

## Evaluation and Management Rules

This section contains ~~guidelines~~ rules and codes used to report evaluation and management services. ~~provided in the physician's office or in an outpatient facility or other ambulatory facilities.~~

Note: Rules used by all physicians in reporting their services are presented in the General ~~Guidelines~~ Rules section.

### I. Definitions and Rules

Definitions and rules pertaining to evaluation and management services are as follows:

**A. Consultations.** The CPT book defines a consultation as “a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.” (This includes referrals for a second opinion.) Consultations are reimbursable only to physicians with the appropriate specialty for the services provided.

*In order to qualify as a consultation the following criteria must be met:*

- *The verbal or written request for a consult must be documented in the patient's medical record;*
- *The consultant's opinion and any services ordered or performed must be documented by the consulting physician in the patient's medical record;*
- *The consulting physician must provide a written report to the requesting physician or other appropriate source.*

*A payer/employer may request a second opinion examination or evaluation for the purpose of evaluating temporary or permanent disability or medical treatment being rendered, as provided in MCA §71-3-15(1) (Rev. 2000). This examination is considered a confirmatory consultation. The confirmatory consultation is billed using the appropriate level and site specific consultation code, 99241–99245 for office or other outpatient consultations and 99251–99255 for inpatient consultations, appended with modifier 32 to indicate a mandated service.*

**B. Referral.** *Subject to the definition of “consultation” provided in this Schedule, a referral is the transfer of the total or specific care of a patient from one physician to another and does not constitute a consultation. (Initial evaluations and subsequent services are designated as listed in E/M services).*

**C. New and Established Patient Service.** *Several code subcategories in the Evaluation and Management section are based on the patient's status as new or established. The new versus established patient guidelines also clarify the situation in which a physician is on call or covering for another physician. In this instance, classify the patient encounter the same as if it were for the physician who is unavailable.*

**New Patient.** A new patient is one who has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.

**Established Patient.** An established patient is a patient who has been treated for the same injury by any physician, ~~regardless of the same~~ specialty, who belongs to the same group practice. ~~Because initial records such as history and physical are available within the group's facility, an initial new patient visit would not be indicated.~~

**D. E/M Service Components.** The first three components of history, examination, and medical decision-making are the keys to selecting the correct level of E/M codes, and all three components must be met or exceeded in the documentation of an initial evaluation. However, in established, subsequent, and follow-up categories, only two of the three must be met or exceeded for a given code.

1. The history component is categorized by four levels:
  - a. **Problem Focused.** Chief complaint; brief history of present illness or problem.
  - b. **Expanded Problem Focused.** Chief complaint; brief history of present illness; problem-pertinent system review.
  - c. **Detailed.** Chief complaint; extended history of present illness; problem-pertinent system review extended to include a review of limited number of additional systems; pertinent past, family medical and/or social history directly related to the patient's problems.
  - d. **Comprehensive.** Chief complaint; extended history of present illness; review of systems that are directly related to the problems identified in the history of the present illness, plus a review of all additional body systems; complete past, family, and social history.
2. The physical exam component is similarly divided into four levels of complexity:
  - a. **Problem Focused.** An exam limited to the affected body area or organ system.
  - b. **Expanded Problem Focused.** A limited examination of the affected body area or organ system and other symptomatic or related organ systems.
  - c. **Detailed.** An extended examination of the affected body areas and other symptomatic or related organ systems.
  - d. **Comprehensive.** A general multi-system examination or a complete examination of a single organ system.

The CPT book identifies the following body areas:

- Head, including the face
- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks

- *Back*
- *Each extremity*

*The CPT book identifies the following organ systems:*

- *Constitutional symptoms (fever, weight loss, etc)*
- *Eyes*
- *Ears, nose, mouth, and throat*
- *Cardiovascular*
- *Respiratory*
- *Gastrointestinal*
- *Genitourinary*
- *Musculoskeletal*
- *Skin*
- *Neurologic*
- *Psychiatric*
- *Hematologic/lymphatic/*
- *Allergic/immunologic*

*3. Medical decision-making is the final piece of the E/M coding process. Medical decision-making refers to the complexity of establishing a diagnosis or selecting a management option that can be measured by the following:*

- a. The number of diagnoses and/or the number of management options to be considered.*
- b. The amount and/or complexity of medical records, diagnostic tests, and other information that must be retrieved, reviewed, and analyzed.*
- c. The risk of significant complications, morbidity, mortality, as well as co-morbidities associated with the patient's presenting problems, the diagnostic procedures, and/or the possible management options.*

#### ***E. Contributory Components.***

*1. Counseling, coordination of care, and the nature of the presenting problem are not major considerations in most encounters, so they generally provide contributory information to the code selection process. The exception arises when counseling or coordination of care dominates the encounter (more than 50 percent of the time spent). Document the exact amount of time spent to substantiate the selected code and what was clearly discussed during the encounter. Counseling is defined in the CPT book as a discussion with a patient and/or family concerning one or more of the following areas:*

- a. Diagnostic results, impressions, and/or recommended diagnostic studies;*
- b. Prognosis;*
- c. Risks and benefits of management (treatment) options;*
- d. Instructions for management (treatment) and/or follow-up;*
- e. Importance of compliance with chosen management (treatment) options;*
- f. Risk factor reduction;*

g. *Patient and family education.*

2. *E/M codes are designed to report actual work performed, not time spent. But when counseling or coordination of care dominates the encounter, time overrides the other factors and determines the proper code. For office encounters, count only the time spent face-to-face with the patient and/or family. For hospital or other inpatient encounters, count the time spent rendering services for that patient while on the patient's unit, on the patient's floor, or at the patient's bedside.*

**F. Interpretation of Diagnostic Studies in the Emergency Room**

1. Only one fee for the interpretation of an x-ray or EKG procedure will be reimbursed per procedure.

2. The payer is to provide reimbursement to the provider that directly contributed to the diagnosis and treatment of the individual patient.

3. It is necessary to provide a signed report in order to bill the professional component of a diagnostic procedure. The payer may require the report before payment is rendered.

4. If more than one bill is received, physician specialty should not be the deciding factor in determining which physician to reimburse.

Example: In many EDs, an emergency room (ER) physician orders the x-ray on a particular patient. If the ER physician interprets the x-ray making a notation as to the findings in the chart and then treats the patient according to these radiological findings, the ER physician should be paid for the interpretation and report. There may be a radiologist on staff at the particular facility with quality control responsibilities at that particular facility. However, the fact that the radiologist reads all x-rays taken in the ED for quality control purposes is not sufficient to command a separate or additional reimbursement from the payer.

5. There is a provision for payment of a second interpretation under unusual circumstances such as a questionable finding for which the physician performing the initial interpretation requests the expertise of another physician (i.e., expertise of a radiologist). The CPT code 76140 is to be used when a second opinion is required for a radiological procedure. Reimbursement is limited to the professional component listed in the Fee Schedule for that procedure.

6. A review alone of an x-ray or EKG does not meet the conditions for separate payment of a service, as it is already included in the ED visit.

**II. General Guidelines**

*The E/M code section is divided into subsections by type and place of service. Keep the following in mind when coding each service setting:*

- *A patient is considered an outpatient at a health care facility until formal inpatient admission occurs.*
- *All physicians use codes 99281-99285 for reporting emergency department services, regardless of hospital-based or non-hospital-based status.*

- Admission to a hospital or nursing facility includes E/M services provided elsewhere on the same day.

### **III. Office or Other Outpatient Services (99201-99215)**

Use the Office or Other Outpatient Services codes to report the services for most patient encounters. Multiple office or outpatient visits provided on the same calendar date are billable if medically necessary and include documentation to support medical necessity.

### **IV. Hospital Observation Services (99217-99220)**

CPT codes 99217 through 99220 report E/M services provided to patients designated or admitted as “observation status” in a hospital. It is not necessary that the patient be located in an observation area designated by the hospital to use these codes; however, whenever a patient is placed in a separately designated observation area of the hospital or emergency department, these codes should be used.

The instructional notes for Initial Hospital Observation Care include the following:

- A. Use these codes to report the encounters by the supervising physician when the patient is designated as “observation status.”
- B. These codes include initiation of “observation status,” supervision of the health care plan for observation, and performance of periodic reassessments.
- C. When a patient is admitted to observation status in the course of an encounter in another site of service (e.g., hospital emergency department, physician’s office, nursing facility), all E/M services provided by that physician on the same day are included in the admission for hospital observation. Only one physician can report initial observation services. Do not use these observation codes for post-recovery of a procedure that is considered a global surgical service.
- D. Observation services are included in the inpatient admission service when provided on the same date. Use Initial Hospital Care codes for services provided to a patient who, after receiving observation services, is admitted to the hospital on the same date. The observation service is not reported separately.
- E. Admission to a hospital or nursing facility includes evaluation and management services provided elsewhere (office or emergency department) by the admitting physician on the same day.
- F. For a patient admitted to the hospital on a date subsequent to the date of observation status, the hospital admission would be reported separately with the appropriate Initial Hospital Care code 99221-99223.
- G. For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with codes 99234-99236.

*See Office and Other Outpatient Consultation codes to report observation encounters by other physicians.*

#### **V. Observation Care Discharge Services (99217)**

*A. CPT code 99217 is used only if discharge from observation status occurs on a date other than the initial date of observation. The code includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records.*

*B. If a patient is admitted to and subsequently discharged from observation status on the same date, ~~report only the Initial Observation Services code~~, see codes 99234-99236.*

*C. Do not report observation discharge 99217 in conjunction with a hospital admission.*

#### **VI. Hospital Inpatient Services (99221-99239)**

*The codes for hospital inpatient services report admission to a hospital setting, follow-up care provided in a hospital setting, and hospital discharge day management. For inpatient care, the time component includes not only face-to-face time with the patient but also the physician's time spent in the patient's unit or on the patient's floor. This time may include family counseling or discussing the patient's condition with the family; establishing and reviewing the patient's record; documenting within the chart; and communicating with other health care professionals, such as other physicians, nursing staff, respiratory therapists, etc.*

*A. If the patient is admitted to a facility on the same day as any related outpatient encounter (office, emergency department, nursing facility, etc.), report the total care as one service with the appropriate Initial Hospital Care code.*

*B. For initial hospital care of a patient admitted on one date and discharged a subsequent day, report 99221-99223 for the initial inpatient care, 99231-99233 for the subsequent hospital care excluding the discharge day.*

*C. For a patient admitted and discharged for inpatient services or observation status on the same date, report the service with CPT codes 99234-99236.*

*D. Code 99238 or 99239 reports hospital discharge day management, but excludes discharge of a patient from observation status and inpatients admitted and discharged on the same date. When concurrent care is provided on the day of discharge by a physician other than the attending physician, report these services using Subsequent Hospital Care codes.*

#### **VII. Multiple Hospital Visits**

*Not more than one hospital visit per day shall be payable except when documentation describes the medical necessity of more than one visit by a particular practitioner. Hospital visit codes*

shall be combined into the single code that best describes the service rendered.

### **VIII. Consultations (99241- ~~99275~~ 99255)**

Consultations in CPT 2007 fall under ~~four~~ two subcategories: Office or Other Outpatient Consultations, and Initial Inpatient Consultations, ~~Follow-up Inpatient Consultations, and Confirmatory Consultations~~. If counseling dominates the encounter, time determines the correct code. ~~in three of the four subcategories. Confirmatory consultations have no times established.~~

Most requests for a consultation come from the attending physician, the employer, an attorney, or other appropriate source. Include the name of the requesting physician or other source on the claim form or electronic billing. Confirmatory consultations may be requested by the patient and/or family or may result from a second (or third) opinion. When requested by the patient and/or family the service is not reported with consultation codes, but may be reported using the office, home service, or domiciliary/rest home care codes. When **required** by the attending physician or other appropriate source, report the service with a consultation code for the appropriate site of service, 99241-99245 for office or other outpatient consultation or 99251-99255 for inpatient consultation.

The consultant may initiate diagnostic and/or therapeutic services, such as writing orders or prescriptions and initiating treatment plans.

The opinion rendered and services ordered or performed must be documented in the patient's medical record and a report of this information communicated to the requesting entity.

Report separately any identifiable procedure or service performed on, or subsequent to, the date of the initial consultation.

When the consultant assumes responsibility for the management of any or all of the patient's care subsequent to the consultation encounter, consult codes are no longer appropriate. Depending on the location, identify the correct subsequent or established patient codes.

### **IX. Emergency Department Services (99281-99288)**

Emergency department (ED) service codes do not differentiate between new and established patients and are used by hospital-based and non-hospital-based physicians. The notes in the CPT book clearly define an emergency department as "an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day." This guideline indicates that care provided in the ED setting for convenience should not be coded as an ED service. Also note that more than one ED service can be reported per calendar day if medically necessary.

Codes 99281-99288 are used to report services provided in a medical emergency. If, however, the physician sees the patient in the emergency room out of convenience for either the patient or physician, the appropriate office visit code should be reported (99201-99215) and reimbursement will be made accordingly.

## **X. CRITICAL CARE SERVICES (99291-~~99292~~ 99300)**

*Critical care is the direct delivery by a physician(s) of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition. Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition. Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure. Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life threatening situations when these elements are not present. Critical care may be provided on multiple days, even if no changes are made in the treatment rendered to the patient, provided that the patient's condition continues to require the level of physician attention described above. Providing medical care to a critically ill, injured, or postoperative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility.*

*Critical care services provided to infants 29 days through 24 months of age are reported with pediatric critical care codes 99293 and 99294. Critical care services provided to infants older than one month of age at the time of admission to an intensive care unit are reported with critical care codes 99291 and 99292. Critical care services provided to neonates (30 28 days of age or less at the time of admission to an intensive care unit) are reported with the neonatal critical care codes 99295, 99296, ~~99297~~ and 99298, 99299, and 99300. The neonatal critical care codes are reported as long as the neonate qualifies for critical care services during the hospital stay. The reporting of pediatric and neonatal critical care services is not based on time, the type of unit (e.g., pediatric or neonatal critical care unit) or the type of provider delivering the care. For additional instructions on reporting these services, see the Inpatient Neonatal Intensive and Pediatric Critical Care section of the CPT book and codes 99293-99300~~99295-99298~~.*

*Services for a patient who is not critically ill but happens to be in a critical care unit are reported using other appropriate E/M codes.*

*Critical care and other E/M services may be provided to the same patient on the same date by the same physician.*

*The following services are included in reporting critical care when performed during the critical period by the physician(s) providing critical care: the interpretation of cardiac output measurements (93561, 93562), chest x-rays (71010, 71015, 71020), pulse oximetry (94760, 94761, 94762), blood gases, and information data stored in computers (e.g., ECGs, blood pressures, Hematologic data (99090)); gastric intubation (43752, 91105); temporary*

transcutaneous pacing (92953); ventilatory management (~~94656, 94657~~, 94002-94004, 94660, 94662); and vascular access procedures (36000, 36410, 36415, 36540, 36600). Any services performed which are not listed above should be reported separately when performed in conjunction with critical services reported with code 99291-99292. When reporting inpatient neonatal and pediatric critical care services 99293-99300, consult the CPT book for additional procedures that are bundled into codes 99293-99300.

Codes 99291-99292 should not be reported for the physician's attendance during the transport of critically ill or injured patients to or from a facility or hospital. Physician transport services of the critically ill or injured pediatric patient (24 months of age or less) are separately reportable, see 99289, 99290.

The critical care codes 99291 and 99292 are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured patient, even if the time spent by the physician on that date is not continuous. For any given period of time spent providing critical care services, the physician must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time.

#### **XI. Nursing Facility Services (99304-993186)**

Nursing facility E/M services have been grouped into ~~two~~ four subcategories: Comprehensive Initial Nursing Facility Assessments Care, and Subsequent Nursing Facility Care, Nursing Facility Discharge Services, and Other Nursing Facility Services. Included in these codes are E/M services provided to patients in nursing facilities (formerly called skilled nursing facilities (SNFs)), intermediate care facilities (ICFs), long-term care facilities (LTCFs), and psychiatric residential treatment centers. ~~These Psychiatric residential treatment centers facilities~~ must provide a "24 hour therapeutically planned and professionally staffed group living and learning environment." Report other services, such as medical psychotherapy, separately when provided in addition to E/M services.

#### **XII. Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Services (~~99321~~99324-9933399340)**

The evaluation and management codes are used to report care given to patients residing in a facility that provides room and board and other personal assistance services. The facility is generally a long-term facility. The facility's services do not include a medical component. Typical times have not been established for this code group.

#### **XIII. Home Services (99341-99350)**

Services and care provided at the patient's home are coded from this subcategory. Typical times have not been established for this code group.

#### **XIV. Prolonged Services (99354-~~99360~~99359)**

*A. Prolonged Physician Service with Direct Patient Contact (99354-99357). Prolonged physician services are reportable in addition to other physician services, including any level of E/M service. The codes report the total duration of face-to-face time spent by the physician on a given date, even if the time is not continuous.*

*Codes 99354 or 99356 report the first hour of prolonged service on a given date, depending on the place of service. Code 99355 or 99357 is used to report each additional 30 minutes beyond the first hour. Services lasting less than 15 minutes are not reportable in this category, and the services must extend 15 minutes or more into the next time period to be reportable. For example, services lasting one hour and twelve minutes are reported by code 99354 or code 99356 alone. Services lasting one hour and seventeen minutes are reported using the code for the first hour plus the code for an additional 30 minutes.*

*Prolonged physician services should be reported only once per date of service, even if the time spent is not continuous. Please refer to CPT ~~2002~~ 2007 for a more complete explanation of prolonged physician care.*

*B. Prolonged Physician Service without Direct Patient Contact. Use code 99358 to report the first hour and 99359 for each additional 30 minutes. All aspects of time reporting are the same as explained above for direct patient contact services.*

*Prolonged physician services without direct patient contact may include review of extensive records and tests, and communication (other than telephone calls, 99371-99373) with other professionals and/or the patient and family. These are beyond the usual services and include both inpatient and outpatient settings. Report these services in addition to other services provided, including any level of E/M service.*

#### **XV. Physician Standby Services (99360)**

*Code 99360 is used to report physician standby service that is requested by another physician and that involves prolonged physician attendance without direct (face-to-face) patient contact. The physician may not be providing care or services to other patients during this period. This code is not used to report time spent proctoring another physician. It is also not used if the period of standby ends with the performance of a procedure subject to a “surgical” package by the physician who was on standby.*

*Code 99360 is used to report the total duration of time spent by a physician on a given date on standby. Standby service of less than 30 minutes total duration on a given date is not reported separately.*

*Second and subsequent periods of standby beyond the first 30 minutes may be reported only if a full 30 minutes of standby was provided for each unit of service reported.*

#### **XVI. Case Management Services (99361-99373)**

*Physician case management is a process in which a physician is responsible for direct care of a patient, and for coordinating and controlling access to or initiating and/or supervising other health care services needed by the patient.*

### ***XVII. Care Plan Oversight Services (99339-99340, 99374-99380)***

*Care plan oversight services are reported separately from codes for office/outpatient, hospital, home, nursing facility, or domiciliary services. The complexity and the approximate physician time spent in care plan oversight services provided within a 30-day period determines the code to be billed.*

*Only one physician may report care plan oversight services during a given period of time, reflecting the physician's sole or predominant supervisory role with the patient. These codes should not be used for supervision of a patient in a nursing facility or under the care of a home health agency unless they require recurrent supervision of therapy. Care plan oversight services are considered part of the patient evaluation and management services when less than ~~30~~ 15 minutes are provided during a 30-day period.*

### ***XVIII. Special Evaluation and Management Services (99450– 99456)***

*This series of codes was introduced in CPT 1995 to report physician evaluations in order to establish baseline information for insurance certification and/or work-related or medical disability.*

### ***XIX. Other Evaluation and Management Services (99499)***

*This is an unlisted code to report E/M services not specifically defined in the CPT book.*

### ***XX. Modifiers***

*Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code, separated by a hyphen. If more than one modifier is needed, place the multiple modifiers code (99) after the procedure code to indicate that two or more modifiers will follow. Modifiers commonly used with E/M procedures are as follows:*

#### ***21 Prolonged Evaluation and Management Services***

*When the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service within a given category, it may be identified by adding modifier 21 to the evaluation and management code number. A report may also be appropriate.*

### **24 Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period**

*The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.*

### **25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service**

*The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57.*

### **32 Mandated Services**

*Services related to mandated consultation and/or related services (eg, PRO, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.*

### **52 Reduced Services**

*Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).*

### **57 Decision for Surgery**

*An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.*

## Anesthesia Rules

### I. Introduction

The base units in this section have been determined on an entirely different basis from the relative values in other sections. A conversion factor applicable to this section is not applicable to any other section.

The American Society of Anesthesiologists' (ASA) *Relative Value Guide*<sup>7</sup>™ is recognized as an appropriate assessment of current relative values for specific anesthesiology procedures. It is the basis for the assigned base units for CPT codes in the Anesthesia section of the Fee Schedule.

The conversion factor for anesthesia services has been designated at \$42.00 ~~40.00~~ per unit.

Total anesthesia value is defined in the following formula:

$$\text{Base units} + \text{time units} + \text{modifying units} \times \text{conversion factor} = \text{reimbursement}$$

### II. Base Units

Base units are listed for most procedures. This value is determined by the complexity of the service and includes all usual anesthesia services except the time actively spent in anesthesia care and the modifying factors. The base units include preoperative and postoperative visits, the administration of fluids and/or blood incident to the anesthesia care, and interpretation of noninvasive monitoring (ECG, temperature, blood pressure, oximetry, and other usual monitoring procedures). The basic anesthesia unit includes the routine follow-up care and observation (including recovery room observation and monitoring). When multiple surgical procedures are performed during the same period of anesthesia, only the highest base unit allowance of the various surgical procedures will be used.

### III. Time Units

Time begins when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or in an equivalent area. Time ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision. The anesthesia time units will be calculated in 15-minute intervals, or portions thereof, equaling one (1) time unit. No additional time units are allowed for recovery room time and monitoring.

### IV. Special Circumstances

#### A. Physical Status Modifiers

Physical status modifiers are represented by the initial letter P followed by a single digit from one (1) to six (6) defined below:

Status	Description	Base Units
P1	A normal healthy patient	0
P2	A patient with mild systemic disease	0
P3	A patient with severe systemic disease	1
P4	A patient with severe systemic disease that is a constant threat to life	2
P5	A moribund patient who is not expected to survive without the operation	3
P6	A patient declared brain-dead whose organs are being removed for donor purposes	0

The above six levels are consistent with the American Society of Anesthesiologists (ASA) ranking of patient physical status. Physical status is included in the CPT book to distinguish between various levels of complexity of the anesthesia service provided.

## B. Qualifying Circumstances

1. Qualifying circumstances warrant additional value due to unusual events. The following list of CPT codes and the corresponding anesthesia unit values may be listed if appropriate. The unit value listed is added to the existing anesthesia base units.

CPT	Description	Units
99100	Anesthesia for patient of extreme age, <del>under</del> <u>younger than</u> one year and <del>over</del> <u>older than</u> seventy (List separately in addition to code for primary anesthesia procedure)	1
99116	Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure)	5
99135	Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure)	5
99140	Anesthesia complicated by emergency conditions (specify conditions) (List separately in addition to code for primary anesthesia procedure) (An emergency is defined as existing when delay in treatment of a patient would lead to a significant increase in the threat to life or body part.)	2

2. Payers must utilize their medical consultants when there is a question regarding modifiers and/or special circumstances for anesthesia charges.

## V. Monitored Anesthesia Care

Monitored anesthesia care occurs when the attending physician requests that an anesthesiologist be present during a procedure. This may be to insure compliance with accepted procedures of the facility. Monitored Anesthesia Care includes pre-anesthesia exam and evaluation of the patient. The anesthesiologist must participate or provide medical direction for the plan of care. The anesthesiologist, resident, or nurse anesthetist must be in continuous physical presence and

provide diagnosis and treatment of emergencies. This will also include noninvasive monitoring of cardiocirculatory and respiratory systems with administration of oxygen and/or intravenous administration of medications. Reimbursement will be the same as if general anesthesia had been administered (time units + base units).

## **VI. Reimbursement for Anesthesia Services**

**A. Criteria for Reimbursement.** Anesthesia services may be billed for any one of the three following circumstances:

1. An anesthesiologist provides total and individual anesthesia service.
2. An anesthesiologist directs a CRNA or AA.
3. Anesthesia provided by a CRNA or AA working independent of an anesthesiologist's supervision is covered under all the following conditions:

       a. The service falls within the CRNA's or AA's scope of practice and scope of license as defined by law.

       b. The service is supervised by a licensed health care provider who has prescriptive authority in accordance with the clinical privileges individually granted by the hospital or other health care organization.

## **B. Reimbursement**

1. ~~Reimbursement for anesthesia services must be made at the provider's usual charge or the maximum reimbursement allowance outlined in the fee schedule.~~ The maximum reimbursement allowance for anesthesia is calculated by adding the base unit value, the number of time units, any applicable modifier and/or unusual circumstances units, and multiplying the sum by a dollar amount (conversion factor) allowed per unit.

2. Reimbursement includes the usual pre- and postoperative visits, the care by the anesthesiologist during surgery, the administration of fluids and/or blood, and the usual monitoring services. Unusual forms of monitoring, such as central venous, intra-arterial, and Swan-Ganz monitoring, may be reimbursed separately.

3. When an unlisted service or procedure is provided, the value should be substantiated with a report. Unlisted services are identified in this schedule as by report (BR).

4. When it is necessary to have a second anesthesiologist, the necessity should be substantiated BR. The second anesthesiologist will receive five base units + time units (calculation of total anesthesia value).

5. Payment for covered anesthesia services is as follows:

a. When the anesthesiologist provides an anesthesia service directly, payment will be the lesser of the billed charge or the total (100%) of the maximum allowable in the fee schedule made in accordance with the Billing and Reimbursement Rules of this Schedule.

b. When an anesthesiologist provides medical direction to the CRNA or AA providing the anesthesia service, then the reimbursement will be divided between the two of them at fifty percent (50%).

c. When the CRNA or AA provides the anesthesia service directly, then payment will be the lesser of the billed charge or eighty percent (80%) of the maximum allowable listed in the fee schedule for that procedure.

6. Anesthesiologists, CRNAs, and CRNA's AAs must bill their services with the appropriate modifiers to indicate which one provided the service. Bills NOT properly coded may cause a delay or error in reimbursement by the payer. Application of the appropriate modifier to the bill for service is the responsibility of the provider, regardless of the place of service. Modifiers are as follows:

AA Anesthesiologist services performed personally by an anesthesiologist

AD Medical supervision by a physician: more than four concurrent anesthesia procedures

QK Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals (CRNA or AA) by an anesthesiologist

QX CRNA or AA service: with medical direction by an anesthesiologist

QY Medical direction of one certified registered nurse anesthetist (CRNA or AA) by an anesthesiologist

QZ CRNA service: without medical direction by an anesthesiologist

~~provided by a C.R.N.A. will be limited to the lesser of the actual charge or eighty percent (80%) of the maximum reimbursement allowance. Use Mississippi modifier -46. When an anesthesiologist directs a C.R.N.A., the total reimbursed amount for anesthesia will not exceed the amount allowed for that procedure. (You may not bill one hundred percent (100%) for the anesthesiologist and eighty percent (80%) for the C.R.N.A.)~~

## **VII. Anesthesia Modifiers**

All anesthesia services are reported by using the anesthesia five-digit procedure codes. The basic value for most procedures may be modified under certain circumstances as listed below. When applicable, the modifying circumstances should be identified by the addition of the appropriate modifier (including the hyphen) after the usual anesthesia code. Certain modifiers require a special report for clarification of services provided.

Modifiers commonly used in anesthesia are as follows:

### **22 Unusual Procedural Services**

When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number. A report may also be appropriate.

*Mississippi's note: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement.*

### 23 Unusual Anesthesia

Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier [23](#) to the procedure code of the basic service.

### 32 Mandated Services

Services related to mandated consultation and/or related services (eg, PRO, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier [32](#) to the basic procedure.

#### ~~46 Anesthesia Services by C.R.N.A. (Mississippi Modifier)~~

~~Anesthesia services provided by a C.R.N.A. may be reported by adding modifier '46' to the basic service.~~

~~Mississippi's note: C.R.N.A. services are reimbursed at eighty percent (80%) of the allowable under the fee schedule.~~

### 53 Discontinued Procedure

Under certain circumstances the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier [53](#) to the code reported by the physician for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.

### 59 Distinct Procedural Service

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier [59](#) is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate, it should be used rather than modifier [59](#). Only if no more descriptive modifier is available, and the use of modifier [59](#) best explains the circumstances, should modifier [59](#) be used.

AA Anesthesia Services performed personally Performed Personally by the anesthesiologist:  
Anesthesiologist:

Report modifier AA when the anesthesia services are personally performed by an anesthesiologist.

AD Medical Supervision by a Physician; More Than Four Concurrent Anesthesia Procedures:

Report modifier AD when the anesthesiologist supervises more than four concurrent anesthesia procedures.

QK Medical Direction of Two, Three, or Four Concurrent Anesthesia Procedures Involving Qualified Individuals:

Report modifier QK when the anesthesiologist supervises two, three, or four concurrent anesthesia procedures.

QX CRNA or AA Service with Medical Direction by a Physician:

Regional or general anesthesia provided by the CRNA or AA with medical direction by a physician may be reported by adding modifier QX.

QY Medical Supervision by Physician of One CRNA or AA:

Report modifier QY when the anesthesiologist supervises one CRNA or AA.

QZ CRNA or AA Service without Medical Direction by a Physician:

Regional or general anesthesia provided by the CRNA or AA without medical direction by a physician may be reported by adding modifier QZ.

## Pain Management Rules

In addition to the General ~~Guidelines~~ Rules, this section ~~applies to the unique~~ provides specific rules ~~guidelines~~ for Pain Management services.

### I. Reimbursement for Pain Management Services

#### A. Pain Management Base Units for Professional Services

Base units for professional services in the Pain Management section are state-specific and have been authorized by the Mississippi Workers' Compensation Commission for the professional reimbursement of procedures in Pain Management. Reimbursement is for base units only. Time units will not be considered for reimbursement purposes.

           The conversion factor for Pain Management is forty-two dollars (\$42.00) per unit. The formula for calculating professional reimbursement is:

           Base unit x conversion factor (\$42.00) = professional reimbursement

#### B. Facility Fees

Pain management facility fees are state-specific and are based upon the intensity of the procedure and the amount of resources required in completing the procedure. The facility fee is paid for the use of personnel, materials, drugs, equipment and space. The facility reimbursement is all-inclusive and will not be unbundled.

The facility reimbursement amount for pain management services are listed below ~~in the Facility Fee column~~. This amount is specific to the the pain management section and the facility and not to be used for any other section or physician services. Reimbursement for multiple pain procedures performed in a facility shall be:

- One hundred percent (100%) for the primary procedure
- Fifty percent (50%) for the second and any subsequent procedures

~~Only one (1) fluoroscopy fee per date of service will be reimbursed. CPT 76005 is to be reimbursed as separate procedure and multiple procedure rule would not apply.~~

The reimbursement for the use of fluoroscopy (CPT codes 77002 and 77003) is to be one hundred dollars (\$100.00), regardless of the number of procedures performed, and may only be billed once per date of service. ~~(In addition to the facility fee if fluoroscopy is performed and not included in the descriptor for the procedure)~~

CPT code 77002 is to be used for fluoroscopic guidance for needle placement for CPT code 64510 (cervical stellate ganglion) sympathetic block), or CPT code 64520 (thoracic or lumbar blocks).

CPT code 77003 is to be used for fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (i.e., epidural, transforaminal epidural, paravertebral facet joint or facet joint nerve, or sacroiliac joint), including neurolytic agent destruction.

## **Guidelines for Facility Reimbursement for Pain Management**

### **Facility Reimbursement Levels**

~~Level I Procedures — \$ 75.00~~

~~Level II Procedures — \$ 120.00~~

~~Level III Procedures — \$ 380.00~~

~~Level IV Procedures — \$ 480.00~~

~~Level V Procedures — \$ 790.00~~

~~Level VI Procedures — \$ 990.00~~

**Fluoroscopy** \$ 100.00

### Recovery times

~~Minimal: ————— 1-15 minutes~~

~~Short: ————— 15-30 minutes~~

~~Moderate: ————— 30-60 minutes~~

~~Extended: ————— > 60 minutes~~

### **LEVEL I**

~~Minimal equipment requirements~~

~~Generally minimal or no recovery time~~

~~No necessity for IV or sedation~~

~~Minimal personnel requirements (number and time)~~

~~Minimal risk for cardiovascular changes or major neurological impairment post procedure~~

### **LEVEL II**

~~Minimal equipment requirements~~

~~May involve short recovery periods~~

~~IV sedation or fluid requirement unlikely~~

~~Minimal personnel requirements (number and time)~~

~~Minimal risk for cardiovascular changes or major neurological impairment~~

### **LEVEL III**

~~May require specialized equipment~~

~~Moderate recovery times likely~~

~~Minimal personnel requirements (number and time)~~

~~IV sedation or fluids likely~~

Moderate likelihood of slight cardiovascular or major neurological impairment

#### LEVEL IV

May require specialized equipment  
 Extended recovery times likely  
 Increased personnel requirements (number and time)  
 IV sedation or fluids likely  
 Moderate cardiovascular or major neurological impairment likely

#### LEVEL V

Requires highly technical specialized equipment (e.g. radio frequency, cryoanesthesia)  
 Extended recovery times expected  
 Increased personnel requirements  
 IV sedation or fluids likely  
 Substantial cardiovascular or major neurological impairment likely

### C. Reimbursement for Injection/Destruction Procedures

1. The new current CPT codes for Pain Management typically have separate codes for injections that may involve additional levels (i.e.g., 64470 is for injection of cervical facet single or - first level, and 64472 is used for additional levels.) The 'PM' modifier would therefore only apply to the 64472 code. This rule also applies to lumbar facets and neurolytic (destruction) procedures such as 64626. As only 2 levels can be reimbursed for transforaminal epidural injections (CPT 64479, 64480, 64483, 64484) the 'PM' modifier would not apply because the additional level code could only be used once.

2. Facet injections, medial branch blocks and nerve destruction procedures are reimbursed at a maximum of three (3) total anatomic joint levels. Additional level or bilateral modifiers may be used to allow up to a maximum of two (2) additional services levels (but not more) for facet or medial branch blocks in the cervical/thoracic (64472) or lumbar (64476) for a maximum of three (3) procedures levels reimbursed per treatment session or day. Therefore, the 'PM' modifier would only be used a maximum of one time (i.e. a 3 level lumbar facet injection would be billed as 64475 for 1st level, 64476 for 2nd level, and 64476-PM for 3rd level.) Additional injected sites levels, beyond the first three (3), will not be reimbursed. These procedures are unilateral by definition. Bilateral modifiers may be used when nerves are treated bilaterally. Reimbursement of the bilateral modifier is fifty percent (50%) of the base amount for the second or contralateral side. Procedures are considered inherently bilateral, and modifiers denoting to allow bilateral injections do not alter reimbursement amounts.

3. Reimbursement for injection/destruction procedure codes is made on the basis of nerves treated (i.e.g., destruction by neurolytic agent of the L4-L5 facets counts as two (2) levels/nerves and should be billed as 64622 (first level/nerve) and 64623 (each additional level).] There are two nerves supplying each joint and reimbursement is based upon nerve(s) treated, not the joint levels treated. This applies to CPT codes 64622, 64623 (lumbar), and

64626, 64627 (cervical/thoracic). These procedures are unilateral by definition. **Additionally, bilateral** modifiers may be used when nerves are treated bilaterally. Reimbursement of the bilateral modifier is fifty percent (50%) of the base amount for the second or contralateral side.

4. Multiple Epidural Injections in a Single Treatment Day/Session. In order to obtain reimbursement for more than one epidural injection in a single treatment day/session (either multiple levels or bilateral injections) there must be appropriate documentation in the medical records of a medical condition for which multiple injections would be appropriate. For bilateral injections, this includes the presence of significant bilateral radiating/radicular pain. For multiple level injections, this includes conditions for which an additional injected level could be anticipated to result in improved clinical outcomes. These conditions would include:

- \* Disc pathology (e.g., protrusion) at one level with a dermatomal pain distribution of an adjacent level (e.g., disc affects the traversing nerve root, such as an L4);
- \* 5 disc herniation affecting the traversing L5 nerve root);
- \* Multiple dermatomal nerve root involvement.

A maximum of two (2) levels of transforaminal epidural steroid injections are reimbursable for a given date of service. This applies to codes 64479, 64480, 64483, and 64484.

Reimbursement is still limited to two epidural procedures (either two levels, or one level bilaterally) per date of service.

5. A maximum of one (1) interlaminar epidural steroid injection is reimbursable for a given date of service. This applies to codes 62310 and 62311.

6. A maximum of three (3) facet level procedures are reimbursable for a given date of service. This [BOLD]maximum[END BOLD] applies to facet joint injections and nerve blocks, codes 64470–64476.. Nerve destruction procedures, codes 64622–64627, are limited to two (2) facet levels (three (3) nerve branches), unilateral and bilateral, per given date of service.

#### **D. Multiple Procedure Reimbursement**

Reimbursement for multiple pain procedures shall be:

- One hundred percent (100%) for the primary procedure
- Fifty percent (50%) for the *second and any subsequent* procedures.  
~~25% for the 3<sup>rd</sup> procedure~~

For purposes of reimbursement, each injection is considered a separate procedure and will be reimbursed according to the multiple procedure rule. Multiple level injection codes reported with add-on codes (e.g., 64480, 64484, **64486**, 64627) shall be reimbursed as additional procedures under applicable multiple injection rules as explained in this section. The reimbursement rate for these add-on procedure codes is fifty percent (50%) of the rate for the primary (base) procedure. Because these are add-on codes, the listed amount for the procedure is

fifty percent (50%) of the primary (base) procedure and the add-on code will be reimbursed at the full amount listed in the fee schedule.

No more than two (2) types of pain management procedures can be performed on a given day, unless otherwise approved by the payer. "Type" is defined as any procedure code involving an anatomically different structure (e.g., spinal nerve, facet joint, sacroiliac joint, trigger point, etc.). Joints and nerves in different anatomical regions (cervical, thoracic, lumbar, sacral) are considered to be different "types" and are limited to two (2) procedures per given day. Additional level injections in the same area are not considered different "types," and for the purpose of this rule, are considered to be the same "type." However, the multiple level restrictions, as detailed herein, still apply.

Example: A three-level lumbar facet injection would be billed as 64475 —reimbursement would be 100% for the first level and 64476 for each additional level; 64476-PM for the third level—reimbursed at 25%. Reimbursement is as follows:

<u>Level</u>	<u>Code</u>	<u>Base Units</u>	<u>Reimbursement</u>
First	64475	10	\$420.00
Second	64476	5	\$210.00
Third	64476	5	\$210.00
<u>Total Reimbursement</u>			<u>\$840.00</u>

**Note:** The reimbursement for each of the additional levels is fifty percent (50%) of the reimbursement amount for the first level. However, because these are add-on codes, the reduction in reimbursement is a function of the reduction in the base units. The base units for the second and additional levels already reflect the fifty percent (50%) reduction, so an additional reduction would not be applied when adjudicating the claim. Add-on codes are reimbursed at one hundred percent (100%) of the allowable.

There is no reimbursement for more than two (2) procedures on a given date of service, except as allowed by the PM modifier.

## **II. Reimbursement for Refill of Pain Pumps**

A. Code 95990. This CPT code, which applies to refilling and maintenance of an implantable pump or reservoir for drug delivery spinal (intrathecal, epidural) or brain (intraventricular), is reimbursed at the specified MRA listed in the Medicine section of the Fee Schedule.

B. Evaluation and Management Services. Refilling and maintenance of implantable pump or reservoir for pain management drug delivery is a global service. An evaluation and management service is not paid additionally unless significant additional **or other** cognitive services are provided and documented. To report a significant, separately identifiable evaluation and management service, append modifier 25 to the appropriate evaluation and management code. Documentation is required and, payment will be allowed if supported by the documentation.

C. **Drugs.** Those drugs used in the refill of the pain pump shall be reimbursed in accordance with the Pharmacy Rules contained in the Pharmacy Rules section of this Fee Schedule.

D. **Compounding Fee.** If the drugs used in the refill of the pain pump must be compounded, the compounding service shall be reimbursed at \$157.44 per individual refill. Report the compounding service with code S9430, Pharmacy compounding and dispensing services.

E. **CPT Code 95990.** This CPT code which applies to refilling and maintenance of an implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), is reimbursed per the physicians' fee schedule.

### **III. “Diagnostic Only” Injections and Procedures**

A. Valid “diagnostic only” injections require a reasonably alert patient capable of adequately determining the amount or level of pain relieved or produced by the procedure. This requires judicious use of sedatives in the performance of such procedures. Clearly analgesic medications such as intravenous narcotics are to be avoided during the procedure and evaluation phase of testing, as these medications can affect the validity of such diagnostic tests. The results of the tests and drugs used during the injection or procedure must be part of the medical records, and available for review by the payer. Failure to document the patient’s response to a diagnostic procedure or injection, and the level of alertness following the procedure or injection, could result in denial of reimbursement.

B. Discography requires a reasonably alert patient capable of discriminating the quality and quantity of discomfort during the performance of the procedure in order to provide valid information on concordant or non-concordant pain. The results of the tests and drugs used during the procedure must be part of the medical records, and available for review by the payer. Failure to document the patient’s response to the procedure, and level of alertness during discography could result in denial of reimbursement.

C. Medial branch (facet nerve) or diagnostic intra-articular facet injections require an alert patient, free from undue influence of intravenous narcotics in order to more reliably determine the analgesic response to the procedure. Failure to document the patient’s response to the procedure or injection, and level of alertness after the procedure for diagnostic facet nerve or facet intra-articular injections could result in denial of reimbursement.

D. Diagnostic injections with local anesthetics require documentation of analgesic response through any validated pain measurement test (e.g., numerical pain scale, visual analogue scale). This should be performed after the procedure during the time that there would be an expected analgesic response (every thirty (30) minutes for at least one (1) hour). This must be documented and the documentation must be available to the payer for review. The documentation must also include the drugs used during the procedure, and comments on the patient’s level of alertness at each time period when the pain or response is evaluated. If the

patient's pre-procedure pain was determined by provocative exam tests or maneuvers, these should be repeated during the evaluation period following the procedure, to differentiate analgesia related to the procedure from positional analgesia, such as, for example, that which may be provided by lying in a recovery bed.

E. Intravenous narcotic pain medications are typically to be avoided for diagnostic analgesic injections, such as facet joint or nerve blocks, as they would be expected to provide an analgesic benefit completely independent of the injection itself. Sedatives such as midazolam or propofol can be used judiciously, if necessary, avoiding excessive post-procedure sedation. Proper documentation must be provided to support a request for reimbursement.

F. Other injections with both therapeutic and potentially diagnostic benefit, such as selective nerve root or peripheral nerve blocks or therapeutic facet injections (see -T modifiers), would ideally be performed with minimal sedation and avoidance of intravenous narcotics. However, as these injections also have potential therapeutic benefit, this is NOT a requirement for reimbursement.

#### **IV. Physical Therapy**

In the pain management setting, no more than two (2) modalities and/or procedures may be used on a date of service (e.g., heat/cold, ultrasound, diathermy, iontophoresis, TENS, electrical stimulation, muscle stimulation, etc.). Multiple modalities should be performed sequentially. Only one (1) modality can be reported for concurrently performed procedures.

#### **V. Guidelines General Rules**

A. Reimbursement for an approved epidural series is limited to **two injections**. Further injections require a positive analgesic response for approval. For the first injection, the initial analgesic response may be temporary. However, after the second injection, there must be a residual and progressive analgesic benefit in order to perform a third injection. Documentation of a positive patient response will be required to continue ~~prior to continued~~ epidural treatment. If there is no documented pain relief after two (2) injections, no further injections will be considered medically necessary.

B. Reimbursement will be limited to three (3) epidural pain injections in a **twelve (12) month** period ~~at any one level~~ unless the payer gives prior approval for more than three (3) **such injections**. Separate billing for the drug injected is not appropriate and will not be reimbursed.

C. Modifiers

~~PM Pain Management~~

Modifier PM, The '-PM' modifier, which was is a Mississippi-specific pain management code modifier, is no longer required, and will not be recognized for reimbursement for dates of service beginning July1, 2007.or reimbursed. The '-PM' modifier is a

Mississippi specific pain management code. ‘PM’ modifier is used to charge for the third injection of a specific injection/destruction series.(i.e.CPT 64470 is the primary procedure; and CPT 64472 is the additional level injection; and CPT 64472-PM is for the third level injection of a three level injection series. Procedures billed with the ‘PM’ modifier are reimbursed at 25% of the primary procedure allowable reimbursement; 50% of add-on.

### -T and -D Modifiers T and D (Mississippi State Modifiers)

Facet joint/nerve injections can be used for diagnostic or therapeutic indications, or both. These injections should be used with modifier “-D” to indicate a diagnostic intention of the injection, or with a “-T” modifier to indicate a therapeutic intention of the injection.

Intra-articular joint injections (cervical, thoracic, lumbar), which can have both diagnostic and therapeutic indications, should always be considered primarily therapeutic and should be billed using the “-T” modifier.

The number of facet injections subject to reimbursement is limited to four (4) dates of service with a maximum of two (2) therapeutic and two (2) diagnostic injections for the initial twelve (12) month period of treatment per anatomical region.. This allows for a total of four (4) dates of service, regardless of the number of levels treated, which levels are treated, or which side (left or right or bilateral) is treated, in the same anatomical region.

For coding purposes, the spine is divided into three (3) anatomical regions, cervical, thoracic, and lumbar/sacral. If treatment for facet related pain continues past twelve (12) months, further injections are limited to a total of three (3) dates of service per twelve (12) month period. This limit applies to both therapeutic and diagnostic injections combined, and reimbursement beyond the initial twelve (12) month period is further limited to no more than two (2) injections of either type, as determined by modifiers “-T” or “-D”, per twelve (12) month period. Failure to designate injections with the appropriate “-T” or “-D” modifier will limit reimbursement to no more than two (2) facet joint/nerve injections per twelve (12) month period.

This rule applies to cervical, thoracic and lumbar facet joint and facet joint nerve injections. Facet injections in different anatomical areas are not subject to the above limits, as each different anatomical area would be subject to its own separate limit as described above.

Facet nerve (medial branch ablation) for cervical, thoracic or lumbar nerves will only be reimbursed once per nine (9) month period. Reimbursement for more than one (1) facet injection or more than one (1) sacro iliac injection per calendar year will require prior approval from the payer. Only two (2) diagnostic medial branch facet nerve blocks are allowed per calendar year.

E. Contralateral facet injections performed within a month of each other are considered part of the same procedure and will not command a separate reimbursement.

D. In order to be eligible for reimbursement under this Fee Schedule, pain management procedures or services which are specifically governed by the rules in this Pain Management section of the Fee Schedule must be performed by a licensed physician holding either an M.D. or D.O. degree. Pain management procedures specifically governed herein which are performed by any other person, such as a Certified Registered Nurse Anesthetist (CRNA), shall not be reimbursed under this Schedule.

E. Trigger point injection is considered one (1) procedure and is reimbursed as such regardless of the number of injection sites. Billing for multiple injections, and multiple regions, falls under the same one-procedure rule. Two codes are available for reporting trigger point injections: use 20552 for injection(s) of single or multiple trigger point(s) in one or two muscles, or 20553 when three or more muscles are involved. When billing for multiple injections, and multiple regions, only code 20552 OR 20553 is allowed per date of service

F. Sacroiliac arthroscopy (CPT code 73542) assumes the use of a fluoroscope and is considered an integral part of the procedure(s). ~~and therefore does not command~~ Therefore, an additional fee for the fluoroscopy (CPT code 77002) is not warranted and will not be reimbursed.

G. Epidurography (CPT code 72275), a/k/a “epidural myelogram” or “epidural without dural puncture,” is the proper code to use for contrast material injected into the epidural space. The epidurography code involves the inherent use of a fluoroscope, and, therefore, an additional ~~charge would not be allowed.~~ fluoroscopy fee for procedure code 77003 is not reimbursable.

H. CPT code 62318 includes needle placement, catheter infusion and subsequent injections. Code 62318 should be used for multiple solutions injected by way of the same catheter, or multiple bolus injections during the initial procedure. The epidural needle or catheter placement is inherent to the procedure, and, therefore, no additional charge for needle or catheter placement is allowed.

I. Investigational Procedures. The following procedures are considered investigational, and, therefore, do not presently qualify for reimbursement under the Mississippi Workers’ Compensation Medical Fee Schedule:

1. Intradiscal electrothermal therapy (IDET) (22526, 22527) and intradiscal annuloplasty by other method (0062T, 0063T);
2. Intraventricular administration of Morphine;
3. Pulse radiofrequency, regardless of procedure involved or indication (e.g., medial branch radiofrequency, dorsal root radiofrequency, etc.). If pulsed radiofrequency is used, but not specifically recorded as such in the medical records, the payer may retroactively deny payment for the service and request for reimbursement from the provider.
4. Intradiscal therapies used in discography, such as percutaneous disc decompression (Dekompressor), fluoroscopic, laser, radiofrequency, and thermal disc therapies.
5. Percutaneous disc nucleoplasty.

6. Epidural adhesiolysis, also known as Racz procedure or lysis of epidural adhesions.:

J. The following procedures must be performed fluoroscopically in order to qualify for reimbursement:

1. Facet injections (64470, 64472, 64475, 64476)
2. Sacroiliac (SI) Injections (27096)
3. Transforaminal epidural steroid injections (64479, 64480, 64483, 64484)
4. Cervical translaminar/interlaminar epidural injections (62310)

K. Any ~~anesthesia~~analgesia/sedation used in the performance of the procedures in this section is considered integral to the procedure, and will not be separately reimbursed. This rule applies whether or not the person administering the analgesia/sedation is the physician who is performing the pain management injection. Administration of analgesia/sedation by a different person from the physician performing the injection, including an RN, PA, CRNA, or MD/DO, DOES NOT allow for separate billing of analgesia/sedation.

~~L. **Interdisciplinary Chronic Pain Management Program** is a highly structured, goal-oriented, individualized treatment program. These programs are interdisciplinary in nature with a capacity for addressing the functional, physical, and emotional/behavioral health needs of the person served. An interdisciplinary team must be incorporated to include a physical therapist, occupational therapist, psychologist, and dietary education. The program must have oversight supervision by a physician.~~

~~Reimbursement is based on an hourly charge and should be billed using code Q0105. For easier reference, code Q0105 is listed in both the Pain Management and Physical Medicine sections.~~

L. Anatomical descriptions of the procedures performed must accompany the bill for service in order for reimbursement to be made. These descriptions must include landmarks used in determining needle positioning, needles used, and the type and quantity of drugs injected. Tolerance to the procedure, and side effects or lack thereof should be included in this documentation.

M. Discography. Discography is a diagnostic test to identify (or rule out) painful intervertebral discs. Discography is appropriate only in patients for whom no other treatment options remain except for possible surgical stabilization (spinal fusion). A discography is then used on these patients to determine which discs, if any, are painful and abnormal, so that a surgical correction (fusion) can be performed. If a patient is not considered to be a candidate for surgery (fusion), then a ~~discogram is not considered medically necessary-discography should not be performed.~~ Investigational intradiscal therapies such as percutaneous disc decompression (Dekompressor), fluoroscopic, laser, radiofrequency, and thermal disc therapies are not an indication for a discography.

**Reimbursement of Discography:** ~~May be used only once, regardless of number of levels tested~~

~~62290 —, 62291 - 12 10 units; additional levels denoted with modifier -51 or -59 are reimbursed at five (5) units per level;~~

~~62291 — 12 units; additional levels denoted with modifier -51 or -59 are reimbursed at six (6) units per level;~~

~~72285, 72295 — 8 units;~~

~~The radiographic interpretation codes 72285 and 72295 can only be used ONCE per treatment session and additional level modifiers are not allowed.~~

~~When reporting the radiological supervision and interpretation professional components for discography (72285, 72295), the anatomical localization for needle placement is inclusive with the procedure and code 77003 should NOT be additionally reported.~~

~~Radiographic interpretation codes 72285 and 72295 must include a thorough description of radiographic findings available in a separate report with hard copy radiographs or other media, such as digital, that will allow review of images (AP and lateral at a minimum).~~

N. BOTOX. BOTOX is not indicated for the relief of musculoskeletal pain, and its use as such is not covered by the Fee Schedule. An exception is made when BOTOX treatment is indicated for spasticity or other indications and requires prior approval.

O. Use of Opioids or Other Controlled Substances for Management of Chronic (Non-Terminal) Pain. It is recognized that optimal or effective treatment for chronic pain may require the use of opioids or other controlled substances. The proper and effective use of opioids or other controlled substances has been specifically addressed by the Mississippi Board of Medical Licensure. Unless otherwise directed by the Commission, reimbursement for prescriptions for opioids or other controlled substances used for the management or treatment of chronic, non-terminal pain shall not be provided under this Fee Schedule unless treatment is sufficiently documented and complies with the following Rules and Regulations, as promulgated by the Mississippi State Board of Medical Licensure, and supplemented by the Commission accordingly:

1. DEFINITIONS: For the purpose of this provision, the following terms have the meanings indicated:

a. “Chronic Pain” is a pain state in which the cause of the pain cannot be removed or otherwise treated and which in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, evaluation by the attending physician and one or more physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain. Further, if a patient is receiving controlled substances for the treatment of pain for a prolonged period of time (more than six (6) months), then they will be considered for the

purposes of this regulation to have “de facto” chronic pain and subject to the same requirements of this regulation. “Terminal Disease Pain” should not be confused with “Chronic Pain.” For the purpose of this section, “Terminal Disease Pain” is pain arising from a medical condition for which there is no possible cure and the patient is expected to live no more than six (6) months.

b. “Acute Pain” is the normal, predicted physiological response to an adverse chemical, thermal, or mechanical stimulus and is associated with surgery, trauma and acute illness. It is generally time limited and is responsive to therapies, including controlled substances as defined by the U.S. Drug Enforcement Administration. Title 21 CFR Part 1301 Food and Drugs.

c. “Addiction” is a neurobehavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.

d. “Physical Dependence” is a physiological state of neuroadaptation to a substance which is characterized by the emergence of a withdrawal syndrome if the use of the substance is stopped or decreased abruptly, or if an antagonist is administered. Withdrawal may be relieved by re-administration of the substance. Physical dependence is a normal physiological consequence of extended opioid therapy for pain and should not be considered addiction.

e. “Substance Abuse” is the use of any substance(s) for non-therapeutic purposes; or use of medication for purposes other than those for which it is prescribed.

f. “Tolerance” is a physiological state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect or a reduced effect is observed with a constant dose. Tolerance occurs to different degrees for various drug effects, including sedation, analgesia and constipation. Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. Such tolerance may or may not be evident during treatment and does not equate with addiction.

2. Notwithstanding any other provisions of these rules and regulations, a physician may prescribe, administer, or dispense controlled substances in Schedules II, IIN, III, IIIN, IV and V, or other drugs having addiction-forming and addiction-sustaining liability to a person in the usual course of treatment of that person for a diagnosed condition causing chronic pain.

3. Notwithstanding any other provisions of these rules and regulations, as to the prescribing, administration, or dispensation of controlled substances in Schedules II, IIN, III, IIIN, IV and V, or other drugs having addiction-forming and addiction-sustaining liability, use of said medications in the treatment of chronic pain should be done with caution. A physician may administer, dispense or prescribe said medications for the purpose of relieving chronic pain, provided that the following conditions are met:

a. Before initiating treatment utilizing a Schedules II, IIN, III, IIIN, IV or V controlled substance, or any other drug having addiction-forming and addiction-sustaining liability, the physician shall conduct an appropriate risk/benefit analysis by reviewing his own records of prior treatment, or review the records of prior treatment which another treating physician has provided to the physician, that there is an indicated need for long term controlled substance therapy. Such a determination shall take into account the specifics of each patient's diagnosis, past treatments and suitability for long term controlled substance use either alone or in combination with other indicated modalities for the treatment of chronic pain. This shall be clearly entered into the patient medical record, and shall include consultation/referral reports to determine the underlying pathology or cause of the chronic pain.

b. Documentation in the patient record shall include a complete medical history and physical examination that indicates the presence of one or more recognized medical indications for the use of controlled substances.

c. Documentation of a written treatment plan which shall contain stated objectives as a measure of successful treatment and planned diagnostic evaluations, e.g., psychiatric evaluation or other treatments. The plan should also contain an informed consent agreement for treatment that details relative risks and benefits of the treatment course. This should also include specific requirements of the patient, such as using one physician and pharmacy if possible, and urine/serum medication level monitoring when requested, but no less than once every twelve (12) months.

d. Periodic review and documentation of the treatment course is conducted at reasonable intervals (no less than every six months) with modification of therapy dependent on the physician's evaluation of progress toward the stated treatment objectives. This should include referrals and consultations as necessary to achieve those objectives.

4. No physician shall administer, dispense or prescribe a controlled substance or other drug having addiction-forming and addiction-sustaining liability that is non-therapeutic in nature or non-therapeutic in the manner the controlled substance or other drug is administered, dispensed or prescribed.

5. No physician shall administer, dispense or prescribe a controlled substance for treatment of chronic pain to any patient who has consumed or disposed of any controlled substance or other drug having addiction-forming and addiction-sustaining liability other than in strict compliance with the treating physician's directions. These circumstances include those patients obtaining controlled substances or other abusable drugs from more than one physician and those patients who have obtained or attempted to obtain new prescriptions for controlled substances or other abusable drugs before a prior prescription should have been consumed according to the treating physician's directions. This requirement will not be enforced in cases where a patient has legitimately temporarily escalated a dose of their pain medication due to an acute exacerbation of their condition but have maintained a therapeutic dose level, however, it will be required of the treating physician to document in the patient record that such increase in dose level was due to a recognized indication and was within appropriate therapeutic dose

ranges. Repetitive or continuing escalations should be a reason for concern and a re-evaluation of the present treatment plan shall be undertaken by the physician.

6. No physician shall prescribe any controlled substance or other drug having addiction-forming or addiction-sustaining liability to a patient who is a drug addict for the purpose of “detoxification treatment,” or “maintenance treatment,” and no physician shall administer or dispense any narcotic controlled substance for the purpose of “detoxification treatment” or “maintenance treatment” unless they are properly registered in accordance with section 303(g) 21 U.S.C. 823(g). Nothing in this paragraph shall prohibit a physician from administering narcotic drugs to a person for the purpose of relieving acute withdrawal symptoms when necessary while arrangements are being made for referral for treatment. Not more than one (1) day’s medication may be administered to the person or for the person’s use at one time. Such emergency treatment may be carried out for not more than three (3) days. Nothing in this paragraph shall prohibit a physician from administering or dispensing narcotic controlled substances in a hospital to maintain or detoxify a person as an incidental adjunct to medical or surgical treatment of conditions other than addiction.

7. In addition to the specific Rules and Regulations promulgated by the Mississippi State Board of Medical Licensure as set forth above and incorporated herein, the payer may, as in other cases, obtain a second opinion from an appropriate and qualified physician to determine the appropriateness of the treatment being rendered, including but not limited to the appropriateness of the continuing use of opioids or other controlled substances for treatment of the patient’s chronic pain. However, any such second opinion shall not be used as the basis for abrupt withdrawal of medication or payment therefor. Nothing in this paragraph shall prohibit a physician from administering narcotic drugs to a person for the purpose of relieving acute withdrawal symptoms when necessary while arrangements are being made for referral or discontinuance of treatment, and the payer shall provide reimbursement in accordance with this schedule, as follows: not more than one (1) day’s medication may be administered to the person or for the person’s use at one time. Such emergency treatment may be carried out for not more than three (3) days. Discontinuance of treatment or reimbursement of prescriptions based on a second opinion obtained hereunder shall be subject to review by the Commission pursuant to the Dispute Resolution Rules set forth in the Dispute Resolution Rules section in this Fee Schedule.

P. Radiographic Codes in Pain Management. Beginning January 1, 2007, code 76003 is replaced by code 77002, and code 76005 (fluoroscopy for injection) is replaced by code 77003. Description of service and reimbursement will remain the same.

Codes 72000– – 72220 which apply to radiographic examination of the spine are not reimbursed concurrent with the pain management procedures in this section or with fluoroscopy services.

Code 73542 is not separately reimbursed with facet or sacroiliac joint injections.

Q. Soft Tissue Injections. “Myofascial, myoneural, and trigger point injections” are synonymous and are to be reimbursed with the 20552 and/or 20553 codes. Modifiers for

additional injections are not allowed with these codes. Reimbursement for codes 20552 and 20553 will be identical, and not additive.

Codes 20550 and 20551 are used for the injections of tendon origins and are NOT to be used for “myofascial, myoneural or trigger point” injections. Failure to observe this rule could result in denial of service on retrospective review and/or request for reimbursement.

Code 20612 is to be used for the aspirations/injection of a ganglion cyst and NOT for “myofascial, myoneural, or trigger point” injections. Failure to observe this rule could result in denial of service on retrospective review and/or request for reimbursement.

R. Implantation of spinal cord stimulators. The following conditions must be met for consideration of spinal cord stimulators.

- Patient must have a medical condition for which spinal cord stimulation (SCS) is a recognized and accepted form of treatment.
- There must be a trial stimulation that includes a minimum seven (7) day home trial with the temporary stimulating electrode.
- During the trial stimulation, the patient must report at least fifty percent (50%) pain reduction during the last four (4) days of the stimulation trial.
- Psychological screening must be used to determine if the patient is free from:
  - Substance abuse issues
  - Untreated psychiatric conditions
  - Major psychiatric illness that could impair the patient’s ability to respond appropriately to the trial stimulation

## Surgery Rules

### I. General Guidelines

#### A. Global Reimbursement

The reimbursement allowances for surgical procedures are based on a global reimbursement concept that covers performing the basic service and the normal range of care required after surgery.

Global reimbursement includes:

1. The operation per se
2. Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
3. Subsequent to the decision and/or authorization for surgery, one related E/M encounter on the date immediately prior to or on the date of the procedure (including history and physical), but does not include the initial consultation.
4. Immediate postoperative care, including dictating operative notes, talking with the family and other physicians
5. Writing orders
6. Evaluating the patient in the postanesthesia recovery area
7. Normal, uncomplicated follow-up (FU) care for the time periods indicated in the follow-up days (FUD) column to the right of each procedure code. The number in that column establishes the days during which no additional reimbursement is allowed for the usual care provided following surgery, absent complications or unusual circumstances.
8. The maximum reimbursement allowances cover all normal postoperative care, including the removal of sutures by the surgeon or associate. Follow-up days are specified by procedure. Follow-up days listed are for 0, 10, or 90 days and are listed in the Fee Schedule as 000, 010, or 090. Follow-up days may also be listed as MMM indicating that services are for uncomplicated maternity care, XXX indicating that the global surgery concept does not apply, YYY indicating that the follow-up period is to be set by the payer (used primarily with BR procedures), or ZZZ indicating that the code is related to another service and is treated in the global period of the other procedure billed in conjunction with the ZZZ procedure (used primarily with add-on and exempt from modifier 51 codes). The day of surgery is day one when counting follow-up days. Hospital discharge day management is considered to be normal, uncomplicated follow-up care.

#### B. Follow-up Care for Diagnostic Procedures

Follow-up care for diagnostic procedures (e.g., endoscopy, injection procedures for radiography) includes only the care related to recovery from the diagnostic procedure itself. Care of the condition for which the diagnostic procedure was performed or of other concomitant conditions is not included and may be charged for in accordance with the services rendered.

#### C. Follow-up Care for Therapeutic Surgical Procedures

Follow-up care for therapeutic surgical procedures includes only care that is usually part of the surgical procedure. Complications, exacerbations, recurrence, or the presence of other diseases or injuries requiring additional services concurrent with the procedure(s) or during the listed period of normal follow-up care may warrant additional charges.

#### **D. Separate Procedures**

Separate procedures are commonly carried out as an integral part of another procedure. They should not be billed in conjunction with the related procedure. These procedures may be billed when performed independently by adding modifier 59 to the specific “separate procedure” code.

#### **E. Additional Surgical Procedure(s)**

When an additional surgical procedure(s) is carried out within the listed period of follow-up care for a previous surgery, the follow-up periods will continue concurrently to their normal terminations.

#### **F. Operating Microscope (69990)**

~~Additional reimbursement for the use of an operating microscope (excluding loupes or other magnifying devices) will be allowed when the listed code does not state the use of the microscope is inherent in the procedure.~~

~~*Mississippi Note: The use of an operating microscope with procedure codes 63075\_63078 shall be reimbursed separately and in addition to the reimbursement for the procedure itself.*~~

#### **F. Microsurgery, Operating Microscope, and Use of Code 69990**

The surgical microscope is employed when the surgical services are performed using the technique of microsurgery. Code 69990 should be reported (without modifier –51 appended) in addition to the code for the primary procedure performed. Do not use 69990 for reporting visualization with magnifying loupes or corrected vision. Do not report code 69990 in addition to procedures where the use of the operating microscope is considered an inclusive component.

The operating microscope is considered inclusive in the following codes only: 15756-15758; 15842; 19364; 19368; 20955-20962; 20969-20973; 26551-26554; 26556; 31526; 31531; 31536; 31541; 31545; 31546; 31561; 31571; 43116; 43496; 49906; 61548; 63075-63078; 64727; 64820-64823; 65091-68850. For purposes of clarification, if microsurgery technique is employed and the primary procedure code is not contained in the aforementioned list, it is appropriate to report 69990 with the primary procedure performed and reimbursement is required for said services.

(For example, code 63030 is not included in the aforementioned list and, as such, it is appropriate for providers to report 69990 along with 63030 to describe microsurgical technique.

Reimbursement for 69990 is required provided operative documentation affirms microsurgical technique and not just visualization with magnifying loupes or corrected vision.)

#### **G. Unique Techniques**

A surgeon is not entitled to an extra fee for a unique technique. It is inappropriate to use modifier 22 unless the procedure is significantly more difficult than indicated by the description of the code.

#### **H. Surgical Destruction**

Surgical destruction is part of a surgical procedure, and different methods of destruction (e.g., laser surgery) are not ordinarily listed separately unless the technique substantially alters the standard management of a problem or condition. Exceptions under special circumstances are provided for by separate code numbers.

#### **I. Incidental Procedure(s)**

An additional charge for an incidental procedure (e.g., incidental appendectomy, incidental scar excisions, puncture of ovarian cysts, simple lysis of adhesions, simple repair of hiatal hernia, etc.) is not customary and does not warrant additional reimbursement.

#### **J. Endoscopic Procedures**

When multiple endoscopic procedures are performed by the same practitioner at a single encounter, the major procedure is reimbursed at one hundred percent (100%). If a secondary procedure is performed through the same opening/orifice, fifty percent (50%) is allowable as a multiple procedure. However, diagnostic procedures during the same session and entry site are incidental to the major procedure.

#### **K. Biopsy Procedures**

A biopsy of the skin and another surgical procedure performed on the same lesion on the same day must be billed as one procedure.

#### **L. Repair of Nerves, Blood Vessels, and Tendons with Wound Repairs**

The repair of nerves, blood vessels, and tendons is usually reported under the appropriate system. The repair of associated wounds is included in the primary procedure unless it qualifies as a complex wound, in which case modifier 51 may be applied. Simple exploration of nerves, blood vessels, and tendons exposed in an open wound is also considered part of the essential treatment of the wound closure and is not a separate procedure unless appreciable dissection is required.

#### **M. Suture Removal**

Billing for suture removal by the operating surgeon is not appropriate as this is considered part of the global fee.

#### **N. Joint Manipulation Under Anesthesia**

There is no charge for manipulation of a joint under anesthesia when it is preceded or followed by a surgical procedure on that same day by that surgeon. However, when manipulation of a joint is the scheduled procedure and it indicates additional procedures are necessary and appropriate, fifty percent (50%) of the manipulation may be allowed.

### **O. Supplies and Materials**

Supplies and materials provided by the physician (e.g., sterile trays/drugs) over and above those usually included with the office visit may be listed separately using CPT code 99070 or specific HCPCS Level II codes.

### **P. Plastic and Metallic Implants**

Plastic and metallic implants or non-autogenous graft materials supplied by the physician are to be reimbursed at cost.

### **Q. Aspirations and Injections**

Puncture of a cavity or joint for aspiration followed by injection of a therapeutic agent is one procedure and should be billed as such.

### **R. Surgical Assistant**

1. Physician surgical assistant — For the purpose of reimbursement, a physician who assists at surgery is reimbursed as a surgical assistant. Assistant surgeons should use modifier 80 and are allowed twenty percent (20%) of the maximum reimbursement allowance (MRA) for the procedure(s).

2. Registered Nurse Surgical Assistant (~~R.A.~~)

       a. Registered nurses who have completed an approved first assistant training course may be allowed a fee when assisting a surgeon in the operating room (O.R.).

       b. The maximum reimbursement allowance for the registered nurse first assistant (R.N.F.A.) is ten percent (10%) of the surgeon's fee for the procedure(s) performed.

       c. Under no circumstances will a fee be allowed for an assistant surgeon and a R.N.F.A. at the same surgical encounter.

       d. Registered nurses on staff in the O.R. of a hospital, clinic, or outpatient surgery center do not qualify for reimbursement as a R.N.F.A.

       e. CPT codes with modifier AS should be used to bill for R.N.F.A. services on a CMS-1500 form and should be submitted with the charge for the surgeon's services.

### **S. Operative Reports**

An operative report must be submitted to the payer before reimbursement can be made for the surgeon's or assistant surgeon's services.

### **T. Needle Procedures**

Needle procedures (lumbar puncture, thoracentesis, jugular or femoral taps, etc.) should be billed in addition to the medical care on the same day.

#### **U. Therapeutic Procedures**

Therapeutic procedures (injecting into cavities, nerve blocks, etc.) (CPT codes 20526-20610, 64400, 64450) may be billed in addition to the medical care for a new patient. (Use appropriate level of service plus injection.)

In follow-up cases for additional therapeutic injections and/or aspirations, an office visit is only indicated if it is necessary to re-evaluate the patient. In this case, a minimal visit may be listed in addition to the injection. Documentation supporting the office visit charge must be submitted with the bill to the payer. Reimbursement for therapeutic injections will be made according to the multiple procedure rules.

Trigger point injection is considered one procedure and reimbursed as such regardless of the number of injection sites. Two codes are available for reporting trigger point injections. Use 20552 for injection(s) of single or multiple trigger point(s) in one or two muscles or 20553 when three or more muscles are involved.

#### **V. Anesthesia by Surgeon**

In certain circumstances it may be appropriate for the attending surgeon to provide regional or general anesthesia. Anesthesia by the surgeon is considered to be more than local or digital anesthesia. Identify this service by adding modifier 47 to the surgical code. Only base anesthesia units are allowed. See the Anesthesia section.

#### **W. Therapeutic/Diagnostic Injections**

Injections are considered incidental to the procedure when performed with a related invasive procedure.

#### **X. Intervertebral Biomechanical Device(s) and Use of Code 22851**

The code 22851 describes the application of an intervertebral biomechanical devices to a vertebral defect or interspace. Code 22851 should be listed in conjunction with a primary procedure without the use of modifier -51. The use of 22851 is limited to one instance per single interspace or single vertebral defect regardless of the number of devices applied and infers additional qualifying training, experience, sizing, and/or use of special surgical appliances to insert the biomechanical device. Qualifying devices include manufactured pre-machined synthetic or allograft biomechanical devices, or methyl methacrylate constructs, and are not dependant on a specific manufacturer, shape, or material of which it is constructed. (For example, the use of code 22851 would be appropriate during a cervical arthrodesis (22554) when applying a synthetic alloy cage, a threaded bone dowel, or a pre-machined hexahedron tricortical allograft biomechanical device. Surgeons utilizing generic non-machined bony allografts or autografts are referred to code sets 20930-20931, 20936-20938 respectively.)

## II. Ambulatory Surgery Centers

### A. Definition

For purposes of this section of the fee schedule, "ambulatory surgery center" means an establishment with an organized medical staff of physicians; with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; with continuous physicians and registered nurses on site or on call; which provides services and accommodations for patients to recover for a period not to exceed twenty-three (23) hours after surgery. An ambulatory surgery center may be a freestanding facility or may be attached to a hospital facility. For purposes of Workers' Compensation reimbursement to ASCs, the facility must be an approved Medicare ASC.

### B. Coding and Billing Rules

1. Facility fees for ambulatory surgery must be billed on the UB-04 form.
2. The CPT/HCPCS code(s) of the procedure(s) performed determines the reimbursement for the facility fee. Report all procedures performed.
3. If more than one surgical procedure is furnished in a single operative encounter, the multiple procedure rule applies. The primary procedure is reimbursed at one hundred percent (100%) of the maximum reimbursable allowance (MRA), the second and subsequent, ~~up to a total of 5~~ procedures, is reimbursed at fifty percent (50%) of the MRA.
4. If the billed total for an outpatient surgical encounter is less than the ASC MRA, the lesser of the charges is paid to the facility.
5. The payment rate for an ASC surgical procedure includes all facility services directly related to the procedure performed on the day of surgery. Facility services include:
  - Nursing and technician services
  - Use of the facility
  - Drugs, biologicals, surgical dressings, splints, casts and equipment directly related to the provision of the surgical procedure
  - Materials for anesthesia
  - Administration, record keeping and housekeeping items and services
6. Separate payment is not made for the following services that are directly related to the surgery:
  - Pharmacy
  - Medical/surgical supplies
  - Sterile supplies
  - Operating room services
  - Anesthesia
  - Ambulatory surgical care
  - Recovery room
  - Treatment or Observation room
7. Facility fees do not include physician services, x-rays, diagnostic procedures, laboratory procedures, C.R.N.A. or anesthesia physician services, prosthetic devices, ambulance services,

braces, artificial limbs or DME for use in the patient's home. These items will be reimbursed according to fee schedule MRA or HCPCS MRA, whichever is appropriate.

### C. Facility Fee Reimbursement for ASCs

1. The Mississippi Worker's Compensation Commission has adopted the Medicare ASC Payment Groups for classifying payment of facility fees for ambulatory surgery.
2. The ASC payment rate has been added to the CPT code listing of fees in the Surgery section of the Fee Schedule. The column lists the total approved facility fee for that particular CPT code.
3. The facility fees will be paid for medically necessary services only. All ambulatory elective procedures must be precertified according to the rules and guidelines of the Fee Schedule.
4. Procedures not assigned an ASC facility fee will be reimbursed according to the lesser of total billed charges or usual and customary rates.

## III. Multiple Procedures

### A. Multiple Procedure Reimbursement Rule

Multiple procedures performed during the same operative session at the same operative site are reimbursed as follows:

- One hundred percent (100%) of the allowable fee for the primary procedure
- Fifty percent (50%) of the allowable fee for the second and subsequent procedures through fifth procedure
- ~~Sixth and subsequent procedures are reimbursed by report.~~

### B. Bilateral Procedure Reimbursement Rule

Physicians and staff are sometimes confused by the definition of bilateral. Bilateral procedures are identical procedures (i.e., use the same CPT code) performed on the same anatomic site but on opposite sides of the body. Furthermore, each procedure should be performed through its own separate incision to qualify as bilateral. For example, open reductions of bilateral fractures of the mandible treated through a common incision would not qualify under the definition of bilateral and would be reimbursed according to the multiple procedure rule. Medicare's accepted method of billing bilateral services is to list the procedure once and add modifier 50. Mississippi is adopting this same policy. Refer to the example below:

#### **69300-50 Otoplasty, protruding ear**

Place a "2" in the UNITS column of the CMS-1500 claim form so that payers are aware that two procedures were performed. List the charge as one hundred fifty percent (150%) of your normal charge. Reimbursement shall be at one hundred fifty percent (150%) of the amount allowed for a unilateral procedure(s). For example, if the allowable for a unilateral surgery is \$100.00 and it is performed bilaterally, reimbursement shall be \$150.00. However, if the procedure description

states “bilateral,” reimbursement shall be as listed in the fee schedule since the fee was calculated for provision of the procedure bilaterally.

### C. Multiple Procedures--Different Areas Rule

When multiple surgical procedures are performed in different areas of the body during the same operative sessions and the procedures are unrelated (e.g., abdominal hernia repair and a knee arthroscopy), the multiple procedure reimbursement rule will apply independently to each area. Modifier 51 must be added.

### D. Multiple Procedure Billing Rules

1. The major primary procedure, which is defined as the procedure with the highest RVU, must be billed with the applicable CPT code.
2. The second or lesser or additional procedure(s) must be billed by adding modifier 51 to the codes, unless the procedure(s) are exempt from modifier 51 or qualify as add-on codes.
3. ~~Surgical procedure codes that contain the words “each” (e.g., each tendon, after the first), are subject to the multiple procedure rule and must have modifier 51 added to the procedure code.~~
4. ~~Surgical codes that contain the words “each additional” in their descriptions are typically add-on codes that have already been reduced. (Do not apply multiple procedure rule reimbursement. Do not add modifier 51 to the procedure code.)~~

## IV. Repair of Wounds

### A. Definitions

Wound repairs are classified as simple, intermediate, or complex.

1. Simple repair — Simple repair is repair of superficial wounds involving primarily epidermis and dermis or subcutaneous tissues without significant involvement of deeper structures and simple one layer closure/suturing. This includes local anesthesia and chemical or electrocauterization of wounds not closed
2. Intermediate repair — Intermediate repair is repair of wounds that requires layered closure of one or more of the subcutaneous tissues and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure. Single-layer closure of heavily contaminated wounds that require extensive cleaning or removal of particulate matter also constitutes intermediate repair.
3. Complex repair — Complex repair is repair of wounds requiring more than layered closure, scar revision, debridement (e.g., traumatic lacerations or avulsions), extensive undermining, stents or retention sutures. It may include creation of the defect and necessary preparation for repairs or the debridement and repair of complicated lacerations or avulsions.

### B. Reporting

The following instructions are for reporting services at the time of the wound repair:

1. The repaired wound(s) should be measured and recorded in centimeters, whether curved, angular, or stellate.
2. When multiple wounds are repaired, add together the lengths of those in the same classification (see above) and anatomical grouping and report as a single item. When more than one classification of wound is repaired, list the more complicated as the primary procedure and the less complicated as the secondary procedure using modifier 51.
3. Debridement is considered a separate procedure only when gross contamination requires prolonged cleansing, when appreciable amounts of devitalized or contaminated tissue are removed, or when debridement is carried out separately without immediate primary closure (extensive debridement of soft tissue and/or bone).
4. Report involvement of nerves, blood vessels, and tendons under the appropriate system (nervous, musculoskeletal, etc.) for repair. The repair of these wounds is included in the fee for the primary procedure unless it qualifies as a complex wound, in which case modifier 51 applies.
5. Simple ligation of vessels in an open wound is considered part of any wound closure, as is simple exploration of nerves, blood vessels, or tendons.
6. Adjacent tissue transfers, flaps and grafts include such procedures as Z-plasty, W-plasty, V-4-plasty or rotation flaps. Reimbursement is based on the size of the defect. Closing the donor site with a skin graft is considered an additional procedure and will be reimbursed in addition to the primary procedure. Excision of a lesion prior to repair by adjacent tissue transfer is considered “bundled” into the tissue transfer procedure and is not reimbursed separately.
7. Wound exploration codes should not be billed with codes that specifically describe a repair to major structure or major vessel. The specific repair code supersedes the use of a wound exploration code.

## **V. Musculoskeletal System**

### **A. Casting and Strapping**

This applies to severe muscle sprains or strains that require casting or strapping.

1. Initial (new patient) treatment for soft tissue injuries must be billed under the appropriate office visit code.
2. When a cast or strapping is applied during an initial visit, supplies and materials (e.g., stockinet, plaster, fiberglass, ace bandages) may be itemized and billed separately using the appropriate HCPCS [Level II](#) code.
3. When initial casting and/or strapping is applied for the first time during an established patient visit, reimbursement may be made for the itemized supplies and materials in addition to the appropriate established patient visit.
4. Replacement casts or strapping provided during a follow-up visit (established patient) include reimbursement for the [replacement](#) service as well as the removal of casts, splints, or strapping. Follow-up visit charges may be reimbursed in addition to replacement casting and strapping only when additional significantly identifiable medical services are provided. Office notes should substantiate medical necessity of the visit. [Cast supplies](#) may be billed [using the appropriate HCPCS Level II code](#) and reimbursed separately.

## **B. Fracture Care**

1. Fracture care is a global service. It includes the examination, restoration or stabilization of the fracture, application of the first cast, and cast removal. Casting material is not considered part of the global package and may be reimbursed separately. It is inappropriate to bill an office visit since the reason for the encounter is for fracture care. However, if the patient requires surgical intervention, additional reimbursement can be made for the appropriate E/M code to properly evaluate the patient for surgery. Use modifier 57 with the E/M code.
2. Reimbursement for fracture care includes the application and removal of the first cast or traction device only. Replacement casting during the period of follow-up care is reimbursed separately.
3. The phrase “with manipulation” describes reduction of a fracture.
4. Re-reduction of a fracture performed by the primary physician may be identified by the addition of modifier 76 to the usual procedure code to indicate “repeat procedure” by the same physician.
5. The term “complicated” appears in some musculoskeletal code descriptions. It implies an infection occurred or the surgery took longer than usual. Be sure the medical record documentation supports the “complicated” descriptor to justify reimbursement.

## **C. Bone, Cartilage, and Fascia Grafts**

1. Reimbursement for obtaining autogenous bone, cartilage or fascia grafts, or other tissue through separate incisions is made only when the graft is not described as part of the basic procedure.
2. Tissue obtained from a cadaver for grafting must be billed using code 99070 and accompanied by a report in order to ensure an equitable reimbursement by the payer.

## **D. Arthroscopy**

———Note: -Surgical arthroscopy always includes a diagnostic arthroscopy. Only in the most unusual case is an increased fee justified because of increased complexity of the intra-articular surgery performed.

1. Diagnostic arthroscopy should be billed at fifty percent (50%) when followed by open surgery.
2. Diagnostic arthroscopy is not billed when followed by arthroscopic surgery.
3. If there are only minor findings that do not confirm a significant preoperative diagnosis, the procedure should be billed as a diagnostic arthroscopy.

## **E. Arthrodesis Procedures**

Many revisions have occurred in CPT coding for arthrodesis procedures. References to bone grafting and fixation are now procedures which are listed and reimbursed separately from the arthrodesis codes.

To help alleviate any misunderstanding about when to code a discectomy in addition to an arthrodesis, the statement “including minimal discectomy” to prepare interspace has been added

to the anterior interbody technique. If the disk is removed for decompression of the spinal cord, the decompression should be coded and reimbursed separately. ~~Reimbursement for discectomy is fifty percent (50%) of the MRA, when performed with an arthrodesis procedure.~~

#### **F. External Spinal Stimulators Post Fusion**

1. The following criteria is established for the medically accepted standard of care when determining applicability for the use of an external spinal stimulator. However, the medical necessity should be determined on a case-by-case basis.
  - a. Patient has had a previously failed spinal fusion, and/or
  - b. Patient is scheduled for revision or repair of pseudoarthrosis, and/or
  - c. The patient smokes greater than a pack of cigarettes per day and is scheduled for spinal fusion
2. The external spinal stimulator is not approved by the Mississippi Workers' Compensation Commission for use in primary spinal fusions.
3. The external spinal stimulator will be reimbursed by report (BR).
4. Precertification is required for use of the external spinal stimulator.

#### **G. Carpal Tunnel Release**

The following intraoperative services are included in the global service package for carpal tunnel release and should not be reported separately and do not warrant additional reimbursement:

- Surgical approach
- Isolation of neurovascular structures
- Video imaging
- Stimulation of nerves for identification
- Application of dressing, splint, or cast
- Tenolysis of flexor tendons
- Flexor tenosynovectomy
- Excision of lipoma of carpal canal
- Exploration of incidental release of ulnar nerve
- Division of transverse carpal ligament
- Use of endoscopic equipment
- Placement and removal of surgical drains or suction device
- Closure of wound

## **VI. Burns, Local Treatment**

### **A. Degree of Burns**

1. Code 16000 must be used when billing for treatment of first degree burns when no more than local treatment of burned surfaces is required.
2. Codes 16020-16030 must be used when billing for treatment of second and third degree partial-thickness burns only.
3. The claim form must be accompanied by a report substantiating the services performed.

4. Major debridement of foreign bodies, grease, epidermis, or necrotic tissue may be billed separately under codes 11000-11001. Modifier 51 does not apply.

### **B. Percentage of Total Body Surface Area**

The following definitions apply to codes 16020-16030:

1. “Small” means less than ~~nine~~ five percent (5%) of the total body surface area
2. “Medium” means whole face or whole extremity or ~~nine~~ five to ten ~~eighteen~~ percent (5%-10%) of the total body surface area
3. “Large” means more than one extremity or greater than ten ~~eighteen~~ percent (10%) of the total body surface area

### **C. Reimbursement**

1. To identify accurately the proper procedure code and substantiate the descriptor for billing, the exact percentage of the body surface involved and the degree of the burn must be specified on the claim form submitted or by attaching a special report. Claims submitted without this specification will be returned to the physician for this additional information.
2. Hospital visits, emergency room visits, or critical care visits provided by the same physician on the same day as the application of burn dressings will be reimbursed as a single procedure at the highest level of service.

## **VII. Nerve Blocks**

### **A. Diagnostic or Therapeutic**

1. Please refer to the Pain Management section for guidelines and reimbursement of nerve blocks.
2. Medications such as steroids, pain medication, etc., may be separately billed using the appropriate HCPCS Level II code.
  - a. The name of the medication(s), dosage, and volume must be identified.
  - b. Medication will be reimbursed according to fees listed in the HCPCS section. If not listed in HCPCS, reimbursement will be according to the Pharmacy section in the General Guidelines.

### **B. Anesthetic**

When a nerve block for anesthesia is provided by the operating room surgeon, the procedure codes listed in the Anesthesia section must be followed.

## **VIII. Modifiers**

Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of the appropriate modifier

code. The modifier may be reported by a two-digit number placed after the usual procedure number and separated by a hyphen. If more than one modifier is used, place the multiple modifiers code 99 immediately after the procedure code. This indicates that one or more additional modifier codes follow. Modifiers commonly used in surgery are as follows:

## 22 Unusual Procedural Services

When the services provided are greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number. A report may also be appropriate.

*Mississippi's note: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement.*

## 26 Professional Component

Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

## 32 Mandated Services

———Services related to mandated consultation and/or related services (e.g., PRO, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

## 47 Anesthesia by Surgeon

Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) Note: Modifier 47 would not be used as a modifier for the anesthesia procedures 00100-01999.

*Mississippi's note: Reimbursement is made for base units only.*

## 50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed during the same operative session should be identified by adding modifier 50 to the appropriate five-digit code.

## 51 Multiple Procedures

When multiple procedures, other than evaluation and management services, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated “add-on” codes (see Appendix D of the [applicable](#) CPT book).

*Mississippi's note: This modifier should not be appended to designated "modifier 51 exempt" codes as specified in Appendix E the applicable CPT book.*

## 52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

## 53 Discontinued Procedure

Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.

## 54 Surgical Care Only

When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

## 55 Postoperative Management Only

When one physician performed the postoperative management and another physician performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

## 56 Preoperative Management Only

———When one physician performed the preoperative care and evaluation and another physician performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

## 57 Decision for Surgery

———An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

#### 58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

The physician may need to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. Note: This modifier is not used to report the treatment of a problem that requires a return to the operation room. See modifier 78.

#### 59 Distinct Procedural Service

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

#### 62 Two Surgeons

When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If an additional procedure(s) (including an add-on procedure(s)) is performed during the same surgical session, a separate code(s) may be reported with modifier 62 added. Note: If a co-surgeon acts as an assistant in the performance of an additional procedure(s) during the same surgical session, the service(s) may be reported using a separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

#### 66 Surgical Team

Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel and various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician with the addition of modifier 66 to the basic procedure number used for reporting services.

#### 76 Repeat Procedure by Same Physician

The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

#### 77 Repeat Procedure by Another Physician

The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.

#### 78 Return to the Operating Room for a Related Procedure During the Postoperative Period

The physician may need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first and requires the use of the operating room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures on the same day, see modifier 76.)

#### 79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period

The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

#### 80 Assistant Surgeon

Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

*Mississippi's note: Reimbursement is twenty percent (20%) of the maximum reimbursement allowance.*

#### 81 Minimum Assistant Surgeon

Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.

*Mississippi's note: Physician reimbursement is ten percent (10%) of the allowable.*

#### 82 Assistant Surgeon (when qualified resident surgeon not available)

The unavailability of a qualified resident surgeon is prerequisite for use of modifier 82 appended to the unusual procedure code number(s).

#### 90 Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier 90 to the usual procedure number.

#### 99 Multiple Modifiers

Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

#### AS Assistant At Surgery Services Provided By Registered Nurse First Assistant

Assistant at surgery services provided by a Registered Nurse First Assistant (RNFA), Nurse Practitioner or Clinical Nurse Specialist are identified by adding modifier AS to the listed applicable surgical procedures. The use of the AS modifier is appropriate for any code that otherwise is reimbursable for a physician assisting a surgeon in the operating room.

Mississippi's note: Modifier AS reimbursement is ten percent (10%) of the allowable.

### **IX. Modifiers Approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use**

#### 25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57.

#### 27 Multiple Outpatient Hospital E/M Encounters on the Same Date

For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (e.g., hospital emergency department, clinic). Note: This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient evaluation and management services provided by the same physician on the same date and performed in multiple outpatient setting(s) (e.g., hospital emergency department, clinic), see Evaluation and Management, Emergency Department, or Preventive Medicine Services codes.

## 50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding the modifier 50 to the appropriate five digit code.

## 52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

## 58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

The physician may need to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. Note: This modifier is not used to report the treatment of a problem that requires a return to the operating room. See modifier 78.

## 59 Distinct Procedural Service

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

## 73 Discontinued Out-Patient Hospital/ Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical

preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of modifier 73. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

#### 74 Discontinued Out-Patient Hospital/ Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of modifier 74. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

#### 76 Repeat Procedure by Same Physician

The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

#### 77 Repeat Procedure by Another Physician

The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.

#### 78 Return to the Operating Room for a Related Procedure During the Postoperative Period

The physician may need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures on the same day, see modifier 76.)

#### 79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period

The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

#### 91 Repeat Clinical Diagnostic Laboratory Test

In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. Note: This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

## **Radiology Rules**

### **I. Scope**

The following guidelines apply to radiology services provided in offices, clinics, and under some circumstances in hospital x-ray departments. This section also contains guidelines that include nuclear medicine and diagnostic ultrasound.

### **II. Guidelines**

#### **A. Total Component**

A total fee includes both the professional component for the radiologist and the technical component needed to accomplish the procedure. Explanations of the professional component and the technical component are listed below. The values as listed in the Amount column represent the total reimbursement.

#### **B. Professional Component**

The professional component represents the reimbursement allowance of the professional radiological services of the physician and is identified by the use of modifier 26. This includes examination of the patient when indicated, performance or supervision of the procedure, interpretation and written report of the examination, and consultation with the referring physician. In the majority of hospital radiology departments, the radiologist submits a separate statement to the patient for professional services rendered, which are listed as the professional component. Values in the PC Amount column are intended for the services of a radiologist for the professional component only and do not include any other charges. To identify a charge for a professional component only, use the five-digit code followed by modifier 26.

#### **C. Technical Component**

The technical component includes charges made by the institution or clinic to cover the services of technologists and other ~~helpers~~ [staff members](#), the film, contrast media, chemicals and other materials, and the use of the space and facilities of the x-ray department. To identify a charge for a technical component only, use the five-digit code followed by ~~Mississippi modifier -~~ [HCPCS Level II modifier TC](#).

#### **D. Review of X-rays**

Billing code 76140 is not appropriate in the following circumstances because review of the x-rays is inherent to the evaluation and management code:

- The physician, during the course of an office visit or consultation, reviews an x-ray made elsewhere.
- The treating or consulting physician reviews x-rays at an emergency room or hospital visit.

- CPT code 76140 ~~X-ray consultation~~ *Consultation on x-ray examination made elsewhere, written report*, will only be paid when there is a documented need for the service and when performed by a radiologist or physician certified to perform radiological services.

#### **E. Additional X-rays**

No payment shall be made for additional x-rays when recent x-rays are available except when supported by adequate information regarding the need to retake x-rays. The use of photographic media and/or imaging is not reported separately, but is considered to be a component of the basic procedure and shall not merit any additional payment.

#### **F. Contrast Material**

1. Complete procedures, interventional radiological procedures, or diagnostic studies involving injection of contrast media include all usual pre-injection and post-injection services (e.g., necessary local anesthesia, placement of needle catheter, injection of contrast media, supervision of the study, and interpretation of results).
2. Low osmolar contrast material and paramagnetic contrast materials shall only be billed when not included in the descriptor of the procedure. When appropriately billed, the contrast media is reimbursed according to the maximum reimbursement allowance rate (MRA) listed in the HCPCS section of the [Fee Schedule](#). Supplies should be billed with the appropriate HCPCS [Level II](#) code and will be reimbursed according to the [Fee Schedule](#).
3. When contrast can be administered orally (upper G.I.) or rectally (barium enema), the administration is included as part of the procedure.
4. When an intravenous line is placed simply for access in the event of a problem with a procedure or for administration of contrast, it is considered part of the procedure and does not command a separate fee.

#### **G. Urologic Procedures**

In the case of urologic procedures (e.g., CPT codes 74400-74485), insertion of a urethral catheter is part of the procedure and is not separately billed.

#### **H. Separate or Multiple Procedures**

1. When multiple procedures are performed on the same day or at the same session, it is appropriate to designate them by separate entries. Surgical procedures performed in conjunction with a radiology procedure will be subject to the rules and regulations of the Surgery section.
2. When x-rays of multiple sections of a body area are billed separately, the total reimbursement must not exceed the maximum reimbursement allowance of the complete body area.

#### **I. Outpatient CT Scans and MRIs**

CT scans and MRIs, when performed on an outpatient basis, are subject to the limitations of the fee schedule, regardless of site of service.

## J. Unlisted Service or Procedure

A service or procedure may be provided that is not listed in the most recent edition of the CPT book. When reporting such a service, the appropriate unlisted procedure code may be used to indicate the service, identifying it by special report. The unlisted procedures and accompanying codes are as follows:

- 76496 Unlisted fluoroscopic procedure (eg, diagnostic, interventional)*
- 76497 Unlisted computed tomography procedure (eg, diagnostic, interventional)*
- 76498 Unlisted magnetic resonance procedure (eg, diagnostic, interventional)*
- 76499 Unlisted diagnostic ~~radiologic~~-radiographic procedure*
- 76999 Unlisted diagnostic ultrasound procedure*
- 77299 Unlisted procedure, therapeutic radiolog, clinical treatment planning*
- 77399 Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services*
- 77499 Unlisted procedure, therapeutic radiology ~~clinical~~ treatment management*
- 77799 Unlisted procedure, clinical brachytherapy*
- 78099 Unlisted endocrine procedure, diagnostic nuclear medicine*
- 78199 Unlisted hematopoietic, reticuloendothelial (~~R-E~~) and lymphatic procedure, diagnostic nuclear medicine*
- 78299 Unlisted gastrointestinal procedure, diagnostic nuclear medicine*
- 78399 Unlisted musculoskeletal procedure, diagnostic nuclear medicine*
- 78499 Unlisted cardiovascular procedure, diagnostic nuclear medicine*
- 78599 Unlisted respiratory procedure, diagnostic nuclear medicine*
- 78699 Unlisted nervous system procedure, diagnostic nuclear medicine*
- 78799 Unlisted genitourinary procedure, diagnostic nuclear medicine*
- 78999 Unlisted miscellaneous procedure, diagnostic nuclear medicine*
- 79999 Unlisted radiopharmaceutical therapeutic procedure*

## K. Special Report

A service that is rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary to provide the service. Special reports to justify the necessity of a service do not warrant a separate fee.

## L. By Report (BR)

“BR” in the Amount column indicates services that are too new, unusual, or variable in the nature of their performance to permit the assignment of a definable fee. Such services should be substantiated by documentation submitted with the bill. Sufficient information should be included to permit proper identification and a sound evaluation. If the service is justified by the report, the actual charge shall be paid in full, unless the payer has evidence that the actual charge exceeds the usual and customary charge for such service.

## M. Radiology Supervision and Interpretation Procedures

There are times when a single physician may perform the procedure and supervise the imaging and interpretation. On other occasions, one physician may perform the procedure, and the imaging supervision with interpretation may be performed by another physician. The appropriate radiology codes are to be used for supervision and interpretation of the imaging. The appropriate surgical codes are to be used for the procedure, including necessary local anesthesia, placement of needle or catheters, injection of contrast media, etc. The surgical codes are subject to the rules and regulations of the Surgery section, and the radiology codes are subject to this section of radiology rules and regulations.

### N. ~~Diagnostic Radiology~~

~~1. *Limited Examination:* This is an examination that usually includes anterior posterior and lateral views but is not a complete examination.~~

~~2. *Complete Examination:* This is an examination that includes, as necessary, views for optimal examination of the part of the body that has sustained an on-the-job injury or illness.~~

## N. Written Report(s)

A written report, signed by the interpreting physician, should be considered an integral part of a radiological procedure or interpretation.

## O. Facility Fee

The facility fee is the Amount increased by 10 percent.

## III. Modifiers

Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of the appropriate modifier code. The modifier may be reported by a two-digit number placed after the usual procedure number, separated by a hyphen. If more than one modifier is used, place the multiple modifiers code (99) immediately after the procedure code. This indicates that one or more additional modifier codes will follow. Modifiers commonly used in radiology (including nuclear medicine and diagnostic ultrasound) are as follows:

### 22 Unusual Procedural Services

When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number. A report may also be appropriate.

*Mississippi's note: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement.*

## 26 Professional Component

Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier [26](#) to the usual procedure number.

## TC Technical Component (~~Mississippi~~ [HCPCS Level II](#) Modifier)

Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier [TC](#) to the usual procedure number.

*Mississippi's note: The technical component is calculated by subtracting the PC Amount from the Amount for the reimbursement.*

## 32 Mandated Service

Services related to mandated consultation and/or related services (e.g., PRO, ~~3rd~~ [third-party](#) payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

## 51 Multiple Procedures

When multiple procedures, other than E/M services, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated “add-on” codes ([see Appendix D of the CPT book](#)).

## 52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

## 53 Discontinued Procedure

Under certain circumstances the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but

discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

#### 76 Repeat Procedure by Same Physician

The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

#### 77 Repeat Procedure by Another Physician

The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.

#### 99 Multiple Modifiers

Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

## Pathology and Laboratory Rules

### I. Guidelines

#### A. Pathology Services

Services in pathology and laboratory are provided by the pathologist, or by the technologist, under responsible supervision of a physician.

#### B. Separate or Multiple Procedures

It is appropriate to designate multiple procedures rendered on the same date by separate entries.

#### C. Unlisted Service or Procedures

A service or procedure may be provided that is not listed in this fee schedule. When reporting such a service or procedure, the appropriate unlisted procedure code may be used to indicate the service, identifying it by special report as discussed below. The unlisted procedures and accompanying codes for Pathology and Laboratory are as follows:

*81099 Unlisted urinalysis procedure*  
*84999 Unlisted chemistry procedure*  
*85999 Unlisted hematology and coagulation procedure*  
*86586 Unlisted antigen, each*  
*86849 Unlisted immunology procedure*  
*86999 Unlisted transfusion medicine procedure*  
*87999 Unlisted microbiology procedure*  
*88099 Unlisted necropsy (autopsy) procedure*  
*88199 Unlisted cytopathology procedure*  
*88299 Unlisted cytogenetic study*  
*88399 Unlisted surgical pathology procedure*  
*89240~~399~~ Unlisted miscellaneous pathology test*

#### D. Special Report

A service that is rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary to provide the service. Additional items that may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care. This report does not command a separate fee for completion.

#### E. By Report (BR)

“BR” in the Amount column indicates services that are too new, unusual, or variable in the nature of their performance to permit the assignment of a definable fee. Such services should be substantiated by documentation submitted with the bill. Sufficient information should be included to permit proper identification and a sound evaluation. If the service is justified by the report, the actual charge shall be paid in full, unless the payer has evidence that the actual charge exceeds the usual and customary charge for such service.

## **F. Facility Fee**

The facility fee is the Amount increased by 10 percent.

## ***II. General Information and Instructions***

### **A. Panel Tests**

The billing for panel tests must include documentation listing the tests in the panel. When billing for panel tests (~~800508004880099~~80048-80076), use the code number corresponding to the appropriate panel test. These tests will not be reimbursed separately.

The panel components do not preclude the performance of other tests not listed in the panel. If other laboratory tests are performed in conjunction with a particular panel, the additional tests may be reported separately in addition to the panel.

### **~~B. Automated Multichannel Tests~~**

*The following list contains those tests that can be frequently done as groups and combinations (profiles) on automated multichannel equipment. For any combination of tests among those listed immediately below, use the appropriate number 80048-80090. Groups of the tests listed here are distinguished from multiple tests performed individually for immediate or “stat” reporting. (For the handling of specimens, see 99000 and 99001.)*

~~✖ Alanine aminotransferase (ALT, SGPT)~~

~~✖ Albumin~~

~~✖ Aspartate aminotransferase (AST, SGOT)~~

~~✖ Bilirubin, direct~~

~~✖ Bilirubin, total~~

~~✖ Calcium~~

~~✖ Carbon dioxide content~~

~~✖ Chloride~~

~~✖ Cholesterol~~

~~✖ Creatinine~~

~~✖ Glucose~~

~~✖ Lactate dehydrogenase (LD)~~

~~✖ Phosphatase, alkaline~~

~~✖ Phosphorus (inorganic phosphate)~~

~~✖ Potassium~~

~~✖ Protein, total~~

~~✖ Sodium~~

~~✖ Urea Nitrogen (BUN)~~

~~✖ Uric Acid~~

## **B. Handling and Collection Process**

1. In collecting a specimen, the cost for collection is covered by the technical component when the lab test is conducted at that site. No separate collection or handling fee for this purpose will be reimbursed.
2. When a specimen must be sent to a reference laboratory, the cost of specimen collection is covered in a collection fee. This charge is only allowed when a reference laboratory is used, and modifier 90 must be used.

## **C. Global, Professional, and Technical Components**

Some procedures in the Pathology and Laboratory section are considered global fees and do not qualify for a separate technical (TC) or professional (PC) component. Some procedures are listed with a PC fee in addition to the global fee. For procedures listed with a PC fee, the TC reimbursement rate is calculated by subtracting the PC amount from the total amount.

Whereas these guidelines are written to be all-inclusive, there are instances when the reviewer must make an informed decision regarding the PC/TC reimbursements. Request for PC reimbursement will only be considered if:

- The physician performs the procedure or reviews the results.
- A written report, not a computer generated report, is submitted with the request for payment

## **III. Modifiers**

Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of the appropriate modifier code. The modifier may be reported by a two-digit number placed after the usual procedure number and separated by a hyphen. If more than one modifier is used, place the multiple modifiers code (99) immediately after the procedure code. This indicates that one or more additional modifier codes will follow. Modifiers commonly used in pathology and laboratory are as follows:

### 22 Unusual Procedural Services

When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number. A report may also be appropriate.

*Mississippi's note: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement.*

## 26 Professional Component

Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number

## TC Technical Component (~~Mississippi~~ [HCPCS Level II](#) Modifier)

Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

*Mississippi's note: The technical component is calculated by subtracting the PC Amount from the Amount for the reimbursement.*

## 32 Mandated Services

Services related to mandated consultation and/or related services (eg, PRO, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

## 52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

## 53 Discontinued Procedure

Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a

result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

#### 59 Distinct Procedural Service

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

#### 90 Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier 90 to the usual procedure number.

#### 91 Repeat Clinical Diagnostic Laboratory Test

In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. Note: This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when another code(s) describes a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used for a laboratory test(s) performed more than once on the same day on the same patient.

#### 99 Multiple Modifiers

Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

## Medicine Services Rules

In addition to the general rules, this section applies to unique guidelines for medicine specialties. Physical medicine and rehabilitation guidelines, as well as chiropractic and osteopathic services, are listed in a separate section following Medicine Services.

### I. Guidelines

#### A. Unlisted Services or Procedures

When a service or procedure is provided that is not specifically listed in the fee schedule, documentation must be submitted to substantiate the charge.

#### B. Multiple Procedures

It is appropriate to designate multiple procedures rendered on the same date by separate entries. ~~For example: If individual medical psychotherapy (e.g., 90841) is rendered in addition to subsequent hospital care (e.g., 99231), the psychotherapy would be reported separately from the hospital visit. In other words, both 99231 and 90841 would be reported.~~

#### C. Separate Procedures

Some of the listed procedures are commonly carried out as an integral part of a total service and, as such, do not warrant a separate identification. When, however, such a procedure is performed independently of, and is not immediately related to other services, it may be listed as a “separate procedure.” Thus, when a procedure that is ordinarily a component of a larger procedure is performed alone for a specific purpose, it may be reported as a separate procedure.

#### D. By Report (BR) Procedures

“BR” in the Amount column indicates services that are too new, unusual, or variable in the nature of their performance to permit the assignment of a definable fee. Such services should be substantiated by documentation submitted with the bill. Sufficient information should be included to permit proper identification and a sound evaluation. If the service is justified by the report, the actual charge shall be paid in full, unless the payer has evidence that the actual charge exceeds the usual and customary charge for such service.

#### E. Special Report

A service that is rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary to provide the service. Additional items that may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

## **F. Materials Supplied by Physician**

Supplies and materials provided by the physician over and above those usually included with the office visit should be identified with [CPT code 99070](#) or [specific HCPCS Level II](#) ~~the appropriate HCPCS~~ code. Reimbursement shall be limited to the fee schedule maximum reimbursement allowance (MRA) or the usual and customary rate for items not listed in this fee schedule.

## **G. Audiological Function Tests**

The audiometric tests (92551-92596) require use of calibrated electronic equipment. Other hearing tests (e.g., whisper voice or tuning fork) are considered part of the examination and not paid separately. All descriptors refer to testing of both ears.

## **H. Psychological Services**

\_\_\_\_\_ Payment for a psychiatric diagnostic interview includes history and mental status determination, development of a treatment plan when necessary, and the preparation of a written report that must be submitted with the required billing form.

\_\_\_\_\_ Psychotherapy codes (90804-90857) must be billed under the CPT code most closely approximating the length of the session. The codes for individual therapy services designate whether the service includes medical evaluation. Only a psychiatrist (M.D. or D.O.) may bill for those codes that include medical evaluation (procedure codes 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829).

\_\_\_\_\_ A service level adjustment factor is used to determine payment for psychotherapy when a provider other than a psychiatrist provides the service. In those instances, the reimbursement amount for the CPT code is paid at eighty-five percent (85%) of the maximum reimbursement allowance. This applies to psychologists, social workers, and counselors.

## **I. Electromyography (EMG)**

Payment for EMG services includes the initial set of electrodes and all supplies necessary to perform the service. The physician may be paid for a consultation or new patient visit in addition to the EMG performed on the same day. When an EMG is performed on the same day as a follow up visit, payment may be made for the EMG only unless documentation supports the need for a medical service in addition to the EMG.

## **J. Manipulative Services**

Chiropractic manipulative services, which are medicine services, will be discussed in the Physical Medicine section.

## **II. Modifiers**

Listed services and procedures may be modified under certain circumstances. When applicable, identify the modifying circumstance by the addition of the appropriate modifier code, which may be reported by a two-digit number placed after the usual procedure number separated by a hyphen. If more than one modifier is used, place the multiple modifiers code (99) immediately after the procedure code. This indicates that one or more additional modifier codes will follow. Modifiers commonly used in Medicine Services are as follows:

## 22 Unusual Procedure Services

When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number. A report may also be appropriate.

*Mississippi's note: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement.*

## 26 Professional Component

Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

## TC Technical Component (~~Mississippi~~ [HCPCS Level II](#) Modifier)

Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

*Mississippi's note: The technical component is calculated by subtracting the PC Amount from the Amount for the reimbursement.*

## 32 Mandated Services

Services related to mandated consultation and/or related services (eg, PRO, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

## 51 Multiple Procedures

When multiple procedures, other than E/M services, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated “add-on” codes ([see Appendix D of the CPT book](#)).

*Mississippi's note: This modifier should not be appended to designated "-modifier 51 exempt" codes as specified in Appendix E the CPT book.*

## 52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

## 53 Discontinued Procedure

Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

## 55 Postoperative Management Only

When one physician [performed](#) the postoperative management and another physician performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

## 56 Preoperative Management Only

When one physician [performed](#) the preoperative care and evaluation and another physician [performed](#) the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

## 57 Decision for Surgery

An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

#### 58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

The physician may need to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. Note: This modifier is not used to report the treatment of a problem that requires a return to the operating room. See modifier 78.

#### 59 Distinct Procedural Service

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

#### 76 Repeat Procedure by Same Physician

The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

#### 77 Repeat Procedure by Another Physician

The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.

#### 78 Return to the Operating Room for a Related Procedure During the Postoperative Period

The physician may need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures on the same day, see modifier 76.)

#### 79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period

The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

#### 90 Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier 90 to the usual procedure number.

#### 99 Multiple Modifiers

Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

## Physical Medicine Rules

### I. Scope

#### A. Physical Medicine

Physical medicine is an integral part of the healing process for a variety of injured workers. Recognizing this, the fee schedule includes codes for physical medicine, modalities, procedures, tests, and measurements in the Physical Medicine section representing specific therapeutic procedures performed by licensed physicians, chiropractors, licensed physical therapists, and licensed occupational therapists.

#### B. Physical Medical Assessment

1. An assessment must be performed to determine if a patient will benefit from physical medicine therapy.
2. When a physician examines a patient and an assessment for physical medicine is performed, the billing for the office visit includes the physical medicine assessment.
3. Procedure code 97001 is to be used for an initial assessment by physical therapists. Code 97002 is to be used for re-evaluation of a patient by physical therapists. Procedure code 97003 is to be used for an initial assessment by occupational therapists. Code 97004 is to be used for re-evaluation of a patient by occupational therapists.

#### C. Plan of Care

1. An initial plan of care must be developed and filed with the payer regardless of whether therapy is provided by a physician or practicing therapist. The content of the plan of care, at a minimum, should contain:
  - a. The specific therapies to be provided, including the frequency and duration of each
  - b. The estimated duration of the therapeutic regimen
  - c. The potential degree of restoration and measurable goals (e.g., potential restoration is good, poor, low, guarded)
2. The initial plan of care must be signed by the treating physician and submitted to the payer within 14 days of approval. Physicians are required to sign the plan of care for physical and/or occupational therapy. The physician's signature indicates approval of the therapy the patient is receiving and for the length of time established for the therapy.
3. The physician has the responsibility of providing documentation of medical necessity to the payer whenever there are questions regarding the extent of therapy being provided or the appropriateness of the therapy regimen.

\_\_\_\_\_ 4. A plan of care must be updated at least every thirty (30) days and submitted to the payer.

\_\_\_\_\_ 5. Preparation of a care plan does not warrant a separate fee.

#### **D. Qualifications for Reimbursement**

\_\_\_\_\_ 1. The patient's condition must have the potential for restoration of function.

\_\_\_\_\_ 2. The treatment must be prescribed by the authorized attending or treating physician.

\_\_\_\_\_ 3. The treatment must be specific to the injury and have the potential to improve the patient's condition.

\_\_\_\_\_ 4. The physician or therapist must be on-site during the provision of services.

## **II. Reimbursement**

### **A. Guidelines**

\_\_\_\_\_ 1. Visits for therapy may not exceed one visit per day without prior approval from the payer.

\_\_\_\_\_ 2. Therapy exceeding fifteen (15) visits or thirty (30) days, whichever comes first, must have prior authorization from the payer for continuing care. It must meet the following guidelines:

\_\_\_\_\_ a. The treatment must be medically necessary.

\_\_\_\_\_ b. Prior authorization may be made by telephone. Documentation should be made in the patient's medical record indicating the date and name of the payer representative giving authorization for the continued therapy.

\_\_\_\_\_ 3. Reimbursement is limited to no more than two modalities and/or two procedures, for a total of four, concurrently at the same visit. In the event of multiple treatment areas, an additional two modalities and/or two procedures per treatment day may be allowed at the payer's discretion and with pre-authorization.

*[In the pain management setting, no more than two (2) modalities and/or procedures may be used on a given day (e.g., heat/cold, ultrasound, diathermy, iontophoresis, TENS, electrical stimulation, muscle stimulation, etc.). No more than one (1) modality may be used concurrently.]*

\_\_\_\_\_ 4. Payment for 97010, which reports application of hot or cold packs, is bundled into payment for other services. Separate reimbursement for hot and cold packs will *not* be allowed in the treatment of work-related injury/illness.

\_\_\_\_\_ 5. No more than four (4) 15-minute procedures and/or modalities will be reimbursed at each encounter without prior authorization.

\_\_\_\_\_ 6. Only one (1) work hardening or work conditioning program is reimbursed per injury.

## **B. Treatment Areas**

\_\_\_\_\_ 1. Spinal areas are recognized as the following five distinct regions:

- Cranial
- Cervical
- Thoracic
- Lumbar
- Sacral

\_\_\_\_\_ Transitional areas of the spine are not recognized as distinctly different areas (e.g., cervicothoracic, lumbosacral).

\_\_\_\_\_ 2. Pelvis

\_\_\_\_\_ 3. Upper extremity (either left or right) is recognized as the following six distinct regions:

- Shoulder
- Upper arm
- Elbow
- Forearm
- Wrist
- Hand

\_\_\_\_\_ 4. Lower extremity (either left or right) is recognized as the following eight distinct regions:

- Hip
- Thigh
- Knee
- Calf
- Ankle
- Foot
- Rib cage
- Anterior trunk

## **C. Tests and Measurements**

\_\_\_\_\_ 1. When two or more procedures from 95831 through 95852 are performed on the same day, reimbursement may not exceed the maximum reimbursement allowance (MRA) for procedure code 95834 *Total evaluation of body, including hands*.

\_\_\_\_\_ 2. Functional capacity ~~testing~~-evaluation (FCE) must have pre-authorization from the payer before scheduling the tests. Reimbursement will be one hundred dollars (\$100.00) per hour for a maximum of five (5) hours.

\_\_\_\_\_ 3. Reimbursement for extremity testing, muscle testing, and range of motion measurements (95831, 95832, 95833, 95834, 95851, 95852) will not be made more than once in a 30-day period for the same body area. If a physician's order specifically indicates testing in more than one plane of motion, (e.g., flexion/extension and internal/external rotation), then each plane of motion test is reimbursable, but not more than once in a 30-day period for that same body area. The multiple procedure rule would apply.

#### **D. Fabrication of Orthotics**

\_\_\_\_\_ 1. Procedure code ~~97504~~ 97760 must be billed for the professional services of a physician or therapist to fabricate orthotics.

\_\_\_\_\_ 2. Orthotics, prosthetics, and related supplies used may be billed under the appropriate HCPCS code. The maximum reimbursement allowance is listed in the DME and Other HCPCS Codes section of the Fee Schedule. For orthotics and supplies not listed in the DME and Other HCPCS Codes section, use CPT code 99070. Reimbursement may not exceed a twenty percent (20%) mark-up of the provider's cost and an invoice may be required by the payer before reimbursement is made.

#### **E. Follow-up Examination of an Established Patient**

A physician, physical therapist, or occupational therapist may charge and be reimbursed for a follow-up examination for physical therapy only if new symptoms present the need for re-examination and evaluation as follows:

\_\_\_\_\_ 1. There is a definitive change in the patient's condition

\_\_\_\_\_ 2. The patient fails to respond to treatment and there is a need to change the treatment plan

\_\_\_\_\_ 3. The patient has completed the therapy regimen and is ready to receive discharge instructions

### **III. Work Hardening Rules**

A. Work hardening programs are interdisciplinary, goal-specific, vocationally-driven treatment programs designed to maximize the likelihood of return to work through functional, behavioral, and vocational management.

B. Not all claimants require these programs to reach a level of function that will allow successful return to work.

C. Only those programs that meet all of the specific guidelines will be defined as work hardening programs.

D. Programs will be reimbursed per the fee schedule after meeting all other requirements.

E. Work hardening will be reimbursed for a maximum of four weeks with prior authorization from the payer. The payer may approve additional two-week increments if the patient demonstrates substantial improvement.

F. For pre-admission criteria all claimants must complete a preprogram assessment, including a functional capacity evaluation (FCE). The goal of the program is return to work; therefore, for all anticipated returns to previous employment or placement with a new employer, the following must be provided:

- \_\_\_\_\_ 1. Specific written critical job demands and/or job site analysis
- \_\_\_\_\_ 2. Verified written employment opportunities

G. For the evaluation process, initial screening evaluation is performed to determine if the injured worker will benefit from a work hardening program. The outcome of this evaluation will be:

- \_\_\_\_\_ 1. Recommendation of release to return to work
- \_\_\_\_\_ 2. Acceptance into the program with an individual written rehabilitation plan stating specific goals and recommended services
- \_\_\_\_\_ 3. Rejection from program for specific reasons
- \_\_\_\_\_ 4. Referral back to the provider for medical evaluation

H. The individualized work hardening plan must be supervised by a licensed physical or occupational therapist and/or physician within a therapeutic environment. Although some time is spent on a one-to-one basis, more than fifty percent (50%) of the time is self-monitored under the supervision of a physical or occupational therapist and/or physician. Recommended group size is no larger than five-to-one (5 patients to 1 therapist).

I. Progress should be documented and reviewed to ensure continued progress.

J. Simultaneous utilization of work conditioning and work hardening is not allowed. Prior authorization is required for either one of these services and requires documentation of specific goals and outcomes.

K. Discharge criteria must be provided to all claimants in writing prior to initiation of treatment at the time program goals are determined.

L. Voluntary discharge is achieved by:

- \_\_\_\_\_ 1. Meeting program goals
- \_\_\_\_\_ 2. Early return to work
- \_\_\_\_\_ 3. Acute or worsening medical condition
- \_\_\_\_\_ 4. The claimant declining further treatment

M. Non-voluntary discharge may be necessary in cases of:

- \_\_\_\_\_ 1. Failure to comply with program policies
- \_\_\_\_\_ 2. Absenteeism
- \_\_\_\_\_ 3. Lack of demonstrable benefit from treatment

N. Non-voluntary discharge requires written documentation of prior and repeated counseling of the claimant, and immediate notification of the employer, insurer, case manager, and treating and attending (if different) provider.

O. Under all circumstances of voluntary and non-voluntary discharge, the claimant will return to the attending provider for release from the program.

P. The attending provider must sign a release to return to work when the program goals are achieved.

Q. The exit/discharge summary should delineate the person's:

- \_\_\_\_\_ 1. Present functional status and potential
- \_\_\_\_\_ 2. Functional status related to the targeted job, alternative occupations, or competitive labor market

R. For program evaluation, programs must provide insurers and referring providers with:

- \_\_\_\_\_ 1. Initial interdisciplinary team evaluation report
- \_\_\_\_\_ 2. Proposed treatment plan
- \_\_\_\_\_ 3. Progress reports at weekly intervals
- \_\_\_\_\_ 4. The opportunity to attend team meetings
- \_\_\_\_\_ 5. Final discharge summary report

S. Fees for work hardening programs will be paid in accordance with the Fee Schedule, with written prior approval by the payer, utilizing the following guidelines:

- \_\_\_\_\_ 1. In all cases, for both voluntary and non-voluntary discharge, payment is for the actual duration of treatment provided.
- \_\_\_\_\_ 2. Non-multi disciplinary work conditioning programs will be reimbursed utilizing existing physical therapy, occupational therapy, and physical medicine codes. CPT code 97545 (initial two hours) and code 97546 (each additional hour) are to be used to bill work hardening. CPT code 97545 is to be billed for the initial two hours of the work hardening program. This is a one-time charge. CPT code 97546 is to be used for billing each additional hour of the work hardening program after the initial two hours (indicated by code 97545).

#### **IV. Functional Capacity Evaluations**

A. The functional capacity evaluation (FCE) is utilized for the following purposes:

- \_\_\_\_\_ 1. To determine the highest level of safe functionality and of maximal medical improvement.

- \_\_\_\_\_2. To provide a pre-vocational baseline of functional capabilities to assist in the vocational rehabilitation process.
- \_\_\_\_\_3. To objectively set restrictions and guidelines for return to work.
- \_\_\_\_\_4. To determine whether specific job tasks can be safely performed by modification of technique, equipment, or by further training.
- \_\_\_\_\_5. To determine whether additional treatment or referral to a work hardening program is indicated.
- \_\_\_\_\_6. To assess outcome at the conclusion of a work hardening program.

## **B. General Requirements**

- \_\_\_\_\_1. The FCE may be prescribed only by a licensed physician, or may be required by the payer when indicated.
- \_\_\_\_\_2. The FCE requires prior authorization by the payer.
- \_\_\_\_\_3. The FCE should be billed using ~~state-specific code Q0111~~ [code 97750](#) Functional capacity evaluation.

## **V. TENS Units**

- A. TENS (transcutaneous electrical nerve stimulation) must be provided under the attending or treating physician's prescription.
- B. Authorization from the payer must be sought before purchase or rental arrangements are made for a TENS unit. The payer has sole right of selection of vendors for rental or purchase of equipment, supplies, etc.

## **VI. Supplies, Equipment, Orthotics, and Prosthetics**

- A. Physicians and therapists must obtain authorization from the payer before purchase/rental of supplies, equipment, orthotics, and prosthetics costing more than fifty dollars (\$50.00) per item for workers' compensation patients. When submitting bills, include the appropriate HCPCS [Level II](#) code. Or, if there is not an appropriate HCPCS code, use CPT code 99070.
- B. The payer has sole right of selection of vendors.

## **VII. Other Instructions**

- A. Charges will not be reimbursed for publications, books, or videocassettes unless prior approval of the payer is obtained.
- B. All charges for services must be clearly itemized by CPT code, and the state professional license number must be on the bill.

- C. The treating physician must approve and sign all physical capability/restriction forms for the work-related injury/illness. This form must be submitted to the payer within fourteen (14) working days of the release to work.
- D. Documentation may be required by the payer to substantiate the necessity for treatment rendered. Documentation to substantiate charges and reports of tests and measurements are included in the fee for the service and do not warrant additional reimbursement.
- E. When patients do not show measurable progress, the payer may request the physician discontinue the treatment or provide documentation to substantiate medical necessity.
- F. CPT code 97110 is to be used for each first fifteen (15) minutes of exercise therapy. The total reimbursement for code 97110 is limited to two (2) fifteen (15) minute charges in one day.
- G. When physical medicine therapies are provided to more than one body area, modifier 51 must be added to the procedure code or codes billed for the additional body area and will be reimbursed according to the multiple procedure rule.
- H. Non-surgical debridement should be billed as CPT code ~~97601~~ [97597](#) or 97602.

## VIII. Back Schools

All back school programs shall require prior authorization from the payer. The payer and the back school program may agree upon the daily, weekly, or other time-based payment to be made for services provided to the injured/ill worker. This agreement shall supersede the use of this physical medicine section when calculating reimbursement, but it shall not exceed the usual and customary fee.

### IX. Chronic Pain Program

~~*Interdisciplinary Chronic Pain Program is a highly structured, goal-oriented, individualized treatment program. These programs are interdisciplinary in nature with a capacity for addressing the functional, physical, and emotional/behavioral health needs of the person served. An interdisciplinary team must be incorporated to include a physical therapist, occupational therapist, psychologist, and dietary education. The program must have oversight supervision by a physician. Reimbursement is based on an hourly charge and should be billed using code Q0105.*~~

## IX. Massage Therapy

Massage therapy requires prior authorization of the payer before treatment can be rendered. Medical necessity must be established prior to approval. Reimbursement must be arranged between the payer and provider.

## X. Chiropractic Manipulative Treatment

Codes 98940 through 98943 are used to code chiropractic manipulative treatment. Like any other service, a spinal manipulation includes pre-evaluation and post-evaluation that would make it inappropriate to bill with an E/M service. However, if the patient's condition has deteriorated or

an injury to another site has occurred, reimbursement can be made for an E/M service if documentation substantiates the additional service. Modifier 25 is added to an E/M service when a significant, separately identifiable E/M service is provided and documented as medically necessary.

## **Dental Rules**

A. Dental codes (D0120–D9999), also referred to as D-codes, are a separate category of HCPCS Level II national codes that contain the complete *Current Dental Terminology (CDT)* code set, which is developed, maintained, and copyrighted by the American Dental Association (ADA).

B. CDT is updated every two years. The current edition is *CDT 2007/2008*, which is the edition that has been used in this Fee Schedule.

C. Decisions regarding the modification, deletion, or addition of CDT codes are made by the ADA and not the national panel responsible for the administration of HCPCS. The Department of Health and Human Services has an agreement with the ADA to include *CDT 2007/2008* as a set of HCPCS Level II codes used to report dental services.

## **RULES FOR DURABLE MEDICAL EQUIPMENT (DME), ORTHOTICS, PROSTHETICS AND OTHER HCPCS CODES**

### **I. DEFINITION**

HCPCS is an acronym for CMS's Healthcare Common Procedural Coding System. *It is divided into two subsets. HCPCS Level I codes are CPT codes developed and maintained by the AMA. HCPCS Level II codes, with the exception of the dental codes (D0120-D9999), are developed and maintained by CMS and include codes for procedures, equipment, and supplies not found in the CPT book. This section of the fee schedule contains HCPCS Level II codes. (See the Dental section for D codes.) HCPCS Level II codes that are excluded from the Fee Schedule are Physician Voluntary Reporting Program Codes (G8006-G9139), Alcohol/Drug Abuse Treatment Services (H0001-H2037), National Codes for State Medicaid Agencies (T1000-T5999). These three sections are not included because there is no fee associated with the code (G8006-G9139) or the code was created for State Medicaid agencies (H0001-H2037, T1000-T5999) and no fee data is available. Code categories included are as follows:*

<u>Transportation Services Including Ambulance</u>	<u>A0021 – A0999</u>
<u>Medical/Surgical Supplies</u>	<u>A4206 –</u>
	<u>A8004</u>
<u>Administrative, Misc., and Investigational</u>	<u>A9150 –</u>
	<u>A9999</u>
<u>Enteral/Parenteral Therapy</u>	<u>B4034 –</u>
	<u>B9999</u>
<u>Outpatient PPS</u>	<u>C1300 –</u>
	<u>C9727</u>
<u>Durable Medical Equipment (DME)</u>	<u>E0100 –</u>
	<u>E8002</u>
<u>Procedures/Professional Services (Temporary)</u>	<u>G0008 – G3001</u>
<u>Physicians Voluntary Reporting Program Codes</u>	<u>G8006 – G9139</u>
<u>Alcohol/Drug Abuse Treatment Services</u>	<u>H0001 –</u>
	<u>H2037</u>
<u>Drugs and Biologicals</u>	<u>J0120 – J9999</u>
<u>K Codes (Temporary)</u>	<u>K0001 –</u>
	<u>K0899</u>
<u>Orthotic Procedures</u>	<u>L0112 –</u>
	<u>L4398</u>
<u>Prosthetic Procedures</u>	<u>L5000 –</u>
	<u>L9900</u>
<u>Medical Services</u>	<u>M0064 –</u>
	<u>M0301</u>
<u>Pathology and Laboratory Services</u>	<u>P2028– P9615</u>

<u>Q Codes (Temporary)</u>	<u>Q0035 –</u>
	<u>Q9964</u>
<u>Diagnostic Radiology Services</u>	<u>R0070 –</u>
	<u>R0076</u>
<u>Temporary National Codes (Non-Medicare)</u>	<u>S0012– S9999</u>
	<u>National Codes for State Medicaid Agencies – T1000–T5999</u>
<u>Vision Services</u>	<u>V2100 V2020–</u>
	<u>V2799</u>
<u>Hearing Services</u>	<u>V5000V5008 –</u>
	<u>V5364</u>

~~for DME and supplies that are most commonly associated with workers' compensation bills. The codes listed are not a complete listing of HCPCS codes.~~

## **II. Guidelines**

### **A. Transportation Services Including Ambulance (A0021-A0999)**

1. Transportation service codes include ground and air ambulance, nonemergency transportation (taxi, bus, automobile, wheelchair van), and ancillary transportation-related fees.

2. Modifiers are required when reporting transportation services. Modifiers are single digits used to identify origin and destination. The first modifier identifies the transport place of origin and the second modifier the destination. Origin and destination modifiers are as follows:

<u>D</u>	<u>Diagnostic or therapeutic site other than those identified in “P” or “H”</u>
<u>E</u>	<u>Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility)</u>
<u>G</u>	<u>Hospital-based dialysis facility (hospital or hospital-related)</u>
<u>H</u>	<u>Hospital</u>
<u>I</u>	<u>Site of transfer (for example, airport or helicopter pad) between types of ambulance</u>
<u>J</u>	<u>Non-hospital-based dialysis facility</u>
<u>N</u>	<u>Skilled nursing facility (SNF)</u>
<u>P</u>	<u>Physician’s office (includes HMO non-hospital facility, clinic, etc.)</u>
<u>R</u>	<u>Residence</u>
<u>S</u>	<u>Scene of accident or acute event</u>
<u>X</u>	<u>Intermediate stop at physician’s office enroute to the hospital (includes HMO non-hospital facility, clinic, etc.)</u>

3. Transportation codes can also be found in the S- codes and T-codes. See S0207, S0208, S0209, and S0215, and T2001-T2007.

### **B. Medical and Surgical Supplies (A4206-A8004)**

1. A wide variety of medical, surgical, and some DME related supplies and services are represented in this section.

2. For rules related to DME supplies, accessories, maintenance, and repair, see G. Durable Medical Equipment below.

### **C. Administrative, Miscellaneous, and Investigational (A9150-A9999)**

1. These codes cover nonprescription drugs, exercise equipment, radiopharmaceutical diagnostic imaging agents, as well as other miscellaneous supplies.

### **D. Enteral and Parenteral Therapy (B4034-B9999)**

1. This section covers enteral formulae, enteral medical supplies, parenteral nutrition solutions and supplies, and enteral and parenteral pumps.

### **E. Outpatient PPS (C1300-C9727)**

1. These codes report drugs, biologicals, and devices used by hospitals.

2. These codes are only used for facility (technical) services.

### **F. Dental (D0120-D9999)**

1. D codes are a separate category of HCPCS Level II national codes that contain the complete Current Dental Terminology (CDT) code set, which is developed, maintained, and copyrighted by the American Dental Association (ADA).

2. CDT is updated every two years. The current edition is CDT 2007/2008.

3. Decisions regarding the modification, deletion, or addition of CDT codes are made by the ADA and not the national panel responsible for the administration of HCPCS. The Department of Health and Human Services has an agreement with the ADA to include CDT 2007/2008 as a set of HCPCS Level II codes used to report dental services.

### **G. Durable Medical Equipment (DME) (E0100-E8002)**

1. All durable medical equipment shall have prior authorization from the payer before obtaining the equipment. The payer has the choice of vendor for purchase or rental of DME.

2. If an injured/ill employee is receiving DME items for both compensable and non-compensable medical conditions, only those items that apply to the work related injury should be listed on claims and invoices submitted to the employer.

3. If the rental price for DME exceeds or equals the total purchase price, the employer shall purchase instead of renting equipment. The vendor shall make the payer aware of the price options.

\_\_\_\_\_ 4. The return of rented equipment is the dual responsibility of the injured worker and the DME supplier. The employer is not responsible for additional rental periods solely due to delay in equipment return.

~~5. Items listed in the DME section of the fee schedule are reimbursed at the lesser of:~~

~~✗ The provider's usual charge, or~~

~~✗ The maximum reimbursement allowance according to the fee schedule~~

~~6. Items not listed in the fee schedule are reimbursed at usual and customary rates for the geographical area.~~

~~7. If a payer has a contractual agreement with a vendor that reduces the cost of DME for workers' compensation claims, the payer may choose to reimburse according to the contractual agreement and not according to the fee schedule. However, a payer must choose the reimbursement method (contractual or fee schedule) and use one or the other.~~

#### H. Procedures/Professional Services (Temporary) (G0008-G3001)

1. G codes identify professional health care procedures and services that would otherwise be reported using CPT codes.

2. Procedures and professional services identified by G codes may have a corresponding CPT code. When both a G code and CPT code describe the same procedure, the CPT code is required for reporting purposes.

3. G codes also include procedures and professional services that do not currently have a valid CPT code. In such cases, the applicable G code should be used for reporting purposes.

#### I. Drugs and Biologicals (J0120-J9999)

1. These codes report drugs and biologicals that cannot be self administered and are typically administered by injection, infusion, or inhalation. Exceptions include oral immunosuppressive and oral chemotherapy drugs.

2. These codes report only the costs associated with provision of the drug. Administration including injection, infusion, or inhalation is reported separately using the applicable CPT code(s).

3. For oral anti-emetic drugs provided in conjunction with chemotherapy treatment, see Q0163-Q0181.

4. Other Additional codes for drugs and biologicals may also be found in the Q-codes and S-codes.

#### **J. Temporary Codes (K0001-K0899)**

1. These codes are temporary codes used to report durable medical equipment that does not yet have a permanent national code.

2. For rules related to DME supplies, accessories, maintenance, and repair, see G. Durable Medical Equipment above.

#### **K. Orthotic Procedures and Devices (L0112-L4398) and Prosthetic Procedures (L5000-L9900)**

##### ~~B. Prosthetics, Orthotics, and Braces~~

1. The payer shall only pay for orthotics and prosthetics prescribed by the treating physician for a compensable injury/illness. Prior authorization must be obtained from the payer.

~~2. Orthotics, prosthetics, and braces must be billed with the appropriate HCPCS code. Reimbursement will be made according to the lesser of:~~

~~✖ The provider's usual charge~~

~~✖ Maximum reimbursement allowance of the fee schedule~~

~~3. For orthotics, prosthetics or braces not listed in the fee schedule, reimbursement will be made at the usual and customary rate for the geographical area when medical necessity is documented.~~

#### **L. Medical Services (M0064-M0301)**

1. These codes are used to report office services, cellular therapy, prolotherapy, intragastric hypothermia, IV Chelation therapy, and fabric wrapping of an abdominal aneurysm.

2. These codes are rarely reported and may not be reimbursed as they represent services for which the therapeutic efficacy has not been established, the procedure is considered experimental, or the procedure has been replaced with a more effective treatment modality.

#### **M. Pathology and Laboratory Services (P2028-P9615)**

1. Included in this section are codes for chemistry and toxicology tests, pathology screening tests, microbiology tests, blood, and blood products.

2. Blood and blood products codes report the supply of the blood or blood product only.

3. The administration of blood or blood product is reported separately.

4. Code 36430 for transfusion of blood or blood components is reported only once per encounter regardless of the number of units provided.

**N. Temporary Codes (Q0035-Q9964)**

1. These temporary codes were developed for reporting services and supplies that do not have a permanent national HCPCS code or CPT code. Included in this section are codes for

a. Oral anti-emetic drugs

b. Casting supplies

c. Splint supplies

d. Low osmolar contrast

e. High osmolar contrast

f. Other supplies/services

2. Cast supplies and splints should be reported with the appropriate code from Q4001-Q4051. These codes report the cost of the supply only

3. Cast supplies and splints are reported in addition to the CPT code for fracture management.

4. Cast supplies and splints are reported in addition to CPT codes for application of the cast or splint.

5. Refer to the CPT Guidelines ~~book guidelines~~ for rules related to reporting of fracture management and cast application of casts.

**O. Diagnostic Radiology Services (R0070-R0076)**

1. These codes are used for transportation of portable x-ray and/or EKG equipment.

2. Only a single reasonable transportation charge is allowed for each trip to a single location.

3. When more than one patient receives x-ray or EKG services at the same location, the allowable transport charge is divided among all patients.

**P. Temporary National Codes (Non-Medicare) (S0012-S9999)**

1. These codes were developed by the Blue Cross/Blue Shield Association (BCBSA) and the Health Insurance Association of America (HIAA) to report drugs, services, and supplies

for which there are no CPT or HCPCS Level II codes, but for which codes are needed by the private sector to implement policies, program, or claims processing.

2. See J-codes for reporting rules related to drugs and biologicals.

T. National Codes for State Medicaid Agencies (T1000-T5999)

1. These codes were developed for use by Medicaid state agencies to report services and supplies for which there are no CPT or HCPCS Level II codes but for which codes are needed to administer the Medicaid program.

### **Q. Vision, Hearing, and Speech-Language Pathology Services (V2020-V5364)**

1. Vision services includes codes for reporting vision-related supplies, including spectacles, lenses, contact lenses, prostheses, intraocular lenses, and miscellaneous lenses.

2. Hearing services includes codes for hearing tests and related supplies and equipment, speech-language pathology screenings, and repair of augmentative communicative systems.

### **III. Modifiers**

HCPCS Level II modifiers are required for some supplies and services. Commonly reported HCPCS Level II modifiers include:

AU Item furnished in conjunction with a urological, ostomy, or tracheostomy supply

AV Item furnished in conjunction with a prosthetic device, prosthetic, or orthotic

AW Item furnished in conjunction with a surgical dressing

KC Replacement of special power wheelchair interface

NU Purchased new equipment

RR Rental equipment (listed amount is the per-month allowance)

UE Purchased used equipment

# **Inpatient Hospital Payment Schedule and Rules**

## **I. Inpatient Reimbursement Methodology**

Inpatient hospital maximum reimbursement allowable (MRA) totals are provided by DRG in this schedule. As of the date of publication, the DRG maximum reimbursement allowable is based upon the 2007 CMS relative weights multiplied by a base rate of \$8,436.00. Any DRGs outside of this schedule will be reimbursed at seventy-five percent (75%) of charge. DRG MRAs represent payment in full, unless the outlier payment is applicable or a contract between a payer/provider is negotiated.

## **II. Implants, Durable Medical Equipment (DME), and Supplies**

Generally, durable medical equipment and supplies provided or administered in a hospital setting are not separately reimbursed since they are included in the payment reimbursement.

Implantables are included in the applicable DRG reimbursement for inpatient treatment, and, therefore, the provider of inpatient services is not required to furnish the payer with an invoice for implantables. For implantables used in the outpatient setting, reimbursement shall be made separately from the facility fee and all other charges; and the provider shall furnish a suitable invoice evidencing the cost of the implantable to the payer within sixty (60) days from the date of service the implantable is used. Upon receipt of this invoice, the payer shall pay the amount due within thirty (30) days thereafter.

Only the actual invoiced cost of the item(s), plus ten percent (10%), will be reimbursed. Tax, handling, and freight charges are included in the facilities invoiced cost and shall not be reimbursed separately.

## **III. Payment for Outliers**

Most DRG payments will be at the base rate times the DRG weight. However, to provide additional reimbursement where the Mississippi Workers' Compensation Commission deems the DRG payment inadequate to cover the costs incurred by the facility, the Commission has established an outlier payment for high-cost cases.

The outlier payment will be made according to the following calculation:

**Step 1:** Are Total Billed Charges  $\leq$  DRG Payment?

**If Yes:** Total Billed Charges = Total Payment

**If No:** Continue to Step 2

**Step 2:** Are Total Billed Charges  $>$  (2.5 x DRG Payment)?

**If No:** Outlier Payment Add-on = \$0.00 and Total Payment = DRG Payment

**If Yes:** Outlier Payment Add-on = (Total Billed Charges – (2.5 x DRG Payment) x 0.75

Continue to Step 3

**Step 3:** Total Payment = (DRG Payment) + (Outlier Payment Add-on)

Example for DRG 127:

	<u>Total Billed Charges</u>	<u>DRG Payment</u>	<u>Outlier Threshold Trigger</u>	<u>Outlier Payment Add-on</u>	<u>Total Payment</u>
<u>Example A</u>	<u>\$30,000</u>	<u>\$8,849.36</u>	<u>Yes</u>	<u>\$5,907.45</u>	<u>\$14,756.81</u>
<u>Example B</u>	<u>\$5,000</u>	<u>\$8,849.36</u>	<u>No</u>	<u>\$0.00</u>	<u>\$5,000.00</u>
<u>Example C</u>	<u>\$15,000</u>	<u>\$8,849.36</u>	<u>No</u>	<u>\$0.00</u>	<u>\$8,849.36</u>
<u>Example D</u>	<u>\$50,000</u>	<u>\$8,849.36</u>	<u>Yes</u>	<u>\$20,907.45</u>	<u>\$29,756.81</u>

**Example A Detail**

**Step 1:** Are Total Billed Charges ≤ DRG Payment?

Total Billed Charges = \$30,000

DRG Payment = \$8,849.36

**No: Continue to Step 2**

**Step 2:** Are Total Billed Charges > (2.5 DRG Payment)?

Total Billed Charges = \$30,000

2.5 x DRG Payment = \$22,123.40

Is \$30,000 > \$22,123.40?

**Yes**

Outlier Payment Add-on = Total Billed Charges – (2.5 x DRG Payment) x 0.75

Total Billed Charges = \$30,000

2.5 x DRG Payment = \$22,123.40

\$30,000 – \$22,123.40 x 0.75 = \$5,907.45

**Continue to Step 3**

**Step 3:** Total Payment = (DRG Payment) + (Outlier Payment Add-on)

DRG Payment = \$8,849.36

Outlier Payment Add-on = \$5,907.45

\$8,849.36 + \$5,907.45 = **\$14,756.81**

**A. Outliers for DRG 462, Rehabilitation.**

The percent of outlier payment for DRG 462 only will be ninety percent (90%) rather than the seventy-five percent (75%) listed above. Therefore, in Step 2 above, the calculation for DRG 462 would be:

Outlier Payment Add-on = Total Billed Charges – (2.5 x DRG Payment) x 0.90

**IV. DISPUTED MEDICAL CHARGES**

Merged file

Disputes over charges, fees, services or other issues related to treatment under the terms of the Workers' Compensation Law shall be resolved in accordance with the Dispute Resolution Rules set forth elsewhere in this Schedule.

## FORMS

### I. GUIDELINES

A. Reproduced on the following pages are the forms that should or may be used by providers when billing workers' compensation related services. Instructions are given below.

B. Bills for services rendered should be sent directly to the party responsible for reimbursement. Do not send bills directly to the Medical Cost Containment Division as this will delay payment.

C. The following forms should be used for provider reimbursement:

CMS-1500 (08/05) (Projected to be effective June 1, 2007 pending correction of printed format) Electronic equivalent 837p;

UB-~~9204~~ (effective May 23, 2007) Electronic equivalent 837i;

~~13-27-DJ400~~ 2006-Dental Form

D. The information to include on each form where appropriate is:

1. Claimant's full name and address as shown on the employer's record
2. Social security number should be entered in the field for insured's ID number; this cuts down on errors and helps correlate the billing to the appropriate file
3. Correct date of injury. Some claimants have multiple open files and can only be assigned by date
4. Proper name and address of the employer, not just an individual's name
5. Name of the insurance payer as registered with the state
6. Date the claimant's disability should begin per the attending physician
7. Attending physician's diagnoses and claimant's complaints
8. Disabilities the claimant has that are not related to this injury
9. Description of treatment plan, including any prescriptions
10. Indication if the injury/illness appears to be work related
11. Indication as to whether the claimant can be released to light or full duty work. Full duty is considered to be the work at the time of the accident.
12. Length of time the claimant should be off work as a result of the injury or illness
13. Date of the visit, the service(s) or procedure(s) performed, and charges
14. Physician's complete name and address
15. Physician and provider group national provider identifier (NPI) for billing group and treating physician
16. Physician's or group's federal tax identification number (tax identification number [TIN] or social security number)
16. Injury/illness as described by the claimant

E. The following pages have samples of the CMS-1500 (08/05), UB-9204, 2006 American Dental Association Dental Claim Form J400, Request for Resolution of Dispute, ~~Quarterly Report, Payer's Utilization Management Program~~, and Utilization Review Request Form. ~~The Quarterly Report Form is to be submitted to the Commission each quarter, and should be dated as follows:~~

~~Jan 1-March 31~~

~~April 1-June 30~~

~~July 1-Sept 30~~

~~Oct 1-Dec 31~~

## II. UTILIZATION REVIEW REQUEST FORM

The form entitled Mississippi Workers' Compensation Utilization Review is a communication tool for use between the provider and the utilization review company. The form can be faxed between the provider and payer as applicable.

The utilization review process is mandatory under the ~~Official~~ *Mississippi Workers' Compensation Medical Fee Schedule*; however, the use of the Utilization Review Request Form is optional. The use of the form is encouraged if it proves helpful in the timely processing of requests for utilization review of medical services.