Provider Administrative

Handbook

CENTRUS HEALTH DIRECT

C

Centrus Health Direct

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Centrushealthdirect.com

Centrus Health Direct

*Powered by Sync*

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## Welcome to Centrus Health Direct

Centrus Health Direct is excited to have you participate in the provider network, HCH Sync Centrus.

The provider network is Centrus Health Direct’s proprietary network that is growing rapidly and will cover the Kansas and Missouri markets. This Administrative Handbook provides the policies, processes and guidelines for providers participating in this network.

PARTICIPANT ACCESS TO THE CENTRUS HEALTH DIRECT NETWORK

Plan Participants access the network and are directed to network participating providers. A sample ID card can be found below.



|  |  |  |
| --- | --- | --- |
| **Participants accessing the HCH Sync Centrus Network:** | **The Participant’s ID Card identifies how the Participant accesses the network:** | **Responsible party for Plan Administration:** |
| Payer Access utilizing the HCH Sync Centrus Provider Network | The Employer’s and/or Administrator’s name will be identified on the front of the ID card | Third Party Plan Administrators |

**NOTE:** Applicable Laws, Regulations and Contractual Provisions: This Administrative Handbook outlines the general operational policies and procedures Providers should follow to ensure compliance with Centrus Health Direct requirements for claim payment, UM, credentialing, quality program and claim/UM appeals. All applicable laws, regulations and provider contract terms shall supersede those specific areas of this Administrative Handbook when what is contained in them conflicts with this document. All provisions of this document not in conflict with applicable laws, regulations and contractual provisions remain in effect for contracted providers.

Important Information to Know

The table below provides important information you need to know along with contact information when you need assistance:

|  |  |
| --- | --- |
| **Information Source** | **Centrus Plan Direct Participants** |
| Group ID | Access the Centrus Health Direct Provider Portal or refer to the participant's ID card |
| Electronic Claim Filing Payor ID | Access the Centrus Health Direct Provider Portal or refer to the participant's ID card |
| EFT/ERA Payment System | Refer to the participant’s ID card |
| Claims Address and Claims Appeals | Refer to the participant’s ID card |
| Customer Service | Refer to the participant’s ID card |
| Medical Managementand Precertification | Refer to the participant’s ID card |
| Online Eligibilityand Benefits | Refer to the participant’s ID card |
| List of Network Providers | Refer to the participant’s ID card, or in Texas, visit [healthcarehighways.com/provider-search/](file:///C%3A%5CUsers%5Cdgrote%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CINetCache%5CContent.Outlook%5CAC4MVGJK%5Chealthcarehighways.com%5Cprovider-search%5C) |
| Claims and Eligibility Inquiries | Refer to the participant’s ID card |
| Provider Portal | Refer to the participant’s ID card |
| Provider Demographic Updates | <https://www.healthcarehighways.com/providers>. Under the Helpful Resources section, find the “Update your information” link. |

## Network Participation – Provider Responsibilities

Proprietary Information

All information and materials provided to you by Centrus Health Direct, Clients or Administrators remain proprietary to Centrus Health Direct, Clients or Administrators. This includes, but is not limited to, your Participating Provider Agreement and its terms, conditions, and negotiations; any Program, rate or fee information; Centrus Health Direct Client or Administrator lists; any administrative handbook(s), and/or other operations manuals. You may not disclose any of such information or materials or use them except as may be permitted or required by the terms of your Centrus Health Direct Participating Provider Agreement.

Verifying Eligibility and Benefits

It is important to check the Participant’s eligibility and benefits prior to rendering services. This helps ensure that the claim is submitted correctly, allows you to collect copayments, coinsurance and deductible amounts, and secure pre-cert as required and reduces denials for non-covered services.

Please note that while coinsurance and deductible amounts may be accurate at the time benefits are provided, other provider claims could be processed prior to changing the coinsurance and/or deductible amounts a Participant owes. When Participants are due a refund, Providers should refund such amounts as soon as possible but no later than 15 days following receipt of an explanation of payment showing the correct Participant responsibility that should have been collected.

Access Standards

Primary Care Providers must arrange for 24-hour coverage of their patients, seven days per week. If you are unable to provide care and are arranging for a covering physician, we ask that you arrange for care from other providers who participate with the Centrus Health Direct network, so that services may be covered under the Participant’s network benefit. To find the most current directory of Centrus Health Direct’ Network of Providers, go to [www.healthcarehighways.com/providers.](http://www.healthcarehighways.com/providers.)

Centrus Health Direct has established standards for appointment access and after-hours care to help ensure timely access to care for Participants.

|  |  |
| --- | --- |
| Preventive Care | Four (4) Weeks |
| Regular/Routine Care | Two (2) Weeks |
| Urgent Care | Same Day |
| Emergency Care | See below |
| After-Hours Care | For PCPs, 24 hours, seven days per week |

**Preventive care** is defined as medical care that seeks to prevent illnesses, for example, yearly mammograms or regular checkups.

**Routine care** is defined as the regular care a patient gets from his/her primary care physician or specialty providers. Routine care can include checkups, physicals, health screenings and care for health problems like diabetes, hypertension and asthma.

**Urgent care** is defined as a health situation that is not an emergency but is severe or painful enough that medical treatment is required to prevent serious deterioration of the patient’s condition or health.

**Emergency care** is defined as medical services required for the immediate diagnosis and treatment of health conditions which, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death.

**After-Hours Care** is medical care provided after the regular practice schedule of physicians. Usually after- hours care is designed to deliver 24-hour-a-day and 365-day-a-year patient care coverage for emergencies, triage, pediatric care, or hospice care.

It is important that every Participant calling a provider’s office after-hours is provided emergency services or directions whether a line is answered by a live person or by a recording. Callers with an emergency are expected to be told to:

* Hang up and dial 911
* Go to the nearest emergency room

In non-emergent circumstances, we would prefer that you advise callers who are unable to wait until the next business day to:

* Go to a network urgent care center at www.healthcarehighways.com/providers or (for member searches) Error! Hyperlink reference not valid.
* Stay on the line to be connected to the physician on call
* Contact their applicable telemedicine providers
* Leave a name and number with the answering service (if applicable) for a physician or qualified health care professional to call back within specified time frames
* Call an alternative phone or pager number to contact the physician on call

Provider Privileges

Providers who provide care to patients in a facility must have privileges at applicable participating facilities or arrangements with a participating practitioner to admit and provide facility services to Participants. This includes, but is not limited to, full admitting hospital privileges, ambulatory surgery center privileges, and/or dialysis center privileges. This helps our Participants get access to appropriate care and to minimize their out-of-pocket costs.

Notification of Provider Changes

Centrus Health Direct is committed to providing you and our Participants an excellent service experience with the most accurate and up-to-date information about the Centrus Health Direct network including accurate phone numbers and addresses of our participating providers and facilities. It is important that Centrus Health Direct receive proactive notification of any changes which should be updated in the Centrus Health Direct database including the below examples:

* Office and/or billing address(es) and phone number(s)
* Provider email address
* A change in physician panel status: accepting new patients, current patients only or closed to all new patients
* Hospital affiliation(s)
* Provider’s specialty
* The provider’s license(s)
* Tax identification number (requires submission of W-9)
* NPI(s)
* Office hours
* Any changes to participating providers in the group

Providers failing to provide such information may cause claim payment delays and any applicable late claims payment penalties will not apply.

Updating Your Information with Centrus Health Direct

Providers can update information using any of the following options:

* Online using the “Provider Updates” form at [www.healthcarehighways.com/providers](http://www.healthcarehighways.com/providers%20) in the Providers section of the site.
* Email: centrusproviderupdates@healthcarehighways.com
* Work directly with your Provider Relations contact
* Call us at: 888.806.3400
* Secure Fax: 469.533.1646
* Mail Attn: Network Development, 3001 Dallas Parkway, Ste. 700, Frisco, TX 75034.

Additional pertinent documents (such as your W9, or licensure) can be attached to the online form before submission, or they can be sent separately to Centrus Health Direct via email, secure fax, or mail.

When sending additional documents via email or secure fax, please note “Provider Update” in the subject line of your communication and let us know that you have also sent information via our online website form, so we can ensure that we have received all information submitted.

Please allow up to thirty (30) days for Centrus Health Direct to make the requested changes in our system.

Prevention Of Fraud, Waste and Abuse

If a Provider or Provider Organization identifies potential fraud, waste, or abuse (FWA), they must report it to Centrus Health Direct immediately. Centrus Health Direct maintains a telephone and email FWA reporting system as a mechanism for Provider Organizations, providers, employees, Participants, and others to: hch.operations@healthcarehighways.com.

Report concerns and possible violations of law, regulations, policies, procedures; ask questions about the Compliance Program; and seek advice about how to handle compliance-related situations at work.

The FWA Reporting System is anonymous. All calls are treated confidentially, and senders/callers can remain anonymous if they so choose. Callers may be asked whether they are willing to identify themselves so that an issue may be followed up with the caller after the call ends. Retaliation against anyone who raises a concern is prohibited.

If you have a compliance-related question, concern, or suspect a problem, please call the Centrus Health Direct Fraud Line at 888.806.3400

Charging Participants Additional Fees

You may collect Participant financial responsibility for Covered Services. However, it is not appropriate to charge Participants fees beyond copayments, coinsurance, or deductibles as described in the Participant benefit plans. This includes fees for membership/concierge practices or other administrative fees. This does not prevent you from charging Participants nominal fees for missed appointments, medical record requests/transfers or completion of camp/school forms.

Charging Participants for Non-covered Services

You may seek and collect payment from Participants for services not covered under the applicable benefit plan, provided you first obtain the Participant’s written consent to render payment for the services that are not covered. The consent must be signed and dated by the Participant prior to rendering the specific service(s) in question. Retain a copy of this consent in the Participant’s medical record. If you know, or have reason to suspect, the service may not be covered (as described below), the written consent also must include: (a) an estimate of the charges for that service; (b) a statement of reason for your belief the service may not be covered; and (c) planned services which are not covered services, a statement that Centrus Health Direct or plan administrator has determined the service is not covered and that the Participant, with knowledge of this determination, agrees to be responsible for those charges.

Balance Billing

Providers may not balance bill Participants for additional payment of covered services beyond a Participant’s cost share amounts (copayments, deductibles, or coinsurance) associated with their benefit plan.

## Network Participation – Claim Administration

Claims Subject to Subrogation and Coordination of Benefits

Centrus Health Direct benefit plans are subject to subrogation and Coordination of Benefits (COB) rules.

Subrogation

To the extent permitted under applicable state and federal law and the applicable benefit plan, we reserve the right to recover benefits paid for a Participant’s health care services when a third party causes the Participant’s injury or illness.

Coordination of Benefits (COB)

Coordination of Benefits is administered according to the Participant’s benefit plan and in accordance with applicable law. We accept secondary claims electronically as well as paper claims. When filing for secondary payment submit the payment advice/EOP from the primary payor with your claim as the secondary. Medical necessity determinations of the primary payor will be accepted by Centrus Health Direct as the secondary payor. When coordinating benefits with Medicare, if Medicare is the primary payor, we will process up to the Medicare allowed amount. CMS determines the rules for instances when Medicare processes claims as the primary or secondary payor.

Benefit Maximums

When a Participant’s annual benefit maximum for a particular type of Covered Service has been met, you may not “balance bill” Participants for the difference in billed charges and the Contract Rates. However, unless otherwise stated in your provider agreement, you may bill the Participant for the Contracted Rate once the Participant has reached the Benefit Program Maximum.

A benefit maximum limits the Centrus Health Direct cumulative responsibility for payment of a select set of services to some annual dollar amount or service encounters such as chiropractic or long-term acute care. Benefit maximums apply annually when the patient remains a Participant under a Program. When a service, treatment or supply is not covered pursuant to the Program and/or does not qualify under any circumstance as a Covered Service for the Participant, Network Providers may bill the Participant at your billed charges for the “excluded” service.

## Network Participation – Quality Management

Quality Management Program

The Quality Management (QM) program focuses on helping to ensure access to the delivery of health care services for all our members through the implementation of a comprehensive, integrated, systematic process that is based on quality improvement principles. The Program includes the following areas:

* Measuring adherence to physician service standards in areas such as wait times for appointments, in- office care and practice size and availability. To measure this, we use compliance data, and random surveys of Provider office scheduling time frames.
* Evaluating and resolving complaints originating from various sources including Participants, Clients and Administrators regarding the delivery of health care services and managing resolution through a standard process.
* Monitoring performance of QM-related functions which includes activities such as oversight of medical policies and procedures, clinical coverage policies, medical record maintenance, encounter reporting, and regulatory compliance.

Provider Credentialing and Recredentialing

The Centrus Health Direct network credentialing process is designed to provide initial and ongoing assessment of the provider’s ability to deliver patient care and treatment within limits defined by licensure, liability coverage, certification and/or accreditation.

Centrus Health Direct may be responsible for the credentialing process unless you participate through a physician organization that has been delegated credentialing by Centrus Health Direct. If credentialing is not delegated and required by Centrus Health Direct, applicable providers may be contacted to initiate the credentialing process.

Office-based practitioners are encouraged to complete the CAQH ProView database online application and authorize Centrus Health Direct to their application.

Ancillary Providers can obtain a Healthcare Delivery Application to initiate their credentialing with Centrus Health Direct.

Facilities

Centrus Health Direct may credential acute inpatient facilities, behavioral health facilities, skilled nursing facilities, ambulatory surgery centers and home health providers.

Centrus Health Direct verifies:

* State license
* Accreditation
* Excluded Parties List System
* Office of the Inspector General
* National Provider Identifier

Following the verifications, the Medical Committee reviews facility applications for final approval

Physicians / Providers

Physician credentialing uses CAQH applications and attestations. All physicians that meet requirements are referred to the Credentialing and Peer Review Committee for final approval.

Following are the Centrus Health Direct credentialing criteria:

* Verification of unrestricted state medical license with appropriate licensing agency
* Verification of valid, unrestricted DEA certificate and CDS certificate, if required by the state
* Verification of clinical privileges in good standing on the medical staff at a participating hospital
* Board certification status with the American Board of Medical Specialties or the American Osteopathic Association
* Verification of education and training
* Review of work history (not needed for recredentialing)
* Verification of prior sanctioning activities by regulatory bodies and by CMS
* Review of malpractice claims history
* Verification of adequate malpractice insurance
* Proof of appropriate professional licensing (only for practitioners whose professions do not require medical licensure)

Recredentialing of providers occurs every three years. Information from Quality Management (QM), Utilization Management (UM), Participant Services, and Appeals & Grievances is considered at the time of recredentialing. Provider status and performance is continuously monitored between recredentialing cycles by Centrus Health Direct or its delegated entity. Ongoing monitoring of reports by regulatory agencies of sanctions, limitations on licensure, and complaints are also performed between recredentialing cycles.

Centrus Health Direct complies with applicable state and federal requirements and NCQA standards in credentialing and recredentialing its providers. Providers must maintain a good standing with state and federal regulatory and licensing bodies.

Credentialing Delegation and Oversight

Centrus Health Direct may delegate credentialing activities to contracted Provider Organizations that have administrative capacity to provide such services and meet delegation requirements as demonstrated in a pre-delegation review. Approved Provider Organizations shall execute a delegation agreement at the time of approval.

Centrus Health Direct may perform and requires delegated entities to perform ongoing internal audits to ensure the credentialing status of its providers remains current. Audits include validation of licensure, malpractice, DEA, OIG and other sanctions, and current status of applicable certification and/or accreditation. This oversight includes annual audits of the delegated Provider Organizations credentialing documentation and procedures.

Credentialing/Recredentialing Appeals

Providers who have been declined participation or participation has been terminated due to credentialing determination have the right to appeal. Appeals should be made in writing within 30 days of the date on the denial notification and sent 3001 N Dallas Pkw, Ste. 700, Frisco, TX 75034. All necessary information will be included in the notification sent to the provider.

Non-Discrimination Policy

Centrus Health Direct has the following processes and criteria in place to prevent discriminatory credentialing. Any delegated entities must similarly comply.

* Tracking and trending of reasons for denial and/or termination
* Semi-annual audits of files in process for greater than six (6) months to determine compliance with practitioner contact criteria
* Non-discrimination clause on the “Statement of Confidentiality” signed by Participants, staff, and guests of the Credentialing Committee on an annual basis
* Non-discrimination statement on Credentialing Committee attendance sign-in form. Information submitted to the Credentialing Committee for approval, denial or termination must not designate a provider’s race, ethnic/national identity, gender, age, sexual orientation, types of procedures performed.

Medical Record Documentation

Centrus Health Direct established medical record standards to facilitate communication, coordination, and continuity of care, and to promote good professional medical practice and appropriate healthcare management. Centrus Health Direct regularly assesses compliance with these standards. These standards are a compilation of the standards required by the Centers for Medicare and Medicaid Services (CMS).

Centrus Health Direct provides these Medical Records Standards to providers to address the following:

* Confidentiality of medical records
* Medical record documentation standards
* Organized medical recordkeeping system
* Standards for the availability of medical records
* Performance goals to assess the quality of medical record documentation

In addition, Centrus Health Direct has developed procedures to improve medical record documentation. The following standards have been defined for each category of the medical record documentation.

Timeliness of Response to Medical Record Request

By contract, provider offices must provide medical records in a timely manner upon request by Centrus Health Direct. Response timeliness is scored as part of the record review.

Member Identification

* Member name or identification number on all pages
* Personal/biographical information (i.e., date of birth, member address, employer, home, and work phone number(s))
* Member ethnicity documented on an intake form or with biographical information

Quality of Medical Records

All medical record entries are to be documented as follows:

1. Date of entry and the date of encounter
2. Author of each entry signed or co-signed
3. Each page of medical record must be legible
4. History and physical examination of current medical conditions noted and dated
5. Past medical history noted, easily identifiable, and to include serious accidents, operations, and illnesses for members having at least three (3) visits
6. Health maintenance is noted
7. Problems list is updated as necessary
8. Medication list (including both current and PRN medication) is updated as necessary; what is working; what is not working; and what medications were completed, renewed, or are new
9. Tobacco, alcohol, substance use, and sexual activity
10. Physical examinations are documented
11. Clinical findings and evaluation for each visit

Advance Directives

All adult member charts should include documentation of Advance Directive discussion. An adult is any member aged 18 or older. Documentation should include whether the member did or did not execute an Advance Directive and a copy should be included in the medical record.

Adverse Reactions

Medication allergies and adverse reactions are prominently noted and dated in the record. If no known allergies, the following abbreviations are acceptable: NKA (no known allergies) or NKDA (no known drug allergies)

Behavioral Health (BH) Conditions

Member charts should include documentation for behavioral health conditions, as appropriate. This includes evidence of the following:

* Diagnosis and/or BH history (including BH-related screening, assessment, or treatment information)
* Medication review, including dosage and frequency
* Communication between Primary Care and Behavioral Health Providers

Continuity and Coordination of Care Labs/Tests

* **The Primary Care Provider (PCP) reviews results of all ancillary services and diagnostic tests or studies ordered by other providers. It may be initialed or a note indicating the lab work was reviewed may be present in the progress/office note**
* **Documentation that the member has been notified of abnormal test or lab results and explicit follow-up plans for all abnormal lab or test results**

Consults

* Consultant's reports or documentation of discussions with consulting physicians should be in the medical record
* Upon review of the provider's summary, the provider should initial or include a note indicating that the reports and/or summaries were reviewed; this documentation should be present in the progress/office note and fastened or secured in the chart
* Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits; the specific time of return is noted in weeks, months, or as needed
* There is a notation of any instructions/education given to members regarding follow-up visits, care, treatment, or medication schedules, and diagnostic and therapeutic services where members are referred for services
* Home health nursing reports
* Specialty physician reports
* Hospital discharge reports
* Outpatient/ambulatory surgery reports

Immunization Record

Childhood, adolescent, and adult immunizations per preventive health guidelines based on the Centers for Disease and Control.

Preventive Healthcare Services

Preventive healthcare services should be noted in the medical records for members, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program services. The information should include the following:

* Evidence of required age-specific preventive screenings based on approved national practice guidelines
* Obesity screening with each physical examination and EPSDT visit, which shall include assessment and documentation of age, height, and gender appropriate weight, height/length measurements, and Body Mass Index percentile designation

Lead Screening

Lead screening based on national and state requirements such as EPSDT or individual risks.

Verifying Eligibility and Benefits

It is important to check the Participant’s eligibility and benefits prior to rendering services. This helps ensure that the claim is submitted correctly, allows you to collect copayments, coinsurance and deductible amounts, and secure pre-cert as required and reduces denials for non-covered services. Please refer to the Participant’s identification card for the Customer Service phone number to verify eligibility and benefits.

Please note that while coinsurance and deductible amounts may be accurate at the time benefits are provided, other provider claims could be processed prior to yours changing the coinsurance and/or deductible amounts a Participant owes. When Participants are due a refund, Providers should refund such amounts as soon as possible but no later than 15 days following receipt of an explanation of payment showing the correct Participant responsibility that should have been collected.

Utilization Management

You are required to participate in and observe the protocols of Client or Administrator’s Utilization Management programs for health care services rendered to Participants. Utilization Management requirements may vary by Client or Administrator, and by the Participant’s Program and may include, but is not limited to, pre-cert, concurrent review, and retrospective review. Utilization Management programs may also include case management, maternity management, and mental health management services.

Pre-Certification of Services

Some Utilization Management programs used by Client or Administrators require Pre-Cert. Please verify any certification or other Utilization Management requirements at the time you verify benefits and eligibility. As part of the Certification process, please be prepared to provide the following information by telephone, fax, or through any other method of communication acceptable to the Client or Administrator’s Utilization Management program:

* Client or Administrator name
* Group policy number or name
* Policyholder’s name, social security number and employer (group name)
* Patient’s name, sex, date of birth, address, telephone number and relationship to policyholder
* Participating Provider’s name and specialty, address and telephone number
* Facility name, address and telephone number
* Scheduled date of admission/treatment
* Diagnosis and treatment plan
* Significant clinical indications
* Length of stay requested

Based upon the Client or Administrator’s Utilization Management program you may be required to obtain Pre-cert for the following:

* Inpatient admissions
* Outpatient surgery
* Emergency admissions - Pre-cert of all admissions following an emergency room visit is usually required within forty-eight (48) hours after the admission
* Length of stay extensions - In the event a length of stay extension is required for those health care services initially requiring pre-cert, you may be required to obtain additional pre-cert from the Utilization Management program prior to noon of the last certified day.

To obtain pre-cert for the above procedures, call the telephone number on the Participant ID card. You may be required to obtain separate pre-cert for multiple surgical procedures. To facilitate a review, be sure to initiate the pre- certification process a minimum of seven to ten (7-10) days before the date of service.

Concurrent Review

Network Facilities may be required to participate in the Utilization Management program of Concurrent Review. A nurse reviewer performs Concurrent Review to document medical necessity and facilitate discharge planning.

Case Management

Case management identifies those Participants whose diagnoses typically require post-acute care or high level and/or long-term treatment. The case manager works with providers and family Participants to formulate a plan that efficiently utilizes health care resources to achieve the optimum patient outcome. Case management services may be provided for Participants who may benefit from:

* Change in facility or location of care
* Change in intensity of care
* Arrangements for ancillary services
* Coordination of complex health care services

Referrals

Refer Participants to Centrus Health Direct participating providers when referrals are required. Our participating provider network can be found at [www.healthcarehighways.com/providers.](http://www.healthcarehighways.com/providers.%20) Referring to participating providers minimizes a Participant’s out-of-pocket costs.

Appeals Process for Care Management Decisions

The appeals process may vary by the Client or Administrator’s Utilization Management program and/or as mandated by state or federal law. In the event you or a Participant do not agree with a noncertification determination made under the Utilization Management program, you or the Participant has the right to appeal the determination in accordance with the Client or Administrator’s Utilization Management program appeals process.

To obtain details of the Client or Administrator’s Utilization Management program appeals process, please contact the appropriate Client or Administrator.

Failure to observe the protocols of the Utilization Management program may also result in a reduction of benefits to the Participant. You are responsible for notifying the Participant of any potential financial implications associated with failure to observe the Utilization Management Program protocols.

## Claims Information and Reimbursement Policies

Claim Submission

The following elements are required for claim payment:

* Participant’s name, address, gender, date of birth (dd/mm/yyyy), relationship to subscriber (policy owner)
* Subscriber’s name (enter exactly as it appears on the Participant’s health care ID card), ID number, employer group name and employer group number
* Rendering provider’s name, their signature or representative’s signature, address where service was rendered, “Remit to” address, phone number, NPI and federal TIN
* Referring physician’s name and TIN (if applicable)
* Complete service information, including date of service(s), place of service(s), number of services (day/ units) rendered, current CPT and HCPCS procedure codes, with modifiers where appropriate, current ICDCM diagnostic codes by specific service code to the highest level of specificity (it is essential to communicate the primary diagnosis for the service performed, especially if more than one diagnosis is related to a line item)
* Charge per service and total charges
* Detailed information about other insurance coverage
* Information regarding job-related, auto or accident information, if available

Additional Information Needed for a Complete Ub-04 Or Cms-1450 Form:

Your claim may be pended, rejected, or not processed if you omit any of the following:

* Date and hour of admission
* Date and hour of discharge
* Participant status-at-discharge code
* Type of bill code (three digits)
* Type of admission (e.g., emergency, urgent, elective, newborn)
* Current four-digit revenue code(s)
* Attending physician ID
* For outpatient services/procedures, the specific CPT or HCPCS codes, line-item date of service, and appropriate revenue code(s) (e.g., laboratory, radiology, diagnostic or therapeutic)
* Complete box 45 for physical, occupational or speech therapy services (revenue codes 0420- 0449)

Claim Editing and Bundling

Centrus Health Direct uses industry standard claim editing and bundling programs such as CMS and McKesson when processing claims.

Evaluation and Management

Centrus Health Direct incorporates standards established by the Centers for Medicare and Medicaid Services (CMS) for our evaluation and management (E&M) services reimbursement policy. All services should be coded to the appropriate level of care, as laid out in the CMS guidelines, and should be able to be substantiated by medical records.

**Modifiers**: Code modifiers used for E&M services billing should be appropriate for the services rendered and should be able to be supported by medical records. Centrus Health Direct may request medical records to ensure that the included modifiers adhere to the standards outlined by the CMS.

Obstetrical Care Bundling Reimbursement Policies

Maternity care includes antepartum care, delivery services, and postpartum care. This policy describes reimbursement for global obstetrical (OB) codes and itemization of maternity care services. In addition, the policy indicates what services are and are not separately reimbursable to other maternity services. Unless otherwise specified, for the purposes of this policy Same Group Physician and/or Other Health Care Professional includes all physicians and/or other healthcare professionals of the same group reporting the same federal tax identification number.

**Global Obstetrical Care**

Global Obstetrical Care as defined by the American Medical Association (AMA), "the total obstetric package includes the provision of antepartum care, delivery, and postpartum care." When the Same Group Physician and/or Other Health Care Professional provides all components of the OB package, report the global OB package code.

**Antepartum Care Only**

Accommodates for situations such as termination of a pregnancy, relocation of a patient or change to another physician. In these situations, all the routine antepartum care (usually 13 visits) or global (OB) care may not be provided by Same Group Physician and/or Other Health Care Professional.

**Delivery Services Only**

Includes admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery.

**Postpartum Care Only**

Includes the postpartum period to be six weeks following the date of the cesarean or vaginal delivery.

**Delivery + Postpartum Care**

Sometimes a physician performs the delivery and postpartum care with minimal or no antepartum care. In these instances, the CPT book has codes for vaginal and cesarean section deliveries that encompass both services. The following are CPT defined delivery plus postpartum care codes:

|  |  |  |
| --- | --- | --- |
| **Code(s)** | **Description** | **Code Type** |
| 59400 | Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care | Global Obstetric |
| 59510 | Routine obstetric care including antepartum care, cesarean | Global Obstetric |
| 59610 | Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery | Global Obstetric |
| 59618 | Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery. | Global Obstetric |
| 59425 | Antepartum care only; 4-6 visits | Antepartum Care Only |
| 59426 | Antepartum care only; 7 or more visits | Antepartum Care Only |
| 59409 | Vaginal delivery only (with or without episiotomy and/or forceps) | Delivery Services Only |
| 59514 | Cesarean delivery only | Delivery Services Only |
| 59612 | Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps) | Delivery Services Only |
| 59620 | Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery | Delivery Services Only |
| 59430 | Postpartum care only (separate procedure) | Post-Partum CareOnly |
| 59410 | Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care | Delivery + Post- Partum |
| 59515 | Cesarean delivery only; including postpartum care | Delivery + Post-Partum |
| 59614 | Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care | Delivery + Post- Partum |
| 59622 | Cesarean delivery only following attempted vaginal delivery after previous cesarean delivery; including postpartum care. | Delivery + Post- Partum |

**High Risk/Complications**

A patient may be seen more than the typical 13 antepartum visits due to high risk or complications of pregnancy. These visits are not considered routine and can be reported in addition to the global obstetrical codes. The submission of these high risk or complication services is to occur at the time of delivery, because it is not until then that an appropriate assessment for the number of antepartum visits can be made. Centrus Health Direct will separately reimburse for E/M services associated with high risk and/or complications when modifier 25 is appended to indicate it is significant and separate from the routine antepartum care and the claim is submitted with an appropriate high risk or complicated diagnosis code.

**E/M Service with an Obstetrical (OB) Ultrasound Procedure**

Centrus Health Direct follows ACOG coding guidelines and considers an E/M service to be separately reimbursed in addition to an OB ultrasound procedures (CPT codes 76801-76817 and 76820- 76828) only if the E/M service has modifier 25 appended to the E/M code. If the patient is having an OB ultrasound and an E/M visit on the same date of service, by the Same Individual Physician or Other Health Care Professional, per ACOG coding guidelines the E/M service may be reported in addition to the OB ultrasound if the visit is identified as distinct and separate from the ultrasound procedure. Per CPT guidelines, modifier 25 should be appended to the E/M service to identify the service as separate and distinct.

**Multiple Gestation**

Centrus Health Direct reimbursement for twin deliveries follows ACOG's coding guidelines for vaginal, cesarean section, or a combination of vaginal and cesarean section deliveries.

Observation

Except when modified per your participation agreement, an Observation Stay is an alternative to an inpatient admission that allows reasonable and necessary time to evaluate and render medically necessary services to a Participant whose diagnosis and treatment are not expected to exceed 24 hours but may extend to 48 hours upon approval by Centrus Health Direct, and the need for an inpatient admission can be determined within this specific period. Centrus Health Direct separately reimburses observation services performed in an Centrus Health Direct contracted facility only under specific circumstances.

Observation stays that are discharged within the 24-hour time window do not require pre-cert and can be billed as outpatient, pre-cert may extend the observation to 48 hours.

**Inpatient Admission Following Observation Stay**

If an observation stay is within 48 hours and followed by an inpatient admission, only the inpatient stay will be paid. The inpatient stay requires prior authorization and should be billed separately. If an observation stay exceeds 48 hours, it should be billed as an inpatient stay and will be subject to prior authorization.

**Emergency Department Services Preceding Observation Stay**

When emergency department services precede an observation or inpatient stay, the emergency department services are incidental to the observation and inpatient stay and therefore are not reimbursed separately but per the inpatient payment agreed to in the participation agreement, unless your Participating Provider Agreement states differently.

**Obstetrical Observation Stay**

When an obstetrical patient is placed in observation status: The entire episode is considered an inpatient admission if delivery occurs prior to discharge. The episode is considered an observation stay if delivery does not occur and the Participant is sent home. Reimbursement includes diagnostic testing performed in conjunction with an obstetrical observation stay.

Observation stay is not considered an appropriate designation for the following, and is therefore not reimbursed:

* Preparation for, or recovery from, diagnostic tests (e.g., fetal non-stress test, sleep studies)
* The routine recovery period following a surgical day care or an outpatient procedure
* Services routinely performed in the emergency department or outpatient department
* Observation care services submitted with routine pregnancy diagnoses
* Retaining a Participant for socioeconomic factors
* Custodial care

Hospital Based Clinics

Centrus Health Direct reimburses professional providers for covered services provided in a facility clinic setting when reported on a professional CMS 1500 form with a place of service office. This reimbursement includes both the professional services and the associated overhead. Centrus Health Direct will not separately reimburse a facility for facility clinic visits and services billed on a UB-04 when reported with revenue codes 510-519, 520-529 and any successor codes unless your Participating Provider Agreement states differently.

The technical and overhead component of the facility clinic visit is included in the benefit paid to the professional provider for professional services, which encompasses but is not limited to E&M services in a clinic setting. The facility may not seek reimbursement for any technical or overhead component of the clinic charge from Centrus Health Direct or the Participant. The Participant is held harmless for these clinic charges.

510 – 519 Bill with appropriate CPT/HCPCS codes; E&M codes will be denied. 520 - 529 Bill with appropriate CPT/HCPCS codes; E&M codes will be denied. 960 - 969 Bill with appropriate E&M codes.

G0463 Hospital Outpatient clinic visit for assessment and management of a patient is not reimbursed.

Transfers

In cases where a patient is transferred during an inpatient stay between acute care facilities, Centrus Health Direct may reimburse both the transfer and the transferee depending on the terms of your Participating Provider Agreement.

For hospitals reimbursed using a DRG base rate, Centrus Health Direct reimburses the transferring hospital the lesser of the per diem rate and the total negotiated case rate. The per diem rate is calculated by dividing the negotiated rate by the geometric mean length of stay for the assigned DRG. For hospitals reimbursed at a per diem rate, the payment is calculated at the negotiated per diem rate.

The receiving hospital is paid at the negotiated rate.

Readmissions

For all inpatient stays reimbursed at a case rate, Centrus Health Direct reserves the right to review readmissions for the same or related conditions within 15 days of discharge.

If Centrus Health Direct determines upon review that a readmission arose from premature discharge or failure of the facility to manage the discharge properly, Centrus Health Direct will potentially deny payment for either the readmission or the original stay, regardless of the medical necessity of the readmit.

Assistant Surgeon Reimbursement

An assistant surgeon is considered medically necessary when the complexity of the operation necessitates the primary surgeon have additional skilled operative assistance from: 1) Another surgeon, 2) Licensed Physician Assistant, 3) Registered Nurse First Assistant. Centrus Health Direct provides coverage for assistant surgeons based on guidance from the Centers for Medicare and Medicaid Services (CMS).

An assistant surgeon is distinguished from an “assistant-in-surgery.” Generally, assistants-in-surgery are non- MD professionals such as nurses, operating room technicians, or other specially trained professionals, whose services are included in the primary surgeon’s, or the facility’s, reimbursement. These services are not separately reimbursed.

There may be times when a physician elects to utilize more than one assistant during the operative session. However, only one assistant per operative session will be reimbursed. Claims for services of an assistant surgeon should be filed with modifier 80, 81, 82 or AS. Use of modifiers is required for proper payment.

Centrus Health Direct follows criteria based on the CMS National Physician Fee Schedule Relative Value File (NPFS) status indicators. All codes in the NPFS with the following status code indicator "2" for "Assistant Surgeons" are considered by Centrus Health Direct to be reimbursable for Assistant Surgeon services, as indicated by an Assistant Surgeon modifier (80, 81, 82, or AS).

Health care professionals acting as assistant surgeons should report their services under a surgeon's provider number.

**Reimbursement**

Centrus Health Direct’s standard reimbursement for qualified assistant surgeon services is 16% of the allowable amount when performed by a physician and 14% of the allowable amount when performed by a non-physician (as defined above). This percentage is based on CMS.

Co-Surgeons / Team Surgeons Reimbursement Policies

The use of multiple surgeons for a single procedure is considered medically necessary when the nature and/or complexity of the procedure necessitates contribution and expertise from more than one surgeon. Centrus Health Direct provides coverage for multiple surgeons based on guidance from the Centers for Medicare and Medicaid Services (CMS).

Centrus Health Direct follows criteria based on the CMS National Physician Fee Schedule Relative Value File (NPFS) status indicators. All codes in the NPFS with status code indicators "1" or "2" for "Co-Surgeons" are considered by Centrus Health Direct to be eligible for Co-Surgeon services as indicated by the co-surgeon modifier 62.

All codes in the NPFS with the status code indicators "1" or "2" for "Team Surgeons" are considered by Centrus Health Direct to be eligible for “Team Surgeon” services as indicated by the team surgeon modifier 66. Use of modifiers is required for proper payment. Physicians acting in the more limited capacity of an “Assistant Surgeon”, should bill with modifiers 80 or 82, and are not eligible for co-surgeon reimbursement.

Each co-surgeon should submit the same Current Procedural Terminology (CPT) code with modifier 62. Consistent with CMS guidelines, Centrus Health Direct will reimburse co-surgeon services at 62.5% of the allowable amount to each surgeon subject to additional multiple procedure reductions if applicable. The allowable amount is determined independently for each surgeon and is the amount that would be given to that surgeon performing the surgery without a co-surgeon.

Each Team Surgeon should submit the same CPT code with modifier 66 along with written medical documentation describing the specific surgeon's involvement in the total procedure. Centrus Health Direct will review each submission with its appropriate medical documentation and will make reimbursement decisions on a case-by-case basis.

Non-Reimbursable Services Reimbursement Policies

Consistent with guidelines specified by the Centers for Medicare and Medicaid Services (CMS), Centrus Health Direct does not reimburse for the procedures or categories of codes outlined in this policy. This list is not all-inclusive. Denials include non-covered services defined as exclusions in the Participant’s benefit program, payment included in the allowance of another service (i.e., global) and procedure codes submitted that are not eligible for payment.

**Coding Category II CPT Codes (XXXXF)**

These codes are intended to facilitate data collection about quality of care. Use of these codes is optional, not required for correct coding, and may not be used as a substitute for Category I codes.

Bundled Services/Supplies (Status “B” or “T” Procedure) Codes identified with a CMS indicator of “B” or “T” (bundled code) in the CMS NPFS (National Physician Fee Schedule), will not be separately reimbursed to physicians by Centrus Health Direct. Payments for these procedures are always bundled into payment for other services and separate payment is not made.

**PC/TC Indicator 5 Codes**

Centrus Health Direct denies “Incident To” codes identified with a CMS PC/TC indicator 5 in the NPFS when reported in a facility place of service when billed by a physician. Modifiers -26 and TC cannot be used with these codes.

Anesthesia

Centrus Health Direct reimburses anesthesia based on the concepts of basic values, time unit values, and conversion factors. Basic values are defined by the ASA and time units are calculated on a 15-minute interval basis and rounded to the nearest decimal point (e.g. 32 minutes of anesthesia equals 2.1 time units). Conversion factors are either explicitly listed in your Participating Provider Agreement or based on CMS localities.

Anesthesia time starts when the anesthesiologist begins to prepare the patient for induction and ends when the patient can safely be placed under postoperative supervision. The following formula is used to determine anesthesia reimbursement:

**(Base Value + Time Units) x Conversion Factor = Reimbursement Physical status modifiers.**

Bilateral Procedures

Bilateral procedures are procedures performed on both sides of the body during the same encounter on the same day. Centrus Health Direct follows the bilateral procedure CMS standards in the NPFS (National Physician Fee Schedule) for adjustment of payment.

Bilateral services must be billed on a single line with modifier -50 appended. Modifier -50 is not applicable to procedures that are bilateral by definition, or procedures with descriptions that include such terminology as “bilateral” or “unilateral.” Do not use Modifiers RT and LT when modifier -50 applies.

Reimbursement Procedure Eligible for Bilateral Payment Adjustment Status Indicator 1: If the procedure is billed with the -50-bilateral modifier, a 150% payment adjustment applies. Status Indicator 3: Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures with CMS status indicator 1. If a procedure is reported with modifier -50, payment is based on 100% of the standard reimbursement for each side.

In-Office Physician Laboratory Services (IPLS)

The In-Office Physician Laboratory Services (IPLS) is a list of laboratory procedural/testing codes that Centrus Health Direct will reimburse its Physicians to perform in their offices. This list represents procedures/tests that Centrus Health Direct Physicians can perform in their offices and will be reimbursed by Centrus Health Direct. All other lab procedures/tests must be performed by one of the participating laboratories in Centrus Health Direct’s network or reimbursement to the physician’s office is reduced to a level according to the terms of Providers’ Participating Agreement.

|  |  |
| --- | --- |
| **Tx IPLS Codes** | **Description** |
| 81000 | Urinalysis nonauto w/scope |
| 81001 | Urinalysis auto w/scope |
| 81002 | Urinalysis nonauto w/o scope |
| 81003 | Urinalysis auto w/o scope |
| 81025 | Urine pregnancy test |
| 82247 | Bilirubin total |
| 82270 | Occult blood feces |
| 82272 | Occult blood feces 1-3 tests |
| 82803 | Blood gases any combination |
| 82948 | Reagent strip/blood glucose |
| 82962 | Glucose blood test |
| 83014 | H pylori drug admin |
| 83026 | Hemoglobin copper sulfate |
| 83655 | Assay of lead |
| 83861 | Microfluid anal tears |
| 84146 | Assay of prolactin |
| 84443 | Assay thyroid stim hormone |
| 85007 | Bl smear w/diff wbc count |
| 85013 | Spun microhematocrit |
| 85018 | Hemoglobin |
| 85025 | Complete cbc w/auto diff wbc |
| 85027 | Complete cbc automated |
| 85651 | Rbc sed rate nonautomated |
| 86403 | Particle agglut antibody scrn |
| 87070 | Culture other specimen aerobic |
| 87081 | Culture screen only |
| 87177 | Ova and parasites smears |
| 87210 | Smear wet mount saline/ink |
| 87220 | Tissue exam for fungi |
| 87804 | Influenza assay w/optic |
| 87880 | Strep a assay w/optic |
| 88738 | Hgb quant transcutaneous |
| 89300 | Semen analysis w/huhner |
| 89310 | Semen analysis w/count |
| 89320 | Semen analysis vol/count/mot |
| 89321 | Semen analysis sperm detection |
| 89322 | Semen analysis strict criteria |

Drug Testing

Claims for specific, multiple drug class CPT and HCPCS codes for presumptive and definitive drug tests, will be reimbursed following Medicare’s policy. This means that only those presumptive and definitive drug testing CPT/HCPCS codes outlined in this policy will be reimbursed. Reimbursement is subject to medical record documentation, including appropriately documented orders, correct CPT/HCPS coding, participant benefits and eligibility.

Quantity Limits

Centrus Health Direct’s policy is to allow reimbursement for up to one definitive or one presumptive drug test per date of service, limited to 20 reimbursable units total per plan year unless a participant’s benefit plan specifically allows for more.

**Reimbursable Codes**

* Presumptive Drug Test 80305, 88306, 80307
* Definitive Drug Test G0480, G0481, G0482, G0483 and G0659

Mid-Level Providers

Centrus Health Direct reimbursement for the mid-level specialties listed in the table below is equal to 85% of the physician’s allowable when billed by physician with modifier SA.

* Physician Assistant
* Nurse Practitioner
* Certified Clinical Nurse
* Nurse
* Midwife
* Certified Surgical Assistant
* Nutritionist
* Physical Therapist
* Audiologist

Multiple Procedures Reimbursement

When multiple procedures are performed on the same day, by the same group, physician, or other healthcare professional, reduction in reimbursement for secondary and subsequent procedures will occur. Centrus Health Direct follows the multiple procedure CMS standards for reduction of payment. The use of modifier 51 appended to a code is not a factor in determining which codes are considered subject to multiple procedure reductions.

**Surgical / Endoscopic Procedures (Status Indicators 2 & 3)**

If a procedure is reported on the same day as another procedure with an indicator of 2 or 3, the procedures with the greatest reimbursable amount will be paid at 100% followed by 50% for the next greatest reimbursable amount followed by 25% for all subsequent procedures. Payment is based on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.

Special rules for multiple endoscopic procedures apply if an endoscopic procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in the Endobase field of the CMS NPFS Relative Value File. The multiple endoscopy rules are applied to a family before ranking the family with the other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with only its base procedure, the base procedure is not separately payable. Payment for the base procedure is included in the payment for the other endoscopy.

The following modifiers should also be applied to distinguish when services are not directly performed by an anesthesiologist:

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Provider** | **Code** | **Description** | **Payment** |
| Anesthesiologist | AD | Medical supervision for more than four concurrent anesthesia procedures is provided | Reimbursed at a rate equal to three base value units |
| GC | Services performed in part by a resident under the direction of a teaching physician | Services are reimbursable at 100% of the allowable when billed by the teaching anesthesiologist. (Note: the teaching anesthesiologist must bill with the “AA” modifier in the first field and the “GC” certification modifier in the second field.) |
| QK | Medical direction of two, three or four concurrent anesthetic procedures involving qualified individuals (e.g.,CRNAs or residents) | Allows 50% of fee schedule payment based on the appropriate unit rate |
| QY | Anesthesiologist medically directed one CRNA | Allows 50% of fee schedule payment based on theappropriate unit rate |
| CRNA | QZ | CRNA performed services without medical direction | 100% of fee schedule based on appropriate unit rate |
| QX | CRNA performed services under the medical direction of an anesthesiologist | Allows 50% of fee schedule payment based on the appropriate unit rate |

**Imaging / Radiology (Status Indicator = 4)**

If a diagnostic imaging procedure is billed with or reported in the same session on the same day, as another diagnostic imaging subject to a multiple imaging reduction (services with an ‘88’ diagnostic imaging family indicator), Centrus Health Direct pays 100% of the technical component for the highest priced procedure, and 50% for the technical component of each subsequent procedure.

**Cardiovascular Services (Status Indicator = 6)**

For cardiovascular services, full payment is made for the service with the highest payment. Payment is made at 75 percent for subsequent services furnished by the same physician (or by multiple physicians in the same group. Reduction is taken only on the technical component; the professional component is paid at 100% for all procedures.

**Ophthalmology Services (Status Indicator = 7)**

For ophthalmology services, full payment is made for the service with the highest payment. Payment is made at 75 percent for subsequent services furnished by the same physician (or by multiple physicians in the same group practice, to the same patient on the same day). Reduction is taken only on the technical component; the professional component is paid at 100% for all procedures.

**Global / Case Rate Adjustment**

When a procedure requires a multiple procedure reduction but is billed as a global / case-rated procedure, Centrus Health Direct will apply an appropriate technical component reduction on a fixed 60% of the total payable amount. If a professional component payment reduction is appropriate, it is applied on a fixed 40% of the total payable amount.

Unlisted and Unspecified Procedures

Unlisted procedure codes are used when the services performed do not have specific codes assigned to them. When submitting claims with such unlisted or unspecified procedures, it is necessary to attach supporting documentation describing the services that were performed. Such documentation should include the following information:

* A clear description of the nature, extent, and need for the procedure or service
* Whether the procedure was performed independently of other services provided, or if it was performed at the same surgical site or through the same surgical opening
* Any extenuating circumstances which may have complicated the service or procedure
* Time, effort, and equipment necessary to provide the service
* The number of times the service was provided

When submitting documentation, designate the portion of the report that identifies the test or procedure associated with the unlisted procedure code.

Claims submitted with unlisted procedure codes and without supporting documentation will be denied. No additional reimbursement is provided for special techniques/equipment submitted with an unlisted procedure code. When performing two or more procedures that require the use of the same unlisted CPT code, the unlisted code should only be reported once to identify the services provided (excludes unlisted HCPCS codes; for example, DME/unlisted drugs). Unlisted codes for DME, orthotics, and prosthetics require appropriate NU, RR or MS modifier to be considered for reimbursement. All other unlisted procedure codes appended with a modifier will be denied.

Required Documentation to file unlisted or unspecified procedures:

|  |  |  |
| --- | --- | --- |
| **Procedure Type** | **Service Code Range** | **Required Documentation** |
| Laboratory or pathology | CPT Codes 80047-89398 | Laboratory or pathology report |
| Surgical procedures | CPT Codes 10021–69990 | Operative or procedure report |
| Radiology/imaging procedures | CPT Codes 70010–79999 | Imaging report |

|  |  |  |
| --- | --- | --- |
| Medical procedures | CPT Codes 90281–99607 | Office notes and reports |
| Unlisted HCPCS procedure codes |  | Operative or procedure report |
| Unclassified drug codes |  | NDC Number with full description, name, strength of drug |
| Unlisted HCPCS DME codes |  | Provide narrative on the claim |

Medically Unlikely, Mutually Exclusive and Component Procedures

Centrus Health Direct reimburses providers for services that are medically appropriate and adhere to CMS standard coding conventions. Centrus Health Direct follows Medicare National Correct Coding Initiative (NCCI) standards for not reimbursing services that are mutually exclusive, medically unlikely, or component services reported alongside more comprehensive procedures.

Mutually exclusive procedures are codes that cannot reasonably be done at the same anatomic site, during the same patient encounter, or the coding combination represents two methods of performing the same service. An example of mutually exclusive procedures is the repair of an organ, performed by two different methods since only one method can be chosen to repair the organ. Mutually exclusive coding combinations are considered submitted in error and only one of the services will be reimbursed. The Medicare National Correct Coding Initiative (NCCI) has published procedure-to-procedure (PTP) claims edits that prevent inappropriate payment in these scenarios. Centrus Health Direct adopts these claims edits and will not reimburse providers for mutually exclusive procedures.

Medically unlikely procedures are codes that are anatomically or clinically limited with regard to the number of times they may be performed on a single day. In addition to the PTP edits, NCCI has published medically unlikely claims edits (MUEs) that prevent payment for an inappropriate number or quantity of the same service on a given day. Centrus Health Direct adopts these claims edits and will not reimburse providers for services flagged as medically unlikely.

Comprehensive and Component Procedures NCCI’s PTP edits also address component and comprehensive procedures. Services that are integral to another service are component parts of the more comprehensive procedure. The PTP edits prevent payment for component services reported alongside comprehensive services. Centrus Health Direct adopts these claims edits and will not separately reimburse providers for component services if reported alongside comprehensive services.

Surgical Supplies

This policy describes the reimbursement methodology for general surgical supplies associated with outpatient physician surgical services. Consistent with CMS, Centrus Health Direct does not reimburse providers for general surgical supplies.

Supply Code 99070 For reimbursement of covered medical and surgical supplies, an appropriate Level HCPCS code must be submitted. The non-specific CPT code 99070 (supplies and materials, except spectacles, provided by the physician, hospital, ambulatory surgical center or other qualified healthcare professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)) is not reimbursable in any setting.

Surgical Tray Code A4550 CPT code will not be reimbursed separately. This code is part of a physician’s practice expense and thus reimbursement of this code is included in the payment of other codes billed by the physician.

Dual Preventative and Problem-Oriented Visit

Preventive Medicine Services include annual physical and well child examinations, usually separate from disease related diagnoses. Occasionally, an abnormality is encountered, or a pre-existing problem is addressed during the Preventive visit, and significant elements of related Evaluation and Management (E/M) services are provided during the same visit. When this occurs, Centrus Health Direct will reimburse the Preventive Medicine service plus the following problem-oriented E/M service codes when that code is appended with modifier 25. If the code is not submitted with modifier 25 appended, it will not be reimbursed.

Provider Claim Inquiry Process

You may initiate the Provider Appeal Process by submitting your appeal to the address on the back of the member ID card within 180 days from the date of receipt of explanation of payment (or per your provider agreement). Provider Appeals shall be reviewed and responded to within thirty (30) days.