PROVIDER***ALERT***

To: **AmeriHealth Caritas Louisiana Providers**

Date: **August 5, 2024**

Subject: **Three New LDH Approved Policies**

Summary: Three new guidelines for Reimbursement Policies: Bundling (Status B, P, T); Co-Surgeon and Diagnosis Procedure Age Guidelines.

AmeriHealth Caritas Louisiana would like to inform you of three new policies that have been approved by the Louisiana Department of Health in accordance with La. R.S. 46:460.54. The guidelines are effective on **September 4, 2024**, and will be posted at the following link on our website under Reimbursement Policies: https://www.amerihealthcaritasla.com/provider/resources/index.aspx.

1. Bundling (Status B, P, T)
2. Co-Surgeon
3. Diagnosis Procedure Age Guidelines

Reminder: If your practice is not registered with our website portal, NaviNet, we highly recommend registering. To register, please visit www.navinet.net to sign up or contact your Provider Account Executive for details.

Questions: Thank you for your continued support and commitment to the care of our members. If you have questions about this communication, please get in touch with AmeriHealth Caritas Louisiana Provider Services at 1-888-922-0007 or your Provider Network Management Account Executive.

Missed an alert? You can find a complete list of provider alerts on our website's Provider Newsletters and Updates page.

Need to update your provider information? Send full details to network@amerihealthcaritasla.com.

AmeriHealth Caritas Louisiana

Bundling (Status B, P, T)

Reimbursement Policy ID: RPC.0022.2100

Recent review date: 09/2023

Next review date: 08/2024

AmeriHealth Caritas Louisiana reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas Louisiana may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including but not limited to Current Procedural Terminology (CPT®), the Healthcare Common Procedure Coding System (HCPCS), and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM). Other factors that may affect payment include but are not limited to medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other policies. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all healthcare services billed on CMS-1500 forms or its electronic equivalent and, when specified, billed on UB-04 forms or its electronic equivalent.

Policy Overview

This policy describes bundled payment status indicators in professional claims processing by AmeriHealth Caritas Louisiana.

The Centers for Medicare and Medicaid Services (CMS) bundles payment for services that are incidental to other services by the same provider. Any physician or other qualified health care professional from the same group practice, under the same specialty, and with the same Tax Identification Number (TIN) is considered the same provider.

AmeriHealth Caritas Louisiana aligns with the Centers for Medicare and Medicaid Services (CMS) regarding bundled payment criteria.

Exceptions

Any conflicting explicit state coverage provisions take precedence.

Reimbursement Guidelines

AmeriHealth Caritas Louisiana utilizes CMS Physician Fee Schedule (PFS) payment status indicators to classify bundled payments for services. No separate payment is made for procedure codes with CMS PFS status indicators

of “B,” “P,” or “T”:

- “B” Bundled Codes represent services that are always considered incidental to other services rendered by the same provider on the same date of service. Payment is bundled with those other services.
- “P” Bundled and Excluded Codes represent services that are considered incidental to other services rendered by the same provider on the same date of service, or services that are not payable to a professional provider.
- “T” Only Service Paid Codes represent services that are considered incidental to other services, represented by procedure codes with a PFS status indicator of “A” or “R,” for the same date of service by the same provider. Payment is bundled with those other services.

Refer to CPT/HCPS manuals for complete descriptions of procedures, PFS files for status payment indicators, and state billing resources for fee schedules and billing guidelines. Refer to Policy RPC.0026.2100 and associated policies regarding procedures and other services that are considered incidental under CMS National Correct Coding Initiative (NCCI).

Definitions

N/A

Edit Sources

I. *Current Procedural Terminology* (CPT®), *Healthcare Common Procedure Coding System* (HCPCS), and associated publications and services.
II. Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule Relative Value Files: https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/pfs-relative-value-files
III. State provider manuals, fee schedules, and other billing resources.

Attachments

N/A

Associated Policies

RPC.0026.2100: National Correct Coding Initiative

Policy History

09/12/2023	Reimbursement Policy Committee Approval
08/25/2023	Removal of Policy Implemented by AmeriHealth Caritas from Policy History section
01/10/2023	Template Revised Revised preamble Removal of Applicable Claim Types table Coding section renamed to Reimbursement Guidelines Added Associated Policies section

AmeriHealth Caritas Louisiana

Co-Surgeon

Reimbursement Policy ID: RPC.0005.2100

Recent review date: 11/2023

Next review date: 11/2025

AmeriHealth Caritas Louisiana reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas Louisiana may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including but not limited to Current Procedural Terminology (CPT), the Healthcare Common Procedure Coding System (HCPCS), and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM). Other factors that may affect payment include but are not limited to medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other policies. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all healthcare services billed on a CMS-1500 form or its electronic equivalent, and, when specified, billed on a UB-04 form or its electronic equivalent.

Policy Overview

This Co-Surgeon policy identifies the guidelines for reimbursement of Co-Surgeon services, as identified by CMS, and the Louisiana Department of Health (LDH) Medicaid program.

Exceptions

Reimbursement for Co-Surgery services furnished by a non-physician practitioner (NPP) is not available from AmeriHealth Caritas Louisiana. The CMS claims processing manual guidelines for Co-Surgery refer to surgical procedures involving two different surgeons, usually of different specialties.

Reimbursement Guidelines

AmeriHealth Caritas Louisiana will follow CPT and State guidelines for Co-Surgery reimbursement. Modifier 62 identifies a Co-Surgeon involved in the care of a patient performing distinct parts of a procedure. To qualify for reimbursement, each Co-Surgeon must submit the same Current Procedural Terminology (CPT) code with modifier 62, for the same date of service. For services included on the CMS Co-Surgeon eligible list, AmeriHealth Caritas Louisiana will reimburse Co-Surgeon services per applicable LDH Medicaid fee schedule(s) subject to additional multiple-procedure reductions, if applicable.

All codes with CMS status code indicators "1" or "2" for "Co-Surgeons" are considered by AmeriHealth Caritas Louisiana to be eligible for Co-Surgeon reimbursement if billed with the Co-Surgeon modifier 62. For each Co-

Surgeon to be reimbursed for the procedure, each Co-Surgeon must report the same CPT code(s) with modifier 62 on procedures that required the skill of two surgeons.

AmeriHealth Caritas of Louisiana reimburses co-surgery procedures reported with modifier 62 at the lesser of billed charges or 80% (eighty percent) of the fee on file for each surgeon. Multiple procedure reductions apply to Co-Surgeon claim submissions when one or more physicians are billing multiple CPT codes that are eligible for reductions.

Definitions

Modifier 62
Two (2) surgeons of the same or different specialties who work together as primary surgeons performing distinct part(s) of a surgical procedure.

Multiple procedure reduction
Multiple procedures performed by the same physician, or other qualified health care professional, on the same date of service during the same patient encounter may be subject to multiple procedure reduction for secondary and subsequent procedures.

Nonphysician practitioner (NPP)
A healthcare provider who is not a physician but who practices in collaboration with or under the supervision of a physician. Nonphysician practitioners may also be known as mid-level practitioners or physician extenders (e.g., Physician Assistants (PA), Nurse Practitioners (NP), and Clinical Nurse Specialists (CNS)).

Edit Sources

IV. Current Procedural Terminology (CPT),
V. Healthcare Common Procedure Coding System (HCPCS),
VI. International Statistical Classification of Diseases and Related Health Problems (ICD), and associated publications and services.
VII. Louisiana Department of Health (LDH) Medicaid Fee Schedule(s).

Attachments

N/A

Associated Policies

N/A

Policy History

12/2023	Reimbursement Policy Committee Approval
11/2023	Updated to biennial policy
08/2023	Removal of policy implemented by AmeriHealth Caritas from Policy History section
01/2023	Template revised. • Preamble revised. • Applicable Claim Types table removed. • Coding section renamed to Reimbursement Guidelines • Associated Policies section added

AmeriHealth Caritas Louisiana

Diagnosis Procedure Age Guidelines

Reimbursement Policy ID: RPC.0030.2100

Recent review date: 04/2024

Next review date: 12/2025

AmeriHealth Caritas Louisiana reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas Louisiana may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all healthcare services billed on a CMS-1500 form or its electronic equivalent, or, when billed on a UB-04 form or its electronic equivalent.

Policy Overview

This policy addresses age-specific coding edits involving select International Classification of Diseases,10th Revision, Clinical Modification diagnosis codes and procedure codes from the Procedure Code System (ICD-10-CM and ICD-10-PCS). It also addresses select codes from the Current Procedural Terminology (CPT) code set and Healthcare Common Procedure Coding System (HCPCS) that have age limitations. Age designations are assigned to codes based on code descriptions or on publications and guidelines from sources such as professional specialty societies, the World Health Organization (WHO), the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), or the American Hospital Association (AHA) Coding Clinic.

Exceptions

N/A

Reimbursement Guidelines

The policy develops edits for age for certain codes based on code descriptions, publications and guidelines from sources such as professional specialty societies or similar institutions and from the entities that create the codes [e.g., WHO, CMS, AMA]. AmeriHealth Caritas Louisiana will apply age edits when diagnosis and/or procedure codes are reported inappropriately for the patient's age. Diagnosis and procedure age conflicts will be considered billing errors and will not be reimbursed. For example, if the diagnosis code Z00.00 "Encounter for general adult medical

examination with abnormal findings” is billed for a 10-year-old, the claim will not be reimbursed.

Claims submitted with an age-based diagnosis or procedure code that conflicts with the patient’s age will be denied. For example, a claim for five-year-old male patient with a diagnosis code for benign prostatic hypertrophy will be denied because that diagnosis code is applicable only to adult patients ages 15 to 124, inclusive. Similarly, a claim for a 78-year-old patient with a cesarean section delivery procedure code will be denied because pregnancy diagnosis/procedure codes are only valid for patients ages 12 to 55. Corrected claims are required for payment.

Definitions

N/A

Edit Sources

VIII. Current Procedural Terminology (CPT)
IX. Healthcare Common Procedure Coding System (HCPCS)
X. International Classification, 10th revision, Clinical Modification (ICD-10-CM), and associated publications and services, https://www.cms.gov/files/document/fy-2024-icd-10-cm-coding-guidelines.pdf
XI. International Classification, 10th revision, Procedure Code System (ICD-10-PCS), https://www.cms.gov/files/document/2024-official-icd-10-pcs-coding-guidelines.pdf

Attachments

N/A

Associated Policies

N/A

Policy History

04/2024	Revised preamble
02/2024	Reimbursement Policy Committee Approval
08/2023	Removal of policy implemented by AmeriHealth Caritas Louisiana from Policy History section
01/2023	Template revised • Preamble revised • Applicable Claim Types table removed • Coding section renamed to Reimbursement Guidelines • Associated Policies section added