Pain Management services with modifier and incorrect authorization.

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

Pain management services with an incorrect authorization pertain to the evaluation of claims (both HCFA1500 and UB04) for pain management procedures featuring bilateral modifiers (50 or both LT-RT), where the authorized approval does not encompass the requisite modifier.

Reimbursement Guidelines

This policy applies, but is not limited, to the following service codes:

64490	64491	64492	64493	64494	64495
64633	64634	64635	64636	62320	62321
62322	62323	64479	64480	64484	27096
64451	64625	64450	64454	64624	1991
01992	64417	64418	64420	64421	64425
64430	64445	64446	64449	64461	64462
64463	64483	64505	64510	64517	64520
64530	64620	64625	64630	64632	64640

It is important to note that this policy applies to services billed with a service code and/or include a bilateral modifier (50 or both LT and RT), as well as claims with approved authorization (Header and Line level) with no bilateral modifier included in the authorization.

Supplemental Information

Definitions

Term	Definition
CMS	the Centers for Medicare & Medicaid Services. It is a federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.
Bilateral Modifier - Modifier 50	This modifier represents a service or procedure performed on both sides of the body during the same session.
Bilateral Modifier – Modifier LT and RT	This modifier is used to indicate that the procedure is performed on only one side of the body • LT – Left side • RT – Right side

State Exceptions

State	Exception
WI	**<u>The following are excluded from this policy:</u>** • Medicaid – Claims more than one year from paid date. • Marketplace – Claims more than one year from paid date. • Medicare – Claims more than one year from paid date. **<u>Aurora Health specific exclusions include:</u>** • Marketplace • Medicare – Claims more than one year from paid date.

Documentation History

Type	Date	Action
Published		
Revised Date		

References

This policy was developed using.

- CMS
- State Medicaid Regulatory Guidance
- State Contracts