hydration	The purpose of this policy is to serve as a reference guide for coding IV infusions for hydration purposes for reimbursement.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.013	Clinical Validation of Modifer 25	This policy applies to the use of modifier 25, which should only be used to indicate that a “significant, separately identifiable evaluation and management service (was provided) by the same physician on the same day of the procedure or other service.”	Medicare, Medicaid	18-Dec-19
PA.CC.PP.014	Clinical Validation of Modifier 59	This policy applies to the use of modifier 59, which should only be used to indicate that two or more procedures are performed at different anatomic sites or different patient encounters.	Medicare, Medicaid	18-Dec-19

PA.CC.PP.015	Moderate Conscious Sedation	The purpose of this policy is to serve as a reference guide for coding drug induced depression of consciousness for reimbursement.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.016	Global Maternity Package	The purpose of this policy is to serve as a reference guide for coding the global obstetrical package for reimbursement.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.017	Never Paid Events	The purpose of this policy is to serve as a reference guide for Never Events for non-payment.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.018	Inpatient Only Procedures	The purpose of this policy is to serve as a reference guide on procedures that will reimbursed as inpatient only services.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.019	Professional Services (Visit Codes) Billed With Labs	The purpose of this policy is to serve as a reference guide for coding physician visits with laboratory tests performed in a hospital.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.020	Distinct Procedural Modifiers: XE, XS, XP, & XU	This policy applies to use of 4 new modifiers to be used in place of modifier 59.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.021	Clean Claims	The purpose of this policy is to define the minimum claim submission requirements for processing from all providers, including facilities and professional providers.	Medicare, Medicaid	18-Dec-19

PA.CC.PP.022	Clinical Laboratory Improvement Amendments (CLIA)	CLIA was established in 1988 and mandates that all laboratories, (including physician's office laboratories), which perform non-research testing on human specimens, provide accurate laboratory procedures that will assess, diagnose, prevent or treat diseases and impairments. Under the CLIA program, laboratories must obtain certification to perform certain laboratory tests to receive payments	Medicare, Medicaid	18-Dec-19
PA.CC.PP.023	Hospital Visit Codes Billed with Labs	The purpose of this policy is to serve as a reference guide for coding hospital visits with laboratory tests.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.024	Cosmetic Procedures	Cosmetic procedures or procedures connected with cosmetic surgery are not reimbursable. The Centers for Medicare and Medicaid Services (CMS) define cosmetic procedures as “any surgical procedure, directed at improving appearance, except when required for prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member.”	Medicare, Medicaid	18-Dec-19

PA.CC.PP.025	Pulse Oximetry	The purpose of this policy is to define payment criteria for pulse oximetry testing when billed separately from an office visit.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.027	Professional Component	Certain procedure codes represent both the technical and professional component of a procedure or service.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.028	Modifier to Procedure Code Validation	Providers append modifiers to procedure codes to indicate that a procedure or service has been altered by some circumstance, but the definition of the procedure or the procedure code itself is unchanged. This policy is relevant to modifiers identified as affecting payment.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.029	Assistant Surgeon	The purpose of this policy is to define payment criteria for procedures which are appropriate to be billed with the assistant surgeon modifier to be used in making payment decisions and administering benefits.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.030	Add on Code Billed Without Primary Code	The purpose of this policy is explain the parameters for add-on codes submitted on physician claims.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.031	NCCI Unbundling	The health plan administers unbundling edits based on the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI). NCCI edit reimbursement methodologies dictate that when two related procedure codes are billed for the same member, by the same provider on the same date of	Medicare, Medicaid	18-Dec-19

		service, only the most comprehensive code is reimbursable.		
PA.CC.PP.032	Supplies Billed on Same Day As Surgery	The purpose of this policy is to define payment criteria for supplies billed on the same date as a surgical procedure to be used by the health plan in making payment decisions.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.033	Multiple CPT Code Replacement	When a single, more comprehensive procedure code exists to describe a service, the single more comprehensive code should be used versus multiple CPT codes.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.034	Modifier DOS Validation	This policy establishes guidelines surrounding correct coding of modifiers with regards to the date that services were rendered.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.035	Sleep Studies Place of Service	The purpose of this policy is to define the appropriate place of service for sleep studies.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.036	New Patient	The purpose of this policy is to define payment criteria and appropriate use of new patient evaluation and management (E&M) procedure codes.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.037	Bilateral Procedures	Bilateral services are procedures performed on both sides of the body during the same session or on the same day. The purpose of this policy is to define the	Medicare, Medicaid	18-Dec-19

		appropriate billing criteria for bilateral services.		
PA.CC.PP.038	Inpatient Consultation	The purpose of this policy is to outline how the health plan evaluates CPT consultation codes 99251-99255 and HCPCS codes G0406-G0408 for reimbursement, particularly identifying those that should have been billed at the appropriate level of subsequent hospital care.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.039	Outpatient Consultations	The purpose of this policy is to outline how the health plan evaluates CPT consultation codes 99241-99245 and HCPS codes G0425-G0427 for reimbursement, particularly identifying those that should have been billed at the appropriate level of office visit, established patient or subsequent hospital care.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.040	Visits On Same Day As Surgery	For purposes of this policy, “same day visits” addresses evaluation and management services that occur on the same day as a surgical procedure.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.041	Preoperative Visits	The purpose of this policy is to define payment criteria for E&M visits when billed with surgical procedures having a 000, 010 or 090, MMM, and ZZZ global period to be used in making payment decisions and administering benefits.	Medicare, Medicaid	18-Dec-19

PA.CC.PP.042	Postoperative Visits	The purpose of this policy is to define payment criteria for E&M services when billed with surgical procedures having a 000, 010 or 090, MMM, and ZZZ global period to be used in making payment decisions and administering benefits.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.043	Unbundled Professional Services	The purpose of this policy is to define payment criteria for national specialty society code pair edit relationships to be used in making payment decisions and administering benefits.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.044	Duplicate Primary Code Billing	By definition, certain Current Procedural Terminology (CPT®) procedure codes are appropriately billed only once per date of service. A billing error is identified when these codes are billed in a quantity greater than one, for the same member on a single date of service. When indicated, providers should bill the appropriate add-on code to indicate additional intra-service work associated with the procedure.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.045	Unbundled Surgical Procedures	The purpose of this policy is to define payment criteria for national specialty society surgical code pair edit relationships to be used in making payment decisions and administering benefits.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.046	Status "B" Bundled Services	The purpose of this policy is to define payment criteria for covered services designated by CMS as always bundled to another procedure or service to be used in making	Medicare, Medicaid	18-Dec-19

		payment decisions and administering benefits.		
PA.CC.PP.047	Transgender Related Services	The purpose of this policy is to define payment criteria for gender-specific procedure codes when billed for members whose recorded gender differs from the gender-specific procedure code billed.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.049	Status P Bundled Services	The purpose of this policy is to define payment criteria for covered services designated by CMS as always bundled to another physician's procedure or service to be used in making payment decisions and administering benefits.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.050	Robotic Surgery	This policy defines payment criteria for robotic surgeries to be used in making payment decisions and administering benefits.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.051	E&M Medical Decision Making	The policy discusses the appropriate assignment of moderate to high complexity E&M services with an emphasis on medical decision making as a key component of the assignment process.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.052	Problem Oriented Visits with Surgical Procedures	The purpose of this policy is to define payment criteria for problem-oriented visits when billed on the same day as a surgical procedure to be used in making payment decisions and administering benefits.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.054	Physician's Consultation Services	The purpose of this policy is to define payment criteria for consultation services to be used in making payment	Medicare, Medicaid	18-Dec-19

		decisions and administering benefits.		
PA.CC.PP.055	Physician's Office Lab Testing	The purpose of this policy is to define payment criteria for in-office laboratory procedures to be used in making payment decisions and administering benefits. Furthermore, to encourage the specialization of independent labs to ensure higher quality laboratory tests are performed in the appropriate setting.	Medicare, Medicaid	1-Jun-19
PA.CC.PP.056	Urine Specimen Validity Testing	The purpose of this policy is to define payment criteria for urine specimen validity testing to be used in making payment decisions and administering benefits.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.057	Problem Oriented Visits with Preventative Visits	The purpose of this policy is to define payment criteria for problem-oriented visits when billed with preventative visits to be used in making payment decisions and administering benefits.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.058	Leveling of Care Professional	The purpose of this policy is to define payment criteria for emergency room services to be used in making payment decisions and administering benefits.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.059	Clinic Facility Charge	The purpose of this policy is to define payment criteria for facility charges rendered at outpatient hospital clinics to be used in making payment decisions and administering benefits.	Medicare, Medicaid	18-Dec-19

PA.CC.PP.063	Place of Service Mismatch	The purpose of this policy is to identify instances in which a procedure code is billed with an inappropriate place of service per CPT/HCPCS guidelines.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.064	Emergency Department (ED) Evaluation and Management (E&M) Coding for Facility Claims	The purpose of this policy is to define payment criteria for emergency room claims when billed with Level 4 and Level 5 E/M codes to be used in making payment decisions and administering benefits.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.500	3 Day Payment Window	Aims to ensure that payment for the technical component of all outpatient diagnostic services and related non-diagnostic services are bundled with the claim for an inpatient stay when services are furnished within 3 calendar days.	Medicare, Medicaid	18-Dec-19
PA.CC.PP.501	30-Day Readmission	Aims to incentivize providers to increase quality of care by denying payment to providers for preventable readmissions within 30 days of initial discharge.	Medicare, Medicaid	18-Dec-19
PA.CP.MP.123	Laser Skin Treatment	This policy defines the medically necessary indications for excimer laser based targeted phototherapy.	Medicare, Medicaid	19-Dec-19