

1 Claims, Billing & Reimbursement

CLAMS SUBMISSIONS

To facilitate claims processing, all claims must

- be submitted within 180 calendar days of the date of service (Empire will not process or pay claims submitted beyond this time frame).
- include the member's name, ID number and plan prefix (exactly as it appears on the ID card).
- include the member's relation code (for HMO and POS). (This information can be found on the member's ID card. Please refer to Chapter 2 for a Sample ID card.)
- include the member's date of birth.
- include the physician's or practitioner's name and provider number for the plan.
- include the physician's or practitioner's tax ID number.

All physicians or practitioners who participate in an Empire network have a provider number issued by Empire. Providers are only issued one number per tax identification number regardless of the number of Empire plans or networks in which they participate. Remember, it is important to include the provider number on all claims.

Coding Claims

Correct coding of claims expedites processing and speeds payment for services. When submitting claims or referral forms, it is important to use the most up-to-date ICD-9-CM and CPT codes.

When completing field 23 of the HCFA-1500 claim form, if more than one diagnosis is appropriate, list all the diagnoses that affect the treatment received. PCPs cannot bill for consultations.

Physicians may verify benefits by calling Empire Physician Services at 1-800-552-6630, Monday – Friday, 8:30 a.m. to 5:00 p.m. EST or by logging in to Physician Online Services at www.empireblue.com. For managed care or indemnity, call 1-800-343-7283. ID cards vary in appearance depending on the plan and employer.

Physicians should keep a photocopy of the member's ID card (front and back) on file and ask the member if coverage has changed upon each visit. Please refer to Chapter 2 of this Sourcebook for a Sample ID Card.

CO-PAYMENTS AND OTHER COST-SHARING

Members are responsible for the co-payment amount indicated on their ID cards. Co-payments apply to home and office visits but do not apply to in-network Well-Child Care visits, maternity care, laboratory tests or X-rays. There may be exceptions depending on the member's contract.

Co-payments may be collected at the time of the patient's visit. Coinsurance and deductibles should be collected from members after you receive the explanation of benefits (EOB).

COORDINATION OF BENEFITS

When a member is covered by more than one insurance plan, health insurers coordinate benefits by determining who is the primary and secondary carrier. This prevents duplicate payments and overpayments.

General Guidelines:

- If a member holds a contract for a group insurance plan and is listed as a dependent on another insurance plan, the plan for which the member is a

contract holder is primary.

- For covered dependent children, the plan of the parent whose birthday falls earlier in the year is primary (Birthday Rule). Only the month and day are considered when determining whose birthday falls earlier.
- For covered dependent children with separated or divorced parents, if a court has established which parent is responsible for the child's healthcare expenses, that parent's plan is primary. When financial responsibility has not been established, the plan covering the parent with legal custody is primary.
- A group that does not have a coordination of benefits provision will be primary over one that does.
- If a member holds two or more group insurance plans, the policy that considers the member an active employee is primary. If both of the member's policies are active, the policy that has been active longer or longest is primary.
- If a member is covered by a group insurance plan through TEFRA or DEFRA, this group insurance plan is primary over Medicare.

Empire, as the primary carrier, pays the full benefits under a member's contract and providers are reimbursed as described below. If Empire coverage is secondary, providers must first submit claims to the primary carrier. When providers receive the other plan's EOBs, they should submit claims with the EOBs to Empire. Empire's benefits are reduced by the amount paid or provided by the primary plan for the same service.* Empire's payment can match but not exceed the amount which would have been paid if Empire had been primary.

* This may not apply to some special accounts.

Attach the referral form or include the authorization number found in the upper right-hand corner of the form. Failure to do this will result in delayed payment when the service cannot be matched with the referral from the Primary Care Physician. If Empire does not have a referral form on file, the claim may be denied for HMO members and processed as an out-of-network benefit for POS members.

ELECTRONIC CLAIMS SUBMISSION

The benefits of Electronic Claims Submission:

- Faster Payment
- Cleaner claims
- Reduce administrative cost
- Faster notification of rejected claims

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) was enacted in 1996. The "Administrative Simplification" provisions of HIPAA require that certain types of transactions among healthcare entities be conducted in a standard format when they are conducted electronically. These transactions include:

- Submitting claims
- Receiving remittance advice statements
- Querying patient eligibility
- Checking claims status
- Requesting prior authorization where required

When the HIPAA standards are fully implemented, Medicare contractors and other healthcare payers will be prohibited from issuing or accepting electronic transactions that do not meet the new standards. Ultimately, it is hoped that physicians can benefit from the standardization of electronic transactions, as it will enable many billing, clinical, and financial applications to be accomplished in a faster and more cost-effective way. Our electronic connectivity systems, policies, procedures, and supporting business processes meet the HIPAA compliance standards.

Healthcare providers and suppliers who conduct business electronically with Empire are urged to complete quickly all steps they may need to take to upgrade their software or service to conform to the new standards. While Empire is continuing to accept non-compliant transactions (as of December 2004), under a contingency plan, we will, at some currently unspecified date, no longer be able to accept such non-compliant transactions. (Transactions through Empire's Physician Online Services are fully compliant.)

For questions about your electronic connectivity, please contact your current software vendor or call Empire's Electronic Services Customer Support line at 1-866-889-7322, 8:30 a.m. – 4:30 p.m. EST, Monday – Friday.

WEB-BASED CLAIMS SUBMISSION

Physician Online Services

Empire's Physician Online Services is a secure website designed to help physicians with plan administration. Through Physician Online Services, you can create and submit a claim to Empire and also check a claim's status in real time. This is the fastest and easiest way to submit HIPAA-compliant claims.

Personal Computer (PC) Application

PC-ACE Pro32 and E-link

Physicians register with Empire to send their electronic claims directly to us using PC-ACE.

PC-ACE Pro32 in conjunction with e-link helps you to create HIPAA-compliant claims and then submit them to Empire.

PC-ACE Pro32 is a Windows-based system that creates batch claims into HIPAA-compliant formats to enable them to be submitted to Empire. PC-ACE Pro32 is used to create HIPAA-compliant professional (Blue Shield) as well as Medicare Part B electronic claims for **medical providers only**.

Claims can be entered into PC-ACE Pro32 in one of two ways:

- You can manually enter your claims into PC-ACE Pro32, or if your claims are created by another software other than PC-ACE that your practice uses, you can import these claims into PC-ACE Pro32.
- Empire e-link is an application that enables you to then transfer HIPAA-compliant claims files securely to Empire for processing. In addition to facilitating claims submissions, e-link also enables you to download reports about the status of your claims and enables you to receive remittances. Empire and AT&T have worked with our business partner IVANS to establish this network application. Over 10,000 healthcare providers and facilities rely on this secure, high-speed tool to submit claims to Empire.

SUBMITTING CLAIMS THROUGH VENDORS

Practice Management System Vendors (PMMS) — Physicians purchase software that automates their office workflow, including claim creation and collection; enables electronic submission of claims to payers. May work in conjunction with a clearinghouse. Examples of PMMS are IDX and Misys.

Clearing Houses — Physicians may contract with a clearinghouse to send their claims electronically (from Practice Management System) in the specific formats for each of their payers. Examples of clearinghouses are WebMD, Envoy, McKesson, and ProxyMed.

Billing Services/Service Bureau — Physicians may contract with a billing service for claims management. These third-party organizations have agreements with Empire to submit claims electronically on behalf of a physician.

Examples of Billing Services are e.g. WebMD, Envoy, Accordis and McKesson.

To obtain a list of Practice Management Systems, Clearinghouses or Billing Services go to www.empiremedicare.com.

Registration for Electronic Claims Submission

Providers are required to enroll before submitting electronically. Forms can be found at Empire's website www.empireblue.com.

UNDERSTANDING YOUR ELECTRONIC CLAIMS REPORTS

The reports you receive from Empire, your billing service and/or your clearinghouse are important for maintaining control over your claims transmissions. These reports provide valuable information about your transmission as well as status of which claims were accepted, and or rejected. Empire provides the EMC Receipt Report to the submitter of the electronic transmission.

If you have contracted with a third party e.g., a Billing Service or Clearinghouse to submit your claims, you will not receive an EMC Receipt Report from Empire. Your Billing Service or Clearinghouse should provide you with reports that will allow you to track the claims they have submitted. Please take the time to familiarize yourself with those reports to alleviate any potential delay with your claims process.

Any claim rejected by Empire is not considered a clean claim and thus is not considered submitted within 180 days timely filing.

The EMC Receipt Report

There are five levels of validation performed in the EMC front-end system. The EMC Receipt Report will provide the status of each level described below:

Level 1 ISA Edits

Level 2 X12 997 Functional Acknowledgment (Standard Syntax)

Level 3 GS Edits

Level 4 Implementation Guide (IG) Edits

Level 5 Empire Business Edits

Bulletins explaining these reports can be found at Empire's website, www.empireblue.com.

For additional information on electronic claim submis-

sion or technical support, please call Empire’s Electronic Services Customer Support Line at 1-866-889-7322, 8:30 a.m. – 5:00 p.m. EST, Monday – Friday.

PAPER CLAIMS

Effective October 1, 1998, paper claims will be accepted only when the HCFA-1500 claim form is used.

After this date, Empire will no longer accept claims submitted in any other paper format. Superbills will not be accepted, even if they are attached to incomplete HCFA-1500 claim forms.

Please note, if paper claims are submitted to Empire in any format other than the HCFA-1500 form, they will be returned to you for resubmission.

A sample of the HCFA-1500 form is enclosed in Chapter 13: Sample Forms of this Sourcebook. Additional HCFA-1500 claim forms may be ordered through your medical supply vendor.

Paper Claims must be submitted on a HCFA-1550 claim form.

Note: Empire will accept original claim forms only. Copies will not be processed. Paper claims should be sent to the appropriate locations as follows:

Plan	Prefix	Address
Direct HMO	YLN*, YLP	Empire BlueCross BlueShield
HMO		PO Box 1407
POS		Church Street Station
Child Health Plus SM		New York, NY 10008-1407
Healthy New York		
EPO	YLB*	Empire BlueCross BlueShield
PPO	YLD	PO Box 1407
	YLE	Church Street Station
	Or unique prefix	New York, NY 10008-1407

* Some accounts may have a unique prefix, which should be included on claims. Please refer to the Dedicated Service Centers Directory in Chapter 1 of this Sourcebook.

REIMBURSEMENT

In-Network Reimbursement

Claims are reimbursed according to the following schedules:

Physician	Fee Schedule/Rates	Member
HMO*	HMO rates	HMO and EPO
HMO	PPO rates	PPO
HMO	IPN rates	IPN
PPO†	\$0	HMO (nonparticipating)
PPO	PPO rates	EPO
PPO	PPO rates	PPO
PPO	IPN rates	IPN

Please note: Physicians will be paid at the lesser of practitioner’s actual charges if the amount set forth is lower than the appropriate Fee Schedule.

* HMO physicians and practitioners serve the following members:

- Direct HMO
- HMO
- Direct POS
- DirectShare POS
- Senior Plan**
- Network One
- Direct Pay HMO
- Direct Pay HMO/POS
- Healthy New York
- Child Health Plus
- PPO
- EPO
- BlueCard® PPO
- Indemnity

** If the provider has an affiliation with a contracted Senior Plan Direct hospital (when specialty requires admitting privileges) and the provider signs the Senior Plan Direct agreement.

† PPO/EPO physicians and practitioners serve the following members:

- PPO
- EPO
- BlueCard PPO
- Indemnity

Out-of-Network Reimbursement

Out-of-Network services are subject to deductibles and coinsurance. Qualifying out-of-network services are reimbursed at 60% – 90% of the Empire allowed amount depending on the member’s particular plan.

CLAIMS REIMBURSEMENT POLICIES FOR COMMON SERVICES

Anesthesia in the Office

When medically appropriate, Empire will reimburse an anesthesiologist for monitored anesthesia in the office setting when the applicable HCPCS modifiers (G8, G9, QS) are reported. The anesthesiologist may request that the member agree to and sign a waiver of balance billing restrictions for monitoring services denied as not medically appropriate.

Empire considers conscious sedation (CPT 99141-99142) to be incidental to the procedure when reported by the operating surgeon and separate reimbursement is not available.

Empire considers the administration of general anesthesia in the office setting to be not appropriate and reimbursement is not available.

Assistant Surgeon

Reimbursement for assistant surgeon services is generally provided at 20 percent of the allowed amount of the surgical procedure. Benefits are available for one assistant surgeon per inpatient operative session when the hospital does not employ a house staff of surgeons/surgical residents. The complexity of the surgical procedure will determine if the assistant surgeon services are appropriate and covered. Empire generally follows the CMS list of allowed assistant surgeon procedures.

Registered Nurse First Assistants (RNFA) and Certified Surgical Assistants (CSA) are recognized providers and reimbursement is made at one-half of the assistant surgeon’s rate, generally 10 percent of the allowed amount for the surgical procedure. A procedure code with the Health Care Common Procedure Coding System (HCPCS) Level II modifier AS must be used for accurate reimbursement of the RNFA and CSA serving as the surgical assistant.

Bilateral Procedures

Empire has adopted the CMS reimbursement for bilateral procedures. When the procedure is classi-

fied as “unilateral or bilateral,” the use of modifiers 50, LT/RT is inappropriate. Reimbursement will be made at 100 percent of the allowed amount one time. When the procedure is classified as “unilateral” and physiology permits the service to be performed bilaterally, the use of modifiers 50, LT/RT is appropriate and reimbursement will be made at the full allowed amount plus one-half of the allowed amount.

Consultation

Coverage of consultation services may be limited by the member’s contract.

Separate reimbursement for consultation services will be made when reported with a diagnostic procedure. When the consultation is reported with a definitive therapeutic surgical procedure and modifiers 25 or 57 are not reported, reimbursement will be limited to the surgical procedure only. Once treatment is rendered, the consultation will be considered to be a medical visit (E&M). The consultation will be allowed separately when modifier 25 or 57 is reported. Claims reporting “pre-op clearance” will be considered to be medical care and not a consultation. Reimbursement for “consultation” by a PCP is not available for his/her own patients because the PCP is already responsible for the care of his/her own patients and such services are really “evaluations” rather than “consultations.” Subsequent consultations for the same patient by the same physician will be considered to be medical care because the consultant has assumed the responsibility for the care of the patient. Telephone consultations are not a covered service.

Cosmetic and Reconstructive Surgery

Cosmetic surgery is not a covered service because it is performed to reshape the structure of the body in order to alter the appearance or to alter the manifestation of the aging process. Reconstructive surgery is covered when it is performed to improve or restore bodily function or to correct a functional defect resulting from disease, trauma, or congenital or developmental anomalies. When surgery is done for both cosmetic and reconstructive purposes, the allowed amount will be prorated based on the percentage of the surgery that was reconstructive in nature. However, breast reconstruction following mastectomy for cancer is not considered cosmetic. This includes surgery on the contralateral breast for symmetry.

Empire has identified, based on a review of claims and records, diagnoses that will be regarded as cosmetic and

denied when they are removed or ablated, which includes epidermal inclusion or pilar cyst, fibroma, keloid scar, lipoma, papilloma, seborrheic keratosis and skin tags.

The physician may appeal such denials by demonstrating the medical necessity for the removal of the lesion, including pruritis, infection, bleeding, inflammation, recurrent trauma and suspicion of malignancy. Upon appeal, with demonstration of medical necessity, such claims will be paid.

Co-surgeon

When it is necessary for more than one surgeon to participate in an operation, reimbursement will be determined by the co-surgeon’s specialties, the number of incisions or approaches, the number of organs involved and the number of diagnoses.

Reimbursement will be as follows:

Provider/Procedure	Reimbursement
When the providers represent different specialties and different incisions are involved on different organs for different diagnoses	Full allowed amount for each procedure
When the providers represent different specialties and different incisions are involved on the same organ for the same diagnosis	Full allowed amount for the procedure with the higher allowed amount and 50 percent for the procedure with the lower allowed amount
When the providers represent the same specialty and the same incision is involved on the same organ for the same diagnosis	Full allowed amount for the procedure with the higher allowed amount plus 25 percent of the allowed amount for the same procedure

When two surgeons participate in the same surgical procedure and AMA-CPT modifier 62 is reported, Empire will reimburse 62.5 percent of the surgical allowance to both surgeons. When two surgeons participate in the same surgical procedure and AMA-CPT modifier 62 is not reported, Empire will reimburse 100 percent of the allowed amount to the first surgeon whose claim is received, and 25 percent to the second surgeon.

Evaluation and Management (E&M) Recoding

Empire has developed its own correct coding initiative, based on typical billing patterns for evaluation and management (E&M) visits to treat certain diagnoses that appear to be prone to potentially inappropriate billing.

As part of that program, Empire has established presumptive E&M service levels for office visit, consultation and hospital visit services provided for specified diagnoses. Bills that deviate from the norm are recoded to more accurately reflect the typical level of service required to treat the reported condition and are paid accordingly.

Providers may contest the recoding of any specific claim through Empire’s normal provider grievance process. Providers are required to send their office notes for the visit to be reviewed for intensity of service and complexity of decision-making. The records should reflect the complete history, physical examination, and complexity of problem-solving, as described in the American Medical Association’s CPT definitions of E&M service levels. Empire uses CMS standards in its review of the records for documentation of the E&M services provided. If the notes support the code billed, Empire will pay the balance of the amount due for that code.

Providers may be exempted from the program by demonstrating proper coding and billing in the claims that they submit to Empire. At the present time 85 percent of providers are exempt.

We recommend that providers take the following steps to avoid inclusion in the recoding program:

- Physicians should carefully document each service provided, according to CMS guidelines. These may be viewed online at <http://cms.hhs.gov/medlearn/emdoc.asp>.
- Physicians should personally designate the level of E&M service and ICD9 codes on a bill, rather than delegating this function to a billing manager or service.
- Office and billing staff should be trained to follow CMS guidelines for E&M coding, and provide feedback on proper documentation when needed.

Facility/Non-Facility Reimbursement (Site-of-Service Differential)

Empire has adopted the CMS facility/non-facility differential reimbursement logic. The differential is based on the Resource-Based Relative Value Scale (RBRVS) calculation of the fee schedule, which includes the physician work, liability and overhead cost components. For certain procedures indicated by CMS, Empire will provide a higher reimbursement to the physician when the procedure is performed in the office rather than in a facility setting to compensate the physician for the overhead costs he/she incurs. When these services are performed in inpatient, outpatient, ambulatory sur-

gery and emergency room hospital settings, it is the facility that incurs these overhead costs, and those costs are already reflected in the fee paid to the facility.

Incidental Procedures

Procedures that are performed concurrently with, and are clinically an integral part of, the primary procedure will not be reimbursed separately. The fees for any incidental procedure will be denied and Empire will reimburse the allowed amount for the primary procedure only.

Empire considers the use of the conscious sedation, surgical trays and supplies to be incidental (part of the technique) to surgical procedures and therefore not separately reimbursed. Empire's fees for surgical procedures include these items and techniques.

Empire has made a commitment to adopt CMS CCI and CPT bundling policies whenever feasible and will continue, over time, to adopt additional CMS policies. To assist in facilitating that process, some of Empire's policies have been adopted from HBOC-McKesson-GMIS or iHealth, a vendor, which derives its bundling logic from CMS CCI and from specialist panel recommendations.

Injectable Drugs Administered in Provider's Office

Participating providers must obtain certain drugs administered in the provider's office from a pharmacy designated by Empire. Providers will be furnished a list of such drugs. The pharmacy will drop-ship the drug to the provider's office and bill Empire directly for the cost of the drug. As a result, participating providers will not have to pay for, or bill claims for, these drugs. Participating providers who obtain these drugs from another source will not be reimbursed for the cost of the drugs, except in the case of an emergency. Providers may not bill the covered person for the cost of such drugs.

Lab Bundling

When three or more components of certain lab panels (CPT 80048, 80050, 80076, 80053) are reported, Empire will reimburse the lesser of the fee for the entire panel, or the sum of the fees of the individual components that were reported.

Medical Care in Office with Surgical Procedures

The allowed amount for all surgical procedure includes related E&M services. Following CMS and CPT guidelines, new or established patient E&M codes will be

reimbursed separately when CPT modifier 25 is reported to identify that the visit was significant and separately identifiable. Without modifier 25, the E&M service will be denied as incidental to the surgical procedure(s) reported on the same day.

Exception: New patient E&M codes reported with minor surgical procedures (formerly identified in Current Procedural Terminology (CPT) as Starred Procedure (*)) will be reimbursed separately with or without modifiers 25 or 57.

Medical Care Prior To and Following Surgery ("Global Surgical Aftercare")

The length of global surgery period varies by the complexity of the procedure and is based on the time determined by CMS (0, 10 or 90 days).

Reimbursement for a surgical procedure with a 90-day global surgery period includes a 1-day pre-operative exam. E&M reported on the day before or the day of surgery with a 90-day aftercare period will be reimbursed separately only when modifier 57 is reported to identify that the decision for surgery was initially made during the visit.

E&M reported on the day of surgery will be reimbursed separately when modifier 25 is reported to identify that the evaluation was significantly above and beyond the usual preoperative care.

Reimbursement for E&M follow-up visits is included in the allowed amount for the surgical procedure.

Reimbursement for E&M visits following surgery is allowed separately only when modifier 24 is reported or the diagnoses are unrelated.

Medically Necessary Care

Empire will reimburse for medically necessary services according to criteria listed below.

The care must be

- consistent with the symptoms or diagnosis and treatment of the condition, disease, ailment or injury.
- in accordance with standards of good medical practice.
- not solely for the convenience of the patient or the provider.
- not primarily custodial.
- the most appropriate supply or level of service that can be safely provided.

Mental Healthcare by Medical Providers and PCPs

Mental health benefits are considered separately from medical benefits under Empire's member contracts. The mental health benefits are structured so that once a member has an established psychiatric diagnosis the care of the patient must be provided by a mental health specialist.

Empire reimburses a PCP or non-psychiatric physician for only the first visit for any mental health diagnosis, in order to make the initial diagnosis. For subsequent visits for psychiatric diagnoses, Empire requires that the PCP refer the patient to a psychiatric provider in Empire's mental health (Magellan) network. This is a consequence of Empire's benefit structure, rather than any reflection on the ability or experience of a primary care physician to treat psychiatric conditions (or mental health conditions which have a biochemical basis). Subsequent visits (E&M) for mental health diagnoses will be denied to the PCP or non-psychiatric provider.

Conditions which include an organic component, such as Alzheimer's disease and attention deficit disorder, are not considered mental health diagnoses. Covered services for the care of patients with such conditions will be reimbursed under the medical benefits to non-psychiatric MDs. Common mental health diagnoses such as anxiety, depression, ADHD, etc., are considered mental/behavioral in nature and care must be provided by the mental health specialist.

The PCP and other medical providers will be reimbursed for pharmacologic medication management for any psychiatric diagnosis, on a first or subsequent visit, if the code 90862 or M0064 is billed.

Multiple Evaluation and Management (E&M) Visits on the Same Date of Service

Empire will allow only the E&M service with the highest allowed value when more than one E&M service is billed for a member for a given date of service for the same or similar condition. This policy is adopted from CMS and also defines the provider according to their tax identification number (TIN) and specialty.

If more than one E&M service per day is reported by the same provider, the provider should bill a level of service representative of the combined visits. This reimbursement policy will be applied to E&M Services (99201-99499), General Ophthalmological Services (92002-92014), Preventative Medicine Services (99381-99397), attendance at delivery (99436), and routine oph-

thalmological exam with refraction (S0620-S0621). It does not apply to critical care services (99289-99298), prolonged visit codes (99354-99359), multiple Emergency Room visits, when the E&M services are for different conditions or when providers of different specialties bill for separate E&M services.

Multiple Surgical Procedures

In accordance with Empire's member contracts, when multiple surgical procedures are performed through the **same incision or via the same operative field/approach** during the same operation, Empire reimburses only for the procedure with the **highest** allowance. If two or more separate incisions are required at two or more different sites, reimbursement will be provided at the allowed amount for the procedure with the highest allowance and at 50 percent of the allowed amount for the other procedure(s).

The term "approach" will apply to the method of external access to the internal organs or the incision into the body (e.g., laparotomy, thoracotomy, and scope).

"Incision" will apply to the incisions made on an actual organ. All minor incisions to get through the fascia are incidental. Each tendon or nerve is considered a different organ. In the abdominal cavity each organ is considered a separate organ.

Procedures identified in CPT codes as "separate" may be considered an integral component of a total service and may not be reimbursed separately. Empire does not necessarily follow CMS' Correct Coding Initiative (CCI) to determine incidental, bundled or mutually exclusive procedures. This policy is based on NY State Insurance Law (11 NYCRR Section 52.17(a) and 11 NYCRR Section 52.18(b)).

Physician Assistant Services

Reimbursement for Physician Assistant services is made to the supervising physician when claims are submitted by the supervising physician. Physician Assistant services should be performed under the observation, direction and supervision of the reporting physician.

When the Physician Assistant functions as the assistant at surgery, reimbursement is made at one-half of the assistant surgeon's rate, generally 10 percent of the allowed amount for the surgical procedure. A procedure code with the HCPCS Level II modifier AS must be used for accurate reimbursement of the Physician Assistant serving as the surgical assistant.

Physician Office Lab (POL) List

Empire has established a list of in-office lab tests that will be reimbursed to physicians under Empire's HMO, POS, PPO and EPO plans. Other lab tests must be sent to a participating network lab, as listed in Empire's physician directory or at www.empireblue.com/physician. Empire's rationale for choosing which tests to separately reimburse to the physician was based on: (1) analysis of claims to determine which lab tests are typically done in physicians' offices, (2) consideration of the accuracy of lab tests performed in the office, and (3) determination of the immediate, significant impact of a lab result on the physician's medical decision-making for patient management. This restriction does not apply to Empire's indemnity plans.

Procedures in the Global Surgery Period

Consistent with CMS policy, Empire will consider procedures performed in the postoperative period that are related to the primary surgical procedure to be included in the reimbursement for the primary procedure. This does not include procedures unrelated to the primary procedure or procedures billed with the following modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD and RC, 24, 25, 57, 58, 59, 78, 79 and 91.

Professional/Technical Component Pricing

Empire has adopted the CMS reimbursement policy for professional and technical pricing. This logic applies to radiological services, diagnostic tests and physician pathology services that involve a two-component concept (the physician/professional component and the technical component). Modifier 26 identifies the physician or professional component. Modifier TC identifies the technical component that is mainly an institutional (facility) charge and is not reported by the physician. When a procedure, identified (by CMS) as applicable to professional/technical component pricing, is reported in an inpatient or outpatient hospital setting, only the professional component allowance will be reimbursed whether modifier 26 is reported or not. Reimbursement of the professional component allowed amount to the physician may be affected by the agreement between Empire and the hospital facility.

E&I List

The first step in determining eligibility of a medical procedure for coverage is evaluating its health effects, a process known as "Technology Assessment." Empire develops and/or adopts technology-related clinical policies through a formal process that evaluates new

developments in technology and new applications of existing technology. The review and decisions are based on a preponderance of expert opinion and published peer-reviewed medical literature proving that the technology is effective for its intended use.

We have stated that our primary source of information is CMS (Medicare), but information from the FDA, research entities such as HAYES and ECRI, the NIH, the CDC, the Association of Community Cancer Centers Compendia and the Blue Cross Blue Shield Association Technology Evaluation Criteria is also heavily considered.

Procedures or services failing proof of efficacy and safety compared to standard procedures as a result of Empire's technology evaluation process will be considered "Experimental/Investigational" (E/I) and denied for coverage under the member's contract.

Policy

1. There are some procedures that may be considered investigational for certain clinical indications or situations. If Empire has identified that the procedure has some merit for specific uses or if the procedure is already mentioned in a specific policy statement, the procedure will not appear in this document; refer to the specific policy statement for instructions. Procedures appearing on the following list are considered investigational and denied.
2. Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the Food and Drug Administration (FDA), Empire will not cover any treatment, procedure, drug, biological product or medical device or any hospitalization in connection with such technology if, in our sole discretion, the technology is experimental or investigational.
3. Experimental/investigational means that the technology, in comparison to standard treatments or services, is
 - not of proven benefit for the particular diagnosis or treatment of the covered person's particular condition; or
 - not generally recognized by the medical community as reflected in the published peer-reviewed medical literature as effective or appropriate for the particular diagnosis or treatment.
4. We will not cover any technology or any hospitalization in connection with such technology if, in our

sole discretion, such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment.

5. Appeals of denials for experimental procedures would be reconsidered pending submission of peer-reviewed medical literature by the requesting physician.

See Appendix 1 at the back of this Sourcebook to view the complete E&I List.

Well-hospital visits for normal newborns

Empire's contracts generally cover only one hospital visit for a well newborn, plus a last-day visit for discharge management. This policy covers the majority of cases of vaginal deliveries, where the mother and newborn stay in the hospital for only two days.

In the case of a C-section, normal neonates remain in the hospital more than two days only because the mother is held extra days in the hospital. Similarly, if a mother is retained for complications after a vaginal delivery, her normal newborn may be retained in the hospital for no medical reason. Such babies are not themselves ill, and do not require subsequent medical visits every day, any more than normal newborns do immediately after discharge from the hospital. Therefore, Empire does not reimburse for visits to normal newborns other than the initial and discharge exam. Hospital visits on interim days to normal newborns are considered incidental to the initial and discharge visits and cannot be balance-billed to members.