

Policies and Procedures

This section provides information on policies and procedures for your CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) patients.

Per the terms of the Participation Agreement, all providers are required to adhere to all policies and procedures contained in this manual, as applicable.

If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this section and notify you through [email](#) and [BlueLink](#), our online provider newsletter.

Specific requirements of a member's health benefits vary and may differ from the general procedures outlined in this manual. If you have questions regarding a member's eligibility, benefits or claims status information, we encourage you to use one of our self-service channels; [CareFirst Direct](#) or [CareFirst on Call](#). Through these channels, simple questions can be answered quickly.

Read and print the [Guidelines for Provider Self-Services](#).

Medical policy and technology assessment

Medical policies and medical policy operating procedures

CareFirst evidence-based medical policies and medical policy operating procedures can be found in the [Medical Policy Reference Manual](#) (MPRM). This manual is an informational database, which, along with other documentation, is used to assist CareFirst reach decisions on matters of medical policy and related member/subscriber coverage. These policies and procedures are not intended to certify or authorize coverage availability and do not serve as an explanation of benefits or a contract. Member/subscriber coverage will vary from contract to contract and by line of business, and benefits will only be available upon the satisfaction of all terms and conditions of coverage. Some benefits may be excluded from individual coverage contracts.

Medical policies and medical policy operating procedures are not intended to replace or substitute for the independent medical judgment of a practitioner or other health professional for the treatment of an individual. Medical technology is constantly changing, and CareFirst reserves the right to review and update its medical policy periodically and as necessary.

For specific reporting codes and instructions, refer to the appropriate and current coding manual, such as the CMS Healthcare Common Procedure Coding System (HCPCS, Level II codes), the International Classification of Diseases (ICD), and the American Medical Association's Current Procedural Terminology (CPT) (HCPCS Level I codes).

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The **MPRM** is organized according to specialty, and in some cases, subspecialty, as follows:

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- 03 Mental Health
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- 05 Prescription Drug
- 06 Radiology/Imaging
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The introduction to the **MPRM** should be referenced prior to reviewing the medical policies and procedures. This section describes the medical policy process, format of documents, and definitions and interpretive guidelines of key terms such as medical necessity, cosmetic, and experimental/investigational.

It should be noted that the medical policies and procedures located in the Medical Policy Reference Manual provide guidelines for most local lines of business. Many national accounts, processed through the NASCO system, and subscribers with federal employee program (FEP) benefits, may defer to policies promulgated by the Blue Cross and Blue Shield Association. Therefore, there may be differences in medical policy and technology assessment determinations depending on the subscriber contract; and benefits and coverage determinations should be verified prior to providing services.

Technology assessments

Technology assessment is a process in which current or new/emerging technologies are thoroughly researched, evaluated and formulated, as appropriate, into evidenced-based CareFirst medical policy. Technologies include drugs, devices, procedures, and techniques. CareFirst has adopted the criteria of the Blue Cross and Blue Shield Association Technology Evaluation Center (TEC) for

use in determining a technology's appropriateness for coverage. These criteria, along with an explanation of how they are applied, can be found in the introduction of the **MPRM** under *Definitions and Interpretive Guidelines*.

Technology assessments are presented, with supportive data, to the CareFirst technology assessment committee (TAC) which meets on a regular basis. TAC is comprised of members of the health care policy department, CareFirst medical directors, and specialty consultants, as appropriate. Determinations of the status of the technology (i.e., whether or not the technology is experimental/investigational) are made by consensus of the TAC. TAC determinations are effective on the first day of the month following the meeting.

Confidentiality

CareFirst has implemented policies and procedures to protect the confidentiality of member information.

General policy

- All records and other member communications that have confidential medical and insurance information must be handled and discarded in a way that ensures the privacy and security of the records.
- All medical information that identifies a member (a person who signs a policy with CareFirst) is confidential and protected by law from unauthorized disclosure and access.
- The release or re-release of confidential information to unauthorized persons is strictly prohibited.
- CareFirst limits access to a member's personal information to persons who need to know, such as our claims and medical management staff.
- The disposal of member information must be done in a way that protects the information from unauthorized disclosure.
- CareFirst releases minimum necessary protected health information (PHI) in accordance with the Privacy Rule as outlined in the Health Insurance Portability and Accountability Act (HIPAA) and our notice of privacy practices (NPP).

Member access to medical records

The member must follow the provider's procedures for accessing medical information. Members may access their medical records by contacting the primary care provider's (PCP) office or the provider of care (such as a hospital).

Treatment setting

Practitioners and providers are expected to implement confidentiality policies that address the disclosure of medical information, patient access to medical information and the storage/protection of medical information. CareFirst reviews practitioner confidentiality processes during pre-contractual site visits for primary care physicians.

Quality improvement measurement

Data for quality improvement measures is collected from administrative sources, such as claims and pharmacy data, and/or from member medical records.

CareFirst protects member information by requiring that medical records are reviewed in non-public areas and do not include member-identifiable information.

Notice of privacy practice

CareFirst is committed to keeping the confidential information of members private. Under HIPAA, we are required to send our notice of privacy practices to fully insured members. The notice outlines the uses and disclosures of protected health information, the individual's rights and CareFirst's responsibility for protecting the member's health information.

Reimbursement policy statements

Overview

Claim adjudication policies and associated edits are based on thorough reviews of a variety of sources including, but not limited to:

- CareFirst medical policy
- American Medical Association (AMA) guidelines (i.e., current procedural terminology, CPT)

- Centers for Medicare and Medicaid Services (CMS) policies
- Professional specialty organizations (i.e., American College of Surgeons, American Academy of Orthopedic Surgeons, American Society of Anesthesiology)
- State and/or federal mandates
- Subscriber benefit contracts
- Provider contracts
- Current health care trends
- Medical and technological advances
- Specialty expert consultants

Therefore, our policies and clinical rules are developed through a compilation of information from a variety of sources. The clinical rules we utilize are designed to verify the clinical accuracy of procedure code relationships on professional (non-institutional) claims. CareFirst utilizes McKesson ClaimsXten® software as a part of the overall editing process for claims. The ClaimsXten software is updated quarterly and provides a means for our claims systems to recognize new and/or revised CPT and HCPCS codes, including any reclassifications of existing CPT codes. Providers are notified of key policy changes through [BlueLink](#), weekly News You Can Use emails and/or newsflash updates at carefirst.com/providernews. It is recommended that providers also regularly access and review these policy statements to keep current with changes and updates.

Inclusion of codes from CPT, HCPCS, or ICD-10 reflect the use of nationally published and recognized clinical coding systems of definitions and clinical rationales for use in claims processing to fully communicate and accurately identify the services being rendered by the health care provider. Each is a HIPAA compliant code set, and reference to and/or use or interpretation of the codes does not represent an endorsement of any procedure or service or any related consequences or liability by the organizations that developed the codes.

Professional services and procedures are identified by the appropriate and current CPT or HCPCS

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reporting code. The descriptor of the code is used to fully communicate and accurately identify the services provided to the subscriber. ICD-10 diagnosis codes are utilized to indicate the appropriate patient diagnoses for which these services or procedures were provided. Claims are filed utilizing these reporting codes and are reviewed to determine eligibility for reimbursement. If services are determined to be incidental, mutually exclusive, integral to or included in other services rendered or part of a global allowance, they are not eligible for separate reimbursement. Participating providers may not balance bill members for these services.

Claims are edited for:

- Services reported together on the same claim
- Services reported on separate claims
- Services performed on the same date or within global periods
- Procedure code/modifier validity
- Age conflict
- Gender conflict
- Allowed frequency
- Duplicate procedures
- Unbundled procedures
- Incidental, integral, included in procedures
- Mutually exclusive procedures
- Assistant at surgery
- Cosmetic procedures
- Experimental/investigational procedures

The inclusion of a code in CPT, HCPCS, or ICD-10 does not imply that the service is a covered benefit, or that it will be reimbursed by CareFirst. Codes are not reassigned into another code or considered ineligible for reimbursement based solely on the format of code descriptions in any codebook (i.e., indentions). In addition, codes are not automatically changed to ones reflecting a reduced intensity of service when codes are among or across a series that include those that differentiate among simple, intermediate, and complex; complete or limited; and/or size.

Reporting Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes

CareFirst does not usually receive claims with procedure codes specific to Medicare and Medicaid, or temporary national codes (non-Medicare). Therefore, unless otherwise directed through [BlueLink](#) or other communication means, providers should report services for our members using the standard CPT codes instead of comparable Level II HCPCS codes. This includes, but is not limited to Medicare temporary G-codes and Q-codes; Hand T-codes which are specific to Medicaid; and non-Medicare S-codes.

This policy does not apply to:

- Crossover claims which are reimbursed by CareFirst as secondary to Medicare;
- Claims for durable medical equipment (DME) supplies, orthotics/prosthetics, or drugs for which there is no comparable CPT code; or
- Select services as outlined in the federal employee health benefit plan (FEHBP) manual

Reporting ICD-10 diagnosis codes

Carefully follow coding guidelines outlined in the most current ICD-10 coding book. Guidelines of particular importance include:

- Code to the highest level of specificity, as appropriate;
- List the primary or most important diagnosis for the service or procedure, first;
- Code chronic complaints only if the patient has received treatment for the condition;
- When referring patients for laboratory or radiology services, code as specifically as possible and list the diagnosis that reflects the reason for requesting these services

Claims that are not coded properly may be returned to the reporting provider, which will delay adjudication.

For additional information, visit [carefirst.com/icd10](https://www.carefirst.com/icd10).

Requests for clinical information

In order to accurately adjudicate claims and administer subscriber benefits, it is necessary to request medical records. The following is a list of claims categories from which CareFirst may routinely require submission of clinical information, either before a service has been rendered, or before or after adjudication of a claim. Some of these specific modifiers are discussed in more detail throughout this manual. These categories include:

- Procedures or services that require pre-certification/pre-authorization
- Procedures or services involving determination of medical necessity, including but not limited to those outlined in medical policies
- Procedures or services that are or may be considered cosmetic or experimental/investigational
- Claims involving review of medical records
- Claims involving pre-existing condition issues
- Procedures or services related to case management or coordination of care
- Procedures or services reported with unlisted, not otherwise classified, or miscellaneous codes
- Procedures or services reported with CPT modifiers 22, 62, 66, and 78
- Quality of care and/or quality improvement activities (i.e., data collection as required by accrediting agencies, such as NCQA/HEDIS/Quality Rating System)
- Claims involving coordination of benefits
- Claims being appealed
- Claims being investigated for fraud and abuse or potential inappropriate billing practices
- Claims that are being investigated for fraud or potential misinformation provided by a member during the application process

This list is not intended to limit the ability of CareFirst to request clinical records. There may be additional individual circumstances when these

records may be requested. By contract, these records are to be provided without charge.

Basic claim adjudication policy concepts

The following represent key coding methodologies, claims adjudication policies and reimbursement guidelines.

Note: These claim adjudication and associated reimbursement policies are applicable to local CareFirst lines of business. Adjudication edits/policies may differ for claims processed on the national processing system (i.e., NASCO) depending on the account's home plan.

CPT codes and descriptions only are copyright of the 1966 American Medical Association. All rights reserved.

Unbundled procedures

Procedure unbundling occurs when two or more procedure codes are used to report a service when a single, more comprehensive procedure code exists that more accurately represents the service provided. Unbundled services are not separately reimbursed. If the more comprehensive code is not included on the claim, the unbundled services will be re-bundled into the comprehensive code; and if it is a covered benefit, the more comprehensive service will be eligible for reimbursement. Always report the most comprehensive code(s) available to describe the services provided.

Incidental procedures

An incidental procedure is carried out at the same time as a more complex primary procedure and/or is clinically integral to the successful outcome of the primary procedure. When procedures that are considered incidental are reported with related primary procedure(s) on the same date of service, they are not eligible for reimbursement.

Integral/included in procedures

Procedures that are considered integral or included in occur in a variety of circumstances including, but not limited to, services that are a part of an overall episode of care; and multiple surgery situations,

when one or more procedures are considered to be an integral part of the major procedure or service. An example of this is a procedure code designated by CPT as separate procedure. Separate procedures should not be reported when they are carried out as an integral component of a total service or procedure. Integral or included in procedures are not eligible for reimbursement.

Providers should refer to CPT guidelines for reporting separate procedures when they are not a component of a total service. CPT modifier-59 should be appended to the separate procedure code to indicate that it is a distinct, independent procedure and not related to the primary procedure.

Mutually exclusive procedures

Mutually exclusive procedures include those that may differ in technique or approach but lead to the same outcome. In some circumstances, the combination of procedures may be anatomically impossible.

Procedures that represent overlapping services are considered mutually exclusive. In addition, reporting an initial and subsequent service on the same day is considered mutually exclusive. Procedures reported together on the same anatomic site with terms such as open/closed, partial/total, unilateral/bilateral, simple/complex, single/multiple, limited/complete, and superficial/deep usually result in mutually exclusive edits. In these instances, if both procedures accomplish the same result, the procedure with the higher relative value unit (RVU) will usually be eligible for reimbursement. The higher valued procedure is likely to be the more clinically intense procedure, but the RVU will determine which procedure/service is reimbursed.

Global allowances

Reimbursement for certain services is based on a global allowance. Services considered to be directly included in a global allowance are considered integral to that allowance and are not eligible for separate reimbursement.

Add-on procedures

Procedure codes designated as add-on (or list separately in addition to the code for primary procedure for CPT), are only reported in addition to the specific code for the primary (or parent) procedure. These add-on codes are not eligible for separate reimbursement when reported as stand-alone codes or, in some instances, when the primary procedure is not covered.

Add-on codes are not subject to multiple procedure fee reductions as the RVUs assigned to these add-on procedure codes have already been reduced to reflect their secondary procedure status.

If several procedures are performed during the same session by the same physician, and the primary (or parent) code needs to be distinguished as a distinct procedure (i.e., CPT modifier-59 is appended to the primary code), then CPT modifier-59 must also be appended to any add-on codes related to the parent code.

Duplicate services and multiple reviews

Paying more than one provider for the same procedure or service represents duplicate procedure reimbursement. This includes, but is not limited to, multiple interpretations or reviews of diagnostic tests such as laboratory, radiology, and electrocardiographic tests reported with CPT modifier 26 (professional component), 59 (distinct procedural service), 76 (repeat procedure or service by same physician or other qualified health care professional), 91 (repeat clinical diagnostic laboratory test), or CPT 76140 (consultations on X-ray exams performed at other sites.)

CareFirst will reimburse only once for a service or procedure. Duplicate procedures, services, and reviews, whether reported on the same or different claims, are not eligible for reimbursement.

Unlisted procedures

In the Federal Register, Center for Medicare and Medicaid Services (CMS) establishes and publishes RVUs for most CPT and some HCPCS Level II codes. RVUs are a weighted score used to determine the fee scales for procedures and services performed

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by professional providers. These RVUs are used to determine allowances for reimbursement. CMS, however, does not assign RVUs to all procedure codes. Some codes are unlisted (no specific definition) and no RVU is assigned. Therefore, the unlisted code has no established allowance.

Unlisted CPT and HCPCS codes should only be reported when there is not an established code to describe the service or procedure provided.

Submissions of claims containing an unlisted code are reviewed by our Medical Review Department. A reimbursement allowance is established based on this review using a variety of factors including, but not limited to, evaluating comparable procedures with an established RVU. To be considered for reimbursement, an unlisted CPT or HCPCS code must be submitted with a complete description of the service or procedure provided. Any applicable records or reports must be submitted with the claim.

All applicable reimbursement policies will apply (i.e., incidental procedures, multiple procedures, bilateral procedures, global periods) in relation to claims submitted with unlisted codes.

All modifiers will be considered invalid with unlisted codes. Do not report modifiers with any unlisted procedure codes.

Fragmented billing

Reporting services provided on the same date of service on multiple CMS 1500 claim submissions is considered fragmented billing. This practice may lead to incorrect reimbursement of services, including delays in claims processing or retractions of overpaid claims. Historical claims auditing is performed to ensure that all services or procedures performed on the same date are edited together. Therefore, services or procedures performed by a provider on the same date must be reported together on the same claim whether submitted electronically or on a paper form.

modifier reimbursement guidelines

CareFirst accepts all valid CPT and HCPCS modifiers. A modifier enables the provider to indicate that a service or procedure performed has

been altered in some way but that the standard definition and associated reporting code remains unchanged. modifiers may be used to indicate that:

- A service or procedure was provided more than once
- A service or procedure was performed on a specific anatomical site
- A service or procedure has both a professional and technical component
- A bilateral procedure was performed
- A service or procedure was performed by more than one provider and/or in more than one location
- A service was significant and separately identifiable from other services or procedures

Up to four modifiers may be reported per claim line. CareFirst claims systems are capable of adjudicating multiple modifiers. modifiers that may affect reimbursement should be listed first.

Services reported with an invalid modifier-to-procedure code combination will be denied. Claims must be resubmitted with the correct modifier (or without the invalid modifier) in order to ensure appropriate claim adjudication.

modifiers may or may not affect reimbursement. Certain modifiers are for informational purposes only and assist in correct application of benefits.

The following CPT modifiers may affect reimbursement:

-22	-54	-77
-24	-55	-78
-25	-56	-79
-26	-57	-80
-50	-59	-81
-51	-62	-82
-52	-66	-91
-53	-76	

The following HCPCS modifiers may affect reimbursement:

RT	TA-T9	TC	GC
LT	LC	AA	QK
E1-E4	LD	AD	QX
FA-F9	RC	AS	QY

Examples of modifiers that are used for informational purposes and do not affect reimbursement are:

-23	-33	-90
-32	-63	-99

The following CPT modifiers do not affect reimbursement:

-47	-63
P1-P6	-92

Examples of modifiers that may affect how member benefits are determined and reimbursed:

BR	BP	KI	UE
BU	KA	K2	QE
KI	KH	K3	QF
KJ	KM	K4	QG
KR	KN	NR	QH
LL	KS	NU	GO
MS	KX	RA	GP
RR	KO	RB	

CareFirst follows the CMS guidelines when determining if particular diagnostic or therapeutic tests and procedures can be reported as a global (total) service, or if they can also be reported as either a technical or professional component of the service. It is important to report these services according to the following guidelines:

- Report the procedure as a global (total) service, without a modifier. If you own the equipment, administer the test and provide the interpretation
- Report the procedure as a technical component (along with HCPCS modifier TC) if you only perform the technical portion of the procedure

- Report the procedure as a professional component (along with CPT modifier-26) if you only perform the interpretation and/or supervision portion of the procedure

In instances where one provider is reporting the technical component and another is reporting the professional component, both providers should submit separate claims, with the same procedure code(s), with the appropriate modifier, and with the same date of service. As noted above, services reported with an invalid modifier-to procedure code will be denied and must be resubmitted.

Submissions of claims containing the following CPT modifiers are reviewed by our Medical Review Department, and should be submitted with the pertinent medical records (i.e., complete operative record, office notes, etc.) in order to be appropriately and expeditiously adjudicated. Documentation should clearly support the intent of the modifier and demonstrate the reason for its submission.

- CPT modifier-22: Not valid with evaluation and management (E/M) codes. Pertinent medical records that clearly demonstrate the reason that the procedure/service requires “substantial additional work” than that of the reported procedure must accompany the claim. This modifier should be reported only when the procedure or service is clearly out of the ordinary for the particular procedure. While not required, it is often helpful for the provider to attach a separate letter to the medical records that outlines why the procedure or service was particularly unusual
- CPT modifier-62: Only valid with surgery procedure codes. Operative records that clearly demonstrate that each surgeon performed distinct and separate parts of a procedure must be made available if requested. Each surgeon submits a separate claim for the operative session. CPT modifier-62 should be appended only to procedures performed by the two surgeons. Do not use in lieu of CPT modifier-66 or CPT modifiers-80,-81,-82, or HCPCS modifier-AS

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- CPT modifier-66: Only valid with surgery procedure codes. Operative records that clearly demonstrate that each surgeon performed components of a procedure in a team fashion must accompany the claim

CPT modifier-78: Only valid with surgery procedure codes. Operative records that clearly demonstrate a related procedure had to be carried out during the post-operative period must accompany the claim

Global surgical, anesthesia and maternity reimbursement guidelines

Surgical procedures described in CPT (see CPT surgical package definition in the CPT manual) usually include, at a minimum, the following components, in addition to the surgery itself:

- Local infiltration, select blocks or topical anesthesia
- After the decision for surgery is made, one E/M visit on the day before or on the day of surgery (including history and physical exam)
- The surgical procedure/intraoperative care
- Immediate post-operative care
- Interacting with the patient's significant other and other care providers
- Writing post-operative orders
- Assessing the patient in the post-anesthesia care area
- Usual post-operative follow-up care

Separate benefits **are** provided for moderate (conscious) sedation whether rendered by the physician performing the diagnostic or therapeutic service the sedation supports or by another physician. Moderate sedation codes are not used to report administration of medications for pain control, minimal sedation (anxiolysis), deep sedation, or monitored anesthesia care. Refer to medical policy operating procedures 9.01.001A, 9.01.003A, 9.01.004A, 9.01.007A in our [Medical Policy Reference Manual](#).

Combining the above services and reporting them under a single fee as a surgical package, is referred to as global billing. In the event that only

a component of the surgical package is provided, follow CPT guidelines for reporting the following split care CPT modifiers-54,-55, and -56.

Depending on the nature of the procedure, subscriber or provider contract, or specific policies, certain services may include additional components in the global allowance, such as for maternity or anesthesia services. Examples of services that are reimbursed with a global allowance can be found in the following references:

- Maternity services that are and are not included in the global allowance
 - Refer to global maternity services, 4.01.006A in our [Medical Policy Reference Manual](#)
- Surgical services and related global periods
 - Refer to global surgical procedure Rules, 10.01.009A in our [Medical Policy Reference Manual](#)
- Anesthesia services that are/are not included in the global anesthesia allowance
 - Refer to anesthesia services, 9.01.001A in our [Medical Policy Reference Manual](#)
- Procedures containing the term "one or more sessions" in the description. When reporting services where the procedure code indicates "one or more sessions," the CPT code should be reported only one time for the entire defined treatment period, regardless of the number of sessions necessary to complete the treatment. While the defined treatment period is determined by the physician and varies depending on the patient, diagnosis, and often the location of treatment, these services may be reported only once during the global post-operative period assigned to the specific code.
 - Refer to CPT guidelines.

CPT modifiers -58, -76, -77, -78, and -79 identify procedures performed during the global surgical period. Follow CPT reporting guidelines for these modifiers. Submissions of claims containing CPT modifier-78 are reviewed by our medical review department and should be submitted

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with a complete operative record in order to be appropriately adjudicated.

CPT modifier-24 identifies an unrelated E/M service provided during the global post-operative period. Follow CPT reporting guidelines for this modifier.

Bilateral procedures reimbursement guidelines

Bilateral procedures are defined as surgeries rendered by the same provider, during the same operative session, on paired anatomical organs or tissues.

Bilateral procedures are typically reimbursed at 150 percent of the allowance of the unilateral procedure (i.e., 100 percent for one side, and 50 percent for the other side). For bilateral secondary surgical procedures, bilateral surgical adjudication edits are applied first, and then multiple surgical edits are applied. The primary bilateral procedure is reimbursed at 150 percent (100 percent for the first side, and 50 percent for the second side). The second bilateral procedure is reimbursed at 100 percent (50 percent for the first side and 50 percent for the second side).

Policy guidelines for reporting bilateral procedures

Bilateral procedures are reimbursed based on either CPT coding guidelines or the CMS list of procedure codes that are eligible for CPT modifier-50. When CPT modifier-50 is valid, the appropriate code for the bilateral procedure should be reported on one line with the CPT-50 modifier appended and a frequency of one in the unit field. If a claim for a bilateral procedure is not submitted this way, the claim will be returned with a request to resubmit it properly. Claims submitted with a procedure that is invalid with CPT modifier-50 will be returned with a request to resubmit a corrected claim.

When reporting bilateral primary and secondary procedures, CPT modifier-50 should be reported in the first modifier position. CPT modifier-51 may be reported in the second modifier position.

HCPCS Level II modifiers -RT (right side) and -LT (left side) are used when a procedure is performed either on one side of the body rather than both sides, or when CPT modifier-50 is not valid for a procedure code but the procedure is performed on both sides of paired organs. When -RT and -LT modifiers are both used for the same procedure, report the procedure code on two lines with the -RT and -LT appended to each code.

If the description of the procedure code contains the phrase bilateral, it is eligible for reimbursement only once on a single date of service. Report the single procedure code with a frequency of one in the Unit field.

If the description of the procedure code contains the phrase unilateral/bilateral, it is eligible for reimbursement only once on a single date of service. If the code includes unilateral/bilateral in the description, it is not appropriate to report the code with CPT modifier-50. The fee schedule allowance is the same regardless of whether it is performed on one side or both sides. Report the single procedure code with a frequency of one in the Uunit field.

If the description of the procedure code specifies unilateral and there is another code that specifies bilateral for the same procedure, the bilateral code will replace the unilateral codes when they are reported more than once for the same date of service. Code replacements will also occur when one procedure code specifies a single procedure and a second procedure code specifies multiple procedures. Do not report CPT modifier-50 in this circumstance. Always report the most comprehensive code for the procedure(s) performed.

Certain procedures may only be reported a specified number of times on a single date of service. Once the maximum number is reached, all additional submissions of the procedure code will not be eligible for reimbursement.

Multiple surgical and diagnostic procedures reimbursement guidelines

General guidelines

Multiple surgical and select diagnostic procedures (including endoscopic and colonoscopy procedures) are edited to ensure appropriate reimbursement for the benefit.

Covered procedures performed during the same operative session, through only one route of access and/or on the same body system and that are clinically integral to the primary procedure, are usually considered incidental, integral to/included in, or mutually exclusive to the primary procedure. The primary procedure is reimbursed at 100 percent of the allowed benefit. Incidental, integral to/included in, or mutually exclusive procedures are not eligible for reimbursement.

Covered procedures performed during the same operative session that are not clinically integral to the primary procedure (i.e., those performed at different sites or through separate incisions) are usually eligible for separate reimbursement. The most clinically intense procedure is reimbursed at 100 percent of the allowed benefit; and the second and subsequent procedure(s), at 50 percent of the allowed benefit.

Multiple procedures not considered to be integral to the primary procedure should be reported with the CPT modifier-51 appended to the second and subsequent procedure codes.

Some surgical, diagnostic, or therapeutic procedures may appear to be integral, included in, mutually exclusive or duplicates of other procedures performed during the same encounter or session by the same provider. In order to distinguish these procedures as distinctly different (i.e., different operative site or procedure, separate incision, etc.), CPT modifier-59 should be appended to these select procedures. Carefully follow CPT guidelines for reporting CPT modifier-59.

As one factor in determining a fee schedule allowance, CareFirst typically uses the fully implemented non-facility total RVU (as published

annually in the CMS national physician fee schedule) for all places of service. In addition to including the provider work and malpractice factor, this RVU also includes a robust practice expense (PE) component. The use of this RVU is particularly significant when multiple procedures are performed during the same session by the same provider, as its value determines the ranking of these procedures (i.e., what is considered the primary procedure, and how any subsequent/secondary procedures are ranked.) It should be noted that beginning in 2007, CMS has changed the way it determines the resource-based direct and indirect practice expenses. As a result of the changes to the Physician Fee Schedule described above, CareFirst will utilize the transitioned non-facility total RVU (Column P) as published by CMS for both new and pre-existing codes beginning in mid-April 2007 at the time of our next claims software upgrade.

For additional information on this methodology, visit the CMS website at [cms.hhs.gov/PhysicianFeeSched/](https://www.cms.hhs.gov/PhysicianFeeSched/).

Effective with claims processed on and after January 1, 2013, CareFirst will utilize the non-facility total RVU (Column L) now that the transition period has been completed.

Multiple endoscopic procedures through the same scope

When an endoscopic procedure is considered to be a component of a more comprehensive endoscopic procedure, the more clinically comprehensive procedure is usually eligible for reimbursement.

Multiple endoscopic and open surgical procedures

Endoscopic and open surgical procedures performed in the same anatomic area are not usually eligible for separate reimbursement. If an open surgical procedure and an endoscopic procedure accomplish the same result, the more clinically intense procedure is usually reimbursed. The comparable procedure is considered mutually exclusive and is not eligible for reimbursement.

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If a number of endoscopic-assisted, open surgical procedures are performed on the same anatomic area during the same operative session. In accordance with multiple procedure editing, these procedures are usually eligible for separate reimbursement based on the additional time, skill, and physician resources required when two approaches are used for a surgical procedure.

Serial surgery reimbursement guidelines

Separate or additional reimbursement is not made each time a procedure is performed in stages or for procedures identified as “one or more sessions” in the code definition. Global surgical rules apply.

Multiple provider participation in surgical procedures

Certain procedures may require the participation of more than one provider in order to accomplish the desired outcome. Information outlining policies and reporting guidelines for these situations are as follows:

Surgical assistant or assistant at surgery

Assistants at surgery are distinct from team and co-surgery, as described below. For information on this topic refer to [Medical Policy Reference Manual](#) operating procedure 10.01.00 8A, Surgical Assistants. The American College of Surgeons (ACS) is the primary source for determining reimbursement for assistant at surgery designations of always or never. The ACS utilizes clinical guidelines (instead of statistical measures) to determine the appropriateness of assistants at surgery. A variety of sources, including expert clinical consultants, specialty organizations (i.e., American Academy of Orthopedic Surgeons and CMS) are used to determine reimbursement for assistant at surgery ACS designations of sometimes.

CPT modifiers -80, -81, or -82 are reported for the services of an MD or DO. HCPCS modifier -AS is reported for the services of the non-physician assistant (i.e., physician assistant, nurse practitioner).

CPT modifiers -80, -81, -82, and HCPCS modifier -AS are currently reimbursed at 16 percent of the allowance for the procedure(s) for which assistant services are eligible for reimbursement.

All applicable reimbursement policies will apply to an assistant at surgery the same as it would apply to the primary surgeon (i.e., incidental procedures, multiple procedures, bilateral procedures, global periods).

Team surgery

The term “team surgery” describes circumstances in which two or more surgeons of the same or different specialties are required to perform separate portions of the same procedure at the same time. Examples of these circumstances include procedures performed during organ transplantation or re-implantation of limbs, extremities or digits. In these instances, the surgeons are not acting as an assistant at surgery, but rather as team surgeons.

To report as team surgeons, each surgeon participating in the surgical procedure(s) must file a separate claim and append CPT modifier -66 to the specific procedure code(s) used for reporting the services provided.

Submissions of claims containing CPT modifier -66 are reviewed by our medical review department, and should be submitted with the complete operative record in order to be appropriately adjudicated. The unique surgical services and level of involvement of each surgeon should be documented in a single operative report that is signed by all participants.

If a surgeon functions as both a team surgeon and an assistant at surgery for different portions of the total operative procedure, then CPT modifier -66 should be appended to the procedure applicable to team surgery and CPT modifier -80, -81, or -82, as appropriate, should be appended to the procedure(s) in which the surgeon acted as an assistant.

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The percentage of the allowed benefit apportioned to each of the team surgeons will be determined based on several factors, including but not limited to:

- The complexity of the individual surgical services performed
- The amount of involvement in the operating room
- The amount of pre- and post-operative care required
- Whether the procedures performed are related, incidental, or unrelated to each other

All applicable reimbursement policies will apply (i.e., incidental procedures, multiple procedures, bilateral procedures, global periods) in relation to claims submitted with CPT modifier -66.

Co-surgeon

The term “co-surgery” describes circumstances in which the individual skills of two or more surgeons, often of different specialties, are required to perform the same procedure. In these instances, the surgeons are not acting as an assistant at surgery, but rather as a co-surgeon.

To report as co-surgeons, each surgeon participating in the surgical procedure(s) must file a separate claim and append CPT modifier-62 to the specific procedure code(s) used for reporting the services each provided.

Effective with claims processed on and after Jan. 1, 2012, providers will no longer be required to submit operative reports or other clinical records to be reimbursed for claim lines containing modifier-62 alone. Our revised policy will be to reimburse each surgeon at 50 percent of the allowed amount for the procedure after all other edits (i.e., multiple surgery reductions, incidental, mutually exclusive, etc.) have been applied.

Providers will need to send in the appropriate clinical documentation for claim lines that contain modifier-62 and any other modifier on the same line that would potentially impact reimbursement. If an additional modifier, such as modifier-22 or -78 is appended to a procedure also containing

modifier-62, then the appropriate clinical documentation will be reviewed to determine an appropriate reimbursement.

If a surgeon functions as both a co-surgeon and an assistant-at surgery for different portions of the total operative procedure, then CPT modifier-62 should be appended to the procedure(s) applicable to co-surgery, and CPT modifier -80, -81, or -82, as appropriate, should be appended to the procedure in which the surgeon acted as an assistant.

If additional procedures (including each additional procedure) are performed during the same operative session by one of the surgeons, the additional procedure code(s) should be reported by that surgeon only, without CPT modifier-62 appended.

All applicable reimbursement policies will apply (i.e., incidental procedures, multiple procedures, bilateral procedures, global periods) in relation to claims submitted with CPT modifier-62.

Multiple provider participation in patient care

Consultations

Consultation services should be reported using the appropriate consultation E/M codes (office/outpatient, inpatient) according to CPT reporting guidelines and as follows.

Consultation services are reimbursed according to the terms of the member’s benefit contract and applicable claims adjudication policies. A consultation occurs when the attending physician or other appropriate source asks for the advice or opinion of another physician for the evaluation and/or management of the patient’s specific problem. The need for a consultation must meet medical necessity criteria and be documented in the referring physician’s medical record.

A physician consultant may initiate diagnostic and/or therapeutic services as a part of or during the consultation process. The request for a consultation from the attending physician or other appropriate source and the reason for the consultation must be documented in the

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patient's medical record. The consultant's opinion/recommendation and any services that were ordered or performed must also be documented in the medical record and communicated to the requesting provider.

If the attending physician requests a second or follow-up office or outpatient consultation, an office/outpatient consultation E/M visit may be reported a second time, as there is no follow-up consultation code for this setting.

A consultation initiated by the patient and/or family, and not requested by a physician should not be reported using consultation codes. Report these services using the setting specific non-consultation E/M codes, as appropriate.

A consultation code is not eligible for reimbursement when an attending physician requests that the second (consulting) physician take over care of the patient. If the attending physician decides to transfer care of the patient to the consultant after the consultation, the consultant may not continue to report a consultation visit. The consultant should begin reporting the appropriate non-consultation E/M codes. (See CPT E/M services guidelines.)

Concurrent care

Reimbursement may be made for multiple providers caring for a patient during an episode of care, according to the terms of the subscriber's benefit contract and applicable claims adjudication policies. This includes providers of multiple specialties caring for a patient in an inpatient setting on the same date of service. The need for multiple provider participation in the patient's care must meet medical necessity criteria and be documented in the medical record (see also consultations above and CPT E/M services guidelines regarding concurrent care and transfer of care).

Standby services

Standby services are not eligible for reimbursement (see medical policy operating procedures, 10.01.004A, Standby Services), except for attendance at delivery when requested by the

obstetrician (see our [Medical Policy Reference Manual](#), procedure 10.01.002A, Attendance at Delivery).

Evaluation and management (E/M) services

Benefits are available for E/M services according to the terms of the subscriber's benefit contract and applicable claims adjudication policies. Incidental, integral to/included in, mutually exclusive, and global services editing policies apply to all E/M services.

E/M services are reported for the appropriate level of service in accordance with CPT guidelines and must be supported in the medical record according to the CareFirst Medical Record Documentation Standards, located in Operating Procedure, 10.01.013A, in our [Medical Policy Reference Manual](#).

CPT modifier-25

In many instances, E/M services are considered included in or mutually exclusive to other procedures and services reported on the same date, and are therefore not eligible for separate reimbursement.

CPT modifier-25 is used to describe a significant, separately identifiable E/M service by the same physician on the same day of a procedure or other service. CPT modifier-25 is only valid with E/M codes.

Reporting with a CPT modifier-25 does not require a different diagnosis as the procedure or other service, but documentation in the medical record must support that a significant, separately identifiable E/M service was provided. To be eligible for reimbursement for CPT modifier-25, the key components of the E/M service (i.e., history, physical, decision-making, as outlined in CPT) must be performed and documented in the medical record.

There are many instances in which CPT modifier-25 may be appropriately reported, as described throughout these reimbursement guidelines.

New patient visit frequency

According to CPT guidelines, a new patient is one who has not had services from the same physician or group in the same specialty in the past three years. An established patient E/M visit must be reported if the patient is seen, for any reason, by the same physician or member of the group, within the three-year timeframe. This also applies to physicians who are on-call for or covering for another physician. In this case, the patient's E/M service is classified as it would be for the physician who is not available. The covering physician should report the appropriate level E/M service according to the three-year timeframe as described above. Refer to CPT reporting guidelines for further instructions.

If a new patient E/M code is reported more than once by the same provider/group within the three-year timeframe, the code will automatically be replaced with a corresponding established E/M code.

Preventive services

Preventive services, also known as health maintenance exams, include preventive physical examinations; related x-ray, laboratory, or other diagnostic tests; and risk factor reduction counseling. Most CareFirst subscriber contracts include a benefit for these preventive examinations, many of which are limited to once per benefit year/annually. It is important, therefore, that preventive services (CPT 99381-99397) are only reported when providing the complete health maintenance exam and related tests and immunizations. Routine, age-specific immunizations are reported separately (see Reimbursement for Injectables, Vaccines, and Administration). Providers must report the appropriate E/M codes (i.e., CPT 99201-99215) for other encounters such as preoperative or pre-diagnostic procedure evaluations.

For additional information, refer to the [CareFirst Preventive Services Guidelines](#) available in the Resources tab at provider.carefirst.com.

Preventive services under the Affordable Care Act (ACA)

As part of the ACA, certain preventive services for children and adults must be covered at no cost to the member when using in-network providers.

As a reminder, providers should use the proper diagnosis screening code and CPT code in order to be reimbursed.

Multiple E/M services on the same date

Multiple E/M services reported by the same provider on the same date of service are usually considered mutually exclusive. The most clinically intense service is usually reimbursed.

There are times however, that a patient may be present for health maintenance/preventive medicine service visit, and a condition or symptom is identified that requires significant additional effort to address and treat. If the treatment of the condition or symptom requires the performance of the key components of a problem-oriented service, then it may be appropriate to report the appropriate level E/M code in addition to the preventive care visit code. CPT modifier-25 must be appended to the E/M code to indicate that a significant separately identifiable E/M service was provided in addition to the preventive service.

CareFirst considers significant additional effort as encompassing all of the following:

- Additional time is required to diagnose and treat the presenting problem; and
- The physician develops and initiates a treatment program for the identified condition by the end of the office visit

If a physician monitors a chronic condition (i.e., hypertension, diabetes) at the time of the preventive medicine visit, and the condition does not require a significant change in the plan of care, then CareFirst considers this monitoring to be part of the comprehensive system review and assessment. Likewise, if a patient requires problem-focused care (i.e. for a sore throat or viral illness) or needs to be referred to a specialist, this is considered to be included in preventive medicine evaluation and management and is not considered

significant additional effort. In both these instances it would not be appropriate to report an E/M service in addition to the preventive visit.

Counseling services

Carefully follow CPT guidelines when reporting preventive counseling services (i.e., CPT codes 99401-99429). Since these guidelines indicate that these codes are used for persons without a specific illness, it is inappropriate to report these codes for services such as preoperative counseling.

Care plan oversight

CareFirst provides a benefit for care plan oversight services (CPT codes 99374-99380) to one physician who provides a supervisory role in the care of a member receiving complex case or disease management services. These services are reported in accordance with CPT guidelines (i.e., time spent per 30 days) and may be reported in addition to direct patient care E/M services as appropriate.

Advance planning

CareFirst provides a benefit for advance care planning (CPT 99497, 99498). These codes are used to report the face-to-face service between a physician or other qualified health care professional and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. Refer to CPT guidelines for reporting CPT 99497 and 99498 separately if performed on the same day as another evaluation and management service.

Chronic care coordination services

CareFirst provides a benefit for complex chronic care coordination services (CPT 99487-99490), effective Jan. 1, 2015. These services are reported in accordance with CPT guidelines (i.e., time spent per calendar month, etc.) and may be reported in addition to direct patient care E/M services as appropriate, as outlined in the CPT code book. Attention should be given to the services that may not be separately reported during the month for which chronic care coordination services are reported, also as outlined in the CPT code book

Transitional care management services

CareFirst provides a benefit for transitional care management services (CPT 99495-99496), effective Jan. 1, 2013. These services are reported in accordance with CPT guidelines (i.e., calendar days between discharge and a face-to-face visit, who may report these services, etc.) and may be reported in addition to direct patient care E/M services as appropriate, as outlined in the CPT code book. Attention should be given to the services that may not be separately reported during the timeframes during which transitional care management services are reported, also as outlined in the CPT code book.

Online/internet and telephone services

CareFirst does not provide benefits for non-face-to-face services via telephone or internet (CPT 99441-99443; 99444; 98966-98968; 98969; or effective 1/1/2014, Inter-professional Telephone/Internet Consultations (CPT 99446-99449). All of these services are considered integral to/included in all other services, whether reported alone or in addition to other services or procedures. Integral to/included in services are not eligible for reimbursement.

Telemedicine

Telemedicine services refers to the use of a combination of interactive audio, video, or other electronic media used by a licensed health care provider for the purpose of diagnosis, consultation, or treatment consistent with the provider's scope of practice. Use of audio-only telephone, e-mail, online questionnaires or FAX is not considered a telemedicine service. Services for diagnosis, consultation or treatment provided through telemedicine must meet all the requirements of a face-to-face consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services. Diagnostic, consultative and treatment telemedicine services should be reported with the appropriate category I CPT code and the HCPCS modifier-GT (via interactive audio and video telecommunication systems). Diagnostic consultative and treatment telemedicine services

should be reported with the appropriate category I CPT code and the HCPCS modifier-GT (via interactive audio and video telecommunication systems) or CPT modifier-95 (synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system).

CareFirst does provide benefits for telemedicine services under certain circumstances. Refer to medical policy 2.01.072, Telemedicine (Unified Communications), in the [Medical Policy Reference Manual](#), for details.

E/M services during the global periods

E/M services reported on the same date as zero day global period procedures are edited as follows

- Initial/new Patients: the E/M service is eligible for reimbursement in addition to the procedure
- Follow-up/established patients: only the procedure is eligible for reimbursement unless CPT modifier-25 is appended to the visit code to indicate that a significant, separately identifiable E/M service was provided at the time of the procedure

E/M services for new or established patients reported on the same date as a 0/10 and 1/90 day global period procedure are not eligible for reimbursement. An exception to this is when CPT modifier-57 (see below) or CPT modifier-25 is appended to the visit code to indicate that a significant, separately identifiable E/M service was provided in conjunction with the procedure. The E/M service is then eligible for separate reimbursement.

CPT modifier-24 identifies an unrelated E/M service provided during the global post-operative period. Follow CPT reporting guidelines for this modifier.

See also *Collecting copayments/coinsurance during global surgical periods*.

CPT modifier-57

When an E/M visit results in the initial decision to perform surgery for a major (i.e., 1/90 global period) procedure, CPT modifier-57 should be

appended to the E/M service code. The E/M service is then eligible for separate reimbursement. Refer to CPT reporting guidelines.

CPT modifier-57 is not eligible for reimbursement in the following circumstances:

- When reported with non-E/M codes;
- When the initial decision to perform surgery is a minor surgical procedure (i.e., a procedure with a 0 or 10 day global period); or
- When E/M visit code is used for the preoperative history and physical exam prior to the surgical procedure

E/M services in conjunction with immunizations

If immunization(s) and administration of the drug are reported together, both are eligible for separate reimbursement. Covered E/M services are also eligible for separate reimbursement at the same visit as the immunization, with the exception of CPT code 99211. If a significant, separately identifiable CPT code 99211 is rendered at the time of the immunization/injection, CPT modifier-25 should be appended.

Prolonged services

Prolonged physician service codes (CPT codes 99354-99359) may be reported when there is patient contact beyond the usual E/M service in either the inpatient or outpatient setting.

Several of these are add-on codes and must be reported in addition to other E/M codes. They are not valid when reported with any other procedure or service. See CPT guidelines when reporting CPT 99358-99359 as these may be reported on a different date from the E/M visit under certain circumstances.

Prolonged service codes are not eligible for reimbursement in combination with the following:

- Emergency services (CPT 99281-99288)
- Observation services (CPT 99217-99220)
- Observation or inpatient services (CPT 99234-99236)
- Critical care services (CPT 99291-99292)

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Prolonged services are not eligible for reimbursement for time spent by a non-physician incidental to the physician's service (i.e., office staff discussing dietary concerns with a patient).

Carefully follow CPT reporting guidelines when reporting prolonged services, including base codes with which they may be reported. Because these are time-based codes, documentation in the medical record must clearly reflect exact times spent on base and prolonged services in order to verify appropriate use of these codes.

Intensity of service auditing

CareFirst will no longer automatically reassign or reduce the code level of E/M codes for covered services, except in the case of replacing a new patient visit code with an established patient visit code, in accordance with CPT guidelines. We will evaluate and reduce or reassign code levels if it is determined through review of clinical information that the reported code(s) is not reflective of the service rendered.

General and specialty-related claim adjudication policies and reimbursement guidelines

The following represent highlights of certain policies, edits, and reimbursement guidelines that may be of interest to many providers in the CareFirst networks. Since there is no way we can address all editing scenarios in this document, please contact your provider services representative with questions of a more specific nature.

Multiple specialties

Billing for services rendered to patients

Except for very limited circumstances ((i.e., physician assistants or registered nurses administering injections), providers may only report and submit claims for services rendered to patients that the practitioner individually and personally provides. CareFirst contracts with participating providers to perform services for an agreed upon fee. It is that provider, and only that provider, who can submit a claim and receive

reimbursement. As outlined in the CareFirst medical record documentation standards policy, 10.01.013A, participating providers must accurately and completely document the medically necessary services they perform in the appropriate medical record, and sign the document(s) attesting that they performed the service. Attending physicians and other qualified health care professionals who supervise and teach residents or students are allowed to submit claims for those services the resident or student in training provides, only if the supervising provider also interacts with the patient/family, examines the patient (if applicable) and personally documents their patient encounter in the medical record. Services rendered by residents, associates, graduate students, or others in training, in any discipline, specialty or occupation are not eligible for reimbursement unless these requirements are met.

Reporting medication administration

In all instances, one should only report the actual services provided to the patient, including medications administered in any setting. CareFirst will only reimburse providers for the amount of the medication administered. Providers should schedule patients to minimize any waste and utilize medications efficiently. If a specific dose of medication is drawn from a multi-dose vial, only the amount of medication administered to the patient is to be reported— not the total amount of the drug in the vial.

Reimbursement for injectables, vaccines and administration

Covered vaccines and injectables are reimbursed and administered according to an established fee schedule. Newly recommended vaccines are eligible for reimbursement as of the effective date of a recommendation made by any of the following:

- The U.S. Preventive Services Task Force
- The American Academy of Pediatrics
- The Advisory Committee on Immunization Practices

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Benefits for vaccinations and immunizations are contractually determined. It is advised that providers ensure that benefits are available prior to rendering these services.

Additional information is available in the [Medical Policy Reference Manual](#) (i.e., medical policy 5.01.001) and the [CareFirst Preventive Services Guidelines](#), both of which are located on [provider.carefirst.com](#).

For information regarding procurement of office administered medications, refer to *Injectable drugs in the administrative functions* section of this manual.

Collecting copayments/coinsurance during global surgical periods

- If an E/M service/visit is allowed, regardless if rendered before, during or after a global surgical period, a claim should be submitted, and the applicable copayment or coinsurance may be collected
- If an E/M service/visit is disallowed and/or bundled into the global surgical allowance, a claim should not be submitted, and a copayment or coinsurance may not be collected

It is not appropriate to collect a copayment/coinsurance from a subscriber/member and not submit a claim for a service/visit. See also medical policy operating procedure 10.01.009A, Global Surgical Care Rules, in the [Medical Policy Reference Manual](#).

Special services

Services rendered during off-hours, on weekends, on holidays, on an emergency basis, and for hospital mandated on call (CPT 99026-99060) are considered incidental or mutually exclusive to other services. Incidental and mutually exclusive services are not eligible for reimbursement.

Exception: CPT 99050 and 99051 are eligible for separate reimbursement to primary care providers (PCPs) for after hours service. After hours is defined as medical office services rendered after 6 p.m. and before 8 a.m. weekdays; or weekends and national holidays. This code may be reported

in addition to other services on the claim. The following types of practitioners are considered PCPs: general practice, family medicine, internal medicine, pediatrics and geriatrics. CPT 99050 and 99051 are not eligible for separate reimbursement at urgent care centers.

Cerumen removal

Removal impacted cerumen (ear wax) using irrigation/lavage unilateral, CPTcode 69209 (effective 1/1/2016), has been established to report the removal of impacted cerumen by irrigation and/or lavage. Several exclusionary and instructional notes were added to the CPT guidelines to ensure appropriate reporting of CPT codes 69209 and 69210 Removal impacted cerumen requiring instrumentation, unilateral. A new code was warranted to differentiate between direct and indirect approaches of removing impacted cerumen performed or supervised by physicians or other qualified health care professionals. Impacted cerumen is typically extremely hard and dry and accompanied by pain and itching, and can lead to hearing loss. CPT 69210 only captures the direct method of earwax removal utilizing instrumentation such as curettes, hooks, forceps, and suction. Another less invasive method uses a continuous low pressure flow of liquid (i.e., saline water) to gently loosen impacted cerumen and flush it out with or without the use of a cerumen softening agent (i.e., cerumenolytic) that may be administered days prior to the procedure or at the time of the procedure. CPT 69209 enables the irrigation or lavage method of impacted cerumen removal to be separately reported, and not mistakenly reported with CPT 69210. CPT codes 69209 and 69210 should not be reported together when both services are provided on the same day on the same ear. Only one code (CPT 69209 or 69210) may be reported for the primary service (most intensive time or skilled procedure) provided on that day on the same ear. Two instructional parenthetical notes have been added following CPT 69209 and 69210 to exclude them from being reported together. If either one of the cerumen removal procedures is done on both ears, modifier-50 should be appended as indicated in the new parenthetical note added following CPT

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codes 69209 and 69210. The E/M codes should be reported when non-impacted cerumen is removed according to the section category defined by the site of service (i.e., office or other outpatient, hospital care, nursing facility services) as instructed in the parenthetical notes following CPT 69209 and 69210.

Critical care services

CPT describes reporting guidelines for the time-based, critical care services codes (CPT 99291-99292) that are consistent with CareFirst policy. These guidelines also define procedures and services that are considered incidental to critical care. Examples of additional procedures that CareFirst considers to be incidental to critical care are as follows:

- Venipuncture, under age 3 (CPT 36400, 36405, 36406)
- Venipuncture (CPT 36415)
- Insertion of needle/catheter (CPT 36000)
- Transfusion procedures (CPT 36430)
- Intravenous fluid administration (i.e., CPT 96360–96379)
- Incidental services and procedures are not eligible for reimbursement.

Handling and conveyance

Handling and conveyance (CPT 99000–99002) is considered integral to most procedures and services including, but not limited to E/M, surgery, surgical pathology. Integral services are not eligible for reimbursement.

Hot and cold packs

Hot and cold packs (CPT 97010) are considered incidental or mutually exclusive to most services, including but not limited to, chiropractic manipulation, therapeutic exercise, therapeutic activity, manual therapy, massage, and whirlpool therapy. Incidental or mutually exclusive services are not eligible for reimbursement.

Supervision, interpretation and/or guidance for diagnostic tests

Interpretation of diagnostic studies, including but not limited to, laboratory, radiology,

electrocardiographic tests, are considered incidental or integral to all E/M services and other services that include evaluation components. Incidental or integral services are not eligible for reimbursement.

Specialty physicians (i.e., radiologists, cardiologists, pathologists) that perform the final interpretation and separate, distinctly identifiable, signed, written report (per CPT guidelines) of a diagnostic service may be eligible to receive reimbursement when the procedure is reported with CPT modifier-26.

CPT codes reported for supervision and interpretation and radiologic guidance (i.e., fluoroscopic, ultrasound or mammographic) are eligible for reimbursement to the extent that the associated procedure code is recognized and eligible for reimbursement, and provided that the associated procedure code does not include supervision and interpretation or radiologic guidance services. For each procedure (i.e., review of x-ray or biopsy analysis or ultrasound guidance), only one qualified provider/health care professional shall be reimbursed.

Reimbursing more than one provider for the same service represents duplicate procedure payment. Duplicate services are not eligible for reimbursement. (See also: *Duplicate services and multiple reviews*)

Introduction of intravenous needles/ catheters

Introduction of a catheter/needle (CPT 36000) is considered incidental to all anesthesia services, select radiology procedures, critical care E/M services, and all procedures that typically require the patient to have a peripheral IV line. Incidental procedures are not eligible for reimbursement.

Hydration, infusions and injections

Carefully follow CPT guidelines when reporting hydration, injection and infusion services alone or in conjunction with other infusion/injection procedures and/or chemotherapy. Because a number of factors determine correct code assignment (i.e., reason for encounter, indications for additional procedures, sequencing of initial, subsequent and concurrent procedures,

inclusive services and time) it is imperative the medical record documentation be accurate and clearly identify all of these pertinent issues to ensure reporting is accurate. Incidental and/or mutually exclusive editing will apply when certain inappropriate code combinations are reported together.

Select intravenous fluids, needles, tubing and other associated supplies are considered incidental to the administration of infusion /injection procedures. Incidental procedures are not eligible for separate reimbursement.

Routine injections (i.e., CPT 96372) are usually eligible for separate reimbursement when reported with office E/M services (exception CPT 99211) and a covered pharmaceutical agent. Carefully follow CPT guidelines when reporting injection procedures. Injections are considered incidental when reported with services such as, anesthesia, emergency and inpatient E/M, surgery, select radiology, and select therapeutic and diagnostic procedures. Incidental procedures are not eligible for reimbursement.

Hydration, infusion, and injection procedures provided in inpatient and/or outpatient centers are typically provided by personnel in those settings and reported on claims for those facilities. It is not appropriate, therefore, for the professional provider to report those services unless that provider personally performs the service.

Pulse oximetry

Non-invasive pulse oximetry determinations (CPT 94760–94762) are considered incidental when reported with E/M services, anesthesia, and other procedures. Incidental procedures are not eligible for reimbursement. These codes are only eligible for reimbursement when they are reported as stand-alone procedures (i.e., when no other services are provided to the patient on the same date).

Vital capacity measurements

This procedure (CPT 94150) is considered incidental to all other procedures. Incidental procedures are not eligible for reimbursement. This code is only eligible for reimbursement when it is reported as a stand-alone procedure (i.e., when no other services are provided to the patient on the same date.)

Supplies and equipment

CareFirst follows the CMS guidelines in terms of what is included in the practice expense for each procedure code. A portion of a procedure code's relative value unit (RVU) and associated reimbursement allowance is practice expense. The practice expense portion includes medical and/or surgical supplies and equipment commonly furnished in a practice, and are a usual part of the surgical, medical, anesthesiology, radiology, or laboratory procedure or service. This includes, but is not limited to:

- Syringes, biopsy and hypodermic needles (A4206–A4209, A4212–A4215)
- IV catheters and tubing (A4223)
- Gowns/gloves/masks/drapes (A4927–A4930)
- Scalpels/blades
- Sutures/steri-strips
- Bandages/dressings/tape (A4450–A4452, A6216–A6221)
- Alcohol/betadine/hydrogen peroxide (A4244–A4248)
- Sterile water/saline (A4216–A4218)
- Thermometers (A4931–A4932)
- Trays and kits (A4550)
- Oximetry and EKG monitors
- Blood pressure cuffs (A4660–A4670)

Therefore, additional charges for routine supplies and equipment used for a procedure, service, or office visit, and reported with CPT 99070, HCPCS code A4649 and any other code that describes these supplies or equipment, are considered incidental to all services and procedures. This is applicable whether or not the supply is reported with other procedures/services or is reported alone. Incidental services are not eligible for reimbursement and subscribers may not be balance-billed for them.

Note: Supplies and equipment used while treating a patient in an institutional or outpatient facility should not be reported by the professional provider, as these supplies are reported on the facility claim.

Miscellaneous services

Educational supplies (CPT 99071), medical testimony (CPT 99075), physician educational services (CPT 99078), special reports (CPT 99080), unusual travel (CPT 99082), telephone calls (CPT 99441–99443), and collection/interpretation/analysis of data stored in computers (CPT 99090–99091) are considered incidental to all services.

CareFirst subscriber contracts do not provide benefits for these services, and are not eligible for reimbursement.

Venipuncture

Venipuncture procedures (CPT 36400–36410) which require a physician's skill are eligible for separate reimbursement when reported with laboratory tests from the CPT 8xxxx series. Please note these procedures are not to be used for routine venipuncture. In addition, separate procedure rules apply.

Routine venipuncture procedures (CPT 36415) are considered incidental to all laboratory services. Incidental procedures are not eligible for reimbursement. Venipunctures may be eligible for separate reimbursement when reported with an E/M service or alone.

If a routine venipuncture (as noted above), laboratory test from the CPT 8xxxx series, and an E/M service are reported on the same claim, same date of service, and from the same provider, the venipuncture will be considered incidental to the laboratory test.

Visual acuity testing

Visual acuity screening (CPT 99173) is considered incidental to new and established office or other outpatient E/M services. Incidental procedures are not eligible for reimbursement. However, this procedure is eligible for separate reimbursement when reported with a new or established preventive medicine E/M service.

Medical/clinical photography

Photographs taken for any purpose are considered the same as the medical documentation for a patient. As with written or typed documentation, photography, regardless of the individual performing the photography, is considered to be an integral part of any service, procedure, or

episode of care. Integral services are not eligible for separate reimbursement.

Emergency medicine

Emergency medicine E/M services (CPT 99281–99285) are provided in a hospital-based emergency department (see CPT reporting guidelines).

Many procedures are performed on patients during the emergency care encounter and are provided by personnel employed by the hospital (i.e., nurses, respiratory therapists, phlebotomists, technicians). Procedures performed by hospital personnel are included in the facility charge, and should not be reported on the professional claim unless personally provided by the emergency physician or other qualified provider.

Services personally rendered by other physicians (consultants) are reported separately by those providers.

Procedures including, but not limited to the following, are considered incidental or mutually exclusive to emergency medicine E/M services:

- Inhalation treatment (CPT 94640)
- Ventilation management (CPT 94002–94004)
- Ear or pulse oximetry (CPT 94760–94762)
- Sedation (See operating procedure 9.01.003A in the [Medical Policy Reference Manual](#))
- Physician direction of EMS (CPT 99288)
- Interpretation of diagnostic studies

Certain procedures when personally performed by the emergency physician are usually eligible for separate reimbursement and include:

- Wound repair (CPT 12001–14350)*
- Endotracheal intubation (CPT 31500)
- Insertion of central venous catheter* (CPT 36555–36571)

* Global surgical rules apply. This means that E/M services are not eligible for separate reimbursement when provided with procedures for which the E/M is considered part of the surgical package. CPT modifier-25 may be required if there is a significant, separately identifiable E/M service provided on the same date as certain procedures (see *E/M Services During the Global Periods*). Emergency physicians who perform surgical procedures should report these with CPT modifier-54, as appropriate, since they typically provide the surgical component, not the pre-or post-operative component of the surgical package.

Physician direction of EMS (CPT 99288) when reported alone is not eligible for reimbursement.

Surgery/orthopedics

Anesthesia by operating surgeon

Administration of anesthesia by the surgeon, assistant surgeon, nursing staff or any other provider within the same clinical practice (same tax ID number) during a procedure is considered included in the allowance for the surgical procedure. This includes any method of anesthesia (i.e., general anesthesia, moderate (conscious) sedation, local or regional anesthesia, nerve blocks). Included in procedures are not eligible for reimbursement.

Fracture care, strapping/casting

Carefully follow CPT guidelines when reporting fracture care and casting/strapping. Fracture care provided by multiple providers on various days, is subject to historical claims auditing.

Certain casting supplies (i.e., HCPCS A4580, A4590) are eligible for separate reimbursement when reported with fracture care, and casting and strapping procedures.

Gender reassignment and transgender services

Gender reassignment and transgender services are often defined by the subscriber contract. For additional information on this topic, including authorization requirements, refer to medical policy 7.01.123 Gender Reassignment Services and 7.01.017 Cosmetic and Reconstructive Surgery with Attached Companion Table in the [Medical Policy Reference Manual](#).

Lesion removals and biopsies

Covered, non-cosmetic lesion removals are eligible for separate reimbursement according to the terms of the subscriber contract and applicable medical policies. Follow CPT guidelines for reporting excision, destruction, and shaving of benign and malignant lesions. Multiple lesion removal procedures reported together with the same CPT code are usually considered duplicates or mutually exclusive to each other because the claims systems

assumes same site. CPT modifier-59 should be appended to lesion removals subsequent to the primary procedure to indicate that they were distinct procedures (i.e., separate sites, separate lesions). Multiple procedure editing rules apply.

Lesion excision and wound closures

Follow CPT guidelines for reporting single and multiple wound closures. When intermediate, complex, or reconstructive closures are reported with lesion excisions, both procedures may be eligible for separate reimbursement. Simple wound repair procedures (CPT 12001) are considered incidental to excision of lesions in the same anatomic site. Incidental procedures are not eligible for separate reimbursement.

Surgical trays

As discussed in the supplies and equipment section of this guide, a portion of the RVU is practice expense. This also includes trays necessary for surgical procedures performed in the office setting. Therefore, additional charges for trays (HCPCS code A4550) used for a surgical procedure or during an office visit are considered incidental to all services and procedures. Incidental procedures are not eligible for reimbursement.

Nasal sinus endoscopy/debridement

Nasal sinus endoscopy (CPT 31237, separate procedure) is eligible for separate reimbursement when performed as postoperative care following functional endoscopic sinus surgical (FESS) procedures that have a zero day global period or after a ten day global period. Endoscopic surgical sinus cavity debridement is not eligible for separate reimbursement when performed as a postoperative treatment related to major surgeries (septoplasty) within a 90-day global period. When the patient is being followed postoperatively for both a zero or 10-day global and a major (90-day global) procedure, append CPT modifier-79 to CPT 31237 to indicate that the debridement is unrelated to the major procedure. In addition, ensure that medical record documentation and associated ICD-10 diagnosis codes accurately describe for which procedure(s) the endoscopic sinus debridement is being performed. It should

be noted that many nasal surgery codes are considered unilateral. Append CPT modifier-50 as appropriate when a procedure is performed bilaterally. As always, separate procedure rules apply, according to CPT guidelines.

Medicine/oncology

Allergy testing/immunotherapy

Allergy services and procedures benefits are often defined by the subscriber contract. For additional information on this topic, refer to medical policy 2.01.023, Allergy Testing, medical policy 2.01.017, Allergy Immunotherapy, and other applicable policies in the [Medical Policy Reference Manual](#).

Chemotherapy (office, inpatient and outpatient settings)

Chemotherapy procedures (CPT 96401–96549) are considered independent from E/M services. E/M services, when reported with chemotherapy, are not eligible for reimbursement unless CPT modifier-25 is appended to the E/M code to indicate that a significant, separately identifiable E/M service was performed in addition to the chemotherapy.

Carefully follow CPT guidelines when reporting chemotherapy services alone or in conjunction with other infusion and injection procedures. Because a number of factors determine correct code assignment (i.e., reason for encounter; indications for additional procedures; sequencing of initial, subsequent and concurrent procedures; inclusive services; and time) it is imperative the medical record documentation be accurate and clearly identify all of these pertinent issues so reporting is accurate. Incidental and/or mutually exclusive editing will apply when certain inappropriate code combinations are reported together.

Select intravenous fluids, needles, tubing and other associated supplies are considered incidental to the administration of chemotherapy. Incidental procedures are not eligible for separate reimbursement.

Medically necessary, non-experimental/ investigational chemotherapeutic agents and other drugs are usually eligible for separate reimbursement when reported with the appropriate HCPCS code.

Chemotherapy procedures provided in inpatient and/or outpatient centers are typically provided by personnel in those settings and reported on claims for those centers. It is not appropriate, therefore, for the professional provider (physician) to report those services unless that provider personally performs the service.

Nutrition therapy and counseling

Follow CPT guidelines for reporting nutritional therapy services. For instance, non-physicians should report these services using CPT codes 97802-97804. Physician providers are instructed to report these services with an appropriate E/M code.

Sleep disorders

CareFirst provides benefits for the diagnosis and management of sleep disorders, including oral appliances. Most sleep disorder services can be provided in the home setting. Refer to medical policy 2.01.018 in the [Medical Policy Reference Manual](#) for details and authorization requirements.

Genito-urinary

Erectile dysfunction

Refer to medical policy 2.01.025, Erectile Dysfunction, in the [Medical Policy Reference Manual](#).

Pediatrics/neonatology

Normal newborn

Benefits for newborn care are defined by the subscriber contract. Carefully follow CPT guidelines when reporting all aspects of newborn care. For further information, refer to medical policy 10.01.006, Care of the Normal Newborn in the [Medical Policy Reference Manual](#).

Neonatal and pediatric intensive care services

Carefully follow CPT guidelines for reporting pediatric critical care transport (CPT 99466–99467 and 99485–99486), inpatient neonatal and pediatric critical care (CPT 99468–99476), and initial and continuing intensive care services (CPT 99477–99480). Note that these represent 24-hour global services (except pediatric critical care transport), and may only be reported once per day, per

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patient. These guidelines also define procedures and services that are considered incidental to CPT 99468–99480.

Incidental services are not eligible for separate reimbursement.

Obstetrics & gynecology

Lactation consultations

Lactation consultation refers to the educational services provided to women who plan to breastfeed but encounter difficulties due to anatomic variations, complications and feeding problems with newborns by providing lactation support and counseling. Refer to medical policy 4.01.005, Lactation Consultations in the [Medical Policy Reference Manual](#).

Maternity services

Maternity benefits are defined by the subscriber contract. Carefully follow CPT guidelines for reporting maternity services, including reporting non-global services (i.e., separate antepartum, delivery, and/or postpartum care). Refer to medical policy operating procedure 4.01.006A, Global Maternity Care in the [Medical Policy Reference Manual](#).

Multiple Births: Refer to medical policy operating procedure 4.01.006A, Global Maternity Care in the [Medical Policy Reference Manual](#).

Contraceptive devices

Family planning services are defined by the subscriber contract. Established patient E/M services reported with insertions and removals of intrauterine devices (IUD) (CPT 58300-58301) are considered to be included in the surgical package for the procedure, and thus are not eligible for separate reimbursement unless the E/M service is a significant, separately identifiable service. In that case, CPT modifier-25 should be appended to the E/M service.

Diaphragm/cervical cap fitting (CPT 57170) is considered incidental to all established patient E/M services. Incidental procedures are not eligible for reimbursement.

Radiology/imaging

Mammography

Mammography benefits are defined by the subscriber contract. Depending on the subscriber contract and related [CareFirst Preventive Services Guidelines](#), both a screening and/or diagnostic mammogram may be eligible for reimbursement on the same date of service. In this case, the procedure with the higher RVU will be reimbursed at 100 percent of the allowed benefit, and the procedure with the lesser RVU will be reimbursed at 50 percent of the allowed benefit.

Digital breast tomosynthesis

CPT codes 77061 digital breast tomosynthesis; unilateral, 77062 digital breast tomosynthesis; bilateral and 77063 screening digital breast tomosynthesis, bilateral were added effective 1/1/2015. These codes were established to report diagnostic and screening breast tomosynthesis, unilateral and bilateral procedure. The digital breast tomosynthesis images, and if acquired, the conventional mammography images, are utilized for interpretation for screening and diagnostic mammograms. The addition of digital breast tomosynthesis to conventional mammography has been shown to be more sensitive and specific for breast cancer screening.

Instructional parenthetical notes have been added to ensure appropriate reporting of breast tomosynthesis imaging procedures. It is appropriate to report CPT 77061 and 77062 (diagnostic breast tomosynthesis) in conjunction with CPT 77055 and 77056 (conventional diagnostic mammography). It is appropriate to report CPT 77063 (bilateral screening breast tomosynthesis) in conjunction with CPT 77057 (conventional bilateral screening mammography).

Exclusionary parenthetical notes have been added to further clarify the reporting of breast tomosynthesis imaging procedures. It would not be appropriate to report add-on CPT code 77063 (screening breast tomosynthesis) in conjunction with CPT codes 77055 and 77056 (conventional diagnostic mammography) or CPT 76376 or 76377 (three-dimensional reconstruction). It would not

be appropriate to report CPT 77061 and 77062 (diagnostic breast tomosynthesis) in conjunction with CPT 77057 (conventional screening mammography) or CPT 76376 or 76377 (three-dimensional reconstruction).

Diagnostic ultrasound with ultrasound (US) guidance procedures

- Limited diagnostic ultrasound procedures reported with ultrasound guidance procedures
 - When a limited diagnostic ultrasound (CPT 76705) and an ultrasonic guidance procedure (CPT 76942) are reported on the same date, it is assumed by our claims system that both were performed during the same session in the same anatomic area. Based on CPT guidelines, an ultrasound (US) guidance procedure includes imaging protocols that are comparable to the limited diagnostic US. Therefore, when these two procedures are reported together on the same date, the limited US is considered mutually exclusive to the US guidance. Mutually exclusive services are not eligible for separate reimbursement. The procedure with the higher RVU value is eligible for reimbursement.
- Diagnostic ultrasound procedures reported with ultrasound guidance procedures
 - When an US guidance procedure (CPT 76942) and an US procedure (CPT 76536) are reported on the same date, it is assumed by our claims system that both were performed during the same session in the same anatomic area. Based on CPT guidelines an US guidance procedure includes imaging protocols that are comparable to the US procedure. Therefore, when these two procedures are reported together on the same date, the US procedure is considered mutually exclusive to the US guidance. Mutually exclusive services are not eligible for separate reimbursement. The procedure

with the higher RVU value is eligible for reimbursement.

- Ultrasound guidance procedures reported with ultrasound guidance procedures
 - When multiple US guidance procedures (i.e., CPT 76930 and CPT 76942) are reported on the same date, it is assumed by our claims system that both were performed during the same session in the same anatomic area and for similar clinical indications. When these procedures are reported together on the same date, the code with the lower RVU value will be considered mutually exclusive to the code with the higher RVU value. Mutually exclusive services are not eligible for separate reimbursement. The procedure with the higher RVU value is eligible for reimbursement.

In each of these scenarios there may be particular clinical circumstances in which the procedures are performed on separate anatomic sites, and/or there may be distinct clinical indications for each study. In these circumstances, it will be necessary to append the appropriate modifier(s) to the code(s) to indicate such. Documentation in the medical record must support the reason for multiple reporting of these procedures.

Invasive and non-invasive diagnostic tests and procedures

Many of these tests and procedures (i.e., cardiac catheterizations, electrophysiological studies, imaging studies) can be reported several ways depending on ownership of equipment, place of service, who is performing the service and who is supervising and/or interpreting the results of the test. Providers must report these services appropriately in order for the claim to be properly adjudicated. Refer to the basic claim adjudication policy concepts section, under modifier reimbursement guidelines, regarding reporting global and/or components of these services. (See also *Duplicate Services and Multiple Reviews*)

