AmeriHealth Caritas Ohio

Medicaid Reimbursement Policy Overview

Payment Policy ID: RPC.0001.7700

Recent review date: 11/2022

Next review date: 11/2023

AmeriHealth Caritas Ohio Family of Companies claim payment policies and the 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 regulatory agencies, and medical specialty professional societies. In making claim payment determinations, the health plan also uses coding terminology and methodologies that are based on accepted industry standards, including the Healthcare Common Procedure Coding System (HCPCS) manual, the Current Procedural Terminology (CPT) codebook, the International Statistical Classification of Diseases and Related Health Problems (ICD) manual, and the National Uniform Billing Code (NUBC).

Other factors affecting reimbursement may supplement, modify, or in some cases supersede medical/claim payment policy. These factors may include but are not limited to: legislative or regulatory mandates, a provider's contract, and/or a member's eligibility to receive covered health care services

Policy Overview

This policy is an overview of the categories/topics and the associated claim edits for AmeriHealth Caritas Ohio reimbursement policies. The information given in this overview should not supersede the information given in individual reimbursement policies.

Reimbursement policies are intended as a general reference on coding/billing information, and do not constitute an authorization for services or guarantee of payment. AmeriHealth Caritas Ohio adheres to all requirements by Ohio Department of Medicaid (ODM) and the Centers for Medicare and Medicaid (CMS). In the absence of any state or federal requirements, AmeriHealth Caritas Ohio follows industry standard coding/billing guidelines from *Current Procedural Terminology* (CPT©), *Healthcare Common Procedure Coding System* (HCPCS), and *International Statistical Classification of Diseases and Related Health Problems* (ICD); and specialty society coding/billing guidelines as applicable.

Exceptions

Contains any exception to the Reimbursement Policy. An example is new vs established patient when the member gives birth.

Coding

Category	Topic	Edit Overview
Acupuncture Policy		Reimbursement policy addresses billing and/or payment of acupuncture services. Reimbursement has frequency restrictions.
Add-on Code Policy		Reimbursement policy addresses billing and/or payment of add-on codes. A claim for an add-on code without its

		primary procedure code on the same date of service will be denied.
Ambulance Policy		Reimbursement policy addresses billing and/or payment of ambulance services.
	Ambulance Mileage	A claim for ambulance mileage must be billed with the applicable ambulance service code(s) and modifier(s).
Ambulatory Surgical Center (ASC) Policy		Reimbursement policy addresses billing and/or payment of procedures/services billed from an ASC. Procedures must be on the list approved for ASC.
	ASC Bilateral Modifier 50	ASC facility, specialty 49, claims billed with the bilateral modifier 50 will be denied.
	Non-covered Enhanced Ambulatory Patient Group (EAPG) Ohio Enhanced Ambulatory Patient Groups (OPH) Not Covered	A claim for a service considered non-covered by ODM will be denied. Source: Ohio Department of Medicaid/Providers/Fee Schedule and Rates/Schedules and Rates/Ambulatory Surgical Centers
	ASC Never Events	Services are considered non-covered when billed with the following modifiers: • PA - Surgical or other invasive procedure on wrong body part • PB - Surgical or other invasive procedure on wrong patient • PC - Wrong surgery or other invasive procedure on patient
	ASC Skin Substitute Application Procedure Without Appropriate Skin Substitute Procedure Code	A claim for skin substitute product procedures without a substitute application code billed on the same date of service will be denied.
Anesthesia Policy		Reimbursement policy addresses billing and/or payment of anesthesia services.
	Multiple General Anesthesia (ASA) Services on Same Day	Reimbursement for multiple general ASA codes billed by the same provider on the same date of service is limited to the code billed with the highest submitted charge amount.
	Maternity	Per OAC rule 5160-4-21, reimbursement of neuraxial labor analgesia is limited to 240 minutes.
Asthma and Allergy		Reimbursement policy addresses billing and/or payment of asthma and allergy treatment procedures/services, including allergy study and allergen immunotherapy.
Assistant Surgeon		Reimbursement policy addresses billing and/or payment of assistant surgeons, including surgical PAs.
	Assistant Surgeon Not Allowed	A claim for an assistant surgeon when the procedure code is not designated as such will be denied. Documentation must support the service being billed
Behavioral Health Readmission		Reimbursement policy addresses Readmissions for Behavioral Health within 30 days.
Bilateral Procedures Policy		Reimbursement policy addresses billing and/or payment of bilateral procedures.
Bundled Services Policy		Reimbursement policy addresses billing and/or payment of bundled services per payment status indicators.
	Bundled Services – Facility	Per CMS, patient transportation to another hospital or other site for temporary specialized care is covered under the inpatient admission if the patient maintains inpatient status at the original inpatient hospital or a Critical Access Hospital (CAH).
Cardiology Policy		Reimbursement policy addresses billing and/or payment of cardiology procedures, including non-Invasive vascular

		diagnostic studies, cardiovascular evaluation with tilt table testing, electrocardiogram (ECG), and E/M services with cardiac device monitoring.
Claims Processing Parameters Policy	Missing or Incomplete Claim Information.	A claim must have complete claim information, including member information, procedure and diagnosis codes, POS code, provider information, referring physician information, to and from dates of service, and discharge status if applicable.
	Dates of Service (DOS) to Units Discrepancy	A claim line with a discrepancy between DOS and number of units will be denied.
CMS Coverage Policy		Reimbursement policy addresses CMS coverage limitations.
Co-Surgeon Policy	Co-Surgeon Not Allowed	A claim for co-surgery when the procedure code is not designated as such will be denied. Documentation must support the service being billed.
Dermatology Policy		Reimbursement policy addresses billing and/or payment of dermatology procedures, including actinotherapy and photochemotherapy, and laser treatment of psoriasis.
Device and Supply Policy		Reimbursement policy addresses billing and/or payment of devices/supplies with specific services, including nuclear medicine imaging services billed with radiopharmaceutical agents or implant procedures that require the billing of the implant device. Reimbursement has frequency restrictions.
Diagnosis Code Guideline Policy		Reimbursement policy addresses coding/billing with diagnoses using ICD-10-CM guidelines.
	Behavioral Health Services	Behavioral Health Claims line(s) require a diagnosis code to support medical necessity. Sources: Ohio Medicaid Behavioral Health/Provider/Manuals, Rates & Resources/Billing, and IT Resources/Additional Resources/2019 ICD-10 DX Code Groups BH Redesign; Behavioral Health Redesign/Provider/Manuals, Rates & Resources/Billing and IT Resources.
	Diagnosis Procedure Policy	Reimbursement for certain procedures/services is limited to the conditions indicated by the diagnosis code(s) reported on the claim.
	Diagnosis Validity Policy	Diagnosis codes are revised annually per ICD-10-CM.
Drug and Biologicals		Reimbursement policy addresses billing and/or payment of drugs and biologicals.
	Drug waste	Drug wastage must be reported with modifier JW, using the least available vial size.
Duplicate Services Policy		Reimbursement policy addresses the definition of duplicate services.
Durable Medical Equipment and Supplies Policy		Reimbursement policy addresses billing and/or payment of DME and supplies, including orthotics and prosthetics, drugs used with DME, parenteral and enteral nutrition.
Ears, Nose, and Throat (ENT)		This policy manages the use and coding of diagnostic procedures for Ears, Nose and Throat (e.g., Impacted Cerumen Removal, Tympanometry).
Evaluation and Management Services Policy		Reimbursement policy addresses billing and/or payment of E/M services.
	Multiple Evaluation & Management	Reimbursement for multiple E/M services billed by the same provider on the same date of service is limited the code with the highest RVU, unless modifier 25 is applicable.
	New Patient	A claim for new patient E/M service must not have had a face-to-face service by the same provider within the last three years.

Federally Qualified Health Centers (FQHC)		Reimbursement policy addresses billing and/or payment of services by a FQHC. A FQHC claim must have a FQHC payment code and a qualifying visit code.
	Federally Qualified Health Center (FQHC) Fluoride Varnish Required Codes-Professional	Per OAC rule 5160-28, claim lines without the required additional procedure code will be denied.
Frequency Policy		Reimbursement policy addresses billing and/or payment on the frequency of certain services, including chiropractic manipulation, diabetic screening, presumptive and definitive drug testing, care coordination services, and ESRD treatment.
	Screening Mammography	Per OAC rule 5160-4-25, screening mammography for women is covered once for women between ages 35 to 39, and is covered once per twelve months for women aged 40 or over.
	Spinal Manipulation	Per OAC rule 5160-8-11, spinal manipulation is limited to 30 dates of service per benefit year for individuals under 21, and 15 dates of service per benefit year for 21 years and over. Additionally, more than one spinal manipulation billed on a date of service will be denied.
	Behavioral Health Frequency	Reimbursement policy addresses behavioral health frequency limits per the Ohio behavioral health manual.
	Fluoride Varnish Application by Non-Dental Health Providers	Per OAC rule 5160-4-33, fluoride varnish application by non-dental health providers to a patient under 6 years old is limited to once per 180 days.
Gastroenterology		Reimbursement policy addresses billing and/or payment of gastroenterology procedures, including colonoscopy and upper endoscopy.
Genetic Testing Policy		Reimbursement policy addresses billing and/or payment of genetic testing, including molecular pathology procedures and prenatal cytogenetic testing.
Global Obstetrical		Reimbursement policy addresses payment by the global obstetrical package.
Global Surgery Policy		Reimbursement policy addresses payment by the global surgical package.
	Post-Operative Services During Global Surgery Period	A claim billed during the postoperative period of a procedure code by the same surgeon, without the appropriate modifier and/or diagnosis code(s), will be denied.
Home Health/Home Infusion and related services		Reimbursement policy addresses billing and/or payment of home health, or home infusion and related services, including supplies and equipment when billed the same date of service as a home infusion per diem code.
Incident to services		Reimbursement policy addresses the coding/billing of incident-to services consistent with CMS.
Investigational/Experimental		Reimbursement policy addresses billing and/or payment of investigational/experimental procedures or devices.
Laboratory-Pathology Policy	Clinical Diagnostic and Pathology Procedures	Reimbursement policy addresses billing and/or payment of clinical diagnostic and pathology procedures, including CLIA waived tests, lab panel tests, folate tests, and surgical pathology.
Maximum Units Policy		Units billed in excess of the daily assigned allowable unit(s) for that procedure code will be denied. See MUE.
Medically Unlikely Edits (MUE)		Units billed in excess of the daily assigned allowable unit(s) for that procedure code will be denied. See Maximum Units.

Modifier Policy		Reimbursement policy addresses coding/billing using modifiers. Claim lines with inappropriate modifiers will be denied.
Multiple Procedure Reduction	Multiple Diagnostic Imaging Reduction	Per OAC rule 5160-4-25, MPPR applies to diagnostic imaging.
	Multiple Surgery Reduction	Per OAC rule 5160-1-60, MPPR applies to surgical procedures.
	Multiple Therapy Reduction	Per AOC rule 5160-8-35 MPPR applies to therapy services.
National Correct Coding Initiative (NCCI)	NCCI Policy	Reimbursement policy addresses coding/billing using NCCI policy.
	Medicaid Unbundling	Per OAC 5160-4-22, providers should not itemize or "unbundle" individual components of surgical procedures/services.
Neurology		Reimbursement policy addresses billing and/or payment of neurology procedures/services, including electroencephalogram (EEG), needle EMG, polysomnography, and sleep study. Reimbursement has frequency and diagnosis code restrictions.
Once Per Lifetime		Certain procedure codes can be billed for a patient only once in a patient's lifetime.
Ophthalmology		Reimbursement policy addresses billing and/or payment of ophthalmologic procedures/services including diagnosis code restrictions.
Pain Management	Implantable Neurostimulator Electrode	A claim for the implantable neurostimulator electrode code with the percutaneous implantation of neurostimulator electrode array code already billed will be denied.
Place of Service		Reimbursement policy addresses billing and/or payment of procedures using the appropriate POS code.
Post Payment Review		Post Payment reviews may require medical records to support services were paid accurately and according to coding/medical record documentation and state guidelines.
Procedure Code	CPT/HCPCS	Reimbursement policy addresses billing and/or payment of procedures/services using CPT/HCPCS manual instructions.
	Procedure Code Definition	Claims should be coded based on the definition or nature of a procedure code or a combination of procedure codes.
	Procedure Code guidelines	Throughout the AMA CPT Manual and CMS HCPCS Level II Manual, the publishers have provided instructions on code usage.
	Procedure Age Policy	Certain procedure codes, by definition or nature of the procedure, are limited to the treatment of a specific age or age group.
	Procedure-Gender Policy	Certain procedure codes, by definition or nature of the procedure, are limited to one gender.
Professional, Technical, and Global Services Policy		Reimbursement policy addresses billing and/or payment of professional/technical components of diagnostic tests and radiology services.
Psychiatry-Psychology	Transcranial Magnetic Stimulation (TMS)	A claim for subsequent transcranial repetitive magnetic stimulation without a claim for initial transcranial repetitive magnetic stimulation billed during the previous week will be denied.
Quality of Care		Reimbursement policy addresses the scope of services that may be billed by a certain specialty, and the specialties that may bill certain services.

Radiation Oncology		Reimbursement policy addresses billing and/or payment of radiation oncology procedures/services.
Radiology		Policies associated with angiography, DXA Bone Density, Radiological Examinations and Ultrasounds.
Readmission	Three (3) Calendar Day Roll-in	Per OAC rule 5160-2-2(B)(2), services that are usually considered outpatient services provided within three calendar days of an inpatient admission will be covered under the inpatient admission if provided at the same hospital.
	Behavioral Health Readmission	Reimbursement for behavioral health readmissions within 30 days will be subject to medical record review.
Revenue Code Policy		Reimbursement Policy addresses Revenue codes and accompanying CPT, HCPCS code or bill type.
Team Surgery Policy		Reimbursement policy addresses team surgery and associated guidelines.
Telehealth		Reimbursement policy addresses allowed telehealth services including the use of modifiers and place of service guidelines.
Transportation Services	Non-Covered Transportation Services	These policies address claim line(s) that are considered non-covered. Source: OAC- 5160-15 Medical Transportation.
Vaccines		Vaccines are covered as required by Ohio Department of Medicaid pertaining to age and gender when applicable.
	Covid-19 Vaccine	Covid-19 vaccine products must be submitted with the corresponding administration code by manufacturer and age restrictions. Guidelines are supported by the Ohio Department of Medicaid and should include allowed place of service and modifier if applicable.
Vision Services		Deny claim line(s) when billed with procedure codes considered non-covered per AOC-5160-6 Vision Care Services.

Applicable Claim Types

	Facility	**Professional**
Medicare	**No**	**No**
Medicaid	**Yes**	**Yes**
ACA Exchange	**No**	**No**

Edit Sources

I. Current Procedural Terminology (CPT©), Healthcare Common Procedure Coding System (HCPCS), International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM); International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS); and associated publications and services.

II. Centers for Medicare and Medicaid Services (CMS): https://www.cms.gov/

III. *The Medicaid National Correct Coding Initiative*: https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicaid

IV. Ohio Administrative Code » 5160 *Ohio Department of Medicaid*: https://codes.ohio.gov/ohio-administrative-code/5160
V. Ohio Department of Medicaid (ODM): https://medicaid.ohio.gov
VI. Coding guidelines from specialty societies, including but not limited to American Academy of Family Practitioners (AAFP), American Academy of Pediatrics (AAP), American Congress of Obstetricians and Gynecologists (ACOG), American College of Surgeons (ACS), American Society for Radiation Oncology (ASTRO).

Attachments

N/A

Policy History

12/01/2022	Policy Implemented by AmeriHealth Caritas
10/13/2022	Reimbursement Policy Committee Approval