PROVIDENCE
Health Plan

Payment and Coding Policy Alerts

September/October 2020

This is the September/October 2020 issue of the Providence Health Plans Payment and Coding Policy Alerts. The focus of this update is to communicate to providers new or revised payment policies and coding policies, as well as general billing and coding information.

PROVIDENCE Health Plan

GENERAL BILLING/CODING INFORMATION

Robotic Surgical Systems	Robotic-assisted surgery is the application of computer-assisted robotic devices to perform various surgical procedures. The use of this technique is considered integral to the performance of the procedure. As such, it is considered incidental to the professional services and is included in the payment for the surgical procedure. HCPCS code S2900 is used to report, "Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure)." This code has historically been denied based on PHP's medical policy for "Robotic Surgical Systems." The denial has been transferred to PHP Payment Policy 13.0 (Bundled or Adjunct Services), and HCPCS code S2900 is now listed on Payment Policy 13.0 as a bundled service. Bundled services are not payable, even if they are the only services provided on that day. Payment for these services is bundled into payment for other services, whether or not the other services are performed on the same day as the bundled service. Providers should not use an unlisted code or add Modifier 22 to the code for the surgery when performed with robotic assistance. PHP Payment Policy 10.0 (Modifier 22, Increased Procedural Services) states: "An increased allowance for surgical codes is NOT considered warranted for the use of robotic assisted surgery device."
Multiple Interpretations for Diagnostic Tests or Procedures	PHP will not pay for multiple interpretations of the same diagnostic test or procedure. For diagnostic tests or procedures with both a technical and a professional component, the professional component (Modifier 26) is the complete, official interpretation of the diagnostic test or procedure. The interpretation should be a separate written report containing all of the elements of the diagnostic study or procedure and a clinical interpretation of the results in accordance with standards established by the medical specialty for that particular service. PHP accepts only one official interpretation of any diagnostic study, and that is the complete report written by a specialist in the field. A preliminary review of the diagnostic test or procedure by the treating provider is considered part of other services rendered, such as the Evaluation and Management service or diagnostic procedure. Even if the study is not sent to a specialist for interpretation, the treating provider may not bill separately for an interpretation without a complete, written report similar to that which would be prepared by a specialist in the field.
Unbundling of Laboratory Panels	Multiple related tests can often be combined into testing panels that are requested with a single testing order, completed with a single biological specimen, and billed using a single code. Testing panels are typically less costly to complete than if each test were ordered and performed individually. Unbundling occurs when a laboratory bills separately for some or all tests analyzed as part of a panel. When no specific CPT or HCPCS code exists for the panel, the provider is required to bill using an unlisted code. It is not appropriate for the provider to bill any of the tests in a panel separately as if they were performed individually. This is a misrepresentation of services performed and is not appropriate based on either CPT or CMS guidelines. In a "Healthcare Fraud Prevention Partnership" white paper published in May, 2018, CMS identified unbundling of lab panels as an example of fraudulent billing.

Update to E&M Codes in 2021	The AMA and CMS are proposing major changes to Evaluation and Management (E&M) codes for office visits. These changes will take effect on January 1, 2021. PHP will follow CMS guidelines for use of these codes. A brief summary of the proposed changes includes: • CPT code 99201 will be deleted. There will be only four codes (99202-99205) for new patient office visits. • The level of E&M service billed may be determined by time alone OR by medical decision making. • Time used to support the level of service may be both face-to-face and non-face-to-face time. Because of this, CMS will no longer allow codes 99358/99359 (prolonged non-face-to-face services) to be billed with office visit E&M codes. • There will be a new code for prolonged services billed in 15-minute increments beyond the time for the base code, to be used only with the highest level of service in each category, i.e., 99205 or 99215. • CPT code 99211 will be used only when the health care professional's time is spent in supervision of clinical staff who perform the face-to-face services.

PHARMACY CODING POLICY UPDATE

Pharmacy Policy "Infusion Therapy Site of Care (SOC)" Updated 9/1/2020

Providence Health Plan (PHP) requires a prior authorization for site of care for certain infusion medications provided in an unapproved outpatient hospital infusion setting. This site of care prior authorization is in addition to the prior authorization for the medication, if required. Refer to individual drug specific policies for clinical criteria. Please be aware that approval for site of care is based on medical necessity for infusion services. It is not a determination of network benefits. Any applicable out of pocket expense for the member is determined by the design of the members Plan benefits.

Infusion medications included in this Infusion Therapy Site of Care policy are as follows:
Note: Additional medications will be added to the Infusion Therapy Site of Care policy over time.

HCPCS	BRAND NAME	GENERIC NAME
INFLAMMATORY CONDITIONS		
J3262	Actemra®	Tocilizumab
J0490	Benlysta®	Belimumab
J3380	Entyvio®	Vedolizumab
Q5103	Inflectra®	Infliximab-dyyb
J0129	Orencia®	Abatacept
J1745	Remicade®	Infliximab
Q5104	Renflexis®	Infliximab-abda
J1602	Simponi Aria®	Golimumab
Q5121	Avsola®	Infliximab-axxq
MULTIPLE SCLEROSIS		
J2350	Ocrevus®	Ocrelizumab

MISCELLANEOUS DISEASES		
J0584	Crysvita®	Burosumab-twza
J1300	Soliris®	Eculizumab
J1303	Ultomiris®	Ravulizumab-cwvz
ENZYME REPLACEMENT THERAPY		
J1786	Cerezyme®	Imiglucerase
J3060	Elelyso®	Taliglucerase alfa
J2840	Kanuma®	Sebelipase alfa
J1458	Naglazyme®	Galsulfase
J3385	VPRIV®	Velaglucerase alfa
INTRAVENOUS IMMUNE GLOBULIN		
J1566	Carimume® NF, Gammagard® S/D	
J1555	Cuvitru®	
J1572	Flebogamma®, Flebogamma® DIF	
J1569	Gammagard®	
J1561	Gammaked®, Gamunex-C®	
J1557	Gammaplex®	
J1559	Hizentra®	
J1568	Octagam®	
J1459	Privigen®	
J1558	Xembify®	

A prior authorization for site of care will not be required when these medications are administered in an approved site of care. Approved Sites of Care include:

- Home Infusion (POS 12)
- Ambulatory Infusion Centers (POS 49)
- Physician Offices and Clinics (POS 11)
- Certain approved outpatient hospital facilities

Transition Period:

- For Members with existing prior-authorizations for one of the drugs above at an unapproved outpatient hospital facility, providers will have 60 days to coordinate transition of patient infusions at an approved site of care location or request a prior authorization for site of care.

	• For all new starts at an unapproved outpatient hospital facility, a 60-day transition period will be allowed to coordinate patient transfers to an approved Site of Care request a prior authorization for site of care, or administer an initial dose of an infusion medication in a hospital infusion setting. Infusion medications will be covered at the unapproved outpatient hospital facility during the transition period. Who is excluded from the Infusion Therapy Site of Care policy? • Providence Medicare and Medicaid members • Certain Commercial Plan members (ALL Providence St. Joseph Healthcare employer group) • Members 12 years of age and under A Site of Care prior authorization is required for the use of an unapproved hospital-based outpatient infusion center. An unapproved hospital-based outpatient infusion center may be considered medically necessary if the patient has concomitant conditions or clinical history that may increase the risk of infusion reactions or drug specific adverse events. Please see the Infusion Therapy Site of Care policy for a complete list of criteria. • Submit PA requests through ProvLink https://phpprovider.providence.org/portal/ • The full policy can be found in ProvLink. Search the Literature Rack for "Infusion Therapy Site of Care."