Reimbursement Policy designation of Professional or Facility application is respective to how the provider is contracted with The Plan. Provider contractual agreement terms in direct conflict with this Reimbursement Policy may supersede this Policy’s direction and regional applicability.

PURPOSE:

This policy is to provide direction on The Plan’s reimbursement of global surgery services and subsequent hospital visits and hospital discharge day management services. Surgery is classified as either definitive/major or diagnostic/minor. Definitive/major surgical procedures have designated post-operative days (90 days) while diagnostic/minor surgical procedures have ten (10) or zero (0) post-operative days based on CMS Global Days.

REIMBURSEMENT GUIDELINES:

Section A - Applicable to Commercial

Pre and Post-operative Care

In-hospital, the allowance for a surgical procedure includes payment for routine in-hospital pre-operative care and routine post-operative care, in or out of the hospital, when provided by the surgeon, his assistant, or associate as defined by the CMS Global Days field (e.g. 0, 10, or 90 days).

*Other than in-hospital, the allowance for a surgical procedure, as defined by the CMS Global Days field (e.g. 0, 10, or 90 days), includes routine post-operative care when provided by the surgeon, his assistant, or associate.

*Note: As permitted under state license/accreditation and Highmark policies.
**Note:** Reimbursement may be made for an unrelated Evaluation and Management (E/M) service by the same physician during the post-operative period when modifier 24 is reported with the E/M service.

**Surgery and Medical Care on the Same Day**

Regardless of place of service, medical care provided on the same day as a surgical procedure, as defined by the CMS Global Days field (e.g. 0, 10, or 90 days) by the same physician, for the same condition is not eligible for reimbursement.

An E/M visit is included in the global allowance for the surgery and not separately reimbursable and when the medical care is contractually excluded, the visit is not covered.

**Note:** Reimbursement may be made for a significant, separately identifiable E/M service by the same physician on the same day as defined by the CMS Global Days field (e.g. 0, 10, or 90 days) when modifier 25 is reported with the E/M code. When the 25 modifier is reported, the patients’ records must clearly document separately identifiable medical care was rendered. Modifier 25 should only be used on claims for E/M services, and only when these services are provided by the same physician (or same qualified non-physician practitioner) to the same patient on the same day as another procedure or other service. The plan will reimburse for an E/M service provided on the day of a procedure with a global fee period only when the physician indicates the service was for a significant, separately identifiable E/M service above and beyond the usual pre-and post-operative work of the procedure. Both the medically necessary E/M service and the procedure must be sufficiently documented in the patient’s medical record by the physician or other qualified non-physician practitioner to support the claim for these services.

Reimbursement may also be made for an E/M service that results in the initial decision to perform the surgery when modifier 57 is reported with the E/M code.

**Procedures Reported with Modifier 78**

Modifier 78 should be reported with procedure codes for treatment of postoperative complications that require a return trip to the operating room. An operating room is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term operating room includes a cardiac catheterization suite, a laser suite and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an operating room.)

**Note:** A new Global Period will not apply to a procedure meeting these requirements and reported with modifier 78.

**Section B - Applicable to Medicare Advantage**

**Global Surgery**

Certain services are paid for under what are known as “global fees”. These fees incorporate the reimbursement for services performed at different times by the same provider (or group), but all in conjunction with one medical procedure or episode of care.
Standard packages of preoperative, intraoperative and postoperative services are included in the payment for a surgical procedure.

All surgical procedures are classified as one of the following:

1. Major surgery: Procedures have a 90-day postoperative period
2. Minor or Endoscopic surgery: Procedures have either a 10-day postoperative period or a 0-day postoperative period

Components of a Global Surgical Package

When different physicians in a group practice participate in the care of the patient; the group bills for the entire global package.

The approved amount for surgical procedures includes reimbursement for the following services related to the surgery when furnished by the physician who performs the surgery:

- Preoperative Visits -- Preoperative visits beginning with the day before the date of surgery for major procedures (those having a Global Days value of 90) and the day of surgery for minor procedures (those having a Global Days value other than 90).
- Intraoperative Services -- Intraoperative services normally a usual and necessary part of the surgical procedure, including postoperative work in the hospital.
- Complications Following Surgery -- All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications, which do not require additional trips to the operating room.
- Postoperative Visits -- Follow-up visits during the postoperative period of the surgery related to recovery from the surgery.
- Post-surgical Pain Management -- By the surgeon.
- Supplies -- See exception to this under “Services not included in the Global Surgical Package.”
- Miscellaneous Services -- Items such as dressing changes; local incisional care; removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.
- A surgical tray (A4550) is not separately reimbursable because it is considered a bundled service. Therefore, it is non-covered and non-billable to the member.

Services Not Included in the Global Surgical Packages

The following services are not included in the global surgical package and can be paid for separately in addition to the surgical procedure:

- The initial evaluation of the problem by the surgeon to determine the need for surgery. Modifier 57 must be reported with the E/M service if this evaluation is the day before major surgery or the day of major surgery (those procedures having a Global Days value of 90). The initial evaluation is always included in the allowance for a procedure having a Global Days value other than 90.
- A visit on the same day as a minor or endoscopic procedure for a significant separately identifiable service, above and beyond care normally associated with the procedure.
Modifier 25 must be reported with the E/M service to identify it as a significant separately identifiable service. Modifier 25 should only be used on claims for E/M services and only when these services are provided by the same physician (or same qualified non-physician practitioner) to the same patient on the same day as another procedure or other service. Different diagnoses are not required for reporting the E/M service on the same date as the procedure or other service. Modifier 25 must be added to the E/M code on the claim. Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented by the practitioner in the patient’s medical record to support the claim for these services.

- Services of other physicians except where the surgeon and the other physician(s) agree on the transfer of care. This agreement may be in the form of a letter or an annotation in the discharge summary, hospital record, or ASC record.
- Visits following the patient’s discharge unrelated to the diagnosis for which the surgical procedure is performed (unless due to complications of the surgery). Modifier 24 must be reported with the E/M service to identify it as unrelated. Additionally, sufficient documentation must show that the visit was unrelated to the surgery. A diagnosis code that clearly indicates the reason for the encounter was unrelated to the surgery is sufficient documentation.
- Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery.
- Diagnostic tests and procedures including diagnostic radiological procedures.
- Physical therapy.
- Clearly distinct surgical procedures during the postoperative period which are not reoperations or treatments for complications. Modifier 58 should be used to identify procedures done in two (2) or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Modifier 79 must be reported to identify unrelated procedures performed during the post-operative period.
- Treatment for postoperative complications which require a return trip to the operating room. An operating room for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures, including a cardiac catheterization suite, a laser suite and an endoscopy suite. It does not include a patient’s room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient’s condition was so critical there would be insufficient time for transportation to an OR). Modifier 78 must be reported with the subsequent surgical procedure.
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately. Modifier 58 must be reported with the second procedure.
- Major surgery performed on the same day or in the postoperative period of a diagnostic biopsy with a 10-day global period is separately payable.
- Splints and casting supplies for fractures or dislocations may be reimbursed when performed in a physician’s office (codes A4649 and L0210).
- Recasting’s during the global period of the treatment of a fracture. Modifier 58 (staged procedure) or Modifier 79 (unrelated procedure) should be reported with the recasting code.
- Immunosuppressive therapy for organ transplants. Modifier 24 should be reported to identify the care (even if it is during the same hospital stay as the surgical procedure). It will be necessary for the provider to submit medical records and/or additional documentation to determine coverage in this situation.
- Critical care services (code 99291) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician. Modifier 25 must be reported with code 99291 if rendered in the pre-operative period and modifier 24 for post-operative care. Documentation the critical care was unrelated to the specific anatomic injury or
surgical procedure must be submitted. A diagnosis code which clearly indicates the critical care was unrelated to the surgery is acceptable documentation.

Subsequent Hospital Visits During the Global Surgery Period

Reimbursement for surgical procedures includes all the services and visits (e.g., E/M visits) part of the global surgery reimbursement including when such surgical procedures may be fragmented.

Subsequent Hospital Care visits (codes 99231, 99232 and 99233) are not separately reimbursed when included in the global surgery payment.

Hospital Discharge Day Management Service

A Hospital Discharge Day Management Service, (codes 99238 or 99239) is a face-to-face evaluation and management (E/M) service between the attending physician and the patient. The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified non-physician practitioner even if the patient is discharged from the facility on a different calendar date. Only one hospital discharge day management service is reimbursed per patient per hospital stay.

Only the attending physician of record reports the discharge day management service. Physicians or qualified non-physician practitioners, other than the attending physician, who have been managing concurrent health care problems not primarily managed by the attending physician, and who are not acting on behalf of the attending physician, shall use Subsequent Hospital Care (codes 99231, 99232 and 99233) for a final visit.

Reimbursement for general paperwork is included through the pre-and post-service work of evaluation and management (E/M) services.

Applicable codes: 99231 99232 99233 99238 99239

Subsequent Hospital Visit and Discharge Management on Same Day

Payment will only be made for the hospital discharge management code on the day of discharge unless it is also the day of admission.

Physicians shall use the Observation or Inpatient Care Services (Including Admission and Discharge Services) for a hospital admission and discharge occurring on the same calendar date and when the following criteria are met:

- When the patient was admitted to inpatient hospital care for less than 8 hours on the same date, then Initial Hospital Care can be reported by the physician. The Hospital Discharge Day Management service shall not be reported for this scenario.

- When a patient was admitted to inpatient initial hospital care and then discharged on a different calendar date, the physician can report an Initial Hospital Care and a Hospital Discharge Day Management service.
When a patient was admitted to inpatient hospital care for a minimum of eight (8) hours but less than twenty (24) hours and discharged on the same calendar date, Observation or Inpatient Hospital Care Services (Including Admission and Discharge Services), can be reported.

A subsequent hospital visit in addition to a hospital discharge day management service reported for the same date of service by the same physician is not eligible for reimbursement.

Applicable codes: 99234 99235 99236 99238 99239

**Hospital Discharge Management and Death Pronouncement**

Only the physician who personally performs the pronouncement of death shall bill for the face-to-face Hospital Discharge Day Management Service, code 99238 or 99239. The date of the pronouncement shall reflect the calendar date of service on the day it was performed, even if the paperwork is delayed to a subsequent date.

**Procedures Reported with Modifier 78**

Modifier 78 should be reported with procedure codes for treatment of postoperative complications that require a return trip to the operating room. An operating room is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term operating room includes a cardiac catheterization suite, a laser suite and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an operating room.)

**Note:** A new Global Period will **not** apply to a procedure meeting these requirements and reported with modifier 78.

**RELATED HIGHMARK POLICIES:**

Refer to the following Medical Policies for additional information:

- Medical Policy S-52: Postoperative Services Following Definitive Surgery

Refer to the following Reimbursement Policies for additional information:

- Reimbursement Policy RP-009: Modifiers 25, 59, XE, XP, XS and XU
- Reimbursement Policy RP-005: Modifiers 54 and 55

**REFERENCES:**

- Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations.
• Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.

• Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim.

• CMS Online Manual Pub. 100-4, Chapter 12, Sections 30.6.9.1 and 30.6.9.2.

• CMS Transmittal 1460, CR 5794.

• CMS Online Manual Pub. 100-04, Chapter 12, 40.0-40.44.

• CMS Transmittal 954, CR 5025.
PURPOSE:

This policy is to provide direction on The Plan’s reimbursement of global surgery services and subsequent hospital visits and hospital discharge day management services. Surgery is classified as either definitive/major or diagnostic/minor. Definitive/major surgical procedures have designated post-operative days (90 days) while diagnostic/minor surgical procedures have ten (10) or zero (0) post-operative days based on CMS Global Days.

REIMBURSEMENT GUIDELINES:

Section A - Applicable to Commercial

Pre and Post-operative Care

In-hospital, the allowance for a surgical procedure includes payment for routine in-hospital pre-operative care and routine post-operative care, in or out of the hospital, when provided by the surgeon, his assistant, or associate as defined by the CMS Global Days field (e.g. 0, 10, or 90 days).

*Other than in-hospital, the allowance for a surgical procedure, as defined by the CMS Global Days field (e.g. 0, 10, or 90 days), includes routine post-operative care when provided by the surgeon, his assistant, or associate.

*Note: As permitted under state license/accreditation and Highmark policies.
Note: Reimbursement may be made for an unrelated Evaluation and Management (E/M) service by the same physician during the post-operative period when modifier 24 is reported with the E/M service.

Surgery and Medical Care on the Same Day

Regardless of place of service, medical care provided on the same day as a surgical procedure, as defined by the CMS Global Days field (e.g. 0, 10, or 90 days) by the same physician, for the same condition is not eligible for reimbursement.

An E/M visit is included in the global allowance for the surgery and not separately reimbursable and when the medical care is contractually excluded, the visit is not covered.

Note: Reimbursement may be made for a significant, separately identifiable E/M service by the same physician on the same day as defined by the CMS Global Days field (e.g. 0, 10, or 90 days) when modifier 25 is reported with the E/M code. When the 25 modifier is reported, the patients’ records must clearly document separately identifiable medical care was rendered. Modifier 25 should only be used on claims for E/M services, and only when these services are provided by the same physician (or same qualified non-physician practitioner) to the same patient on the same day as another procedure or other service. The plan will reimburse for an E/M service provided on the day of a procedure with a global fee period only when the physician indicates the service was for a significant, separately identifiable E/M service above and beyond the usual pre-and post-operative work of the procedure. Both the medically necessary E/M service and the procedure must be sufficiently documented in the patient’s medical record by the physician or other qualified non-physician practitioner to support the claim for these services.

Reimbursement may also be made for an E/M service that results in the initial decision to perform the surgery when modifier 57 is reported with the E/M code.

Procedures Reported with Modifier 78

Modifier 78 should be reported with procedure codes for treatment of postoperative complications that require a return trip to the operating room. An operating room is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term operating room includes a cardiac catheterization suite, a laser suite and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an operating room.)

Note: A new Global Period will not apply to a procedure meeting these requirements and reported with modifier 78.

Section B - Applicable to Medicare Advantage

Global Surgery

Certain services are paid for under what are known as “global fees”. These fees incorporate the reimbursement for services performed at different times by the same provider (or group), but all in conjunction with one medical procedure or episode of care.
Standard packages of preoperative, intraoperative and postoperative services are included in the payment for a surgical procedure.

All surgical procedures are classified as one of the following:

1. Major surgery: Procedures have a 90-day postoperative period
2. Minor or Endoscopic surgery: Procedures have either a 10-day postoperative period or a 0-day postoperative period

Components of a Global Surgical Package

When different physicians in a group practice participate in the care of the patient; the group bills for the entire global package.

The approved amount for surgical procedures includes reimbursement for the following services related to the surgery when furnished by the physician who performs the surgery:

- Preoperative Visits -- Preoperative visits beginning with the day before the date of surgery for major procedures (those having a Global Days value of 90) and the day of surgery for minor procedures (those having a Global Days value other than 90).
- Intraoperative Services -- Intraoperative services normally a usual and necessary part of the surgical procedure, including postoperative work in the hospital.
- Complications Following Surgery -- All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications, which do not require additional trips to the operating room.
- Postoperative Visits -- Follow-up visits during the postoperative period of the surgery related to recovery from the surgery.
- Post-surgical Pain Management -- By the surgeon.
- Supplies -- See exception to this under “Services not included in the Global Surgical Package.”
- Miscellaneous Services -- Items such as dressing changes; local incisional care; removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.
- A surgical tray (A4550) is not separately reimbursable because it is considered a bundled service. Therefore, it is non-covered and non-billable to the member.

Services Not Included in the Global Surgical Packages

The following services are not included in the global surgical package and can be paid for separately in addition to the surgical procedure:

- The initial evaluation of the problem by the surgeon to determine the need for surgery. Modifier 57 must be reported with the E/M service if this evaluation is the day before major surgery or the day of major surgery (those procedures having a Global Days value of 90). The initial evaluation is always included in the allowance for a procedure having a Global Days value other than 90.
- A visit on the same day as a minor or endoscopic procedure for a significant separately identifiable service, above and beyond care normally associated with the procedure.
Modifier 25 must be reported with the E/M service to identify it as a significant separately identifiable service. Modifier 25 should only be used on claims for E/M services and only when these services are provided by the same physician (or same qualified non-physician practitioner) to the same patient on the same day as another procedure or other service. Different diagnoses are not required for reporting the E/M service on the same date as the procedure or other service. Modifier 25 must be added to the E/M code on the claim. Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented by the practitioner in the patient’s medical record to support the claim for these services.

- Services of other physicians except where the surgeon and the other physician(s) agree on the transfer of care. This agreement may be in the form of a letter or an annotation in the discharge summary, hospital record, or ASC record.

- Visits following the patient’s discharge unrelated to the diagnosis for which the surgical procedure is performed (unless due to complications of the surgery). Modifier 24 must be reported with the E/M service to identify it as unrelated. Additionally, sufficient documentation must show that the visit was unrelated to the surgery. A diagnosis code that clearly indicates the reason for the encounter was unrelated to the surgery is sufficient documentation.

- Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery.

- Diagnostic tests and procedures including diagnostic radiological procedures.

- Physical therapy.

- Clearly distinct surgical procedures during the postoperative period which are not reoperations or treatments for complications. Modifier 58 should be used to identify procedures done in two (2) or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Modifier 79 must be reported to identify unrelated procedures performed during the post-operative period.

- Treatment for postoperative complications which require a return trip to the operating room. An operating room for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures, including a cardiac catheterization suite, a laser suite and an endoscopy suite. It does not include a patient’s room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient’s condition was so critical there would be insufficient time for transportation to an OR). Modifier 78 must be reported with the subsequent surgical procedure.

- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately. Modifier 58 must be reported with the second procedure.

- Major surgery performed on the same day or in the postoperative period of a diagnostic biopsy with a 10-day global period is separately payable.

- Splints and casting supplies for fractures or dislocations may be reimbursed when performed in a physician’s office (codes A4649, L0210, Q4001-Q4051).

- Recasting’s during the global period of the treatment of a fracture. Modifier 58 (staged procedure) or Modifier 79 (unrelated procedure) should be reported with the recasting code.

- Immunosuppressive therapy for organ transplants. Modifier 24 should be reported to identify the care (even if it is during the same hospital stay as the surgical procedure). It will be necessary for the provider to submit medical records and/or additional documentation to determine coverage in this situation.

- Critical care services (code 99291) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician. Modifier 25 must be reported with code 99291 if rendered in the pre-operative period and modifier 24 for post-operative care. Documentation the critical care was unrelated to the specific anatomic injury or
surgical procedure must be submitted. A diagnosis code which clearly indicates the critical care was unrelated to the surgery is acceptable documentation.

Subsequent Hospital Visits During the Global Surgery Period

Reimbursement for surgical procedures includes all the services and visits (e.g., E/M visits) part of the global surgery reimbursement including when such surgical procedures may be fragmented. Subsequent Hospital Care visits (codes 99231, 99232 and 99233) are not separately reimbursed when included in the global surgery payment.

Hospital Discharge Day Management Service

A Hospital Discharge Day Management Service, (codes 99238 or 99239) is a face-to-face evaluation and management (E/M) service between the attending physician and the patient. The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified non-physician practitioner even if the patient is discharged from the facility on a different calendar date. Only one hospital discharge day management service is reimbursed per patient per hospital stay.

Only the attending physician of record reports the discharge day management service. Physicians or qualified non-physician practitioners, other than the attending physician, who have been managing concurrent health care problems not primarily managed by the attending physician, and who are not acting on behalf of the attending physician, shall use Subsequent Hospital Care (codes 99231, 99232 and 99233) for a final visit.

Reimbursement for general paperwork is included through the pre-and post-service work of evaluation and management (E/M) services.

Applicable codes: 99231 99232 99233 99238 99239

Subsequent Hospital Visit and Discharge Management on Same Day

Payment will only be made for the hospital discharge management code on the day of discharge unless it is also the day of admission.

Physicians shall use the Observation or Inpatient Care Services (Including Admission and Discharge Services) for a hospital admission and discharge occurring on the same calendar date and when the following criteria are met:

- When the patient was admitted to inpatient hospital care for less than 8 hours on the same date, then Initial Hospital Care can be reported by the physician. The Hospital Discharge Day Management service shall not be reported for this scenario.

- When a patient was admitted to inpatient initial hospital care and then discharged on a different calendar date, the physician can report an Initial Hospital Care and a Hospital Discharge Day Management service.
• When a patient was admitted to inpatient hospital care for a minimum of eight (8) hours but less than twenty (24) hours and discharged on the same calendar date, Observation or Inpatient Hospital Care Services (Including Admission and Discharge Services), can be reported.

A subsequent hospital visit in addition to a hospital discharge day management service reported for the same date of service by the same physician is not eligible for reimbursement.

Applicable codes: 99234 99235 99236 99238 99239

Hospital Discharge Management and Death Pronouncement

Only the physician who personally performs the pronouncement of death shall bill for the face-to-face Hospital Discharge Day Management Service, code 99238 or 99239. The date of the pronouncement shall reflect the calendar date of service on the day it was performed, even if the paperwork is delayed to a subsequent date.

Procedures Reported with Modifier 78

Modifier 78 should be reported with procedure codes for treatment of postoperative complications that require a return trip to the operating room. An operating room is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term operating room includes a cardiac catheterization suite, a laser suite and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an operating room.)

Note: A new Global Period will not apply to a procedure meeting these requirements and reported with modifier 78.

RELATED HIGHMARK POLICIES:

Refer to the following Medical Policies for additional information:

• Medical Policy S-52: Postoperative Services Following Definitive Surgery

Refer to the following Reimbursement Policies for additional information:

• Reimbursement Policy RP-009: Modifiers 25, 59, XE, XP, XS and XU
• Reimbursement Policy RP-005: Modifiers 54 and 55

REFERENCES:

• Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations.
- Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.

- Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim.

- CMS Online Manual Pub. 100-4, Chapter 12, Sections 30.6.9.1 and 30.6.9.2.

- CMS Transmittal 1460, CR 5794.

- CMS Online Manual Pub. 100-04, Chapter 12, 40.0-40.44.

- CMS Transmittal 954, CR 5025.