Reimbursement Policies
Pursuant to PAR, PPO and HMO Coverage

For the purposes of this document, the SSI Affiliates identified in Exhibit A of the Southeast Services, Inc. Agreement (or identified in the "Definitions" section of the SSI Dental Provider and Oral Surgery Provider Agreements) and HealthKeepers, Inc., Peninsula Health Care, Inc., and Priority Health Care, Inc., are collectively referred to herein as "Health Plan" unless otherwise noted. HealthKeepers, Inc., Peninsula Health Care, Inc., and Priority Health Care, Inc., may also be collectively referred to herein as the "HMOs." These Reimbursement Policies for determining reimbursement shall apply to Covered Services rendered to Covered Persons or Members, except as otherwise may be provided herein.

The Health Plan's fee schedules list the maximum amount payable for each Covered Service that corresponds to a single service code. The preponderance of valid service codes is from Current Procedural Terminology (CPT), Healthcare Common Procedural Coding System (HCPCS), American Dental Association (ADA), or National Drug Codes (NDC). For Covered Services represented by a single code, the maximum fee schedule amount is the fee schedule amount determined by the Health Plan in its sole discretion or your usual charge for the service, whichever is less. Most fee schedule amounts are based upon external benchmarks of relative value, for example, the Federal Resource Based Relative Value Scale (RBRVS), American Society of Anesthesiologists (ASA) relative value and Medicare's laboratory, drug and Durable Medical Equipment (DME) fees.

When more than one service (represented by more than one service code) is provided to the same patient on the same day (or sometimes, within the same episode of care), the total fee schedule amount may be less than the sum of fee schedule amounts for individual billed service codes. Aggregations of different service codes may be subject to bundling via the Health Plan's multiple, incidental, combination, global processing and other reimbursement and edit rules. The Health Plan reserves the right to apply the most restrictive rule.

Although the details of rebundling logic will vary from payer to payer, the concepts of quantity limits as well as multiple, incidental, combination and global processing are industry standards utilized by most payers, including Medicare. The Health Plan's rebundling logic for Par, PPO and Medicare Advantage lines of business is developed internally. The HMOs use ClaimCheck from McKesson. ClaimCheck is widely utilized in the healthcare financing industry, and is updated by the vendor from time-to-time. The HMOs may adopt the vendor's updates as they occur. See the remainder of this document for key reimbursement policies and edits.

NOTE: The Health Plan will be migrating its claim processing systems as part of an enterprise initiative to consolidate the multiple platforms that are in existence today. This migration is expected to commence in early to mid 2011 and will take approximately 18 – 24 months to complete.

Concurrent with the claim processing system migration, the Health Plan will begin migrating lines of business to utilize the McKesson ClaimsXten claims editing solution. ClaimsXten will replace the internally developed editing logic currently used for PAR and PPO lines of business, including FEP. It will also replace the McKesson ClaimCheck editing solution that is currently used for HMO lines of business, including Medicaid.

See the remainder of this document for key reimbursement policies and edits.

Limits, Secondary and Subsequent Procedures
Multiple units of the same service code may be subject to limits and to fractional payments for secondary and subsequent units of service. For some service codes which may be provided multiple times to a single patient on a single day, the Health Plan allows a fraction (typically one-half, one-third, or one-fourth) of the usual fee schedule amount for secondary and subsequent units of service. For some such service codes, the Health Plan establishes a maximum total fee schedule amount (limit), notwithstanding the number of units provided. An example of a service limited in this way is cryoablation of small skin lesions.

Multiple Surgeries/Procedures (billed with or without modifier 51)
Multiple surgery/procedure reimbursement rule (100% primary procedure and 50% for each subsequent procedure) is normally applied to claims for multiple surgeries/procedures performed at the same operative session (however see exception to subsequent percentage reimbursement for multiple endoscopic procedure codes). Codes denied as part of incidental processing are not subject to any reimbursement. When extraordinary circumstances exist, the
Health Plan reserves the discretion to establish a case rate, or whole case allowance. The Health Plan uses the CMS multiple procedure indicators 2 and 3 as designated in the National Physician Fee Schedule Relative Value File to determine which procedures are eligible for multiple surgery reductions, however “CPT Add-on” and “Exempt from Modifier 51” procedures are exempt from multiple surgery reduction rules.

Multiple surgery claims for HMO products are processed based on the existing order of the procedure codes on the claim. The claim is paid in the order that the surgical code is billed, not on the allowance or RVU assigned to the procedure. The primary procedure must be billed on the first claim line in order to be paid the full allowance.

Note – Multiple surgery processing of bilateral surgeries may differ under the ClaimsXten claims editing solution. If the bilateral surgery is considered a secondary surgery procedure (as opposed to the primary surgery procedure), ClaimsXten will first apply the bilateral modifier percentage of 150%, then apply the multiple surgery reduction percentage of 50%, for an effective reimbursement percentage of 75% of the fee allowance.

**Multiple Endoscopic Procedure Code Reduction**

Multiple endoscopic surgical reimbursement (100% primary and a reduced reimbursement % for each subsequent procedure within the base family) is normally applied to claims for multiple endoscopy procedures performed at the same operative session, with the same endoscopic base code as defined by CMS. Codes denied as part of incidental processing would not be subject to any reimbursement. The code ranges are as follows:

- Codes 29805 – 29828 (Shoulder arthroscopy) 100% primary; 30% subsequent
- Codes 29830 – 29838 (Elbow arthroscopy) 100% primary; 25% subsequent
- Codes 29840 – 29847 (Wrist arthroscopy) 100% primary; 25% subsequent
- Codes 29860 – 29863 (Hip arthroscopy) 100% primary; 25% subsequent
- Codes 29870 – 29887 (Knee arthroscopy) 100% primary; 35% subsequent
- Codes 31622 – 31625, 31628 – 31631, 31635, 31636, 31638, 31640, 31641, 31645 (Bronchoscopy) 100% primary; 25% subsequent
- Codes 43231, 43232, 43235 – 43259 (Upper GI endoscopy) 100% primary; 25% subsequent
- Codes 43260 – 43272 (ERCP) 100% primary; 25% subsequent
- Codes 45378 – 45392 (Colonoscopy) 100% primary; 25% subsequent

**Incidental Processing**

When multiple codes are billed together, some codes may be considered incidental to other codes and may contribute nothing to the total fee schedule amount for the aggregation of billed codes. A code which is a subset of another code per reasonable interpretation of CPT verbiage will be incidental to the latter code. Code combinations prescribed by the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative will be subject to incidental processing. In addition, the Health Plan will consider a code incidental to another if the incremental value of the former is less than one-fourth of its usual value when provided in combination with the latter. This will typically be the case when the lesser services do not pertain to different routes of access, different organ systems, different pathological processes, or to multiple trauma.

**Combination Processing**

For some aggregations of service codes, the Health Plan will allow the fee schedule amount for an altogether different service code while disallowing the billed codes. The Health Plan refers to this as combination processing. Codes to which billed services combine are usually a superset of the billed codes. An example would be a set of laboratory codes that are all contained within a single “panel” or “multichannel” test. Less frequently, the Health Plan will combine billed codes into a code which is not a superset by strict definition, but does represent the value of the combined services billed. In no case will the Health Plan reimburse more in aggregate for individually billed codes that are part of a “panel”, than what the Health Plan reimburses for the “panel” code alone, regardless of whether all individual codes that make up the “panel” are billed.
Global Processing

For some services (typically surgical services), the Health Plan imposes “global processing” rules, wherein some services (typically evaluation and management services) are incidental to other services (typically procedural services) when provided within a defined time period, relative to the procedural service. The Health Plan follows CMS conventions regarding global designations and time periods for major and minor surgery.

Age/Sex Restrictions

Some services (e.g., hysterectomy) are allowed for only one sex. Some services (e.g., neonatal intensive care) are allowed only for certain age ranges.

History Edits

These edits apply to once-in-a-lifetime procedures, i.e., appendectomy. They also apply to items like drugs or supplies that may have monthly limits. In addition, history edits may apply to certain codes, which denote services for a specified time period (e.g., weekly or monthly radiology or renal dialysis).

Health Services Review

Some services may be non-covered, or only partially covered if they do not have a health service review.

Screening and Preventive Services

Screening and Preventive services are provided in the absence of signs or symptoms of illness, injury or pregnancy. Some of the Health Plan’s Contracts do not cover these services.

Venipuncture (Blood Collection)

In addition to a covered laboratory blood test, the Health Plan will reimburse one venipuncture code per member per date of service. Therefore, if more than one of the following codes is reported for the same member on the same date of service, the second code will be denied as not eligible for separate reimbursement.

The venipuncture codes are: 36415, 36416, S9529

Lab Handling and Conveyance

The Health Plan considers the handling and conveyance of a laboratory specimen, to be included in a provider’s management of a patient. Therefore codes 99000, 99001 are not eligible for separate reimbursement.

Modifier – 26 with Pathology and Laboratory Codes

Modifier 26 is reimbursable only when billed for select pathology and laboratory CPT codes that require a separately identifiable professional interpretation beyond the technical component. The list of pathology and laboratory codes for which Modifier 26 may be reimbursed may change from time to time and is based upon the CMS National Physician Fee Schedule Relative Value File.

Direct Payment for Laboratory Services

Laboratory services must be billed to the Health Plan by the provider of service. This means that laboratory services provided in the provider’s office should continue to be billed by the provider. However, services provided by an outside laboratory must be billed directly to the Health Plan by the laboratory. For purposes of this Agreement, an outside laboratory must be a reference laboratory or a laboratory in which the referring provider or provider group has no financial or ownership interest, and which accepts samples for review from all providers.

No Reimbursement for Technical Only or Complete Service for a Hospital Inpatient or Outpatient

Physicians who provide clinical lab, pathology, radiology or other diagnostic testing services to hospital inpatients or outpatients shall only be reimbursed for the professional component fee allowance (when the code has a separate professional component RVU assigned based on CMS guidelines). There will be no reimbursement to the physician for the technical component only, or the complete service. Such reimbursement has been included in the payment to the hospital.

Reimbursement for LDL Cholesterol

In cases where a Lipid Panel, code 80061 is rendered, and the LDL cholesterol measurement is calculated based on subtracting the HDL cholesterol measure from the Total cholesterol measure, no additional reimbursement is provided. Separate reimbursement for the LDL cholesterol will only be provided when there is a direct measurement.
New Patient Evaluation and Management Service

A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years. The Health Plan will deny billings for inappropriate use of a new patient visit code within the three year time period when the provider is the same, or different, and has the same specialty and group tax ID as the provider of the original new patient visit.

Therapeutic, Prophylactic or Diagnostic Injections

Therapeutic, prophylactic or diagnostic injection, code 96372, is considered incidental when billed with any of the following: Immunization Administration Codes 90465 – 90466 and 90471 – 90474; Vaccine codes 90581 – 90749; Allergy Immunotherapy codes 95515 – 95517 and Chemotherapy Administration codes 96401 – 96402.

Per CPT billing guidelines, immunization administration codes 90465 – 90474 should be used when the provider is administering a vaccine/toxoid (code range 90581 – 90749). Modifier 51 should not be appended to the vaccine/toxoid code. Allergy immunotherapy injections should be billed with CPT codes 95115 – 95117. Anti-neoplastic nonhormonal chemotherapy should be billed with CPT code 96401. Anti-neoplastic hormonal chemotherapy should be billed with CPT code 96402.

Injection and Infusion Reimbursement in a Facility Setting

New changes to the 2008 AMA CPT coding guidelines have been made related to physician reporting for hydration, injections, infusions, and chemotherapy administration. These reporting guidelines specify that CPT codes for Hydration, Therapeutic, Prophylactic and Diagnostic Injections and Infusions (CPT codes 96360 – 96379), and CPT codes for Chemotherapy Administration (CPT codes 96401 – 96549), are not intended to be reported by the physician in the facility setting.

Claims for these codes that are billed with a facility place of service will not be reimbursed. Facility settings include inpatient hospital, outpatient hospital, emergency department, ambulatory surgical center, birthing center, military treatment facility, skilled nursing facility, inpatient behavioral health facility, outpatient behavioral health facility, and behavioral health residential treatment facility.

Bundled Services and Supplies

There are numerous services and supplies that are not eligible for separate reimbursement when reported by a professional provider. These services and/or supplies may be reported with a primary service or as a stand alone service.

In most cases, services rendered without direct (face-to-face) patient contact are considered to be an integral component of the overall medical management service and are not eligible for separate reimbursement. In addition, modifier 59 will not override the denial for the bundled services and/or supplies listed below.

These bundled services and supplies may include, but are not limited to:

1. administrative services requiring physician documentation (e.g. recertification, release forms, physical/camp/school/daycare forms, etc.)
2. all practice overhead costs, such as heat, light, safe access, regulatory compliance including CDC and OSHA compliance, general supplies (paper, gauze, band aids, etc.), insurance (including malpractice insurance), collections
3. collection/analysis of digitally/computer stored data
4. computer aided detection with chest radiography
5. copies of test results for patient
6. costs to perform participating provider agreement requirements, such as prior authorizations, appeals, notices of non coverage
7. determination of venous pressure
8. DME delivery and/or set up fees
9. handling and/or conveyance fees
10. heparin lock flush solution or kit for non therapeutic use
11. insertion of a pain pump by the operating physician during a surgical procedure
12. peak expiratory flow rate
13. photography
14. pharmacy dispensing services and/or supply fees, etc.
15. physician care plan oversight
16. post op follow up visit during the global period for reasons related to the original surgery
17. prescriptions, electronic, fax or hard copy, new and renewal, including early renewal
18. pulse oximetry
19. recording or generation of automated data
20. review of medical records
21. robotic surgical system
22. routine post surgical services such as dressing changes and suture removal
23. supplemental tracking codes for performance measurement (Category II CPT®Codes)
24. surgical/procedural supplies and materials supplied by the provider rendering the primary service (e.g. surgical trays,
syringes/needles, sterile water etc.)
25. telephone consultations with the patient, family members, or other health care professionals
26. team conferences to coordinate patient care

The following table identifies by code some of the procedures and supplies that are described above. The inclusion or
exclusion of a specific code does not indicate eligibility for coverage under all circumstances. This table is provided as
an informational tool only, to help identify some of the procedures described above.

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| 0174T | Bundled Supplies with Injection and Infusion Administration

Services related to intravenous infusion such as local anesthesia, IV start or access to a catheter or port, and flushing
to procedures should not be reported separately, and are not eligible for separate reimbursement.

Materials and supplies used during the course of the administration of intravenous infusion or for injections are
considered to be an integral component of the reimbursement for the services provided and are not reimbursed
separately. These supplies include but are not limited to:

- needles and syringes
- needle free injection devices
- sterile water, saline, heparin, and/or dextrose diluent/flush
- refill kits
- disinfectant wipes and agents such as alcohol, peroxide, iodine, Betadine, and pHisohex,
- tape, gauze, gloves, trays, etc.
- ambulatory infusion pumps
The following supplies are incidental to injection and infusion codes (96360 to 96379, 96401 to 96549), and will not be separately reimbursed:

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### Supplies and Materials For Office Based Services

Supplies and materials provided by the physician that are necessary and/or routinely included as an inherent part of a diagnostic, therapeutic, or surgical procedure are not separately reimbursable. Examples of these supplies and materials would be needles, syringes, tape, gauze, gloves, trays, local anesthetic, etc. The office based fee allowance is inclusive of all routine supplies and materials overhead associated with the office based procedure. Some procedural examples where these supplies and materials are included in the office based allowance are 20526, 20550 – 20553, 20600 – 20615, 27096, 64470 – 64484.

Another procedural example would be a diagnostic sleep study with initiation of CPAP, code 95811. The office based reimbursement for this procedure would include supplies such as the CPAP device, humidifier, face mask, headgear, tubing, filters, etc.

### After Hour Charges in the Office Setting

The Health Plan’s definition of after hours is between 5 p.m. and 8:30 a.m. on weekdays, and anytime on weekends and holidays. After hours charges are only reimbursed for services in the office setting.

### Intermediate Repair in conjunction with Excision of Non-facial Benign Lesions

Intermediate repair codes 12031, 12032, 12041, 12042 are considered incidental to excision of non-facial benign lesion codes with excised diameter of 1.0 cm or less each (codes 11400, 11401, 11420, and 11421). This rule does not apply to excision of malignant lesions or lesions of the face, ears, eyelids, nose, lips and/or mucous membranes. Use of modifier 59 will not override these incidental edits.

### Anesthesia Reimbursement

Services involving the administration of anesthesia are to be reported by the use of the anesthesia five-digit procedure codes (00100 – 01999) plus an anesthesia modifier code (AA, AD, GB, G9, P1, P2, P3, P4, P5, P6, QK, QS, QX, QY, QZ, 23, 47).

No reimbursement will be allowed for anesthesia services billed with a CPT procedural code (10021 – 69990).

No reimbursement for anesthesia services will be allowed to the physician who also furnishes the medical or surgical service. In this case, reimbursement for the anesthesia service is included in the reimbursement for the medical or surgical service. This includes anesthesia services rendered by a CRNA employed or under contract with the physician who furnishes the medical or surgical service.

Reimbursement for administration of anesthesia is determined by multiplying the sum of the base units for the anesthesia code, and the time units reported, by the anesthesia conversion factor. Anesthesia time units are defined as each 15-minute period of administration of anesthesia.

When two or more anesthesia procedure codes are billed during the same operative session, reimbursement of base units will only be made for the anesthesia procedure code with the highest base units. Reimbursement of the time units will be made for the combined total of administration of anesthesia for all procedures rendered.

Management of intravenous patient controlled analgesia subsequent to the initial insertion procedure should not be reported separately and will not be reimbursed. Management of intravenous patient controlled analgesia is the responsibility of the surgeon as part of the post-operative care and is included in the global surgery fee allowance.
**Moderate (Conscious) Sedation**

Drugs routinely used with conscious sedation such as meperidine, fentanyl citrate, droperidol, and morphine sulfate will not be reimbursed separately when the service is identified in Appendix G of the CPT manual as inclusive of conscious sedation. These drugs include, but are not limited to: J1170, J1810, J2175, J2180, J2250, J2270, J2271, J2275, J2300, J2310, J2410, J2550, J2560, J3010 and J3360.

**Nerve Block billed in addition to General Anesthesia**

A nerve block billed on the same day as general anesthesia by the same provider, for non-obstetrical cases, will be reimbursed at 50% of the Health Plan allowance. A nerve block billed on the same day as obstetrical anesthesia by the same or different provider, is included in the maternity anesthesia case rate, and is not subject to additional reimbursement. Nerve block codes subject to this reimbursement guideline are 62310 – 62318, and 64400 – 64530.

Claims for HMO products are processed based on the existing order of the procedure codes on the claim. For the provider to receive full reimbursement for general anesthesia, the anesthesia procedure code must be billed on the first claim line. Nerve blocks billed on subsequent claim lines will be subject to the 50% reimbursement.

**Experimental/Investigational**

Services or supplies must meet all of the following coverage eligibility criteria. If they do not, they are considered to be experimental/investigational.

1. Drugs and devices must have final market approval from the Food and Drug Administration (FDA).
2. There must be sufficient information in the peer-reviewed medical and scientific literature to enable the Health Plan to make conclusions about safety and efficacy.
3. The available scientific evidence must demonstrate a net beneficial effect on health outcomes. That is, the technology’s beneficial effects on health outcomes should outweigh any harmful effects on health outcomes. Diagnostic tests must be explicitly linked to therapeutic decisions that improve outcomes.
4. Drugs, devices and procedures must be as safe and effective as existing diagnostic or therapeutic alternatives.
5. Drugs, devices and procedures should reasonably be expected to satisfy criteria #3 and #4 when applied outside the research setting.

These criteria are defined in the Health Plan’s Contracts. A drug, device, procedure, or other service will be experimental or investigational if the Health Plan decides that any one of the five criteria is not met. Experimental or investigational services are non-covered.

**Telemedicine**

Telemedicine services, as it pertains to the delivery of health care services, means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Telemedicine services do not include an audio-only telephone conversation, electronic mail message, or facsimile transmission. Telephone only and electronic mail message codes not eligible for separate reimbursement are 98966, 98967, 98968, 98969, 99441, 99442, 99443, 99444.