

January 5, 2018

RE: New policy updates (CLINICAL PAYMENT, CODING AND POLICY CHANGES)

Dear (Provider),

We hope you had a very Happy and Healthy New Year! The purpose of this letter is to notify you of new policy updates that will be effective for dates of service beginning **01/30/2018**.

Bundled Facility Payment Policy-Pre-Admission Outpatient Services Treated as Inpatient Services -

According to CMS policy, outpatient services provided on the date of inpatient admission are included in the Inpatient Prospective Payment System (IPPS) payment when provided by the same admitting hospital. This includes all services with the exception of ambulance.

Bundled Facility Payment Policy-Outpatient Services Treated as Inpatient Services-A

According to CMS policy, services provided by an outpatient hospital during an inpatient admission are not separately billable as they are included in the inpatient facility payment.

Bundled Services Policy- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Bundled to the Inpatient Admission-

According to CMS policy, Durable Medical equipment/supply items are for use by a member in his or her home. No separate payment will be made to a professional provider for DME items for a member's use in an inpatient institution. The institution is expected to provide all medically necessary DME items during a member's stay.

Evaluation and Management Services Policy-Observation Services-

Observation Discharge- According to the AMA CPT Manual, an observation care discharge code is to be utilized for discharge of a patient when the discharge is on a day other than the initial day of observation status. A qualifying observation care admission code/subsequent observation care code should be reported prior to the observation discharge care date of service.

Initial/Subsequent Observation Services for the Same Date of Service- According to CMS policy, the initial observation care may only be billed by the physician who ordered the hospital outpatient observation services and was responsible for the patient during his/her observation care. Payment for an initial observation care code is for all the care rendered

by the ordering physician on the date the patient is in an observation status and may only be billed once per day. Additional observation services cannot be reported by the same physician for the same date of service.

In addition, other physicians who may contribute to the care of the patient cannot report observation services for the same date of service. (The care rendered by a physician other than the ordering physician should be reported with the appropriate outpatient E/M codes.)

Evaluation and Management Services Policy- New Patient Visits-

According to the AMA CPT Manual and CMS policy, a new patient is one who has not received any professional services from the physician or another physician of the same specialty and subspecialty who belongs to the same group practice, within the past three years.

Given this definition, if a physician bills a new patient visit and the same physician or a physician from the same group practice with the same specialty and subspecialty has performed any other face-to-face service in the previous three years an established patient E&M should be reported. This includes professional services billed by a certified nurse midwife, clinical nurse specialist, nurse practitioner, or physician assistant as well; if any face-to-face services have been billed in the previous three years by the same Tax ID and any specialty.

Neurology Policy-

Ambulatory or 24-hour EEG Monitoring-

According to CMS policy, ambulatory or 24-hour EEG monitoring (95950, 95951, 95953 or 95956) is appropriate for diagnoses such as seizure disorders, meningococcal encephalitis or unspecified coma.

Neurophysiology Evoked Potential (NEP) Studies-Brainstem Auditory Evoked Potentials and Responses (BAEPs/BAERs) –

BAEPs/BAERs use an acoustic transducer inside an earphone or headphones to measure the brain wave activity from the ears through the brain stem that occurs in response to clicks or certain tones.

According to CMS policy, brainstem auditory evoked potential and response (BAEP/BAER) testing should be reported with an appropriate diagnosis (for example, evaluation of acoustic neuroma or unilateral tinnitus).

EEG-Frequency Limitations-According to CMS policy, it would not be expected to see more than three EEG services billed in most circumstances within a one-year period.

EEG In the Evaluation of Headache or Migraine-According to the American Academy of Neurology, no study has consistently demonstrated that an EEG improves diagnostic accuracy for the headache sufferer. An EEG has not been convincingly shown to identify headache subtypes, nor has it been shown to be an effective screening tool for structural causes of headache. Therefore, EEGs would not be expected to be performed for a diagnosis of headache or migraine.

Polysomnography and Sleep Studies-According to our policy, which is based on CMS Policy, providers should not submit two separate claims if they perform a split-night service on a single night.

Place of Service Policy- Mutually Exclusive Places of Service-

According to CMS policy, the place of service (POS) code used should indicate the setting in which the patient received a face-to-face encounter or where the technical component of a service was rendered, in the case of an interpretation. However, when a patient is in a registered inpatient status, all services billed by all providers should reflect and acknowledge the patient's inpatient status. When a physician/practitioner/supplier furnishes services to a registered inpatient, payment is made under the Medicare Physician Fee Schedule at the facility rate. A physician/practitioner/supplier furnishing services to a patient who is a registered inpatient shall, at a minimum, report the inpatient hospital POS code 21 irrespective of the setting where the patient actually receives the face-to-face encounter.

We appreciate your continued service to our members.

Thank you,

Provider Relations Department

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