This manual will apply to BadgerCare Plus plans and Quartz Health Solutions Commercial (i.e. commercial plans underwritten by Unity Health Plans Insurance Corporation, Gundersen Health Plan, Inc. and Gundersen Health Plan Minnesota).
# Table of Contents

- Historical Background ................................................................................................................................................................................. 4
- Access Standards................................................................................................................................................................................................... 5
- After-Hours Care .................................................................................................................................................................................................. 5
- Medical Claims ........................................................................................................................................................................................................ 7
- Dental Claims ........................................................................................................................................................................................................... 7
- Medicare Claims ..................................................................................................................................................................................................... 8
- The Medicare Remittance Advice ........................................................................................................................................................................ 8
- Medicare Crossover .................................................................................................................................................................................................. 9
- Coordination of Benefits ................................................................................................................................................................................................ 10
- Coding Policies and Procedures ....................................................................................................................................................................... 11
  - Remittance Advice ..................................................................................................................................................................................................... 11
  - Recoupment ........................................................................................................................................................................................................ 13
  - Subrogation ........................................................................................................................................................................................................... 13
  - Three Month Grace ................................................................................................................................................................................................... 13
- Confidentiality ........................................................................................................................................................................................................... 14
  - General Policy ....................................................................................................................................................................................................... 14
  - Release of Protected Health Information without Authorization ................................................................................................................................................................................... 14
  - Member Access to Medical Records ........................................................................................................................................................................ 14
  - Treatment Setting ...................................................................................................................................................................................................... 15
- Coverage ................................................................................................................................................................................................................ 16
  - Chartwell Health Resources .............................................................................................................................................................................. 16
  - Durable Medical Equipment (DME) and Medical Supplies ......................................................................................................................................................................................... 16
  - Home Health Care .................................................................................................................................................................................................. 16
  - Home Infusion Therapy .................................................................................................................................................................................................... 17
  - Behavioral Health and Chemical Dependency Benefits ..................................................................................................................................................................................... 17
  - Skilled Nursing Facility (SNF) ............................................................................................................................................................................... 18
  - Hearing Aid Coverage ..................................................................................................................................................................................................... 18
  - Vision Coverage ........................................................................................................................................................................................................ 18
- Credentialing ............................................................................................................................................................................................................. 20
  - Initial Credentialing .................................................................................................................................................................................................. 20
  - Recredentialing ....................................................................................................................................................................................................... 21
  - Practitioner Rights .................................................................................................................................................................................................... 21
  - Credentialing Confidentiality Policy ...................................................................................................................................................................... 21
  - Physician Office Audits ................................................................................................................................................................................................ 21
- Emergency Room .......................................................................................................................................................................................................... 23
  - Definition of “Emergency” .................................................................................................................................................................................................. 23
- Interpreter Services ....................................................................................................................................................................................................... 23
- Health Management Programs .................................................................................................................................................................................. 24
- Health Coaching ............................................................................................................................................................................................................ 24
# Table of Contents

Preventive and Wellness Services ................................................................. 24
Shared Decision-Making ............................................................................. 25

BadgerCare Program .................................................................................. 26
  Claims Submission and Medicaid Certificate .................................................. 26
  Policies Related to Medicaid Managed Care Program Providers ......................... 27
  Provider Preventable Conditions ..................................................................... 27
  HealthCheck .................................................................................................. 28
Wisconsin Women, Infants and Children (WIC) Nutrition Program ................... 31
Routine Visits ................................................................................................. 32

Immunizations / Vaccinations ....................................................................... 32
Sterilization / Hysterectomy / Abortion Procedures for BadgerCare Plus Members .................. 33

Medical Records .......................................................................................... 35
  Member Satisfaction Surveys ............................................................................ 36
  Members’ Rights and Responsibilities ................................................................. 36
MyPlanToolsSM ............................................................................................. 38
NCQA Accreditation ...................................................................................... 38

New Medical Technology Evaluation ............................................................ 39
  Requesting a New Medical Technology Evaluation ........................................... 39
Pharmacy .......................................................................................................... 40
  Prescription Drug Formulary ............................................................................ 40
  Specialty Pharmaceutical Benefit ...................................................................... 41
  Pharmacy Program Coordination ...................................................................... 42
  Formulary Decision-Making Process ................................................................. 44
  Medication Prior Authorization ....................................................................... 44
Practitioner Appeals Process ........................................................................... 46
  Appealing a Denial of Coverage ...................................................................... 46
  Expedited Reviews ............................................................................................ 46
Product Descriptions ....................................................................................... 47
Member Identification Cards ........................................................................... 47
Promotional Marketing Assistance ................................................................. 48

Provider Relations ......................................................................................... 48
  Provider Coordinators ..................................................................................... 48
  Provider Coordinator Service Area ................................................................. 49

Quality Management and Population Health ................................................ 50
  QI Program ..................................................................................................... 51
  HEDIS® ........................................................................................................... 51
Continuity & Coordination of Care ................................................................. 52
Complex Case Management ........................................................................... 54
Referrals ........................................................................................................... 55
Table of Contents

Utilization Management ................................................................................................................................. 56
Prior Authorization ........................................................................................................................................ 57
Appendix A ....................................................................................................................................................... 60
Introduction

Welcome to Quartz Health Solutions, Inc. (Quartz). We are pleased to have you in our network of providers and look forward to a long, mutually satisfying relationship.

The purpose of this manual is to inform and educate you about Quartz, our policies and procedures, our Quality Improvement Program and our quality initiatives. If you have questions or concerns after reading the manual, please discuss them with us. We welcome and appreciate your ideas for improving our services.

Historical Background

Formal agreements documenting integration between Unity Health Insurance and Gundersen Health Plan were completed in 2016. The agreement between Quartz and Physicians Plus was completed in 2017. The integration combines operations of the three insurers, not the health systems with whom they are affiliated.

All insurers have a long presence in their local markets. Under the structure, Quartz, GHP and Physicians Plus are co-owned by UW Health and Gundersen Health System. The integrated entities serve members throughout southern and western Wisconsin and parts of Illinois, Iowa and Minnesota. The size, range of products and expanded geography enhances the companies’ ability to leverage best products and practices and grow beyond current service areas. The integrated organizations serve approximately 300,000 members.

Disclaimer: This manual will apply to BadgerCare Plus plans and Quartz Health Solutions Commercial. (i.e. commercial plans underwritten by Unity Health Plans Insurance Corporation, Gundersen Health Plan, Inc, and Gundersen Health Plan Minnesota)

Please see the individual provider manuals for Medicare Advantage (Senior Preferred) at https://www.seniorpreferred.org/ and Quartz ASO (self-funded plans) at https://quartzaso.com/ under the practitioners tab.
Access Standards

Upon arriving for a scheduled appointment, in-office wait times shall not exceed 15 minutes without explanation. Providers are encouraged to have signage that members should report to the reception desk if the in-office wait time exceeds 15 minutes. Quartz will monitor this through member inquiries and complaints along with annual provider surveys reported, as a requirement for National Committee for Quality Assurance (NCQA).

Any identified issues will be discussed at the Member Services Committee and action will be taken as appropriate.

All participating PCP providers are expected to develop a comprehensive treatment plan, based on results from internal monitoring and on assessed needs of Quartz members. The treatment plan will include assessment and care coordination, follow-up and care planning strategies.

Our Primary Care Practitioner Standards are (as defined by the Consumer Assessment of Healthcare Providers and Systems survey CAHPS®) –

- **Emergent Care** – Symptomatic, not interfering with daily functions, 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 days*

**Our Behavioral Health Appointment Standards** –

- **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*

Behavioral Health Care Management Telephone Standards –

- Callers will reach a non-recorded voice within 30 seconds
  - Abandonment rates do not exceed five percent at any given time

At least annually, Quartz measures against access and satisfaction via Quartz’s Monthly Member Satisfaction Survey, CAHPS, Behavioral Health Satisfaction Survey, behavioral health provider phone survey and the behavioral health management phone statistics.

**Minnesota Access Standards**

- Thirty (30) minutes or thirty (30) miles to primary care, thirty miles for Minnesota service area;
- Sixty (60) minutes or sixty (60) miles to specialty care, behavioral health, institutional, and inpatient, sixty miles for Minnesota service area;
- Thirty (30) miles for outpatient behavioral health and general hospital services for Minnesota service area

**After-Hours Care**

Quartz wants our members to be able to obtain care or medical advice any time the need arises. Thus, after-hours care is an important service. Members must have access to care during and after normal clinic office hours. Quartz measures after-hours access to ensure members have this access.

All network primary care clinics must have a system in place to ensure that Quartz members have adequate access to care after normal hours of clinic operation. The system should include –

- Providing information to members about how to access care after normal clinic hours
- Describing how the system assists members with gaining access to care after clinic hours and responds to those inquiries
- Describing who is responsible for assuring the system is operational

Quartz procedures for assuring access to primary care clinics are –

1. Quartz will inform members through written communication in the Member Guide on how to obtain information about after-hours care.
2. The clinic must have a telephone answering system or a live person answering after-hours calls. The system must either –
Access Standards

- Have a person on duty to answer specific medical questions and direct care as appropriate, or
- Provide information on how to access care on an immediate basis if needed.

Quartz monitors compliance with this measure through our Monthly Member Satisfaction Survey.
Claims

In 1998, an imaging workflow system was implemented 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 insurance carrier’s explanation of benefits (EOB) form, if applicable.

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

- Include the member’s current person code in the subscriber number field.
- 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 Identifier (NPI) number.
- Indicate the 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.

Dental Claims

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

- Submit only claims for Oral Surgery, Temporomandibular Disorders (TMJ / TMD) and Accident Claims to Quartz.
- Submit all other claims to the member’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 temporomandibular joint disorder (TMJ / TMD), submit this diagnosis code on the claim.
- Whenever possible, do not send photocopies or claims on onion-skin or colored paper.
- Indicate “Pre-treatment Estimate” on the envelope, when applicable.
- Attach the primary insurance’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.
Claims and Coding Policies and Procedures

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

- Include the member’s current person code in the subscriber number field.
- Put all dates of service on one claim form, not to exceed ten lines, when submitting an ADA claim form.
- Submit only one provider of service per claim.
- Include the appropriate National Provider Identification (NPI) number.
- 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.

Medicare Claims

Upon receipt of payment from Medicare for the claim, submit the following to Quartz if the remittance advice does not contact MA07 or MA18 (see Medicare Crossover Section for more details)

- A copy of the Medicare claim as filed with Medicare showing the Quartz subscriber number; AND
- The Explanation of Medicare Benefits (EOMB) form.

The Medicare Remittance Advice

Quartz will reimburse the provider for the Medicare deductible and any other appropriate balances according to the member’s policy.

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 member’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 610
Sauk City, WI 53583-0610

For PPO claims, please submit to –

HealthEOS, by MultiPlan
P.O. Box 6090
De Pere, WI 54115-6090

Questions on the claim submission process should be directed to –

Quartz Customer Service . . . (800) 362-3310

For the hearing impaired:
TTY / TDD: 711 or toll free (800) 877-8973

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.
Claims

Electronic Claims Submission (EDI)
EDI, also known as Electronic Claims Submission, allows medical providers to send and receive health care claims information. Quartz supports all HIPAA-compliant electronic transactions. For more information regarding EDI claim submission / electronic claim payment / Remittance advice (835) along with the list of Quartz compatible trading partners, please go to our website at:

Quartz / Electronic Data Interchange

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. Electronic payments will be electronically deposited into your checking account weekly. This will include a tracing number to allow for easy posting of payments.

For more ETF information, or if you are interested in signing up, EFT forms can be found on the Quartz website at:

Quartz / Electronic Data Interchange

If you have questions regarding this process or need assistance, please contact our EDI Analysts for more information:

Email: EDI@quartzbenefits.com
Phone: (800) 362-3310 (ask for EDI)

Medicare Crossover
If you have questions regarding this process or need assistance, please contact our EDI Analysts for more information.

Quartz coordinates Medicare Part A and Part B claims with CMS through CMS’ Medicare Crossover program. Quartz sends an eligibility file to CMS on a bi-weekly basis (Monday) for all lines of business. Once eligibility is submitted, any claim which meets the selection criteria would crossover to Quartz. Any paid claims will be sent to Quartz after 14 days from the claim receipts has passed, while denied and adjusted claims will be sent to Quartz after CMS has processed the claim.

To determine if a claim has been sent to Quartz, please refer to the CMS remittance advice (RA) for one of the following codes:

- **MA07 Alert:** The claim information has also been forwarded to Medicaid for review.

- **MA18 Alert:** The claim information is also being forwarded to the patient’s supplemental insurer. Send any questions regarding supplemental benefits to them.

- **MA68 Alert:** We did not crossover this claim because the secondary insurance information on the claim was incomplete. Please supply complete information or us the PLAN ID of the insurer to assure correct and timely routing of the claim.

- **N8:** Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication.

Since payment from supplemental insurers should, as a rule, occur only after the Medicare payment has been issued, CMS requests that you do not bill your patients’ supplemental insurers for a minimum of 15 work days after receiving the Medicare payment.

If you have questions regarding this process or need assistance, please contact our EDI Analysts for more information:

Email: EDI@quartzbenefits.com
Phone: (800) 362-3310 (ask for EDI)
**Coordination of Benefits**

Patients may have dual coverage. For example, more than one carrier may be involved or there may be other types of coverage, such as Workers Compensation insurance. To help us determine payment responsibility, please check for the following –

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quartz is the secondary carrier</td>
<td>▪ Submit claim to the primary carrier first.</td>
</tr>
<tr>
<td></td>
<td>▪ After the primary carrier pays, submit claim and Explanation of Benefits (EOB) to Quartz for consideration.</td>
</tr>
<tr>
<td></td>
<td>▪ Quartz will allow up to one year from the date of service, or 30 days from payment or denial by the other carrier, to submit a claim.</td>
</tr>
<tr>
<td>If it is unclear whether Quartz is the primary or secondary carrier, or if Quartz receives an erroneous “primary” carrier claim</td>
<td>▪ Submit the claim to both carriers.</td>
</tr>
<tr>
<td></td>
<td>▪ If review shows Quartz is primary, we will process the claim for benefit determination.</td>
</tr>
<tr>
<td></td>
<td>▪ If review shows Quartz is secondary, we will deny and inform you and the member that Quartz is not the primary carrier and that we must have an EOB from the primary carrier to determine Quartz’s liability.</td>
</tr>
</tbody>
</table>
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 or provider that rendered services.
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 amount 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.
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. Member ID Number
   e. Date of Birth

f. Member 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) 362-3310

Quartz contracted providers cannot attempt to recover from the member the difference between charges and reimbursement, except for copayments, deductibles, coinsurance, and services that are excluded under the member’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 Quartz allowable, or a charge that Quartz does not cover.

The member may be billed for only the “Copayment/Deductible Amount,” “Coinsurance Amount” 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 member may NOT be billed for any of the following –

- “Charges Exceeding Maximum Allowance”
- “Reserve Amounts”
- “Capitated Procedures”
- Procedures that are in the “not-covered” column which have a line description, stating “member 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
Coding Policies and Procedures

Remit Copy Example:

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Vendor</th>
<th>Claim#</th>
<th>Check#</th>
<th>Check Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/28/2018</td>
<td>7:10 PM</td>
<td>EYE CONTACT MEDICAL PT PL</td>
<td></td>
<td>8417507</td>
<td>6/3/15</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Procedure</th>
<th>Date</th>
<th>/BOG</th>
<th>Billed</th>
<th>Allowed</th>
<th>Discount</th>
<th>Withhold</th>
<th>Response</th>
<th>Penalty</th>
<th>Disallow</th>
<th>Net Covered</th>
<th>Excess</th>
<th>Deduct</th>
<th>Copr/Adj</th>
<th>Fat OOP</th>
<th>Adjust</th>
<th>Net Payment</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5/14/15</td>
<td>111.50</td>
<td>57.05</td>
<td>54.45</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>30.00</td>
<td>--</td>
<td>0.00</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>5/14/15</td>
<td>27.50</td>
<td>14.57</td>
<td>12.93</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>--</td>
<td>0.00</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>5/14/15</td>
<td>55.00</td>
<td>44.65</td>
<td>10.35</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>--</td>
<td>0.00</td>
</tr>
<tr>
<td>Claim Totals:</td>
<td></td>
<td>249.00</td>
<td>160.92</td>
<td>88.08</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>41.62</td>
</tr>
</tbody>
</table>

Total for Processed Claims: 389.00

*Code descriptions can be found on the last page of the remit.

Provider responsibility if an authorization is not in place. Patient responsibility if procedure is not covered by their benefit plan.

Capitation dollars.

Provider payment for this claim.

Amounts can be withheld based on a providers contract.

Amount the provider is responsible for. Typically when a claim is denied due to provider error, or no prior authorization for inpatient stays.

Only populated when member has other insurance. It is the difference between the balance due from the patient after primary payment, and the amount Unity is liable for. This amount should be ignored by providers.

Codes' will be found here to explain how claim paid. The most common code is 24, showing the payment is capitated.

Codes' explain how the claim paid.
Coding Policies and Procedures

Recoupment
Quartz’s most common method of claim payment correction is the recoupment process. This means that any amount owed to Quartz will be offset from future payments. All recoupments 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 to Quartz 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 to Quartz.

Example –
A claim was submitted to Quartz and was paid in the amount of $39.43. Quartz then receives notice that the member 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 member 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 to Quartz 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 Quartz benefit plans and provider contracts entitles Quartz to recover from a responsible third party when Quartz pays benefits on behalf of a member. Members and providers must cooperate to assist Quartz in protecting its subrogation rights.

Subrogation efforts will not affect your reimbursement. The intent of subrogation is to secure a recovery from the party responsible for the injuries or illnesses of Quartz members.

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

Quartz used Meridian Resource Company, LLC, (Meridian) to administer subrogation through the end of calendar year 2016. In calendar year 2017 Quartz uses Discovery Health Partners. Discovery or Meridian may contact the provider for needed information.

Three Month Grace
Since January 1, 2014, individuals who purchase their health plan through the Health Insurance Marketplace and receive tax credits to help pay for their premium will have a new three-month grace period when they don’t pay their premium.

If an individual misses a payment, he / she will receive a letter indicating that he / she has entered the grace period. If the premium is paid, within the first month of grace the individual will keep his / her current coverage. If the member doesn’t pay, the member will enter month two of the three-month grace. During months two and three of grace, dental and medical claims will be held until the past due premium owed, is paid. Also, pharmacy claims will not be covered, however individuals may be reimbursed for covered out of pocket pharmacy costs once their premium is paid.

If the full amount of premium owed is paid in full before the end of the third month, then claims will be paid. If premium is not paid, then the individual will lose his / her coverage. Claims in the first month will remain paid; however, all claims in the second and third months will be denied.

Quartz will send a notification to affected providers when we receive a claim for one of their Quartz patients in the second and third month of the grace period. It will let them know that we may deny payment of claims incurred during the second and third months of the grace period.

If you have any questions about the three-month grace period, contact your provider coordinator.
Confidentiality

As required by HIPAA and NCQA, Quartz has developed policies and procedures to protect the confidentiality of member information. Quartz’s Privacy and Security Committee sets standards for some external parties, such as Quartz’s subcontractors. The duties of the Privacy and Security Committee include—

- Overseeing Quartz’s compliance with HIPAA, including internal and external requests for member information.
- Addressing concerns regarding the use of member data for various purposes.
- 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 member information.

General Policy
Quartz’s policies and procedures are designed to safeguard the confidentiality of individually identifiable member 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
Quartz may disclose protected health information without a member’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 member 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 member for marketing purposes.
- Release of certain information to an employer, a family member or a friend.
- Release of information to a personal representative.

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

Disclosure of Information to Employers
Quartz provides certain types of information to employers as part of standard health insurance processes. Disclosure of information to employers (acting as plan sponsors) is limited to summary information and limited information that the employer needs to administer, amend or terminate a health plan. Employers do not have access to explicitly individually-identifiable health information relating to their employees without specific member authorization.
Confidentiality

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 physicians and for some specialists.

Measuring Quality Improvement
Quartz collects data from administrative sources, (e.g., claims and pharmacy data) and medical records to measure quality improvement. Quartz protects member information by ensuring that medical records are reviewed in non-public areas and that reports do not include individually identifiable information.
Coverage

Chartwell Health Resources

Chartwell Health Resources (CHR) contracts with Quartz for medical management and care coordination of home health, home infusion, and respiratory therapy / durable medical equipment (RT / DME) services. Medical management activities include benefit verification, patient needs assessment, patient care set up, authorization of services, provider network development and claims management. The CHR team coordinates care for Quartz members through a statewide network of providers credentialed by CHR. This allows Chartwell to offer patients the best choice for safe care in their local community. If you have questions, please contact Quartz’s Customer Service.

Chartwell Midwest WI Health Resources

Toll-Free  (800) 730-8555
Local  (608) 831-8555
Fax  (608) 664-6193

Durable Medical Equipment (DME) and Medical Supplies

Durable Medical Equipment and medical supplies must be ordered by the Primary Care Physician (PCP) or a referred-to provider and must be obtained from Quartz-participating DME providers if the member has an HMO plan. Members with a Regional PCP (regardless of where they live) will need to contact Chartwell Health Resources for participating provider information. DME items (such as crutches, braces, etc.) dispensed immediately following an outpatient procedure or visit to the Emergency Room, are considered “back cabinet” items and will be reimbursed at the provider’s contractual rate.

Coverage Limitations

DME and medical supplies must be medically necessary and a covered item or service to qualify for coverage. Providers may contact Quartz Customer Service to obtain coverage details.

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 is required for some DME and medical supplies. If Prior Authorization is not obtained, coverage will not be provided. You may contact Quartz Customer Service or go to our website quartzbenefits.com to verify whether Prior Authorization is required. 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 the member.

Coverage Exclusions may include* –

- Equipment and appliances that are not prescribed for the treatment of illness or injury.
- Repairs and replacement of DME (some plans may cover this).
- 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.

*Additional exclusions may apply depending on the member’s certificate of coverage.

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

Home Health Care

Home Health Care is covered when the member requires skilled nursing care that cannot be provided by a family member or other person and, if not provided, would require the member to be hospitalized or placed in a skilled nursing facility. In order for home health care services to be reimbursed, the member must be homebound, the attending physician must submit a treatment plan prior to initiating the care, and must obtain Prior Authorization from the Medical Management Department. HMO members must use Quartz participating providers for home health care services. All Quartz- providers are state licensed or Medicare certified. Point of Service (POS) members, when choosing out-of-network providers, must use a state licensed or Medicare certified home health provider.

You can verify the type of plan and coverage a member has by calling Quartz Customer Service. In most instances, home
Coverage

Health care is limited to 50 visits per benefit year. State of Wisconsin members have 50 visits per calendar year and may be eligible for additional visits per calendar year if medically necessary. One home care visit consists of up to four consecutive hours in a 24-hour period.

Home Infusion Therapy

Quartz encourages 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
- Catheter Maintenance
- Tocolytics

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.

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 you need assistance choosing a contracted Quartz Home Infusion Therapy provider or initiating service, please call the Medical Management staff.

Behavioral Health and Chemical Dependency Benefits

For members with HMO plans, Behavioral Health and AODA Services must be provided by the member’s PCP or a participating behavioral health professional. Members with POS and PPO plans have benefits for services outside of Quartz’s provider network. All inpatient services must be Prior Authorized except for emergency admissions. Emergency admissions require notification within three business days of the admission. Members are asked to contact UW Health – Behavioral Health Care Management for assistance in accessing behavioral health services.

Behavioral Health and AODA Services

For assistance coordinating your behavioral health services, including alcohol and drug treatment services, please contact UW Health – Behavioral Health Care Management at (608) 422-8380 or (800) 683-2300.

Behavioral Health and AODA Benefits for HMO, POS and PPO Members

Service limitations vary by benefit plan. For large and small group plans, including State and Local government participants, Behavioral Health and AODA Benefits are the same as for all other medical conditions, and are subject to deductible, coinsurance and co-payments.

There is no coverage for behavioral / conduct disorders, learning disabilities, and developmental delay (except autism spectrum disorders), and court-ordered treatment that does not otherwise qualify for coverage.

Non-covered services may include:

- Hypnotherapy
- Marriage counseling
- Biofeedback

NOTE: Personal Options is an individual plan. Not all Personal Options members have behavioral health and chemical dependency coverage.

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

Medical Management

Toll-Free (888) 829-5687
Local (608) 821-4200
Fax (608) 821-4207
Coverage

Providers’ hours of operation must not discriminate against BadgerCare Plus members.

Behavioral Health and AODA Services for BadgerCare Plus (Medicaid) members depends on –

- the location of their doctor
- if they have dependent children living with them

To see which clinic to call, refer to the table below

<table>
<thead>
<tr>
<th>Primary Care Physician (PCP)</th>
<th>About the patient</th>
<th>Clinic to call</th>
</tr>
</thead>
<tbody>
<tr>
<td>The PCP is located inside Dane County, but NOT in Cambridge or Mazomanie</td>
<td>You HAVE dependent children living with you OR You are younger than 19 years old</td>
<td>Journey Mental Health (608) 280-2720</td>
</tr>
<tr>
<td>The PCP is located inside Dane County, but NOT in Cambridge or Mazomanie</td>
<td>You DO NOT HAVE dependent children living with you AND You are 19 years or older</td>
<td>Behavioral Health Care Management (800) 683-2300</td>
</tr>
</tbody>
</table>

If the patient’s PCP is located outside of Dane County or in Cambridge or Mazomanie, call Behavioral Health Care Management at (800) 683-2300.

Skilled Nursing Facility (SNF)

Quartz encourages the use of skilled nursing and rehabilitation facilities in lieu of acute hospitalization whenever medically appropriate. Care that can be safely provided in a home or outpatient setting is not considered skilled care. Ongoing confinement in a skilled nursing facility is regularly reviewed as part of the medical management process. Please note that custodial, maintenance or long term care is not a covered benefit.

Coverage applies 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. All SNF admissions require Prior Authorization.

Generally, care that will not be covered is

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

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

Hearing Aid Coverage

Quartz provides coverage for hearing aids in accordance with federally mandated coverage requirements for HMO, Point of Service (POS) and Preferred Provider (PPO) members. Please note this does not apply to members with State and Local Government Plans or BadgerCare Plus plans.

Since April 1, 2014, 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. Participating hearing aid providers must submit both the appropriate code along with the manufacturer and model on the claim for appropriate coverage determination. The approved model list will be updated annually and is available on our website at QuartzBenefits.com/hearingaids.

Effective January 1, 2016, participating hearing aid providers must submit the appropriate code along with the manufacturer model and technology level on the claim for appropriate coverage determination.

Vision Coverage

Coverage for routine / preventive vision exams for fully insured large and small groups and Senior Preferred benefit plans:

- First routine exam of the year will be covered without cost-sharing when submitted with the following diagnosis codes:
Coverage

- Z01.00: Encounter for examination of eyes and vision without abnormal findings or
- Z01.01: Encounter for examination of eyes and vision with abnormal findings
- Comprehensive Eye Exam CPT codes 92004 or 92014

- Subsequent exams will be covered including cost sharing according to medical necessity
- Includes one exam (CPT) code plus / minus a refraction code
- Does not apply to Individual plans, Senior Choice, Medicare Select or BadgerCare Plus plans

NOTE: Please verify coverage at MyPlanTools.com for self-funded plans
Credentialing

Initial Credentialing

Credentialing is an important process Quartz uses to ensure that we offer quality care to our members. Quartz’s credentialing and recredentialing processes follow National Committee for Quality Assurance (NCQA) guidelines for the acceptance, discipline and termination of practitioners based on the practitioner’s education and history.

The Credentialing Committee makes all credentialing and recredentialing decisions. The committee reserves the right to determine, based on a practitioner’s credentials, which health care practitioners are eligible to participate in Quartz’s Network. Practitioners are required to complete the credentialing process, and be approved by the committee, prior to treating Quartz members.

What practitioners are subject to credentialing

- Physicians (MD, DO, DPM, OD)
- Oral Surgeons
- Chiropractors
- Nurse Practitioners and Midwives
  - Iowa NP’s must maintain an Advanced Registered Nurse Practitioner license to practice independently.
  - No additional specific licensure applies, beyond specialty certification for Minnesota NP’s and Midwives
- Behavioral Health (MD, PhD, PsyD, ACADC, APSW, BCBA, CADC, CSAC, LADC, LCSW, LICSW, LISW, LMFT, LMHC, LMSW, LPC, LPCC, MSSW, SAC)

Practitioners who do not need to be credentialed

- Anesthesiologists (unless they provide pain management services)
- Audiologists
- Autism providers
- Behavioral Health In-Training providers
- CRNA
- Dentists (General) and Orthodontics
- Dieticians
- Emergency Room providers
- Genetic Counselors
- Hospice providers
- Locum Tenens
- Pathologists
- Physical Therapists
- Physician Assistants
- Occupational Therapists
- Radiologists (unless they provide Radiation Oncology services or Interventional Radiology services)
- Speech Therapists
- Urgent Care providers

Note: Effective 1/1/2017: Quartz will begin to credential all state licensed behavioral health practitioners. This will include all mid-level behavioral health practitioners previously outside Quartz’s credentialing parameters. When a new practitioner joins your facility, please complete and submit the New Practitioner Form which is found on our website at unityhealth.com.

Chemical dependency counselors must be certified by the International Alcohol and Drug Counselor (I.A.D.C.) if practicing in Iowa. If practicing in Minnesota they must be certified by the Minnesota Department of Health as a L.A.D.C.

Non-Wisconsin providers must meet the certifications and requirements set forth within their state, where applicable.

Effective 7/1/2017, Quartz will credential Nurse Practitioners and Nurse Midwives, according to our credentialing guidelines. Any Nurse Practitioner or Nurse Midwife that you add to your facility after 7/1/17 will be pended in our system until they have completed credentialing. When Provider Services receives the completed form, it will be reviewed and we will contact your office if there are any questions. The information will be forwarded to Quartz’s Credentialing Specialist, who will submit it to Quartz’s primary source verification delegate, Rural Wisconsin Health Cooperative (RWHC) to begin the process. Typically, the credentialing process will take less than 90 days from the time RWHC receives the completed application packet, but it can take up to 180 days.

RWHC will send out a credentialing packet to the practitioner within seven calendar days. If your facility prefers to have the practitioner application sent to a staff member, please indicate this on the New Practitioner Form.

RWHC provides Quartz with daily emails regarding receipt of completed applications. The process RWHC follows is –

- 14 calendar days after the application is mailed, if RWHC has not received the completed application, a second request letter is sent to the individual.
- Seven calendar days after the second request letter is mailed, if RWHC has not received the completed application, a third request letter is sent to the individual.
Credentialing

- Seven calendar days after the third request letter is mailed, if RWHC has not received the completed application, RWHC will inactivate the application.

Notification of each action is provided to the Credentialing Specialist. The Provider Coordinator will assist in asking the individual to return the application in a timely manner, when needed.

When RWHC has completed the verification process, all documentation is provided to the Credentialing Specialist. The completed application is then presented to the Credentialing Committee which meets on a monthly basis. The Credentialing Committee reviews the completed file and either –

(a) accepts,

(b) accepts with restrictions or conditions, or

(c) denies the application.

Within one week of the Credentialing Committee’s decision, an appropriate notification letter is sent to the individual practitioner. Shortly thereafter, the Provider Coordinator notifies the facility that the individual practitioner has been presented to Credentialing Committee, approved and able to see Quartz members.

An appeal process is offered to practitioners who are denied credentialed status. This allows the practitioner an opportunity to clarify or correct the information submitted regarding the practitioner.

Recredentialing

Recredentialing takes place every three years. Practitioners who are due for recredentialing will receive their recredentialing packet from RWHC approximately five to six months in advance. This enables Quartz to complete the process within the required time frames and will prevent termination of Network participation. The same process that is used for credentialing is followed for the recredentialing process.

Practitioner Rights

Practitioners have the right to review the information submitted in support of their credentialing application and to correct erroneous information that was reviewed by the Credentialing Committee. Quartz’s credentialing staff will notify the practitioner of any information obtained during the credentialing process that varies substantially from the information provided to Quartz by the practitioner. The practitioner has up to 30 days to submit corrections to Quartz. The practitioner also has the right to request application status during the credentialing or recredentialing process.

Credentialing Confidentiality Policy

Access to information obtained during the credentialing process will be carefully monitored and will not be released to outside parties without permission of the practitioner involved, or as permitted by law, including the Health Care Quality Improvement Act of 1986.

Access to the credentialing data in Quartz’s provider database is limited to those with “a need to know;” this includes the Credentialing Committee, the credentialing staff and the Quality Relations and Improvement Department staff which may include Quartz’s Medical Director or appropriate network medical directors.

An individual practitioner may request to review the information contained in his / her file (except for information obtained from the National Practitioner Data Bank or peer review sources). To request a review, the practitioner should contact the Credentialing Specialist who will schedule an appointment.

Physician Office Audits

Quartz strives to provide its members with access to quality care. To this end, Quartz may conduct site visits of practitioner offices.

The site visit is a structured review of the quality of key elements of the facility and includes –

- Physical Access and Accessibility
- Waiting, Exam and Restrooms
- Fire and Safety
- Medical Record-Keeping Practices
- Control of Medications
- Policies and Procedures
- Confidentiality
- Infection Control

An audit may be triggered by member complaints. If a member complaint is made regarding clinic physical accessibility, appearance or adequacy of waiting room or exam rooms, the Credentialing Specialist will conduct an on-site audit, using a tool approved by NCQA.
**Credentialing**

If the clinic is found to be deficient in any area, a corrective action plan will be required. The clinic will have the opportunity to make correction and become compliant. The final audit results will be presented to Quartz’s Credentialing Committee.

Quartz will make every effort to assist the facility to achieve compliance. However, if compliance cannot be obtained, the Credentialing Committee may take action, up to and including a recommendation that Quartz terminate its contract with the facility or provider.
Emergency Room and Interpreter Services

Emergency Room
With the exception of life-threatening emergencies, Quartz members should contact their PCP or clinic before seeking treatment.

Definition of “Emergency”
Federal law defines an emergency medical condition as a condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson who has an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention will likely result in any of the following –

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 member is able to receive emergency care from a Quartz network hospital. However, if a member is unable to reach a plan hospital, he / she should go to the nearest hospital emergency room for treatment. Quartz applies the “prudent layperson” standard when determining whether claims for emergency room visits should be covered.

Follow-up Treatment
The PCP should perform or arrange follow-up evaluation and treatment required after emergency care.

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

Hospital Emergency Room Copayment
Most benefit plans require a copayment for using the hospital emergency room. This copayment is waived if the member is admitted as an inpatient to the hospital directly from the emergency room.

Interpreter Services
Quartz has bilingual Customer Service Representatives available to communicate with our Spanish speaking population. Quartz contracts with Pacific Interpreters to provide interpreter services for our members who are not able to communicate in Spanish or English. When Quartz is informed that a member needs such services, a Customer Service team member will connect to Pacific Interpreters; an interpreter will listen to the speaker, analyze the message and convey its original meaning back to the Customer Service team member. The process is repeated until the call is complete.

This service is not available during a patient’s office visit.
Health Management Programs

Quartz has developed Health Management Programs to measure and improve the health status and quality of life of our members. Services include, but are not limited to the following –

- Asthma
- Diabetes

Delegates from UW Health and Gundersen Health System, on behalf of Quartz, communicate with practitioners and members throughout the year regarding evidence-based guidelines, recommended labs and screenings, and self-management tools / resources. Communication channels are most often via Quartz newsletters, paper mailings, Quartz’s website, and electronic messages in Quartz’s provider portal or MyChart.

Quartz’s Health Management Programs are confidential; available to members at no additional cost and participation in the programs is voluntary. Each program provides a variety of services for at-risk members with chronic conditions. The goal is to promote member self-management, and offer resources and support to assist the primary care practitioner in managing their patients’ conditions.

Member 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, and recommended frequency of practitioner visits.
- Annual influenza vaccine reminder.
- Ongoing educational mailings regarding helpful important 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 follow up to members following an inpatient stay or ED visits.
- Condition-specific magazine subscription (diabetes program only).

Copies of the letters and resources sent to our members are on the MyPlanTools portal for your reference.

Practitioner resources and services include –

- Practitioner-specific notification of members recently seen in the ED or hospitalized with a condition-specific diagnosis.
- Periodic reminders regarding missing labs or tests for their patients.
- Information about how to contact Quartz to enroll / remove a member from a health management program is provided on the Quartz website.

Health Coaching

Telephonic health coaching is offered to eligible members identified via claims (post hospitalization) or following completion of a Health Risk Assessment and / or biometric screening event or through self / practitioner referrals.

Health Coaching involves –

- Talking with a coach telephonically and working together to identify strengths, create a plan, and develop action steps / tasks to reach goals; as well as explore potential 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.
- Confidential and free of charge.
- Brief – Three to six telephonic sessions guided by the principles of motivational interviewing.

Preventive and Wellness Services

Quartz provides reminders to members on a variety of preventive health topic services. Reminders are sent to members 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>Postpartum checkup</td>
<td>1 – 3 weeks post-delivery reminder about the need for a postpartum exam between 21 and 56 days</td>
</tr>
<tr>
<td>Immunization – Childhood</td>
<td>10 and 19 months and 12 years</td>
</tr>
</tbody>
</table>
Health Management Programs

<table>
<thead>
<tr>
<th>HPV</th>
<th>Between 1st &amp; 2nd dose Between 2nd &amp; 3rd dose (if applicable) Annual reminder mailing for members who have started, but not yet completed the series.</th>
</tr>
</thead>
<tbody>
<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>Pap &amp; Mammography</td>
<td>Females past due</td>
</tr>
<tr>
<td>Influenza</td>
<td>Annually</td>
</tr>
<tr>
<td>Diabetes lab &amp; screening</td>
<td>Goal of two HbA1c a microalbumin urine, and eye exam each year</td>
</tr>
</tbody>
</table>

Interactive quizzes and educational topics are available on a variety of topics at quartzbenefits.com.

A Quartz wellness program is also available to members. You may learn more at https://unityhealth.com/members/wellness-rewards

To enroll a member in any of these services, or to learn more, call (866) 884-4601

**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.

Quartz encourages health practitioners to use shared decision-making methods with their patients and provides some interactive shared decision-making tools on the unityhealth.com site. Tools are updated frequently and include different health topics as –

- Adolescent & Adult Vaccinations
- Alcohol Abuse & Dependence Screening
- Asthma Control Test
- Breast Cancer Screening
- COPD Screening
- Depression Screening
- Health Decision
- Low Back Pain – Should I Have an MRI?
- Do I need surgery?
- Should I Have Spinal Manipulation?
BadgerCare Program

The next several pages explain Quartz’s BadgerCare Plus services, including care initiatives such as HealthCheck, blood lead testing, immunizations, outreach program, and case management program. Please call Quartz Customer Service at (800) 362-3310 if you have questions about the BadgerCare Plus program that are not answered below.

How can I tell if a Quartz BadgerCare Plus member is subject to copayments?
Ask the member to present their Quartz ID card. The group number the ID card will indicate that the member has Standard Plan benefits and whether the member is subject to copayments.

<table>
<thead>
<tr>
<th>Benefit Plan Name</th>
<th>Benefit Plan Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>QUARTZ BADGERCARE PLUS STANDARD</td>
<td>QUARTZ BADGERCARE PLUS STANDARD W/COPAY</td>
</tr>
<tr>
<td>Group ID</td>
<td>Group ID</td>
</tr>
<tr>
<td>9016162</td>
<td>9016161</td>
</tr>
<tr>
<td>9016164</td>
<td>9016163</td>
</tr>
<tr>
<td>9016166</td>
<td>9016165</td>
</tr>
<tr>
<td>9016168</td>
<td>9016167</td>
</tr>
<tr>
<td>9016170</td>
<td>9016169</td>
</tr>
<tr>
<td>9016172</td>
<td>9016171</td>
</tr>
<tr>
<td>9016173</td>
<td>9016177</td>
</tr>
<tr>
<td>9016174</td>
<td>9016178</td>
</tr>
<tr>
<td>9016175</td>
<td>9016179</td>
</tr>
<tr>
<td>9016176</td>
<td>9016182</td>
</tr>
<tr>
<td>9016180</td>
<td>9016183</td>
</tr>
<tr>
<td>9016181</td>
<td>9016186</td>
</tr>
<tr>
<td>9016184</td>
<td>9016187</td>
</tr>
<tr>
<td>9016185</td>
<td>9016190</td>
</tr>
<tr>
<td>9016188</td>
<td>9016191</td>
</tr>
<tr>
<td>9016189</td>
<td>9016194</td>
</tr>
<tr>
<td>9016192</td>
<td>9016195</td>
</tr>
<tr>
<td>9016193</td>
<td>9016198</td>
</tr>
<tr>
<td>9016196</td>
<td>9016199</td>
</tr>
<tr>
<td>9016197</td>
<td>9016210</td>
</tr>
</tbody>
</table>

How can I tell which Quartz BadgerCare Plus members are assigned to my clinic?
There are two easy ways to identify these members—

- Ask to see the member’s Quartz ID card. Their assigned PCP will be listed on the card.

If you are paid by capitation, review the capitation list that accompanies your cap check. This list identifies the benefit plan number of each member. BadgerCare Plus members have the following benefit plan numbers:

- Standard Plan – 50115, 50116

Claims Submission and Medicaid Certificate
When billing Quartz for BadgerCare Plus members, you must follow the same procedure used when billing the Department of Health Services (DHS) for BadgerCare Plus “Fee for Service” members.

Providers must submit claims with the certified Wisconsin Department of Health Services (DHS) national provider identifier (NPI) and Taxonomy codes. Providers should bill with a DHS certified NPI and Taxonomy code that corresponds to the services being billed. Those providers who have multiple taxonomy codes on file with DHS within their provider enrollment file are required to include their provider taxonomy code along with their NPI and their practice location ZIP + 4 code so the provider can be uniquely identified within our system. If the provider NPI and / or taxonomy code information is missing when required, your claims will be denied.
BadgerCare Plus Program

BadgerCare Plus providers must keep their Medicaid certification up-to-date. Any lapse in certification may result in denial of claims.

Please refer to Appendix A to obtain information on Quartz’s coding policies and procedures. Providers are also required to reference the Forward Health portal, online Medicaid Handbook and Forward Health updates for additional Medicaid guidelines.

A few specific reminders –

- For billing labs, you must be Clinical Laboratory Improvement Amendment (CLIA) certified. Be sure to check that the appropriate modifiers are used for your lab codes. Reference this website www.cms.gov/clia/ for questions.

- Quartz has partnered with Chartwell Health Resources for the management of Home Health and Durable Medical Equipment(DME) services. Please contact Chartwell with questions regarding these services at:
  - CHARTWELL HEALTH RESOURCES
    - (800) 730-8555
    - (608)831-8555

- Bill all Therapy (PT, OT and Speech) services on a CMS 1500 claim form. Refer to ForwardHealth Update 2014-72 for more information

- Bill with a valid NPI and Taxonomy code that is DHS-certified and appropriate for the services being billed. This includes all emergency room and ambulance claims

- Quartz BadgerCare Plus members have Quartz ID cards and can be identified by looking at the network section as identified below

Policy:

Providers are allowed to educate / inform their patients about the BadgerCare Plus and Medicaid SSI HMOs with which they contract.

Providers are allowed to inform their patients of the benefits, services, and specialty care services offered through the HMOs in which they participate.

Providers are allowed to give a patient contact information for a particular HMO, but only at the patient’s request.

Providers are allowed to assist potentially eligible individuals with enrollment in the BadgerCare and / or Medicaid SSI programs by helping them:

- Apply online at the Access website: www.access.wisconsin.gov;

- Complete the online form at: www.dhs.wisconsin.gov/forms/F1/F10182.pdf; or

- Call or go to their county IM agency or tribal agency to complete an application; for a map of the different IM agencies per county, go to: www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm

Providers are allowed to assist potentially eligible individuals with the BadgerCare Plus express enrollment process, as described on the ForwardHealth Portal at www.forwardhealth.wi.gov, if they qualify.

Providers are allowed to refer patients with questions about the BadgerCare Plus and / or Medicaid SSI programs to an HMO Enrollment Specialist at (800) 291-2002.

HMOs are allowed to conduct orientations, health fairs, or community Quartz baby showers for their members in a private setting at a provider’s office.

Providers are prohibited from recommending one HMO over another HMO, offering patients incentives to select one HMO over another HMO, or assisting the patient in deciding to select a specific HMO.

Provider Preventable Conditions

Providers are required to identify provider preventable conditions as a condition of payment. Quartz will not issue payment for provider-preventable conditions.

Health care acquired conditions for non-payment include hospital-acquired conditions as identified by Medicaid other than Deep Vein Thrombosis (DVT) / Pulmonary Embolism (PE) with total knee replacement surgery in pediatric and obstetric patients.
BadgerCare Plus Program

Other provider-preventable conditions for non-payment are identified as:

- Wrong surgical or other invasive procedure performed on a patient;
- Surgical or other invasive procedure performed on the wrong body part;
- Surgical or other invasive procedure performed on the wrong patient.

HealthCheck

If requested, Quartz will send you a list of members who have missed or are due for a HealthCheck visit. If a patient name appears on this report and they have not been seen at your clinic, please inform Quartz Customer Service. We will follow up with the patient to determine if they are being seen at another clinic, or if they currently are not under the care of a physician. We will encourage the patient to choose a PCP and get routine care services.

HealthCheck is Wisconsin’s Early and Periodic Screening Diagnosis and Treatment Program (EPSDT). It is a federally-mandated comprehensive health check-up program for children under 21 years old who are on BadgerCare. Legislation mandates that HMOs achieve an 80 percent HealthCheck screening exam rate.

For more information about HealthCheck Services, please see ForwardHealth Online Handbook: https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Print.aspx?ia=1&p=1&sa-24&s=2&c=61&nt=

HealthCheck Reimbursement

Reimbursement for HealthCheck exams is higher than similar services, such as well-baby or well-child examinations. Laboratory and immunization charges are billed and paid separately from a HealthCheck exam. Therefore, it is important to code these visits correctly.

Frequency of HealthCheck Screenings

A HealthCheck screening should be completed at each of the following ages –

- Birth to First Birthday – One month, two months, four months, six months, nine months and 12 months
- First Birthday to Second Birthday – 15 months, 18 months and 24 months
- Second Birthday to Third Birthday – 30 months and 36 months
- Third Birthday to 21st Birthday – annually

Procedure Codes for HealthCheck Exams

The appropriate codes for a HealthCheck screening are listed below. These are the same as those required by the State of Wisconsin for fee-for-service Medicaid and BadgerCare recipients.

Number of comprehensive screenings completed by age group is identified by the following procedure codes:

CPT-4 Codes: Preventive Medicine Services*

- - 99381 – New patient under one year
- - 99382 – New patient (ages 1 – 4 years)
- - 99383 – New patient (ages 5 – 11 years)
- - 99384 – New patient (ages 12 – 17 years)
- - 99385 – New patient (ages 18 – 39 years)
- - 99391 – Established patient under one year
- - 99392 – Established patient (ages 1 – 4 years)
- - 99393 – Established patient (ages 5 – 11 years)
- - 99394 – Established patient (ages 12 – 17 years)
- - 99395 – Established patient (ages 18 – 39 years)
- - 99460 – Initial hospital or birthing center care for normal newborn infant
- - 99461 – Initial care in other than a hospital or birthing center for normal newborn infant
- - 99463 – Initial hospital or birthing center care of normal newborn infant (admitted/discharged same date)

*These CPT codes do not require use of an ICD-9-CM “V” code or an ICD-10-CM “Z” code.

CPT – 4 codes: Evaluation and Management Codes**

- 99202-99205: New patient
- 99213-99215: Established patient

** These CPT-4 codes must be used in conjunction with:

- ICD-9-CM codes V20-V20.2, V20.3, V20.31 and V20.32 and/or V70.0 and/or V70.3-V70.9
- ICD-10-CM codes:
  - Z76.2 – Encounter for health supervision and care of other healthy infant and child,
  - Z00.121 – Encounter for routine child health examination with abnormal findings,
BadgerCare Plus Program

- Z00.129 – Encounter for routine child health examination without abnormal findings.
- Z00.110 – Health examination for newborn under 8 days old and
- Z00.111 – Health examination for newborn 8 to 28 days old and/or
- Z00.00-01 – Encounter for general adult medical examination without/with abnormal findings and/or
- Z02.0 – Encounter for examination for admission to educational institution,
- Z02.1 – Encounter or pre-employment examination,
- Z02.2 – Encounter for examination for admission to residential institution,
- Z02.3 – Encounter for examination for recruitment to armed forces,
- Z02.4 – Encounter for examination for driving license,
- Z02.5 – Encounter for examination for participation in sport,
- Z02.6 – Encounter for insurance purposes,
- Z02.81 – Encounter for paternity testing,
- Z02.82 – Encounter for adoption services,
- Z02.83 – Encounter for blood-alcohol and blood-drug test,
- Z02.89 – Encounter for other administrative examinations,
- Z00.5 – Encounter for examination of potential donor of organ and tissue,
- Z00.70 – Encounter for examination for period of delayed growth in childhood without abnormal findings,
- Z00.71 – Encounter for examination for period of delayed growth in childhood with abnormal findings.

HealthCheck Components
- A comprehensive health and developmental history (including anticipatory guidance).
- A comprehensive unclothed physical exam.
- An age-appropriate vision screen.
- An age-appropriate hearing screen.
- An oral assessment plus referral to a dentist beginning at age 3.
- Appropriate immunizations (according to age and health history).
- Appropriate laboratory tests (including blood lead level testing when appropriate for age.

CMS (Centers for Medicare and Medicaid Services) requires that all children who are enrolled in Medicaid/BadgerCare Plus receive a blood lead test at about 12 months and again by the second birthday. In addition, children between the ages of 3 and 5 must receive a blood lead test if they have never been tested before.

Quartz reviews data each month to determine the HMO performance rates for HealthCheck exams, blood lead testing and childhood immunizations. There have been instances where blood lead testing and other comprehensive HealthCheck components are missing. Requirements are that a blood lead test be done at age 12 months and again by the second birthday, and that a pure tone audiogram be done annually from age 3 years to 8 years and then every four years up to age 16 years.

* According to the Division of Health Care Access and Accountability, blood lead screening requirements resulted from a court judgment. It is therefore imperative that a blood lead test be performed on all one- and two-year olds, even if they have been identified as low-risk for lead exposure.

The Division of Health Care Access and Accountability recognizes that a pure tone audiogram may not be age-appropriate for all three-year olds.

According to the Division of Health Care Access and Accountability, “... hearing assessment requires documentation of age-appropriate screening. When a child is old enough, pure tone testing should be used. This does not mean an entire audiogram or testing of all possible tones must occur, but instead a screening of tones (often three levels) is adequate. If a problem is suspected based on this screening, the child should be referred for comprehensive hearing testing.”

HealthCheck Prompt

The following HealthCheck prompt is provided for your convenience.

Lead Risk Screening and Blood Lead Test as follows –
Risk assessment at each visit from age six months through 72 months
- Blood lead test at age 12 months and again by the second birthday is a requirement of the Federal Government.
Testing of all children enrolled in ForwardHealth Medicaid/BadgerCare applies regardless of the presence or absence of recognized lead exposure risks.

Providers are required to repeat blood lead testing near age 2, by the second birthday, regardless of the results of the 1-year test.

Children ages 3 to 5 must receive a blood lead test if they have never been tested before.

Follow-up blood test: See CDC guidelines.

Age-Appropriate Hearing Screening for includes –

- Otoscopic exam and / or tympanometric measurement in infancy and early childhood for the detection of chronic or recurrent otitis media.

- Risk Assessment for hearing problems from birth through two years. See ForwardHealth form F-01067 HealthCheck/Your Child’s Speech and Hearing.

- Pure tone audiometric screening as follows –
  - Annually for children age 3 through 8 years, then every four years up to age 16 years.
  - For children older than age eight years with excessive exposure to noise, delayed speech and language development, or who are receiving a HealthCheck screening for the first time.

Health, Nutritional, and Developmental Assessment that includes –

- Health History with a review of patient and family’s health and treatment history.

- Nutritional Assessment with review of patient’s eating pattern / habits.

- Health Education / Anticipatory Guidance including preventive health education. and an explanation of screening findings.

- Developmental Behavioral Assessment, including comparison of observed behavior and attainment of developmental milestones (including emotional status) compared to age-specific norm.

Physical Assessment that includes –

- Unclothed Physical Exam should be a systematic examination of each body system. Blood pressure readings must be taken for all children beginning at age three years.

- Growth Assessment, including height and weight with comparison to age-specific norms – also head circumference comparison to norm up to age two years. Growth assessment includes the calculation of the child’s length to age percentile, weight to length percentile, and head circumference to age percentile.

- Sexual Development Assessment for patients who have reached puberty. The Tanner Sex Maturity Ratings is a useful tool.

Age-appropriate Vision Screening Exam

All children should be observed for –

- Appropriate visual acuity

- Strabismus

- Abnormal disc reflex (under age one year)

- Amblyopia

- Response to cover test

- Color blindness

Use of vision charts must be attempted to measure visual acuity beginning at age four years

Examination of Oral Health that includes –

- An exam sufficient to identify children in need of early exam by a dentist

- Dental referral for children three years or older if not already seeing a dentist
BadgerCare Plus Program

Appropriate Immunizations (according to age and health history)

Other Procedures –
The following procedures should be performed when age, gender, race or other clinical indicators warrant further testing.

- Hemoglobin / Hematocrit
- Urinalysis
- Tuberculin Test
- Pap Smear / Pelvic Exam
- HIV

HealthCheck Outreach Initiatives
Legislation mandates that HMOs achieve an 80 percent HealthCheck physical exam performance rate. Preventive health care services are a priority for Quartz. Therefore Quartz strives to meet the 80 percent mandate and has developed several HealthCheck-related programs (listed below) to increase member awareness and adherence.

- Send HealthCheck information and availability of services to all new BadgerCare Plus Quartz members.
- Offer a HealthCheck incentive program called “Get In and Win.” Members who have had a HealthCheck exam are eligible to win a Walmart gift card.
- Send HealthCheck birthday cards to all members.
- Send HealthCheck proactive screening reminder cards to members at appropriate intervals from ages zero to three years.
- Phone members to remind them about their HealthCheck exam as needed.
- Send letters to members who are due or behind in their HealthCheck services, as needed.
- Send HealthCheck appointment cards, missed appointment and thank you cards to members from information obtained from clinic providers as needed.
- Conduct on-site clinic visits by Quartz staff, educating providers on HealthCheck, components, schedule and coding.
- Provide targeted HealthCheck member lists to clinics and support staff for outreach purposes as needed.

Quartz also supports clinic-sponsored HealthCheck Fairs that have demonstrated marked improvement in the HealthCheck rate. The goal is to make the Clinic HealthCheck Fairs a fun and less threatening medical environment. Clinic personnel see patients that are assigned to them during extended or evening clinic hours and scheduled appointments may not be needed. Quartz coordinates member outreach regarding the fair via phone contact and mailed information. Please contact Quartz’s BadgerCare Plus Outreach Community Liaison / Member Advocate at (800) 362-3310 if you are interested in discussing or scheduling a HealthCheck fair at your clinic.

The Quartz BadgerCare Plus staff is willing to discuss other possible HealthCheck outreach plans with you and your staff. Contact Quartz’s BadgerCare Plus Community Liaison at (800) 362-3310.

Wisconsin Women, Infants and Children (WIC) Nutrition Program

WIC can provide your patients, our members, with nutrition and breastfeeding information, along with nutritious foods at critical periods of growth and development. WIC encourages health care providers to inform families of members who may be eligible for the program.

Services that WIC offers are –

- Nutrition education
- Breastfeeding education and support
- Supplemental nutritious foods and / or infant formula
- Periodic nutrition screening to determine eligibility for WIC
- Immunization screening and referrals for children
- Referrals to other area health and social service programs

Quartz BadgerCare Plus members who are involved in the WIC program may mistake the WIC screening as a complete HealthCheck exam. The WIC screening does not include all of the necessary components of a HealthCheck exam. A Medicaid-certified provider still needs to complete the HealthCheck physical exam.

Your patients may qualify for WIC if they –

- Are pregnant, breastfeeding or new mother
- Are an infant or child up to age five.
- Have a health or nutrition need, as determined by WIC risk criteria.
BadgerCare Plus Program

To locate the WIC office near your patient or for more information, please call (800) 722-2295 (Maternal and Child Health Hotline).

Routine Visits
Routine health care is care that is not urgent or emergency care. Quartz regards routine visits as health care that allows enough lead time to make an appointment. BadgerCare members should choose a primary care provider and get all routine care at their Quartz network provider.

Immunizations / Vaccinations
Immunizations and vaccinations are an integral part of routine care. As a Quartz provider, it’s important that your clinic makes sure these services are available to Quartz’s BadgerCare members. When these services are done within your clinic, you can –

- Track the status of the member’s Immunization Record, and
- Help your patient maintain his / her records.

When outside sources, such as Public Health Departments, give immunizations or vaccinations, you should attempt to obtain that information and include it within the patient’s medical record. Quartz has agreements with Public Health Departments that include language to facilitate this exchange of communication.

Other important considerations for this exchange of communication are –

- Avoiding duplication of services
- Removal of access barriers
- Successful provision of the services to individual recipients

In addition, the State of Wisconsin Department of Health Services (DHS) has developed an immunization registry that Quartz strongly encourages all providers to access. To learn more about the registry, contact Wisconsin Immunization Registry (WIR) at (608) 266-9691, or http://dhfs.wisconsin.gov/immunization/wir.htm.

Quartz BadgerCare Plus Health Outreach Support Staff
Quartz employs dedicated personnel to coordinate services and provide support to our BadgerCare Plus providers and members. Services that the Outreach staff provides include –

- Develop and implement programs to improve access to care.
- Create a strong link between BadgerCare Plus members and providers to increase adherence to clinical care and to assist members in obtaining needed care and screenings.
- Advocate for and assist members with high-risk health care needs.
- Help providers coordinate patient care.
- Educate BadgerCare Plus members and practitioners about HealthCheck exams and other quality care measures.
- Work with members, practitioners and clinic staff to promote early prenatal care and timely postpartum care.
- Enroll pregnant BadgerCare Plus members in 9 Months & More℠ Program as early as possible.
- Instruct and follow-up with clinics to ensure blood lead testing is provided for one- and two-year olds.
- Actively engage and educate our members in our Pay For Performance (P4P) quality health measures –
  - Diabetes – HbA1c Testing and Control
  - High Blood Pressure Control
  - Childhood Immunizations
  - Anti-depressant Medication Management (AMM) – Continuation
  - Breast Cancer Screening
  - Tobacco Cessation Counseling
  - Follow-up After Hospitalization for Mental Health
  - Alcohol and Other Drug Abuse (AODA) – Treatment Engagement
  - Timely Prenatal and Post-partum Care
  - Emergency Department Utilization
  - HealthCheck exam rate
  - Blood Lead Testing rate
- Assist members to receive Behavior Health services as needed.
- Help providers resolve member adherence issues.
- Inform providers about new State BadgerCare Plus programs and initiatives.
BadgerCare Plus Program

If you need assistance working with a Quartz BadgerCare Plus patient, please call Quartz Customer Service at (800) 362-3310 and they will direct you to the appropriate BadgerCare Plus Outreach staff. Quartz serves BadgerCare members in the following 17 counties –

- Buffalo, Columbia, Crawford, Dane, Dodge, Grant, Fond du Lac, Green, Jackson, Jefferson, Juneau, La Crosse, Monroe, Rock, Sauk, Trempealeau, and Vernon

Quartz BadgerCare Plus Complex Case Management

Quartz BadgerCare Plus Complex Case Management service is for members with multiple or complicated medical problems and significant psychosocial problems. Our RN Case Managers and Social Work Case Manager staff –

- Focus on members who have experienced a critical event or diagnosis that requires extensive use of resources.
- Help members access care and resources.
- Address barriers that get in the way of positive health outcomes.
- Support provider care plans and coordinate care.
- Develop and implement case management plans with performance goals, monitoring and follow-up.

The overall goal of Complex Case Management is to help members improve their ability to navigate the healthcare system and improve their self-care management.

If you have a Quartz BadgerCare Plus patient who could qualify for Quartz BadgerCare Plus Complex Case Management services, please call Medical Management at (888) 829-5687.

Transportation to the Clinic for Health Services

BadgerCare Plus members need to contact Medical Transportation Management Inc. (MTM Inc.) for all non-emergency medical rides to see their health care provider for covered services. To schedule rides to an appointment, contact MTM at (866) 907-1493 Monday through Friday between 7 a.m. and 6 p.m.

Members or Providers will need to call at least two days before a routine appointment to schedule a ride. If you cannot call two days before an appointment, you may need to reschedule the appointment. If there is an urgent appointment and the member cannot wait two days to go to an appointment, a ride may be scheduled within three hours. Providers or members should call the “Where’s My Ride” line number at (866) 907-1494 if a ride is more than 15 minutes late.

Providers are able to schedule and cancel rides online. Providers wishing to schedule rides online should call the MTM Inc. facility line or visit the MTM Inc. website at https://www.mtm-inc.net/wisconsin-website/wisconsin-home/ for more information.

To file a complaint with MTM Inc., providers can do one of the following –

- Call MTM Inc’s “We Care” number at (866) 436-0457
- Write to MTM Inc. at the following address – MTM Inc. Quality Management 5117 W Terrace Dr. Ste. 400 Madison WI 53718
- Log a complaint online at https://www.mtm-inc.net/wisconsin-website/wisconsin-home/.

When filing a complaint, providers are required to have the member’s ForwardHealth ID number, name and date of service or the trip number.

Sterilization / Hysterectomy / Abortion Procedures for BadgerCare Plus Members

Prior Authorization

Sterilization and hysterectomy procedures are covered benefits for BadgerCare Plus members. However, a written Prior Authorization request that is approved in advance by Quartz Medical Management is required for these procedures.

Sterilization

For elective sterilization, the Wisconsin Medicaid Sterilization Informed Consent form (HCF 1164) must be fully completed and submitted to Medical Management with the written Prior Authorization request. Please refer to the ForwardHealth Online Handbook to view and download the consent form and instructions. A consent form in Spanish is also available.

Medicaid reimbursement for sterilization is dependent on providers fulfilling all federal and state requirements and

Quartz Provider Manual Revised May 2018 Page 33
satisfactory completion of a Sterilization Informed Consent form, HCF 1164. There are no exceptions.

Federal and state regulations require the following –

- The member is not an institutionalized individual.
- The member is at least 21 years old on the date the informed written consent is obtained.
- The member gives voluntary informed written consent for sterilization.
- The member is not a mentally incompetent individual. Wisconsin Medicaid defines a “mentally incompetent” individual as a person who is declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes that include the ability to consent to sterilization.

At least 30 days, excluding the consent and surgery dates, but not more than 180 days, must pass between the date of written consent and the sterilization date, except in the case of premature delivery or emergency abdominal surgery if –

- In the case of premature delivery, the sterilization is performed at the time of premature delivery and written informed consent was given at least 30 days before the expected date of delivery and at least 72 hours before the premature delivery. The 30 days excludes the consent and surgery dates.
- The sterilization is performed during emergency abdominal surgery and at least 72 hours have passed since the recipient gave written informed consent for sterilizations.

**Hysterectomy**

An Acknowledgment of Receipt of Hysterectomy Information form (HCF 1160) must be completed and submitted with the Prior Authorization request for a hysterectomy procedure to Quartz’s Medical Management Department prior to the surgery. The form is also available in Spanish (F-01160S) and Hmong (F-01160H). Please refer to the ForwardHealth Online Handbook to view and download a form. A 30-day waiting period is enforced before the procedure can be performed.

**Abortion**

In accordance with s. 20.927, Wis. Stats., abortions will be covered for BadgerCare Plus members only when one of the following situations exists –

- The abortion is directly and medically necessary to save the life of the woman, provided that prior to the abortion the physician attests, based on her or his best clinical judgment, that the abortion meets this condition by signing a certification.
- In the case of sexual assault or incest, provided that prior to the abortion, the physician attests to his or her beliefs that sexual assault or incest has occurred, by signing a written certification and provided that the crime has been reported to the law enforcement authorities.
- Due to a medical condition existing prior to the abortion, the physician determines that the abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the woman, provided that prior to the abortion, the physician attests, based on his or her best clinical judgment, that the abortion meets the condition by signing a certification.

Refer to the ForwardHealth Online Handbook for the Abortion Certification Statements form (HCF 1161). This form must be completed and submitted to Quartz’s Medical Management Department with the written prior authorization request for the abortion.
Medical Records

Importance of Medical Records
The medical record communicates the member’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 member receives and may be billed. Sometimes medical records need to be reviewed by Quartz to determine claims payment or approval for 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 member’s medical record be available to the practitioner at the time of the member’s appointment. The confidentiality of the medical record information must be assured.
Members

Member Satisfaction Surveys

Gaining input from our members is important to us. Quartz conducts various member satisfaction surveys. We use survey information to implement initiatives to maintain or improve our members’ level of satisfaction.

Surveys include, but are not limited to –

- Monthly Member Satisfaction Survey – This survey is distributed to a random sample of members who have either incurred a claim or called Quartz Customer Service during the measurement month.
- Consumer Assessment of Health Plan Survey (CAHPS) – The CAHPS survey enables consumers to compare health plans using a similar tool. It is part of the annual NCQA review process.
- New Member Satisfaction Survey – This measures new members’ understanding of Quartz information.

Quartz’s Member Services Committee is responsible for reviewing all satisfaction indicators and recommending interventions to improve member satisfaction. An annual Member Grand Analysis is produced, as a part of the Quality Improvement Program Evaluation, to identify and recommend service improvements.

If you have any questions about Quartz’s service initiatives, please contact us at (800) 362-3309 and ask for the Quality Relations and Improvement Department.

Members’ Rights and Responsibilities

Quartz’s Member Rights and Responsibilities Statement shows our commitment to a mutually respectful relationship with our members and practitioners. This policy assures members that we respect their rights and communicates our expectations of the members’ responsibilities as follows –

**Member Rights:**

**To choose** – Members have the right to choose a personal physician from the Primary Care Physicians (PCPs) who participate in their plan’s provider network.

**To obtain information** – Members have the right to receive information about their rights and responsibilities as a member of Quartz. Members have the right to make recommendations regarding Quartz’s Member Rights and Responsibilities Statement. Members have the right to obtain information about Quartz and information relating to covered and excluded health plan benefits. Members also have the right to obtain information on available primary and specialty care practitioners and providers. Members have the right to receive preventive care information and information about their illness and treatment options. Members have the right to obtain information about how to file a complaint, appeal or grievance.

**To have privacy and confidentiality** – Members have the right to privacy and confidentiality in communications and records about their care.

**To participate in their care** – Members have the right to be active in decisions about their treatments. Members have the right to have a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage. Members have the right to obtain information about the risks and benefits of treatment. Members also have the right to refuse care.

**To present a complaint, appeal or grievance** – Members have the right to voice concerns and to receive a prompt and fair review of their concerns.

**To be treated with respect and dignity** – Members have the right to be treated with respect and dignity regardless of their race, age, gender, sexual orientation or creed.

**Member Responsibilities:**

**To choose a personal physician** – Members have a responsibility to choose a personal physician from the PCPs who participate in their plan’s provider network and to establish a relationship with that physician.

**To know their benefits and requirements** – Members have a responsibility to understand their health plan benefits and limitations and to follow required procedures. Members also have a responsibility to know how to use their plan’s provider network and to ask questions about things they do not understand.

**To provide accurate information** – Members have a responsibility to provide accurate and complete information about their health history, their eligibility and their enrollment. Members have a responsibility to show their ID card each time they receive services and to pay any out-of-pocket expenses they incur.

**To participate in their care** – Members have a responsibility to participate in their care by asking questions about their health. Members also have a responsibility to follow the recommended and agreed upon treatment plan for their illness and to make healthy lifestyle choices to maintain their health or manage their illness.
Members

To keep their appointments – Members have a responsibility to keep their appointments or to give early notice if they must cancel.

To show consideration and respect – Members have a responsibility to show consideration and respect to health plan staff and health care providers.

Members Rights – State of Minnesota

Minnesota 62Q.556

Enrolled Quartz members underwritten by Gundersen Health Plan Minnesota have certain rights Minn.62Q.55 when non-participating provider services are rendered at participating hospitals and facilities;

- Unless the member gives the provider advanced, written consent to use the non-participating provider, the member cannot be held liable for non-participating provider charges and will only be responsible for in-network cost sharing and deductibles;

- If the member did not provide the provider with written consent and receives a bill from a non-participating provider while using an in-network hospital or facility, member should submit the bill to GHP for processing; and

- If they have questions, they should contact GHP customer services for more information.
MyPlanTools™ and NCQA Accreditation

MyPlanTools™

MyPlanTools is a secure, on-line tool that can be used by Quartz providers to perform administrative tasks, including reviewing –

- Patient Eligibility
- Member Demographics
- Creating and Viewing authorizations
- Viewing Remittance Advices
- Claim status and Denial Descriptions
- Summary of Benefits & Coverage
- Benefit Riders
- 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) 362-3310, Monday through Friday, 7:00 a.m. – 5:00 p.m.)

If you would like access to MyPlanTools, please access the:

MyPlanTools Online Access Request Form

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 username and choose Forgot your password. You will be prompted to enter your username again choose the Email Password. A new password will be emailed to you immediately.

NCQA Accreditation

What is NCQA Accreditation?

The National Committee for Quality Assurance (NCQA) is an independent, not-for-profit organization that reviews and accredits health plans. The NCQA accreditation standards establish the principles of continuous quality improvement by looking at an organization’s actual practice patterns over time, in addition to written policies and procedures. NCQA places emphasis on the measurement of quality initiatives and the implementation of opportunities for improvement. It is the expectation that health plans works to identify and pursue quality improvement opportunities in clinical practice and service areas.

Why is NCQA accreditation important?

Health plans are facing increased demands for information about the quality of care provided. NCQA accreditation is a measurable mark of quality within an organization. Some reasons that NCQA accreditation is important include –

- NCQA requirements provide data and information to help Quartz identify areas of opportunity and initiate programs to improve care to your patients, our Quartz members.
- NCQA accreditation requires a fundamental change in organizational culture. Using systematic, data-driven processes to improve our workplace and products says we are a progressive, proactive organization that values our members.
- State and federal governments require review of the effectiveness of quality assurance plans

Maintaining full compliance with all NCQA standards is a high priority for Quartz.

Please visit http://www.ncqa.org/ for information about Quartz’s quality rating and NCQA.
New Medical Technology Evaluation

The health care industry changes rapidly. The medical community develops new medical treatments and procedures on a daily basis. To ensure Quartz members receive the safest and most effective care possible, Quartz reviews and assesses new medical technologies as well as new applications of existing technologies.

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 Quartz member, either you or the member may contact Quartz to initiate the preliminary medical review and obtain information about the process. Quartz benefit plans 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 Quartz policy and Quartz’s certificate of coverage), or 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. Quartz reviews medical policies and published criteria at least annually. Any changes to requirements for prior authorization will be communicated to providers as appropriate. Subsequent medical reviews will take the decision from each request into account when reviewing future requests for coverage and benefits.

Quartz members 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) 362-3310.
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 members and work within the Quartz system to ensure the best possible care for your patients.

**Prescription Drug Formulary**

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

Quartz’s 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 the most cost-effective drugs covered by Quartz. 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 from Quartz 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 by the prescription drug benefit plan. For most members, 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 UW Health Pharmacy Benefit Management Program prior to medication administration in the clinic. These medications are noted on the formulary listing under Medical Benefit Medications (MB) and are also noted on the Quartz Prior Authorization List.

**How is the Formulary Developed?**

Quartz’s Pharmacy & Therapeutics (P&T) Committee is responsible for creating and maintaining the prescription drug formulary. This committee is made up of physicians and pharmacists who care for Quartz members 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 the most 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.

Quartz’s formulary is subject to change at any time. There may be co-pay differences between the various Quartz benefit plans. Some benefit 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 Quartz’s current drug formulary, visit [QuartzBenefits.com/drugformulary](https://www.QuartzBenefits.com/drugformulary). There are multiple formularies listed and vary based on the member’s plan. Most members use the standard or the standard choice formulary listing. The formulary is also available at Surescripts for electronic prescribing systems that connect to the Surescripts hub. Formulary changes are noted on the website.

**Pharmacy Benefit Basics**

In order to meet the wide-ranging needs of the marketplace, Quartz has developed a variety of pharmacy benefits for employers to choose. The employer purchasing the policy 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 Schedule of Benefits 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 and medical services, or it may only count pharmacy costs. In either case, 100 percent of the covered drug costs are paid until the deductible is met. Once the deductible is met, the member pays nothing for covered prescriptions until the end of the benefit year. Deductible amounts with these benefits start at around $1,200 for individuals and $2,000 for families and go up to as much as $10,000 / $20,000.
With deductible requirements, it is important that the member has their pharmacy submit claims on-line to Quartz even though they will be paying 100 percent until the deductible is met. This is important because the member will get a lower negotiated price and the amount the member pays will be applied toward the deductible amount as tracked in our system.

Member 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 patient’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 patient to the pharmacy. 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 Quartz’s benefits are as follows:**

<table>
<thead>
<tr>
<th>Copay Tier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Preferred Generics</td>
</tr>
<tr>
<td>2</td>
<td>Preferred Brands</td>
</tr>
<tr>
<td>3</td>
<td>Non-preferred Brands or Generics</td>
</tr>
<tr>
<td>4</td>
<td>Specialty Medications</td>
</tr>
</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 members depending on what benefit plan the employer purchased, however, the majority of Quartz’s members have a Tier 3 benefit with a copay structure of $10 / $25 / $50, with or without a $100 specialty tier. Other Tier 3 benefits offered by Quartz have copay ranges for Tier 1 of $0 to $10, Tier 2 of $15 to $35 and Tier 3 of $30 to $60. The tier of a medication can be determined by reviewing Quartz’s formulary. Please note that patients with the Three Tier benefit cannot have a Tier 3 copayment reduced to a Tier 2 copayment. Copayment tiers are fixed based on formulary 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 member is required to pay. Coinsurance may range from 0 to 50 percent depending on the benefit. Since the prices of drugs can change, the cost share for that drug may also change from time to time. When the patient 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 will 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 Quartz prescription benefit. Some are covered only under specific circumstances. Categories of non-covered drugs are described below.

**Exclusions** – Some drugs or groups of drugs are excluded from coverage under the Quartz drug benefit. Examples include a drug for cosmetic use or a drug that is classified as a medical food.

**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 Quartz’s formulary.

**Non-preferred drugs** – Some of Quartz’s drug benefits 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. Refer to your patient’s Quartz Prescription Drug Rider to find out if your patient’s benefit requires prior authorization for non-preferred drugs.

**Specialty Pharmaceutical Benefit**

Some employers have purchased a Specialty Pharmaceutical Benefit; this benefit requires the use of the Specialty Pharmaceuticals Program for certain medications, and a $100 copayment per prescription is charged, regardless of the formulary status. Medications included in the Specialty
Pharmacy

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

RX Outcomes Benefit
Some employers have purchased the RX Outcomes benefit; this benefit provides a lower copay for selected medications on a Value Tier that have a greater impact on medical outcomes. Medications included in the Value Tier are in a special category that provides an incentive for staying on therapy by reducing the copayment to $5. Medications in the Value Tier are noted by RXO on the formulary listing, or as listed in Appendix B.

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 specifically on the formulary listing and in Appendix A.

Please note that State of Wisconsin Employees with Quartz medical coverage obtain drug benefits through Navitus Health Solutions and BadgerCare members with Quartz medical coverage obtain drug benefits through the State Medicaid Program; these members do not have drug benefits through Quartz; therefore, the above information does not pertain to State or BadgerCare members. Quartz has no responsibility for the services provided by Navitus or ForwardHealth or the decision to use Navitus or ForwardHealth.

Pharmacy Program Coordination

The UW Health Pharmacy Benefit Management Program (PBMP) coordinates the pharmacy program on behalf of Quartz. The program staff develops and coordinates medication use policy and drug information for Quartz. In addition, the staff provides the Quartz 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 or new FDA indications that are not specifically excluded from coverage are reviewed by staff within 90 days of release to the market or as updated by the FDA.

- A coverage decision will be made by the P&T committee within 180 days of release to the market.
- Practitioners may request 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 indication, the P&T Committee will be appraised of the situation and clinical justification of the delay in 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) for Quartz’s population.
- 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, interactions 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 the review is established. Reviews are assembled by clinical pharmacists from the UW Health Pharmacy Benefit Management Program and consist of a three-stage process. The reviews incorporate biomedical...
evidence from clinical research in the primary literature, FDA documents, expert opinion and established national treatment guidelines to determine the efficacy, safety, compliance implications and cost effectiveness of the medication. Claims data from Quartz’s insured population are used to understand utilization patterns.

Comparisons between the drug being reviewed and existing medications help to determine whether or not it offers a different or better treatment modality and the place in therapy. The cost of the drug is then factored in to try to determine the relative value or the medication as compared to other available therapies.

Based on the review, the Pharmacy Program staff recommends an appropriate formulary status and restriction status for the drug, as well as any applicable prior authorization criteria. The Quartz 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.) For medical benefit medications, a formulary status is not determined by the P&T Committee as the medical benefit does not utilize a formulary. Restriction status, quantity limitations and any prior authorization criteria or other coverage requirements for medical benefit medications may be determined by the P&T Committee.

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 members and providers.

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

- Drugs that are less costly and provide better outcomes than current therapies are preferred.
- Drugs that are more costly and are not better than current products are non-preferred.
- 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 Quartz 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 Quartz cost become considerations.
Medication Prior Authorization

A medication prior authorization request may be started by members, providers or designated representatives via the web, fax, mail, or telephone. Quartz strongly recommends that you, the health care practitioner, initiate the prior authorization request process on behalf of your patient. This is because you will be able to include the medical history necessary for a timely decision to be made based on all of the relevant information.

When a prior authorization request is submitted, there are two types of requests –

1. **Standard** – for a standard request the Medication Prior Authorization Request Form should be completed by the prescriber and submitted online or via fax. We will accept standard request forms from members or their authorized representatives but recommend having the health care practitioner complete the forms as the medical history required to make a timely decision can be more adequately provided. Quartz makes decisions on standard requests within 15 calendar days depending on how quickly the information is received. Notification of the decision will be provided to the requesting provider via fax and member via mail. If the pharmacy fax information is included, the pharmacy will be notified of approvals via fax.

2. **Urgent** – An Urgent Request is defined as a request in a situation when making routine or non-life threatening determination could jeopardize the patient life, health, or safety or of others, due to your psychological state, or in the opinion of the practitioner (as provided in documentation) could put cause the risk of adverse health consequences without the medication being requested being available in an expedited manner.

For an Urgent request, the Medication Prior Authorization Request Form should be completed by the prescriber and submitted online or via fax. We will accept standard request forms from members or their authorized representatives; however the health care practitioner must document the urgent need and include the prescriber’s signature. If the urgent need is not documented and does not contain the prescriber signature, it may be treated as a standard request.

Coverage determination for an urgent request for new medication therapy will be decided within 72 hours unless more information is needed and in which case, the provider will be given an additional 48 hours to respond. Additional information will not be requested if not provided for Exceptions Requests.

Coverage determination for an urgent request for medication the patient is currently taking will be decided within 24 hours. Another option is to file a standard request and use Quartz’s Emergency Drug Supply or New Member Drug Supply to obtain the medications while the review is in process.

**Emergency Drug Supply Policy** – Quartz members can get a five day supply of restricted medication at no copay for emergency or urgent situations in which a prior authorization cannot be obtained, unless a prior authorization was denied within the past month, the medication is excluded, or the medication is in the Quartz Specialty Program (e.g. TNF inhibitors, Hepatitis C medications, Multiple Sclerosis disease-modifying agents). Members, pharmacy staff, and provider staff can call Medimpact Customer Service at (800) 788-2949 to get this authorization. A prior authorization still needs to be submitted for consideration of coverage beyond these five days and a five-day supply does not guarantee continued coverage.

**New Member Drug Supply Policy** – Members who are new to Quartz and are currently taking a restricted medication can get three 1-month fills within the first 90 days of eligibility. Members, pharmacy staff, and providers can call Medimpact Customer Service at (800) 788-2949 to get this authorization. A prior authorization still needs to be submitted and approved for consideration of coverage after the three months.

Send Comments, Questions, or Suggestions to: UW Health Pharmacy Benefit Management Program Staff
Pharmacy

Toll-Free: (888) 450-4884
Fax: (608) 265-7382
Toll-free Fax: (888) 450-4711

Medical Director

Toll-Free: (608) 643-1530
Fax: (608) 643-2564
Practitioner Appeals Process

Quartz is committed to a fair and thorough process for making medical management decisions. To ensure fair decision-making, Quartz invites practitioners to discuss such decisions with the medical director if necessary.

Appealing a Denial of Coverage

When Quartz or one of its medical management teams denies coverage of a service or supply, the member 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 to Monday-Friday during normal business hours. Practitioners may appeal on behalf of a member when coverage of any service is denied or when an adverse determination is rendered. For non-expedited appeals the member must sign an appointment of authorized representative form. This gives the practitioner permission to appeal on behalf of the members. The form can be found at: QuartzBenefits.com/appoint-rep

The Appeal cannot be started until Quartz’s appeals department has this form completed properly with the member’s consent. The process meets all standards of licensure set forth by the State of Wisconsin, State of Minnesota, and the State of Iowa

Minnesota and Iowa members with plans underwritten by Gundersen Health Plan have the option to submit a complaint to the Office of the Commissioner of Insurance in the state of Wisconsin, the Iowa Insurance Division in the state of Iowa, the Department of Health in the state of Minnesota, American Arbitration Association, or an Independent Review Organization. Please contact the Quartz Appeals Specialist for more information.

Expedited Reviews

An expedited review process is available when a delay in decision-making might seriously jeopardize the life or health status of a Quartz member. We provide a decision no later than 72 hours after the request is received. A Quartz member, or practitioner acting on behalf of a member, may request an expedited appeal. The member does not need to sign an appointment of authorized representative form for a practitioner to appeal on behalf of the member in expedited situations. 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 a decision is grieved the following timeline applies –

- The grievance will be acknowledged in a letter to the practitioner and member within five (5) business days of receipt.
- All efforts will be made to resolve the grievance within thirty (30) calendar days of receipt. However, if the grievance cannot be resolved within this time frame due to circumstances beyond Quartz’s control (e.g. medical records are not received from the provider), Wisconsin insurance regulations provide for an additional thirty (30) calendar days within which to resolve the grievance.
- The Appeals Specialist will send the member written notice of the time and place of the Committee meeting at least seven calendar days in advance of the meeting.
- Once the appeal is reviewed by the Grievance Reconsideration Committee, the Appeals Specialist will compose a letter and provide attachments, as appropriate to the member that will contain the decision with the specific reason(s) for the decision, in easily understandable language. This is sent within the 30 – 60 day notification period depending on if an extension had been filed.

For further information regarding the formal appeals process, please contact the appropriate medical management or behavioral health team or Quartz.

Quartz Health Insurance (800) 362-3310
UWMF Case Managers (888) 829-5687
UWBH (800) 683-2300
Pharmacy (888) 450-4884
Product Descriptions

This section of the Provider Manual highlights Quartz’s products and services. It is designed to save you time while providing you with details on Quartz’s products and services. Quartz has several managed health care products available for members –

**Health Maintenance Organization (HMO) Plan**
Quartz provides a variety of HMO plans, including copayment, deductible and coinsurance plans. Members with an HMO plan must select a PCP and obtain all non-emergent health care services through a defined network of practitioners, hospitals and other medical professionals.

**Preferred Provider Organization (PPO) Plan**
Quartz contracts with MultiPlan to offer the HealthEOS and PHCS preferred provider organization networks. HealthEOS providers include hospitals, clinics and physicians throughout Wisconsin. PHCS (MultiPlan) includes providers throughout the United States.

**Point-of-Service (POS) Plan**
POS members must select a participating Quartz PCP; however, they are not required to seek services from or through their PCP. Quartz's POS plan pays benefits at two different levels: In-Plan or Out-of-Plan, depending on the “point” at which the care is accessed.

- **In-Plan** – Member seeks care from PCP or from any participating specialist available to the member based on their PCP selection.
- **Out-of-Plan** – These benefits apply when a member receives medically necessary services from a practitioner / provider who is not part of Quartz’s provider network.

**Medicare Select**
Medicare Select is a managed care product designed to supplement Medicare Part A & Part B. Quartz covers the portion of Medicare-approved benefits that Medicare may not cover. In addition, Medicare Select will pay for some services that Medicare does not cover; for example, routine physicals, eye exams, and hearing exams.

**Individual Health Insurance Plan**
Individual HMO plans offer a variety of different coverage levels for individuals and families who do not have, or are not eligible for, group health insurance through an employer. These plans include those purchased through the Health Insurance Marketplace or directly from Quartz.

Member Identification Cards

Please access this document for the latest ID cards: [QuartzBenefits.com/idcards](http://QuartzBenefits.com/idcards)

**Understanding the Quartz Member Identification Card**
All Quartz subscribers or policyholders receive two individualized Member Identification Cards. The Member 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. For example, a Quartz member’s ID card will indicate “Quartz” in the “Your Network” section of the ID card. Use “Quartz” to search for providers in Find A Doctor.

**Subscriber Number** – The subscriber number is a unique number assigned to each individual subscriber.

**Group Number** – The group number identifies the subscriber’s employer group and is usually the same for all employees and their dependents within that employer group. In a few instances, employees of the same employer will have different group numbers due to different locations and / or benefit coverage.

**Subscriber Name** – Full name of the subscriber.

**Date Printed** – This is the date the ID card was printed. This date is not the date coverage starts. Members should log into MyChart account or contact Customer Service to find out when coverage started. Practitioners may login to MyPlanTools.com for that information.
Promotional Marketing Assistance & Provider Relations

Promotional Marketing Assistance
All marketing materials which reference Quartz Health Solutions require written prior approval by Quartz’s Marketing Department. Quartz’s Marketing Department is available to assist you with the proper use and approval of Quartz’s references in your promotional materials or links from your website.

Marketing activities for plans underwritten by Gundersen Health Plan are strictly regulated by the Office of the Commissioner of Insurance for the State of Wisconsin and the Department of Health for the State of Minnesota.

Please call (608) 821-1105.

Provider Relations

Provider Coordinators
Quartz’s has dedicated Provider Coordinators to service your clinic / facility needs. You can reach your Provider Coordinator by calling (800) 362-3309 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 ensure accurate claims processing, notification to providers and members and continuity of care processes. You can complete a change form at QuartzBenefits.com/providerforms Please notify Quartz as soon as possible of any changes, such as –

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

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 Notification. When Quartz receives the completed form, it will be reviewed and you may be contacted if additional information is needed. If credentialing is required, the form will be forwarded to the Rural Wisconsin Health Cooperative (RWHC), Quartz’s primary source verification delegate, to start the credentialing process. RWHC will mail a credentialing application packet to the contact person listed on the New Practitioner Notification Form.

- Please see the Credentialing Section of the Provider Manual for additional information on Credentialing and Re-credentialing of practitioners.

- In the event that a practitioner leaves your clinic, please notify Quartz with the Practitioner Termination 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. Depending on the type of your new facility, a site visit may be required before Quartz members may receive services at the new location.

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

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

- Practitioner changing name, specialty, degree / credentials.
- Minimal clinic changes – such as a name change, address change (such as adding a suite number).
- Changing a phone or fax number.
- Changing a billing address.

All forms are submitted electronically through our web site.
Promotional Marketing Assistance & Provider Relations

Provider Coordinator Service Area

Provider Coordinators

For assistance, call 800.362.3309 or:

- Cali - 608.881.8232
- Kathy - 608.643.1442
- Laurie - 608.471.4703
  (Includes UW Health / Meriter, Physicians for Women [Mellus - Dane], Wildwood - Dane, DME Labs / Out-of-State)
- Leslie - 608.471.4701
- Tammy - 608.643.1524
  (Includes AGHC-Dane, Associated Physicians - Dane, Journey - Dane, Madison Women’s Health - Dane, Leading Choice)

UH01756 (0218)  Effective February 2018
Quality Management and Population Health

Quartz is committed to the ongoing improvement and evaluation of the quality and safety of medical and behavioral health care services provided to members. Quartz credentials a comprehensive practitioner network that delivers high quality, cost-effective care. The Quartz Quality Management and Population Health (QMPH) department is charged to facilitate this commitment and follows these guiding principles:

- seek to maximize the quality of care and services received by members.
- elicit involvement, input and support from our practitioner network.
- recognize and value preventive health care and health maintenance.
- communicate our efforts to members and actively seek feedback for improving care and services.
- monitor and evaluate the services and care provided to members.
- committed to providing superior service, without discrimination, to all members including those who have special needs and those who are at high risk of developing special needs.
- strive to serve a culturally and linguistically diverse membership efficiently and without discrimination.

The QMPH department is designed to objectively, systematically and continuously monitor, evaluate and improve the delivery of health care and related services provided to members. The goals of the program are listed below.

- Provide high quality, accessible, cost-effective health care, and identify opportunities for improvement in the areas of clinical and behavioral health practice, service, and safety.
- Establish outcome measures to monitor the quality of care members receive. Participate in annual HEDIS® (Healthcare Effectiveness Data and Information Set) data collection and reporting.
- Elicit and support practitioner participation in quality improvement activities and to collaborate with provider organizations to enhance and assist with quality improvement programs.
- Assess member satisfaction through the CAHPS® (Consumer Assessment of Healthcare Providers and Systems) Survey. (CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.)
- Monitor access and availability of practitioner services in collaboration with the Provider Relations (PR) Department.
- Monitor adverse events.
- Promote preventive services and wellness initiatives.
- Identify chronic medical and behavioral health conditions relevant to members and implement Disease Management and Complex Case Management programs for the purpose of monitoring recommended services, supporting self-management skills, and providing disease-specific education.
- Identify opportunities for improvement in the areas of clinical and behavioral health practice, service, and safety.
- Develop or adopt evidence-based clinical practice and preventive care guidelines in collaboration with participating practitioners. Disseminate the guidelines and monitor whether members receive care consistent with the guidelines.
- Identify quality concerns through evaluation of member grievances, complaints, and appeals.
- Ensure confidentiality of patient information and medical records.
- Ensure best practices for medical record documentation.
- Be compliant with all quality improvement activities required by Centers for Medicare & Medicaid Services (CMS), the Department of Health Services (DHS) and state regulatory agencies.
- Implement and maintain programs/interventions that support a National Committee for Quality Assurance (NCQA) rating of “Excellent”.
- Monitor and facilitate continuity and coordination of care between medical and behavioral health care practitioners and providers, and between primary care providers and specialists.
- Continually evaluate the effectiveness of programs/interventions.
Quality Management and Population Health

- Provide superior service without discrimination to all members, including those who have special needs and those who are at high risk of developing special needs.
- Serve a culturally and linguistically diverse membership by performing one or more of the following:
  - Analyze existence of significant health care disparities in clinical areas
  - Use practitioner and provider chart reviews and interviews to understand the differences in care provided and outcomes achieved
  - Conduct patient-focused interventions with culturally competent outreach materials that focus on race/ethnicity/language specific risks
  - Conduct focus groups or key informant interviews with cultural or linguistic minority members to determine how to better meet their needs
  - Identify and reducing a specific health care disparity
  - Provide information, training, and tools to staff and practitioners to support culturally competent communication

At Quartz, we define quality as the degree of adherence to generally recognized standards of medical practice and anticipated outcomes for a service, procedure, diagnosis or clinical condition. Continuous quality improvement involves an organization-wide program to objectively monitor and evaluate the quality and appropriateness of patient care and to resolve identified problems.

Several committees within Quartz work on Quality Improvement (QI) issues. Membership includes Quartz staff, delegates and participating practitioners, and may include representatives from other organizations.

The Board of Directors has ultimate responsibility for the quality of care and services provided to members and for oversight of the QI Program. The Board of Directors delegates primary responsibility for the oversight of the QI Program to the Board Quality Committee.

Board Quality Committee provides oversight and guidance for the QI Program including approving policies, reviewing and evaluating results of QI activities, ensuring appropriate practitioner participation in the QI program, instituting needed actions and ensuring follow-up. The Executive Quality Improvement Committee (EQIC) assures the implementation and ongoing services for utilization management, medical management, behavioral health management, quality improvement, health services, credentialing of affiliates and, where applicable, delegated credentialing activities. EQIC reports up to the Board Quality Committee.

QI Program

Each year, Quartz develops a quality improvement program description and work plan. This plan outlines efforts to improve clinical care and service to our members. We often identify areas for improving clinical services based on annual reviews of health care services, such as immunization rates and cervical and colorectal screening rates. Quartz also evaluates the prevalence of chronic conditions of our members and implements programs to improve their care.

We also identify areas for improving service via surveys and through Quartz Customer Service. Quartz conducts monthly and annual member satisfaction surveys. We document member phone calls, track the information, and use it to identify opportunities to better serve our members.

For more information about our QI Program, including a more detailed report of activities and progress toward goals, please call the Quartz Quality Management and Population Health Quartz department at (866) 884-4601.

HEDIS®

NCQA’s mission is to assess and report the quality of managed care organizations. One of the methods NCQA uses to achieve its mission is the Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS).

*HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA)

A managed care organization is ultimately responsible for the quality of care provided to its members. The information provided by HEDIS helps employers understand the “value” a health plan offers and how to hold a health plan accountable for its performance. An increasing number of employers request HEDIS reports for evaluating cost, quality and for making comparisons among health plans. Currently, the State of Wisconsin mandates HEDIS reporting for managed care organizations that provide coverage to State employees.

Collecting data for HEDIS reports can be challenging. While claims and other pertinent data are collected by the managed care organization, such data is not always complete for accurate reporting, especially for clinical measurements.
Quality Management and Population Health

Often a review of the medical record is needed to provide accurate reporting of performance levels.

To accomplish this, Quartz staff and delegates review medical records at the provider site or requests that practitioners submit information regarding services provided as part of an annual chart audit. This process allows Quartz to obtain and report data that accurately reflects the quality of care offered by its practitioners.

The five major areas of performance measured in HEDIS are—

1. Effectiveness of Care
2. Access and Availability of Care
3. Experience of Care
4. Utilization and Relative Resource Use
5. Health Plan Descriptive Information

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) – CAHPS is a standardized survey performed annually by an NCQA-certified vendor according to the HEDIS® survey protocol. It is designed to capture consumer and patient perspectives on health care quality and access.

If you have any questions about the HEDIS/CAHPS measurement process or Quartz individual results, please contact Quartz at (800) 362-3308 and ask for the Director, Accreditation and Quality Improvement.

Clinical practice guidelines are designed to help practitioners make decisions about appropriate health care for targeted conditions. Quartz adopts evidenced-based clinical practice guidelines through its Quality Improvement Committee. The use of clinical practice guidelines allows Quartz to measure current practices against a guideline and provide feedback to practitioners on gaps that exist between actual practice and recommended care.

Wellness Initiatives

Utilization of preventive health services is monitored through the use of HEDIS measurements in areas such as childhood immunizations; breast, cervical and colorectal cancer screening; prenatal and postpartum care; smoking cessation and screening rates.

Quartz has developed a worksite wellness program with the goal of promoting health and wellness to our members at their worksite. Wellness initiatives include offering health risk assessments (HRAs), and health coaching for individuals at high risk for diabetes, cardiovascular disease or behavior health issues. Additional services include: Lunch & Learn sessions, health fairs, educational materials and table top displays. Members are encouraged to share their HRA results with their practitioner.

Continuity & Coordination of Care

Quartz expects specialty care providers, as well as hospitals, skilled nursing facilities, home health agencies, and ambulatory surgical centers that provide care to our members to communicate with the member’s Primary Care Physician (PCP). All medical and behavioral health practitioners play a role in providing continuous, quality care in an efficient, cost-effective manner. The role of the PCP is to know the patient’s medical history and coordinate all their medical needs, as well as to be aware of the specialty care received by patients, including behavioral health treatment.

Quartz actively works to improve communication between the primary care practitioners and all medical, surgical and behavioral health consultants, hospitals, skilled nursing facilities, home health agencies, and ambulatory surgical centers. Feedback obtained from practitioners via the annual practitioner survey helps Quartz focus these communication improvement efforts.

Patient Safety

Quartz has a patient safety program with the goal of fostering a supportive environment to provide quality patient health care through reduction in avoidable medical errors. Quartz encourages and endorses patient safety initiatives.

Quartz’s Patient Safety Objectives

- Support of an ongoing collaboration with participating health care practitioners and facilities to encourage and endorse external patient safety activities.
- Work with external accrediting agencies toward a safe healthcare system.
- Encourage participation in national and local collaborative efforts to encourage safe practices; and
- Educate practitioners and members about safe practices.

Resources Available

Resources are available to you for information and to assist in the continuation of safe practices. Quartz encourages and endorses all participating practitioners and providers to be
familiar with and actively participate in patient safety practices.

The following organizations have active programs and materials that you may find useful –

http://myhealthwi.org
MyHealthWI.org is a tool to help patients find doctors in your area who are right for patients and their families. It also offers information and resources to help patients play a more active role in their health care. MyHealthWI.org is supported by the Wisconsin Health Information Organization (WHIO).

wchq.org
Wisconsin Collaborative for Healthcare Quality (WCHQ) publicly reports and brings meaning to performance measurement information that improves the quality and affordability of healthcare in Wisconsin. WCHQ builds consensus and drives improvement by practicing these values: trust, participation, inclusiveness, shared responsibility, openness, adaptive self-governance, intellectual output, acknowledgement, and transparency. WCHQ is a multi-stakeholder, voluntary consortium of Wisconsin organizations. WCHQ draws its membership from health systems, medical groups, hospitals and health plans.

wicheckpoint.org
A subsidiary of the Wisconsin Hospital Association, the WHA Information Center is dedicated to collecting and providing information about services provided by Wisconsin hospitals.

metastar.com
MetaStar, as part of the Centers for Medicare & Medicaid Services national quality improvement program, partnering WHITEC, physicians, patients and the community to improve rates of immunizations and cancer screenings and improve outpatient cardiovascular care. For additional information, see http://www.metastar.com/services/meaningful-use-consulting/healthitextension/.

IHI Triple Aim

The IHI Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance where new designs must be developed to simultaneously pursue three dimensions, called the “Triple Aim” –

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

Contact
Quartz has many resources to help and encourage you to adopt safe practices at your facility. For more information, please contact (608) 821-4991 or email patientsafety@quartzbenefits.com
Complex Case Management

Using the health care system can be confusing, especially for patients with many health-related needs. That is why Quartz offers a service called Complex Case Management. The goal of Complex Case Management is to work closely with members to coordinate healthcare services and resources to make sure these members get the best care possible.

How does Complex Case Management work?
A registered nurse and/or social service case manager works with members and / or caregivers who are eligible for these services. The case manager helps members by:

- coordinating care between multiple health care providers
- assisting in identification of personal health goals
- explaining health care benefits
- providing education about health conditions
- finding support groups or programs that may be helpful

Who is eligible?
This program is for Quartz members who have experienced:

- multiple medical conditions and / or trauma
- multiple hospital or emergency room visits
- health conditions that are high-cost or high risk

Is there a fee to participate?
No. Our services and materials are provided at no cost to eligible members.

Would you like to learn more or enroll a Quartz member in Complex Case Management?
Call Quartz's Complex Case Management at (608) 422-5444 or customer service at (800) 362-3309.
Referrals

Quartz requires all members to choose a Primary Care Physician (PCP). The PCP is responsible for providing primary care services and for coordinating health care needs. In most cases, the PCP can provide the medical care needed; however, when necessary, the PCP will refer a member to a participating Quartz specialist for specialty care. Quartz does 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 all out-of-plan requests (for HMO members) require Prior Authorization (see section below on Prior Authorization). If you require further clarification, please contact Quartz Customer Service at (800) 362-3310.

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 must complete a Prior Authorization Request Form. This request must be submitted to and approved by Quartz 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 require Prior Authorization. The provider requesting the service must obtain approval from Quartz 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. Please note that if the required prior authorization is not obtained and you provide the service, those services will be denied as provider liability and the member may not be billed. If an approved prior authorization is not obtained for a member to obtain services out of network, the member could be held financially responsible for those charges.

Note: Quartz will not approve retrospective prior authorizations received later than six months after the service has been provided.

If you have specific questions about Prior Authorization or would like to submit a written Prior Authorization Request Form, please contact –

Medical Management
Toll-Free (888) 829-5687
Local (608) 821-4200
Fax (608) 821-4207

Behavioral Health Care Management
Toll-Free (800) 683-2300
Local (608) 422-8380
Fax (608) 422-8381

Chartwell Midwest WI Health Resources
(Durable Medical Equipment and supplies)
Toll-Free (800) 730-8555
Local (608) 831-8555
Fax (608) 664-6193
Utilization Management

Medical and Behavioral Health Management

The health care industry recognizes that the best 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 the best medical care in the most efficient and economical manner. Quartz uses a variety of processes to evaluate the utilization and quality of health care services provided to Quartz members. Quartz has medical management and behavioral health departments who perform utilization management functions.

All Quartz members are managed by -

- Medical Management: UW Health & Gundersen Health System
- The UW Health Pharmacy Benefit Management
- Behavioral Health: UW Health – Behavioral Health Care Management
- For AODA Management: UW Health – Behavioral Health Care Management

Services for BadgerCare (Medicaid) members depends on the location of their doctor and if they have dependent children living with them.

Information regarding which clinic department to call can be found within the Coverage Section.

The UW Health Pharmacy Benefit Management Program offers comprehensive pharmacy services for all members receiving prescription benefit coverage through Quartz. Additionally, medication utilization management services are provided for selected medications covered under the medical benefit for all members. The UW Health Pharmacy Benefit Management Program uses internally derived criteria specific to each individual drug requiring prior authorization. The criteria are developed, approved and adopted by a committee of pharmacists and physicians from Quartz’s provider network.

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 InterQual criteria for inpatient care.

Decisions are also made based on UW Health policies and procedures. Behavioral Health Care Management also utilizes InterQual for all Behavioral Health and AODA services which require a prior authorization.

The InterQual criteria are a set of clinical practice benchmarks for treating common conditions. They describe the most 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 Medical Policies
  - The Member’s Benefits Certificate

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 to ensure appropriate utilization and prevent inappropriate denials. In addition, Quartz’s Utilization Management / Technology Assessment Committee (UM / TAC) consists of plan physicians who oversee UM activities including assessments of new technology and new applications of existing technology.

Quartz does not provide financial incentives based on utilization management denials / decisions. All UM decision making is based solely on appropriateness of care and service. Quartz does not offer incentives to encourage inappropriate underutilization, nor does it provide rewards for issuing denials.

Quartz is committed to a fair and thorough process for making utilization decisions. As a practitioner, you may
Utilization Management

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, at the numbers noted below.

For utilization management inquiries, assistance or to request a free copy of UM criteria, please contact the medical, behavioral health or pharmacy management personnel. Staff is available weekdays during normal business hours (8 a.m. to 5 p.m.). UM staff can also receive inbound communication after normal business hours. Physician-to-physician or pharmacist consultation is available to discuss medical necessity determinations.

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. A toll-free number is also available to accept and address any concerns.

Medical Management
(888) 829-5687

UW Health – Behavioral Health Care Management
(800) 683-2300

Quartz Health Insurance
(800) 362-3309

Quartz provides utilization management for Chiropractic care (800) 362-3310

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

Hospital Admissions Policy
When arranging for an elective hospital admission, remember that all Quartz members must be admitted to a participating hospital. Exceptions are emergencies, or when the member has a point-of-service (POS) product and has benefits for medical care services outside of Quartz’s provider network. For HMO members, 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
Quartz requires notification of all inpatient hospital admissions of its members. This requirement applies when Quartz is considered the primary insurer, secondary insurer, or insurance is supplementary to Medicare. Notifications can be made via our toll-free numbers –

Quartz Health Insurance
(800) 362-3310

Medical Management
(888) 829-5687

Behavioral Health Care Management
(800) 683-2300

Prior Authorization
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 sanctions to the admitting physician / provider.

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

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

Concurrent Review
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.
Utilization Management

**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, Quartz authorizes longer stays based on medical necessity. We will authorize inpatient days whenever standard intensity and severity criteria for medical necessity exist. At times, Quartz will require attending physician input 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.
### Who to Contact

Quartz hours of operation are 7 a.m. to 7 p.m., Monday through Friday.

<table>
<thead>
<tr>
<th><strong>Quartz</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Customer Service</strong></td>
</tr>
<tr>
<td><strong>Hearing impaired</strong></td>
</tr>
<tr>
<td><strong>General Information</strong></td>
</tr>
<tr>
<td><strong>Web site</strong></td>
</tr>
<tr>
<td><strong>Email</strong></td>
</tr>
<tr>
<td><strong>Claims Submission Address and Correspondence:</strong> Quartz P.O. Box 610 Sauk City, WI 53583-1374</td>
</tr>
<tr>
<td><strong>Customer Service</strong></td>
</tr>
<tr>
<td><strong>Hearing impaired</strong></td>
</tr>
<tr>
<td><strong>General Information</strong></td>
</tr>
<tr>
<td><strong>Web site</strong></td>
</tr>
</tbody>
</table>

### Electronic Submission of Claims

| **ClaimLogic** | (405) 942-9800 |
| **Netwerkes** | (800) 765-6713 |
| **PayerPath** | (877) 347-6691 |
| **SSI Group** | (800) 880-3032 |
| **G and C Clearing House** | (888) 456-9707 |
| **Healthcare Data Systems** | (800) 486-2273 |
| **CPSI** | (251) 662-4078 |
| **ClaimLogic** | (405) 942-9800 |
| **Viatrack** | (800) 426-3385 |
| **Health Claims Services** | (608) 831-1563 |
| **Outsource Inc** | (262) 544-4442 |

### Behavioral Health Care Management:

<table>
<thead>
<tr>
<th><strong>Journey Mental Health – Dane County BadgerCare Plus Members – Behavioral Health and Chemical Dependency</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Local</strong></td>
</tr>
<tr>
<td><strong>Fax</strong></td>
</tr>
</tbody>
</table>

### UW Patient Resources / Welcome Center

<table>
<thead>
<tr>
<th><strong>UW Health Services Department (UWMF)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Toll-free</strong></td>
</tr>
<tr>
<td><strong>Local</strong></td>
</tr>
<tr>
<td><strong>Fax</strong></td>
</tr>
</tbody>
</table>

### Pharmacy Director

<table>
<thead>
<tr>
<th><strong>Medical Management</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Local</strong></td>
</tr>
<tr>
<td><strong>Fax</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Marketing and Use of Quartz’s Promotional Materials</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Local</strong></td>
</tr>
</tbody>
</table>
# Appendix A Coding and Reimbursement Policies

<table>
<thead>
<tr>
<th>Policy Name</th>
<th>Last Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Coding Applications</td>
<td>April 2015</td>
</tr>
<tr>
<td>Adaptive Behavior Treatment &amp; Assessment</td>
<td>May 2017</td>
</tr>
<tr>
<td>Add-on Codes</td>
<td>April 2017</td>
</tr>
<tr>
<td>Anesthesia Care</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>April 2015</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 51 – Multiple Procedures</td>
<td>April 2015</td>
</tr>
<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 59, XE, XP, XS, XU – Distinct Procedural Service</td>
<td>August 2016</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>
</tr>
<tr>
<td>Modifier 66 – Surgical Team</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier 73 – Discontinued Out-Patient Hospital/ASC Prior to Anesthesia</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier 74 – Discontinued Out-Patient Hospital/ASC After Anesthesia</td>
<td>April 2015</td>
</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>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier 78 – Unplanned Return to Operating or Procedure Room</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier 79 – Unrelated Procedure or Service During Post Op Period</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier 80 – Assistant Surgeon</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier 81 – Minimum Assistant Surgeon</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier 82 – Assistant Surgeon – Qualified Resident Not Available</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier 91 – Repeat Clinical Diagnostic Laboratory Test</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier AA – Anesthesia Services Performed By Anesthesiologists</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier AD, QK, QY – Medical Supervision, Direction by Physician</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier AJ – Clinical Social Worker</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier AS – Non-Physician Assistant Surgeon</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier AT – Chiropractic Acute Treatment</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier P – Anesthesia Physical Status</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier QE, QF, QG – Prescribed Amount of Oxygen</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier QX, QZ – CRNA Service W/Without Medical Direction</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier RT/LT – Bilateral Procedure</td>
<td>April 2015</td>
</tr>
<tr>
<td>Modifier SZ – Habilitative Services</td>
<td>August 2016</td>
</tr>
</tbody>
</table>
General Coding Applications Policy and Procedure

Last Revision/Review Date: 4/1/2015

Organization and Associated Product Lines

<table>
<thead>
<tr>
<th>Organization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ Unity Health Plans Insurance Corporation</td>
</tr>
<tr>
<td>Product Lines:</td>
</tr>
<tr>
<td>☑ All Lines</td>
</tr>
<tr>
<td>☑ Medicare Supplement</td>
</tr>
<tr>
<td>☐ HMO</td>
</tr>
<tr>
<td>☐ Medicaid Suppport</td>
</tr>
<tr>
<td>☐ Individual Exchange</td>
</tr>
<tr>
<td>☐ Individual Non-Exchange</td>
</tr>
<tr>
<td>☑ PPO</td>
</tr>
<tr>
<td>☑ POS</td>
</tr>
<tr>
<td>☐ UWA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Organization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ Quartz ASO</td>
</tr>
<tr>
<td>Product Lines:</td>
</tr>
<tr>
<td>☑ TPA</td>
</tr>
</tbody>
</table>

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 on 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**

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>09-09-2013</td>
<td>Revision</td>
<td>Manager, Claims Coding and Compliance Manager</td>
<td>10-11-2013</td>
</tr>
<tr>
<td>2</td>
<td>06-01-2014</td>
<td>Revision</td>
<td>Manager, Claims Coding and Compliance Manager</td>
<td>06-01-2014</td>
</tr>
<tr>
<td>3</td>
<td>04-1-2015</td>
<td>Revision</td>
<td>Manager, Claims Coding and Compliance Manager</td>
<td>04-1-2015</td>
</tr>
</tbody>
</table>

NOTE:
Organization and Associated Product Lines

<table>
<thead>
<tr>
<th>Organization:</th>
<th>Organization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ Quartz Health Solutions</td>
<td>✔ Quartz ASO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product Lines:</th>
<th>Product Lines:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ All Lines</td>
<td>☐ HMO</td>
</tr>
<tr>
<td>☐ Medicare Supplement</td>
<td>☐ Medicaid</td>
</tr>
<tr>
<td>☐ Exchange</td>
<td>☐ Non-Exchange</td>
</tr>
<tr>
<td>☐ TPA</td>
<td></td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>Document Owner:</th>
<th>Manager, Special Investigation Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document Location:</td>
<td>Adaptive Behavioral Treatment.doc</td>
</tr>
<tr>
<td>Next Review:</td>
<td>March 1, 2018</td>
</tr>
</tbody>
</table>
Adaptive Behavior Treatment & Assessment Policy & Procedure
Last Revision/Review Date: 03/01/2017

<table>
<thead>
<tr>
<th>Description of Change(s) (Created, Reviewed/Revised or Approved)</th>
<th>Name, Title or Committee</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creation</td>
<td>Manager, Special Investigation Unit</td>
<td>3/1/2017</td>
</tr>
<tr>
<td>Reviewed/Revised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approved</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Organization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unity Health Plans Insurance Corporation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product Lines:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ All lines  ☐ HMO  ☐ PPO  ☐ POS  ☐ UWA</td>
</tr>
<tr>
<td>☐ Medicare Supplement  ☐ Medicaid  ☐ Individual Exchange  ☐ Individual Non-Exchange</td>
</tr>
</tbody>
</table>

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.
Add-on Codes
Policy and Procedure
Last Revision/Review Date: 4/1/2015

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.
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

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>4</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

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 Supplement ☐ Medicaid ☐ Individual ☐ 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 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.
Anesthesia Care
Policy and Procedure
Last Revision/Review Date: 4/1/2015

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

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>2</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>3</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

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
### Document Logistics & Revision History

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>2</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>3</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claims Coding and Compliance Manager</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

**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.
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

**Document Logistics & Revision History**

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>11-1-2013</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>12-1-2013</td>
</tr>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

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

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.
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
Document Owner: Manager, Claim Coding and Compliance
Document Location: Claims: Coding Policies and Procedures

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>2</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>3</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

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

Organization and Associated Product Lines

Organization:
- Quartz Health Solutions

Product Lines:
- All Lines

Organization:
- Quartz ASO

Product Lines:
- TPA

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)
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
Document Owner: Manager, Special Investigation Unit
Document Location: Modifier 22 (3).doc 2-10-2017.doc

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>11-1-2013</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>11-1-2014</td>
</tr>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
<tr>
<td>4</td>
<td>4-1-2017</td>
<td>Revision</td>
<td>Manager, Special Investigation Unit</td>
<td>4-1-2017</td>
</tr>
</tbody>
</table>

NOTE:
Modifier 23 – Unusual Anesthesia
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Organization and Associated Product Lines

- Unity Health Plans Insurance Corporation

Product Lines:
- All lines
- 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 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.
Modifier 23 – Unusual Anesthesia
Policy and Procedure
Last Revision/Review Date: 4/1/2015

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**

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>7-1-2014</td>
</tr>
<tr>
<td>2</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>3</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

**NOTE:**
Modifier 25 – Significant, Separately Identifiable E&M 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 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.

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

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 25 – Significant, Separately Identifiable E&M Policy and Procedure
Last Revision/Review Date: 4/1/2015

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.
**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**

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>7-1-2014</td>
</tr>
<tr>
<td>2</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>3</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

**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 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.
Modifier 50 – Bilateral Procedure
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 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

Document Logistics & Revision History

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>4</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

NOTE:
Modifier 51 – Multiple Procedures
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 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 curettetment) 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.
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

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**

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>8-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>8-1-2014</td>
</tr>
<tr>
<td>4</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>5</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

NOTE:
Modifier 52 – Reduced Service 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 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.
Modifier 52 – Reduced Service
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**
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).
Modifier 52 – Reduced Service
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

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>4</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

NOTE:
Modifier 53 – Discontinued Procedure
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Organization and Associated Product Lines

<table>
<thead>
<tr>
<th>Organization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ Unity Health Plans Insurance Corporation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product Lines:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ All lines</td>
</tr>
<tr>
<td>☐ HMO</td>
</tr>
<tr>
<td>☐ PPO</td>
</tr>
<tr>
<td>☐ POS</td>
</tr>
<tr>
<td>☐ UWA</td>
</tr>
<tr>
<td>☐ Medicare Supplement</td>
</tr>
<tr>
<td>☐ Medicaid</td>
</tr>
<tr>
<td>☐ Individual Exchange</td>
</tr>
<tr>
<td>☐ Individual Non-Exchange</td>
</tr>
</tbody>
</table>

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.
Modifier 53 – Discontinued Procedure
Policy and Procedure
Last Revision/Review Date: 4/1/2015

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

Document Logistics & Revision History

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>4</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

NOTE:
Modifier 54 – Surgical Care 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 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 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

Document Logistics & Revision History

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>4</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

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

**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.
Modifier 55 – Post Operative Management Only
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 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

**Document Logistics & Revision History**

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>4</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

**NOTE:**
Modifier 56 – Pre Operative Management Only
Policy and Procedure
Last Revision/Review Date: 4/1/2015

**Organization and Associated Product Lines**

<table>
<thead>
<tr>
<th>Organization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unity Health Plans Insurance Corporation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product Lines:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ All lines ☐ HMO ☐ PPO ☐ POS ☐ UWA</td>
</tr>
<tr>
<td>☐ Medicare Supplement ☐ Medicaid ☐ Individual Exchange ☐ Individual Non-Exchange</td>
</tr>
</tbody>
</table>

**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

_Document Logistics & Revision History_

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>4</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

_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.
Modifier 57 – Decision for Surgery
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

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>7-1-2014</td>
</tr>
<tr>
<td>2</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>3</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Organization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unity Health Plans Insurance Corporation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product Lines:</th>
</tr>
</thead>
<tbody>
<tr>
<td>All lines</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>4</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

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
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**

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9-9-2013</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-11-2013</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
<tr>
<td>4</td>
<td>8-26-2016</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>8-26-2016</td>
</tr>
</tbody>
</table>

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

Organization and Associated Product Lines

<table>
<thead>
<tr>
<th>Organization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unity Health Plans Insurance Corporation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product Lines:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ All lines</td>
</tr>
<tr>
<td>☑ Medicare Supplement</td>
</tr>
</tbody>
</table>

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 procedure(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. A
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 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 62 – Two Surgeons, Co-Surgery  
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 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**

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9-9-2013</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-11-2013</td>
</tr>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

**NOTE:**
Modifier 63 – Procedure Performed on Infant Less Than 4kgs
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Organization and Associated Product Lines

<table>
<thead>
<tr>
<th>Organization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unity Health Plans Insurance Corporation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product Lines:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ All lines</td>
</tr>
<tr>
<td>☐ HMO</td>
</tr>
<tr>
<td>☐ PPO</td>
</tr>
<tr>
<td>☐ POS</td>
</tr>
<tr>
<td>☐ UWA</td>
</tr>
<tr>
<td>☐ Medicare Supplement</td>
</tr>
<tr>
<td>☐ Medicaid</td>
</tr>
<tr>
<td>☐ Individual Exchange</td>
</tr>
<tr>
<td>☐ Individual Non-Exchange</td>
</tr>
</tbody>
</table>

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.
Modifier 63 – Procedure Performed on Infant Less Than 4kgs
Policy and Procedure
Last Revision/Review Date: 4/1/2015

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).
Modifier 63 – Procedure Performed on Infant Less Than 4kgs
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

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>4</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

NOTE:

Policy and Procedure Form Version 1 – 4-1-2015
Modifier 66 – Surgical Team
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Organization and Associated Product Lines

<table>
<thead>
<tr>
<th>Organization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ Unity Health Plans Insurance Corporation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product Lines:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ All lines</td>
</tr>
<tr>
<td>☐ Medicare Supplement</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>4</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

NOTE:
 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

Organization and Associated Product Lines

<table>
<thead>
<tr>
<th>Organization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ Unity Health Plans Insurance Corporation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product Lines:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ All lines</td>
</tr>
<tr>
<td>☑ Medicare</td>
</tr>
<tr>
<td>☑ Medicaid</td>
</tr>
<tr>
<td>☑ Individual</td>
</tr>
<tr>
<td>☑ Exchange</td>
</tr>
<tr>
<td>☑ Individual</td>
</tr>
<tr>
<td>☑ Non-Exchange</td>
</tr>
</tbody>
</table>

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.
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

**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

**Document Logistics & Revision History**

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-1-2014</td>
</tr>
<tr>
<td>4</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>
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

**Organization and Associated Product Lines**

<table>
<thead>
<tr>
<th>Organization:</th>
<th>□ Unity Health Plans Insurance Corporation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Product Lines:</td>
<td>□ All lines □ HMO □ PPO □ POS □ UWA</td>
</tr>
<tr>
<td></td>
<td>□ Medicare Supplement □ Medicaid □ Individual Exchange □ Individual Non-Exchange</td>
</tr>
</tbody>
</table>

**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

**Document Logistics & Revision History**

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>4</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

**NOTE:**
Modifier 76 and Modifier 77 Repeat Procedure or Service
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 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 willperiodically 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**

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>11-11-2014</td>
<td>Initial</td>
<td>Manager, Claim Coding and Compliance</td>
<td>11-11-2014</td>
</tr>
<tr>
<td>2</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

Note:
Modifier 78 – Unplanned Return to Operating or Procedure Room
Policy and Procedure
Last Revision/Review Date: 4/1/2015

**Organization and Associated Product Lines**

<table>
<thead>
<tr>
<th>Organization:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ Unity Health Plans Insurance Corporation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product Lines:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ All lines</td>
<td>☐ HMO</td>
</tr>
</tbody>
</table>

**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

Document Logistics & Revision History

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>4</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Organization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unity Health Plans Insurance Corporation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product Lines:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ All lines</td>
</tr>
<tr>
<td>☐ Medicare</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>11-14-2014</td>
<td>Initial</td>
<td>Manager, Claim Coding and Compliance</td>
<td>11-14-2014</td>
</tr>
<tr>
<td>2</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

Note:
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 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

Department Logistics & Revision History

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9-9-2013</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-11-2013</td>
</tr>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

NOTE:
Modifier 81 – Minimum Assistant Surgeon
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Organization and Associated Product Lines

<table>
<thead>
<tr>
<th>Organization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unity Health Plans Insurance Corporation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product Lines:</th>
</tr>
</thead>
<tbody>
<tr>
<td>All lines</td>
</tr>
<tr>
<td>Medicare Supplement</td>
</tr>
</tbody>
</table>

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.
Modifier 81 – Minimum Assistant Surgeon
Policy and Procedure
Last Revision/Review Date: 4/1/2015

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.
Modifier 81 – Minimum Assistant Surgeon
Policy and Procedure
Last Revision/Review Date: 4/1/2015

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

**Document Logistics & Revision History**

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>4</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

**NOTE:**
Modifier 82 – Assistant Surgeon (When Qualified Resident Surgeon Not Available)
Policy and Procedure
Last Revision/Review Date: 4-1-2015

Organization and Associated Product Lines

<table>
<thead>
<tr>
<th>Organization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ Unity Health Plans Insurance Corporation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product Lines:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ All lines  □ HMO  □ PPO  □ POS  □ UWA</td>
</tr>
<tr>
<td>□ Medicare Supplement  □ Medicaid  □ Individual Exchange  □ Individual Non-Exchange</td>
</tr>
</tbody>
</table>

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.
Modifier 82 – Assistant Surgeon (When Qualified Resident Surgeon Not Available)
Policy and Procedure
Last Revision/Review Date: 4-1-2015

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

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9-9-2013</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-11-2013</td>
</tr>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

NOTE:
Modifier 91 – Repeat Clinical Diagnostic Laboratory Test
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Organization and Associated Product Lines

<table>
<thead>
<tr>
<th>Organization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ Unity Health Plans Insurance Corporation</td>
</tr>
</tbody>
</table>

Product Lines:

| ☑ All lines | ☐ HMO | ☐ PPO | ☐ POS | ☐ UWA |
| ☐ Medicare | ☐ Medicaid | ☐ Individual | ☐ Individual |
| Supplement | 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 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 (eg, 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.
Modifier 91 – Repeat Clinical Diagnostic Laboratory Test
Policy and Procedure
Last Revision/Review Date: 4/1/2015

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

Document Logistics & Revision History

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>4</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

NOTE:
Modifier AA – Anesthesia Services Performed Personally By Anesthesiologists
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Organization and Associated Product Lines

<table>
<thead>
<tr>
<th>Organization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ Unity Health Plans Insurance Corporation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product Lines:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ All lines</td>
</tr>
<tr>
<td>□ HMO</td>
</tr>
<tr>
<td>□ PPO</td>
</tr>
<tr>
<td>□ POS</td>
</tr>
<tr>
<td>□ UWA</td>
</tr>
<tr>
<td>□ Medicare Supplement</td>
</tr>
<tr>
<td>□ Medicaid</td>
</tr>
<tr>
<td>□ Individual Exchange</td>
</tr>
<tr>
<td>□ Individual Non-Exchange</td>
</tr>
</tbody>
</table>

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.
Modifier AA – Anesthesia Services Performed Personally By Anesthesiologists
Policy and Procedure
Last Revision/Review Date: 4/1/2015

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

**Document Logistics & Revision History**

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>4</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

**NOTE:**

Policy and Procedure Form Version 1 – 4-1-2015
Confidential
Modifier AD, QK, QY—Medical Supervision, Direction Services By a Physician
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Organization and Associated Product Lines

<table>
<thead>
<tr>
<th>Organization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unity Health Plans Insurance Corporation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product Lines:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ All lines</td>
</tr>
<tr>
<td>☑ HMO</td>
</tr>
<tr>
<td>☑ PPO</td>
</tr>
<tr>
<td>☑ POS</td>
</tr>
<tr>
<td>☑ UWA</td>
</tr>
<tr>
<td>☑ Medicare Supplement</td>
</tr>
<tr>
<td>☑ Medicaid</td>
</tr>
<tr>
<td>☑ Individual Exchange</td>
</tr>
<tr>
<td>☑ Individual Non-Exchange</td>
</tr>
</tbody>
</table>

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
- 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.
Modifier AD, QK, QY—Medical Supervision, Direction Services By a Physician
Policy and Procedure
Last Revision/Review Date: 4/1/2015

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
- Manager, Financial Analysis, Provider Relations

**Document Logistics & Revision History**

<table>
<thead>
<tr>
<th>Document Owner:</th>
<th>Manager, Claim Coding and Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document Location:</td>
<td>Claims: Coding Policies and Procedures</td>
</tr>
<tr>
<td>Ver #</td>
<td>Revision or Review Date</td>
</tr>
<tr>
<td>------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>2</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>10-1-2014</td>
</tr>
<tr>
<td>4</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>
Modifier AJ – Clinical Social Worker
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Organization and Associated Product Lines

<table>
<thead>
<tr>
<th>Organization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unity Health Plans Insurance Corporation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product Lines:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ All lines</td>
</tr>
<tr>
<td>☐ HMO</td>
</tr>
<tr>
<td>☐ PPO</td>
</tr>
<tr>
<td>☐ POS</td>
</tr>
<tr>
<td>☐ UWA</td>
</tr>
<tr>
<td>☐ Medicare</td>
</tr>
<tr>
<td>☐ Medicaid</td>
</tr>
<tr>
<td>☐ Individual Exchange</td>
</tr>
<tr>
<td>☐ Individual Non-Exchange</td>
</tr>
</tbody>
</table>

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 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.
Modifier AJ – Clinical Social Worker
Policy and Procedure
Last Revision/Review Date: 4/1/2015

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

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>4</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

**NOTE:**
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 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.
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.
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**

<table>
<thead>
<tr>
<th>Document Owner</th>
<th>Manager, Claim Coding and Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document Location</td>
<td>Claims: Coding Policies and Procedures</td>
</tr>
</tbody>
</table>
### Modifier AS – Non-Physician Assistant Surgeon

**Policy and Procedure**

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

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>4</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

**NOTE:**
Modifier AT – Chiropractic Acute Treatment
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 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.
**Modifier AT – Chiropractic Acute Treatment**
**Policy and Procedure**
**Last Revision/Review Date: 4/1/2015**

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

**Document Logistics & Revision History**

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>2</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>3</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

**NOTE:**
Modifier P – Anesthesia Physical Status
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Organization and Associated Product Lines

<table>
<thead>
<tr>
<th>Organization:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ Unity Health Plans Insurance Corporation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product Lines:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ All lines   ☐ HMO   ☐ PPO   ☐ POS   ☐ UWA   ☐ Medicare Supplement   ☐ Medicaid   ☐ Individual Exchange   ☐ Individual Non-Exchange</td>
<td></td>
</tr>
</tbody>
</table>

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 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.
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

**Document Logistics & Revision History**

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>4</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

**NOTE:**
Modifier QE, QF, QG – Prescribed Amount of Oxygen
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 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.
Modifier QE, QF, QG— Prescribed Amount of Oxygen
Policy and Procedure
Last Revision/Review Date: 4/1/2015

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, cannula 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

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>10-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-15-2014</td>
</tr>
<tr>
<td>4</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Organization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unity Health Plans Insurance Corporation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product Lines:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ All lines</td>
</tr>
<tr>
<td>☑ Medicare</td>
</tr>
<tr>
<td>☑ Medicaid</td>
</tr>
<tr>
<td>☑ Individual Exchange</td>
</tr>
<tr>
<td>☑ Individual Non-Exchange</td>
</tr>
<tr>
<td>☑ HMO</td>
</tr>
<tr>
<td>☑ PPO</td>
</tr>
<tr>
<td>☑ POS</td>
</tr>
<tr>
<td>☑ UWA</td>
</tr>
</tbody>
</table>

**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

**Document Logistics & Revision History**

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9-9-2013</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>10-11-2013</td>
</tr>
<tr>
<td>2</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

**NOTE:**
Modifier RT/LT – Bilateral 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 Supplement ☐ Medicaid ☐ Individual ☐ 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 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**

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>11-1-2013</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>12-15-2013</td>
</tr>
<tr>
<td>2</td>
<td>6-1-2014</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>6-1-2014</td>
</tr>
<tr>
<td>3</td>
<td>4-1-2015</td>
<td>Revision</td>
<td>Manager, Claim Coding and Compliance</td>
<td>4-1-2015</td>
</tr>
</tbody>
</table>

**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 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.
Modifier SZ – Habilitative Services
Policy and Procedure
Last Revision/Review Date: 11/1/2016

- 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
## Modifier SZ – Habilitative Services
### Policy and Procedure

**Last Revision/Review Date:** 11/1/2016

---

### Document Logistics & Revision History

<table>
<thead>
<tr>
<th>Ver #</th>
<th>Revision or Review Date</th>
<th>Description of Change(s)</th>
<th>Author; Title</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>11-1-2016</td>
<td>Creation</td>
<td>Manager, Claim Coding and Compliance</td>
<td>11-15-2016</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:**