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# Billing & Reimbursement for Hospital Services

## Overview

The purpose of this section is to describe the specific billing requirements for services rendered in the hospital setting and to supplement the *General Information* section.

## Inpatient Services

Hospitals will be reimbursed for Inpatient Services according to the terms of their Agreement.

- **Reimbursement rates.** The rate of payment is determined by the effective date of a Member's Inpatient Admission and applies for the length of the Admission (i.e., any rate change under the contract during the Member's stay will not apply).
- **Services prior to admission.** Preadmission testing (PAT) is considered a component of an Inpatient stay. Charges for PAT are to be included on the Inpatient claim.
- **Discharge day.** There is no reimbursement for the day of discharge.

## Maternity Admissions

- **Normal delivery claims.** When billing newborn baby charges with revenue codes 0170, 0171, 0172, or 0179, the maternity charges for mother and baby must be combined on the same UB-04 form. Neonatal Intensive Care Unit (NICU) charges should also be added to the mother's Inpatient bill using revenue code 0173 or 0174.
- **"Detained" baby claims.** When the baby remains hospitalized after the mother is discharged (detained baby), a new Admission with its own Preapproval/Precertification is required. The detained baby's Admission date is the same date as the mother's discharge date. A separate claim for the detained baby's Admission is required.

## Outpatient Services

You will be reimbursed for Outpatient Services according to your facility's Agreement. Please use the chart that follows along with the Correlation Table when determining which revenue, CPT and HCPCS® codes to use for billing.

Correlation Tables are emailed quarterly and may be viewed at [www.amerihealth.com/providers/communications/bulletins](http://www.amerihealth.com/providers/communications/bulletins) by selecting the appropriate ancillary or facility bulletin.

Service	Revenue code	CPT and HCPCS required?
Audiology	0470, 0471, 0472, 0479	Yes
Cardiology	0480, 0482, 0483, 0489, 0730-0732, 0739, 0921 <b>EKG procedure codes:</b> 93000, 93005, 93010	Yes
Chemotherapy	0331, 0332, 0335	Yes
Diabetic education	0942	Yes
Dialysis*	0820, 0821, 0829, 0830, 0835, 0839, 0840, 0841, 0845, 0849, 0850, 0851, 0855, 0859	Yes

## Billing & Reimbursement for Hospital Services

Emergency services	0450, 0451, 0452, 0456, 0459 <b>Critical care:</b> 99291	Yes
Gastroenterology	0750 or 0759	Yes
Laboratory services	0300-0307, 0309-0312, 0314, 0319, 0923, 0925	Yes
Sleep study (neurology)	0740 or 0749	Yes
Nutrition therapy services (for Members with a diagnosis of either diabetes or end-stage renal disease)	0949 97802 – medical nutrition therapy; initial assessment 97803 – reassessment and intervention, individual 97804 – group (two or more)	Yes
Observation services	0762	No
Outpatient surgery	<b>Category M:</b> 0360, 0361, 0362, 0367, 0369, 0490 <b>Category 1-8:</b> 0360, 0361, 0362, 0367, 0369, 0490 <b>Category 9:</b> 0481 or 0499	Yes
Outpatient implantable devices	Please refer to contract	When applicable
Pharmacy	0250-0259, 0631-0636 Use 0257 only when a specific pharmacy code does not exist. 0257 does not require a CPT and HCPCS code.	Yes
Pulmonary/Respiratory	0410, 0412, 0413, 0419, 0460, 0469	Yes
Radiation therapy	0280, 0289, 0330, 0333, 0339	Yes
Radiology services	0320-0324, 0329, 0340-0342, 0349-0352, 0359, 0400-0404, 0409, 0610-0612, 0618, 0619 <b>Therapeutic/chemotherapy services:</b> 0330-0333, 0335, 0339	Yes
Short-term rehabilitation services	<b>Physical/occupational services:</b> 0420-0424, 0429, 0430-0434, 0439, 0951, 0952 <b>Speech therapy services:</b> 0440-0444, 0449	Yes

*\*Services performed on the same day as dialysis should be reported on the same bill.*

### Diabetic education

Outpatient diabetic education is a covered benefit for eligible Members who have been diagnosed as having diabetes mellitus and have been referred by their Primary Care Physician (PCP) or attending physician to an AmeriHealth participating Outpatient diabetic education program. In order for a participating hospital's Outpatient diabetic education program to be eligible as an approved diabetic education program in the AmeriHealth network, the program must be certified by the American Diabetes Association (ADA) and specifically referenced in your Agreement.

In addition to hospital-based programs, AmeriHealth contracts with freestanding Outpatient diabetic education facilities whose programs have been certified by the ADA. Services provided by a

# Billing & Reimbursement for Hospital Services

nonparticipating Outpatient diabetic education provider are not covered under our Member's benefits program.

When billing for diabetic education, use the revenue code 0942. You must also include the CPT and HCPCS code, the number of units, and a diabetic diagnosis on the UB-04 form. For correct billing and reimbursement purposes, one unit is equal to one session. A unit/session is defined as one of the following:

- an initial baseline assessment;
- an individual session, which is to be a minimum of one hour in duration;
- a group session, which is to be a minimum of two hours in duration.

## Emergency services

Emergency services are reimbursed in accordance with AmeriHealth's medical policies. Please refer to our policies on [www.amerihealth.com/medpolicy](http://www.amerihealth.com/medpolicy).

- Whenever one of the revenue codes in the 45X series is present, the UB-04 admitting diagnosis and the patient's reason for the visit are required fields for Outpatient claims. Please report one ICD-9 diagnosis code describing the patient's stated reason for seeking care. Emergency room (ER) claims that do not have the required information completed may not be accepted for processing. When multiple ER level of service procedure codes are billed with 99291 (critical care), the claim will be paid at the lower level of service or non-critical care rate. Report coding discrepancies via NaviNet® to request an adjustment.
- ER services are reimbursed according to the hospital's contracted Outpatient fee schedule, unless otherwise specified in your Agreement.
- If the ER visit results in an Inpatient Admission, the date that the physician wrote the order becomes the date of Admission. The ER charges should be included on the Inpatient claim. No separate ER claim is to be filed.
- If an ER visit includes surgery performed in a fully equipped and staffed operating room, the facility will receive fee schedule reimbursement for the ER and for the surgery. The surgery should be billed using the appropriate surgery revenue, CPT, and HCPCS codes.

*Note:* Critical care in the ER is to be billed with procedure code 99291. Code 99292 is not separately payable under our fee schedule reimbursement. A complete list of required codes can be found in the table on [page 7.1](#).

Services billed together	Services reimbursed*
ER and observation services	Both ER and observation services are reimbursed
ER and surgery services	Both ER and surgery services are reimbursed
Surgery and observation services	Surgery services are reimbursed; observation services are not separately reimbursed
ER, surgery, and observation services	ER and surgery services are reimbursed; observation services are not separately reimbursed

*\*Fee schedule reimbursement for these services includes all ancillary services provided during the visit.*

# Billing & Reimbursement for Hospital Services

## *Emergency services review*

If a facility has a triage fee and a claim does not meet the automatic payment criteria, the facility and the physician automatically receive an Emergency department “triage” fee. If the facility wishes to dispute the application of the triage fee, the hospital is instructed to submit a copy of the medical record for review using the *ER Review Form*. A sample form is included in this section.

The review includes the following stages:

- Upon receipt, the medical record is reviewed by a nurse in our Claims Medical Review department who examines the circumstances of the ER visit and makes a determination regarding the appropriate payment of an ER fee.
- A care coordinator, who is a registered nurse, may approve cases where a prudent layperson, acting reasonably, could have believed that an Emergency medical condition existed, as defined in statute and Member coverage materials. Cases that cannot be approved by the care coordinator are referred to a Medical Director for further review and coverage determination.
- If a Medical Director determines that the circumstances of the ER visit did not constitute a medical Emergency, the ER reimbursement may be denied, although the hospital and the physician may receive reimbursement for the evaluation of the patient. The Member may not be billed for any ER services beyond the copayment specified in his or her benefits. The only exception would be if a Member uses the ER solely for elective reasons, such as a checkup or a routine physical exam.
- Follow-up care in an Emergency setting is not eligible for reimbursement consideration.

# Billing & Reimbursement for Hospital Services



## EMERGENCY ROOM REVIEW FORM

*Please complete the following information and attach this form with each Emergency Room Medical Record. Thank You!*

**\*\*\*\*Product (Please Circle One)\*\*\*\***

AmeriHealth Commercial HMO

AmeriHealth Point-of-Service

AmeriHealth 65

AmeriHealth PPO

AmeriHealth 65 Choice

PROVIDER NAME \_\_\_\_\_

NPI and/or 10-DIGIT LEGACY PROVIDER ID NUMBER \_\_\_\_\_

PATIENT ID NUMBER \_\_\_\_\_

DATE OF SERVICE \_\_\_\_\_

AMERIHEALTH CLAIM NUMBER \_\_\_\_\_

PATIENT'S FIRST NAME \_\_\_\_\_

PATIENT'S LAST NAME \_\_\_\_\_

Form Completed By (Please Print) \_\_\_\_\_

( ) \_\_\_\_\_  
Telephone Number

**\*\*\*\*Return Completed Form with Medical Records to:\*\*\*\***

Claims Medical Review - Emergency Room Review  
AmeriHealth  
1901 Market Street  
Philadelphia, PA 19103-148

AmeriHealth HMO, Inc. • AmeriHealth Insurance Company of New Jersey • QCC Insurance Company d/b/a AmeriHealth Insurance Company

# Billing & Reimbursement for Hospital Services

## Laboratory services

**PPO and Comprehensive Major Medical (CMM) coverage.** Members with PPO or CMM coverage may obtain routine and STAT laboratory services from any AmeriHealth participating hospital with a written physician order. For PPO, the Member must be directed to a participating laboratory to obtain in-network benefits.

**HMO/POS coverage.** Members with HMO or POS coverage must be directed to and have services done by the PCP's designated laboratory site.

### *Routine laboratory services*

Participating hospitals should not perform any routine laboratory services for HMO Members unless they are the designated laboratory site. If routine services are provided by a hospital that is not the designated site for that Member, those services will not be reimbursed and the Member may not be billed.

### *Draw station services*

Draw station services apply to routine services. A hospital may have an agreement with a participating laboratory to draw a specimen and forward it to the laboratory for processing. Laboratory agreements include drawing fees; billing arrangements must be handled directly between the hospital and the laboratory. To provide draw station services to HMO Members, participating hospitals must contract directly with one of the designated laboratories.

### *STAT laboratory services*

AmeriHealth has developed a list of laboratory services that can be ordered by a participating PCP or specialist when Medically Appropriate. STAT laboratory services can be provided by any AmeriHealth participating hospital with a written physician order. A Referral is not required for any STAT laboratory tests listed in the medical policy, which can be found at [www.amerhealth.com/medpolicy](http://www.amerhealth.com/medpolicy).

## *Reimbursement*

Payment will be made directly to the facility according to the Outpatient Laboratory Fee Schedule (only if there is no separate designated laboratory agreement). The laboratory fee schedule reimbursement is a global (technical and professional component) payment for services rendered to HMO and PPO Members.

## Observation services

Observation services are defined as short-term services (less than 24 hours) that are reasonable and appropriate to monitor and evaluate a Member's condition, establish diagnosis, or determine the necessity for Inpatient hospitalization.

Observation services are an alternative to Inpatient Services. The payment for observation stays shall not exceed the lesser of 24 hours or your contracted per diem rate. If the observation stay results in an Inpatient Admission, the Inpatient Admission is considered to have started at the time of the Admission for observation services. The Inpatient claim should include all charges incurred during the stay. No separate observation claim is to be filed.

**Example:** A Member is admitted for observation on November 4, admitted to an Inpatient bed on November 5, and discharged on November 7. An Inpatient claim should be submitted with dates of service from November 4 to November 7; no observation claim would be filed.



# Billing & Reimbursement for Hospital Services

## ***How to bill for observation services***

Observation room services must be billed with revenue code 0762 plus the appropriate number of units (1 unit per hour) that the Member spent in observation. No procedure code is required.

## ***Reimbursement***

Observation services are reimbursed in accordance with your Agreement. Reimbursement for these services include all ancillary services provided during the visit.

Please refer to the chart on [page 7.3](#) for more information on both ER and observation services.

## **Outpatient surgery**

Covered surgical services will be reimbursed in accordance with the terms of your Agreement. Reimbursement of Outpatient surgery includes PATs and all facility services provided during the Outpatient surgical procedure and should be billed on the same claim.

With the exception of specified implantable devices, the categories and fees indicated on the fee schedule represent an all-inclusive payment. This applies to laboratory and radiology as well as all PATs.

Each procedure code on the fee schedule is assigned to a category number, and the category number will determine the level of reimbursement. Procedures that are not listed on the Outpatient Hospital Surgery Fee Schedule are individually reviewed for payment consideration when performed in a hospital Outpatient setting.

## ***How to bill for Outpatient surgery services***

Bill Outpatient surgeries with the appropriate revenue code plus the appropriate procedure code (CPT and HCPCS), as listed on the Outpatient Hospital Surgery Fee Schedule. To review correct coding correlation requirements, refer to the current Correlation Table at [www.amerihealth.com/providers/communications/bulletins](http://www.amerihealth.com/providers/communications/bulletins). The Outpatient Surgery Fee Schedule and the Correlation Table are updated periodically to reflect the addition or deletion of codes.

## ***Sequencing***

Claims with multiple surgical procedures are processed in the same order that they appear on the claim. Please be sure to bill the procedure with the highest allowable (primary) procedure first. AmeriHealth does not reorder the claim lines; however, some clearinghouses use software that changes the order, thus affecting the processing by AmeriHealth.

## ***Payment for multiple surgical procedures***

When multiple surgical procedures are performed during the same date of service, the highest allowable (primary) procedure is paid at 100 percent of the fee schedule rate, and the remaining procedures are paid at 50 percent of the fee schedule rate.

## ***Revenue codes***

Hospitals performing Outpatient same day surgeries (SDS) should use the following revenue codes for surgery claims: 0360 and 0361. The same revenue code should be used for each procedure. When providers bill with different revenue codes, there is no additional reimbursement.

# Billing & Reimbursement for Hospital Services

Example 1:	Rev code	CPT and HCPCS	Status	Percent
	0360	23410	Highest allowable (primary)	100%
	0360	36530	Second highest allowable	50%
	0360	11402	Second highest allowable	50%
Example 2:	Rev code	CPT and HCPCS	Status	Percent
	0360	67105	Highest allowable (primary)	100%
	0360	67105	No reimbursement	–

## *Charges for procedures*

All billed procedures must have corresponding charges. AmeriHealth cannot accept procedures with a \$0.00 charge. If your system rolls up all charges to the first procedure, be sure to drop down a nominal amount (e.g., \$1.00) to the other procedures.

Example:	Rev code	CPT and HCPCS	Charges	Status	Percent
	0361	36530	\$1810.00	Highest allowable (primary)	100%
	0361	11402	\$1.00	Second highest allowable	50%

## *Incidental procedures*

When multiple procedures are billed, no additional payment is made to hospitals for procedures that are considered integral to the highest allowable (primary) procedure. The Member may not be balance-billed for incidental procedures (IP).

Payment for an IP is made when that procedure is the only procedure performed or when it is the highest allowable (primary) procedure for the episode of care. IPs are marked as “IP” on the Outpatient Hospital Surgery Fee Schedule.

When multiple procedures are performed and all are incidental, only the IP that is the highest allowable (primary) procedure is reimbursed.

Example:	Rev code	CPT and HCPCS	Incidental	Status	Percent
	0360	29877	IP	Highest allowable (primary)	100%
	0360	29880	IP	Second highest allowable	–
	0360	11402	–	Second highest allowable	50%
	0360	58120	IP	Second highest allowable	–

## *Surgery with observation*

When Outpatient surgical claims are paid according to the fee schedule, there is no additional reimbursement for observation services. Please refer to the chart on page 7.3 for more information.

## *Procedures not found on the Outpatient Surgery Fee Schedule*

All claims submitted for procedures that are not on the Outpatient Hospital Surgery Fee Schedule are suspended for manual prepayment review.

# Billing & Reimbursement for Hospital Services

## *Variations before and after surgery*

Advance approval by AmeriHealth is based on the code for the procedure planned, but the code assigned after the procedure may be different. Assuming the codes are reasonably related, this is not a barrier for payment; however, updated Preapproval/Precertification may be required.

## *Coding discrepancies*

When a claim is suspended because the procedure billed is not on the fee schedule, AmeriHealth's Provider Payment department may also review the CPT and HCPCS coding to ensure that the procedure was not miscoded. The review may involve medical record review. The claim will remain pended until documentation is received. It is in the hospital's best interest to expedite these requests. Coding discrepancies will be discussed with the Medical Records department before any action is taken.

## *Cancelled surgeries*

Currently, three types of Outpatient cancelled surgery scenarios are eligible for reimbursement. In order for these claims to be processed correctly, certain coding and billing criteria must be met. Claims submitted that do not meet these criteria must be returned to the facility for correction, resulting in a delay of the reimbursement cycle. Please note the criteria for each of the scenarios below when coding and billing your claims.

**Scenario 1:** Patient has PAT, but surgery is cancelled. For example, the patient has PAT for intended cataract surgery but subsequently develops a cold and the surgery is cancelled.

Coding and billing requirements:

- Report principal diagnosis code, which is the reason for the surgery.
- Report the secondary diagnosis with the appropriate V code indicating cancelled surgery (V.64.1, V64.2, or V64.3).
- Submit claim for the PAT date of service indicating procedures performed. The hospital will be reimbursed for the PATs according to its Agreement.

**Scenario 2:** Planned surgery is begun but stopped before the entire procedure is completed. For example, the patient has planned a laparoscopic adhesiolysis. Surgery proceeds as far as the insertion of the laparoscope when the patient develops an arrhythmia and the surgery is stopped.

Coding and billing requirements:

- Report principal diagnosis code, which is the reason for the surgery.
- There is no need to use a V code indicating cancelled surgery.
- Code the procedure to the extent it was completed. In this example, the diagnostic laparoscopy code would be used to describe the insertion of the scope.
- Submit the claim through the standard channels — no medical record review is required.

The hospital will be reimbursed to the extent that the procedure was performed (e.g., diagnostic laparoscopy) according to its Agreement.

**Scenario 3:** Patient had been admitted to SDS/short procedure unit, but surgery was cancelled before it began. Some services related to the intended procedure have been rendered. For example, the patient is in the operating room, and anesthesia has been induced. But the patient's blood pressure drops, and the procedure is cancelled.

# Billing & Reimbursement for Hospital Services

Coding and billing requirements:

- Report the principal diagnosis code, which is the reason for the surgery
- Report the secondary diagnosis with the appropriate V code (V64.1-V64.2) to indicate that surgery was cancelled.
- Report the CPT and HCPCS code for the intended procedure with the correct revenue code for Outpatient surgery.
- Submit the claim with medical records for the encounter with the reasons for the cancellation attached.
- Submit claims to your Hospital/Ancillary Services Coordinator.

The hospital/facility may be reimbursed for surgical procedures cancelled for reasons beyond the hospital's control. The hospital will be reimbursed at the minor surgery rate for fee schedule claims or according to their Agreement for all other claims. If the cancellation is administrative (e.g., equipment failure, staffing problems), the procedure will not be reimbursed.

In addition to the criteria specified above, please also note the following guidelines:

- Do not submit claims using facility level of service (clinic) codes (99201-99205, 99211-99215) to describe services.
- Do not use treatment room, observation room, or recovery room revenue codes (0761, 0762, 0710) for place of service.
- Do not submit claims that simply list medications or IV fluids without the corresponding surgical code.
- Claims submitted without the required information will not be considered for payment.

## Outpatient implantable devices

Reimbursement of implantable devices is dependent on the hospital's contracted Outpatient surgery reimbursement methodology.

### *How to bill implantable devices*

Submit the claim electronically through standard channels. Bill the implant using the applicable revenue codes.

Charges must also be assigned to implants. According to the terms of your Agreement, these devices may be reimbursed separately at the provider's cost as documented on the manufacturer's invoice (shipping and sales tax excluded).

The applicable implant revenue code and charges must be billed on initial claim submission. Otherwise, they will not be added when the request for implant reimbursement is submitted.

After the base claim is paid, submit the following documentation:

- operative report
- implant record
- implant manufacturer's invoice (not purchase order)

*Note:* The purchase order is not acceptable in lieu of the manufacturer's invoice. It may be submitted in addition to the manufacturer's invoice to clarify a date discrepancy.

Generally, we will not accept an invoice with a date greater than the date of surgery as applicable documentation. However, it may be your hospital's billing practice to request a device with a purchase

## Billing & Reimbursement for Hospital Services

order, receive the device and utilize it during surgery, and then be billed by the manufacturer after the actual surgery date. If this is the case, include both the invoice and purchase order for documentation and specify that this is your hospital's practice.

A manufacturer's invoice received with handwritten amounts will not be considered acceptable documentation. If an implantable device is ordered in bulk, this invoice is considered acceptable documentation as long as the cost per unit and units per order (e.g., pack, case, box) are identified.

To facilitate processing, include a cover sheet that contains a summary of the required information, including:

- Member's name
- Member's AmeriHealth ID
- Member's claim number
- implant type
- invoice amount

### ***Implant record***

The implant record is required to verify the model and lot/serial number of the implant device. This information is found on the implant labels that are attached to the implant record. Please check with your facility's operating room staff to determine their procedure for implant labels. The facility may place these labels on the operative report, purchase order, or one of the following:

- cardiac catheterization report
- implantable device registration form
- intra-operative nursing record
- medical device or issue tracking form
- operative notes (seeds)
- progress notes

You may submit one of these forms in lieu of the implant record as long as they include the implant label indicating the implant's model and lot/serial number and a brief description of the device.

With the exception of radioactive seeds and some screws, all other types of implantable devices are forwarded by the manufacturer with implant labels.

Implant requests received without all the required documentation will not be considered for reimbursement. All received documentation will be returned to the facility. Please submit the necessary documentation to the attention of your Hospital/Ancillary Services Coordinator (depending on your location) to:

AmeriHealth New Jersey  
8000 Midlantic Drive  
Suite 333 N  
Mount Laurel, NJ 08054

AmeriHealth New Jersey  
485-C Highway 1 South  
Suite 300  
Iselin, NJ 08830

Please note that originally submitted requests for implant payments will be processed in accordance with the timely filing provisions of your Agreement.

# Billing & Reimbursement for Hospital Services

## ***Reimbursement exceptions***

Following are a few examples of circumstances when implant devices are not eligible for reimbursement:

- The type of device is not specified on approved listing.
- There is insufficient documentation.
- The Member is not found or is ineligible on date of service.
- The base surgery claim has been denied, has not yet been paid, or is limited to the lesser of total allowable charges.
- AmeriHealth is not the primary payor.

## **Radiology services**

The following Outpatient radiology services for HMO and PPO Members require Preapproval/Precertification through American Imaging Management, Inc.:

- computed tomography (CT and CTA) scanning
- magnetic resonance imaging (MRI)
- magnetic resonance angiography (MRA)
- nuclear cardiology studies
- positron emission tomography (PET) scanning (PET scans are already subject to Precertification)
- PET/CT fusion (PET/CT fusion are already subject to Precertification)

**HMO/POS coverage.** Radiology services for HMO Members are generally provided by the designated radiology provider under the Capitated Radiology Program\*. A complete listing of the radiology services included in this program can be found at [www.amerihealth.com/medpolicy](http://www.amerihealth.com/medpolicy). Search for the claim payment policy “Diagnostic Radiology Services Included in Capitation.” Outpatient radiology services that are excluded from capitation are paid at the contracted fee schedule.

For HMO Members, hospitals that are not the Member’s designated radiology site may perform and be reimbursed for ultrasounds and testing for identified high-risk patients enrolled in Baby FootSteps®. Pediatric Members (newborn through 4 years old) may be Referred to any radiology facility in the HMO network. While this age group is excluded from the capitation program, a Referral for a Participating Radiology Provider is required.

Services provided by any provider other than the PCP’s designated radiology provider will be denied unless the Member’s PCP or the treating specialist obtains the necessary authorization to have the services performed at a site other than the designated radiology provider.

*\*Applies to Southern New Jersey counties only.*

**PPO coverage.** A Member must receive all non-Emergency diagnostic radiology and imaging studies from a network radiology provider in order to receive in-network benefits. Members with PPO coverage may obtain radiology services from any participating facility in the AmeriHealth PPO network.

**CMM coverage.** Members with CMM coverage may receive radiology services from any AmeriHealth participating facility. All services for CMM Members are reimbursed at the facility’s negotiated Outpatient rate unless otherwise specified in your facility Agreement.

# Billing & Reimbursement for Hospital Services

## *How to bill for radiology services*

- Bill radiology services with one of the following revenue codes: 0320-0324, 0329, 0340-0342, 0349-0352, 0359, 0400-0404, 0409, 0610-0612, 0614-0616, 0618, or 0619. Radiology billing requires that a CPT and HCPCS code is billed with the appropriate revenue codes.
- Bill therapeutic/chemotherapy radiology with one of the following revenue codes: 0330-0333, 0335, or 0339.

## *Requirements for mammography and breast ultrasounds*

- A Referral is not required for HMO/POS Members to obtain screening and/or diagnostic mammography and breast ultrasounds provided by an accredited in-network radiology provider.
- Screening and diagnostic mammograms performed at a network radiology site will be covered in full and will not be subject to any copayment, deductible, or coinsurance.
- There are no age restrictions on the provision and payment of mammograms.
- Radiology facilities may require a physician's written prescription.
- Bill diagnostic mammographies with revenue code 0401, and bill screening mammography services with revenue code 0403.

## *Interventional radiology*

Interventional radiology (IR) involves procedures with both a surgical and radiological component.

**HMO/POS.** For HMO and POS Members, a Referral is required only for the services listed in *Appendix D*. All other IR services require Preapproval/Precertification.

If several IR procedures are being performed, some that are payable with a Referral only and some that require Precertification, you will need to obtain Precertification for the applicable procedure. Claims should be submitted with a radiology revenue code and correlated radiology procedure code in addition to a surgical revenue code and correlated surgical procedure code. The surgical procedure code is reimbursed and includes the radiology services.

## **Short-term rehabilitation therapy services**

**HMO/POS.** Physical therapy and occupational therapy services for HMO Members are generally provided by the designated provider under the Capitated Physical Therapy Program\*. A complete listing of the services included in this program can be found on [www.amerhealth.com/medpolicy](http://www.amerhealth.com/medpolicy). Search for the claim payment policy "Physical Therapy and Occupational Therapy Services Included in Capitation." Any therapy services that are excluded from capitation are paid at the contracted fee schedule.

## *Services excluded from capitation*

The following services are not included in the capitation program:

- diagnosis-specific hand therapy
- speech therapy
- lymphedema therapy
- vestibular rehabilitation
- orthoptic/pleoptic therapy when provided by a licensed ophthalmologist or optometrist

*\*Applies to Southern New Jersey only.*



# Billing & Reimbursement for Hospital Services

## ***Referral requirements***

A Referral (via the IVR system or NaviNet) from the Member's PCP is required whenever a Member is Referred to the designated provider for treatment or evaluation.

Under most circumstances, one Referral per patient per condition is sufficient. The Referral should specify "Rehabilitation (PT/OT) Evaluate and Treat." This will allow the designated physical therapy provider to evaluate the patient and recommend a treatment program, as well as coordinate the course of treatment among the PCP, specialist, and therapist. The therapist, with the approval of the PCP and specialist, will then institute the course of treatment determined to be most appropriate.

## ***Interrupted therapy***

Occasionally, due to a change in the treated condition or a concurrent illness, rehabilitation therapy may be interrupted. For example, a Member receives short-term rehabilitation therapy for an acute condition, during which time he or she has surgery for this condition. The surgery is considered an interruption of therapy, and the Member is eligible to use any of the remaining benefit days postoperatively. The PCP will need to electronically submit a new Referral for any therapy that occurs more than 90 days after the date of the original Referral.

The provision of splints, braces, prostheses, and other orthotic devices is not included in the capitation program. Such devices are provided by participating HMO DME/prosthetic providers and must be Precertified by AmeriHealth's Care Management and Coordination department if more than \$500.

Individual benefits must be verified, as some group plans do not require Preapproval/Precertification for items over \$100. For more information, please refer to our policies at [www.amerihealth.com/medpolicy](http://www.amerihealth.com/medpolicy).

## ***How to bill for physical/occupational/speech therapy services***

Bill physical therapy/occupational therapy (PT/OT) services with one of the following revenue codes: 0420-0424, 0429, 0430-0434, 0439, 0951, 0952. PT/OT billing requires that a CPT and HCPCS code is billed with the appropriate revenue codes. To review AmeriHealth correlation bulletins for acceptable revenue codes, refer to the current Correlation Table Bulletin at [www.amerihealth.com/providers/communications/bulletins](http://www.amerihealth.com/providers/communications/bulletins).

Bill speech therapy services with one of the following revenue codes: 0440-0444, 0449. Speech therapy billing requires that a CPT and HCPCS code is billed with the appropriate revenue codes.

## ***Sleep study***

In order for a participating hospital's sleep study program to be eligible as an approved sleep study program for AmeriHealth's network, it must be accredited by the Joint Commission or the American Association of Sleep Medicine, as specifically referred to in your Agreement. For hospital billing, sleep study is part of the neurology fee schedule and should be billed using the neurological revenue codes.

## ***Additional billing information***

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All claims, regardless of the submission method, should clearly indicate whether the claim is the result of an accident, such as a motor vehicle accident, or related to employment. The claim should be submitted to the appropriate primary insurance carrier, and it should include all services rendered during the patient Admission or date of service.



# Billing & Reimbursement for Hospital Services

## Timely Filing

The standard policy for timely filing includes the following:

- For Inpatient Services, providers should submit claims to AmeriHealth within 12 months following the date of discharge for an Inpatient Admission.
- For all other Covered Services, providers should submit claims within 12 months following the date of service (e.g., outpatient services, office visits, date of medical transport, or date of delivery for DME).

In the event that AmeriHealth's payment responsibility is not determined until after the date of discharge or Covered Services, providers must submit the claim within 12 months of the determination.

Please note that claims will not be accepted for payment if submitted more than 12 months from:

- the date the Covered Services are rendered;
- where AmeriHealth is the secondary payor, the date the primary payor has made payment or denied the claim.

In accordance with the terms of your contract, Members may not be billed for claims that were not accepted because they were not timely filed.