Changes/ Updates to Policy	Effective Date of change	Health Plan Impacted	Product Lines	Provider Types	Main Points	Source	Example
PAY PERCENT THERAPY	8/1/2021	Optima Health	Commercial, Medicaid & Medicare	Professional & Facility	Identifies claim lines which should receive the reduced reimbursement on Physical, Speech and Occupational therapy procedures per CMS for office and non-institutional claims. According the Centers for Medicare and Medicaid Services (CMS) Transmittal #1194, when multiple therapy procedures are performed in an office or non-institutional setting, the primary procedure should receive reimbursement at 100%. All secondary and subsequent procedures should have the non-facility Practice Expense RVU reduced by 50%	CMS	Procedure codes 97112 and 97110 are submitted for the same date of service by the same provider. The procedures will be ranked according to the non-facility PE RVU. The procedure ranked 1 (97112) will not receive a cutback and the procedure code ranked 2 (97110) will receive a reduction in reimbursement.
MUE PRACTITIONER FILTER	8/1/2021	Optima Health	Commercial, Medicaid & Medicare	Professional	Identifies and recommends the denial of claim lines when the quantity billed for the procedure code exceeds the CMS MUE value.	CMS	Procedure 37253 is submitted with a quantity of 6, but CMS has assigned an MUE value = 5. This claim line will be denied, and a new line added with quantity = 5.
PAY PERCENT MULT ENDO	8/1/2021	Optima Health	Commercial, Medicaid & Medicare	Professional & Facility	Identifies multiple endoscopy procedures, reported within the same family, and applies the multiple endoscopy reduction, per CMS guidelines. Additionally, if more than one endoscopy family is reported and/or surgery procedures are reported, a multiple surgery cutback to the appropriate endoscopy family or families and surgery procedures may apply. Furthermore, this rule will also recommend reimbursement adjustments for other applicable payment modifiers and assign the appropriate percentage reduction to the eligible line(s), as well as bilateral, multiple quantity, and assign the appropriate percentage to the eligible line(s)	CMS AMA	Elbow Arthroscopy procedures 29837 and 29834 from same endoscopic family are submitted for the same member, provider, DOS. The procedures will be ranked according to RVU. Procedure 29837 has the higher RVU and will be assigned a rank of 1; procedure 29834 has the lower RVU and will be assigned a rank of 2. Appropriace reimbursement value will be assigned to rank 1 (29837) and a lower reimbursement value will be assigned to rank 2 (29834).
PAY PERCENT MODS	8/1/2021	Optima Health	Commercial, Medicaid & Medicare	Professional & Facility	Identifies an adjustment in the reimbursement when a single procedure is submitted as bilateral, or with multiple quantity, or with additional payment modifiers	CMS AMA	Cardiac procedure 33660 is submitted with modifier -54 (no other procedures that are eligible for multiple procedure adjustment are submitted for the same member, provider, DOS). Based on the fee schedule value for this modifier/procedure combination, a reduction in reimbursement will be recommended for the claim line.
GLOBAL COMP	8/1/2021	Optima Health	Commercial, Medicaid & Medicare	Professional & Facility	Identifies instances where the sum of all payments (total, professional, technical) for a procedure across multiple providers exceeds the amount that would have been paid for the total procedure. Evaluates the same member ID, the same date of service, across providers.	CMS	When procedure code 51725-26 is submitted and 51725 was previously submitted by a different provider on the same date of service, 51725-26 is recommended for denial.
PAY PERCENT ASST SURG	8/1/2021	Optima Health	Commercial, Medicaid & Medicare	Professional	Identifies an adjustment in the reimbursement for lines submitted with an assistant surgeon modifier (-80, -81, -82, -AS) by the same provider for the same date of service. Additional adjustments may be made for multiple procedures, bilateral submission, multiple quantity, and additional payment modifiers.	CMS AMA	Cardiac procedures 33660-80 and 33766-80 are both submitted for the same date of service by an assistant surgeon (as indicated by the modifier -80). A reimbursement reduction will be assigned to each line. An additional adjustment to account for multiple procedures may also be applied to procedure 33766.
MOD PROC VALID NP	8/1/2021	Optima Health	Commercial, Medicaid & Medicare	Professional & Facility	Identifies a denial of procedure codes when billed with any non-payment-affecting modifier that is not likely or appropriate for the procedure code billed.	CMS AMA	Procedure code 49000 is submitted modifier -2N. Modifier -2N is not valid with procedure 49000 and the claim line is denied.
OB PACAKGE RULE ICD10	8/1/2021	Optima Health	Commercial, Medicaid & Medicare	Professional	Identifies potential overpayments for obstetric care. Evaluation of claim lines to determine if any global obstetric care codes (defined as containing antepartum, delivery and postpartum services, for example code 59400) were submitted with another global OB care code or a component code such as the antepartum care, postpartum care, or delivery only services, during the average length of time of the typical pregnancy (and postpartum period as applicable) 280 and 322 days respectively.	AMA	Global obstetrical procedure code 59400 (routine obstetric care including antepartum care, vaginal delivery and postpartum care) is submitted on 3/1/2021. In history, global obstetrical procedure code 59400 was previously submitted on 10/1/2020 for the same member, and was paid.
Service Facilitation	8/1/2021	Optima Health	Medicaid/MLTSS	Service Facilitators	Care Coordinators have taken on responsibilities to meet growing members' needs for DME, resolution of PPL payment issues, resolution of transportation issues, identification and education of community resources, and other tasks previously completed by Service Facilitators. As a result, the need for frequent visits by the Service Facilitators has decreased due to the increased role of the Care Coordinator in case management of the members. The Service Facilitator's main responsibilities include assessing an individual's needs related to Consumer Directed services, assisting in the development of the individual's service plan, providing training on how to be an effective employer, and completing ongoing service reviews and monitoring activities. It is important to note that ongoing monitoring does not require a visit, and not all monitoring activities are billable services.	DMAS Guidance	