PROVIDER *Update*

CalViva HEALTH

Health Net COMMUNITY SOLUTIONS

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Implementation of New Payment Integrity Policies

In order to improve affordability for our members and to encourage appropriate utilization of resources and the highest quality of treatment, Health Net Community Solutions, Inc. (Health Net), on behalf of CalViva Health, is implementing four new policies, effective June 19, 2018. These policies follow the Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) guidelines and will impact providers who are coding outside of fair and appropriate use.

These policies outline acceptable billing practices and reimbursement methodologies for certain procedures and services, and are developed based on medical literature and research, and industry standards and guidelines as published and defined by the American Medical Association's CPT,® CMS, and public domain specialty society guidance, unless specifically addressed in the Medi-Cal fee-for-service provider manual published by California. The information included in these policies will help providers bill claims accurately, therefore reducing unnecessary denials and delays in claims processing and payments. These policies include information on:

- Coding inaccuracies
- Diagnosis to procedure code mismatch
- Inappropriately modified procedures
- Unbundling of services
- Incidental procedures
- Duplication of services
- Medical necessity requirements
- Health plan-specific payment rules for procedures and services

The table on page 2 includes a list of the new policies, including the policy number, policy title, impacted line of business, and a brief description.

APPLICATION OF CLAIMS POLICIES

These policies will be applied as medical claims reimbursement edits within the claims adjudication system, in addition to all other reimbursement processes currently employed.

These policies can be accessed via the provider operations manual online through the provider website at provider.healthnet.com under *Working with Health Net > Contractual > Policy Library > Go to the Provider Library*. Once in the Provider Library, go to *Operations Manuals > Claims Coding Policies* or search using keywords.

ADDITIONAL INFORMATION

THIS UPDATE APPLIES TO MEDI-CAL PROVIDERS:

- Physicians
- Participating Physician Groups
- Hospitals
- Ancillary Providers

PROVIDER SERVICES

1-888-893-1569
www.healthnet.com

Relevant sections of the provider operations manuals will be revised to reflect the information contained in this update as applicable.

If you have questions regarding the information contained in this update, contact CalViva Health at 1-888-893-1569.

PAYMENT INTEGRITY POLICIES

Policy Number	Policy Name	Line of Business	Description
CC.PP.053	Non-Emergent Emergency Room Services	Medi-Cal	The purpose of this policy is to define payment criteria for non-emergent emergency room services. When a hospital, free-standing emergency center or physician bills a level 4 (99284) or level 5 (99285) emergency room service with a non-emergent diagnosis, the provider will be reimbursed at a level 3 (99283) contracted reimbursement rate.
CC.PP.054	Physician's Consultation Services	Medi-Cal	The purpose of this policy is to define payment criteria for consultation services. The provider will be reimbursed consultation codes at the corresponding evaluation and management (E&M) visit level. The provider should bill the E&M code (other than the consultation code) that describes the service provided. The health plan will identify consultation codes 99241-99255 and crosswalk them to the more appropriate level of office visit, established patient or subsequent hospital care procedure code (see actual policy for codes). The provider will be paid according to the fee schedule for the equivalent procedure code.
CC.PP.057	Problem-Oriented Visits with Preventative Visits	Medi-Cal	The purpose of this policy is to define payment criteria for problem-oriented visits when billed with preventative visits. Under modifier -25 correct coding principles, a patient may be seen by the physician for both a preventative E&M service and a problem-oriented E&M service during the same patient encounter. Providers do not incur duplicate indirect expenses with the original E&M (preventative service) when there is a problem-oriented visit on the same date of service. For example, obtaining vital signs, scheduling the visits, staffing, lighting, and supplying the examination room costs are not incurred twice by the provider. The health plan will reimburse the preventative medicine code plus 50 percent of the problem-oriented E&M code.
CC.PP.052	Problem-Oriented Visits with Surgical Procedures	Medi-Cal	The purpose of this policy is to define payment criteria for problem-oriented visits when billed on the same day as a surgical procedure. Under modifier -25 correct coding principles, a patient may be seen by the physician for a problem-oriented E&M service on the same day of a procedure with a 0-, 10- or 90-day global surgical period. Providers do not incur duplicate indirect expenses with the problem-oriented E&M service when there is a surgical procedure on the same date of service. For example, obtaining vital signs, scheduling the visits, staffing, lighting, and supplying the examination room costs are not incurred twice by the provider. The health plan will reimburse the surgical procedure plus 50 percent of the problem-oriented E&M code.