WELLCARE BY `OHANA HEALTH PLAN CLAIM PAYMENT POLICIES

Wellcare's claim payment policies are based on publicly distributed guidelines from established industry sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state health care agencies and medical specialty professional societies. Coding terminology and methodologies are also based on accepted industry standards, including the Healthcare Common Procedure Coding System (HCPCS) manual,, the CPT code book and the International Statistical Classification of Diseases and Related Health Problems (most commonly known by the abbreviation ICD). Policies are applied in accordance with legal and regulatory requirements.

POLICY	DESCRIPTION
Add-On Codes	When an add-on code is submitted and the primary procedure has not been identified on either the same or previous claim, then the add-on code will be denied as an inappropriately coded procedure. If the primary procedure is denied because of some other logic (e.g. Correct Coding Initiative), then the add-on code will also be denied. An add-on code billed with a -51 modifier will be denied as the allowance for these procedures already reflects the reduced service associated to it. Providers should bill the appropriate add-on codes and not bill a primary service/procedure with a quantity greater than one.
Age & Gender Policies	Certain procedure codes, by definition or nature of the procedure, are limited to the treatment of a specific age or age group or gender. Similarly, certain diagnosis codes are age- or gender-specific as well.
Anesthesia	***Anesthesia Claims***: When surgical claims are billed by anesthesiologists, the services will be denied. Likewise, industry-accepted sources have established that anesthesia procedures should be billed by providers with an anesthesia specialty. ***Multiple General Anesthesia Service Same Day***: When multiple anesthesia services are billed for the same day for the same patient, the anesthesiologist should bill only the general anesthesia service for the procedure with the highest base value, plus the time for all anesthesia services

WELLCARE BY `OHANA HEALTH PLAN CLAIM PAYMENT POLICIES

POLICY	DESCRIPTION
	combined. Multiple anesthesia service codes will be processed according to the highest submitted charge as the primary procedure. The secondary anesthesia services will be denied. ***Frequency and Daily Management of Epidurals***: The daily hospital management of epidural or subarachnoid continuous drug administration is limited in frequency following a general anesthesia service. Similarly, these treatments are limited to a set number per year. ***Medical Supervision/Direction:*** When a certified registered nurse anesthetist (CRNA) or other qualified individual has rendered anesthesia services, the anesthesiologist should use the appropriate medical direction modifier.
Assistant Surgeons	For some procedures, assistant surgeons are not allowed or are restricted. Assistant surgeons must bill with the correct modifier. A single surgeon cannot be both the primary and assistant surgeon. Where allowed, there can only be one assistant surgeon.
Benefit Restrictions	Certain state contracts restrict benefits. Included are treatment for Hansen's Disease, pulmonary TB caused by mycobacterium, and podiatrists billing POS 12.
Bundled Services	There are a number of services and supplies whose payment is bundled into the payment for other related services. There are a few categories of bundled services: those that are not separately payable when billed on the same day as other payable services (Status Indicator P) and those that are not payable under any circumstances (Status Indicator B).
Co-Surgeons	For some procedures, co-surgeons of different specialties are allowed when billed with the correct modifier. Similarly, some procedures do not allow or restrict co-surgeons.
Deleted Procedure Codes	Procedure codes, such as Level II HCPCS (Healthcare Common Procedure Coding System) and AMA CPT-4 codes, undergo revision by their governing entities on a regular basis. Revisions typically include adding new procedure codes, deleting procedure codes and redefining the

WELLCARE BY `OHANA HEALTH PLAN CLAIM PAYMENT POLICIES

POLICY	DESCRIPTION
	description or nomenclature of existing procedure codes. These revisions are normally made on an annual basis by the governing entities with occasional quarterly updates. Claims received with deleted procedure codes will be validated against the date of service. If the procedure code is valid for the date of service, then the claim will continue processing.
Device and Supply	This policy addresses appropriate diagnostic imaging agents for specific imaging services, appropriate linkage between implant devices and implant procedures, brachytherapy sources, and blood products and transfusions.
Duplicate Claim	A duplicate claim is a claim or claim line that has been previously processed for payment and submitted by the same provider or different provider. New claims and claim lines received are compared against other claims and claim lines in both history and in the same claim batch. The basic elements of duplicate claims logic are: • Subscriber ID • Dependent ID • Date of service • Procedure code • Modifiers (we utilize proprietary logic to determine if combinations of modifiers indicate that a claim is a duplicate submission from a provider) • Units • Claim type • Specialty • Tax ID
Evaluation and Management (E&M) Services	***New Patient Visits***: The AMA defines a new patient as "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." Given this definition, if a physician bills a

WELLCARE BY `OHANA HEALTH PLAN CLAIM PAYMENT POLICIES

POLICY	DESCRIPTION
	new patient visit, and the same physician or a physician from the same group practice with the same specialty has performed any other evaluation and management code in the previous three years, then the second new patient visit will be denied. ***Multiple E&M Services on the Same Day***: Only one E&M code is allowed for a single date of service for the same provider group and specialty, regardless of place of service. Payment recommendation will be made for the E&M code with the highest average Medicare-allowed amount and all other E&M codes will be denied. Should an E&M service with a lower average Medicare-allowed amount have been previously processed, the second E&M service will be denied even if the average Medicare-allowed amount is higher than that of the first E&M service processed. ***Multiple Inpatient Admission or Consultation Services***: If a provider bills an inpatient admission or consultation service and another inpatient admission or consultation service has been billed in the previous seven days by the same provider, then the second inpatient admission or consultation service will be denied. The exception is if an inpatient discharge service has been billed during the seven-day period.
Frequency	Certain services will be reimbursed only a set number of occurrences per member per year, depending on the type of service performed and what it may be billed with.
Global Obstetrical Package	Certain services, defined by the AMA and the American College of Obstetricians and Gynecologists, will be denied as included if billed within the antepartum, intrapartum or postpartum period of a delivery. Additionally, certain services will be denied as being included in other billed services. Also, only one global delivery and/or cesarean per delivery. Likewise, certain codes can only be billed once per specific time frame.
Global Surgery	Global surgery includes all necessary services normally furnished by the surgeon before, during and after the surgical procedure. The global surgery period applies only to surgical procedures that have postoperative periods of zero, 10 and 90 days,.The global surgery concept applies only

WELLCARE BY `OHANA HEALTH PLAN CLAIM PAYMENT POLICIES

POLICY	DESCRIPTION
	to primary surgeons and co-surgeons. ***Minor surgical procedures***: These are relatively small procedures that include various intra-operative and post-operative services. Procedures with a zero- and 10-day postoperative period are classified as minor procedures. The services included in the minor surgery period are: evaluation and management visits rendered on the same day as the minor procedure are not payable separately; all intra-operative services (same-day services) that are normally part of the surgical procedure and for 10-day global surgery procedures: postoperative visits and related procedures rendered within 10 days of the surgery. ***Major surgical procedures***: These are relatively extensive surgical procedures that include various pre-operative, intra-operative and post-operative services. Procedures with a 90-day postoperative period are classified as major procedures. The services included in the major surgery fee are: Preoperative visits rendered 1 day (24 hours) prior to the surgery, all intra-operative services (same day services) that are normally part of the surgical procedure and postoperative visits and related procedures rendered within 90 days after the surgery.
ICD Specificity	Guidelines instruct providers to bill diagnosis codes that are coded to the highest level of specificity. For most codes, this means the submitted code should be at the fourth or fifth digit. There are very few codes where the three digit code is the highest level of specificity.
ICD-9 Guideline	The ICD-9 book defines the appropriate use of coding diagnoses. It addresses coding for principal diagnoses, secondary diagnoses, manifestation codes, and E diagnosis codes. These guidelines are enforced at the claim-header level.
“Incident To” Services	“Incident to" services are defined as those services furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an illness or injury. A physician may be reimbursed for “incident to” services performed by auxiliary personnel only when an employer relationship exists between the physician and auxiliary personnel.

WELLCARE BY `OHANA HEALTH PLAN CLAIM PAYMENT POLICIES

POLICY	DESCRIPTION
Invalid or Deleted Diagnosis Codes	Diagnosis codes undergo revision by the governing entity. Revisions typically include adding new diagnosis codes, deleting diagnosis codes and redefining the description or nomenclature of existing diagnosis codes. Claims received with deleted diagnosis codes will be validated against the date of service. If the diagnosis code is valid for the date of service, then the claim will continue processing. If the diagnosis code is invalid for the date of service then the procedure will be denied.
Modifiers	Most modifiers have descriptions indicating that the procedure applies to a specific anatomic site, the services were performed distinctly from other services or special circumstances surrounded the performance of services. Procedures billed with inappropriate modifiers will be denied as inappropriately coded procedures.
National Correct Coding Initiative (NCCI)	NCCI is a collection of bundling edits sponsored by CMS that are separated into two major categories: comprehensive and component procedure code edits, and mutually exclusive procedure code edits. Coding not following NCCI guidelines will be denied. Additionally, supplemental edits have been created for the codes not addressed by CMS that mirror the CCI edits associated with the codes CMS does recognize.
NCCI Policies and Guidelines	The National Correct Coding Policy Manual is broken into 12 narrative chapters, with each chapter corresponding to a section of the AMA CPT Manual. Each chapter contains correct coding policies as it relates to the procedure codes contained within its section. In many cases, these policies were either never incorporated or were only partially incorporated into the actual NCCI edits.
National Coverage Determinations (NCD)	CMS has numerous NCDs that deal with such topics as bone-density studies, cardiac rehabilitation, colorectal cancer screening, diabetes self-management training services, home international normalized ratio (INR) monitoring, pacemaker analysis, etc. CMS also has laboratory NCDs that address appropriate diagnosis and medical necessity criteria for many laboratory tests. As part of NCD, CMS has determined that certain procedures can be billed at a certain frequency and that certain procedures need to be billed with certain diagnosis codes.

WELLCARE BY `OHANA HEALTH PLAN CLAIM PAYMENT POLICIES

POLICY	DESCRIPTION
Obstetrical Care	***Global Obstetrical Package***: Separate reimbursement for those services that are included in the global obstetrical package for uncomplicated maternity cases is not allowed. **Global Obstetrical Delivery Post-Operative Care:** Evaluation and management services and postpartum care billed for a date of service within a 42-day time frame will be bundled into the global delivery service when billed by the same provider that performed the delivery, except when the E&M was unrelated to the obstetrical care.. ***Antepartum Care*:** It is not appropriate for a single provider to bill more than one 59425 or 59426 in any combination during the antepartum period. Therefore if more than one of these codes is billed by the same provider in a 240-day period, the subsequent billed codes will be denied. ***Antepartum Care by Different Provider Groups*:** When more than one provider group renders a portion of the antepartum care to a pregnant patient, it is inappropriate for the delivering physician to bill with a global obstetrical delivery code.
Place of Service Policies	Certain procedure codes, by definition, are limited to particular place(s) of service. When these procedure codes are billed in a place of service inconsistent with the procedural definition, the code will be denied (e.g. hospital admission codes [99221-99223] can only be billed for place-of-service inpatient hospital).
Procedure Code Guidelines	Throughout the AMA CPT-4 Book and CMS HCPCS Book, the publishers have provided instructions on code usage. These guidelines have been developed into edits.
Procedure Definition Policies	Policies have been developed that support correct coding based on the definition or nature of a procedure code or combination of procedure codes. These policies will bundle procedures based on the appropriateness of the code selection.

WELLCARE BY 'OHANA HEALTH PLAN CLAIM PAYMENT POLICIES

POLICY	DESCRIPTION
Professional, Technical and Global Policies	***Diagnostic Tests and Radiology Services Performed Outside the Office Setting*:** Procedures with professional, technical and global components should be submitted with an appropriate procedure code modifier that is consistent with the place the service was rendered. It is not appropriate for a provider to bill the global or technical component in a place of service outside their office as the technical component will be billed by the facility in which the service took place. ***Global Payment to the Same Provider*:** A provider will not be reimbursed more than the global component amount. If a provider splits components among different claims, then the claims received subsequent to the first claim will be adjusted based on the payment of the first claim. ***Technical Component-Only Procedures***: Technical component-only services are stand-alone procedure codes that describe only the technical component (e.g., staff and equipment costs only) of a given procedure for which there is either an associated code that describes the professional component of the diagnostic test only or for which there is accompanying professional component. Payment to physicians for these services is limited to the office place of service as the facility will bill for these services when rendered in a non-office setting. It is also inappropriate for a provider to bill these procedures with either modifier 26 (professional component) or TC (technical component) as neither of these modifiers is applicable to this group of procedure codes.
Separate Procedures	The description for many CPT codes includes a parenthetical statement that the procedure represents a "separate procedure." The inclusion of this statement indicates that the procedure should not be reported when it is performed in conjunction with, and related to, a major service.
Split Surgical Care	Split surgical care occurs when different physicians furnish either the pre-operative, intra-operative or post-operative portions of the global surgical package. When split surgical care occurs, each provider is reimbursed according to the portion of surgical care they provided.

WELLCARE BY 'OHANA HEALTH PLAN CLAIM PAYMENT POLICIES

POLICY	DESCRIPTION
Team Surgery Policy	In a team surgery setting, the physicians are typically of different specialties and also include other highly skilled, specially trained personnel. The Medicare Physician Fee Schedule (MPFS) includes a list of procedures where team surgery is not allowed. Likewise, the Medicare fee schedule includes a list of procedures where the team surgeons concept does not apply. These are generally procedures that are minor or non-surgical in nature and will be denied if billed with modifier 66 (team surgery). Additionally, if modifier 66 is missing for an otherwise valid code, then it will be denied.
Timely Filing	CMS and state Medicaid organizations mandate the time in which a provider has to submit a claim. All claim lines submitted within their specific time limit will be processed.