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Subject: Changes for Practitioners Related to Adoption of Uniform Billing and RVU Based Fee Schedule

Effective: August 1, 2001

Programs Affected: Medicaid, Children's Special Health Care Services, State Medical Program

Effective for services rendered on or after August 1, 2001, the Department of Community Health (DCH) is implementing the HCFA 1500 claim form and the ANSI X12N 837 professional, version 3051 electronic format for practitioner billing. These billing standards are consistent with other major payers and are a step toward HIPAA (Health Insurance Portability and Accountability Act of 1996) compliance for transactions and code sets.

On October 1, 2000, physician fees were rebased using the fully implemented relative value units (RVUs) published by HCFA (Health Care Financing Administration) for 2000 and a conversion factor established at \$22.43 based on past utilization and funds appropriated for these services. The Department has committed to adopting standardized coding, billing and specified related payment policies associated with using the HCFA published RVUs. The purpose of this bulletin is to address the reimbursement and policy changes that will occur effective August 1, 2001 for practitioners due to the adoption of these formats and standard reporting of services in an RVU-based fee environment. A major objective of this project is to facilitate electronic claims submission and enhance operational efficiency for providers and the program to the greatest extent possible.

The Department will establish a Medicaid Practitioner Database, similar to the one that HCFA has published for Medicare. The database will include all services covered for practitioners, the RVU if applicable, the fee, and other payment policy indicators such as bilateral services, surgical assistance, professional and technical component services, facility and non-facility payment determinations, assistant surgeons, co-surgeons, prior authorization, consent form requirements, global surgery time frames, partial global surgery payment percentages, etc. This will be posted on the DCH website at www.mdch.state.mi.us. The Medicare Physician Fee Schedule Database will be the basis for many of the indicators along with HCFA Medicare guidelines for service coverage.

Beginning in January 2002, the Department will adopt national coding changes on the same schedule as other payers. The Medicaid Practitioner Database will be updated to correspond with the coding and related RVU changes. As RVUs are established at the national level using a formal structure carried out by the AMA and HCFA, any questions or concerns which providers want addressed in regard to the RVUs must be done through the national process.

The changes identified in this bulletin will become effective August 1, 2001. Policies not addressed will not change at this time. In this period of transition, providers will be notified of changes by bulletin updates which will also be available on the DCH website. Provider policy manuals will be fully revised after all changes are implemented.

Uniform Reporting of Services

Medicaid will use the Medicare Correct Coding Initiative (CCI) policy as a guideline for determining when services are payable in addition to, or are included in, other services provided on the same day. The CPT (Current Procedural Terminology) procedure code definition (descriptor) is based upon the procedure being consistent with current medical practice. In order to submit a CPT code to Medicaid, the provider must have performed all of the services included in the code description. Providers must not submit codes describing components of a comprehensive code in addition to the comprehensive code. Components are individual services necessary to accomplish the more comprehensive procedure/service. In the few instances where Medicaid policy differs from the language in the CPT descriptions, the provider should follow the Medicaid published policy.

Mutually exclusive code pairs represent services or procedures that would not or could not be reasonably performed on one patient at the same session by the same provider based on the CPT code description or standard medical practice. Codes representing these services cannot be billed together.

Certain codes are identified as "separate procedures" by CPT. These are commonly carried out as an integral part of another service and should not be billed additionally. However, at times these services may be provided independently, or unrelated or distinct from other procedures on the same day. It may be appropriate to report a separate procedure with modifier 59 in these instances. The addition of this modifier to a procedure code indicates that the procedure represents a "distinct procedure or service from others billed on the same date of service." This may represent a different session, different surgery, different anatomical site, different agent, different lesion, different injury or area of injury (in extensive injuries). The 59 modifier may not be used with radiation treatment management or evaluation and management services. The 59 modifier should only be used if no other modifier is appropriate.

When CPT descriptors designate several procedures of increasing complexity, only the code describing the most extensive procedure actually performed should be submitted. Certain CPT descriptors designate procedures performed "with" or "without" other services. Submit only the code describing the service actually performed. When the descriptors identify procedures requiring a designation for male or female, submit the appropriate code for the gender of the patient.

Medicaid 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 CPT codes separately is called "unbundling," which is prohibited.

Medicaid policy precludes payment of a separate fee for anesthesia when provided by the same physician performing the medical/surgical procedure. Therefore, do not submit CPT codes describing anesthesia services or services necessary to provide anesthesia with primary procedure/service codes.

When a provider must attempt several procedures in direct succession to accomplish the same end, submit only the procedure that is successfully accomplished. This policy applies to limited procedures that are unsuccessful, thereby requiring that a more comprehensive procedure be performed. If diagnostic procedures are performed to establish the decision to perform the more comprehensive service, they may be billed separately.

Evaluation and Management (E/M) Services

Providers should refer to the CPT explanations, coding conventions, and definitions for evaluation and management (E/M) services. When reporting these services, the appropriate place must be reported as identified below.

Code range	Definition	Allowable place codes
99201-99215	Office or other outpatient visit	11, 22, 34, 53, 62, 65, 71
99221-99233	Inpatient hospital visit	21, 51, 52, 61,
99234-99236	Observation care	21, 22, 23
99241-99245	Office or outpatient consultations	11, 22, 23, 24, 25, 33, 34, 35, 53, 62, 65, 71
99251-99263	IPH consults	21, 31, 32, 51, 52, 61
99271-99275	Confirmatory consults	all
99281-99285	Emergency department services	23
99291-99292	Critical care	21, 22, 23
99295-99298	Neonatal intensive care	21
99301-99313	Nursing facility services	31, 32, 56
99321-99333	Domiciliary, rest home visits	33, 35
99341-99350	Home visits	12
99381-99397	Preventive medicine visits	11, 12, 22, 71
99431, 99433-99440	Newborn care, hospital	21, 22
99432	Newborn care, other than hospital	25, 12

Most E/M services are payable once per day for the same patient. E/M code descriptors state "per day" in many of the categories of service; therefore, the code may be billed only once even though the patient may be seen multiple times. Only one office or outpatient visit will be reimbursed on one day for the same patient unless the visits were for unrelated reasons at different times of the day (e.g., office visit for blood pressure medication evaluation, followed 5 hours later by a visit for evaluation of leg pain following an accident.) If different levels of service are provided, report each on separate lines. If the same level of service is provided both times, report on one claim line with modifier 22. The time of day for each visit must be reported on the claim.

Preventive medicine E/M services are payable and should be reported based on the age of the patient. One preventive medicine E/M service is covered for all beneficiaries annually. For beneficiaries under the age of 21 years, EPSDT (Early and Periodic Screening, Diagnostic and Treatment) screening services are covered according to the American Academy of Pediatrics periodicity schedule and HCFA requirements. (Refer to the EPSDT section of the manual for specific information.) A preventive medicine 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.

Counseling and coordination of care is not a separately billable service. It is reimbursed as part of the E/M service reported when the patient is seen face-to-face. There is no separate payment made for telephone calls, writing prescriptions, completing insurance forms, review and explanation of diagnostic test reports to the patient, etc. Missed appointments cannot be billed to the program. The patient cannot be billed for a missed appointment unless it is normal practice to bill all patients for missed appointments. The Medicaid patient must be informed in advance that there is a charge for missed appointments.

E/M Visits in Relation to Global Surgery Package: An E/M service is not payable on the same day as a procedure with a global surgery period. However, if the patient's condition required a significant, separately identifiable E/M service that is above and beyond the pre- and post-operative care associated with the procedure or service performed, then the appropriate level E/M service can be billed and modifier 25 must be reported.

If E/M services are performed by the surgeon for a reason unrelated to the surgical procedure during the post-operative global surgery period, report modifier 24 with the E/M service. All care provided during the inpatient stay in which the surgery is performed is compensated through the global surgery package and cannot be billed with modifier 24. An E/M visit with modifier 24 cannot be reported on the same day as the surgical procedure.

An E/M service that resulted in the decision for surgery is covered separately when provided by the surgeon on the day before or day of a procedure with a 90-day global period and modifier 57 is reported. An E/M service provided the day before or the day of a procedure with a 0 or 10 day global period is not payable if reported with modifier 57. This is considered a routine pre-operative service included in the global package.

Consultations: A consultation is a service rendered by a physician whose opinion or advice is requested by another appropriate practitioner (e.g., physician, nurse midwife, dentist) for the further evaluation and management of the patient. A consultation is distinguished from a visit because it is done at the request of a referring provider and the consultant prepares a report of his/her findings that is provided to the referring provider for the referring provider's use in treatment of the patient. A consultant may initiate diagnostic and/or therapeutic services. However, when the referring provider orally or in writing transfers completed responsibility for treatment at the time of the request for consultation or referral, the receiving physician may not bill a consultation.

Payment may be made for the consultation if the referring provider does not transfer the responsibility for the patient's care to the receiving physician until after the consultation is completed. After the consulting physician assumes responsibility for the patient's care, subsequent visits should be reported as established patient office visits or subsequent hospital care, depending on the setting.

A consultation is payable if one provider in a group practice requests a consultation from another physician of a different specialty in the same group practice as long as all of the requirements for use of the CPT consultation codes are met. A request for a consultation from the attending provider and the need for consultation must be documented in the patient's medical record. A written report must be furnished to the requesting provider for his/her use in treating the patient. In an inpatient setting, the request may be documented as part of a plan written in the requesting physician's progress notes, an order in a hospital record, or a specific written request for the consultation.

Any claim for a consultation service billed to the program must include the Medicaid 9 digit provider ID number of the referring provider in the appropriate item. If the referring provider is not enrolled in Medicaid, the referring ID must be reported as nine 8s (888888888) and the referring provider's name and professional designation must be provided in the appropriate item on the claim.

Medicaid covers second opinions for any surgery. The second opinion may be billed as a consultation service as long as all criteria for a consultation are met. Any ancillary service provided to a patient in a nursing facility (place 31 or 32) must be ordered by the attending physician and should not be considered a "consultation" unless it was a specific request for opinion and advice and not a request for service. The appropriate code for the service rendered, such as eye exam, nursing home visit, or procedure, should be billed.

Payment for Supplies in the Office Setting

RVU-based payment to practitioners includes payment for the office overhead expense associated with the service. In most cases, the overhead includes the supplies used or provided by the provider in connection with the service. Providers should not require beneficiaries to buy a supply item in advance from a drugstore or other supplier that is necessary to use in providing the service. If a beneficiary needs supplies to use in the home, the provider should write an order that the beneficiary can take to a pharmacy or medical supplier to be filled. Medicaid will not pay providers for "take-home" supplies.

Medicaid will no longer make a separate payment for surgical trays for specified procedures performed in the office setting. The non-facility RVU-based fee screen incorporates an allowance for cost of supplies necessary to perform the procedure in the practice expense portion of the RVU. Payment for any surgical dressings applied by a physician in the office or other non-facility setting is included in reimbursement for the procedure/service itself and is not billable separately.

In keeping with the RVU-based fee schedule, casting and splinting supplies are separately billable when used in the treatment of fractures or dislocations in the office setting. An allowance for these supplies is not included in the following code ranges: 23500-23680, 24500-24685, 25500-25695, 26600-26785, 27500-27566, 27750-27848, 28400-28675, and 29000-29750. Cast/splint supplies are not payable with any codes other than the fracture/dislocation codes listed. Providers may bill the code below as appropriate in addition to the fracture/dislocation treatment service if performed in the office, place 11.

A4565	sling
A4570	splint
A4572	rib belt
A4580	cast supplies
A4590	special cast supplies (e.g., fiberglass)
L4350-L4380	pneumatic splints (air casts)

Unna boots are considered dressings, not casts, and reimbursement is included in the payment for code 29580. Unna boots cannot be billed as cast/splint supplies.

Separate payment may be made for the following when provided in the office setting under the specified circumstances:

- Collagen skin test kit, code G0025, is payable when billed on the same date as 95028.
- Implantable external access device, code A4300, is payable when billed on the same date as 36533.
- Levonorgestrel implants, A4260, is payable in addition to the insertion procedure 11975 or 11977 on the same day.
- Progestasert, X4634, or copper IUD, J7300, is payable in addition to the insertion 58300 on the same day.

Allergy Testing and Immunotherapy

Allergy testing and immunotherapy services are covered. Testing should be billed with the appropriate CPT code reporting the quantity as indicated by the code description. A visit may be billed in addition to testing. Reimbursement includes interpretation of the testing results in relation to the history and physical examination of the patient.

Providers should bill only the component codes for immunotherapy services. The provider who actually prepares and provides the antigens/venoms must bill for the supply on a per dose basis. The provider who parenterally administers the antigen/venom should bill the injection only codes. Physicians providing both the injection and the antigen/venom preparation are paid for both services separately. All services will be reimbursed using the RVUs established for these services.

Visits should not be billed with allergy injection services 95115 or 95117 unless the visit represents another significant, separately identifiable service above and beyond the antigen/venom immunotherapy and modifier 25 is used.

The program assumes antigens are prepared in multiple dose vials to be administered over a period of time in increasing doses. Regardless of whether multiple or single dose vials are reported, all antigens will be paid at the same rate per dose. Following Medicare guidelines, payment will be based on a maximum of 10 doses per multi-dose vial. Medicaid should be billed for a maximum of 10 doses per vial even if more than 10 are obtained. Further, when a vial is diluted (by taking 1 cc aliquot from a multi-dose vial and diluting it with 9 cc's of diluent in a new multi-dose vial) the program should not be billed an additional amount for the diluted doses. If fewer than 10 doses are prepared from one vial, a dose number less than 10 should be reported. A dose is defined as one cc aliquot from a single multi-dose vial.

The program assumes that a reasonable supply of antigen will be provided at one time. The medical record must document the anticipated length of time that each supply will last. We would expect that 10 doses would last a minimum of a month, and longer for patients on maintenance doses.

Any allergy testing and treatments that have not been proven to be effective are **not** covered. This includes, but is not limited to, cytotoxic leukocyte testing, provocation-neutralization testing and treatment, oral and sublingual immunotherapy, candidiasis hypersensitivity syndrome testing and treatment.

Chemotherapy Administration

Medicaid pays for the services of a physician who administers chemotherapy as well as the chemotherapy drugs administered by the physician to office or home patients. The administration should be reported with the appropriate code, and the cost of the drugs should be reported separately. Chemotherapy administration is only covered for administration of antineoplastic agents to a patient with a diagnosis of cancer. Administration of other drugs for diagnoses other than cancer should be reported using the therapeutic, diagnostic or prophylactic injection/infusion administration codes. Separate payment is allowed for chemotherapy administration by push and by infusion techniques on the same day. Only one push administration is covered on a single day.

The physician must personally administer the drug, or a qualified employee of the physician may administer it if the physician is present. If a patient receives chemotherapy administration without face-to-face contact with the physician, the physician may be paid for the services if furnished in the office by a qualified employee under the physician's supervision and the medical record reflects the physician's active participation in and management of the course of treatment. This should be coded as 99211. Chemotherapy administration is payable to the physician when performed in a hospital setting only when the physician personally administers the drug. When the physician does not perform chemotherapy administration in the hospital personally, it is not a separately reimbursable service.

Refilling and maintenance of an implantable pump or reservoir is covered. An E/M service may be payable on the same day if a significant, separately identifiable service is performed by the physician. Chemotherapy administration by IV push, infusion, or intra-arterial technique is not covered in addition to refilling the implantable pump or reservoir. Flushing of a vascular port prior to chemotherapy is included in the administration and not separately reimbursable. If a special visit is made to the physician's office just for port flushing, the service should be reported as 99211.

Payment for hydration therapy intravenous (IV) infusion is considered bundled into the payment for chemotherapy IV infusion when administered simultaneously and will not be paid separately. Separate payment for hydration therapy is allowed when these services are administered sequentially or as separate procedures. Modifier 59 should be reported with the hydration therapy code when performed sequentially.

All supplies necessary to administer chemotherapy in the office setting are included in the overhead expense portion of the administration services. No separate payment will be made for any supplies.

Injectable Drugs and Biologicals

Medicaid covers injectable drugs and biologicals administered by a physician in a non-facility setting. The drug must be FDA approved and reasonable and necessary according to accepted standards of medical practice for the diagnosis or treatment of the illness or injury of the patient.

An injectable drug is not covered if the drug:

- is not specific and effective treatment for the condition for which it is being given, or
- is given for a purpose other than for the treatment of a particular documented diagnosis, illness, or condition (e.g., vitamin injections which are not specific replacement therapy for a documented deficiency or disease and are given simply for the general good and welfare of the patient), or
- is not administered by the recommended or accepted administration method for the condition being treated, or
- is not administered according to the recommended dosing schedule and amount for the condition being treated.

The cost of the drug(s) given is billed separate from the administration using the HCPCS Level II codes. The quantity reported should reflect the dose given according to the description of the code. Use the code with the exact dosage or round the quantity up to best describe the amount given. For example, HCPCS code J1200 is diphenhydramine HCL up to 50 mg. If 120 mg is given, the quantity should be reported as 3. When administering a dose drawn from a multiple dose vial, only the amount given to the patient should be billed to the program. However, if 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. Providers should attempt to use these types of drugs prudently and schedule patients who need them around the same time to use as much product as possible without waste. Fee screens for the cost of the drug will be established at 95% of the average wholesale price (AWP). Drug fees will be updated quarterly.

The appropriate CPT administration code may be billed separately only if the physician is not paid for any other service rendered at the same time. For example, if the physician bills for a visit, the administration of the injection is considered part of the visit and cannot be billed separately.

If the injection services are provided in a hospital setting, physicians cannot bill or be reimbursed for the service. For any injections given by the physician in the office setting, the physician must bill and be reimbursed for the cost of the drug. It is inappropriate to send the patient to a pharmacy to obtain an injectable drug or to have the pharmacy bill directly for ordered drugs under the pharmacy benefit if the physician is administering the drug. The physician should bill for the drug cost.

The cost of injectable drug products used in clinics and physician office settings is reimbursed to the practitioner who administers the drug, NOT to a pharmacy provider. The provider who administers the drug must bill Medicaid for the cost of the product. If a pharmacy sells injectable drug products to a provider, the pharmacy must obtain payment directly from the purchasing provider and cannot bill the program as if it were a prescription item. Injectable drug products are not to be dispensed to the beneficiary for the purpose of administration in the provider's office.

Immunizations (Vaccines and Toxoids)

All vaccines and toxoids (immunizations) are covered when given according to ACIP (Advisory Committee on Immunization Practices) recommendations. For Medicaid children under the age of 19 years old, the VFC (Vaccine for Children) program provides covered vaccines at no cost to the provider. In addition, Michigan offers a similar program for Medicaid adults 19 years old and older called the MI-VFC. Td, MMR, and hepatitis B for adults are available from the local health department at no cost to the provider. Any local health department in the state can be contacted for specifics about the VFC and MI-VFC program, and instructions on enrolling and obtaining vaccine. The program will not make any payment for vaccine costs for any product available free for Medicaid enrollees.

An administration fee will be paid separately for all vaccines and toxoids given to Medicaid beneficiaries whether the vaccine is free or not, and without regard to other services provided on the same day. The administration fee should be billed using CPT code 90471 for one administration and 90472 for each subsequent administration on the same day. The administration fee is set at \$7.00 per immunization. The administration code(s) must be billed in addition to the code(s) for the vaccine given. It is very important that providers code the vaccines properly for purposes of tracking Medicaid beneficiary immunization use. If the vaccine is not available free, reimbursement for the cost of the product, including any applicable federal excise tax, will be made under the appropriate vaccine code. The fee will be based on the estimated acquisition cost for a provider in Michigan to purchase the vaccine.

For vaccines and toxoids available free under the VFC program, Federal statutes limit the amount a provider can bill for the administration of the vaccine. In Michigan, the VFC administration cap or maximum billable amount is \$16.75. Providers cannot charge more for services provided to Medicaid beneficiaries than for services provided to their general patient population. For example, if the charge for administering a vaccine to a private pay patient is \$5.00, then the charge for vaccine administration to the Medicaid patient cannot exceed \$5.00.

The program encourages providers to immunize all Medicaid patients according to the accepted immunization schedule. There should be no financial barrier for any Medicaid patient receiving the appropriate immunizations. For Medicaid beneficiaries enrolled in a health plan, the health plan must ensure that the Medicaid enrollees receive complete and timely immunizations. When a provider contracts with a health plan to provide primary care (which includes

immunizations), then the provider must immunize the patients assigned to him/her by the plan. It is inappropriate to routinely refer patients to a local health department for immunizations. This is contrary to contract requirements and the concept of managed care that is to provide continuity of care in the medical home. Immunization review and administration of any scheduled vaccines is also a required component of EPSDT screening services.

If a patient is in a nursing facility, the facility is responsible for appropriately immunizing the residents. Cost of the immunization is covered in the payment made to the facility. No separate reimbursement will be made to a physician. In the hospital setting, only the facility may be reimbursed for immunization administration or vaccine costs if appropriate.

Services in a Teaching Setting

The administrative costs associated with teaching physician services, as well as payment for direct patient care services provided by an intern, resident, or fellow in a teaching setting and supervised by a teaching physician, are subject to guidelines and conditions developed and published by HCFA for Medicare. Services billed to Medicaid under these guidelines must be identified with modifier GC or GE as appropriate.

Teaching institutions and teaching physicians within those institutions must abide by the HCFA teaching physician guidelines which explain when services provided in teaching settings can be billed to Medicaid on a fee-for-service basis or must be reported as allowable medical education costs on the hospital's cost report.

Briefly, the guidelines require the presence of the teaching physician during the key portion of the performance of the service in which a resident is involved for which payment will be sought by the teaching physician (or the hospital on the behalf of the physician.) The medical record must fully support the physician's presence and participation in the service provided. There are exceptions and other considerations that may apply, and the full text of the guidelines must be consulted to ensure compliance. Any services that meet the teaching physician criteria must be reported with the GC modifier.

HCFA provides an exception to the physician presence requirement for some low and mid-level E/M services furnished in certain primary care centers when specified conditions are met. For Medicaid, the preventive medicine E/M visits are also included under the "presence" exception for services provided in the primary care centers by residents. The GE modifier must be reported when E/M services are provided by residents under the "presence" exception. The E/M codes that can be reported with the GE modifier are: 99201-99203, 99211-99213, and 99381-99397. For higher-level services and all invasive procedures, the teaching physician must be present and modifier GC would apply.

Facility and Non-facility Reimbursement

Medicaid reduces payment for specified procedures provided in the facility setting. This policy is consistent with HCFA's facility and non-facility reimbursement determination. When a provider performs services in a facility setting, costs for certain procedures are reduced as the practitioner does not incur certain overhead expenses (such as clinical staff, supplies, equipment) necessary to provide the service. When a service is performed in a non-facility setting, the payment rate will be based on the non-facility RVU. When the service is provided in

a health care facility, the payment rate will be based on the facility RVU. The payment difference takes into account the higher expenses for the provider in the non-facility setting. For the purpose of this payment policy, a facility includes the following:

- Hospital inpatient and outpatient facilities – place of service codes 21, 22, 23
- Psychiatric facilities – place of service codes 51, 52
- Skilled nursing facilities – place of service code 31
- Ambulatory surgery center - place of service code 24
- Rehabilitation facilities – place of service codes 61, 62

Hospital Services

Physician visits to a hospital inpatient are covered when personal and identifiable professional services are performed, are medically necessary, and are supported by documentation in the patient's medical record. The medically necessary service must involve a personal examination or review of the medical record and results of diagnostic studies and assessment of any changes in the patient's status. An E/M service cannot be billed unless the physician has face-to-face contact with the patient. The medical record must clearly document the service by the physician and the frequency of visits. While a patient may be seen more than once on the same day, only one hospital E/M visit may be billed. Each service date must be reported on a separate claim line using the most appropriate code for the service rendered on the reported date.

Professional services for emergency department care and hospital admission of a single patient are covered separately only when the services are medically necessary and provided by different physicians. When the same physician provides emergency department care and admits the patient, the physician should report care given in the emergency department as part of the appropriate initial hospital care code. Initial critical care and hospital admission services provided on the same date by either the same or different physicians are covered if both services are medically necessary. If the patient is seen for any E/M service in another setting on the same day as admission, all E/M services by the same physician must be reported as part of initial hospital care.

Ventilation Management: Ventilation management (CPT codes 94656, 94657, 94660, and 94662) is separately payable by Medicaid. Payment is not made, however, when an E/M code is billed for the same date of service. Payment for ventilation management is considered bundled into the E/M code. There is no global period associated with ventilation management, so modifier 25 does not justify payment for an E/M service provided on the same day as ventilation management.

Observation Care: Medicaid covers physician observation services for patients admitted and discharged from observation status in the hospital setting for a stay equal to or greater than 8 hours but less than 24 hours. Codes 99234–99236 should be reported for a stay equal to or greater than 8 hours but less than 24 hours on the same date. It is anticipated that the patient would be discharged from the hospital at the end of observation care. The medical record must include the following documentation:

- the length of time of the stay to document that it was a minimum of 8 hours, but less than 24 hours;
- the billing physician was present and personally performed the services;
- the billing physician wrote the admission and discharge notes.

When billing for observation care, all E/M services provided to the patient on the same date, regardless of the setting, are considered part of the observation care and cannot be billed separately. For outpatient surgical procedures, the global surgery rules apply. The surgeon is responsible for all post-operative care in the hospital, and observation care cannot be billed separately. If a patient is admitted for 24 hours or more, services must be coded as inpatient hospital care, not observation care.

Critical Care: Medicaid covers critical care consistent with the CPT definitions and guidelines. Each day that critical care is billed, the medical record must support the level of service provided. Services for a patient who is not critically ill but happens to be in a critical care unit should be reported using the appropriate hospital visit codes. To reliably and consistently determine that delivery of critical care services rather than other evaluation and management services is medically necessary, both of the following criteria must be met in addition to the CPT definitions:

Clinical Condition Criterion: 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.

Treatment Criterion: 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 in the patient's condition.

The actual time spent with the patient delivering critical care services must be documented in the medical record. 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. (See the examples in CPT.) If critical care services are provided for the same date of service as a procedure code with a global surgical period, use modifier 25 on the critical care code(s). Critical care, in addition to cardiopulmonary resuscitation (CPR), may be billed with the 25 modifier if the critical care is a significant, separately identifiable service. (CPR has a global period of 0 days and is not bundled into the critical care codes.) Do not bill ventilation management in addition to critical care services by the same physician on the same day because critical care services include ventilation management. For neonates who are receiving ventilation management services, not critical care, the services should be reported under the ventilation management codes.

Standby Services: Medicaid does not cover the services of a standby surgeon, anesthesiologist or surgical team. Medicaid covers direct patient care only or "hands-on" care, and standing by is not a service to a patient. Physician stand-by services are covered as hospital services. Reimbursement for them is included in the payment made to the hospital for other general services necessary to provide quality care.

Global Surgery

Reimbursement for surgery includes related services that are furnished by the physician who performs the surgery or by members of the same group with the same specialty. This reimbursement method is known as the global surgery package. Medicaid policy is based on HCFA's guidelines for Medicare services for the global surgery package.

The global periods are identified on the Medicaid Physician Database. The payment rules for global surgery apply to codes with entries of 000 (only services on the day of the procedure are included), 010 (10 day global period), 090 (90 day global period), and YYY (global period determined on case-by-case basis). Codes with 000 and 010 global periods are endoscopies and minor procedures. Codes with a 090 post-operative period are major surgeries. Codes with a YYY are individually priced and the program determines the global period.

The Services Included in the Global Surgery Package are:

- Pre-operative visits beginning with the day before the surgery for major surgeries and the day of the surgery for minor surgeries
- Intra-operative services that are a usual and necessary part of a surgical procedure
- 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.)
- Follow-up visits within the post-operative period related to recovery from the surgery
- Post-surgical pain management by the surgeon
- Supplies for certain services furnished in a physician's office
- 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.)

Services Not Included in the Global Surgery Package:

The payment amount for global surgery does not include the following services; they are paid separately.

- The surgeon's initial consultation or evaluation of the problem to determine the need for surgery
- The office or hospital visit to decide upon surgery, if it occurs on the day before or the day of a major surgery (Bill this visit with the appropriate E/M code and modifier 57 only for services on the day of or the day before major surgery.)
- Other physicians' services, except when the surgeon and the other physician(s) agree on the transfer of care (The transfer of care agreement may be in the form of a letter or an annotation in the discharge summary, hospital records, or ASC records.)
- Visits unrelated to the diagnosis for which the surgical procedure is performed (Bill the appropriate E/M code with a 24 modifier; services must be sufficiently documented to establish that the visit was unrelated to the surgery.)
- Treatment of the underlying condition or an added course of treatment that is not part of the normal recovery from surgery

- Diagnostic tests and procedures, including diagnostic radiology procedures
- Clearly distinct surgical procedures that are not re-operations or treatment for complications during the post-operative period (A new post-operative period begins with the subsequent procedure; these services should be billed with the 79 modifier added to the surgical procedure code.)
- Staged procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure (Examples are procedures to diagnose and treat epilepsy in succession within 90 days of each other. Staged procedures should be billed with the 58 modifier added to the surgical procedure code.)
- Laser eye surgeries (and all other services whose narrative includes one or more sessions) performed in a series over a period of weeks or months are not considered staged procedures. (The fee screen amount includes reimbursement for one or more sessions per the CPT definition. All sessions during the post-operative period of the first session are part of the global fee.)
- Chemotherapy and/or radiation therapy following cancer surgery (These services are for treatment of the underlying condition, not part of the normal surgical recovery. Bill with the appropriate E/M code and the 24 modifier.)
- Treatment for post-operative complications that requires a return to the operating room (For this purpose, an operating room is a place of service specially equipped and staffed for the sole purpose of performing surgical procedures, including a cardiac catheterization suite, a laser suite, and an endoscopy suite. Not included is a patient's room, a minor treatment room, a recovery room, or intensive care unit unless the patient's condition is so critical there is insufficient time for transportation to an operating room. Bill these surgical procedures with a 78 modifier even if the CPT code reported is the same as the original surgery.)
- A second, more extensive procedure when a less extensive procedure fails (These services should be billed with the 58 modifier added to the surgical procedure codes.)
- A therapeutic service that is required during the post-operative period of a diagnostic service (Bill the therapeutic service with the 58 modifier added to the surgical procedure code. Example: A D&C followed by a therapeutic hysterectomy performed during the D&C's global period is billed with the 58 modifier added to the surgical procedure code.)
- Immunosuppressive therapy for organ transplants (Bill physician management of immunosuppressive therapy with the appropriate E/M code and 24 modifier.)
- Critical care services (99291 and 99292) unrelated to the surgery when a seriously injured or burned patient is critically ill and requires constant attendance of the physician (Bill these services with 24/25 modifier to be separately allowed.)
- Visits that are a significant, separately identifiable service on the same day as a minor surgery or endoscopy (For example, use modifier 25 to bill a visit for a full evaluation of a lump in the breast on the same day as a removal of a lesion on the back.)

A global surgery package is billed with the code for the surgery(s) only using the date of the surgery as the service date. No other visits or procedures included in the package can be separately billed. When physicians of the same specialty in a group practice provide parts of the global surgery package, only one physician (usually the surgeon) should bill for the service as a global surgery.

When a patient is returned to the operating room for treatment of complications (which is reported by modifier 78), the amount paid to the surgeon will be for the intra-operative portion of the service only.

If a surgical procedure is started and then discontinued, the service should be reported with modifier 53. An explanation of the circumstances must be included with the claim. In instances where a surgery involves significantly increased operative complexity and/or time in a significantly altered surgical field, report modifier 60 and attach an operative report to the claim which documents the complexity encountered. In cases of unusual procedural services not involving an altered surgical field, modifier 22 should be reported and documentation attached explaining the need for additional consideration.

Less than the Full Global Package

Physicians furnishing less than the full global surgery package must bill their portion of care correctly. Modifiers 54 and 55 are used to identify a portion of the global surgery package that may be provided and billed separately by different physicians under certain circumstances. Modifier 56 should not be reported. Only procedures with 10- or 90-day global periods are eligible for partial global surgery payment. Endoscopic or minor procedures identified with a global period of 000 include related pre-operative and post-operative services on the day of the procedure only. E/M services on the day of the procedure are generally not payable. Procedures identified with a ZZZ global period are related to another service and are always included in the global period of the other service.

The surgeon should use modifier 54, surgical care only, to bill for a surgery when another physician 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. The surgeon should bill the surgical code, the date of the surgery and modifier 54. Payment will reflect the pre-operative, intra-operative, and inpatient post-operative services only.

Modifier 55 is used when a physician other than the surgeon provides all or part of the post-operative care after hospital discharge in the global package. 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 the surgery as the service date, report modifier 55, and indicate the date care was relinquished/assumed on the claim. The receiving physician cannot bill for any part of the post-operative care until at least one service has been provided. If the surgeon does not transfer the patient for post-operative care, occasional post-discharge services of a physician other than the surgeon are reported with the appropriate E/M code.

Multiple Surgical Procedures

Multiple surgeries are separate procedures performed by a physician on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants at surgery may participate in performing multiple surgeries on the same patient on the same day. Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure. These intra-operative services, incidental surgeries, or components of more major surgeries are not separately billable.

When the same physician performs multiple surgical procedures during one operative session, all services should be reported on one claim. The provider should report the major or primary surgery first without modifier 51. Each additional surgical procedure should be billed on subsequent lines on the claim with modifier 51. Add-on procedures (identified in CPT) should NOT be reported with modifier 51. If an integral procedure (one that is part of a larger surgery and is necessary to perform the larger surgery) is performed, it should be included in the charge for the larger procedure. If two or more physicians each perform distinctly different, unrelated surgeries on the same patient on the same day (e.g., in some multiple trauma cases), do not use modifier 51 unless one of the surgeons performs multiple surgeries.

Multiple surgery reimbursement policy applies to procedures performed during the same operative session or on the same day by the same physician, or physicians of the same specialty in the same group practice. Medicaid will reimburse 100% for the most complex surgical procedure and 50% for the second through the fifth surgical procedure. (Previously, the reimbursement was 100% for the first, 50% for the second and 25% for each subsequent procedure.) If more than five multiple procedures are performed, an operative report must be provided with the claim. Procedures identified as "add-on procedures" are reimbursed at 100% and are not subject to the multiple surgery payment reduction.

Multiple endoscopy procedures will be reimbursed based on the full fee for the highest paid service plus the difference between the next highest and the base endoscopy. When related endoscopies are performed on the same day as other endoscopies or other surgical procedures, the standard multiple surgery rules apply. The multiple surgery rules consider the total payment for the related endoscopies as one service and any other unrelated endoscopy or procedure as another service.

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" (e.g., code 27395; lengthening of the hamstring tendon; multiple, bilateral) or "unilateral or bilateral" (e.g., code 52290; cystourethroscopy; with ureteral meatotomy, unilateral or bilateral). The RVUs for these codes reflect the work involved if done bilaterally as the description states.

The Medicaid Practitioner Database includes an indicator for those procedures that may be billed with a 50 modifier. If the procedure is performed bilaterally, report the procedure on a single claim line and use 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 fee screen for the procedure. If a procedure is identified as a bilateral procedure according to its CPT narrative, do not report the code with modifier 50.

Assistant Surgeons

Medicaid 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. Surgical procedures that generally do not require assistant surgeon services include endoscopies, angiograms, minor surgeries, and cataract extractions.

Medicaid will not pay for assistant surgeon services in a teaching hospital unless a qualified resident is not available. The medical record must document the circumstances causing the unavailability of a qualified resident. Also, reimbursement for assistant surgeon services will not be allowed when payment for co-surgeons or team surgeons is made.

The surgical procedure(s) should be reported with modifier 80 or 82. Reimbursement for assistant surgeon services will be the lesser of charge or 16% of the fee screen for the surgical procedure.

Multiple Surgeons

Under some circumstances, the individual skills of two or more surgeons are required to perform surgery on the same patient during the same operative session. This may be required due to the complex nature of the procedures or the patient's condition. The Medicaid Practitioner Database includes multiple surgeon indicators on allowable procedures.

Co-surgeons: Two surgeons who work together as primary surgeons performing distinct parts of a total service are considered co-surgeons. The medical record must contain sufficient documentation supporting the medical necessity for co-surgeons. Report modifier 62 when billing for the services furnished by each co-surgeon. The primary procedure will be reimbursed at the full screen times 62.5%. Second and subsequent services will be paid at 50% of the full-allowed amount times 62.5%.

Team Surgeons: Three or more surgeons who work together as primary surgeons to perform a specific procedure are considered team surgeons. Sufficient documentation must be submitted with the claim to establish that a team was medically necessary. If two or more surgeons are of the same specialty, the reason each was needed must be documented also. Report modifier 66 when billing for services rendered by each team surgeon. Each surgeon's dictated operative report must be included with the claims. Reimbursement will be based on individual consideration.

Surgeons Performing Distinctly Different Unrelated Procedures: If two or more physicians each perform distinctly different, unrelated surgeries on the patient on the same day, the payment adjustment rules for multiple surgeries or co-surgeons do not apply. In such cases, modifier 51 should not be used unless one of the surgeons individually performs multiple surgeries.

Emergency Services

All services billed to the program must be identified as an emergency or not an emergency. "Emergency services" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the individual (or, with respect to a pregnant woman, the health of the unborn child) in serious jeopardy,
- serious impairment to bodily functions, or
- serious dysfunction of any bodily organ or part.

Medicaid covers all medically necessary emergency services. The determination of whether the prudent layperson standard has been met must be based on the presenting signs and symptoms, not the final diagnosis. Federal statutes prohibit prior authorization for coverage of emergency services.

Examples of some emergency conditions include:

- severe asthmatic attack
- acute infections such as cellulitis or abscess
- acute urinary retention
- chest pain
- fractures
- hypo/hyperthermia
- lacerations requiring suturing
- loss of consciousness or impaired mentation
- malignant hypertension
- poisonings/overdose
- seizures, trauma, including burns requiring more than first aid
- uncontrolled diabetes
- uncontrolled hemorrhage

The emergency condition must be fully documented in the medical record.

A situation is NOT considered an emergency if one of the following conditions exist:

- the condition is self-limiting (e.g., pharyngitis, minor cuts)
- it is a non-traumatic condition where initiation of treatment can be delayed 12-24 hours without substantial difference in outcome (e.g., uncomplicated urinary tract infection)
- the condition does not require immediate diagnostic procedures such as laboratory testing, x-rays, electrocardiogram, etc.

Maternity Care and Delivery Services

The services normally provided in uncomplicated maternity cases are antepartum care, delivery and postpartum care. These services are included in the global obstetric care and are not coded separately. The global obstetric package should be billed when one physician or physician group practice provides all the obstetric care to a patient.

Antepartum care includes the initial and any 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. Typically, if a patient enrolls in the first trimester and delivers at term, she will have about 13 antepartum visits. This will vary depending on the actual start of antepartum care and the delivery date. For Medicaid, the global package can be billed as long as the provider or group has provided 7 or more antepartum visits, the delivery and the postpartum care. If less than 7 antepartum visits are provided, report the global package with modifier 52 and indicate the number of antepartum visits on the claim. If the total number of antepartum visits exceeds 13 due to a high-risk condition, the additional visits may be reported using the E/M codes with the diagnosis for the high-risk condition.

Delivery includes admission to the hospital, the admission history and physical examination, management of uncomplicated labor, delivery, and all post delivery in-hospital care. All hospital visits within 24 hours of delivery are generally considered part of the global package. If the patient is admitted more than 24 hours before delivery and stays more than 24 hours, then hospital care rendered prior to the day of delivery may be billed separately. Medical problems complicating labor and delivery management that require additional resources can be reported separately.

Postpartum care includes all the visits following a delivery, both in the hospital and in the office. Services provided by physicians within the same group practice should be reported once under the Medicaid ID number of the primary physician responsible for the patient's overall care. When billing the global package, the date of service should be reported as the delivery date. The package cannot be billed until the baby is delivered.

If the same physician or group practice does not provide all the obstetric care, it is appropriate to bill for only the portion of the care provided using the component codes. Antepartum care should be reported based on the number of visits provided. All visits must be provided before the antepartum care is billed. The date of service must reflect the first date of antepartum care as the From date and the last date of care as the To date. If three or fewer antepartum care visits are provided, the service must be reported with Michigan's code:

X4853 – antepartum care only (separate procedure), per visit. Report if three or fewer antepartum care visits are provided by the same physician or group and no delivery services are provided. The date of service should be the actual date the antepartum visit occurred.

Postpartum care is not separately payable unless it is provided by a physician or group other than the one providing the delivery services.

Services that are not included in the global package include:

- maternal or fetal echography or fetal echography procedures
- fetal biophysical profile
- chorionic villus sampling, any method
- fetal contraction stress test
- fetal nonstress test
- hospital and observation care visits for premature labor (prior to 36 weeks gestation)

High-risk pregnancies are those with complicating conditions that are life-threatening to either the mother or fetus and, therefore, require more services than those provided in a routine pregnancy. Effective for prenatal care rendered on or after 8-1-01, the program is discontinuing use of the Michigan specific high-risk antepartum care codes and adopting the CPT coding recommendation for reporting services associated with high-risk care. When high-risk pregnancies require more visits than described for routine obstetrical care, and more laboratory data than normally required, the services should be reported separately in addition to the global package using the E/M codes and the diagnosis for the high-risk condition. If patient visits are required due to conditions unrelated to the pregnancy, they may be reported in addition to the global package using the E/M codes and the appropriate diagnosis.

In the case of multiple gestation, the program will make additional payment for the services provided. For twins, report the appropriate obstetrical service code on one line for the first baby and report it again on the second line with modifier 51 for the second. For more than twins, combine all services for the third or more babies on the second line and report modifier 22, indicating the number of babies involved. Be sure to use a diagnosis code representing multiple gestation.

Prior Authorization

Some services need to be prior authorized in order for the service to be provided and billed to the program. Prior authorization (PA) must be obtained from the program before the service is rendered. The Medicaid Physician Database provides an indicator for the practitioner services that must be prior authorized.

To obtain PA, the provider must submit a letter to:

Prior Authorization and Review Section
Medical Services Administration
P. O. Box 30479
Lansing, Michigan 48909

Or fax it to: (517) 335-0075

The letter requesting prior authorization must include:

- patient name and Medicaid ID number
- provider's name, address, Medicaid provider ID number
- contact person and phone number

- a complete description, including CPT/HCPCS procedure codes as appropriate, of the procedure(s) that will be performed
- the patient's past medical history, including other treatments/procedures that have been tried and the outcome, diagnostic test results/reports, expectations and prognosis for the proposed procedure, and any other information to support the medical need for the service.

The provider will receive a written response from the program. If the authorization is granted, the provider will receive a nine-digit authorization number to report on the claim form when billing for the service. **There is no need to submit a copy of the approval letter with the claim.** If the service must be reported with an "unlisted" code, an explanation for the service or an operative report must be sent with the claim. The physician obtaining PA must make the PA number available to other providers such as the hospital for billing purposes.

If the beneficiary has Medicare and Medicare covers the service, the provider does not have to obtain PA from Medicaid. If Medicare denies a service as not medically necessary, Medicaid will not cover the service even if PA has been obtained. If Medicare identifies a service as an excluded benefit under Medicare and Medicaid requires PA, the provider must pursue PA from Medicaid and a coverage determination will be made. If the beneficiary has commercial insurance that covers the service and the provider reports the coverage correctly on the claim, the provider does not have to obtain PA from Medicaid. If a primary insurer will cover a service but requires PA and the provider does not follow the primary insurance PA process, Medicaid will not make payment for the service either.

Currently, authorization must be obtained for any elective inpatient hospital admission, a readmission within 15 days, and all transfers to and from any hospital that is enrolled with the Michigan Medicaid program. The inpatient hospital process is referred to as PACER (Prior Authorization Certification Evaluation Review). Authorization must be obtained through the Admissions and Certification Review Contractor (ACRC). All cases are screened using the criteria that have been approved by the DCH and the clinical judgement of the review coordinator. An ACRC physician advisor using clinical judgement makes all adverse decisions. If an admission, readmission, transfer or continued stay is not approved, Medicaid will not pay the hospital or the attending physician for any inpatient services rendered.

The attending/admitting physician or representative is responsible for obtaining the PACER number **before** admitting the beneficiary to the hospital. If, when obtaining PA for a procedure, the provider knows that it will be done on an inpatient basis, this must be noted with the PA request. The PACER number cannot be assigned when the PA is approved as services may be prior authorized more than 30 days before the patient is scheduled for the procedure. PACER must be obtained no more than 30 days prior to the admission. Even though the procedure is authorized, the provider must still call for a PACER number for the admission. The provider should be ready to provide the CPT/HCPCS procedure code and the PA number for the approved service, and a PACER number will be assigned for billing purposes.

The telephone number to obtain PACER is 1-800-727-7223. When billing the program for the authorized service provided inpatient, the PACER number must be the number reported as the PA number on the claim. There is no need to attach a copy of the authorization letter – the PACER number will authorize the service as well. If a provider tries to obtain a PACER without having received authorization as necessary for the service, the PACER number will not be provided.

Vision Services

The program covers all medically necessary services for the diagnosis and treatment of complaints or symptoms of an eye disease or injury. An eye exam or service is considered "routine" and subject to vision benefit co-payments and limitations if provided solely for any of the following diagnosis:

ametropia	emmetropia	myopia	refractive error
anisometropia	hypermetropia	"no pathology"	
astigmatism	hyperopia	presbyopia	

If these diagnoses are billed with E/M services, the service will be denied. E/M codes from CPT should only be billed with a medical diagnosis. Routine examinations of the eye must be reported under HCPCS codes as follows:

S0620 - routine ophthalmological examination including refraction; new patient or
S0621 - routine ophthalmological examination including refraction; established patient

A routine eye exam includes history, visual acuity determination, external exam of the eye, binocular measure, ophthalmoscopy with or without tonometry, with plotting of visual fields, with or without biomicroscopy (slit lamp) and with or without refraction. A refraction cannot be billed separately.

Routine eye examinations to determine the need for eyeglasses are payable once every two years. They are subject to a \$2.00 co-payment whether provided by a physician or an optometrist. Providers should consult the Vision Benefit coverage for more information.

Ophthalmologists may transfer post-operative care associated with cataract removal or insertion of an intraocular lens prosthesis to an optometrist. In this case, the ophthalmologist who performs eye surgery but does not provide the post-surgical care must add modifier 54 to the surgery procedure code on the claim. This represents the pre-operative care, the surgery, and any in-hospital post-operative care. Post-operative care after discharge should be reported separately by the provider that the care was transferred to using the surgery code with modifier 55.

Reimbursement for surgical procedures that include the phrase "one or more sessions" includes the payment for all sessions. Reimbursement for these procedures includes the 90-day global period during which the procedure(s) can be completed in one or more session(s). The procedures include trabeculoplasty by laser surgery, iridotomy/iridectomy by laser or photocoagulation, repair of retinal detachment, destruction of retinal or choroid lesions. The code description in CPT identifies when one or more session is included. Claims received for a second or subsequent session of the same procedure during the global period of the initial service will be denied unless the claim includes a modifier (RT, right eye or LT, left eye) to indicate that services were furnished on different eyes.

Radiology Services

All medically necessary radiological services are covered when ordered by a physician to diagnose a specific condition based on the patient's signs, symptoms, and past history as documented in the medical record. Radiology services include diagnostic and therapeutic radiology, nuclear medicine, CT scan procedures, magnetic resonance imaging (MRI) services, diagnostic ultrasound, and other imaging procedures. If a testing modality is considered investigational, or is contraindicated and not reasonable and necessary for diagnosis of the specific patient involved, it is not covered. Medical need for all services must be documented in the medical record and are subject to post-payment review.

Component Services: Many radiology procedures and diagnostic tests are billed as a professional, technical or global service. For Medicaid, physicians may be reimbursed for the global service in a non-hospital setting or the professional component only. The technical component is the actual performance of the test and is payable as a technical component only when provided and billed by a hospital. The reimbursement covers the cost to perform the test including all equipment, supplies and staff. 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.

When a physician bills for the global procedure, the physician is responsible for the overall performance and quality of the test. The physician must either personally perform the test or it must be performed under the physician's supervision and direction. The physician who bills for the test, either the global or professional only service, must personally interpret the results and complete the written report. While some radiology procedures and diagnostic tests may not require the presence of the supervising physician on the premises, other procedures dictate that the physician be present and may even need to be directly involved in the performance of the procedure. In any event, the physician retains full responsibility for the entire service when billing for the global procedure.

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. Review of results and explanation to the patient is part of the attending physician's E/M service and cannot be billed to the program as interpretation of the study. If a hospital requires interpretation of a study for quality purposes, this is considered an administrative hospital service and cannot be billed separately to the program as a service to a patient.

Multiple Services on Same Day: Medicaid covers bilateral x-rays when medically necessary. Bilateral services are studies done on the same body area, once on the right side and once on the left side. Comparison films obtained for routine purposes are not covered. Providers should use the "bilateral" code to bill the service when available. If a bilateral code is not available, report bilateral diagnostic services on two claim lines, one with modifier RT (right side) and the other with modifier LT (left side). The Medicaid Practitioner Database indicates all diagnostic procedures that will be reimbursed as "bilateral" services when reported this way. If multiple studies of the two areas are required, use modifier 22 and provide explanation of the circumstances so a payment determination can be made. An example would be bilateral wrist studies done before and after fracture care on both wrists the same day for the same patient.

When multiple x-rays of the same area are performed on the same patient on the same day and they are not bilateral x-rays, the quantity should be used to report the number of services provided. This may occur when doing films before and after fracture care, or to assess a patient's response to medical care, such as multiple chest films to monitor the cardiopulmonary status of a critically ill patient. Do not use modifier 51 to report multiple radiology studies of the same area on the same day.

Studies of contiguous areas, such as the wrist and hand, lumbosacral spine and pelvis, ankle and foot, are covered on the same day when medically necessary to visualize each space. The medical record must support the need for individual studies. Studies of two segments of the spine (cervical, lumbosacral, or thoracic) are payable as separate services on the same day. If cervical, lumbosacral and thoracic views are performed, an entire spine study should be reported.

Screening mammography is covered according to the American Cancer Society guidelines. Women age 40 and older should have annual breast cancer screening consisting of a clinical breast examination and a mammogram.

Transrectal or prostate ultrasound is covered when the patient is considered at high risk for prostate cancer. It is also covered for pathologic indications that include evaluation of prostatic nodule(s) or abnormalities of the seminal vesicles, staging of prostatic cancer, and monitoring of response to therapy for prostatic cancer.

For CT, MRI and PET scans, all conditions of CON (Certificate of Need) must be met. These services are subject to standards for provision of the service that include specific staff and designation of who is qualified to interpret the results. Any provider billing for interpretation of these services must be credentialed or otherwise qualified according to the CON standards to interpret the scans. All documentation regarding the qualifications of the provider billing for the interpretation of the scan must be on file at the site where the scan is performed, i.e., the site for which the CON applies.

Flat films and CT or MRI studies of the same area are payable on the same day when medically indicated. The provider is responsible for using the most appropriate diagnostic test(s) according to current standards of practice. CT and myelogram may be reimbursed on the same day; however, MRI and a myelogram are not payable on the same day. CT of the spine is limited to one level per day and MRI is limited to two levels of the spine on the same day. Providers should be directing the study at the area of the suspected problem. RVU-based fees reflect payment levels for two MRI sequences on the same day. No additional payment will be made for third or subsequent sequences.

CT and MRI scans may be done with or without contrast media or both. When billing, use the code for the actual service rendered. When a scan is done without contrast followed by another with contrast, report the code that describes the full service. Do not report each service separately. The global RVUs for CT and MRI contrast scans include allowance for high osmolar contrast media, and the RVUs for global MRIs include allowance for paramagnetic contrast media.

In certain instances, an additional allowance for the use of low osmolar contrast media (LOCM) will be made. Additional payment will be made for all medically necessary intrathecal radiology procedures furnished to non-hospital patients. In the case of intra-arterial and intravenous radiological procedures, LOCM will be paid separately for non-hospital patients with one or more of the following:

- a history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting;
- a history of asthma or allergy
- significant cardiac dysfunction, including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension;
- generalized severe debilitation; or
- sickle cell disease.

If the patient does not meet any of these criteria, the payment for contrast media is considered bundled into the global component of the procedure and no additional allowance will be made.

When high dose contrast technique is used with MRI, the global service will be paid for the code designating without contrast, then with contrast. The third MRI (again with contrast) will not be paid separately. No additional payment will be made for the contrast material used in the second MRI procedure. However, the contrast material for the third MRI procedure will be paid separately under code A4643 when billed with 70553, 72156, 72157, and 72158.

Obstetrical ultrasound studies are payable in addition to the global obstetrical package. More than two studies are covered only for high-risk conditions such as bleeding, placental abnormalities, fetal post-maturity, etc. The reason for the additional studies, including the change in clinical symptoms, must be documented. Pelvic ultrasounds are not covered to diagnose pregnancy or vaginal infections, as other more appropriate and less costly diagnostic modes are available. The use of ultrasound studies for routine fetal age determination in or preparatory to pregnancy termination procedures is considered part of the termination procedure and is not payable separately.

Radiation Therapy

Medicaid uses CPT guidelines for radiation therapy services. Payment for radiation treatment management is based on five treatments (fractions) delivered, which comprise one week, regardless of the time interval separating the delivery of treatments. Five treatments must be reported as one (1) service in the quantity field. Three or four additional treatments should also be reported as one service. One or two additional treatments at the end of a course of therapy should not be billed. They are considered paid in the previous week treatment.

If treatment is discontinued after only one or two fractions have been provided, code 77431 should be reported as one (1) service. The reason the treatment was discontinued should be stated on the claim.

When billing the weekly therapy management codes, the first treatment (fraction) date should be reported as the From date and the last fraction in the weekly service should be reported as the To date.

Following the Medicare guidelines, many services are bundled into the treatment management codes and cannot be billed separately when the diagnosis is related to the weekly treatment diagnosis and the services are provided by the radiation oncologists or in conjunction with the therapy. The following services are included in the weekly treatment management regardless of how billed:

- anesthesia
- care of infected skin
- checking treatment charts
- continuing-care patient evaluation and examination
- final medical examination
- nutritional counseling
- pain management
- medical prescription
- review and revision of the treatment plan
- routine medical management of related problems
- special care of ostomy
- verification of dosage
- written reports, progress notes
- follow-up examination and care 90 days after the last treatment

Services furnished by a radiation physicist can only be billed to the program when provided to a non-hospital patient in a freestanding facility. Services provided to hospital patients can be billed as professional services only when personally performed by a physician. Global services may be billed if provided in a freestanding, non-hospital setting.

Nuclear Medicine

Medically necessary nuclear medicine procedures are covered (code range 78000 – 79999). Providers are responsible for complying with the Nuclear Regulatory Commission requirements as necessary, and no information needs to be reported to the program. Practitioners may bill only for professional services rendered to hospital patients, and the facility must bill for any technical or facility charges. Providers should bill for the global service when provided in a freestanding, non-hospital setting. The global RVUs for nuclear medicine do not include the radionuclide used in the procedure. These substances are billed separately under the appropriate HCPCS code.

When specific nuclear medicine diagnostic procedures are performed, the multiple procedure reductions will apply. The first procedure is paid at 100% and the second and subsequent at 50%. This applies to codes 78306, 78320, 78802, 78803, 78806, and 78807. The generation and interpretation of automated data (codes 78890 and 78891) is bundled into the payment for the primary procedure and is not payable separately.

Routine Foot Care

Medicaid does not cover routine services such as the cutting or removal of corns, calluses, or nails whether performed by a podiatrist, MD, or DO. An exception is when the patient suffers from a specific systemic disease of sufficient severity that care by a nonprofessional would be hazardous. The patient should be receiving regular care from a physician for the systemic disease. Some conditions that may meet the exception are diabetes with peripheral circulatory disorders (arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis) or other peripheral neuropathies of the feet such as those associated with chronic renal disease, carcinoma, malabsorption, pernicious anemia, multiple sclerosis, etc. When billing for procedure codes 11055, 11056, 11057, or 11719, the diagnosis reported must fully support the systemic disease.

Anesthesia Procedure Codes

Anesthesia services rendered 8-1-01 or after must be reported using the 5-digit anesthesia CPT codes (00100–01999) instead of the surgical CPT codes reported with type of service 7. The codes describe anesthesia for procedures categorized by areas or systems of the body; and others describe anesthesia for radiological and miscellaneous procedures. To bill for anesthesia administered for multiple surgeries, use the anesthesia code with the highest base unit value and the actual time in minutes that extends over all procedures.

The claim must include the appropriate modifiers describing who performed the anesthesia and under what circumstances (refer to MSA Bulletin 01-07 issued April 1, 2001). If a modifier is not reported, the service will be denied. The QS modifier, monitored anesthesia care (MAC), must be reported in addition to the appropriate modifier in the second modifier position if MAC is provided. Claims with the QS modifier reported alone will be denied.

Anesthesia associated with labor and delivery is reported based on the type of anesthesia provided. If anesthesia is provided by placement of an epidural catheter, either code 00857 or 00955 should be reported depending on the type of delivery. The service includes any needle placement and drug injection and/or any replacement of the epidural catheter during labor. No additional services may be billed. If endotracheal or general anesthesia is provided for the delivery, code 00850 or 00946 as appropriate should be reported. The time should be the time the anesthesia provider is in constant attendance for the actual delivery, not including the time in labor. In the unusual event that an epidural is inserted for labor and delivery but it is later necessary to provide endotracheal anesthesia for the delivery, then the surgical code for the epidural insertion should be reported in addition to the anesthesia code for the delivery. The medical record must fully document the circumstances requiring both types of anesthesia.

When an epidural catheter is placed for post-operative pain management, the surgical code for the continuous epidural may be billed in addition to the anesthesia service only if the epidural is not used as the mode of anesthesia in the surgical case. Post-operative pain management is the responsibility of the surgeon. If it is medically necessary for the anesthesiologist to provide daily management of a continuous epidural on subsequent post-operative days, it should be reported with code 01996 and no anesthesia modifier. A flat rate payment will be made to the anesthesiologist, not the surgeon.

The program does not cover any service related to the treatment of infertility. Therefore, anesthesia for hysteroscopy and/or hysterosalpingography (code 00952) is not covered. Physiological support to harvest organs from a brain-dead patient is not a covered service (code 01990). Additionally, electroconvulsive therapy is generally used to treat patients with serious mental disorders. Coverage of this service would most likely be reserved for Medicaid patients being served by Community Mental Health Service Programs as part of the behavioral health managed care carve-out. Anesthesia providers must bill the program that authorized provision of this service.

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, 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. It is the responsibility of the operating surgeon to obtain this consent. The program has a process whereby the consent form may be faxed to DCH for approval indicating that it is completed correctly and maintained in our file. If this process is followed, providers can indicate "consent on file" on the claim. The consent form does not have to be obtained from the operating surgeon, and a copy does not have to be attached to the claim to receive payment if an approved consent form is on file with us.

The program will be providing more information regarding the use of the CPT anesthesia codes.

Manual Maintenance

Retain this bulletin until the manual is updated.

Questions

Any questions regarding this bulletin should be directed to: Provider Inquiry, Medical Services Administration, P.O. Box 30479, Lansing, Michigan 48909-7979, or e-mail at ProgramSupport@state.mi.us. Providers may phone toll free 1-800-292-2550.

Approved



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