

General Guidelines for the HF, HK, PP2, IHSS Programs

CenCal Health uses the standard guidelines for professional coding developed by the American Medical Association (AMA) in the Current Procedural Terminology (CPT) and the Healthcare Common Procedure Coding System (HCPCS) for claim adjudication and reimbursement.

CenCal Health will accept the uniform billing forms (CMS-1500 and UB-04).

The following are general claim submission guidelines. Claims not submitted in accordance with following requirements cannot be readily adjudicated, and most likely will be denied and returned to the provider for corrective action.

1. HCPCS and CPT Codes – Current HCPCS and CPT codes must be used when billing for medical services. CenCal Health will implement any changes in codes (e.g. new codes, deleted codes) effective for service dates on and after each January 1st.
2. Split Year Claims – For services that begin on or before December 31st but extend into January, split claim billing is required at calendar year end. This is necessary for CenCal Health to accurately track calendar year deductibles and co-payment maximums.
3. Modifiers – Modifiers should be used in accordance with CPT and HCPCS manuals to indicate the following:
 - A service or procedure requiring professional or technical component;
 - A service or procedure performed by more than one physician and/or in more than one location;
 - A service or procedure that increased or was reduced;
 - A service or procedure rendered more than once;
 - Partial procedure performed;
 - Adjunctive services;
 - Bilateral procedures;
 - Unusual events occurred
4. Professional and Technical Components – CenCal Health requires the use of modifier “26” when a physician’s service encompasses only the professional component of a medical procedure, and requires the use of modifier “TC” by a facility when their services only encompass the technical component of a medical procedure. If both the professional and technical components of a procedure are performed by a provider, no modifier is necessary.
5. Anesthesia Services – Consistent with industry guidelines, CenCal Health requires anesthesia service billings to conform to the practice of only using current CPT codes (00100 – 01999) with a physical status modifier (e.g. P1, P2P6).
6. Unlisted Procedure or Service – There may be services or procedures performed by physicians that are not found in CPT or HCPCS; therefore specific codes for reporting unlisted procedures have been designated in the CPT/HCPCS manuals. When an unlisted procedure code is billed, CenCal Health requires a report of the service(s) attached to the claim form.

7. Use HCPCS Level II codes when billing for injections and materials supplied by physicians that are over and above those usually included with an office visit or other service.
8. Multiple Surgery – Multiple surgery claims are priced based on the primary, secondary, and subsequent procedures. When multiple procedures are performed on the same date of service, the primary procedure will be determined according to the appropriate base fee schedule. All base allowable amounts will be evaluated for each line billed. The procedure with the highest dollar amount according to the current fee schedule will be considered as the primary procedure, and each additional procedure will be paid at 50% of the allowable, with the exception of additional procedures that are “add-on” or “modifier -51 exempt”, which are paid at the full allowable.

CenCal Health Allowable Amounts

CenCal Health’s standard allowable amount for published CPT and HCPCS codes are based on Medicare fee schedules developed and published by the Centers for Medicare & Medicaid Services (CMS). The fee schedules identified below can be assessed at www.cms.hhs.gov .

- Physician Fee Schedule – area 99 for Santa Barbara County
- Clinical Lab Fee Schedule – carrier 31146 for So. Calif.
- Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) Fee Schedule – for California.

Generally, at the beginning of the third quarter of each calendar year (July 1st), CenCal Health updates its base fee schedule allowable amounts to match the most recent Medicare fee schedule corresponding to the current calendar year. For a procedure code that is not a Medicare-covered service, and for which there is no defined Medicare rate, CenCal Health will establish an allowable amount based on an existing code which is similar in time and effort, or use a generally accepted industry standard to establish a rate.

Bundled Services

Under Medicare’s Resource Based Relative Value Scale (RBRVS) methodology used to establish Medicare rates, Medicare considers reimbursement for certain codes bundled regardless of the location of service and other codes bundled when the location of service is a physician’s office. These codes are considered as an integral part of or incident to some other service – even if billed alone. These codes are published by Medicare in the National Physician Fee Schedule Relative Value File with a Status Code “B” (regardless of location of service) or a Status Code “P” (location of service is physician’s office). This file can be accessed at www.cms.hhs.gov

Billing with Modifiers

CenCal Health attempts to recognize and use modifiers as outlined in the AMA CPT manual, as well as modifiers generally used with HCPCS codes. Issues

related to specific modifiers which may affect payment processing are outlined below.

Modifier 21 (Prolonged Evaluation and Management Services) – This modifier can only be used with E&M codes. CenCal Health considers this modifier to be informational only, and it has no effect on reimbursement.

Modifier 22 (Unusual Procedural Services) – This modifier is used when service(s) provided is greater than usually required for the listed procedure. CenCal Health requires clinical documentation when processing claims with this modifier. The operative or procedure document should clearly indicate the service provided was greater than what is usually required for the procedure. Before the claim is finalized for adjudication, it will undergo a manual review to determine that the use of the modifier was warranted. When CenCal Health accepts this modifier, 10% is added to the standard allowable amount for reimbursement.

Modifier 23 (Unusual Anesthesia) – This modifier is used when general anesthesia is administered in situations that typically would not require this level of anesthesia, or in situations in which local anesthesia might have been required, but would not be sufficient under the circumstances. This modifier should only be used on basic anesthesia procedure codes (00100 – 01999) and must be accompanied by both documentation and a cover letter from the physician explaining the need for general anesthesia. When CenCal Health accepts this modifier, the standard allowable amount for reimbursement will apply; otherwise without modifier 23 the non-typical anesthesia will not be separately reimbursed.

Modifier 24 (Unrelated E&M Service By Same Physician) – This modifier is used to indicate an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure (e.g. a different diagnosis code is reported with the E&M code identifying the service as unrelated to the original procedure). Only CPT codes 92012 – 92014 and 99201 – 99499 may be billed with this modifier. E&M services provided in a normal postoperative period are reimbursed and included in the global Medicare rate for surgeries and are therefore not paid separately.

Modifier 25 (Significant & Separate E&M Service by Same Physician on the Same Day of the Procedure) – This modifier is used when an E&M service is separate from that required for the procedure and a clearly documented, distinct and significantly identifiable service was rendered. When CenCal Health accepts this modifier, reimbursement will be at the standard allowable amount.

Modifier 26 (Professional Component) – This modifier is used in instances during which a physician provides the interpretation of the diagnostic test/study performed. The interpretation of the test/study has to be separate, distinct, identifiable, written, and signed. Reimbursement on procedure codes billed with this modifier is paid at the standard allowable amount for the professional component.

Modifier 32 (Mandated Services) – This modifier is used for services related to mandated consultation and/or related services (e.g. governmental, legislative, or regulatory requirements). CenCal Health considers this modifier to be informational only, and it has no effect on reimbursement.

Modifier 47 (Anesthesia by Surgeon) – This modifier is used when the anesthesia is administered by the operating physician and denotes the use of regional or general anesthesia. CPT codes for use with this modifier are 10021 – 69990. CenCal Health considers this modifier informational only, and it has no effect on reimbursement.

Modifier 50 (Bilateral Procedure) – This modifier is used when the exact same service/code is reported for each bilateral anatomical site. Report the bilateral procedures with one procedure code appended with modifier “50”. Do not use this modifier when reporting procedure codes that are primarily bilateral by definition (e.g. lengthening of hamstring tendon; multiple, bilateral). Bilateral procedures should be reported as a single line item using the appropriate procedure code, CPT or HCPCS modifier and one unit. Reimbursement on procedure codes billed with this modifier is paid at 150% of the standard allowable amount.

Modifier 51 (Multiple Procedures) – This modifier is used when multiple procedures, other than E&M services, are performed at the same session by the same provider. The additional procedure(s) or service(s) may be identified by appending modifier “51” to the additional procedure or service code(s). This modifier may not be appended to designated add-on codes and codes noted as exempt from modifier -51 (as identified and noted within the AMA’s CPT manual). Report multiple surgery procedures (procedures secondary to the primary surgery procedure) on the same claim using this modifier. Reimbursement on procedure codes billed with this modifier is paid at 50% of the standard allowable amount.

Modifier 52 (Reduced Services) – This modifier is used under certain circumstances when a service or procedure is partially reduced or eliminated at the physician’s discretion. This provides a means of reporting reduced services without disturbing the identification of the basic service. This modifier should not be used for terminated procedures, but rather is intended for procedures which accomplish some result, but less than expected for the procedure. Reimbursement on procedure codes billed with this modifier is paid at 25% of the standard allowable amount.

Modifier 53 (Discontinued Procedure) – This modifier is used under certain circumstances when the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. When a procedure is prematurely terminated or reduced due to physician election, prior to induction of anesthesia, the correct modifier to report this would be “52.” Reimbursement on procedure codes billed with this modifier is paid at 25% of the standard allowable amount.

Modifier 54 (Surgical Care Only) – This modifier is used when one physician performs a surgical procedure and another provides the preoperative and/or postoperative management services. This modifier may only be used with surgical codes. To use modifier “54”, there must be an agreement for the transfer of care between physicians. This modifier is an indicator that multiple physicians are involved with the patient’s surgical care. Each physician must report the service provided so that the correct reimbursement will be made for each claim submission. Total reimbursement for a patient’s surgical care is limited to the same total amount as would have been paid if one physician provided all the care, regardless of the number of caregivers. Reimbursement on procedure codes billed with this modifier is paid at 60% of the standard allowable amount.

Modifier 55 (Postoperative Management Only) – This modifier is used when one physician performs the postoperative management and another physician has performed the surgical procedure, such as when a physician does not perform the surgery but does provide a portion of the postoperative care. This modifier may only be used with surgical codes. Each physician must report the service provided so that the correct reimbursement will be made for each claim submission. Total reimbursement for a patient’s surgical care is limited to the same total amount as would have been paid if one physician provided all the care, regardless of the number of caregivers. Reimbursement on procedure codes billed with this modifier is paid at 20% of the standard allowable amount.

Modifier 56 (Preoperative Management Only) – This modifier is used when one physician performs preoperative care and evaluation, and another physician performs the surgical procedure. This modifier may only be used with surgical codes. Each physician must report the service provided so that the correct reimbursement will be made for each claim submission. Total reimbursement for a patient’s surgical care is limited to the same total amount as would have been paid if one physician provided all the care, regardless of the number of caregivers. Reimbursement on procedure codes billed with this modifier is paid at 20% of the standard allowable amount.

Modifier 57 (Decision for Surgery) – This modifier is used with an evaluation and management service that resulted in the initial decision to perform a surgery. Modifier “57” is not a surgical code modifier, but should only be appended to E&M or ophthalmologic service codes (92012 and 92014). CenCal Health considers this modifier informational only, and it has no effect on reimbursement.

Modifier 58 (Staged or Related Procedure or Service by the Same Physician During the Postoperative Period) – This modifier is used to a physician may need to indicate the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. These circumstances may be reported by adding modifier “58” to the staged or related procedure. Billing for postoperative complications treated in the physician’s office are considered part of Medicare’s global surgical rate and are therefore not paid separately. This

modifier is not used to report the treatment of a problem (use modifier “78” instead) that requires a return to the operating room. Use of this modifier on a claim will entail medical review by CenCal Health for appropriateness. When CenCal Health accepts this modifier, it is considered informational only, and it has no effect on reimbursement for the procedure code.

Modifier 59 (Distinct Procedural Service) – This modifier is used when a physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier “59” is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session, patient encounter, or when billing a combination of codes that would normally not be billed together. This modifier may indicate that the ordinarily bundled code represents a service done at a different anatomic site or at a different session on the same date. This modifier may not be used with E&M codes.

Modifier 62 (Two Surgeons) – This modifier is used when two surgeons work together as primary surgeons performing distinct part(s) of a procedure. Each surgeon should report his/her distinct operative work by adding modifier “62” to the procedure code and each surgeon should report the co-surgery once using the same procedure code. Modifier “62” should only be used when the individual skills of physicians with different specialties are required to perform surgery on the patient during the same operative session because of the complex nature of the procedure(s) and/or the patient’s condition. If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services should be reported using separate procedure code(s) with modifier “80” or modifier “82” added, as appropriate. Additional documentation with the claim submissions using modifier “62” is required. Claims for these procedures must include an operative report that supports the need for co-surgeons. If the surgical procedures performed by each physician can be clearly identified, and each surgeon’s role is explicitly described within the operative report, then only one operative report is necessary. Otherwise, an operative report dictated by each surgeon is required. If the documentation supports the need for co-surgeons, payment for each physician will be made at the lower of the billed amount or 62.5% of the standard allowable amount.

Modifier 63 (Procedure Performed on Infants Less Than 4kg) – This modifier is used when a procedure is performed on an infant or neonate weighing less than 4kg (8.818 lbs), and only applies to surgical codes 20000 – 69990. CenCal Health considers this modifier informational only, and it has no effect on reimbursement.

Modifier 66 (Surgical Team) – This modifier is used with highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, and various types of complex equipment) are carried out under the surgical team concept. Such circumstances should be identified by each participating physician with the addition of modifier “66” to the basic procedure code used

for reporting purposes. If surgery is billed with this modifier, documentation is required that supports the medical necessity for a surgical team. When CenCal Health accepts this modifier, each physician billing for the reported procedure(s) will be reimbursed at the standard allowable amount; otherwise reimbursement will only be paid to the primary surgeon.

Modifier 73 (Discontinued Outpatient Hospital/Ambulatory Surgery Center (ACS) Procedure Prior to Administration of Anesthesia) – This modifier can only be reported by ASC’s and hospital facilities. Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical procedure or diagnostic procedure subsequent to the patient’s surgical preparation, but prior to the administration of anesthesia. Under these circumstances, the intended service that is prepared for but cancelled should be reported by its usual procedure code and the addition of modifier “73.” Reimbursement on procedure codes billed with this modifier is paid at 20% of the standard allowable amount.

Modifier 74 (Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) procedure After Administration of Anesthesia) – This modifier can only be reported by ASC’s and hospital facilities. Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical procedure or diagnostic procedure after the administration of anesthesia. Under these circumstances, the procedure started, but terminated, can be reported by its usual procedure code and the addition of modifier “74.” Reimbursement on procedure codes billed with this modifier is paid at 25% of the standard allowable amount.

Modifier 76 (Repeat Procedure by Same Physician) – This modifier is used when a physician needs to indicate that a procedure or service was repeated subsequent to the original procedure or service, that it was necessary and that it does not represent a duplicate bill. Additional documentation is required when reporting this modifier in order to provide the medical necessity for the repeat procedure. When CenCal Health accepts this modifier, reimbursement is made at the standard allowable amount.

Modifier 77 (Repeat Procedure by Another Physician) – This modifier is used when a physician needs to indicate that a basic procedure or service performed by another physician had to be repeated. This modifier is appended to a CPT code when the same service that was already performed by another physician is repeated by a different physician; usually on the same date of service. Modifier “77” does not guarantee reimbursement of the repeated service as other limitations still apply, such as medical necessity and quantity/time restrictions.

Modifier 78 (Return to Operating Room for a Related Procedure During the Postoperative Period) – This modifier is used when a physician needs to indicate that another procedure was performed during the postoperative period of the initial procedure. Modifier “78” is added to the procedure code when the subsequent procedure is related to the first and requires the use of an operating room. Failure to use this modifier when appropriate may result in denial of the subsequent surgery for lack of prior authorization.

Modifier 79 (Unrelated Procedure or Service by the Same Physician During the Postoperative Period) – This modifier is used when a physician needs to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. Modifier “79” is added to the procedure or service when it is unrelated to the original service or procedure, and a different diagnosis code should be reported.

Modifier 80 (Assistant Surgeon) – This modifier is added to the usual surgical procedure code(s) for the assistant-at-surgery services. Reimbursement is only paid on select surgical procedures for which Medicare has assigned an assistant surgery indicator of “1” or “2.” When CenCal Health accepts this modifier, reimbursement will be made at 20% of the standard allowable amount for the assistant surgeon services.

Modifier 82 (Assistant Surgeon (When a Qualified Resident Is Not Available)) – This modifier is used to indicate a surgical assist when a qualified resident is not available. When reporting modifier “82”, the assistant must provide documentation (certification) stating a qualified resident was not available for this procedure and why the resident was not available. When CenCal Health accepts this modifier, reimbursement will be made at 16% of the standard allowable amount for the assistant surgeon services.

Modifier 90 (Reference (Outside) Laboratory) – This modifier is used when laboratory procedures are performed by a party other than the treating or reporting physician. By appending modifier “90” to laboratory codes, the physician office is indicating the procedures were actually performed by an outside laboratory. Modifier “90” is only used with codes 80048 – 89399.

Modifier 91 (Repeat Clinical Diagnostic Laboratory Test) – This modifier is used for instances when in the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier should not be used when other code(s) describe a series of test results (e.g. glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

Modifier NU (New Equipment Purchase) – This modifier is used to identify the purchase of applicable durable medical equipment, prosthetics, orthotics, and certain medical supplies. The use of this modifier is necessary to ensure proper reimbursement under the Medicare DMEPOS Fee Schedule.

Modifier RR (Rental of DME) – This modifier is used to identify a DME item that is being rented, as opposed to purchased. The use of this modifier is necessary to ensure proper reimbursement under the Medicare DMEPOS Fee Schedule.

Modifier RP (Repair of Equipment, Orthotic, or Prosthetic Device) – This modifier is used to indicate repair of an equipment or device. Billing should be for code corresponding to the part, followed by the modifier RP.

Below are common HCPCS modifiers and include but are not limited to:

A1 – Dressing for one wound	A2 – Dressing for two wounds
A3 – Dressing for three wounds	A4 – Dressing for four wounds
A5 – Dressing for five wounds	A6 – Dressing for six wounds
A7 – Dressing for seven wounds	A8 – Dressing for eight wounds
A9 – Dressing for nine or more wounds	E1 – Upper left, eyelid
E2 – Lower left, eyelid	E3 – Upper right, eyelid
E4 – Lower right, eyelid	F1 – Left hand, second digit
F2 – Left hand, third digit	F3 – Left hand, fourth digit
F4 – Left hand, fifth digit	F5 – Right hand, thumb
F6 – Right hand, second digit	F7 – Right hand, third digit
F8 – Right hand, fourth digit	F9 – Right hand, fifth digit
FA – Left hand, thumb	SG – Ambulatory surgical center (ASC)
	LT – Left side (of body)
	RT – Right side (of body)