Class Action Settlement Recap

Enhancements to Claim Payment Policy, Processing and Payment Disclosure, and an Appeals Process for Class Action Settlement Providers

The following enhancements are effective for providers who agreed to the terms of the court-approved class action settlement ("Settlement Providers"), for Gregg v. AmeriHealth et al, Good v. AmeriHealth et al. and Pennsylvania Orthopaedic Society v. AmeriHealth et al:

- Improving disclosure to Settlement Providers, including standard fee schedules, changes to schedules, and medical and payment policies that may affect payment/reimbursement of services which will be made available online via NaviNet, our secure provider portal.

- Changing claims processing for Settlement Providers on the following: selected modifiers (-25, -50, -51, -59, -62, -66, -80, -81, -82, -RT, -LT); multiple surgical procedures; radiological guidance during a procedure; and certain Current Procedural Terminology (CPT)* code-level designations (Modifier -51 Exempt, Separate Procedure and Add-on codes).

- Introducing a two-level, formal claims appeal process for Settlement Providers.

Certain of these enhancements are currently available. Others will be announced as they become available.

Claim Payment Policy Note
This policy, in whole or in part, is part of the class action settlement with providers. Please note that providers who opted out of the class action settlement may not be entitled to certain claim payment policy changes. Therefore, any payments made pursuant to such policy changes to providers who opted out of the class action settlement are subject to retroactive adjustments.

Modifiers
Clear Claim Connection
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Future Notices

The combined settlement for Gregg v. AmeriHealth et al, Good v. AmeriHealth et al, and Pennsylvania Orthopaedic Society v. AmeriHealth et al includes claims processing enhancements for selected modifiers. These modifiers are already operational. Listed below is a synopsis of each modifier. For a more detailed explanation, please click on the link of the desired modifier.

Modifier -25
Modifier -25 is used to indicate a significant, separately identifiable Evaluation and Management service by the same physician on the same day of the procedure or other service.

Modifier -50
Modifier -50 is used to indicate bilateral procedures which are procedures performed on identical sites, aspects or organs on both sides of the body during the same operative session or on the same day.

Modifier -51
Modifier -51 is used to indicate when multiple procedures, other than evaluation and management services, are performed during the same session by the same provider for the same patient.

Modifier -51 Exempt
Modifier -51 Exempt codes are procedure codes that are exempt or free from being reported with Modifier 51 because the reduction of work values has already been accomplished and reflected in the reimbursement.

Modifier -59
Modifier -59 is a distinct procedural service modifier which is used to indicate procedures that are not normally reported together, but are appropriate under the circumstances.

Modifier -62
Modifier -62 is a co-surgery modifier which is used to indicate when two primary surgeons, typically of different specialties, act as primary surgeon during the same operative procedure because of the complexity of the procedure and/or the patient's condition.

Modifier -66
Modifier -66 is used to indicate a procedure that requires a team of surgeons—more than two surgeons of different specialties—to perform various portions of a complicated surgical procedure.

Modifiers -80, -81, -82
Modifiers -80, -81 and -82 are assistant surgery modifiers that are used to indicate the need for both a primary and assistant surgeon during a surgical procedure because of the procedure's complexity and/or time requirement. The assistant surgeon is one who actively supports and assists the primary surgeon during the procedure.

Modifiers -RT, -LT
Modifiers -RT and -LT are used to indicate the side of the body where a service is performed when that service has the potential to be performed on one or both sides of the body or on paired organs, such as arms, ears, nostrils.

Add-on Codes
Add-on codes are considered eligible only if the primary procedure is a covered service. Add-on codes can be found in sections of the CPT book other than the Surgery section. Additionally, add-

on codes are exempt from multiple surgical reduction guidelines. Add-on codes should not be reported with Modifier -51.

Radiologic Guidance of a Procedure

The reimbursement methodologies applied to claims processing of radiologic guidance and/or supervision and interpretation of a procedure have been revised.

Modifier -25 (April 2005 Update)

Modifier -25 (as defined by the American Medical Association [AMA]; CPT) is used to denote a significant, separately identifiable Evaluation and Management (E/M) service by the same physician on the same day of the procedure or other service. On the day of a minor surgical procedure (zero- or 10-day global period), the physician may need to indicate that the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M procedure may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting the E/M services on the same date. The physician should maintain supportive documentation in the patient's medical records indicating that a separate and distinct medical condition was treated on the same day that a procedure was performed. This distinction may be reported by adding Modifier -25 to the appropriate level of E/M service.

It is **not** appropriate to report Modifier -25 in the following circumstances because either a more appropriate modifier exists to report the service or use of Modifier -25 as described above is not applicable to the reported service:

- Appended to an E/M service that resulted in the decision to perform major surgery (90-day global period).
- When a physician performs ventilation management in addition to an E/M service.
- When an E/M service is performed on a different day than the procedure.
- Appended to a surgical procedure code since this modifier is used to explain the special circumstance of providing the E/M service on the same day as a procedure.
- When the patient's trip to the office was strictly for the minor procedure since reimbursement for the procedure includes the related pre-service work.

Modifier -50 (October 2005 Update)

Modifier -50 is used to denote bilateral procedures which are procedures performed on identical sites, aspects, or organs on both sides of the body during the same operative session or on the same day. The Centers for Medicare & Medicaid Services (CMS) has defined codes that are subject to the bilateral payment rule, i.e., reimbursement at 150% of the fee schedule allowance, which accounts for multiple surgery adjustments when bilateral surgical procedures are performed. However, please note that bilateral surgical procedures performed in conjunction with other surgical procedures may still be subject to multiple surgery reduction guidelines.

Certain other procedures are not subject to the 150% bilateral payment rule but may still be performed bilaterally. Payment for these procedures is based on 100% of the fee schedule allowance for each side as these are typically non-surgical in nature and would therefore not be subject to multiple surgery adjustment when performed bilaterally. Reimbursement consideration for services reported with modifier -50 is contingent upon eligibility, benefits, exclusions, precertification/referral requirements, provider contracts and applicable policies. Since a code appended with modifier -50 already describes a bilateral service, it is not appropriate to report multiple units in the *units* field on the claim. Claims reporting services with modifier -50 and more than one (1) unit will be denied by the Company stating “Multiple units not appropriate with modifier -50.”

CMS utilizes a payment methodology by applying bilateral payment indicators to procedure codes that, when submitted in combination with modifier -50, will allow or restrict payment consideration. The table below identifies and describes each indicator:

CMS Indicator & Description	Outcome for code/Modifier -50 combination
(0) Bilateral payment is inappropriate because of (a) physiology or anatomy or (b) the code descriptor indicates unilateral and another code for bilateral already exists. 150% payment adjustment does not apply.	Invalid procedure code/modifier combination.
(1) Bilateral payment is appropriate. If code is billed with the bilateral modifier -50, payment will be based on 150% of the fee schedule amount for a single procedure as defined by CMS bilateral payment rule.	Eligible for 150% reimbursement consideration. Eligibility benefits, exclusions, precertification/referral requirements, provider contracts and applicable policies still apply.
(2) Bilateral payment is inappropriate because (a) the code descriptor specifically states bilateral; (b) the code descriptor states procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure. 150% payment adjustment does not apply.	Invalid procedure code/modifier combination.

(3) Bilateral payment is inappropriate. If code is billed with the bilateral modifier -50, payment will be based on 100% of the fee schedule for each procedure performed as these are not subject to the bilateral payment rule but may be performed bilaterally.	Eligible for 200% reimbursement consideration. Eligibility benefits, exclusions, precertification/referral requirements, provider contracts and applicable policies still apply.
(9) Concept does not apply.	Invalid procedure code/modifier combination.

Modifier -51 (April 2005 Update)

Modifier -51 (as defined by the AMA CPT) is used to denote when multiple procedures—other than evaluation and management services—are performed at the same session by the same provider for the same patient. The primary procedure or service may be reported as listed and the additional procedure(s) or service(s) may be identified by appending Modifier -51. It is appropriate to report Modifier -51 to identify the secondary procedure or when multiple procedures are performed during a single operative session regardless of whether the procedures were through the same incision or performed at a different anatomical site. It is **not** appropriate to report Modifier -51 in the following circumstances:

- When a procedure code is designated by CPT as an “add-on” code. Add-on codes are always performed in addition to the primary procedure and cannot be performed alone.
- When a procedure code is designated by CPT as Modifier -51 exempt.
- When a procedure is considered a component or incidental to a primary procedure. Any intra-operative services, incidental surgeries, or components of major surgeries are not separately billable.
- When two or more physicians each perform distinctly different, unrelated procedures on the same patient, on the same day.

Modifier -51 Exempt (December 2005 Update)

Recently, AmeriHealth revised the reimbursement methodologies regarding procedure codes that are exempt from being reported with Modifier -51 (multiple procedures).

Modifier -51 is used when multiple procedures other than evaluation and management (E&M) services are performed at the same session by the same provider. Surgical services reported with modifier -51 are subject to multiple surgical reduction guidelines.

As defined by the American Medical Association (AMA), Current Procedural Terminology (CPT)*, modifier -51 exempt codes are procedure codes that are exempt or free from being reported with modifier -51 because reduction of the work values has already been accommodated and reflected in the reimbursement. Multiple surgery reduction logic is not applied to modifier -51 exempt procedure codes.

Modifier -51 Exempt codes:

- Should not be reported with modifier -51 and
- Should not have multiple surgery reduction logic applied when the modifier -51 exempt procedure codes are eligible and reported with other surgical services.

Modifier -59 (December 2004 Update)

In December 2003, AmeriHealth and its affiliates revised the reimbursement methodologies regarding Distinct Procedural Service Modifier-59.When appropriate, this modifier should be appended only to those services designated by the American Medical Association (AMA) Current Procedural Terminology (CPT) as “separate procedures.”

Services defined by CPT as “separate procedures” are commonly performed as an integral component of another service. Under most circumstances, they should not be reported in addition to the code for the total procedure unless carried out independently or considered to be unrelated and/or distinct from the other procedure(s) performed.

Modifier-59 is appended to “separate procedures” to describe unusual circumstances for which the provider may need to indicate that the procedure is not considered a component of another procedure but is actually an independent and unrelated service. Modifier-59 is used to identify procedures that are not normally reported together, but are appropriate under the circumstances.

When the “separate procedure” performed meets medical necessity and is a valid and eligible procedure code, the following circumstances are appropriate in appending modifier-59:

- Services are performed on the same date but during a different session or patient encounter OR
- Services are performed at the same session but at a different anatomic site or organ system OR
- Services are performed on different lesions, through a separate incision/excision or for a separate injury (or area of injuries in extensive injuries) AND
- Services performed are procedures not ordinarily encountered or performed on the same day by the same physician AND
- There is no other modifier that describes the situation more accurately.

It is not appropriate, however, to report modifier-59 in the following circumstances, because either a more appropriate modifier exists to describe the service or the concept of using modifier-59 as described above is not applicable to the reported service:

- Appending modifier-59 to E/M codes.
- Using modifier-59 as a replacement for modifiers 24, 25, 78, or 79.
- Using modifier-59 when another modifier best describes the distinct service.
- Reporting modifier-59 with modifier-51 on the same CPT code.

Billing providers should verify that the medical record clearly supports the appropriate use of modifier-59 and be able to provide documentation upon request.

Claims submitted with modifier-59 are subject to post-payment clinical review and potential retractions for inappropriate use.

Modifier -62 (January 2006 Update)

AmeriHealth has enhanced its processing system to apply the Centers for Medicare & Medicaid Services (CMS) payment methodology for co-surgery modifier -62 as outlined in the Medicare Physician Fee Schedule Database on the CMS website.*

Co-surgery modifier -62 is used to denote when two surgeons act as primary surgeons during the same operative procedure or session for the same individual because of the complexity of the procedure and/or the patient's condition. The co-surgeons are typically of different specialties and perform consecutive or overlapping parts of the same procedure or simultaneous procedures during the same session with one of the following exceptions for co-surgeons of the same specialty:

- Each surgeon must perform a distinct part of the surgical procedure that requires the distinct skills of each surgeon.
- Each surgeon performs the same procedure(s) simultaneously for different regions/organs (e.g., bilateral lung reduction, bilateral knee replacements). In such cases, the operative report must reflect the necessity of two primary surgeons with the same skills.

Each of the two surgeons should submit the same procedure code that represents the entire surgical procedure appended with modifier -62.

The table below identifies and describes the final processing outcome that is associated with each indicator; however, reimbursement consideration for services that are reported with modifier -62 are also contingent upon eligibility, benefits, exclusions, precertification/referral requirements, provider contracts, and applicable policies. Payment for these procedures is based on 62.5% of the fee schedule allowance for the service. Please note that co-surgery services that are performed in conjunction with other co-surgery services are subject to multiple surgery reduction guidelines.

CMS utilizes a payment methodology for these types of services by applying co-surgery payment indicators to procedure codes that, when submitted in combination with modifier -62, will allow or restrict payment consideration:

CMS Indicator & Description	Outcome for code/modifier -62
(0) Co-surgery payment is inappropriate.	Ineligible for co-surgery reimbursement consideration
(1) Co-surgery payment is inappropriate unless supporting documentation establishes medical necessity.	Ineligible for co-surgery; additional consideration determined on an appeal basis only.
(2) Co-surgery payment is appropriate.	Eligible for co-surgery reimbursement consideration.
(9) Concept does not apply.	Invalid procedure/modifier code combination.

It is inappropriate to report modifier -62 when one surgeon acts as an assistant to the primary surgeon or when more than two surgeons act as primary surgeons during the same operative session.

Medical records, operative reports, and/or other supporting documentation should not be appended to the claim or submitted to the Company unless specifically requested by the Company.

Modifier -66 (December 2005 Update)

Beginning in January 2006, AmeriHealth will enhance its processing system to apply the Centers for Medicare & Medicaid Services (CMS) payment methodology for Surgical Team modifier -66 as outlined in their Medicare Physician Fee Schedule Database found on the CMS website.**

Surgical team modifier -66 is used to denote a procedure that requires a team of surgeons (more than two surgeons of different specialties) to perform various portions of a complicated surgical procedure. Each surgeon participating in the team surgery is a member of the surgical team. Participation in team surgery by a surgeon performing a surgical procedure is indicated by appending modifier -66 to the procedure code for that service.

Prior to adjudication, reimbursement consideration for services reported with modifier -66 will be reviewed for medical necessity and documentation completion. All team surgery claims require the submission of a completed surgical team documentation form. When the required documentation is unavailable or incomplete, claims will be denied. Please refer to the enclosed *Surgical Team Documentation* form.

The table below identifies and describes the processing outcome associated with each indicator. However, reimbursement is also contingent upon eligibility, benefits, exclusions, precertification/ referral requirements, provider contracts and applicable policies.

CMS utilizes a payment methodology for these types of services by applying team surgery payment indicators to procedure codes that, when submitted in combination with modifier -66, will allow or restrict payment consideration:

CMS Indicator & Description	Outcome for code/modifier -66 combination
(0) Team surgery payment is inappropriate.	Ineligible for team surgery reimbursement consideration.
(1) Team surgery payment is inappropriate unless supporting documentation establishes medical necessity.	Reimbursement consideration determined upon receipt and review of medical necessity and supporting documentation.
(2) Team surgery payment is appropriate.	Reimbursement consideration determined upon receipt and review of medical necessity and supporting documentation.
(9) Concept does not apply.	Invalid procedure/modifier code combination.

When determined as eligible by AmeriHealth for surgical team services, multiple surgical procedures reported by each surgeon are subject to multiple surgery reduction guidelines.

Medical records, operative reports, the surgical team documentation form and/or other supporting documentation should be submitted at the time of claim submission to the mailing address shown on the surgical team documentation form. The surgical team documentation form is enclosed with this mailing.

Modifiers -80, -81, -82 (January 2006 Update)

AmeriHealth has enhanced its processing system to apply the Centers for Medicare & Medicaid Services (CMS) payment methodology for modifiers that represent assistant surgery [Assistant Surgeon -80; Minimum Assistant Surgeon -81; Assistant Surgeon (when qualified resident surgeon not available) -82] as outlined in the Medicare Physician Fee Schedule Database on the CMS website.*

Assistant surgery modifiers -80, -81, and -82 are used to denote surgical procedures that require both a primary and an assistant surgeon because of the complexity and/or time requirement of the surgery. An assistant surgeon is a surgeon who actively assists and supports a primary surgeon during a surgical procedure. Both primary and assistant surgeons should report the same procedure code. The assistant surgeon should append the most appropriate assistant surgery modifier based on the narrative.

The table below identifies and describes the intended processing outcome that is associated with each indicator. However, reimbursement consideration for services that are reported with modifiers -80, -81, and/or -82 are also contingent upon eligibility, benefits, exclusions, precertification/referral requirements, provider contracts, and/or applicable policies. Payment for these procedures is based on 20% of the fee schedule allowance for the surgical service. Please note that assistant surgical services that are performed in conjunction with other surgical services may be subject to multiple surgery reduction guidelines.

CMS utilizes a payment methodology for these types of services by applying assistant surgery payment indicators to procedure codes that, when submitted in combination with modifiers -80, -81, and/or -82, will allow or restrict payment consideration:

CMS Indicator & Description	Outcome for code/modifier -80, -81, and/or -82 combination
(0) Assistant surgery payment is inappropriate unless documentation supports medical necessity.	Ineligible for assistant surgery; additional consideration determined on an appeal basis only.
(1) Assistant surgery payment is inappropriate.	Ineligible for assistant surgery reimbursement consideration.
(2) Assistant surgery payment is appropriate.	Eligible for assistant surgery reimbursement consideration.
(9) Concept does not apply.	Invalid procedure/modifier code combination.

Medical records, operative reports, and/or other supporting documentation should **not** be appended to the claim or submitted to the Company unless specifically requested by the Company.

Modifiers –RT, -LT (April 2005 Update)

Modifiers -RT and -LT (as defined by the Centers for Medicare and Medicaid Services [CMS] Healthcare Common Procedure Coding System [HCPCS]) are used to denote the side of the body (right or left) where a service is performed when that service has the potential to be performed on one or both sides.

The Modifiers -RT and -LT are appropriately appended to CPT or HCPCS codes that identify procedures which can be performed on paired organs, e.g., arms, ears, eyes, nostrils, kidneys, lungs, and ovaries.

It is **not** appropriate to append Modifiers -RT and -LT to a procedure that is identified in its narrative description as a bilateral service.

Add-on Codes

As defined by the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel, add-on codes describe services/procedures that are always performed in addition to the primary service/procedure. They describe additional intraservice work associated with the primary procedure. Intraservice work varies on the basis of the type of service/procedure provided and the location where the service is provided.

The AMA CPT Editorial Panel uses the following criteria to determine if a code should be designated as an add-on code:

- The service/procedure can never stand alone and must be reported in conjunction with another service/procedure.
- The service/procedure is commonly carried out in addition to the primary service/procedure performed.
- The same physician must perform the service/procedure.
- The add-on code describes additional anatomic sites where the same procedure is performed.
- The add-on code describes a special circumstance under which a specific service/procedure is performed in conjunction with the primary service/procedure.
- The add-on code describes an additional segment of time in a time-based code.

Add-on codes are considered eligible only if the primary procedure is a covered service. Add-on codes can be found in section of the CPT book other than the Surgery section. Additionally, add-on codes are exempt from multiple surgical reduction guidelines. Add-on codes should not be reported with modifier -51.

Radiologic Guidance of a Procedure (December 2005 Update)

AmeriHealth revised the reimbursement methodologies applied to claims processing of radiologic guidance and/or supervision and interpretation of a procedure.

Radiologic guidance and/or supervision and interpretation is performed by either the same professional provider who performs the surgical procedure or a different professional provider. Radiologic guidance and/or supervision and interpretation of a procedure that is performed in conjunction with a covered procedure is eligible for separate reimbursement consideration by AmeriHealth.

When the same provider performs and reports both the radiologic **and** the diagnostic or therapeutic procedures, both procedures are eligible for reimbursement consideration to the provider. However, all of the following requirements must be met:

- Both the radiologic guidance and/or supervision and interpretation service **and** the procedure for which it is performed must be covered for the radiologic guidance and/or supervision and interpretation to be eligible for separate reimbursement consideration.
- Documentation in the medical record must reflect the radiologic guidance and/or supervision and interpretation procedure(s) performed by the physician. The medical record must be available to AmeriHealth upon request. Providers should not submit medical records to AmeriHealth unless otherwise requested.

This information supersedes the information in the policy addressing Interventional Radiology.

AmeriHealth Implements Clear Claim Connection™ for Provider Class Action Settlement Providers

On December 16, 2005, AmeriHealth introduced McKesson's Clear Claim Connection™ to providers who agreed to the court-approved Class Action Settlement in the consolidated cases of Gregg, et al. v. AmeriHealth, et al., Good v. AmeriHealth, et al. and Pennsylvania Orthopaedic Society v. AmeriHealth, et al. Clear Claim Connection™ is a tool that explains how AmeriHealth applies procedure code combination logic; it is available via NaviNet℠, our online provider portal. Access to Clear Claim Connection™ is gained from Plan Central and is password protected (initial use only).

The web-based Clear Claim Connection™ is designed to offer information about how AmeriHealth evaluates certain procedure code combinations during professional claims processing. The information provided in Clear Claim Connection™ only speaks to the clinical relationship logic based within ClaimCheck®, as customized by AmeriHealth. Clear Claim Connection™ supplements the ClaimCheck® system:

- By decreasing time spent researching claims denials due to inappropriate procedure code combinations.
- By providing easy access to rationales for procedure codes that are clinically inappropriate to be submitted together.
- By assisting providers in reporting appropriate procedure code combinations.

Easy Access Online To New Fee Schedule Information Through NaviNet Provider Portal

Beginning December 15, 2006, our fee schedule rates became available to all participating professional providers, via a new Fee Schedule Inquiry Tool accessible through NaviNet's Provider Portal. The fee schedule allowed amounts reflect the provider's specific contract rates for his or her written contractual agreement with AmeriHealth.

This information provides physicians with online access to information about allowed amounts for contractual procedures prior to claim and benefit adjudication, and therefore does not provide the actual payment a provider may receive for a specific submitted claim. The Fee Schedule Inquiry Tool does not include rates for capitated services or special contracting agreements. In addition, facilities and ancillary providers, and their fee schedule rates, are not accessible through this tool.

All professional provider offices that have access to the NaviNet provider portal can access the Fee Schedule Inquiry Tool through our Plan Central screens.