

## Chapter 6

# Physician and Professional Services

The following sections are included in this chapter:

1. Physician services
2. Evaluation and management services
3. Education and counseling
4. Smoking cessation services
5. Medical supplies provided by a physician's office
6. Casting provided in a physician's office
7. Immunization and vaccination
8. Laboratory services
9. EKG interpretations
10. Acupuncture
11. Allergy immunotherapy-allergy testing
12. Surgical services
13. Locum Tenens physicians
14. Reciprocal billing
15. Telemedicine
16. Advanced practice registered nurse services
17. Physician assistant
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19. Outpatient hospital services
20. Hospital Physician Services
21. Urgent care clinic service
22. Authorization Standards
23. Transplant service
24. Medical Nutrition Therapy (MNT)
25. Diabetic outpatient self-management training services
26. Nutritional products
27. Podiatry service
28. Relocation service coordination

## Physician Services

**Physician:** A person who is licensed to provide health services within the scope of his/her profession under [MS 147](#). For purposes of this section, a physician means a licensed doctor of medicine or osteopathy.

## Enrollment Requirements

Physicians must enroll with the Minnesota Department of Human Services (DHS) to receive payment. If you are not eligible for participation with DHS, please contact PrimeWest Health. Physicians must receive an individual National Provider Identifier (NPI) even if they are a member of a group or clinic or are employed by an outpatient hospital or other organized health care delivery system that employs physicians. (Refer to the [Locum Tenens Physicians](#) section of this chapter.)

## Covered Services

Services provided by a physician are not restricted to a specific place of service unless specified by Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code description. Physicians may provide services in the member's home, nursing home, outpatient hospital, inpatient hospital, or other facility.

Physicians may not bill separately for performing administrative or medical functions that are paid through an institution's per diem rate.

A health service must be medically necessary in order to be a covered service. Services listed as provided by a physician in this chapter may be provided by other health care professionals if the service is within the scope of their practice as defined in Minnesota Statutes.

## Evaluation and Management Services (E/M)

PrimeWest Health follows CPT guidelines for billing E/M services.

### Concurrent Care

**Concurrent Care Services:** The provision of similar services (e.g., hospital visits to the same patient by more than one physician on the same day). If a consulting physician subsequently assumes the responsibility for a portion of patient management, it is considered concurrent care.

PrimeWest Health pays concurrent care when the medical condition of the member requires the services of more than one physician. Generally, a member's condition that requires physician input in more than one specialty area establishes medical necessity for concurrent care.

### Non-Covered Concurrent Care Services

PrimeWest Health will not pay for concurrent care when either of the following occurs:

1. The physician makes a routine call at the request of the member and family or as a matter of personal interest
2. Available information does not support the medical necessity of concurrent care

### Billing Concurrent Care

If the member's condition requires concurrent care, bill the appropriate E/M code and modifier.

### Consultation

A consultation is when the treating physician or other qualified health care professional asks the advice or opinion of another physician or qualified health care professional. A consulting physician or qualified health care professional has a wide degree of latitude in providing services but does not assume care or provide treatment plans.

The request for consultation from the attending physician or other appropriate source must be documented in the member's medical record. The consultant's opinion and any services ordered or performed must also be documented in the member's medical record and communicated to the requesting physician.

If the consulting physician assumes responsibility for the continuing care of the patient, any subsequent services rendered will cease to be a consultation.

Effective for dates of service beginning January 1, 2010, PrimeWest Health, following Medicare guidelines, will no longer recognize the following CPT consultation codes:

1. Office/outpatient settings (CPT codes 99241 – 99245)
2. Inpatient consultation codes (CPT codes 99251 – 99255)

This applies to Medicare-covered services only.

1. Medicare Advantage Plans
  - a. Prime Health Complete (HMO SNP)\*
  - b. PrimeWest Senior Health Complete (HMO SNP)\*\*

PrimeWest Health will continue accepting consultation codes for Medicaid-covered services.

Telehealth consultation G codes will not be affected by this change.

PrimeWest Health will allow claims submitted to PrimeWest Health as secondary where primary insurance was billed and paid.

1. If primary insurance denied as non-covered, provider must submit claim by PrimeWest Health rules.

## Critical Care

Use CPT E/M codes to report critical care, which are designed to include both of the following:

1. All diagnostic and therapeutic services listed
2. Direction of care provided by the physician during the period for which this procedure code is billed

Follow CPT guidelines to determine which services are included in reporting critical care codes.

Physicians must not bill separately for procedures included in the code and performed during the critical care hour. Physicians may bill separately for services performed that are not included in the critical care codes.

## Observation Services

Report E/M observation codes and follow CPT guidelines.

1. Observation services are covered with or without being preceded by a medical emergency.
2. Observation services are paid for up to 48 hours and, in some circumstances, up to 72 hours.

## Physician Services While Member is Inpatient Status

Providers may use place of service code 11 (office) for CPT procedure codes in the 90000 – 99999 range, or codes in the 70000 – 79999 range when they include the 26 modifier for the professional component.

For all other procedures done while the patient is considered in an inpatient status, use place of service code 21 (inpatient).

## **Physician Services in Long-Term Care (LTC) Facilities**

Payment for physician and professional services in an LTC must be medically necessary. Refer to the *Physician Extenders* section of this chapter for use of [physician extender](#) services provided in LTC facilities. Refer to [Long-Term Care, Chapter 27](#), for additional information on covered services in LTC facilities.

### **Prolonged Physician Services**

Prolonged services involving direct (face-to-face) patient contact are covered. Report the total duration of face-to-face time spent providing care on a given date.

### **Physician Standby Services**

Standby services are covered when requested by another physician and involve prolonged attendance without direct (face-to-face) patient contact. Standby services are covered only in the case of a documented existing risk or distress, such as documented fetal distress.

### **Physician Case Management (Team Conferences)**

A medical team conference conducted for the purpose of coordinating the activities of a recipient's care with an interdisciplinary team of health professionals or a representative of community agencies is a covered service.

The medical record must document the contents of the conference and the amount of time spent in the conference.

Bill the appropriate CPT E/M code.

### **Medical Conference/Counseling (as part of E/M code)**

Physician services related to counseling are covered as part of the E/M codes if the counseling is conducted face-to-face with the patient, relative, or guardian.

When counseling and/or coordination of care dominates (more than 50 percent) the physician/patient and/or family encounter, time may be considered the key or controlling factor to qualify for a particular level of E/M service. Medical record documentation must reflect the content of the counseling, coordination of care, and the amount of time spent in counseling/coordination.

### **Telephone Calls**

Telephone calls are not covered by PrimeWest Health.

### **Care Plan Oversight**

PrimeWest Health encourages physicians to participate actively in care planning with our elderly members, their families, and our county partner case managers. PrimeWest Health understands that collaboration with county case managers and other team members takes added time. PrimeWest Health has approved the use of specific service codes pertaining to care plan oversight responsibilities and face-to-face visits with county case managers (patient not present). These codes and current rates are summarized in the following table.

<b>PRIMEWEST HEALTH CARE PLAN OVERSIGHT CODES</b>			
CPT/HCPCS Code	Modifier [1]	Code Description	Current Payment Level [2]
99339	HC	Individual physician supervision of a patient (patient not present) <b>in home, domiciliary, or rest home</b> (e.g., assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans; review of subsequent reports of patient status; review of related laboratory and other studies; communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian), and/or key caregiver(s) involved in patient’s care; integration of new information into the medical treatment plan; and/or adjustment of medical therapy, within a calendar month; 15 – 29 minutes;	\$50.00
99340	HC	30 minutes or more	\$80.00

**Please note:**

- CPT codes 99339 – 99340 are to be used for **any member** in the Minnesota Senior Health Options (MSHO) or Minnesota Senior Care Plus (MSC+) programs receiving Elderly Waiver Home and Community Based Services for Care Plan Oversight services in their home, domiciliary, or rest home.
- CPT codes 99339 – 99340 are to be used for the provider’s time involved in care plan oversight work with county case managers. Submit the claim to PrimeWest Health under the member’s name.
- Documentation in the medical record must clearly show both the time and the substance of services performed within each month of billing.
- These codes are differentiated from care plan oversight for case management with a home health agency, hospice, and nursing facility patients.
- A copy of the summary documentation for the care plan oversight should be sent to the county case manager involved. The county case managers depend on current and accurate information from the provider to appropriately meet the needs of the member, and for proper submission to PrimeWest Health.

<b>PRIMEWEST HEALTH FACE-TO-FACE VISIT CODES WITH COUNTY CASE MANAGER</b>			
CPT/HCPCS Code	Modifier [1]	Code Description	Current Payment Level [2]
99367	52, HC	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician	\$36.45

**Please note:**

- This code is to be used for the provider’s time in a face-to-face clinic visit with a county case manager regarding a specific member.
- The modifier 52 (reduced services) is appended to 99367 to show the service provided does not meet all of the elements of 99367.
- Submit 99367-52 to PrimeWest Health under the member’s name.
- Documentation in the medical record must clearly show the substance of counseling and coordination of care.
- A copy of the documentation should be sent to the county case manager as a follow-up. The county case managers depend on current and accurate information from the provider to appropriately meet the needs of the member, and proper submission to PrimeWest Health.

[1] HC = Adult program geriatric. 52 = Reduced services.

[2] = Payment levels are subject to periodic change based on federal or state legislation, regulations, program requirements, or provider contract provisions.

## Preventive Medicine Services

**Preventive Health Service:** A health service provided to a patient to avoid or minimize the occurrence or recurrence of illness, infection, disability, or other health condition. Preventive health services are covered if the service:

1. Is provided in person;
2. Affects a health condition rather than the physical environment;
3. Is not otherwise available to the member without cost as part of another preventive health program funded by a government or private agency;
4. Is not part of another covered service;
5. Avoids or minimizes an illness, infection, or disability that will respond to treatment (e.g., asthma or diabetes education);
6. Is generally accepted by the provider’s professional peer group as a safe and effective means to avoid or minimize the illness; and
7. Is ordered in writing by a physician, advanced practice registered nurse (APRN), physician assistant (PA), and included in the plan of care approved by the primary care provider.

## Comprehensive Elder Health Evaluation (CEHE) Incentive

DHS recently announced the implementation of a Comprehensive Elder Health Evaluation (CEHE) incentive payment for primary care providers.

PrimeWest Health would like to ensure that primary care providers who are currently contracted with us and working in our communities are aware of this opportunity.

CEHE allows caregivers to do a comprehensive preventive health evaluation on an annual basis and receive an additional \$15 above the usual reimbursement for CPT codes 99387 or 99397. If the provider performs and documents an evaluation of influenza and pneumococcal immunization status, mental health status, presence or absence of urinary incontinence, and visual function during the preventive health evaluation, the provider will receive a \$40 reimbursement.

CEHE Service	CPT Code(s)	CPT Code(s) Description	Provider Incentive Payment	Comment
New or established patient annual CEHE visit	99387 or 99397	Initial comprehensive preventive medicine evaluation; 65 years or older	\$15.00	The provider will also receive the established PrimeWest Health reimbursement rate for this code
New or established patient annual CEHE visit along with the following (all five items must be assessed):	99387 or 99397	Initial comprehensive preventive medicine evaluation; 65 years and older	\$40.00	The provider will also receive the established PrimeWest Health reimbursement rate for this code
1. Pneumococcal immunization status	1022F	Pneumococcal immunization status assessed		
2. Influenza immunization status	1030F	Influenza immunization status assessed		
3. Visual functional status	1055F	Visual functional status assessed		
4. Urinary incontinence status	1090F	Presence or absence of urinary incontinence assessed		
5. Mental status	2014F	Mental status assessed		

## Non-covered Preventive Services

The following services are not covered as a preventive service:

1. Services that are only for vocational or educational purposes that are not health related
2. Services that deal with external, social, or environmental factors that do not directly address the member’s physical or mental health

## Preventive Medicine Services/Counseling and/or Risk Factor Reduction

Preventive health counseling to promote health and prevent illness or injury is a covered service. These services should be billed with the appropriate E/M code for preventive medicine, individual counseling, and group counseling.

## Education and Counseling

### Eligible Providers

Eligible providers include: enrolled physicians, physician clinics, community clinics, outpatient hospitals, public health clinics, family planning agencies, certified nurse practitioners, physician assistants, clinical nurse specialists, certified nurse midwives, community mental health centers, and physician extenders. Certified asthma educators are eligible to provide asthma education.

Covered Education or Counseling Services			
Reason for Education or Counseling	HCPCS Code(s)	Eligible Providers	Billing Directions
Education/counseling is the primary reason for the visit.  Services to healthy individuals for the purpose of promoting health and anticipatory guidance (e.g., family planning, smoking cessation, infant safety, etc.).	99401 – 99404 (individual)  99411 – 99412 (group)	<ul style="list-style-type: none"> <li>• Physicians</li> <li>• PAs and APRNs (NPs, CNSs, CNMs)</li> <li>• Physician extenders: APRNs who choose not to enroll, RNs, genetic counselors and licensed acupuncturists</li> </ul>	Use modifier U7 when a physician extender provides the service.
Education/counseling is the primary reason for the visit.  Services to people with symptoms, a diagnosis, or established illness (e.g., prenatal, joint care, pain, HIV, asthma).	99078 (group)	<ul style="list-style-type: none"> <li>• Physicians;</li> <li>• PAs and APRNs (NPs, CNSs, CNMs);</li> <li>• Physician extenders (non-enrolled)</li> </ul>	Use modifier U7 when a physician extender provides the service.
Refer also to nutritional, diabetic, and weight reduction guidelines		<ul style="list-style-type: none"> <li>• APRNs, RNs, genetic counselors, licensed acupuncturists)</li> </ul>	
Education/counseling is an add-on to the office visit (e.g., provided as part of the regular office visit and dominating more than 50% of the visit, then <i>time</i> may be considered the key or controlling factor to qualify for a particular level of E/M service.	99201 – 99205 (new patient)  99211 – 99215 (established patient)	<ul style="list-style-type: none"> <li>• Physicians</li> <li>• PAs and APRNs (NPs, CNSs, CNMs)</li> <li>• Physician extenders: APRNs who choose not to enroll, RNs, genetic counselors and licensed acupuncturists</li> </ul>	Use modifier U7 when a physician extender provides the service.

Asthma education, per session. Asthma education may be reported outside of the office visit when an asthma action plan (AAP) has been written by the clinician and discussed with patient/family, documented in the medical record, and a copy provided to the asthma educator.	S9441	<ul style="list-style-type: none"> <li>Asthma education may be reported with S9441 by using the supervising clinician’s NPI for one of the following: Non-enrolled APRNs (NPs, CNSs, CNMs); RNs Certified Asthma Educators (CAE)</li> </ul>	Bill one unit for each class.
Birthing classes, per session/encounter.	S9442	<ul style="list-style-type: none"> <li>Physicians</li> <li>PAs and APRNs (NPs, CNSs, CNMs)</li> <li>Clinics and outpatient hospitals whose prenatal education program is directed by a PrimeWest Health enrolled provider may report S9442, S9443, and H1003 with one of the following:                             <ul style="list-style-type: none"> <li>RNs</li> <li>Health educators with at least a baccalaureate level degree in health education and/or national certification with ICEA, Lamaze, or NCHEC for prenatal certification; IBCLC for lactation certification.</li> </ul> </li> </ul>	Bill one unit each time the class meets.
Lactation classes, per session/encounter.	S9443		Bill one unit each time the class meets.
Enhanced prenatal services provided to “at-risk” pregnant women only. An at-risk determination is based on the results of a prenatal risk assessment (e.g., ACOG’s Obstetric Medical History).	H1003		Bill one unit for the entire class: 3 weeks of nutrition education = 1 unit.
Counseling to assess and minimize problems hindering normal nutrition, and to improve the patient’s nutritional status.	97802 – initial individual 97803 – reassess individual 97804 – group	Physicians, licensed dieticians, licensed nutritionists	Bill 15 minute unit. MNT is reimbursed when a licensed dietician/nutritionist is under the supervision of a physician.
Reassessment due to change in diagnosis, medical condition, or treatment regimen requiring a second referral in the same year.	G0270 – individual G0271 – group	Physicians, RNs, licensed dieticians, licensed nutritionists	Bill 15 minute unit. MNT is reimbursed when a licensed dietician/nutritionist is under the supervision of a physician.
Diabetic Outpatient Self-management Training services (DSMT) including education about self-monitoring blood glucose, diet, exercise, and sliding scale insulin treatment for the patient who is insulin dependent.	G0108 – individual G0109 – group	Physicians, RNs, licensed dieticians, licensed nutritionist. A provider of dually eligible Medicare/MHCP recipients must be a “certified provider” according to the National Diabetes Advisory Board Standards.	Bill 30 minute unit. Initial training 10 hour limit/12 months. Additional training limited to 1 hour per year.
Car Seat Education	S9447	Public Health Nurse (PHN)	

Refer to the Community Health Worker (CHW) section of [Clinic Services](#), Chapter 8, for covered education services provided by a CHW.

## Non-covered Services

Services provided as part of a day treatment program, partial hospitalization, or other similar health care programs may not be billed as physician services provided in an educational or counseling setting.

## Documentation

A physician order for educational or counseling services is required. Documentation of the member's participation, number of participants in the educational or counseling group, name, and credentials of person who provided the service and topic content must be in the medical record or class record.

## Billing

1. If an educational or counseling group is advertised as “free,” it cannot be billed to PrimeWest Health.
2. The cost of educational materials is included in the payment; no additional payment will be made for handouts, textbooks, or other materials.
3. Physician extenders must modify their services using the appropriate modifier. (Refer to the *Physician Extenders* section in this chapter.)

## Smoking Cessation Services

PrimeWest Health covers smoking cessation education, counseling, and products when they are ordered by a primary care provider and provided by a PrimeWest Health enrolled provider. Smoking cessation products must be approved by the Food and Drug Administration (FDA) and covered under the Medicaid Drug Rebate Agreement.

## Medical Supplies Provided by a Physician Office

### Eligible Providers

For the purpose of this chapter: physicians, APRNs, PAs, and physician clinics.

### Payment Limitations

Payment limitations for medical supplies provided by a physician's office are the same as for medical supplies. Refer to [Equipment and Supplies, Chapter 23](#). Routine supplies are not paid separately. Supplies applied or used in the physician's office or clinic in direct relationship to an illness or injury are generally considered incident to the service and are not separately billable to PrimeWest Health.

## Non-covered Services

Supplies sent home with members are not covered by PrimeWest Health.

The following list of routine physician office supplies cannot be billed separately. This is not an all-inclusive list:

Adhesive tape, all sizes	Betadine, Iodine, Providine swabs/wipes
Alcohol or peroxide, per pint	Betadine, Phisohex, per pint
Alcohol wipes	Chux pads
Autolet	Cold packs
Band-Aids	Cotton balls

Cotton tip application (sterile/non-sterile)	Opsite
Culturette	Patient electrode pads
Emesis basins	Razor
Enema kits	Sanitary belt/napkins, tampons
Gauze pads, sterile or non-sterile	Silver nitrate stick
Gelfoam	Specimen collection
Gloves (latex, plastic, rubber, sterile, etc.)	Steri-strips
Gowns	Sterile saline, 30cc
Hemostatic cellulose (e.g., surgical, any size)	Sterile water, 30cc
IVP dyes	Suction tubing
Kerlix, Kling bandages	Surgical drapes
Masks	Suture removal tray
Microporous tape	Syringe (with/without needles)
Needles, sterile	Thermometer (any size)

## Casting Provided in a Physician Office

Please follow the appropriate CPT coding guidelines for casting and recasting.

1. If no surgery or manipulation is done, bill the appropriate E/M code and HCPCS casting supply code.
2. If surgery or manipulation is done, bill the appropriate CPT surgery code and HCPCS casting supply code.
3. If recasting is done, bill the appropriate CPT casting code and HCPCS casting supply code.

## Immunizations and/or Vaccinations

PrimeWest Health covers vaccines, toxoids, and an administration fee.

PrimeWest Health covers **only** the administration fee for vaccines and toxoids provided free by the Minnesota Vaccines for Children (MnVFC), available through the Minnesota Department of Health (MDH). Most routine childhood vaccines and some adult vaccines are available through the MnVFC program. Refer to the Immunization section of [Children’s Services, Chapter 9](#), and [Immunizations and Vaccinations, Chapter 9A](#).

Please follow current DHS billing policies when you use your private stock of vaccines as replacement for MnVFC vaccine. The DHS policies regarding this may change from year to year.

## Laboratory Services

Refer to [Laboratory/Pathology, Radiology, and Diagnostic Services, Chapter 11](#), for specific information regarding laboratory/pathology, radiologic, diagnostic services, laboratory handling, and specimen collection fees.

### Billing

When a physician or physician clinic bills for CLIA certified lab services and the equipment used is owned by the physician or clinic, the services cannot be separated into a professional and technical component. Bill the appropriate code **without** a modifier.

Physician or physician clinics may choose to bill laboratory services sent out to a hospital or free standing laboratory. The claim line must include the lab procedure code, place of service (where the specimen was sent), and the modifier for reference (outside) laboratory.

Physician or physician clinics may also have the hospital or free standing lab bill PrimeWest Health directly; modifier 90 is not required.

A physician clinic laboratory granted CLIA Waiver Certification may only perform waiver tests. Refer to [Laboratory/Pathology, Radiology, and Diagnostic Services, Chapter 11](#).

Please submit a copy of your CLIA certificate to the PrimeWest Health contracting department with each renewal.

## EKG Interpretations

EKG interpretation services may be billed in addition to the E/M service. PrimeWest Health covers one physician interpretation for each EKG.

## Acupuncture

Acupuncture is covered for chronic pain. Authorization is required in excess of 10 sessions and must be performed by: 1) an MD or licensed acupuncturist employed and supervised by an MD; or 2) provided through a hospital pain management program by an MD or licensed acupuncturist who is supervised by an MD. Use the Physician Extender modifier for non-physician services.

## Allergy Immunotherapy-Allergy Testing

The preparation of allergenic extracts and the administration of allergy immunotherapy are covered services.

**Antigen:** The raw form of pollen (venom, stinging insect, etc.), prior to refinement for administration to humans.

**Allergenic Extract:** The refined injectible form of antigen either commercially prepared or refined in the physician's office under his/her supervision.

**Immunotherapy:** The parenteral administration of allergenic extracts as antigens at periodic intervals, usually on an increasing dosage scale to a dosage which is maintained as maintenance therapy.

**Professional Services:** Physician ordered allergen immunotherapy and services either performed by the physician or qualified personnel under the physician.

### Covered Services

1. Providing the raw pollen
2. Professional services to prepare raw antigen to a refined state that will become an allergenic extract
3. Professional services to administer the allergenic extract
4. Providing the injectible allergenic extract
5. Professional services to monitor the recipient's injection site and observe for anaphylactic reaction
6. Allergy testing
7. Provision of inhalants (a pharmaceutical). Refer to [Pharmacy Services, Chapter 22](#).

### Non-Covered Services

The following allergy testing and treatments have not been proven to be effective, and therefore are **not** covered.

## Testing

1. Cytotoxic leukocyte testing (Brian's test)
2. Leukocyte histamine release testing
3. Provocation-neutralization testing (sublingual, subcutaneous, intradermal, or intracutaneous)
4. Rebeck skin window test
5. Passive transfer or P-K Test (Prausnitz-Kustner) (this has been replaced by RAST)
6. Candidiasis hypersensitivity syndrome testing
7. IgG level testing (IgG level testing for all antibiotics except penicillin)
8. General volatile organic screening test (volatile aliphatic panel)
9. Allergy antibiotic skin testing for all antibiotics except penicillin (penicillin testing is done using penicillin G, Pre-Pen, and penicillin minor determinants)
10. ELISA/ACT immunotherapy (Serammune Physician Lab, Reston VA)
11. Antigen Leukocyte Cellular Antibody Test (ALCAT)

## Treatment

1. Provocation-neutralization treatment (sublingual, subcutaneous, intradermal, or intracutaneous)
2. Oral and sublingual immunotherapy (includes oral drops, solutions, oral capsules, and tablets)
3. Rinkel immunotherapy (serial dilution endpoint titration). Note: Allergy testing using this method is eligible as a variant of conventional intradermal skin testing
4. Autologous urine immunizations
5. Clinical ecology urine immunizations
6. Candidiasis hypersensitivity syndrome treatment and related services
7. IV vitamin C therapy
8. Enzyme potentiated desensitization

## Coverage Limitations

Allergenic extracts may be administered with either one or multiple injections. Documentation in the medical record must support the number of injections administered.

**Preparation of Raw Antigen to Allergenic Extract:** Only physicians who perform the refinement of raw antigens to allergenic extract may bill for this service. This service involves the following:

1. Sterile preparation of an allergenic extract by titration, filters, etc.
2. Checking the integrity of the extract by cultures or other qualitative methods

Purchasing refined antigens, measuring dosages, and adding diluent is **not** refining raw antigens.

**Adding Diluent:** As in any other medication administration, it is not a separately covered service. This service is an integral part of the professional services for providing an allergenic extract.

**Additional Visits:** Payment for injection administration will be adjusted and reflect monitoring of the injection site and observation of the patient for anaphylactic reaction.

A separate visit charge for the provision of allergy services is not allowed unless other identifiable services are performed such as physical examination, review of systems, obtaining a history of current symptoms or illness, laboratory services, and blood pressures, etc. Identifiable services **not** included in an office visit may be billed separately.

## Surgical Services

### Global Surgery Package

PrimeWest Health follows CPT guidelines regarding the global surgical package.

**The global surgical package period:** Surgery and the time following surgery during which routine care by the physician is considered postoperative and included in the surgical fee. Office visits or other routine care related to the original surgery cannot be separately reported if the care occurs during the global period. Global periods may be referred to as "follow-up-days" or FUDs.

PrimeWest Health covers medically necessary surgical services. PrimeWest Health reimbursement for all surgeries is based on a global surgery package, which follows Medicare global surgery guidelines and includes pre-, post-, and intraoperative work related to the surgical procedure. PrimeWest Health starts the global surgery the day of surgery and follows Medicare guidelines for the number of days in the global package. Preoperative physicals by a primary physician are not included in the global package. Evaluation of the need for surgery by the surgeon is also covered outside of the global surgical package.

The visit identifying the need for surgery is not included in the global fee even if occurring on the preoperative day or on the day of surgery. Use CPT modifier 57 to bill the E/M service for established patient visit or consultation the day before or the day of major surgery when the decision for surgery is made during the visit.

For global surgery purposes, surgeries are classified into three categories: exempt/endoscopic, minor, and major. The global surgery package for each category includes the following services.

#### Exempt/Endoscopic (0 days)

1. Physician visit on the same day as surgery
2. The surgical procedure
3. No postoperative days

E/M services provided on the same day as the procedure are generally not payable unless they are significant, separately identifiable, and billed with modifier 25.

#### Minor Surgery (10 days)

1. Physician visit on the same day as surgery
2. The surgical procedure
3. 10 days of postoperative care

E/M services provided on the same day as the procedure are generally not payable unless they are significant, separately identifiable, and billed with modifier 25.

#### Major Surgery (90 days)

1. Preoperative exam on the day of, or the day before surgery
2. The surgical procedure
3. 90 days of postoperative care

The visit identifying the need for surgery is not included in the global fee even if occurring on the preoperative day or on the day of surgery. Use CPT modifier 57 to bill the E/M service for established patient visit or consultation the day before or the day of major surgery when the decision for surgery is made during the visit.

## Postoperative Care

Postoperative care includes:

1. Evaluation and management services
2. Pain management
3. Treatment of complications (e.g., treatment of infection related to the surgery)
4. Miscellaneous service: dressing changes and local incisional care; removal of operative pack, cutaneous sutures and staples, lines, wires, tubes, drains, casts and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes/removal of tracheostomy tubes

## Complications

Complications requiring additional services from the surgeon that do not require a return trip to the operating room are included in the global payment. Surgical complications requiring a return to the operation room are not included in the global fee. Report complications requiring a return trip to the operating room with modifier 78 appended to the original procedure code.

The following services are **not** included in the global package:

1. Initial (new patient) E/M visit
2. Diagnostic tests and procedures
3. Surgical trays
4. Recasting
5. Casting supplies
6. Dialysis
7. Immunosuppressive therapy
8. Radiation oncology services
9. Physical therapy
10. Silicone punctual plugs (A4263) when reported with code 68761 and POS 11 (office)
11. Implantable vascular access device (A4300), when reported with code 36533 and POS 11 (office)
12. Catheter used for treatment of a temporary obstruction and POS 11 (office)

If further specifics are required, refer to the Medicare global surgery guidelines.

## Assistant-at-Surgery

PrimeWest Health follows Medicare's assistant-at-surgery guidelines. PrimeWest Health does not cover assistant-at-surgery services provided by surgical technicians, surgical assistants, RN first assists (RNFA), clinical nurse specialists, or certified nurse practitioners.

MD assistant surgeons or physician assistants are covered for assistant-at-surgery. MD assistant surgeons must bill using the appropriate assistant surgeon modifier.

## Billing

Submit claims for physician services at surgery electronically in the 837P format. Refer to [Federal Indian Health Services](#), Chapter 31, for physician services provided in an IHS, tribal, or 638 facility.

## Bilateral and Multiple Procedure Modifiers

Please refer to the CPT guidelines regarding the appropriate use of modifiers.

Use modifier 50 only when the exact same service/code is reported for each bilateral anatomical site.

1. Report bilateral surgical procedure codes on one line appended with modifier 50.
2. Enter 1 unit on a line reported with modifier 50.
  - a. **Example:** 49500 – 50 – 1 unit
3. Do not use modifier 50 with procedure codes that are identified as bilateral or for codes that use the words **one** or **both** within the code description.

## Multiple Procedures – Modifier 51

Use modifier 51 when multiple surgeries are separate procedures performed by the same physician on the same patient at the same operative session.

1. Report the major surgery without modifier 51.
2. Report additional procedures with modifier 51.
  - a. **Example:** Line 1: 41874 – 1 unit; Line 2 and all subsequent lines: 41874 – 51- 1 unit
3. Do not use modifier 51 for procedures that are considered components or incidental to a primary surgery. MHCP follows Medicare guidelines for excluding modifier 51 for these procedures
4. Do not use modifier 51 with add-on codes (listed in CPT Appendix D) or codes that are modifier 51 exempt (listed in CPT Appendix E).

## Locum Tenens Physicians

PrimeWest Health recognizes that physicians often retain a substitute physician to take over their professional practices while they are absent for reasons such as illness, vacations, continuing medical education, military service, pregnancy, etc. PrimeWest Health further recognizes locum tenens arrangements and pays the regular physician for the services provided by the substitute physician if:

1. The substitute physician generally does not maintain a practice and travels from area to area as needed
2. The regular physician is unavailable to provide services
3. The member has arranged or seeks to receive the services from the regular physician
4. The regular physician pays the locum tenens physician on a per diem or a fee-for-service basis
5. The locum tenens physician does not provide services over a continuous period of longer than 60 days

## Covered Services

PrimeWest Health covers locum tenens physician services using Medicare guidelines.

## Documentation

The regular physician must keep a record of each service provided by the locum tenens physician along with the substitute physician's NPI.

## Billing

1. The recipient's regular physician bills and receives payment for locum tenens physician covered services. Compensation paid by a medical group is considered paid by the physician.
2. The locum tenens physician does not have to be identified on the claim.
3. Bill with modifier Q6.
4. Postoperative services performed by the locum tenens physician during the global surgery period do not require a Q6 modifier (if the services are only in connection with the surgery).

## Reciprocal Billing

**Reciprocal Billing Arrangements:** A member's regular physician may submit a claim for a covered service that the regular physician arranges to be provided by a substitute physician on an occasional reciprocal basis if:

1. The regular physician is unavailable to provide the visit services
2. The member has arranged or seeks to receive services from the regular physician
3. The substitute does not provide services over a continuous period of longer than 60 days

These requirements do not apply to the substitution arrangements among physicians in the same medical group where claims are submitted in the name of the group. On claims submitted by the group, the group physician who actually performed the services must be identified as the rendering physician.

## Covered Services

PrimeWest Health covers substitute physician services using Medicare guidelines.

## Documentation

The regular physician must keep a record of each service provided by the substitute physician along with the substitute physician's NPI.

## Billing

1. The regular physician bills and receives payment for substitute physician covered services.
2. The substitute physician does not have to be identified on the claim nor enrolled with DHS.
3. Bill with modifier Q5.
4. Postoperative services performed by the substitute physician during the global surgery period do not require a Q5 modifier (if the services are in connection with the surgery).

## Telemedicine

**Distant site:** The site where the physician or practitioner providing the professional service is located at the time the service is provided via a telecommunications system.

**Telemedicine:** The use of telecommunications to furnish medical information and services. Telemedicine consultations must be made via two-way, interactive video or store-and-forward technology.

**Two-way Interactive Video:** A type of technology that permits a "real time" consultation to take place. This is used when a consultation involving the patient, the primary caregiver, and a specialist is medically necessary. Video-conferencing equipment at two different locations permits a live non-face-to-face consultation to take place.

**“Store and Forward”:** The asynchronous transmission of medical information to be reviewed at a later time by a physician or practitioner at the distant site. Medical information may include, but is not limited to, video clips, still images, x-rays, MRIs, EKGs, laboratory results, audio clips, and text. The physician at the distant site reviews the case without the patient being present. Store and forward substitutes for an interactive encounter with the patient present; the patient is not present in real-time.

**Hub Site:** A medical facility telemedicine site where the medical specialist is located.

**Spoke Site:** A remote site where the referring health professional and patient are located.

**Consultation:** A type of service provided by a physician whose opinion or advice is requested by another provider.

Asynchronous telecommunications systems in single media format do not include telephone calls, images transmitted via facsimile machines, and text messages without visualization of the recipients (electronic mail). Photographs must be specific to the recipient’s condition and adequate for rendering or confirming a diagnosis or treatment plan.

### **Eligible Providers**

The “spoke,” or referring provider, may be any enrolled PrimeWest Health provider including a physician, nurse practitioner, clinical nurse specialist, physician assistant, certified nurse midwife, podiatrist, or mental health professional.

The “hub,” or consulting provider, is limited to a specialty physician or an oral surgeon.

### **Covered Services**

Coverage for telemedicine includes payment for physician consultations that are performed via two-way interactive video or via store and forward technology.

### **General**

1. Telemedicine consultation coverage is limited to physician services (this includes psychiatrists but does not include PAs, APRNs, or other physician ancillaries).
2. A consultation (as defined by CPT) must take place.
3. A request for a consultation and the need for a consultation must be documented in the patient’s medical record. The consultation opinion must be documented in the patient’s medical record and communicated to the requesting provider.
4. Out-of-state coverage policy applies to services provided via telemedicine. Consultations performed by providers who are not located in Minnesota and contiguous counties require authorization prior to the service being provided.
5. Consultations must be billed with the appropriate modifier indicating services were performed via telemedicine.
6. Telemedicine consultations provided by out-of-network physicians require a [Service Authorization](#).

### **Two-Way Interactive Video Consultations in an Office, Outpatient, or Inpatient Setting**

1. Payment is made to both the consulting physician and the referring physician if the referring physician is present during the consultation.
2. The referring provider bills an office or outpatient E/M code.

3. The consulting physician bills an office, outpatient, or inpatient E/M consultation code with the GT modifier, indicating the service was performed via two-way interactive video.

### **Two-Way Interactive Video Consultation in an Emergency Room (ER)**

Two-way interactive video consultation may be billed when there is no physician in the ER and the nursing staff is caring for the patient at the “spoke” site. The ER physician at the “hub” site bills the ER CPT codes with the GT modifier. Nursing services at the “spoke” site would be included in the ER facility code.

If the ER physician requests the opinion or advice of a specialty physician at a “hub” site, the ER physician bills the ER CPT codes without the GT modifier. The consulting physician bills the consultation E/M code with the GT modifier.

### **“Store and Forward” Telemedicine**

1. CPT definition of a consultation must be met.
2. Consultation E/M codes are billed by the consulting physician with the GQ modifier, used to indicate that the consult was done via store and forward technology.

### **Coverage Limitations**

1. Payment for telemedicine consultation services is limited to three per week per member.
2. Payment will be made for only one reading or interpretation of diagnostic tests such as X-rays, lab tests, and diagnostic assessments.
3. Payment is not available to providers for sending materials.

For more information on telemedicine in the delivery of mental health services, reference [Mental Health Services, Chapter 16](#).

## **Advanced Practice Registered Nurse (APRN) Services**

**Advanced Practice Registered Nurse (APRN):** An individual licensed as a registered nurse by the Minnesota Board of Nursing and certified by a national nurse certification organization acceptable to the Minnesota Board of Nursing to practice as a clinical nurse specialist, nurse anesthetist, nurse-midwife, or nurse practitioner. The practice of advanced practice registered nursing also includes accepting referrals from, consulting with, cooperating with, or referring to all other types of health care providers, including but not limited to physicians, chiropractors, podiatrists, and dentists, provided that the APRN and the other provider are practicing within their scopes of practice as defined in state law. The APRN nurse must practice within a health care system that provides for consultation, collaborative management, and referral as indicated by the health status of the patient.

**Registered nurse anesthetist practice:** The provision of anesthesia care and related services within the context of collaborative management, including selecting, obtaining, and administering drugs and therapeutic devices to facilitate diagnostic, therapeutic, and surgical procedures upon request, assignment, or referral by a patient’s physician, dentist, or podiatrist.

**Clinical Nurse Specialist Practice (CNS):** The provision of patient care in a particular specialty or subspecialty of advanced practice registered nursing within the context of collaborative management, and includes: (1) diagnosing illness and disease; (2) providing nonpharmacologic treatment, including psychotherapy; (3) promoting wellness; and (4) preventing illness and disease. The certified clinical nurse specialist is certified for advanced practice registered nursing in a specific field of clinical nurse specialist practice.

**Nurse practitioner practice:** Practice within the context of collaborative management: (1) diagnosing, directly managing, and preventing acute and chronic illness and disease; and (2) promoting wellness, including providing non-pharmacologic treatment. The certified nurse practitioner is certified for ARNP in a specific field of nurse practitioner practice.

**Nurse-midwife practice:** The management of women’s primary health care, focusing on pregnancy, childbirth, the postpartum period, care of the newborn, and the family planning and gynecological needs of women and includes diagnosing and providing non-pharmacologic treatment within a system that provides for consultation, collaborative management, and referral as indicated by the health status of patients.

## Eligible Providers

Enrolled APRNs will receive 90 percent of the physician rate and should not use modifier U7 when billing PrimeWest Health. The services of APRNs who choose not to enroll will be paid as physician extenders through the supervising physician at 65 percent of the physician rate and will require modifier U7 when billing PrimeWest Health. **Registered nurse certified (RN, C) are not eligible to enroll.**

## Covered Services

Services performed by APRNs are covered if the services are a covered benefit through PrimeWest Health and the services are within the scope of practice for an APRN as described in MS [148.171 through 148.285](#).

## Billing

Bill for APRN services using HCPCS/CPT codes, and follow PrimeWest Health requirements for covered physician and professional services.

1. Enrolled APRNs: enter your individual NPI as the billing provider.
2. Enrolled employers of APRNs: enter the individual NPI of the APRN as the rendering provider
3. Non-enrolled APRNs: list the supervising physician NPI as the rendering provider; use modifier U7 to amend the procedure code.

## Physician Assistants (PA)

**Physician Assistant:** A person registered pursuant to MS [147A](#) who is qualified by academic or practical training or both to provide patient services as specified in MS [147A](#) under the supervision of a supervising physician.

## Eligible Providers

Enrolled PAs receive 90 percent of the physician rate and should not use the physician extender modifier when billing PrimeWest Health. The services of those who choose not to enroll will be paid as physician extender services through the supervising physician at 65 percent of the physician rate and requires modifier U7 when billing PrimeWest Health.

## Covered Services

Services performed by a PA are covered if the services are within the scope of practice for a PA as described in MS [147A](#) and meet all required criteria by the appropriate certifying, regulatory, or licensing entities. PrimeWest Health enrolls PAs as treating providers, not pay-to providers.

## Supervision of PAs

PrimeWest Health allows off-site or remote supervision of PAs, provided the terms of the physician/physician assistant agreement are being met and the physician/physician assistant are, or can be, easily in contact with one another by radio, telephone, or other communication device.

Off-site or remote supervision does not apply to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs), which, under Federal regulations, require that a physician is present for sufficient periods of time, at least once every two week period (except in extraordinary circumstances which must be documented in the records of the clinic) to provide the following:

1. Medical direction
2. Medical services
3. Consultation
4. Supervision

The physician must be available through direct telecommunication for consultation, assistance with medical emergencies, and patient referral.

## Billing

Bill PA services using the appropriate CPT/HCPCS codes. Follow PrimeWest Health requirements for covered physician services.

1. Enter the NPI as the rendering provider.
2. Use the clinic/group name and address and NPI as the billing provider.
3. Non-enrolled PAs must use modifier U7 when billing.
4. Physician assistants should continue to use modifier AS when assisting-at-surgery.

## Non-covered

Nurse practitioners and clinical nurse specialists are not covered for assistant-at-surgery.

## Physician Extenders

PrimeWest Health covers health services provided by a physician extender under the supervision of the physician. Physician extender services are not covered unless they replace or substitute for the physician service.

**Physician Extender:** PA or APRN who chooses not to enroll with PrimeWest Health, genetic counselor, registered nurse, and licensed acupuncturist who is:

1. Employed by the physician provider;
2. Employed by the same provider organization that employs the physician; or
3. Supervised by a physician.

**Registered Nurse (RN):** A nurse licensed under and within the scope of Minnesota Statutes.

**Genetic Counselor or Geneticist:** An individual who is board certified by the American Board of Genetic Counseling (ABGC).

## Supervision of Physician Extenders (Except PAs)

The process of control and direction by which the physician accepts full professional responsibility for the supervisee, instructs the supervisee in his/her work, and oversees or directs the work of the supervisee. The process must meet the following conditions:

1. The physician must be present, available, and on the premises more than 50 percent of the time when the supervisee is providing health services
2. The diagnosis must be made by or reviewed, approved, and signed by the physician
3. The plan of care for a condition other than an emergency may be developed by the supervisee but must be reviewed, approved, and signed by the physician before care is begun
4. The supervisee may carry out the treatment, but the physician must review and countersign the record of a treatment within five working days after the treatment

## Role of Physician Extenders in Long-Term Care (LTC) Facilities

Physician services provided by a physician extender in an LTC facility must be provided under the direction of a physician who is an enrolled PrimeWest Health provider. This means the physician has authorized and is personally responsible for the physician services performed by the physician extender and has reviewed and signed the record of the service no more than five days after the service was performed.

Physician extenders may provide any service within their scope of practice and as delegated and directed by a physician.

As permitted by Minnesota Rules, licensure, and facility policy, APRNs or PAs who are not enrolled with PrimeWest Health and are not employees of the facility (but are working in collaboration with a physician) may provide the following physician services in an LTC facility:

1. Develop a written plan of care as required by federal regulation
2. Conduct a periodic visit as required by federal regulations. At the option of the physician, and in accordance with facility policy, required visits (after the initial visit) may alternate between personal visits by the physician and visits by a physician assistant or APRN.

## Genetic Counselor or Geneticist

A genetic counselor or geneticist may conduct a consultation to render an opinion and/or advice.

1. The genetic counselor or geneticist may only initiate diagnostic or therapeutic services at the request of the attending physician.
2. Follow-up consultations may be performed if it is medically necessary to re-evaluate a recipient for whom an opinion previously has been rendered.
3. Bill consultations provided by a genetic counselor with the appropriate E/M code and use modifier U7.

## Use of Modifiers

Do not use modifier U7 for a minimal service E/M code, as defined in CPT, as it represents a level of service supervised by a physician but does not necessarily require his/her immediate ongoing presence.

Use modifier U7 with all other E/M codes when the physician extender provides services, unless the physician is directly involved more than 50 percent of the time that is required to provide the health service.

Do not use modifier U7 for physician extender services associated with enhanced prenatal care services for “at risk” pregnancies. Refer to the “Family Planning” and “Obstetrics & Gynecology Services” sections of [Reproductive Health – Obstetrics and Gynecology, Chapter 10](#).

## Billing Physician Extender Services

1. Enter the NPI of the physician who supervised the service as the Rendering Provider.
2. Enter the appropriate procedure code for the level of care provided
3. Enter the appropriate modifier.

## Non-covered Services

Services provided by personnel such as office and clerical workers, lab workers, assistants (e.g., surgical and ophthalmic), and aides are not considered physician extender services. These services are considered part of a physician's overhead and cannot be billed separately.

## Outpatient Hospital Services

### Billing Requirements

**Outpatient Hospital Clinic:** For clinic services provided in an outpatient hospital setting, physicians must bill the appropriate HCPCS/CPT code and use place of service 22. Failure to identify the place of service as outpatient hospital services may be considered fraudulent or abusive billing, subject to monetary recovery or program sanctions.

Specific HCPCS codes have been designated in which the individual code may be separated into professional and technical components. Providers billing and delivering professional services in outpatient hospitals will be paid for the professional component. The outpatient hospital will receive the technical component in the form of a "facility fee."

### Provider-Based Status for Clinics

Provider-based clinics are hospital owned clinics authorized with provider based status according to [Federal regulations](#). PrimeWest Health will not accept Method II billing for Medicaid-only eligible members unless they are Medicare primary (MSC+ and Prime Health Complete [HMO SNP] member groups). For members who have PrimeWest Senior Health Complete (HMO SNP) with PrimeWest Health or have Medicare as their primary insurance, submit the claim to PrimeWest Health exactly as you would the Medicare carrier.

## Billing

### Professional Component

For this part of outpatient clinic services provided in a hospital owned clinic, bill professional services in the 837P claim format using the appropriate HCPCS/CPT code; use place of service 22. Failure to identify the place of service as outpatient hospital may be considered fraudulent or abusive billing, and is subject to monetary recovery or program sanctions

### Facility Fee

For this part of outpatient clinic services performed in a hospital owned clinic, bill facility fees in the 837I claim format using the appropriate revenue and HCPCS/CPT coding.

**Urgent Care in Emergency Department:** Non-emergency care provided in an emergency department is urgent care and must be billed as urgent care services.

**Emergency Department:** Emergent care provided in an emergency department is emergency care and must be billed as emergency services. If, in a physician’s professional opinion, emergency treatment for the patient’s condition cannot be provided in the emergency department, the physician may seek inpatient admission certification for the patient and bill inpatient admission services. Refer to [Inpatient Hospital Authorization, Chapter 13](#).

## Hospital Physician Services

### Eligible Providers

Physicians, APRNs, and PAs under the supervision of the physician in accordance with the physician/physician assistant agreement and in accordance with the hospital by-laws, may provide inpatient hospital services.

### Billing

Bill physician services provided in an inpatient hospital setting using the 837P format:

1. Enter the dates of hospital admission and discharge in the appropriate date fields of the 837P format. If the member has not been discharged, leave the “To” field blank.

### Urgent Care Clinic Services

1. Urgent care clinic services are covered for PrimeWest Health members in an outpatient hospital setting.
2. Urgent care services in a freestanding facility (including physician clinics) must be billed as an office visit.
3. No facility fee is paid in a physician’s clinic for after hours care.

## Authorization Standards

### Authorization Standards for Surgery, Including Cosmetic and Reconstructive Surgery

#### Definitions

**Investigative:** A health service/procedure that has progressed to limited human application and trial, lacks wide recognition as a proven and effective procedure in clinical medicine as determined by the National Blue Cross and Blue Shield Association Medical Advisory Committee or by InterQual or other nationally recognized medical or health organizations, and used by PrimeWest Health in the administration of its program using the following criteria:

1. The technology must have final approval from the appropriate government regulatory bodies
2. The scientific evidence must permit conclusions concerning the effectiveness of the technology on health outcomes. Evidence should consist of well designed and well conducted investigations published in peer review journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.
3. The technology must improve the net health outcome
4. The technology must be as beneficial as any established alternatives
5. Improvement must be attainable outside the investigational settings
6. A drug or device that the United States Food and Drug Administration (FDA) has not yet declared safe and effective for the use prescribed. For purposes of this definition, drugs and devices are those identified in the [Food and Drug Act](#).

These criteria determine whether medical devices or treatments are investigational or not. PrimeWest Health then determines coverage based on contract language and medical necessity.

A health service, procedure, or treatment that is concluded to be experimental or investigational in nature is excluded from coverage.

**Plastic Surgery:** The alteration, replacement, or restoration of visible parts of the body performed to correct a structural defect or for cosmetic effect.

**Cosmetic Surgery:** Cosmetic surgery is performed to reshape normal structures of the body in order to improve appearance and self-esteem. The procedure is done for decorative purposes rather than functional, medical, or mental health reasons. Cosmetic surgery is excluded from coverage.

**Reconstructive Surgery:** Performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance. Procedures are done in order to replace, rebuild, restore, or to create one or more body parts or functions.

## Authorization Policy

Authorization is required for all investigative procedures and procedures that may be considered cosmetic. The authorization request originates with the surgeon and must be submitted to PrimeWest Health.

Authorizations are reviewed on a case-by-case basis. Certain situations may require a unique piece of information that will aid the medical review agent in the decision-making process. Since it is impossible to identify all of the diverse information necessary for each case, a request will be made for additional information as the situation requires.

It is the responsibility of the provider requesting authorization to submit sufficient documentation to establish that coverage standards have been met. A provider may choose to submit a summary letter, addressing each element of the standard and current information, in lieu of submitting reports from diagnostic and specialized services noted in the following standards.

If staged plastic and reconstructive surgery is being proposed for correction of a congenital anomaly, the complete plan for future surgeries must be submitted with the first authorization.

The procedure will be authorized, when in the opinion of the medical review agent, all of the following standards are documented:

1. Medical and psychiatric contraindications to the surgery have been ruled out
2. The timing for the procedure has been assessed and found to be medically appropriate for the particular condition, age, and stage of development of the individual
3. Appropriate treatment that is nonsurgical, less intrusive, or less expensive has been tried and was not successful, was contraindicated, not applicable, or not available for the given condition
4. An assessment has been made to determine that the surgical procedure will cause significant improvement of the condition
5. The member, parent, or guardian fully understands the surgical procedure, the risks involved, and the possible side effects of the surgery
6. If the reconstruction procedure requires the insertion of an implant, the implant must be FDA approved
7. Information submitted is sufficient to establish that the standards listed above have been met. This information must include all of the following:
  - a. A statement indicating medical necessity is based on significant medical problems, functional impairment, or is a jeopardy to physical or mental health

- b. Specific diagnosis, date of onset, symptoms, severity, duration, treatment results, and effects on the performance of activities of daily living
- c. When jeopardy to mental health is claimed, an evaluation by a psychologist or a psychiatrist, and an MMPI and interpretation are also required
- d. A summary of past clinical history that relates to the current condition including previous procedures, if any, to correct the condition (include surgical reports)
- e. A description of the proposed procedure and the expected results
- f. Specific and exact surgical site including right, left, upper, lower, unilateral, or bilateral (if bilateral, bill two line items with the modifier reported on the second line item), as appropriate
- g. Specify primary and secondary procedures, if applicable
- h. Photographs for situations that are difficult to describe must be submitted. Several different views of the affected part are helpful (photographs should be limited to the affected part)
- i. Additional information requested by the PrimeWest Health medical review agent

As indicated above, all procedures or surgeries that are cosmetic, investigative, or experimental are not covered. A [Service Authorization](#) request is needed from the provider, and, if PrimeWest Health determines that the surgery is not cosmetic, is not investigative, and/or is not experimental and it meets the medical necessity of the member and standards of practice, an authorization may be granted. Some examples are: abdominoplasty, blepharoplasty, ptosis repair, rhinoplasty, septorhinoplasty, silicone implant removal, lesions destruction (for rosacea), lipectomy, breast reconstruction (not related to breast cancer), cholecystectomy with transduodenal sphincterotomy or sphincteroplasty, scar revisions, sclerotherapy, artificial disc replacement, IFC, SCS, STS, refractive surgery, keratoprosthesis, biofeedback for incontinence, lung removal (for lung volume reduction), LVAD, etc.

In addition to the category listed above and to the specific procedures listed under authorization standards:

1. All implants require [Service Authorization](#) (electric stimulator, epidural, intrathecal, neurostimulator, cochlear, artificial cornea, pillar palatal, etc.)
2. All surgeries for sleep apnea (LAUP, UPPP, Uvelectomy, Pillar Palatal implant, tongue base suspension, etc.) require a [Service Authorization](#)
3. All Temporomandibular Disorder surgery and all temporomandibular (TMJ) treatments require a [Service Authorization](#)
4. All surgeries for weight loss and gastric neurostimulator implants require a [Service Authorization](#)

The following are some of the authorization standards and specific documentation needed. This is not an all inclusive list of all surgeries and procedures that require [Service Authorization](#).

### **Authorization Standards for Insertion of Penile Prosthesis**

Implantation of a penile prosthesis requires authorization from PrimeWest Health. It is the responsibility of the surgeon to submit the authorization request with all the following information:

1. Medical history: history of penile dysfunction and report of physical examination
2. Results of related diagnosis, laboratory tests, and X-rays
3. Past treatments and results for erectile dysfunction (include pharmacotherapy, devices, etc.)
4. Summary of evaluation of suitability for implant

Authorization to implant a penile prosthesis for urinary drainage will be approved when, in the opinion of PrimeWest Health, all the following standards have been met:

1. Other less invasive methods of urine drainage and collection have proven to be inadequate
2. Information submitted is sufficient to determine the standard is met. The information must include all the following:
  - a. Medical history and report of physical exam

- b. Reports of related laboratory tests and X-rays
- c. Summary of approaches to the problems of urinary drainage, with dates indicating periods of time used and when problems began

### **Authorization Standards for Adult Bariatric Surgery**

The following criteria apply only to members ages 18 and over. See the separate criteria for the adolescent population.

All the criteria listed below must be met in order to authorize bariatric surgery. Members not meeting the criteria, who have one or more immediate life-threatening comorbidities, will be considered for approval on a case by case basis.

1. The member is clinically obese with one of the following:
  - a. BMI of over 40
  - b. BMI of 35 – 40 with one or more of the following comorbid conditions:
    - i. Severe cardiac disease (coronary artery disease, pulmonary hypertension, congestive heart failure, cardiomyopathy)
    - ii. Type 2 diabetes
    - iii. Obstructive sleep apnea and other respiratory disease (chronic asthma, obesity hypoventilation syndrome, Pickwickian syndrome)
    - iv. Pseudo tumor cerebri
    - v. Gastroesophageal reflux disease
    - vi. Hypertension
    - vii. Hyperlipidemia
    - viii. Severe joint or disc disease that interferes with daily functioning

The BMI level qualifying the member for surgery (>40 or >35 with one of the above comorbidities) must be of at least three years' duration.

A member's required attempt(s) to lose weight may cause his/her BMI to fluctuate around the discrete required levels during the three-year period. The three-year period will not necessarily start over, or be prolonged, under this scenario, but will be decided on a case-by-case basis.

2. The member has made at least one serious medically supervised attempt to lose weight in the past, under the supervision of a physician, physician's assistant, nurse practitioner, or registered dietitian. The medically supervised weight loss attempt(s) must have been at least six months in duration.
3. Medical and psychiatric contraindications for the surgical procedure have been ruled out through:
  - a. A complete history and physical conducted by the requesting surgeon
  - b. A dietary consult and assessment
  - c. A psychiatric/psychological assessment, conducted by a licensed mental health professional, no more than three months prior to the requested authorization. The assessment must address both potential psychiatric contraindications and patient ability to comply with the postoperative care plan.
4. The member:
  - a. Is motivated and committed to losing weight
  - b. Has realistic expectations of the surgical outcome
  - c. Postoperatively is willing to make permanent lifestyle changes in the areas of: eating behaviors, other behaviors, and exercise therapy
  - d. Is willing to participate in the long-term postoperative care plan offered by the surgery program, consisting of:
    - i. Diet therapy
    - ii. Behavior modification
    - iii. Activity/exercise components

## Required Written Documentation

1. Member's height, weight, and BMI with duration.
2. All comorbid conditions listed and described.
3. A detailed statement of the member's past medically supervised weight loss attempt(s) lasting six months or more (including the duration of each attempt).
4. The member's current eating habits.
5. A list of applicable medical and/or psychiatric contraindications.
6. Indication of exclusion of any Endocrinopathy, PUD, etc.
7. A copy of the current psychiatric/psychological assessment as described above.
8. A drug/alcohol screening.
9. A copy of the dietary assessment.
10. A statement detailing the member's:
  - a. Commitment to lose weight
  - b. Expectations of the surgical outcome
  - c. Willingness to make permanent life-style changes
11. A description of the post-surgical follow-up program (submitted on a one time basis). This description will be kept on file with the medical reviewer for each surgeon.

## Authorization Standards for Adolescents Bariatric Surgery

The following criteria apply only to carefully selected PrimeWest Health members below the age of 18. The procedure will be considered for authorization on a case-by-case basis. The following criteria represent the consensus of available expert opinion.

All of the criteria listed below must be met in order for bariatric surgery to be authorized. Members not meeting the criteria, who have one or more immediate life-threatening comorbidities, will be considered for approval on a case-by-case basis:

1. The member is clinically obese, with:
  - a. BMI of 40 or higher with one or more of the following comorbid conditions:
    - i. Obstructive sleep apnea
    - ii. Pseudotumor cerebri
    - iii. Severe/complicated hypertension
    - iv. Type 2 diabetes; **or**
  - b. BMI of 50 or higher with one or more of the following comorbid conditions:
    - i. Arthropathies in weight-bearing joints
    - ii. Dyslipidemias
    - iii. Gastroesophageal reflux disease
    - iv. Hypertension
    - v. Intertriginous soft tissue infections
    - vi. Non-alcoholic steatohepatitis
    - vii. Obesity related psychosocial distress
    - viii. Significant impairment in activities of daily living
    - ix. Stress urinary incontinence
    - x. Venous stasis disease
2. The member has made at least one serious, medically supervised attempt to lose weight in the past, under the supervision of a physician, physician's assistant, nurse practitioner, or registered dietitian. The medically supervised weight loss attempt(s) as defined above must have been at least six months in duration.
3. Medical and psychiatric contraindications to the surgical procedure were ruled out (and referrals made as necessary) through both of the following:

- a. A complete history and physical, including the exclusion of diagnosis of genetic or syndromic obesity, such as Prader-Willi Syndrome
  - b. A psychiatric/psychological assessment, conducted by a licensed mental health professional, no more than three months prior to the requested authorization. The assessment should address the following issues:
    - i. Ability to provide informed assent without coercion
    - ii. Family and social support
    - iii. Member ability to comply with the postoperative care plan
    - iv. Potential psychiatric contraindications
4. The member:
- a. Has realistic expectations of the surgical outcome
  - b. Is motivated and committed to losing weight
  - c. Postoperatively is willing to make permanent lifestyle changes in the areas of:
    - i. Eating behaviors
    - ii. Exercise therapy with family's support
    - iii. Other behaviors
    - iv. Willing to participate in the adolescent-specific, long-term postoperative care plan offered by the surgery program. The care plan consists of the following:
      - Activity/exercise components
      - Behavior modification
      - Diet therapy
5. The member has attained physiologic maturity, as measured by both:
- a. The attainment of Tanner Stage IV development
  - b. The attainment of 95 percent of adult height based on estimates from bone age

NOTE: Female members cannot be pregnant or breastfeeding and do not plan to become pregnant within two years following surgery.

### **Required Written Documentation**

1. Member's height, weight, and BMI with duration.
2. All comorbid conditions listed and described.
3. A detailed statement of the member's past medically supervised weight loss attempt(s) lasting six months or more (including the duration of each attempt).
4. The member's current eating habits.
5. A list of applicable medical and/or psychiatric contraindications.
6. A copy of the current psychiatric/psychological assessment as described above.
7. A drug/alcohol screening.
8. A copy of the dietary assessment.
9. A statement detailing the member's:
  - a. Commitment to lose weight
  - b. Expectations of the surgical outcome
  - c. Willingness to make permanent lifestyle changes
10. A statement detailing at least one custodial parent or guardian's:
  - a. Commitment to support and facilitate the member's loss of weight
  - b. Expectations of the surgical outcome
  - c. Willingness to support and facilitate member's permanent lifestyle changes
11. A description of the post-surgical follow up-program, which must be part of a multi-disciplinary pediatric weight management program. This description will be submitted (on a one time basis) and kept on file with the medical reviewer for each surgeon and program.

12. A statement verifying the attainment of physiologic maturity as defined above.
13. Verification counseling was provided to female adolescents regarding potential birth defects from nutritional deficiencies if they become pregnant during the weight stabilization period following surgery.

### **Required Documentation for Revision of Bariatric Surgery**

1. Date and type of the initial surgery.
2. Weight loss history after the surgery.
3. Present height and weight.
4. Dietary assessment regarding current eating habits.
5. X-ray or endoscopic report that demonstrates the staple line has failed or the pouch has enlarged.
6. Psychiatric contraindications to the surgery have been ruled out. If the patient is currently receiving psychiatric treatment, a current diagnostic assessment must be submitted.

### **Authorization Standards for Sleep Testing**

PrimeWest Health will not cover unattended home sleep studies as they are considered investigative and not medically necessary.

### **Authorization Standards for Sleep Testing Children**

Authorization is required for patients under the age of 18 years. The following information must be submitted with the authorization request:

1. Current history and physical examination (within last 60 days) from the referring physician, including lab results and medications
2. Diagnosis and how it relates to the need for a sleep study
3. Specific examples of how symptoms impact health, well-being, and functional status
4. Documentation of recent prior conservative interventions

### **Standards for Sleep Testing Adults**

PrimeWest Health will cover sleep studies as medically necessary for the indications listed below. Service Authorization is not needed before performing sleep testing in adults. Testing must be attended by a trained sleep specialist who can monitor technical adequacy and patient compliance; unattended sleep studies are not covered. All studies must be conducted in a sleep laboratory; attended in-home (portable) studies will be covered only in cases where the patient is unable to undergo an in-lab study due to extenuating circumstances such as nonambulation, severe and persistent mental illness, etc. Indications for Adult Sleep Study include the following:

1. Diagnosis of obstructive sleep apnea and other sleep-related breathing disorders
2. Following a careful exam and history that includes a standardized questionnaire
3. For patients with high pre-test-probability, an attended cardiorespiratory (Type 3) sleep study is preferable to full-channel polysomnography
4. Split-night studies should be performed whenever possible
5. Positive airway pressure titration for patients already diagnosed with sleep apnea or other sleep-related breathing disorders
6. Follow-up sleep studies to assess treatment for sleep apnea or other sleep-related breathing disorders
7. Neuromuscular disorders with sleep-related symptoms, which are not adequately diagnosed through sleep history, assessment of sleep hygiene, and review of sleep diaries
8. Suspected narcolepsy

9. Parasomnias (cases of dangerous, violent or injurious behavior, seizure cases with inconclusive EEG, and atypical parasomnias)
10. Periodic limb movement disorder (PLMD)

### **Authorization Standards for Breast MRI**

PrimeWest Health covers breast MRIs when certain criteria are met. Procedure codes requiring authorization include: 0159T, 77021, 77058, 77059, C8903, C8904, C8905, C8906, C8907, and C8908.

### **Authorization Standards for Breast Reduction**

The following documentation must be submitted with the authorization request:

1. Chart notes from the referring or primary physician, including:
  - a. Clinical history/case summary documenting patient complaints; and
  - b. Severity and duration of complaints
2. Height and weight
3. Bra size
4. Previous treatment
5. Number of grams to be removed from each breast
6. Photograph
7. Schnur scale

### **Authorization Standards for Panniculectomy**

Panniculectomy is considered medically necessary when A – C or either D or E of the following are met:

- A. The panniculus hangs to or below the level of the pubis;
  - B. The panniculus causes functional impairment, such as back pain documented by an orthopedic consult; or the pannus itself causes interference with ADL performance; **and**
  - C. There is chronic, recurrent intertriginous rash, cellulitis, or skin necrosis that has failed to respond to medical management in six months (photo required).
- OR**
- D. Panniculectomy is Incidental to intra-abdominal surgery to improve surgical access and wound healing and ONE of criteria A – C.
- OR**
- E. Panniculectomy is incidental to ventral hernia repair to improve wound healing and ONE of criteria A – C.

### **Authorization Standards for Breast Implant Removal**

The following information must be submitted with the authorization request:

1. Reason for initial implantation
2. Chart notes/test results documenting leakage/rupture, if present
3. If rupture is not present, chart notes from the primary or referring physician documenting any medical reasons/symptoms for implant removal (history/case summary, severity and duration, previous treatment)

### **Authorization Standards for Gynecomastia**

The following information must be submitted with the authorization request:

1. Current history and physical examination from the primary care physician
2. History of medication or drug use
3. Results of lab tests, to rule out endocrine abnormalities

4. Evidence that other diseases (which can cause this condition) have been ruled out
5. Height and weight
6. Photograph
7. Pathology report documenting removal of breast tissue rather than fat

### **Authorization Standards for Botulinum Toxin**

Botox (Botulinum Toxin Type A)

Myobloc (Botulinum Toxin Type B)

#### **Criteria**

1. Treatment for FDA-approved indications or for spasticity, including spasticity in cerebral palsy, or for excessive drooling associated with a neurologic disorder not managed by oral therapy.
2. The FDA-approved indications are:
  - a. For Myobloc (Type B): The treatment of patients with cervical dystonia to reduce the severity of abnormal head position and neck pain
  - b. For Botox (Type A):
    - i. Treatments of cervical dystonia in adults to decrease the severity of abnormal head position and neck pain
    - ii. Treatment of severe primary axillary hyperhidrosis that is inadequately managed with topical agents
    - iii. Treatment of strabismus and blepharospasm associated with dystonia, including benign essential blepharospasm or VII nerve disorders in patients 12 years of age and above
3. Botox may also be approved for use of severe bruxism, particularly those with associated movement disorders, when all conservative treatments have failed (mouth guard, oral meds, physical therapy).
4. Botulinum toxin will be approved for incontinence related detrusor overactivity and incontinence of neurogenic origin (i.e., spinal cord injury, multiple sclerosis) that is inadequately controlled with anticholinergic therapy.
5. Use of botulinum toxin, type A or type B, will not be approved for cosmetic purposes such as removal of facial wrinkles or for the treatment of migraines or headaches.
6. Authorizations can be granted for up to 12 months. Each subsequent authorization requires documentation verifying the patient's response to the treatment. The prior authorization will only be granted if the documentation shows a positive response to the treatment.

### **Authorization Standards for Male Circumcision**

PrimeWest Health only covers male circumcision when the procedure is medically necessary (in the opinion of the attending physician, a pathologic condition exists where circumcision is required), and is prior authorized.

Provide documentation of the condition, the symptoms, and the treatment that has been tried.

### **Authorization Standards for Outpatient High Technology Imaging Services**

PrimeWest Health covers medically necessary outpatient high technology imaging including MRI's, MRA's, CT, CTA, and PET scans.

## Authorization Standards for Hysterectomy

Procedure codes: 58150, 58152, 58180, 58200, 58210, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58578, and 59525.

A hysterectomy is a medically necessary procedure or operation for the purpose of removing the uterus. PrimeWest Health does not cover hysterectomy for sterilization purposes.

PrimeWest Health does not require prior authorization for this procedure. PrimeWest Health will periodically perform audits of claims paid for this service. In the event it is determined medical necessity for the procedure was not met, PrimeWest Health will re-adjudicate the claim. If a facility continues to perform procedures and medical necessity is not met, that facility will be required to obtain a [Service Authorization](#) PRIOR TO performing this procedure.

PrimeWest Health requires the provider to secure member authorization to perform a hysterectomy by informing the individual (and her representative, if applicable) that the hysterectomy will make her permanently incapable of reproducing.

A hysterectomy acknowledgement statement (HAS) must be kept in the member's medical record. An example of the HAS can be found in [Reproductive Health – Obstetrics and Gynecology, Chapter 10](#).

Conditions supporting medical necessity for hysterectomy may include, but are not limited to, the following:

1. Malignant disease of the cervix, uterus, ovaries, or fallopian tubes
2. Symptomatic uterine fibroids (leiomyomas) that are either:
  - a. causing bladder pressure, pain, fullness, functional disturbance,
  - b. bleeding unresponsive to conservative therapy; or
  - c. showing rapid and progressive enlargement.
3. Recurrent or persistent uterine bleeding or discharge with failure to respond to conservative management
4. Confirmed diagnosis of endometriosis with documented failure of non-surgical management (e.g., use of hormonal therapy, if not contraindicated, and/or low dose contraceptives)
5. Endometritis that is unresponsive to conservative management
6. Chronic pelvic inflammatory disease unresponsive to conservative management
7. Adenomatous endometrial hyperplasia with moderate or severe atypia recurring despite conservative management
8. Obstetrical catastrophes, such as uncontrollable postpartum bleeding, uterine rupture, uncontrolled uterine sepsis developing from septic abortion, placenta accretion, etc.
9. Septic abortion not responsive to conservative management
10. Removal of the uterus in non-gynecologic pelvic surgery where necessary to encompass disease originating elsewhere, as in uterine involvement in colon cancer or in abscess secondary to diverticulitis.
11. Symptomatic uterine prolapse or descent resulting in general pelvic relaxation
12. Other conditions determined to be medically necessary

## Authorization Standards for Spinal Fusions

PrimeWest Health covers cervical, thoracic, and lumbar spinal fusions when certain criteria are met. Spinal fusion procedure codes that require a Service Authorization before they are performed include: 22532, 22533, 22534, 22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600, 22610, 22612, 22614, 22630, 22632, 22800, 22802, 22804, 22808, 22810, and 22812.

## Documentation Required

1. Condition (acute trauma, osteomyelitis, tumor, etc.), indication of instability confirmed by radiographic (or imaging) studies
2. If a tumor or lesion needs excision, indication if excision will cause vertebral instability?
3. Current symptoms
4. Treatment tried in the past, for how long, and response to treatment
5. Interference with ADLs (for non-traumatic instability and degenerative conditions)

Conditions supporting medical necessity for spinal fusion may include, but are not limited to, the following with radiographic documentation:

1. Epidural compression or vertebral destruction from tumor
2. Idiopathic scoliosis over 40 degrees or progressive degenerative scoliosis
3. Instability after debriement for infection
4. Neural/epidural compression resulting from vertebral or spinal (involving 2 or 3 spinal levels)
5. Other causes of objectively documented symptomatic instability with compression of either the nerve root or the cauda equina
6. Pseudoarthrosis.
7. Spinal tuberculosis

For **lumbar fusions due to degenerative conditions with spinal instability** – In addition to the above, provide the following:

1. Documented unremitting pain and disability that is refractory to intensive conservative therapy for at least eight weeks. The course of intensive conservative therapy must include all of the following:
  - a. An active, organized, and progressive strength and flexibility program
  - b. A psycho-educational component that deals with patient expectations and perceptions as well as the anatomic sources of back pain
  - c. A minimum of two sessions per week over the eight-week period
    - i. Documentation must include Oswestry Disability Index (ODI) scores from the first and last therapy visits
2. Radiographic documentation (plain radiographs, MRI/CT scans) of spinal instability
3. Absence of untreated, underlying, contributory mental health conditions or psychosocial issues (including, but not limited to depression, drug or alcohol abuse).
4. Absence of provider suspicion of secondary gain such as litigation, narcotic use, etc.
5. One of the following:
  - a. Post-laminectomy instability
  - b. Spinal stenosis decompression for any one of the following:
    - i. Associated radical discectomy
    - ii. Flexible or progressive degenerative scoliosis or kyphosis
    - iii. Intraoperative excessive facet removal
    - iv. Multiple recurrent disc herniation with failed laminectomy
    - v. Recurrent spinal stenosis at the same segment
    - vi. Removal of par interarticularis or pars fracture
    - vii. Spondylolisthesis

For **lumbar fusions for chronic discogenic back pain** alone (without instability) provide all of the following:

1. Documented unremitting pain and disability that is refractory to intensive conservative therapy for at least eight weeks. The course of intensive conservative therapy must include all of the following:
  - a. An active, organized, and progressive strength and flexibility program

- b. A psycho-educational component that deals with patient expectations and perceptions as well as the anatomic sources of back pain
- c. A minimum of two sessions per week over the eight-week period
  - i. Documentation must include ODI scores from the first and last therapy visits
2. Degenerative disc disease limited to one or two lumbar levels, documented by appropriate diagnostic imaging
3. Absence of untreated, underlying, contributory mental health conditions or psychosocial issues (including, but not limited to depression, drug or alcohol abuse)
4. Absence of provider suspicion of secondary gain (such as litigation, narcotic use, etc.)

PrimeWest Health will **not** approve lumbar fusions as medically necessary for the management of the following conditions:

1. With initial primary laminectomy/discectomy for nerve root decompression without documented instability
2. Multiple-level degenerative disc disease (more than two levels)

### **Authorization Standards for BRCA Genetic Mutation Testing for Breast and Ovarian cancer Susceptibility**

PrimeWest Health covers genetic mutation testing for breast and cervical cancer susceptibility when certain criteria are met. Procedure codes that require authorization include: S3818 – S3823 and 83890 – 83909 with modifier 0A or 0B. BRCA mutation testing must be conducted in conjunction with pre- and post-test genetic counseling by a physician or a licensed or a certified genetic counselor.

BRCA genetic mutation testing will be approved in cases where the results will impact the care of the individual patient (member). Criteria in either 1 or 2 below must be met:

1. Member is identified as high-risk for a BRCA mutation:
  - a. For women of Ashkenazi Jewish descent (or other ethnicity/population for which “founder” mutations in the BRCA genes have been identified):
    - i. Any first-degree relative (or two second-degree relatives on the same side of the family) with breast or ovarian cancer\*
  - b. For women of ethnicities not described above (one or more of the following):
    - i. Two first-degree relatives with breast cancer, one of whom was diagnosed at age 50 or younger
    - ii. A combination of three or more first- or second-degree relatives with breast cancer regardless of age of diagnosis
    - iii. Any combination of breast and ovarian cancer among any combination of first- and second-degree relatives
    - iv. A first-degree relative with bilateral breast cancer
    - v. A combination of two or more first- and second-degree relatives with ovarian cancer, regardless of age of diagnosis
    - vi. A first or second-degree relative with both breast and ovarian cancer at any age
    - vii. History of breast cancer in a male relative
2. Member has personal history of breast or ovarian cancer and wishes to inform future reproductive decision-making

\*A first degree relative is an individual’s parent, sibling, or child. A second-degree relative is an individual’s aunt, uncle, grandparent, grandchild, niece, nephew, or half sibling.

## Authorization Standards for Radiofrequency Neuroablation for Facet-Mediated Back and Neck Pain

PrimeWest Health covers radiofrequency neuroablation to treat facet-mediated back and neck pain when certain criteria are met. Procedure codes that require authorization include: 64622, 64623, 64626, 64627, and 64640.

Radiofrequency nerve root ablation may be medically necessary for chronic cervical or lumbar facet-mediated spinal pain that is refractory to conservative therapy. The procedure must be conducted under fluoroscopic guidance to assure proper needle positioning.

### Documentation needed:

1. Presence of any neurologic symptoms or findings
2. Indication that the member has facet-mediated spinal pain diagnosed by comparative, controlled medial branch nerve blocks (two or more facet joint injections). The diagnostic nerve blocks must:
  - a. Provide more than 50 percent pain relief using the Visual Analog Scale (VAS) or other validated tool (at least one hour for lidocaine and two hours for bupivacaine) during follow-up assessment
  - b. Not be conducted under intravenous sedation unless specifically indicated
  - c. Not include steroid injections
3. Written description of diagnostic procedure and patient response including degree of pain relief and, if applicable, indications for sedation
4. Facet-mediated pain has been unresponsive to appropriate conservative therapy. Describe prior therapies attempted and patient's response (such as structured exercise, physical therapy, activity modification, pharmacological management, therapeutic nerve blocks, and joint injections) for a period of at least six months.

For repeat procedure (same level), documentation required includes:

1. Date of last radiofrequency nerve root ablation treatment (repeat procedures can be approved at intervals of no less than three months)
2. Patient response to the last radiofrequency nerve root ablation including degree of pain relief. (Repeat procedure may be approved if the member obtained greater than 50 percent relief using the Visual Analog Scale [VAS] or other validated tool for at least 10 – 12 weeks following the previous procedure.)
3. No more than three procedures per a 12 month period will be approved.

## Transplant Services

### Covered Services

PrimeWest Health coverage for organ and tissue transplant procedures is limited to those procedures covered by the Medicare program or approved by the DHS consulting contractor.

Types of transplants:

- |   |                     |
|---|---------------------|
| 1. Autologous pancreatic islet cell transplant (after pancreatectomy) | 7. Kidney           |
| 2. Heart  | 8. Liver            |
| 3. Cornea   | 9. Lung             |
| 4. Heart-lung   | 10. Pancreas        |
| 5. Intestine  | 11. Pancreas-kidney |
| 6. Intestine-liver  | 12. Stem Cell       |

Transplant coverage includes: preoperative evaluation, member, and donor surgery, follow-up care for the member and live donor, and retrieval of organs, tissues. All transplant-related services are billed under the member's PrimeWest Health ID number.

## Eligible Providers

Transplants provided to Medicare/Medicaid dually eligible recipients must be performed in a Medicare certified transplant facility.

Cornea and kidney transplants must be performed in a facility that is a participating provider of the Medicare program.

All organ transplants must be performed at transplant centers meeting United Network for Organ Sharing (UNOS) criteria or be Medicare Approved Heart, Lung, Heart-Lung, Liver, and Intestinal Transplant Centers.

Stem cell transplants must be performed in a tissue transplant center that is certified by and meets the Foundation for the Accreditation of Cellular Therapy (FACT) criteria for stem cells or bone marrow transplants, or be approved by the Advisory Committee on Organ and Tissue Transplants.

All transplant procedures must comply with all applicable laws, rules, and regulations governing the following:

1. Coverage by the Medicare program
2. Federal financial participation by the Medicaid program
3. Coverage by the MA program. All transplants performed out of state must have prior authorization.

It is the responsibility of the transplant center to submit their certification documentation to Provider Enrollment.

## Eligible Recipients

Transplant coverage applies to MA and MinnesotaCare members. MinnesotaCare members should be referred to their county human services agency for application to MA. If a recipient is not eligible for MA, any maximum benefit limits applicable to the MinnesotaCare member will apply. Refer to the MinnesotaCare section of the [Health Care Programs and Services, Chapter 2](#), for further information.

## Authorization

Authorization is required for the following transplant procedures: stem cell, heart-lung, kidney, lung, pancreas, pancreas-kidney, intestine, intestine-liver, liver, heart, and autologous pancreatic islet cell transplant (after pancreatectomy).

The transplant prior authorization request must be submitted to PrimeWest Health Medical Administration by the physician rather than the transplant facility. The transplant facility may request documentation of the prior authorization approval from the physician's office or by calling the PrimeWest Health Provider Contact Center at **1-866-431-0802** (toll free). The medical report must include all of the following information:

1. Diagnosis, including ICD-9-CM diagnosis code
2. Proposed treatment
3. Sufficient, pertinent information

Out-of-state hospitals must include evidence of meeting the requirements of Medicare, UNOS, and Foundation for the Accreditation of Cellular Therapy (FACT).

If a transplant is to be performed out-of-state, the provider must obtain authorization **prior** to the service being rendered. Refer to the instructions in [Authorization, Chapter 5](#), for out-of-state services.

## Heart Transplant

Heart transplants are covered when performed in a facility on the Medicare list of approved heart transplant centers. All heart transplants require authorization.

Artificial heart transplants are **not** covered.

## Heart-Lung Transplant Coverage

Heart-lung transplants for people with primary pulmonary hypertension are covered when performed in a Minnesota facility that meets UNOS criteria to perform heart-lung transplants. Heart-lung transplants require authorization.

## Lung Transplant Coverage

Lung transplants using cadaveric donors and lung lobe transplants from living donors are covered when performed in a Minnesota facility that meets UNOS criteria to perform lung transplants. All lung transplants require authorization.

## Kidney Transplant Coverage

Kidney transplants must be performed in a hospital that is a participating provider of the Medicare program. All kidney transplants require authorization prior to the service being rendered.

## Pancreas and Pancreas-Kidney Transplant Coverage

Pancreas transplants for uremic diabetic members of kidney transplants and people with hypoglycemic unawareness are covered when performed in a Minnesota facility that meets UNOS criteria to perform pancreas and pancreas-kidney transplants. All pancreas and pancreas-kidney transplants require authorization.

## Liver Transplant Coverage

Liver transplants in children (under age 18 years) with extrahepatic biliary atresia or other forms of end-stage liver disease are covered.

Liver transplants for children with a malignancy extending beyond the margins of the liver, or those with persistent viremia, are **not** covered.

Liver transplants using live donors are covered.

Liver transplants are covered for adults with the following conditions:

1. Primary biliary cirrhosis
2. Primary sclerosing cholangitis
3. Post-necrotic cirrhosis, hepatitis B surface antigen negative
4. Alpha-1 antitrypsin deficiency disease
5. Wilson's disease or primary hemochromatosis
6. Alcoholic cirrhosis

7. Any other end-stage liver disease other than hepatitis B
8. Hepatocellular carcinoma
9. End-stage liver disease with the diagnosis of hepatitis B

In cases involving alcoholic cirrhosis:

1. The facility must state its criteria for the period of abstinence required prior to surgery;
2. The facility must include documentation that shows how the patient meets that criteria; and
3. The facility must include documentation showing evidence of social support to assure assistance in alcohol rehabilitation and immunosuppressive therapy following the surgery.

Liver transplants require authorization, including those covered by other third-party payers.

### **Intestine Transplant Coverage**

Intestine transplants for a patient with a diagnosis of short bowel syndrome, parenterally dependent and experiencing life-threatening or potentially life-threatening complications due to the original disease or to complications of total parenteral nutrition (TPN), are covered. Intestine transplants must be performed in a facility that meets UNOS criteria to perform this transplant.

All intestine transplants require authorization.

### **Intestine-Liver Transplant Coverage**

Intestine-liver transplants are covered for people who develop liver disease secondary to TPN treatment. Intestine transplants must be performed in a facility that meets UNOS criteria to perform this transplant. Intestine-liver transplants require authorization.

### **Stem Cell Transplant Coverage**

**Stem Cell Transplantation:** A procedure where stem cells are obtained from a donor's or member's bone marrow or peripheral blood and prepared for intravenous infusion. PrimeWest Health follows Medicare guidelines and is replacing references to bone marrow with stem cell transplantation.

### **Policy**

Transplant centers must be participating providers of the Medicare program and meet Foundation for the Accreditation of Cellular Therapy (FACT) criteria for stem cell transplants and be located in Minnesota or contiguous counties to receive payment for stem cell transplants. All stem cell transplants require authorization.

**Allogenic stem cell transplants** are covered for the treatment of leukemia or aplastic anemia when it is reasonable and necessary for the individual patient to receive this therapy.

### **Autologous Pancreatic Islet Cell Transplant (after pancreatectomy) Coverage**

Autologous pancreatic islet cell transplant (after pancreatectomy) coverage is not to be confused with pancreatic islet cell allograft transplant (non-covered) for a member with a diagnosis of Type 1 diabetes.

Pancreatectomy is covered for a member with a diagnosis of chronic pancreatitis with intractable pain. With pancreatectomy, the pain is relieved, but without the autologous pancreas islet cell transplant, the result is insulin dependent diabetes mellitus. The autologous pancreatic islet cell transplant has the potential to prevent

diabetes or make the diabetes mild. This procedure is covered when performed in a Minnesota facility that meets UNOS criteria. All autologous pancreatic islet cell transplants (after pancreatectomy) require authorization.

## Billing Transplants

The cost of organ, tissue, and stem cell procurement should be included on the inpatient hospital claim. The hospital stay for the donor is included in the diagnosis related group (DRG) payment for the donee (PrimeWest Health member). All charges for the donor should be billed using the donee's PrimeWest Health ID number.

## Other Payers

Liable third-party coverage monies must be used to the fullest extent before PrimeWest Health payment will be made for a transplant. If a third-party payer denies payment, the denial and documentation of efforts to secure payment must be submitted with the claim. If Appeals are available through the insurer, PrimeWest Health will ask the member to pursue these Appeals. Providers must obtain authorization for transplants that require authorization even though private insurance may pay a portion of the charges.

## Medical Nutritional Therapy (MNT)

**Medical Nutritional Therapy (MNT)** is a preventive health service designed to assess and minimize the problems hindering normal nutrition, and to improve the patient's nutritional status. MNT services may be provided in a physician's office, clinic, or outpatient hospital setting. Medical necessity must be documented in the member's medical record.

Licensed dietitians and licensed nutritionists may provide MNT and Diabetic Outpatient Self Management (DSMT) services for PrimeWest Health members when prescribed or referred by a physician.

The medical professionals who may prescribe/refer for MNT and DSMT services include: Physicians, Advanced Practice Registered Nurses, Clinical Nurse Specialists, Nurse Practitioners, Nurse Midwives, and Physician Assistants. Providers should refer to in-plan licensed dietitians and licensed nutritionists. Contact PrimeWest Health to confirm that the provider you are referring to for MNT or DMST is in PrimeWest Health's network. (Out of network MNT or DSMT will require [Service Authorization](#) prior to the service being started this will be granted on a case-by-case basis).

## Eligible Providers

1. Licensed Dietician
2. Licensed Nutritionist

Licensed dietitians cannot enroll in PrimeWest Health independently.

## Covered Services

MNT includes evaluation, follow-up, and/or group counseling prescribed by a physician. The medical necessity for these services must be documented in the medical record.

## Weight Loss Services

PrimeWest Health covers physician visits, MNT, mental health services\*, and laboratory work provided for weight management. Enrolled providers on a component basis with current CPT/HCPCS codes must bill services.

If a PrimeWest Health member elects to participate in a weight loss program, the member may be billed for components of the program that are not covered, as long as the member is informed of charges in advance.

Coverage standards for gastric restrictive surgery: See the *Gastric Restrictive Surgery* section of this chapter.

\*Authorization may be required for mental health services. Refer to [Mental Health Services, Chapter 16](#), for requirements.

## Non-covered Weight Loss Services

1. Weight loss services on a program basis
2. Nutritional supplements or foods for the purpose of weight reduction
3. Exercise classes
4. Health club memberships
5. Instructional materials and books
6. Motivational classes
7. Counseling or weight loss services provided by people who are not PrimeWest Health providers
8. Counseling that is part of the physician's covered services and for which payment has already been made
9. Nutritional counseling for diabetic education when it is part of a diabetic education program (see *Diabetic Self-Management Training Services* section of this chapter).

## Billing

PrimeWest Health reimburses Dietician or Nutritionist services listed **only** when prescribed by a physician and provided in an office or outpatient setting. MNT and DSMT are separate benefits and may not be billed for the same date of service. Payment for medical nutritional therapy provided by a licensed dietician (under the supervision of a physician) is limited to the following codes:

- |              |  |
|--------------|--|
| <b>97802</b> | Initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes. This code is to be used only once per year, for initial assessment of a new patient.  |
| <b>97803</b> | Reassessment and intervention, individual, face-to-face with the patient, each 15 minutes. Use this code for all individual reassessments and all interventions after the initial visit when there is a change in the patient's medical condition that affects the patient's nutritional status. |
| <b>97804</b> | Group (two or more), each 30 minutes.  |
| <b>G0270</b> | Reassessment and subsequent intervention following second referral in the same year due to change in diagnosis, medical condition or treatment regimen, individual, face-to-face with patient, each 15 minutes.  |
| <b>G0271</b> | Reassessment and subsequent intervention following second referral in the same year for change in diagnosis, medical conditions or treatment regimen group (two or more), each 15 minutes.   |

## Dietician or Nutritionist Billing Guidelines for Rendering and Billing Providers' NPI

Enrolled Provider	Billing
Licensed dietitians or nutritionists in private practice	Use your NPI as the billing provider and the rendering provider.
Licensed dietitians or nutritionists who contract with a private agency to provide services	<b>To directly receive payment:</b> Use your NPI as the billing provider and the rendering provider. <b>If the private agency receives payment:</b> It must be an enrolled MHCP Provider. Use the private agency's NPI as the billing provider and the dietician's or nutritionist's NPI as the rendering provider.
Licensed dietitians or nutritionists employed by hospitals, public health or community health clinic, clinic, or an individual physician	Use the hospital, public or community health clinic, clinic, or individual physician's NPI as the billing provider and the dietician's or Nutritionist's NPI as the rendering provider.

If services are rendered somewhere other than the listed billing provider address or in the recipient's home, include the service facility location's name, address, and NPI/UMPI.

## Diabetic Outpatient Self-Management Training Services (DSMT)

**Diabetic Outpatient Self-Management Training Service:** A preventative health service for people diagnosed with diabetes. An outpatient diabetes self-management and training program includes education about self-monitoring of blood glucose, diet and exercise, an insulin treatment plan developed specifically for the patient who is insulin-dependent, and motivates patients to use the skills for successful self-management of diabetes. Diabetic outpatient self-management training services minimize the occurrence of disease and disability through instructions on maintaining health and well being of the patient.

### Eligible Providers

1. Diabetic care instructions may be provided by a physician or registered nurse.
2. Nutritional counseling may be provided by a physician or licensed dietician. Referrals should be made to licensed dietitians for in-depth nutritional counseling.
3. Licensed registered nurses may only provide nutritional counseling to the extent that their scope of practice and education experience allow.

A provider of dually eligible PrimeWest Health members must be a "certified provider" according to Medicare's definition. Certified providers for Medicare's purposes must meet the National Diabetes Advisory Board Standards.

### Covered Services

A physician must order all diabetic DSMT services. DSMT services include:

1. Diabetes overview
  - a. Type of diabetes
  - b. Blood glucose testing
  - c. Blood glucose self-monitoring education
  - d. Insulin treatment plan for patients who are insulin dependent
  - e. Foot, skin, and dental care
2. Diabetes management
  - a. Stress and psychosocial adjustment
  - b. Family involvement and social support

- c. Medications, monitoring, and use of results
  - d. Prevention, detection, and treatment of chronic complications
  - e. Prevention and treatment of low and high blood sugar
  - f. Benefits, risks, and management options for improving glucose control;
3. Nutritional counseling
    - a. Meal planning, carbohydrate counting, label reading
    - b. Dietary fat and cholesterol modification
    - c. Role of fiber on blood sugar and cholesterol control
  4. Exercise and activity
    - a. Relationships among nutrition, exercise, medication, and blood glucose levels
    - b. Behavior change strategies, goal setting, risk factor reduction, and problem solving;
  5. Pre-conception care, pregnancy, and gestational diabetes
  6. Use of health care systems and community resources

## Billing

Use the appropriate DSMT codes below when billing. Do not bill nutritional counseling, office visit (E/M) codes, facility codes, or other procedure codes with DSMT codes.

**G0108** Diabetic outpatient self-management training services; individual session; 1 unit equals 30 minutes of training.

**G0109** Diabetic outpatient self-management training services; group session; 1 unit equals 30 minutes of training.

Bill one unit per each half hour of DSMT services, with a maximum of not more than 10 hours within a continuous 12-month period for each member. After the initial 10-hour training, additional DSMT services are limited to one hour (group or individual) per year.

## Nutritional Products

**Nutritional Product:** A commercially formulated substance that provides nourishment and affects the nutritive and metabolic processes of the body. Nutritional products are covered by PrimeWest Health.

### Providers

A parenteral nutritional product must be dispensed as a pharmacy service as prescribed by a physician. Refer to [Pharmacy Services, Chapter 22](#).

An enteral nutritional product may be supplied by a pharmacy, home health agency, or medical supply provider with a written physician's order.

### Covered Nutritional Services

PrimeWest Health covers enteral nutritional products when the member's diagnosis can be linked to the need for a nutritional product. Refer to [Equipment and Supplies, Chapter 23](#), for additional information.

## Podiatry

### Providers

Podiatrists who practice as defined in MS [153](#) and physicians are eligible for payment for podiatry services.

### Covered Services

1. Debridement or reduction of pathological toenails, and of infected or eczematized corns and calluses
2. Avulsion of nail plate
3. Evacuation of subungual hematoma
4. Excision of nail and nail bed
5. Reconstruction of nail bed
6. Other non-routine foot care

### Payment Limitations for Debridement or Reduction of Nails, Corns, and Calluses

Payment for debridement or reduction of non-pathological toenails, and of non-infected or non-eczematized corns or calluses is limited. These services are considered routine foot care, unless the patient has a systemic condition which may require the expertise of a professional.

Although not intended as a comprehensive list, the following metabolic, neurologic, and peripheral vascular disease (with synonyms in parenthesis) most commonly represent the underlying conditions that may justify coverage for routine foot care:

1. Diabetes mellitus
2. Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, or occlusive peripheral arteriosclerosis)
3. Buerger's Disease (thromboangiitis obliterans)
4. Chronic thrombophlebitis; Peripheral neuropathies involving the feet associated with:
  - a. Malnutrition and vitamin deficiency
    - i. Malnutrition (general, pellagra)
    - ii. Alcoholism
    - iii. Malabsorption (celiac disease, tropical sprue)
    - iv. Pernicious anemia
  - b. Carcinoma
  - c. Diabetes mellitus
  - d. Drugs and toxins
  - e. Multiple sclerosis
  - f. Uremia (chronic renal disease)
  - g. Traumatic injury
  - h. Leprosy or neurosyphilis; hereditary disorders
    - i. Hereditary sensory radicular neuropathy
    - ii. Angiokeratoma corporis diffusum (Fabry's)
    - iii. Amyloid neuropathy

### Non-covered Services

The following list includes, but is not limited to, podiatry services which are **not** covered by PrimeWest Health:

1. Surgical assistant services (differing from assisting surgeons)

2. Local anesthetics that are billed as a separate procedure
3. Operating room facility charges
4. Routine foot care:
  - a. Foot hygiene (cleaning and soaking the feet to maintain a clean condition)
  - b. Cutting or removal of corns and calluses (except as noted above)
  - c. Trimming, cutting, clipping, or debriding of nails (except as noted above)
  - d. Use of skin creams to maintain skin tone
  - e. Any other service performed in the absence of localized illness, injury, or symptoms involving the foot
5. Services not covered by Medicare or services denied by Medicare:
  - a. Subluxation of the foot
  - b. Treatment of flat feet
  - c. Routine foot care
6. Stock orthopedic shoes, except when attached to a leg brace
7. Routine supplies provided in the office. Refer to *List of Routine Supplies* section in this chapter.

## Coverage Limitations

The following coverage limitations apply to podiatry services:

1. When a physician or podiatrist provides services to LTC facility residents:
  - a. The referral must result from the resident, an RN, or LPN employed by the facility, the resident's family, guardian, or attending physician;
  - b. The LTC facility must document the referral in the medical record; and
  - c. LTC facility is responsible for routine foot care.
2. Coverage for the debridement and reduction of nails, corns, and calluses are limited to once every 60 days
3. For established patients, a podiatry visit charge must not be billed on the same day as the date for services described for debridement or reduction of nails, corns, and calluses
4. Provider may bill the avulsion and excision codes only once per nail

## Billing

1. Podiatry services are billed in the 837P format. Refer to [Billing Policy, Chapter 4](#).
2. National foot care modifiers are required on all routine foot care services, regardless of specialty.
3. Refer to [Laboratory/Pathology, Radiology, and Diagnostic Services, Chapter 11](#), for further information.

## Relocation Service Coordination

### Definitions

**Developmental Disability (DD) Screening Document:** Assessment tool required for any person being admitted to an institution. This process is to be used to provide people with community service options in order to prevent admissions OR to provide transition assistance in the event an admission cannot be avoided. If a person is admitted and requests relocation service coordination (RSC) services, this process includes a means for assessing the member's health, psychosocial, and functional strengths and needs, in addition to assisting the member to identify needed and available services.

**Institutions:** Include hospitals, nursing facilities (NFs), including certified boarding care facilities, intermediate care facilities for members with mental retardation or related conditions (ICF/MRs), and regional treatment centers (RTCs) providing inpatient services to members currently receiving Medical Assistance.

**Long-Term Care Consultation (LTC Screening) Document:** An assessment tool required for any member admitted to an institution. The screening is to provide community service options in order to prevent admissions OR to provide transition assistance in the event an admission cannot be avoided. If a member is admitted and requests transition services, the screening includes a means for assessing a member’s health, psychosocial, and functional strengths and needs, in addition to assisting the member identify needed and available services.

**Relocation Service Coordination (RSC):** A type of targeted case management for members residing in eligible institutions who want to move into the community. RSC helps a member who resides in an eligible institution to plan, arrange, and gain access to needed medical, social, educational, financial, housing, and other services and supports that are necessary to move from an eligible institution to the community.

**Targeted Case Management (TCM):** Services that assist a member eligible under the plan in gaining access to needed medical, social, educational, and other services.

### **Eligible Providers**

The county of financial responsibility must assign a county case manager to visit the person within 20 working days of receiving the referral. If it is not practical for the county of financial responsibility to provide RSC, the county may coordinate with a different county or sub-contract with another vendor to provide the service.

### **Eligible Recipients**

MA recipients who reside in an eligible institution and choose to relocate to a community setting are eligible for RSC.

Recipients in an RTC must be:

1. Under age 21 years; or
2. Over age 65 years; and
3. Currently receiving MA

Verify eligibility prior to providing services online through our [Provider Web Portal](#) or [MN-ITS](#) or by calling our Provider Contact Center at **1-866-431-0802** (toll free).

If a recipient is currently enrolled in a Minnesota Senior Health Option (MSHO) or a Minnesota Disability Health Option (MnDHO), the RSC provider must contact the health plan and arrange for that plan to provide relocation assistance.

If a recipient is enrolled in a contracted managed care organization other than MSHO or MnDHO, the RSC provided must take the necessary steps to make sure that all relocation efforts are coordinated with the appropriate health plan to ensure continuity of care and non-duplication of effort.

### **Covered Services**

1. Development, implementation, and review of an individual relocation plan.
2. Communication with all parties necessary for the implementation of the plan.
3. Coordination of referrals to ensure access to medical, social, and other related services and supports.
4. Coordination and monitoring of the implementation of the plan and service delivery.
5. Coordination with the institution discharge planner.
6. Completion and maintenance of required documentation.
7. Travel and documentation necessary to develop and implement the plan.

## Non-covered Services

The following list of non-covered services is not all-inclusive:

1. Transition assistance when a recipient moves from one institution to another. For example, if a nursing facility closes, a provider cannot bill for activities related to finding another nursing facility for the recipient, unless the recipient's relocation plan indicates that a move to another institution is a necessary step toward the eventual community integration of that recipient.
2. Services provided to recipients on home and community-based waivers.
3. Administrative functions:
  - a. Intake for Medical Assistance and other MHCP programs
  - b. Eligibility determinations and re-determinations for MA or an MA funded benefit such ARHMS, waived services, VADD–TCM
  - c. Prior authorization of services
  - d. LTCC or DD screening
  - e. Appeals or conciliation activities
  - f. Direct services such as treatment, therapy, and other habilitative or rehabilitative services provided to the recipient
4. Other non-billable activities:
  - a. Outreach services and marketing activities
  - b. Information and referral activities prior to eligibility determinations
  - c. Services without proper documentation in the recipient's service plan
  - d. Services to recipients ineligible for MA
  - e. Services covered by another billing source such as private insurance or other third party payers
  - f. The time and services of the institution's discharge planner
  - g. Case management activities covered as a part of another covered service such as development of a treatment plan for home care or PT services
  - h. Services prior to the county of financial responsibility (CFR) authorization

## Limitations

Recipients living in the community or an ineligible institution such as an Intensive Residential Treatment Services (IRTS) that is not licensed as a hospital or nursing facility cannot receive RSC–TCM.

The RSC–TCM benefit is available during the last 180 consecutive days of a continuous institutional placement following the date on the first paid claim for RSC–TCM, MH–TCM, or VADD–TCM, regardless of the length of that placement.

RSC–TCM benefits end once a member is discharged from an eligible institution.

RSC–TCM is available for each and every institutional placement episode. If a person is discharged from an institution with or without RSC–TCM services, remains in a community living arrangement for a full day, and then returns to an institution, he/she may receive RSC–TCM services to assist with relocation. PrimeWest Health must have a record of community placement that lasts for at least one day.

Members cannot receive RSC–TCM and another type of targeted case management (MH, VA/DD, CW) during the same month while they reside in an institution. Do not bill for another type of targeted case management during the month(s) RSC–TCM is provided.

Minnesota Senior Health Option (MSHO) or Minnesota Disability Health Option (MnDHO) members should contact PrimeWest Health at **1-866-431-0801** (toll free) to request relocation assistance. The RSC–TCM provider must coordinate with PrimeWest Health to ensure continuity of care and non-duplication of effort.

### **Waiver Transitional Services**

A service provider may simultaneously provide waiver transitional services and RSC–TCM. Waiver transitional services reimburse items, expenses, and related supports necessary and reasonable for the recipient to transition to their permanent place of residence in the community from the institution and do not duplicate these services.

Payment for these services may not duplicate payments made or services provided under other programs authorized for the same purpose.

### **Billing**

To bill RSC, PrimeWest Health requires:

1. An approved screening document within the past 12 months. An LTC screening document must be face-to-face.
2. That RSC be listed as a current service on an approved screening document that covers the date of service of an RSC claim and is within one year of the claim service date.
3. The recipient to be in a facility living arrangement (DHS codes 41, 42, 43, 44, 45, 46, 47, 48, and 50) or a community living arrangement (DHS code 80, to be used with RSC only for an inpatient hospital stay of less than 30 days). If a person is receiving RSC while in an inpatient hospital and the living arrangement is (DHS code 80) (community), the place of service on the claim must be 21 (inpatient hospital).

Billing for RSC is limited to 180 consecutive days. The 180-day limit starts on the date of service listed on the first RSC claim. Providers will not be able to authorize additional days beyond the 180-day limit unless the recipient:

1. Receives RSC
2. Is discharged, and
3. Is re-admitted at a later date

Bill electronically using the 837P claim format. Submit claims throughout the relocation process using the following information:

1. Use procedure code T1017 – Case management, each 15 minutes
2. Limit of 32 units (eight hours) per day
3. Bill each date of service separately, do not bill as a date span
4. Bill using the 837P format with your NPI or UMPI

Certified private agencies, independent providers, and county/tribe contracted providers must work closely with county case managers to avoid claim denials due to ended eligibility or exceeded service limits.

You are not required to wait for discharge to occur before billing. You may submit a claim regardless of whether the community reintegration takes place through a home and community based waiver, by other means, or not at all.

## Legal References

MS [256B.02](#) (definitions)  
MS [256B.77](#) (coordinated service delivery system for disabled)  
MS [256B.0621](#) (TCM covered services)  
MS [256B.0621](#) subd 4(RSC–TCM provider qualifications)  
MS [256B.0621](#) subd 5 (provider qualifications & minimum educational requirements)  
MS [256B.0621](#) subd 6 (eligible services)  
MS [256B.0621](#) subd 7 (timelines)  
MS [256B.0625](#) sub. 20 (mental health case management services)  
MS [256B.092](#) (county of financial responsibility)  
MS [256G.02](#) Subd. 4 CFR definitions  
MS [256B.0625](#), subd. 3; subd. 4 (general information)  
MN Rules [9505.0345](#); [9505.0355](#) (general information)  
MN Rules [9505.0330](#) (outpatient hospital)  
MS [256B.0625](#), subd. 25 (physician assistant standards)  
MN Rules [9505.5010](#) (prior authorization)  
MS [256B.0625](#), subd. 28a  
MS [147A.01](#) (physician assistant)  
MS [256B.0625](#), subd. 28a  
MS [256B.0625](#), subd. 27; 256.0629 (organ transplants)  
MS [256D.03](#), subd. 7 (second medical opinion)  
MN Rules [9505.5035](#) (second medical opinion)  
MS [256B.0625](#), subd. 32 (nutritional products)  
MN Rules [9505.0325](#) (nutritional products)  
MS [153](#) (podiatry licensing)  
MN Rules [9505.0350](#) (podiatry)  
[42 CFR 440.20](#)  
[42 CFR 440.166](#)  
[42 CFR 440.50](#)  
[42 CFR 440.130\(c\)](#)  
MS [148.624](#) subd. 1 (Licensed Dietician)  
MS [148.624](#) subd. 2 (Licensed Nutritionist)