

MARYLAND MEDICAL ASSISTANCE PROGRAM

PHYSICIANS' SERVICES PROVIDER FEE MANUAL

Effective January 2010

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INTRODUCTION

The purpose of this manual is to provide policy and billing instructions for providers who bill on the CMS 1500/837P (professional) claim format and are reimbursed under the physician's fee schedule. Providers include Certified Nurse Midwives, Certified Nurse Practitioners, Certified Registered Nurse Anesthetists, General Clinics, Physicians, Podiatrists, Optometrists, Audiologists, Speech/Language Pathologists, Occupational Therapists, Physical Therapists, Portable X-ray and Other Diagnostic Services. This manual has been prepared to provide a convenient reference source of information for Physicians' Services providers who participate with the Maryland Medical Assistance Fee-For-Service Program. The narrative portion of the manual contains coverage and limitations information and specific billing instructions for physicians. The numeric portion of the manual contains the physicians' fee schedule which is current through 2010 CPT. Additional resources prepared for providers include the Maryland Medical Assistance Provider Handbook and Maryland Medicaid Billing Instructions for the CMS-1500. Contact Provider Relations for either of these documents at (410) 767-5503 or (800) 445-1159.

GENERAL INFORMATION SECTION

ABBREVIATIONS USED IN THE FEE SCHEDULE

A, H, S Form Required. Certain procedures have special requirements which must be met in order for them to be reimbursed by the Program. Providers certify compliance with these requirements by completing specific forms prior to rendering the service. These include the **Certification For Abortion (DHMH 521)**, the **Document For Hysterectomy (DHMH 2990)** and the **Sterilization Consent Form (DHMH 2989)**. (These forms are available from the local Health Departments.)

REPORT/INVOICE By Report/By Invoice When the value of the procedure is to be determined "By Report" or "By Invoice", the following information must be submitted with the claim:

a. For services provided in Medicine or Radiology describe the service or procedure performed. When describing "By Report" procedures for radiology services, specify the method by which the service was performed.

b. For surgical procedures, surgeons and anesthesiologists must provide the following information:

- 1) Diagnosis (post-operative),
- 2) Size, location and number of lesion(s) or procedure(s), where appropriate, and
- 3) Major surgical procedure and supplementary procedure(s)

c. For procedure 99070 and certain HCPCS codes, a copy of a current invoice which clearly shows the per unit cost of the supply or product is required.

P Preauthorization Required. Certain services require prior authorization. Requests for preauthorization are generally made in writing and must document that the services are medically necessary.

0.00 Not Covered/Used When the listed fee is 0.00, the code is either not used by the Program (use other codes or unlisted procedures if appropriate), or the service is not payable by the Program.

NFAC Non-Facility Fee Fee schedule amount for services rendered in places of service 03, 11, 12 and 62 based upon the Medicare Fee Schedule rate.

FAC Facility Fee Fee schedule amount for services rendered in places of services 21, 22, 23, 24, 25, 26, 31, 32, 33, 34, 41, 42, 50, 51, 52, 53, 54, 55, 56, 61, 65, 71, 72, 81 and 99 based upon the Medicare Fee Schedule rate.

26 Modifier 26 Fee schedule amount for the professional component of a service based upon the Medicare Physician Fee Schedule rate.

TC Modifier TC Fee schedule amount for the technical component of a service based upon the Medicare Physician Fee Schedule rate.

BILLING TIME LIMITATIONS

Claims must be received within **12** months of the date that services were rendered. If a claim is received within the 12-month limit but rejected due to erroneous or missing data, a resubmittal will be accepted within 60 days of rejection or within 12 months of the date the service was rendered, whichever is later. If a claim is rejected because of late receipt, the patient may not be billed for that claim. If a claim is submitted and you do not receive a payment or a rejection within 90 days, please resubmit the claim.

NOTE: Medicare/Medicaid Crossover claims must be received within 120 days of the Medicare payment date. This is the date on Medicare's Explanation of Benefits form. The Medical Assistance Program recognizes the billing time limitations of Medicare and will not make payment when Medicare has rejected a claim due to late billing.

COMMON PROCEDURE CODING SYSTEM

The Maryland Medical Assistance Program utilizes the five character Centers for Medicare and Medicaid Services' Common Procedure Coding System (HCPCS) for the billing of services on the CMS-1500/837P claim formats. These include the numeric CPT HCPCS and Level II alpha-numeric HCPCS.

1. CPT HCPCS

The Maryland Medical Assistance Program's Physicians' Services Provider Fee Manual primarily utilizes the codes in the latest revision of the Current Procedural Terminology (CPT). Physicians must have access to the latest revision of CPT in order to properly bill for services rendered. CPT is developed and published by the American Medical Association, and revisions to it are published annually. This fee manual is also updated annually to reflect the new additions, changes or deletions to CPT. For complete explanations and instructions on the use of CPT, you must refer to the introduction section of that book. CPT 2010 CODES, DESCRIPTIONS AND TWO-DIGIT MODIFIERS ONLY ARE COPYRIGHT 2010 AMERICAN MEDICAL ASSOCIATION.

For information on AMA products call (800) 621-8335.

2. LEVEL II HCPCS

The Physicians' Services Program also utilizes national alphanumeric HCPCS for procedures or services which do not appear in CPT. These include the J-codes for billing injectable drugs, A-codes for radiopharmaceuticals, Q-codes for contrast materials and G-codes for digital mammography.

NOTE: The Program considers all of the services necessary to accomplish a given procedure to be included in the description of that procedure as defined by CPT. Ancillary services necessary to accomplish the procedure are considered included, although independent CPT codes may exist for these ancillary services. Billing of these codes separately, called "unbundling," is prohibited.

CONSULTATION AND REFERRAL

A CONSULTATION IS DISTINGUISHED FROM A REFERRAL.

REFERRAL means a transfer of the patient from one physician to another for diagnosis and treatment of the condition for which the referral was made. The physician to whom the referral is made, whether he/she is a generalist or a specialist, will be considered as the primary care physician and not as a consultant.

CONSULTATION requires a written opinion or advice rendered by a consultant-specialist whose opinion or advice is requested by the patient's attending physician for the further evaluation or management of the patient by the attending physician. If the consultant-specialist assumes responsibility for the continuing care of the patient, any subsequent service rendered by him/her is not a consultation but an established patient office visit or subsequent hospital care, depending on the setting. The consultation must be provided in the specialty in which the consultant-specialist is registered with the Program.

ATTENDING PHYSICIAN means a physician, other than a house officer, resident or intern, who is directly responsible for the patient's care. **Medicaid reimbursement for a consultation is not authorized when a member of the house staff either requests or provides the consultation. Providers may not bill the Program for consultations requested or rendered by house staff.**

CONSULTANT-SPECIALIST means a licensed physician who meets one of the following criteria:

1. Has been declared board certified by a member board of the American Board of Medical Specialties and currently retains that status,
2. Can demonstrate satisfactory completion of a residency program accredited by the Liaison Committee for Graduate Medical Education, or the appropriate Residency Review Committee of the American Medical Association,
3. Has been declared board certified by a specialty board approved by the Advisory Board of Osteopathic Specialists and the Board of Trustees of the American Osteopathic Specialists, or

4. Can demonstrate, if a residency program was completed in a foreign country, that qualifications and training are acceptable for admission into the examination system of the appropriate American Specialty Board.

COVERED SERVICES

All services for which reimbursement is sought must be provided in accordance with the Medical Care Program's Physicians' Services regulations, COMAR 10.09.02. Providers furnishing services to Medical Assistance recipients must do so in full compliance with Title VI of the Civil Rights Act of 1964, Maryland statutes and other laws and regulations which prohibit discrimination.

The Program covers the following medically necessary services:

1. Physicians' services rendered in a physician's office, the patient's home, a hospital, a skilled or intermediate care nursing facility, a free-standing clinic, or elsewhere when the services are:
 - a. Performed by a physician, physician group or one of the following:
 - 1) Another licensed physician in the individual physician's or physician group's employ,
 - 2) A certified registered physician's assistant, licensed registered nurse, certified psychologist, or a certified social worker, provided that the individual providing the service is in the physician's or physician group's employ and is under the individual physician's or group rendering physician's direct supervision, and performs the service within the scope of the individual's license or certification for the purpose of assisting in the provision of physicians' services, and
 - 3) A certified nurse-midwife or a certified nurse practitioner provided that the individual performing the service is in the individual physician's or physician group's employ and performs the services within the scope of the individual's license and certification;
 - b. Clearly related to the patient's individual medical needs as diagnostic, curative, palliative or rehabilitative services; and
 - c. Adequately described in the patient's medical record.
2. Consultations;
3. Diagnostic procedures to include:
 - a. Procedures related to the patient's medical needs, and
 - b. Laboratory services performed by a physician or personnel under the physician's direct supervision, when the physician is not required to register his/her office as a medical laboratory pursuant to Health-General Article, Title 17, Subtitle 2, Annotated Code of Maryland;
4. Drugs dispensed by the physician within the limitations of COMAR

10.09.03;

5. Injectable drugs administered by the physician within the limitations of COMAR 10.09.03;

6. Medical equipment and supplies dispensed by the physician within the limitations of COMAR 10.09.12;

7. Abortions upon certification of the physician performing the procedure that the procedure is necessary based upon the physician's professional judgment and that one of the following conditions exists:

a. If continuation of pregnancy is likely to result in the death of the woman,

b. If the woman is a victim of rape, sexual offense or incest which has been reported to a law enforcement agency or a public health or social agency,

c. If it can be ascertained by the physician within a reasonable degree of medical certainty that the fetus is affected by genetic defect or serious deformity or abnormality,

d. If it can be ascertained by the physician within a reasonable degree of medical certainty that termination of the pregnancy is medically necessary because there is a substantial risk that continuation of the pregnancy could have a serious and adverse effect on the woman's present or future physical health, or

e. That there exists medical evidence that continuation of the pregnancy is creating a serious affect on the woman's present mental health and if carried to term there is substantial risk of a serious or long lasting affect on the woman's future mental health; and

8. Sterilizations when performed according to criteria contained in 42 Code of Federal Regulations §§441.250 - 441.258 and when the appropriate forms, as established by guideline, are properly completed and attached to the claim.

FOLLOW-UP OR AFTERCARE DAYS

Listed surgical procedures include the operation per se and normal, uncomplicated follow-up care. Fees for surgical procedures include follow-up care for the number of days listed in the Medicare Fee Schedule. The Program does not pay the surgeon for hospital and office visits during the surgical aftercare period. Complications or the presence of other diseases or injuries requiring additional services should be reported with the appropriate procedures. When the follow-up period is listed as zero, the listed value is for the procedure only. All post-operative care in those cases is to be invoiced on a service-by-service basis.

HIPAA AND NPI

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 require that standard electronic health transactions be used by health plans, including private, commercial, Medicaid and Medicare, health care clearinghouses and health care providers. A major intent of the law is to allow

providers to meet the data needs of every insurer electronically with one billing format using health care industry standard sets of data and codes. HCPCS is the specified code set for procedures and services. More information on HIPAA can be obtained from the CMS web site at www.cms.hhs.gov/medicaid/hipaa/adminsim/hipaapls.htm.

The **National Provider identifier (NPI)** compliance date was July 30, 2007. The implementation of the NPI will impact all business functions of your practice, office or institution, including billing, reporting and payment. The NPI is a 10-digit, numeric identifier that does not expire or change. It is administered by CMS and is required by HIPAA. The NPI will replace all of your existing provider numbers that you use to bill Medicaid, Medicare and other health care payers.

Providers can apply for National Provider Identifiers by using the web-based NPI application process. Log on to the National Plan and Provider Enumeration System (NPPES) and apply on line at, www.nppes.cms.hhs.gov/NPPESWelcome, or obtain a copy of the paper NPI Application/Update Form (CMS-10114) and mail the completed, signed application to the NPI Enumerator located in Fargo, ND. The form is available only upon request through the NPI Enumerator: 1-800-465-3203, customerservice@npienumerator.com or NPI Enumerator, P.O. Box 6059, Fargo, ND 58108-6059.

IF YOU HAVE NOT APPLIED FOR YOUR NATIONAL PROVIDER IDENTIFIER PLEASE DO IT NOW AND REPORT IT TO US. YOU SHOULD BE USING THE NPI AS THE PRIMARY IDENTIFIER AND YOUR MEDICAID PROVIDER LEGACY ID AS THE SECONDARY IDENTIFIER ON ALL PAPER AND ELECTRONIC CLAIMS.

MAXIMUM REIMBURSEMENT

The fees listed in this manual represent the maximum reimbursement allowed for procedures or services described in CPT. Providers must bill the Program their usual and customary charge to the general public for similar services, except for, injectable drugs, the provision of diagnostic or therapeutic pharmaceuticals, and supplies, in which case, providers must bill their acquisition cost.

Payments to providers will be the lower of:

1. Physician's customary charge or acquisition cost, or
2. Program's fee schedule

Providers must consider the fee paid by the Medical Assistance Program as payment in full and are prohibited by law from requesting or receiving additional payment from the recipient or recipient's family members. If the Program denies payment or requests repayment on the basis that an otherwise covered service was not medically necessary, the provider may not seek payment for that service from the recipient or recipient's family members. Acceptance of payment from any person in addition to payments made by the Program constitutes an overpayment which is in violation of federal and state regulations.

MEDICAL RECORD DOCUMENTATION

The following general principles of documenting a patient's medical record **must** be followed in order to assure payment of a claim which requires medical record documentation to be submitted (By Report) for payment determination by a medical reviewer, and to assure that payments previously made are not recovered as a result of a post-payment review

or audit:

1. The medical record should be complete and legible;
2. The documentation of each patient encounter should include: the date; the reason for the encounter; appropriate history and physical exam; review of lab, X-ray data, and other ancillary services, where appropriate; assessment; and, a plan for care (including discharge plan, if appropriate);
3. Past and present diagnoses should be accessible to the treating and/or consulting physician;
4. The reason for and results of X-ray, lab tests, and other ancillary services should be documented or included in the medical record;
5. Relevant health risk factors should be identified;
6. The patient's progress, including response to treatment, change in diagnosis, and patient non-compliance, should be documented;
7. The written plan for care should include when appropriate: treatments and medications specifying frequency and dosage; any referrals and consultations; patient/family education; and, specific instructions for follow-up;
8. The documentation should support the intensity of the patient evaluation and/or treatment, including thought processes and the complexity of decision-making;
9. All entries to the medical record should be dated and authenticated by physician and/or non-physician health care professional signature; and,
10. **The CPT/HCPCS procedure codes and ICD-9-CM codes reported on the claim are supported by the information in the medical record about the patient's condition.**

MEDICARE/MEDICAID RECIPIENTS

Many Medicaid recipients are also eligible for Medicare benefits. The Medical Assistance Program is always the payer of last resort. Whenever a Medical Assistance recipient is known to be enrolled in Medicare, Medicare must be billed first. Providers must accept assignment of Medicare Part B for any services provided to Medicaid beneficiaries for whom coinsurance and deductible may be payable. In most instances, the Medicare number will be imprinted on the Medicaid identification card. CLAIMS FOR THE MEDICARE/MEDICAID RECIPIENT MUST BE SUBMITTED ON THE CMS-1500 DIRECTLY TO THE MEDICARE INTERMEDIARY.

When billing Medicare on the CMS-1500 form, place the recipient's 11-digit identification number in **Block 9a** and check "Accept Assignment" in **Block 27**. This will assure that Medicare will automatically forward the appropriate information to Medical Assistance. Also make certain to check both Medicare and Medicaid in **Block 1** on the top of the CMS-1500. Failure to do so will delay any payments due.

MODIFIERS

A modifier provides the means by which the reporting physician can indicate that a service or procedure that has been performed has been

altered by some specific circumstance but not changed in its definition or code. When applicable, the modifying circumstance would be identified by the appropriate modifier(s), which is a 2-character code appended to the procedure code in **Block 24D** of the CMS-1500. Up to 2 modifiers can be reported on one service line. If more than two must be reported, use the most pertinent modifier in the first position, the second most important modifier in the 2nd position, and identify the additional modifier(s) by line number in **Block 19** of the claim form. Please note that up to four modifiers can be used in the HIPAA compliant electronic format.

Two levels of modifiers are used in this manual. Level I modifiers are those included in CPT and Level II modifiers are national HCPCS updated by CMS. The modifiers listed below must be reported when applicable and affect the processing and/or reimbursement of claims billed to the Program. Other modifiers in Levels I and II may be used to provide additional information about the service but will not be considered in the processing of the claim. Generally, only those modifiers which affect payment should be reported. The payment rate for each modifier is a percentage of the listed fee. Payment rates for multiple modifiers are multiplied together to determine the reimbursement amount.

The use of modifiers is described in more detail in the Services Information Section of this manual under Anesthesia, Evaluation and Management, Radiology and Surgery headings.

| MODIFIER | DESCRIPTION | % of FEE |
|-----------------|--------------------|-----------------|
|-----------------|--------------------|-----------------|

Anesthesia

Anesthesia procedure codes 00100 - 01999 billed without an appropriate modifier will be rejected. Modifiers -AD (Medical supervision by physician: more than 4 procedures) and -47 (Anesthesia by surgeon) are not used/payable by the Program. Modifiers -G8, -G9 and -QS are informational and do not affect payment.

| | | |
|-----|---|--------|
| -AA | Anesthesia performed personally by anesthesiologist | 100 |
| -QK | Medical direction of 2-4 concurrent anesthesia procedures | 50 |
| -QX | CRNA service with medical direction by a physician | 50 |
| -QY | Medical direction of 1 CRNA by an anesthesiologist | 50 |
| -QZ | CRNA service without medical direction by a physician | 100 |
| -23 | Unusual anesthesia | REPORT |

Component Billing

Certain procedures (e.g., radiology, electrocardiograms, specific diagnostic procedures) are a combination of a professional component and a technical component and must be reported in order to receive the correct reimbursement. When the physician component is billed separately, the service must be identified by adding the modifier -26 to the usual procedure code. Modifier -TC (Technical Component) generally is not used/payable by the Physicians' Services Program but is used by certain diagnostic radiology providers.

Medicine

| | | |
|-----|------------------------|------------------|
| -26 | Professional component | Same as Medicare |
|-----|------------------------|------------------|

Radiological Services

-26 Professional component Same as Medicare

Surgical Services

Modifiers -56 (Preoperative management only) and -66 (Surgical team) are not used/payable.

| | | |
|-----|-------------------------------|--------|
| -50 | Bilateral procedure | 150 |
| -51 | Multiple procedure | 50 |
| -52 | Reduced services | REPORT |
| -53 | Discontinued procedure | REPORT |
| -54 | Surgical care only | 80 |
| -55 | Postoperative management only | 20 |

Surgical Assistance

Modifier -81 (Minimum assistant surgeon) is not used/payable.

| | | |
|-----|---|----|
| -80 | Assistant surgeon | 20 |
| -82 | Assistant surgeon (when qualified resident not available) | 20 |

Trauma Services

Trauma services rendered by trauma physicians to trauma patients on the State Trauma Registry in trauma centers are reimbursed at 100% of the Medicare rate.

-U1 Trauma services Medicare conversion factor

NDC REORTING REQUIREMENTS

Federal regulations require States to collect National Drug Code (NDC) numbers from providers for the purpose of billing manufacturers for drug rebates. In order for physician-administered drugs to be reimbursed by Medicaid, the manufacturer must participate in the Federal Drug Rebate Program, and a valid 11-digit NDC number and the quantity administered must be reported on the CMS-1500. This also includes physician-administered drugs for immunizations and radiopharmaceuticals.

Reporting of the NDC/quantity is required when billing for drugs using A-J-Q-codes and certain CPT codes. It is also required when billing with unlisted J-codes (J3490 and J9999). The NDC reporting requirements for physician-administered drugs also extend to claims when Medicaid is not the primary payer but secondary or tertiary payer.

The NDC number reported must be the actual NDC number on the package or container from which the medication was administered. It may be necessary to pad NDC numbers with left-adjusted zeroes in order to report eleven digits. For example, the NDC from the label may appear as 12345-678-90. Using the 5-4-2 format, it should be reported as 12345-0678-90. Or the NDC from the label may appear as 12345-0678-9. It should be reported as 12345-0678-09.

Billing Instructions for CMS-1500: Box 24

1. The top area of the six service lines is shaded and is the location for reporting supplemental information, such as NDCs for drugs. The shaded areas of lines 1 through 6 allow for the entry of 61 characters from the beginning of 24A to the end of 24G.

2. When entering supplemental information for NDC, add in the following order: NDC qualifier, NDC code, one space, unit/basis of measurement qualifier, quantity. The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal. If entering a whole number do not use a decimal. Do not use commas.

Examples: 1234.56
2
99999999.999

3. The National Drug Code qualifier **N4** is used when reporting supplemental NDC information. Begin at 24A by entering the qualifier N4 and then the 11-digit NDC number. Do not enter a space between the qualifier and the NDC number. Do not enter hyphens or spaces within the NDC number.
4. Skip a space and enter the applicable unit/basis of measurement qualifier followed immediately by the numeric quantity administered to the patient. The following qualifiers are used when reporting NDC unit/basis of measurement:

F2 International Unit
GR Gram
ML Milliliter
UN Unit

5. More than one NDC can be reported in the shaded lines of Box 24. Enter the first NDC qualifier, NDC number, unit qualifier and quantity at 24A. Skip one space after the first item and enter the next NDC qualifier, NDC number, unit qualifier and quantity. This may be necessary when multiple vials of the same drug are administered with different dosages and NDCs.

Example: NDC/Quantity Reporting for 1 Unit of J1055
24A
N400009737604 UN1

NOTE: Claims for drugs will be denied when the:

NDC is missing or invalid
NDC is not rebateable
NDC Unit of Measure is missing/invalid
NDC Quantity is missing

NOTE: For reporting the NDC on 837P electronic claims, providers must use the 2410 Loop (Drug Identification):

LIN03 = NDC code
CTP04 = Quantity
CTP05 = Unit of Measure (UOM)

NON-COVERED SERVICES

Services which the Program does not cover are:

1. Physicians' services not medically justified,

2. Non-emergency dialysis services related to chronic kidney disorders unless they are provided in a Medicare-certified facility,
3. Physicians' inpatient hospital services rendered during any period that is in excess of the length of stay authorized by the Utilization Control Agent (UCA),
4. Physicians' services denied by Medicare as not medically necessary,
5. Services which are investigational or experimental,
6. Autopsies,
7. Physicians' services included as part of the cost of an inpatient facility, hospital outpatient department or free-standing clinic,
8. Specimen collections, except by venipuncture and capillary or arterial puncture,
9. Audiometric tests for the sole purpose of prescribing hearing aids,
10. Immunizations required for travel outside the United States,
11. Injections and visits solely for the administration of injections, unless medical necessity and the patient's inability to take appropriate oral medications are documented in the patient's medical record,
12. Visits solely to accomplish one or more of the following:
 - a. Prescription, drug or food supplement pick-up, collection of specimens for laboratory procedures,
 - b. Recording of an electrocardiogram,
 - c. Ascertaining the patient's weight,
 - d. Interpretation of laboratory tests or panels,
13. Medical Assistance prescriptions and injections for central nervous system stimulants and anorectic agents when used for weight control,
14. Drugs, vaccines and supplies dispensed by the physician which are acquired by the physician at no cost,
15. Preoperative evaluations for anesthesia are included in the fee for administration of anesthesia and the provider may not bill them as consultations or hospital visits,
16. Referrals from one physician to another for treatment of specific patient problems may not be billed as consultations,
17. The operating surgeon may not bill for the administration of anesthesia or for an assistant surgeon who is not in the operating surgeon's employ,
18. Laboratory or x-ray services performed by another facility,

19. Services rendered to an inpatient before one preoperative inpatient day, unless preauthorized by the Program,
20. Acupuncture,
21. Radial keratotomy,
22. Disposable medical supplies usually included with the office visit,
23. Services prohibited by the State Board of Physicians,
24. Services which are provided outside of the United States,
25. Services which do not involve direct (face-to-face) patient contact,
26. The provider may not bill the Program or the recipient for:
 - a. Completion of forms and reports,
 - b. Broken or missed appointments,
 - c. Professional services rendered by mail or telephone,
 - d. Services which are provided at no charge to the general public,
 - e. Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of the recipient,
27. Sterilization reversals and gender changes (sex reassignment),
28. The provider may not bill the Program for services rendered by an employed non-physician extender, such as, a physical therapist, an occupational therapist, a speech language pathologist, an audiologist or a nutritionist, under a supervising physician's provider number, and
29. Drugs written on prescription pads which do not prevent copying, modification or counterfeiting.
30. Physician-administered drugs obtained from manufacturers which do not participate in the federal Drug Rebate Program.

PAYMENT IN FULL

Reimbursement for services will be paid up to the maximum fees allowed by the Program. All payments made by the Program to providers shall be considered as payment in full for services rendered and no additional charge shall be made by the provider to any person for covered services. Acceptance of payment from the patient or patient's family in addition to payments made by the Program constitutes an overpayment which is in violation of Federal and State regulations.

PHYSICIANS' SERVICES REIMBURSEMENT

The fee schedule for physicians' services lists the current CPT codes and the maximum fee paid for each procedure. A provider using CPT

terminology and coding selects the procedure or service that most accurately identifies the service performed. Any service or procedure should be adequately documented in the medical record. Providers must maintain such records as are necessary to document fully the services provided. **The records must be retained for six years.** Lack of acceptable documentation may cause the Program to deny payment or, if payment has already been made, to request repayment, or to impose sanctions, which may include withholding of payment or suspension or removal from the Program. Payment for services is based upon the procedure code(s) selected by the provider. Although some providers delegate the task of assigning codes, the accuracy of the claim is solely the provider's responsibility and is subject to audit.

PREAUTHORIZATION

1. Some physician services within the fee schedule require preauthorization. Preauthorization is required for the following procedures or services:

a. **Cosmetic Surgery** - to correct a congenital or acquired anomaly when there is documentation that the anomaly represents a significant deviation from the normal state and affects the patient's health to a degree that it impairs his or her ability to function in society,

b. **Lipectomy and panniculectomy** - when there is an abnormal amount of redundant skin and subcutaneous tissue which is causing significant health problems in the patient,

c. **Transplantations of vital organs** - when more conservative forms of treatment have failed,

d. **Services rendered to an inpatient before one preoperative day,**

e. **Surgical procedures for the treatment of morbid obesity, and**

f. **Elective services from a non-contiguous state.**

2. Services which have been determined by Medicare to be ineffective, unsafe, or without proven clinical value are generally presumed to be not medically necessary, but will be preauthorized if the provider can satisfactorily document medical necessity in a particular case. These services are found in the Medicare Carriers Manual, Part 3, Claims Process, Chapter II, Coverage Issues Appendix.

3. The Program will preauthorize services when the provider submits adequate documentation demonstrating that the service is **medically necessary**. "Medically necessary" means that the service is directly related to diagnostic, preventive, curative, palliative, rehabilitative or ameliorative treatment of an illness, injury, disability or health condition; consistent with current accepted standards of good medical practice; the most cost efficient service that can be provided without sacrificing effectiveness or access to care; and not primarily for the convenience of the consumer, their family or the provider.

Preauthorization for all services which require it must be requested in writing. A Preauthorization Request Form for Physician Services (DHMH 4523) must be completed and submitted to:

**HealthChoice and Acute Care Administration
 Division of Hospital and Professional Services
 201 W. Preston Street, 2nd Floor
 Baltimore, Maryland 21201**

Specific documentation must be attached to the preauthorization request form which includes but is not limited to the following:

- a. Complete narrative justification of the procedure(s),
- b. Brief history and physical examination,
- c. Result of pertinent ancillary studies if applicable, and
- d. Pertinent medical evaluations and consultations if applicable.

For all written requests for preauthorization, the physician will receive written notification of the Program's decision. If the request is approved, a preauthorization number will be given. This number must be entered in **Block 23** of the CMS-1500 claim form when billing for the service. Authorizations are valid for only 60 days from the date of the letter of approval. Program approval of preauthorization requests only relates to the medical necessity of providing the service described in the written request. The approval is not a verification of the patient's eligibility for Medical Assistance.

4. Preauthorization must be obtained prior to making any arrangements for sending a patient out-of-state to a non-contiguous state for elective services. Contiguous states are those which surround the State of Maryland. They are: Delaware, Pennsylvania, Virginia and West Virginia and Washington, D.C. Referrals to these four states and Washington, D.C. do not require an out-of-state preauthorization. They may, however, require preauthorization for other reasons, such as, for organ transplantation.

5. Preauthorization normally required by the Program is waived when the service is covered and approved by Medicare. However, if the entire or any part of a claim is rejected by Medicare, and the claim is referred to the Program for payment, payment will be made for services covered by the Program only if authorization for those services has been obtained before billing.

Please refer to Program regulations COMAR 10.09.02 and current guidelines and/or transmittals for additional information on services requiring preauthorization.

TAMPER PROOF PRESCRIPTION PADS

Prescriptions must be written on pads which prevent copying, modification or counterfeiting. Prescriptions written on pads not meeting these standards will not be filled.

THIRD-PARTY RECOVERIES

In general, the Medical Assistance Program is always the payer of last resort. If a recipient is covered by insurance or other third-party benefits, the provider must seek payment from that source first. The only exception to the MA as payer of last resort rule is for the provision of well child/Healthy Kids services and prenatal care. Bill Medical Assistance first for these services, even if the recipient has

other insurance. If payment of a claim is made by both the Program and a third party, the provider must refund to the Program either the amount paid by the Program or the third party.

UNLISTED PROCEDURES OR SERVICES

A service or procedure may be provided that is not listed in the current edition of CPT. These services may be new, unusual, variable, or rarely provided. When reporting such a service, the appropriate unlisted procedure code ending in "99" should be used. When an unlisted procedure code is used, the service or procedure must be described by a special report attached to the invoice. There are no listed fees for unlisted procedure codes in the physicians' fee schedule (By Report).

Invoices with unlisted services MUST be accompanied by legible surgical notes or other medical record documentation to enable a medical reviewer to arrive at a value for the procedure.

Pertinent information should include an adequate definition or description of the nature, extent and need for the procedure, and the time, effort and equipment necessary to provide the service. Additional items may include the complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems and follow-up care.

SERVICES INFORMATION SECTION

ABORTIONS

Abortions are covered by the Program for only five medical reasons:

- 1) Life of the mother,
- 2) Mother's current or future health,
- 3) Mother's current or future mental health,
- 4) Fetus is probably deformed, and
- 5) Mother was a victim of rape or incest.

A document submitted by an official of a law enforcement agency or public health service where the rape or incest of the mother was reported must include the following information:

- a. name and address of victim,
 - b. name and address of person making report (if different from the victim),
 - c. date of the rape or incest incident,
 - d. date of the report,
 - e. statement that the report was signed by the person making it,
- and
- f. name and signature of the person at the law enforcement agency or public health service who took the rape or incest report.

The "**Certification of Abortion**" **DHMH 521** form must accompany any invoice submitted to the Medical Assistance Program by a practitioner, hospital, clinic or agency when such invoice is for services related to a termination of pregnancy (except spontaneous abortion or treatment of ectopic pregnancy) or for medical procedures necessary to voluntarily terminate a pregnancy for victims of rape or incest. These include surgical CPT procedures **59840-59841, 59850-59852, 59855-59857 and 59866** and anesthesia code **01966**.

NOTE: The medical termination of early intrauterine pregnancy through the administration of mifepristone (Mifeprex) also known as RU-486 should be billed using the unlisted CPT Medicine code **99199**. "Medical Abortion" must be written on the CMS-1500 below the procedure code in **Block 24D**. Diagnosis code **635 or 638** must be entered on Line 1 of **Block 21**. The date of service on the Form 521 and the CMS-1500 is the date that the patient signs the required Patient Agreement and takes orally the 600 mg of mifepristone. The fee for this service is based upon three office or clinic visits over a two-week period for administration of the drug and appropriate follow-up, and the actual cost of the oral drugs. The fee is \$401. The fee for the professional component of this service when rendered in a hospital outpatient setting is \$300. Physicians may not bill for office visits in addition to procedure code 99199.

It is necessary that the medical record reflect the medical necessity for the therapeutic abortion as determined by the certifying physician. The specific condition for which the abortion was performed must be documented in the record. Such documentation must explicitly state, at the time of service, the physician's findings which indicate the basis on which the medical necessity for the abortion was determined. Completion of the certification form alone is not sufficient to serve as documentation, nor is it sufficient to render a clinical opinion and/or diagnosis without supporting evidence in the medical record. Lack of acceptable documentation in the medical record will cause the Program to deny payment, or in those cases where payment has been made, the Program will require repayment from the provider.

ALLERGY IMMUNOTHERAPY

1. Procedure code 95117

The Program will reimburse for a maximum of two units of service for this procedure regardless of the number of injections given at one visit.

2. Procedure codes 95120 through 95134

These codes refer to the injection of the allergen in the prescribing physician's office and include the office visit. Do not bill for an office visit in addition to these codes. The Program will reimburse for only one unit of service for these procedures regardless of the number of injections given at one visit.

When allergy injections are administered in an office other than the prescribing physician's office, use the appropriate office visit code only if there is a separate identifiable medical service, otherwise, use code 95117. The length of observation time spent by the patient in the office or facility does not increase the level of service.

Do not bill for procedure codes 95120 - 95134 in addition to an office visit code.

3. Procedure code 95144

This code refers to the preparation and provision of antigens for the patient and includes an office visit. The Program will reimburse for only one unit of service for this procedure regardless of the number of injections given at the visit.

ANESTHESIA**Procedure Codes**

Procedure codes 00100 - 01999 should be used to report the administration of anesthesia. These codes describe anesthesia for procedures categorized by areas or systems of the body; and others describe anesthesia for radiological and miscellaneous procedures. Only one primary anesthesia service should be reported for a surgical session. Use the anesthesia code related to the major surgery. Every anesthesia service must have an appropriate anesthesia modifier reported on the service line, except for procedures 01995 and 01996.

Modifiers

One of the following anesthesia procedure code modifiers must be reported to identify who rendered the anesthesia service and under what circumstances:

- AA Anesthesia services performed personally by anesthesiologist
- QK Medically directed by a physician: two, three or four concurrent procedures
- QX CRNA with medical direction by a physician
- QY Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist
- QZ CRNA without medical direction by a physician

If an appropriate modifier is not reported, the service will be denied. There is no separate payment made for any anesthesia services performed by the physician who is performing the medical or surgical service requiring anesthesia. **Modifier -47 is not used by the Program.**

There is no separate payment made for any services ordinarily provided as part of the anesthesia service. This includes the pre-anesthetic examination of the patient, pre- or post-operative visits, intubation and normal monitoring functions. These procedures should not be reported separately when provided in conjunction with the provision of anesthesia. Unusual forms of monitoring are not included in the payment for anesthesia services. Unusual forms of monitoring (intra-arterial, central venous and Swan-Ganz) may be reported separately in addition to providing the basic anesthesia administration.

No additional payment will be made for patient risk factors such as patient age and health status (CPT Physical Status Modifiers or Qualifying Circumstance procedure codes), or for monitored anesthesia care (MAC). There is no separate payment for the medical supervision of a CRNA(s) by a physician. **Modifier -AD is not used by the Program.** Use of the modifier -QS will not affect payment.

Occasionally, a procedure which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia, e.g., CAT scans and MRI procedures. This circumstance may be reported by adding the modifier **-23** to the procedure code of the basic service. Whenever this modifier is used, an anesthesia report, which documents the total anesthesia time in minutes and the

qualified individual who performed the anesthesia and under what circumstances, must be submitted with the claim.

Time

Anesthesia time means the time in minutes during which the anesthesia provider is furnishing continuous anesthesia care to the patient and is physically present. It starts when the anesthesia provider begins to prepare the patient for induction of anesthesia and ends when the patient is placed under post-operative supervision and the anesthesia provider is no longer in personal attendance. In counting anesthesia time when an interruption in the anesthesia service occurs, only the actual anesthesia time is counted. The anesthesia start and stop times must be documented in the medical record.

Report the total anesthesia time in minutes in **Block 24G**. Convert hours to minutes and enter the total anesthesia minutes provided for the procedure. Do not include base units and do not divide the total anesthesia time into 15-minute time units. To bill for anesthesia administered for multiple surgeries, use the anesthesia code with the highest anesthesia base unit value and report the actual time in minutes that extends over all procedures.

NOTE: Time units are not recognized for anesthesia procedure code 01996 (daily management of epidural or subarachnoid continuous drug administration). Only one unit of service is allowed. No anesthesia modifier is required to be reported.

Base Units

Base units have been assigned to each anesthesia procedure code and reflect the difficulty of the anesthesia service, including the usual pre-operative and post-operative care and evaluation. Do not include base units when reporting anesthesia time. Base units will be added during claims processing.

Required Forms

If a surgical procedure requires prior authorization, the Program assumes that the operating physician has obtained the appropriate authorization to perform the service. The anesthesia provider will not be held responsible for providing proof that the procedure was authorized. By federal statute, however, all claims for services, including anesthesia claims related to hysterectomies or sterilization procedures, must include proof that informed consent was obtained and meets the Program's consent requirements before payment can be made for the service. Anesthesia claims for induced abortion procedures must include proof that the service was performed for one of the five medical reasons allowed for an abortion.

Medical Direction

The Program will make separate payment to physicians and CRNAs for medically directed anesthesia services. All of the following conditions must be met for medically directed anesthesia services to be reimbursed to the physician. For each patient, the physician must:

1. Perform a pre-anesthetic examination and evaluation;
2. Prescribe the anesthesia plan;

3. Personally participate in the most demanding procedures in the anesthesia plan including, if applicable, induction and emergence;
4. Ensure that procedures in the anesthesia plan that are not performed by the physician are performed by a qualified individual;
5. Monitor the course of anesthesia administration at frequent intervals;
6. Remain physically present and available for immediate diagnosis and treatment of emergencies; and
7. Provide indicated post-anesthesia care.

The medical direction service furnished by a physician is not covered if the physician directs other than a qualified individual. A qualified individual is a physician or CRNA. The physician must document in the patient's medical record that the physician performed the pre-anesthetic exam and evaluation, provided post-anesthesia care, was present during some portion of the anesthesia monitoring and present during the most demanding procedures, including induction and emergence, where indicated. Total anesthesia care time must also be clearly indicated in the medical record.

A physician who is directing the concurrent administration of anesthesia to four or fewer surgical patients should not be involved in furnishing additional services to other patients. If the physician is addressing an emergency of short duration in the immediate area, or administering an epidural or caudal anesthetic to ease labor pain, or providing periodic rather than continuous monitoring of an obstetrical patient, it does not constitute a separate service for the purpose of determining whether the medical direction criteria are met. A physician may also receive patients entering the operating suite for subsequent surgeries, may check on or discharge patients from the recovery room, and may handle scheduling matters while directing concurrent anesthesia procedures without affecting coverage for medical direction.

If the physician leaves the immediate area of the operating suite for other than short durations, devotes extensive time to an emergency case, or is not available to respond to the immediate needs of the surgical patients, the physician's services are considered supervisory and are not covered as medical direction.

Routine post-operative pain management is the responsibility of the surgeon and is part of the global fee paid to the surgeon which includes all care after surgery. Non-routine post-operative pain management, however, may be provided by an anesthesiologist under certain circumstances. Placement of a continuous epidural to manage post-operative pain is separately covered under the appropriate CPT code for a continuous epidural when a physician (or CRNA under a physician's supervision) performed the service for post-operative pain management and the procedure was not used as the mode of anesthesia for the surgery. Daily management of a continuous epidural on subsequent post-operative days is covered under the appropriate procedure code.

Reimbursement

All claims reporting the administration of anesthesia must include the following:

- The appropriate anesthesia procedure code (00100 - 01999)
- Anesthesia time (in minutes)

- The appropriate anesthesia modifier to identify who rendered the service

The anesthesia procedure code, modifier, base units, total time in minutes, and procedure fee are utilized for calculating payments for anesthesia services. The Program does not determine time units on the basis of one time unit for each 15 minutes of anesthesia time. Instead, base units are converted to time units by multiplying them by 15. Payment for anesthesia services will be the sum of the total time in minutes and the base units converted to time units multiplied by the listed fee per unit and by the modifier rate (50% or 100%). Payment will be the lower of the provider's charge or the calculated fee amount. If a physician personally provides the entire anesthesia service, payment will be 100% of the calculated amount. Medically directed anesthesia services will be reimbursed at 50% of the calculated amount for both the CRNA and the physician. Non-medically directed CRNA services are reimbursed at 100% of the calculated fee. Physician supervision services are not reimbursed separately. When billing for anesthesia for multiple surgical procedures, report the anesthesia procedure code with the highest base unit value and indicate the total time for all procedures.

Reimbursement for anesthesia services is based on the following formula:

Time Units (minutes) + (Base Units x 15) x Fee x Modifier = Payment

Example: 00500, time = 300 minutes, ABU's = 15, Modifier = QX

$$300 + (15 \times 15) \times 1.2027 \times 0.50 = 315.71$$

The minimum reimbursement for anesthesia services with modifiers AA and QZ is \$30 and the minimum reimbursement for anesthesia services with modifiers QK, QX and QY is \$15. If the calculated payment is less than these limiting amounts, the minimum amount will be paid.

NOTE: The Program uses the anesthesia relative value units established by Medicare in its reimbursement methodology. The Anesthesia Uniform Relative Value Units Guide can be found on the TrailBlazerHealth web site.

Add-On Codes

Current CPT includes add-on codes for anesthesia involving burn excisions or debridement and obstetrical anesthesia. The add-on codes should be billed in addition to the primary anesthesia code. In the burn area, use code 01953 in conjunction with code 01952. In the obstetrical area, use codes 01968 and 01969 in conjunction with code 01967. The anesthesia time should be reported separately for both the primary and the add-on code based upon the amount of time appropriately associated with each code. The appropriate anesthesia modifier must also be reported with the add-on codes to identify who rendered the service.

NOTE: When surgery is aborted after general or regional anesthesia induction has taken place, report this situation using unlisted procedure code 01999 and include a copy of the anesthesia report with an indication that the surgery was cancelled.

CRITICAL CARE SERVICES

The Program covers critical care services consistent with CPT

definitions and guidelines. Critical care is the direct delivery by a physician of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition. The same definitions for critical care services apply for the adult, child and neonate. Each day that critical care is billed, the medical record must support the level of service provided.

In order to determine that critical care services rather than other evaluation and management services are medically necessary, both the following criteria must be met in addition to the CPT descriptions:

1. There is a high probability of sudden, clinically significant, or life-threatening deterioration in the patient's condition that requires the highest level of physician preparedness to intervene urgently, and
2. Critical care services require direct personal management by the physician. They are life-and organ-supporting interventions that require frequent, personal assessment and manipulation by the physician. Withdrawal of, or failure to initiate, these interventions on an urgent basis would likely result in sudden, clinically significant or life-threatening deterioration of the patient's condition.

Critical Care

Procedure code 99291 is used to report the first 30-74 minutes of critical care provided to a critically ill or injured patient over 24 months of age on a given date. Critical care of less than 30 minutes total duration on a given date should be reported with the appropriate Evaluation & Management code. Procedure code 99292 is used to report additional block(s) of time, of up to 30 minutes each beyond the first 74 minutes.

The actual time spent with the patient delivering critical care services must be documented in the medical record. For any period of time spent providing critical care services, the physician must devote full attention to the patient and cannot provide services to any other patient during the same period of time. When billing, report a quantity of "1" for up to the first 74 minutes of critical care. If 75 or more minutes of care is provided, report a quantity of "1" for each additional 30 minutes of care under the appropriate code.

NOTE: Do not bill ventilation management in addition to critical care services by the same physician on the same day because critical care includes ventilation management. For neonates who are receiving ventilation management services, not critical care, the services should be reported under the ventilation management codes.

The following services are included in reporting the critical care codes 99291-99292 and should not be billed separately: the interpretation of cardiac output measurements (93561, 93562), chest x-rays (71010, 71015, 71020), pulse oximetry (94760, 94761, 94762), blood gases and information data stored in computers (eg, ECGs, blood pressures, hematologic data (99090)); gastric intubation (43752, 91105); temporary transcutaneous pacing (92953); ventilatory management (94656, 94657, 94660, 94662); and vascular access procedures (36000, 36410, 36415, 36540, 36600).

Neonatal and Pediatric

Critical care services provided to neonates (28 days of age or less) are reported with the neonatal critical care codes 99468 and 99469. They represent care starting with the date of admission (99468) and subsequent day(s) (99469) and may be reported only once per day. Once the neonate is no longer considered to be critically ill, the Intensive Low Birth Weight Services codes for those with present body weight of less than 2500 grams (99478, 99479) or the codes for Subsequent Hospital Care (99231-99233) for those with present body weight over 2500 grams should be used.

Critical care services provided to infants (29 days up through 24 months of age) are reported with pediatric critical care codes 99471 and 99472. They represent care starting with the date of admission (99471) and subsequent day(s) (99472) and may be reported by a single physician only once per day, per patient in a given setting. Once an infant is no longer considered to be critically ill but continues to require intensive care, the Intensive Low Birth Weight Services codes (99478, 99479) should be used to report services for infants with present body weight of less than 2500 grams. When the present body weight of those infants exceeds 2500 grams, the Subsequent Hospital Care (99231-99233) codes should be used.

NOTE: For neonatal and pediatric critical care codes age determination in days is calculated by subtracting the date of birth from the date of service.

The neonatal and pediatric critical care codes include those procedures listed above for the hourly critical care codes (99291, 99292). They also include the following services and should not be billed separately: umbilical venous (36510) and umbilical arterial (36660) catheters, central (36488, 36490) or peripheral vessel catheterization (36000), other arterial catheters (36140, 36620), oral or nasogastric tube placement (43752), endotracheal intubation (31500), lumbar puncture (62270), suprapubic bladder aspiration (51000), bladder catheterization (53670), initiation and management of mechanical ventilation (94656, 04657) or continuous positive airway pressure (CPAP) (94660), surfactant administration, intravascular fluid administration (90780, 90781), transfusion of blood components (36430, 36440), vascular punctures (36420, 36600), invasive or non-invasive electronic monitoring of vital signs, bedside pulmonary function testing (94375), and/or monitoring or interpretation of blood gases or oxygen saturation (94760-94762).

EVALUATION AND MANAGEMENT SERVICES

CPT E&M service guidelines apply for determining what level of care is appropriate. Generally CPT descriptions for E&M services indicate "per day" and only one E&M service may be reported per date of service. A preventive exam and another E&M service are not payable on the same day. The provider should select the most appropriate single E&M service based on all services provided. If the service was an EPSDT screening, the preventive medicine code must be reported. An E&M service is also not payable on the same day as a procedure with a global surgery period.

NOTE: Modifier -21 (Prolonged E&M service) is informational and does not affect payment.

To report emergency services in the office, report the applicable procedure or the E&M office visit that represents the level of care provided. Services such as telephone calls, missed appointments and interpretation of lab results cannot be billed as separate services.

FAMILY PLANNING SERVICES

Abortions and hysterectomies are not considered family planning services. Common family planning procedures include:

| <u>Procedure Code</u> | <u>Description of Service</u> |
|-----------------------|-------------------------------------|
| J1055 | Depo-Provera, 150 mg |
| J7300 | IUD Kit |
| 58300 | IUD insertion |
| 58301 | IUD removal |
| J7302 | Mirena |
| J7303 | Hormone containing vaginal ring |
| J7304 | Contraceptive hormone patch |
| A4261 | Cervical cap |
| A4266 | Diaphragm |
| 11976 | Removal implantable capsules |
| 57170 | Diaphragm fitting |
| J7307 | Implanon |
| 11981 | Insertion, drug delivery implant |
| 11982 | Removal, drug delivery implant |
| 11983 | Remove/insert drug delivery implant |
| 99070 | Other contraceptive product |
| 58565 | Essure |

NOTE: A copy of the invoice for the contraception product must be attached to the claim form when billing procedure codes 99070, A4261, A4266, J7303, and J7304.

The following CPT Evaluation and Management codes should be used for billing for family planning services in conjunction with an ICD-9 diagnosis code of V25:

| <u>New Patients</u> | <u>Established Patients</u> |
|---------------------|-----------------------------|
| 99201 - 99205 | 99211 - 99215 |
| 99241 - 99245 | 99394 - 99396 |
| 99384 - 99386 | |

GYNECOLOGY

The appropriate Preventive Medicine codes should be used for annual gynecologic exams for asymptomatic patients. Use **99383 - 99387** for new patients or **99393 - 99397** for established patients. A Pap test is considered part of the office visit and only billable by the laboratory which reads and interprets the slide.

The appropriate Evaluation and Management codes should be used for symptomatic patients. Use **99201 - 99205** for a new patient or **99211 - 99215** for an established patient.

HEALTHY KIDS/EPST

1. Preventive Medicine Services

The Maryland Healthy Kids/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program is a comprehensive pediatric program. This program uses Preventive Medicine (full screening) CPT codes for billing well-child care.

a. 99381 - 99385 - New Patient/Full Screening

A full screening includes a health and developmental history, unclothed physical exam, appropriate laboratory tests, immunizations and health education/anticipatory guidance.

NOTE: A newborn infant history and examination completed in a hospital should be billed using CPT newborn care code 99431.

b. 99391 - 99395 - Established Patient/Full Screening

A full periodic screening is completed on an established patient at subsequent intervals according to the age intervals displayed on the Maryland Healthy Kids Preventive Care Schedule.

c. Preventive Medicine CPT codes are also used to report a full EPSDT screening provided in a hospital outpatient department setting (when the physician's services are **not** included in the cost-based hospital rate) and for patients who are in the care and custody of a State agency pursuant to a court order or a voluntary placement agreement (foster care).

2. Objective Tests

Other procedure codes for objective tests approved by the Maryland Healthy Kids Program which are used in conjunction with the screening procedure codes are:

- a. Developmental Test - 96110, 96111**
- b. Hearing/Screening Test - 92551**
- c. Vision Screen - 99173**

3. Other Ancillary Services

Immunizations, on-site laboratory services and family planning services are additional procedures which can be used in conjunction with a Healthy Kids exam. For additional information call the Maryland Healthy Kids Program at (410) 767-1683 or (877) 463-3464, x1683.

4. Vaccine Administration/Vaccines for Children Program

Eligible providers should bill for administering childhood vaccines received free from the federal Vaccines for Children Program (VFC) by using the appropriate CPT code for the vaccine/toxoid or immune globulin in conjunction with the modifier **-SE** (State and/or Federally-funded programs/services). The maximum reimbursement is \$15.49 per administration. Providers will not be reimbursed for vaccine administration unless the modifier -SE is appended to the appropriate CPT vaccine code.

VFC immunization administration codes are as follows:

VACCINE

CPT-MOD

| | |
|---|----------|
| Hepatitis B Immune Globulin (HBIg) | 90371-SE |
| Hepatitis A, pediatric/adolescent, (2 dose) | 90633-SE |
| Hemophilus influenza b, HbOC conjugate (Hib) | 90645-SE |
| Hemophilus influenza b, PRP-OMP conjugate (Hib) | 90647-SE |
| Hemophilus influenza b, PRP-T conjugate (Hib) | 90648-SE |
| Human Papilloma, quadrivalent, (3 dose) (HPV) | 90649-SE |
| Influenza virus, split virus, 6-35 months, pf | 90655-SE |
| Influenza virus, split, preserv free, > 2 yrs | 90656-SE |
| Influenza virus, split virus, 6-35 months | 90657-SE |
| Influenza virus, split virus, 3-18 years | 90658-SE |
| Influenza virus, live, intranasal | 90660-SE |
| Pneumococcal conjugate, 7 valent, < 5 years | 90669-SE |
| Pneumococcal conjugate, 13 valent | 90670-SE |
| Rotavirus, pentavalent, live, oral, (3 dose) | 90680-SE |
| Rotavirus, monovalent, live, 6-32 weeks | 90681-SE |
| Diphtheria, tetanus toxoids, acellular pertussis and polio virus, inactivated, 5 th dose, 4-6 years (DTaP-IPV) | 90696-SE |
| Diphtheria, tetanus toxoids, acellular pertussis, haemophilus influenza type b, poliovirus, 2-59 months (DTaP-Hib-IPV) | 90698-SE |
| Diphtheria, tetanus toxoids and acellular pertussis, < 7 years (DTaP) | 90700-SE |
| Diphtheria and tetanus toxoids, < 7 years (DT) | 90702-SE |
| Measles, mumps and rubella virus, live (MMR) | 90707-SE |
| Measles, mumps, rubella and varicella (MMRV) | 90710-SE |
| Poliovirus, inactivated (IPV) | 90713-SE |
| Tetanus and diphtheria toxoids, 7-18 years (Td) | 90714-SE |
| Tetanus, diphtheria toxoids and acellular Pertussis (Tdap), 7-18 years | 90715-SE |
| Varicella virus, live | 90716-SE |
| Tetanus toxoid and diphtheria (Td, 7-18) | 90718-SE |
| Diphtheria, tetanus toxoids, acellular pertussis and Hemophilus influenza b (DTaP-Hib) | 90721-SE |
| Diphtheria, tetanus toxoids, acellular pertussis and Hepatitis B and poliovirus (DTaP-HepB-IPV) | 90723-SE |
| Pneumococcal polysaccharide, 23-valent, 2-18 yrs | 90732-SE |
| Meningococcal conjugate, tetravalent | 90734-SE |
| Hepatitis B, adolescent (2 dose) | 90743-SE |
| Hepatitis B, pediatric/adolescent (3 dose) | 90744-SE |
| Hepatitis B and Hemophilus influenza b (HepB-Hib) | 90748-SE |

5. Sick Visits

Preventive Medicine CPT codes can be used when a child is being seen for an illness if the child is due for a well child exam and if all of the requirements for a Healthy Kids exam can be completed. If the child has already received a preventive well child exam or is too sick to complete a full Healthy Kids exam, use the CPT Evaluation and Management codes (99201 - 99215) for sick or acute illness related office visits.

HYSTERECTOMIES

The Program will not reimburse for a hysterectomy performed solely for the purpose of rendering an individual permanently incapable of reproducing, or if there was more than one purpose to the procedure, and it would not have been performed but for the purpose of rendering the

individual permanently incapable of reproducing. Hysterectomies are prohibited when performed for family planning purposes even when there are medical indications, which alone do not indicate a hysterectomy.

The Program will reimburse for a hysterectomy only if the following conditions are met:

1. The physician who secured authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing, that the hysterectomy will render the individual permanently incapable of reproducing, and
2. The individual or her representative, if any, has signed a written acknowledgement of receipt of that information, or
3. The individual was already sterile before the hysterectomy, or
4. The individual requires a hysterectomy because of a life-threatening emergency situation and the physician determines that prior informing and acknowledgement are not possible, and
5. The physician who performs the hysterectomy:
 - a. Certifies, in writing, that the individual was already sterile at the time of the hysterectomy and states the cause of the sterility, or
 - b. Certifies, in writing, that the hysterectomy was performed under a life-threatening emergency situation in which the physician determined that prior acknowledgement was not possible. The physician must also include a description of the nature of the emergency.

Regulations require the physician who performs the hysterectomy (not a secondary provider such as an assisting surgeon or anesthesiologist) to certify that the woman met one of the specified exemptions. A **"Document For Hysterectomy" DHMH 2990** form must accompany every invoice for a hysterectomy (51925, 58150-58294, 58541-58544, 58548, 58550-58554, 58951, 58953-58954, 59135, 59525). Do not bill other services on the same claim form with this procedure. Patient consent (signature) is not needed if the patient is over age 55.

INJECTABLE DRUGS AND BIOLOGICALS

The Program covers injectable drugs and biologicals which are FDA approved and reasonable and necessary according to accepted standards of medical practice for the diagnosis or treatment of an illness or injury of a patient. If a drug is given on the same day as another service, the administration is generally considered part of the other service and cannot be reported separately. If the only service being given is the injection, the administration cannot be billed separately. Only the J-code for the drug can be reported. The Program reimburses providers their acquisition cost for injectable drugs. Providers must bill their actual cost for drugs and biologicals. The Program's maximum reimbursement established for each J-code represents the estimated actual cost of the drug to the provider. If the Program's fee is less than the provider's actual cost, the Program will reimburse the provider upon appeal the difference between their actual cost and the amount paid by the Program. The fees for the J-codes are not listed in this manual.

Physicians must bill their acquisition cost for injectable drugs.

The acquisition cost must be the charge in **Block 24F** of the CMS-1500. The acquisition cost is defined as the purchase price of the drug (less any discounts) for the amount administered, including any portion of tax and shipping. The CMS-1500 must include the J-code in **Block 24D** and the number of units administered in **Block 24G**. The dosage indicated in the J-code description times the number of units reported should equal the total amount of the drug actually given.

When a drug is administered which does not have a specific J-code or the "strength" is different from the ones listed, use the appropriate unclassified J-code in **Block 24D** of the CMS-1500. The maximum number of units which can be administered for an unlisted injectable drug is "1." Use **J9999** for unclassified antineoplastic drugs and **J3490** for all other unclassified drugs.

Claims that contain unlisted codes cannot be processed for payment without an attached copy of a **recent invoice** which clearly shows the per unit cost of the drug. Unclassified procedure codes require manual review and payment may be delayed. Payment processing can be facilitated by writing on the attached invoice the calculation used to determine the acquisition cost of the unlisted drug. The NDC in the shaded area of Block 24 A on the CMS-1500 must agree with the name of the drug listed on the invoice. The actual cost documentation is only required for unlisted injectable drugs. The drug will not be reimbursed if its actual cost can not be determined from the information reported on the claim or from the invoice.

NOTE: The Program does not reimburse separately for immunization administration (CPT 90465 - 90474 are not used/payable), except for, immunizations covered under the Vaccines for Children Program.

NOTE: The quantity reported should reflect the dose given according to the HCPCS description for the code. Use the code with the exact dosage or round the quantity up to best describe the amount given. When administering a dose from a multiple dose vial, only the amount given to the patient should be billed to the Program. If, however, a drug is only available in a single use size and any drug not used must be discarded, the Program will pay for the amount supplied in the vial.

NOTE: The Program will not reimburse providers for drugs unless their manufacturers participate in the federal Drug Rebate Program and the NDC and quantity administered are reported on the CMS-1500. See NDC Reporting Requirements on page 9.

MATERNITY CARE

The services normally provided in uncomplicated maternity cases include antepartum care, delivery and postpartum care. Antepartum care includes the initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. Delivery services include 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 includes hospital and office visits following a vaginal or cesarean section delivery.

The Program does not reimburse providers for "global" maternity care

services. CPT codes 59400, 59510 and 59610 are not used by the Program. Instead, the Program will reimburse providers for vaginal delivery including postpartum care as a separate procedure, CPT code **59410**. Cesarean deliveries are generally billed using code **59515**. Prenatal care services should be billed using the appropriate E&M office/outpatient code for each visit as described in CPT. In general, the first prenatal visit will be the most detailed and comprehensive and follow-up visits will be less comprehensive and require less time. Antepartum care codes 59425-59426 are not used by the Program.

The Program will pay for postpartum care only using procedure code **59430**. Postpartum care includes all the visits following a delivery, both in the hospital and in the office. Postpartum care is not separately payable unless it is provided by a physician or group other than the one providing the delivery service.

For twin gestation, report the delivery services on two lines with no modifier on the first and modifier -51 on the second.

NOTE: Physicians and nurse midwives should bill for vaginal deliveries including postpartum care performed in a home or birthing center using CPT codes 59410 and 59614 with the appropriate place of service, **12** or **25**, reported in **Block 24B** of the CMS-1500. The reimbursement rate for a vaginal delivery in a home setting is \$1,054 and in a birthing center is \$1,395. Bill the unlisted maternity care and delivery code 59899 for supplies used during a vaginal delivery in a home or birthing center. The fee for delivery supplies is \$75.

Vaginal and cesarean deliveries must be billed separately from prenatal care. A claim for a delivery which includes other procedures on the same date of service must list the delivery first and then the subsequent procedures with the appropriate modifier. A tubal ligation performed at the time of a cesarean delivery must be billed separately using procedure code **58611** with a modifier -51 and include the Sterilization Consent Form.

NOTE: Artificial insemination and in-vitro fertilization are not covered services.

Healthy Start Program

In addition to the services normally provided with prenatal and postpartum office visits, physicians may bill for two additional services covered under the Healthy Start Program, risk assessment and enriched maternity services.

| <u>Code</u> | <u>Description of Service</u> |
|--------------|--|
| H1000 | Prenatal Care, At-Risk Assessment |

The Medical Assistance Program requires maternity care providers to complete the Prenatal Risk Assessment form (DHMH 4850) at the time of the initial prenatal visit and to submit the completed form in a timely manner to the recipient's local health department, regardless of risk status. Use procedure code H1000 and a diagnostic code of V22 or V23 to bill for the completion and submittal of the Prenatal Risk Assessment form. Only one assessment will be reimbursed for each pregnancy.

| | |
|--------------|---|
| H1003 | At-Risk Enhanced Service/Education |
|--------------|---|

Enriched maternity services can be provided in conjunction with and in addition to each prenatal and postpartum office visit (up to 60 days after delivery). These services may include counseling, health education, nutrition education, care coordination, referral to services such as WIC, smoking cessation, drug and alcohol treatment or family planning. Use procedure code H1003 with a diagnosis code of V22 or V23 to bill for an enriched maternity service.

Call (410) 767-6750 or (800) 456-8900 for additional information concerning the Healthy Start Program.

NEWBORN CARE

The following CPT codes are used to report the services provided to newborns in several different settings:

| <u>Procedure</u> | <u>Code</u> |
|---|---------------------|
| History and examination | 99460, 99463 |
| Normal newborn care (non-hospital) | 99461 |
| Subsequent hospital care | 99462 |
| Attendance at delivery | 99464 |
| Newborn resuscitation | 99465 |

OPHTHALMOLOGY

A general evaluation of the complete visual system includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated: biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

PATHOLOGY AND LABORATORY

1. Specific information concerning pathology and laboratory services can be found in the Medical Laboratories Provider Manual and Fee Schedule under COMAR 10.09.09. Call (410) 767-1462 or (877) 463-3464, x1462 for additional information or a copy of this document.

2. Physician Office Laboratories

Physicians may only bill the Program for those laboratory procedures which they perform or are performed under their direct supervision. Physicians' services providers cannot be reimbursed for clinical laboratory services without a Clinical Laboratory Improvement Amendments (CLIA) certification and approval by the Maryland Laboratory Administration if located in Maryland. Laboratory procedures which the physician refers to an outside laboratory or practitioner for performance must be billed by that laboratory or practitioner. The physician may not bill for any laboratory procedure which is referred to a laboratory or another physician.

3. Interpretation of laboratory results, or the taking of specimens other than blood, is considered part of the office visit and may not be billed as a separate procedure. Specimen collections for Pap smears and PKU for infants are not billable by a physician. Specimen collection by venipuncture, capillary or arterial puncture are billable.

RADIOLOGY

Radiology services include diagnostic and therapeutic radiology, nuclear medicine, CT scan procedures, magnetic resonance imaging (MRI) services, diagnostic ultrasound and other imaging procedures. The nuclear medicine codes (78000 - 79999) are to be used for in-vivo testing only. In-vitro tests are described in the Pathology and Laboratory section of CPT (80049 - 89399).

Physicians can bill for the global service in a non-hospital setting or professional only component service in any setting. Providers cannot bill for the technical component only. The global service includes all resources necessary to perform the procedure and the professional physician services to interpret the output. The professional component includes the specialized interpretation or reading of the test results and preparation of a detailed written report of the findings for the referring/attending physician. Interpretation of radiology services are payable to any physician trained in the interpretation of the study. The provider who bills for the interpretation must be the provider who evaluates the study and prepares and signs the written report for the medical record and is subject to post-payment review. Review of results and explanation to the patient is part of the attending physician's E&M service and cannot be billed as an interpretation of the study.

When performing radiology services using hospital equipment and/or staff, bill only for the professional component by adding the modifier **-26** to the procedure code. Payment for the professional component is based upon the same percentage of the global fee that Medicare uses in its physician fee schedule.

NOTE: Computerized tomography includes CT's, MRI's, PET's and SPECT's.

Bilateral services are studies done on the same body area, once on the left side and once on the right side. Providers should use the "bilateral" CPT code to bill these services when available. If a bilateral code is not available, use the unilateral procedure code, append the modifier **-50** and report one unit in Block **24G**.

If the same x-ray is repeated on the same patient on the same day, report 2 units in Block **24G** on the claim form. Generally, the maximum units allowed for radiology procedures is two.

CAT scans and MRI's do not require preauthorization. Use procedure codes **77055** (unilateral) or **77056** (bilateral) for diagnostic mammography when the patient is referred by a physician. Use procedure code **77057** for walk-in mammography screening. A physician referral is not required for walk-in mammography screening; however, the patient must be age 21 or older.

NOTE: Radiology services billed with a place of service code of 21, 22 OR 23 will be denied without a modifier -26, except for certain radiology oncology codes where the modifier -26 does not apply.

NOTE: Use G0202 - G0206 for digital mammography.

RADIOPHARMACEUTICALS

Reimbursement for radiopharmaceuticals is usually considered separately from the procedure. Use HCPCS codes A9500 - A9605. If a HCPCS code has not been established for the radiopharmaceutical used, code A4641 should be used for a diagnostic agent and code A9699 should be used for a therapeutic agent. A patient specific invoice is required for reimbursement. The invoice must supply all the following information:

1. Recipient name
2. Name of radiopharmaceutical
3. Dosage being administered
4. Cost of radiopharmaceutical
5. Date radiopharmaceutical was administered

A valid invoice is also required for 10 A-codes which do not have a listed fee: A9512, A9531-A9532, A9542-A9545, A9550, and A9554-A9555.

Use HCPCS codes Q9945 - Q9957 for Low Osmolar Contrast Media (LOCM).

RENAL DIALYSIS

End-Stage Renal Disease

Codes 90951 - 90962 are reported ONCE PER MONTH to distinguish age-specific services related to the patient's end-stage renal disease (ESRD) in an outpatient setting. ESRD-related physician services include establishment of a dialyzing cycle, outpatient evaluation and management of the dialysis visits and patient management during the dialysis, provided during a full month. These codes are not used if the physician also reports hospitalization codes during the month.

Codes 90963 - 90966 are reported ONCE PER MONTH to distinguish age-specific services related to the patient's ESRD performed in the patient's home. Codes 90967 - 90970 are used to report ESRD services less than a full month per day.

Hemodialysis and Miscellaneous Dialysis Procedures

For ESRD and non-ESRD dialysis services performed in an inpatient setting, and for non-ESRD dialysis services performed in an outpatient setting, report codes 90935 - 90937 and 90945 - 90947.

Physicians' services provided to a renal dialysis patient include only those routine professional services that entail substantial direct involvement and the physical presence of the physician in the delivery of services directly to the patient. Routine professional services include all physicians' services furnished during a dialysis session that meet the following requirements:

1. They are personally furnished by a physician to an individual patient,
2. They contribute directly to the diagnosis or treatment of an individual patient, and
3. They ordinarily must be performed by a physician.

Routine professional services associated with renal dialysis include at least **all** of the following services when medically appropriate:

1. Visits to the patient during dialysis and review of laboratory

test results, nurses' notes and any other medical documentation, as a basis for,

- a. Adjustment of the patient's medication or diet, or the dialysis procedure,
- b. Prescription of medical supplies, and
- c. Evaluation of the patient's psychosocial status and the appropriateness of the treatment modality.

2. Medical direction of staff in delivering services to the patient during a dialysis session.

3. Pre-dialysis and post-dialysis examinations, or examinations that could have been furnished on a pre-dialysis or post-dialysis basis.

4. Insertion of catheters for patients who are on peritoneal dialysis and do not have indwelling catheters.

Insertion of a cannula or catheter should be billed using procedure code 49420 or 49421.

NOTE: Physicians' services to a renal dialysis patient must be supported by a contemporaneous entry in the medical record, written and signed by the attending physician, documenting that the physician personally provided the services. Inadequate documentation will result in denial of payment, or if payment has already been made, in recovery of payment.

STERILIZATIONS AND TUBAL LIGATIONS

Sterilizations have special requirements which must be met in order for them to be covered by the Medical Assistance Program. The Program will reimburse for the sterilization of an individual, including a tubal ligation, only if all of the following conditions are met:

1. The individual is at least **21** years of age at the time consent is obtained,

2. The individual is not mentally incompetent,

3. The individual is not institutionalized,

4. The individual has voluntarily given informed consent as described in Part I of the consent document, "**Sterilization Consent Form**" **DHMH 2989**, and

5. At least **30** days, but not more than **180** days, have passed between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

A "**Sterilization Consent Form**" **DHMH 2989** must accompany all invoices for sterilization (55250, 55450, 58565, 58670 - 58671, 58600 - 58615, 58670 - 58671, 58700). A sterilization/tubal ligation procedure must be billed on a separate HCFA-1500 claim form. If the procedure was

performed on the same date of service as another procedure, a modifier -51 is required in Block **24D** for the second or subsequent procedure.

The sterilization form consists of four parts:

Part I - Consent to Sterilization - This section must be completed for all sterilizations and must be signed and dated by the individual being sterilized.

Part II - Interpreter's Statement - This section must be completed only when an interpreter is provided to assist the individual to be sterilized to understand the consent statement.

Part III - Statement of Person Obtaining Consent - This section must be completed for all sterilizations and must be signed and dated by the person who counseled the individual to be sterilized.

Part IV - Physician's Statement - This section must be completed for all sterilizations by the physician. One of the final paragraphs, the one which is not used, must be crossed out. This section is worded so that the physician is required to sign this form on or after the date of sterilization. This section may not be signed or dated by the physician prior to the date of sterilization.

NOTE: The individual is not eligible for the sterilization procedure until the 32nd day after giving consent (signature date).

NOTE: Use procedure code **58565** to bill for the implantation of Essure and the device when provided in the office (Sterilization Consent Form required), and **58340** for the 3-month follow-up hysterosalpingogram to confirm placement of the implants for bilateral occlusion of the fallopian tubes. Use procedure code 99070 for the Essure device when provided in an hospital outpatient setting (invoice required).

SUPPLIES AND MATERIALS

Procedure code **99070** should be used to bill for supplies and materials. Providers will be reimbursed their acquisition cost for these services. **The acquisition cost is defined as the purchase price of the supply or material (less any discounts) for the amount supplied, including any portion of tax or shipping.** Providers must bill their actual cost for supplies and materials. Claims for supplies which cost \$10 or more must report the name of the supply and the amount supplied in Block **24D** of the CMS-1500. A copy of a current invoice which clearly shows the per unit cost of the supply must be attached to the claim. The calculation used to determine the acquisition cost should be written on the invoice. No payment will be made if the actual cost cannot be determined from the documentation provided. No invoice documentation is required for charges less than \$10.

NOTE: Only those supplies provided by the physician over and above those usually included with the office visit or other services rendered may be listed separately under procedure code 99070.

SURGERY

CPT surgery guidelines for add-on, 51-exempt, separate procedures, bilateral and multiple procedures generally apply. Reimbursement for surgery includes related services that are furnished by the surgeon who

performs the surgery or by members of the same specialty group. This reimbursement method is known as the global surgery package which includes the following services:

1. Pre-operative visits beginning with the day before the surgery for major surgeries (90 day post-operative period) and the day of the surgery for minor surgeries,
2. Intra-operative services that are a usual and necessary part of a surgical procedure,
3. Complications following surgery (This includes all additional medical or surgical services required of the surgeon during the post-operative period because of complications that do not require return to the operating room. The surgeon's visits to a patient in an intensive care or critical care unit are also included.)
4. Follow-up visits within the post-operative period related to recovery from the surgery,
5. Post-surgical pain management by the surgeon,
6. Supplies for certain services furnished in a physician's office, and
7. Miscellaneous services and items (For example: dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.)

Multiple Surgical Procedures

For multiple surgical procedures performed during the same surgical session, report the major or primary surgery on the first service line with no modifier. Report each additional procedure performed during the same surgical session on subsequent service lines with the modifier -51. All services should be reported on one claim. Procedures identified as "Add-on" or "-51-Exempt" procedures are reimbursed at 100% and are not subject to the multiple surgery reduction. Add-on and -51-exempt procedures should not be reported with the modifier -51.

There are instances when the primary procedure specifies that each additional procedure should be reported and there are no additional codes to report the second and subsequent procedures. In these cases when there is only one procedure code available, the primary procedure should be reported on one line without a modifier -51 and the additional procedures, second and subsequent, reported on a second line with the same procedure and the modifier -51. When more than one of the same subsequent procedure is performed, indicate the number of services in **Block 24G** on the CMS-1500. If the number of units reported exceeds the Program's maximum for that procedure, the line item will suspend indicating that additional medical documentation is required. Add-on codes and modifier -51 exempt codes should also be reported **when appropriate** with multiple units on a single line without a modifier -51 when there are no additional codes to report the second and subsequent procedures.

NOTE: The maximum units of service allowed for a surgery procedure without a modifier -51, exclusive of certain add-on and -51 exempt codes, is one.

Bilateral Surgery

Bilateral surgeries are procedures performed on both sides of the body at the same operative session or on the same day. The descriptions for some procedure codes include the terms "bilateral" or "unilateral or bilateral." The fee for these codes reflects the work involved if done bilaterally as the description states. If a bilateral procedure is performed, report the bilateral procedure if available. When there is no code describing bilateral services, report the bilateral service on one claim line and add the modifier -50. Reimbursement for a bilateral procedure reported appropriately with modifier -50 is based on the lower of the amount billed or 150% of the listed fee for the procedure. If a procedure is identified as a bilateral procedure according to CPT, do not report the code with modifier -50.

Assistant Surgeons

The Program covers assistant surgeon services for designated surgical procedures. An assistant surgeon is a second physician who actively assists the primary surgeon during a surgical procedure. Assistant surgeon services must be considered reasonable and necessary for the surgery performed.

The surgical procedure(s) should be reported with modifier -80 or -82. Reimbursement for assistant surgeon services will be the lesser of the charge or 20% of the fee for the surgical procedure.

NOTE: Modifier -81 is not used/payable by the Program.

NOTE: Reimbursement for services at the assistant surgeon rate will not be made if reported with modifiers 54 and 55.

Less Than Full Global Package

Physicians furnishing less than the full global surgery package for procedures with 10 or 90 day global periods must bill their portion of care correctly. The surgeon should use modifier -54, surgical care only, to bill for a surgery when another physician who is not a member of the same group provides all or part of the outpatient post-operative care. The Program assumes that the surgeon is responsible for pre-operative, intra-operative and inpatient hospital post-operative care at a minimum. Payment will be 80% of the listed fee for the procedure.

Modifier -55 is used when a physician other than the surgeon provides all or part of the post-operative care after hospital discharge. The surgeon must transfer care to the second physician, and both must keep a copy of the written transfer agreement in the patient's medical record. The physician assuming care must bill the surgical code, use the date of surgery as the service date, and report modifier -55. The physician cannot bill for any part of the post-operative care until at least one service has been provided.

NOTE: Modifier -56 is not used/payable by the Program. Report the modifier -52, reduced services, if a service or procedure

is partially reduced or eliminated at the physician's discretion. A report is required to determine reimbursement.

Report the modifier -53, discontinued procedure, if a surgical or diagnostic procedure is terminated after it was started. A report is required to determine reimbursement.

NOTE: The modifier -22, unusual procedural services, is informational and does not affect payment.

NOTE: The reporting of modifiers is subject to post-payment audit.

TRAUMA SERVICES

Senate Bill 479/House Bill 1 enacted in 2003 established a Trauma Fund to subsidize trauma physicians for uncompensated trauma care. The law also required the Medical Assistance Program to reimburse trauma physicians at the greater of the Program's fee schedule amount or the Medicare facility-based rate for the Baltimore City and surrounding area locality. These bills also allow the Program to be reimbursed for the amount of the trauma fee increases from the Trauma Fund. Due to HIPAA and other implementation requirements, the law was implemented on December 1, 2003. The Maryland Health Care Commission and the Health Services Cost Review Commission have oversight responsibility for the Trauma Fund. The amount of the Medicaid trauma fee increases and reimbursement from the Fund are subject to the availability of monies in the Trauma Fund. The Maryland Health Care Commission may make adjustments to the Medicaid trauma rates in accordance with COMAR 10.25.10 and will provide the Program with at least four months prior notice of such changes.

A trauma physician is defined as a physician who provides care in a trauma center to trauma patients on the State Trauma Registry. Emergency room physicians, however, are eligible for uncompensated care reimbursement only from the Trauma Fund and not from the Medicaid Program. CLAIMS FOR TRAUMA SERVICES BY EMERGENCY ROOM PHYSICIANS WILL BE DENIED.

Trauma services are defined as the care provided to a trauma patient in a trauma center within an emergency room or the inpatient acute care setting. Trauma centers are those designated by the Maryland Institute for Emergency Medical Services System (MIEMSS).

A trauma patient is a patient treated at one of the MIEMSS-designated trauma centers with an injury as defined by ICD-9-CM diagnosis codes 800.00 to 959.9 or with a supplementary classification of external causes of injury and poisoning codes E800 - E999. To be eligible for the Medicaid differential payment, the patient must be included in the Maryland Trauma Registry administered by MIEMSS.

The following billing instructions for the CMS-1500 must be followed by trauma physicians in order to be reimbursed for trauma services at the higher Medicare rate:

1. The modifier -U1 must be reported in one of the modifier positions for the trauma service in Block 24D (modifier field). This modifier is being used to reimburse trauma providers for trauma services at the Medicare rate instead of the Medicaid rate.

2. A primary, secondary or additional diagnosis code listed in **Block 21** (diagnosis or nature of illness or injury field) must be from **800.00 - 959.9**, or if not, a supplementary classification of external causes and injury and poisoning code from **E800 - E999** must appear as a subsequent supplementary classification code in **Block 21**.

3. A primary, secondary or additional diagnosis code listed in **Block 24E** (diagnosis code field) for each line item on the invoice must be from **800.00 - 959.9**, or if not, a supplementary classification of external causes and injury and poisoning code from **E800 - E999** must appear as a subsequent supplementary classification code in **Block 24E** for each line item on the invoice when the U1 modifier is reported.

4. The last 2-digits of the trauma center identification number and the 6-digit trauma registry (patient identification) number must be reported in **Block 23** (prior authorization number field) as an 8-position number. The trauma registry number is available from the trauma center where care was provided. If the trauma registry number is less than six digits, place zeros in front of the trauma registry number until you have a 6-digit number. For example, if there is only a 4-digit trauma registry patient number, fill in the first two positions with zeros.

| FACILITY NAME | TRAUMA CENTER ID (Last 2-Digits of the MIEMSS Facility ID #) + TRAUMA REGISTRY NUMBER |
|--|--|
| <u>State Primary Adult Resource Center</u> R. Adams Cowley, Shock Trauma Center, Baltimore | 34 + 6-Digit Trauma Registry Patient Number |
| <u>Level I Trauma Center</u> Johns Hopkins Medical System, Adult Trauma Center, Baltimore | 04 + 6-Digit Trauma Registry Patient Number |
| <u>Level II Trauma Centers</u> Johns Hopkins Bayview Medical Center, Adult Trauma Center, Baltimore | 01 + 6-Digit Trauma Registry Patient Number |
| Prince George's Hospital Center, Adult Trauma Center, Cheverly | 32 + 6-Digit Trauma Registry Patient Number |
| Sinai Hospital of Baltimore, Adult Trauma Center | 10 + 6-Digit Trauma Registry Patient Number |
| Suburban Hospital, Adult Trauma Center, Bethesda | 49 + 6-Digit Trauma Registry Patient Number |
| <u>Level III Trauma Centers</u> Western Maryland Health System, Cumberland Memorial Trauma Center | 20 + 6-Digit Trauma Registry Patient Number |
| Peninsula Regional Medical Center, Adult Trauma Center, Salisbury | 08 + 6-Digit Trauma Registry Patient Number |
| Washington County Hospital, Adult Trauma Center, Hagerstown | 89 + 6-Digit Trauma Registry Patient Number |

Pediatric Trauma Centers

| | |
|--|--|
| Johns Hopkins Medical System, Pediatric Trauma Center, Baltimore | 05 + 6-Digit Trauma Registry Patient Number |
| Children's National Medical Center, Pediatric Trauma Center, Washington, D.C. | 17 + 6-Digit Trauma Registry Patient Number |

Trauma Specialty Referral Centers

| | |
|--|--|
| Johns Hopkins Medical System, Burn Center, Baltimore | 91 + 6-Digit Trauma Registry Patient Number |
| Johns Hopkins Medical System, Pediatric Burn Center, Baltimore | 93 + 6-Digit Trauma Registry Patient Number |
| Johns Hopkins Medical System, Eye Trauma Center, Baltimore | 95 + 6-digit Trauma Registry Patient Number |
| Union Memorial Hospital, Curtis National Hand Center, Baltimore | 94 + 6-Digit Trauma Registry Patient Number |

5. Only the place of service codes **21** (inpatient) and **23** (emergency room) can be reported in **Block 24B** (place of service field) for trauma services.

6. Enter the ID Qualifier **1D** followed by the 9-digit Medicaid provider number of the hospital where the trauma center is located in **Block 32b** (service facility location information) ON THE CMS-1500.

The increased fees are only applied to the trauma services rendered during the initial admission or trauma center visit and the resulting acute care stay, not for subsequent follow-up services. ALL REPORTING OF THE U1 MODIFIER WILL BE SUBJECT TO POSTPAYMENT AUDIT.

NOTE: The current revision to the Physicians' Services Provider Fee Manual can be obtained from the Department of Health and Mental Hygiene's web site at www.dhmh.state.md.us/mma/providerinfo/.

NOTE: The Program implemented the CMS-1500 (08-05) on July 30, 2007. Billing instructions can be found at www.dhmh.state.md.us/mma/mmahome/. (Click on NPI and Maryland Medicaid Providers).

NOTE: CMS-1500 (08/05) claim form changes include Blocks:

- 17a/b, Name of Referring Provider or Other Source
- 24C, EMG (not required)
- 24i, ID Qualifier
- 24d, Rendering Provider ID #
- 32a/b, Service Facility Location Information
- 33, Billing Provider Info & PH #

NOTE: The 9-digit Medicaid Provider Number will continue to be required on all paper claims. When entering a provider's 9-digit provider number, it must be preceded by the ID Qualifier- **1D**.

MARYLAND MEDICAL ASSISTANCE PROGRAM

**TELEPHONE DIRECTORY
PHYSICIANS' SERVICES PROGRAM**

Policy/Coverage Issues (410) 767-1722

OTHER PROGRAMS

Eligibility Verification System (EVS) (866) 710-1447

Children's Services (410) 767-1903

Healthy Kids Screening/Certification (410) 767-1683

Healthy Start/Family Planning Policy/Coverage (800) 456-8900

Laboratory Services/Policy/Coverage (410) 767-5706

Provider Master File (Enrollment) (410) 767-5340
P.O. Box 17030
Baltimore, MD 21203

Provider Relations (410) 767-5503
P.O. Box 22811 (800) 445-1159
Baltimore, MD 21203

LTC Problem Resolution & (410) 767-8699
Institutional Services (410) 767-5457
201 W. Preston Street
Baltimore, MD 21201

Electronic Media Submittal (410) 767-5863

| | |
|--|----------------|
| Missing Payment Voucher/Lost or Stolen Check | (410) 767-5503 |
| Third Party Liability/Other insurance | (410) 767-1771 |
| Recoveries | (410) 767-1783 |
| Medicaid Training Liaison Unit | (410) 767-6024 |
| Claims (CMS-1500) P.O. Box 1935 Baltimore, MD 21203 | |
| Claims (Adjustments) P.O. Box 13045 Baltimore, MD 21298 | (410) 767-5346 |
| Toll Free Number for any of the (410) 767- exchanges above, ask for the appropriate 4-digit extension | (877) 463-3464 |

