QualityPath® Implementation Overview

Welcome to *QualityPath*®

QualityPath guides consumers to doctors, hospitals and clinics that are at or above national standards for delivering quality care for selected surgeries and tests. These doctors and hospitals also agree to a lower, bundled price and warranties for *QualityPath* procedures.

These features mean that *QualityPath* creates new demands for third-party administrators (TPAs) who administer claims for our members.

Bundled payment for services is part of a bigger movement in health care to move away from paying for volume and toward paying for value. Administrative systems will need to change over time to automate this process. At this time, the *QualityPath* bundle for surgeries requires manual processing; however, the bundle for CT/MRI scans is designed to take advantage of automated solutions. We will continue to do our best in the short-term to alleviate any burden that *QualityPath* places on TPAs.

The Alliance wants to be an ongoing source of information and support for TPAs who help our members offer *QualityPath* to their employees and family members. We have created this Implementation Overview to help you understand some of the key features of *QualityPath* as it impacts TPAs. We intend to regularly update this document with the latest information as it becomes available.

We encourage you to contact Carlene Boehmer, Director of Claims and Customer Service, for additional information or to schedule an implementation overview session for your staff. Carlene can be contacted at 608.210.6601, or cboehmer@the-alliance.org.

Last Update: 2/1/2021

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***QualityPath* for Inpatient Procedures**

***QualityPath* Designated Doctors and Hospitals**

The following hospital/doctor pairings have qualified as *QualityPath* providers for surgeries:

Knee Replacement and Total Hip Replacement

- Dr. Ajmal Matloob at Beloit Health System, Beloit, Wis.
- Dr. Scott R. Baussuener at Gundersen Health System, La Crosse, Wis.
- Dr. Edward (Ted) Riley at Gundersen Health System, La Crosse, Wis.
- Dr. Mark Topolski at Gundersen Health System, La Crosse, Wis.
- Dr. Lance Sathoff at Monroe Clinic, Monroe, Wis.
- Dr. Jonathan Swindle at Monroe Clinic, Monroe, Wis.
- Dr. Matthew M. Hebert at Sauk Prairie Hospital, Prairie du Sac, Wis.
- Dr. Diana L. Kruse at Sauk Prairie Hospital, Prairie du Sac, Wis.
- Dr. Michael D.C. Lamson at Sauk Prairie Hospital, Prairie du Sac, Wis.
- Dr. David M. Marcu at Sauk Prairie Hospital, Prairie du Sac, Wis.
- Dr. Joshua Lindsey at Southwest Health, Platteville, Wis.

Changes in *QualityPath* Designation

QualityPath designation can change over time. Please check our website for a current list of *QualityPath* providers.

Understanding the Bundle for Inpatient Procedures

The bundle for Knee Replacement and Total Hip Replacement are designed to provide a single allowable amount for the episode of care, which includes a "warranty period" of 90 days post-operatively. The services below are part of the bundled payment or its warranty period and will not be separately reimbursable:

- Inpatient facility charges
- Charges by the surgeon and any assistant surgeon for the procedure, routine post-operative care and the treatment of any complications during the warranty period
- Services provided by other professionals during the inpatient stay (radiology, laboratory, anesthesiology and any other medical specialists)
- Outpatient rehabilitation, if provided by the *QualityPath* provider
- Emergency room visits and the treatment of post-operative complications rendered by the *QualityPath* provider or by others
- Readmissions related to the surgery during the warranty period
- Revisions or reoperations during the warranty period
- Presurgical MRI

Services excluded from the episode reimbursement and for which separate payment may be made include:

- Routine pre-operative care
- Charges for care provided post-discharge that are unrelated to the procedure
- Outpatient rehabilitation, if not provided by the *QualityPath* provider
- Unrelated readmissions during the warranty period
- Charges related to the performance of the same procedure on the patient's other knee or hip during the warranty period
- Care related to the procedure rendered outside of the 90-day warranty period

The bundle reimbursement for CABG is designed to provide a single allowable amount for the episode of care, which includes a 'warranty period' of 90 days post-operatively. The services below are part of the bundled payment or its warranty period and are not separately reimbursable:

- Inpatient facility charges
- Charges by the surgeon and any assistant surgeon for the procedure, routine post-operative care and the treatment of any complications during the warranty period
- Services provided by other professionals during the inpatient stay (radiology, laboratory, anesthesiology and any other medical specialists)
- Outpatient rehabilitation, if provided by the *QualityPath* provider
- Emergency room visits and the treatment of post-operative complications rendered by the *QualityPath* provider or by others.
- Readmissions within 30 days of the index procedure.

Services excluded from the episode reimbursement and for which separate payment may be made include:

- Routine pre-operative care
- Charges for care provided post-discharge that is unrelated to the procedure
- Outpatient rehabilitation, if not provided by the *QualityPath* provider
- Readmissions occurring more than 30 days from the index procedure
- Care related to the procedure rendered outside of the 90-day warranty period

Bundle Descriptions and Definitions

Bundle descriptions and definitions for each *QualityPath* procedure – total hip replacement, knee replacement and coronary artery bypass graft – are available for TPAs to download on the TPA page of the *QualityPath* section of The Alliance website (http://www.the-alliance.org/qualitypath/TPAs).

Managing the Warranty for Inpatient Care

The bundled reimbursement includes a warranty period of 90 days post procedure, during which the provider agrees to provide care for complications (in addition to routine follow-up care) without additional reimbursement. The parameters of the warranty period are outlined below:

1) Consumers will be required to return to the hospital at which the surgery was performed for any related readmissions, excluding patients admitted to another hospital directly from its emergency room.
2) Consumers will also be required to have sufficiently complied with post-discharge instructions in order to keep the warranty in effect. Providers will be expected to make reasonable allowances for ordinary patient behavior in evaluating whether the warranty has been voided.
3) In certain circumstances, such as patients who are traveling significant distances, emergency and other urgent care may be provided by a facility other than the *QualityPath* provider. For this reason, the bundled payment will be made in two distinct payments: 90% of the bundle price will be released 30 days following the procedure; the remaining 10% will be released at the completion of the warranty period (120 days following the procedure).
4) This 10% of the bundle price will be held in reserve to offset payments made by the benefit plan for emergency and urgent care by someone other than the *QualityPath* provider. Any amount remaining at the completion of the warranty period will be released to the *QualityPath* provider.

Plan Design for Inpatient Care

Services subject to the bundle as well as any routine pre-operative care provided by the *QualityPath* provider will be covered at 100% of The Alliance repriced amount. The chart in Appendix A outlines benefits covered at 100% under the *QualityPath* level of benefits.

In addition, the program has optional benefits outside of the group health plan, which the employer may or may not look to their TPA partner to administer. Appendix B outlines the various optional coverages that an employer may implement as part of the *QualityPath* program.

These are the essential plan design requirements for members to quality for *QualityPath* bundled pricing:

- The Alliance is the sole provider of *QualityPath* and a patient must be enrolled in The Alliance network to receive the *QualityPath* benefits.
- Employers are required to extend *QualityPath* to all medical-eligible employees and dependents enrolled in The Alliance network (no sub-groups or excluding certain individuals from the benefit enhancements of *QualityPath*).
- A plan member must call The Alliance and enroll in *QualityPath* prior to the procedure being performed in order to qualify for the enhanced benefits and bundled pricing.
- Schedule of Benefits (refer to Appendix A in TPA implementation Overview):
    - 100% coverage for presurgical consult and related lab/diagnostics/imagining at *QualityPath* provider for the *QualityPath* procedure
    - 100% coverage for services provided during the inpatient stay at *QualityPath* provider for the *QualityPath* procedure
    - 100% coverage for post-operative services for 90 days after the surgery for all services covered under the *QualityPath* warranty
    - 100% coverage for rehabilitation services and physical therapy at *QualityPath* provider for the *QualityPath* procedure
    - *OPTIONAL: 100% coverage for rehabilitation services and physical therapy at non-*QualityPath* providers for the *QualityPath* procedure
    - *OPTIONAL: Appendix B in TPA Implementation Overview – Travel/housing payment and additional cash incentives
    - **For Health Savings Account (HSA) plans**: 100% coverage post deductible waiving any additional co-insurance for all of the services listed above and providing the patient with a minimum of a $1,000 cash incentive to be either funded in the HSA account or paid directly to the patient.
- Patients must comply with post-discharge instructions, including outpatient rehabilitation/physical therapy, to be eligible for the warranty benefit.
- Appeals: All appeals related to *QualityPath* program should be included in the standard appeals process and be funneled through the TPA.

Relaying Information to TPAs regarding *QualityPath* Inpatient Procedures

1) Charges subject to the bundle:

Claims subject to the bundle are delivered to the appropriate TPA designate in two packets.

Both packets include a cover sheet indicating that the claims are related to a *QualityPath* Bundle agreement and also relay the benefit level to be applied.

- Packet 1 is released 30 days following the procedure and is based on all charges related to the inpatient stay. The repriced amount will reflect 90% of the total bundle allowable.
- Packet 2 is released 120 days following the procedure and is based on all additional charges related to the bundle that are incurred with the *QualityPath* provider during the 90-day warranty period. The repriced amount relayed in packet 2 will be the remaining 10% of bundle allowable, less any charges incurred for warranty work performed by a non- *QualityPath* provider. This will be relayed via an adjustment on the inpatient hospital claim.

2) Pre-Op work:

Claims for pre-op work will be repriced under Alliance standard agreements, and covered at 100% of reprice. We will forward these claims immediately to the designate at the TPA with a cover letter advising that charges are subject to *QualityPath* benefit level and should be paid at 100% of Alliance reprice.

3) Warranty work not provided by *QualityPath* provider:

These charges are repriced using The Alliance standard agreement. The Alliance will track the repriced amounts internally and subtract them from final bundle allowable amount that is relayed in packet 2.

Warranty services performed by a non-*QualityPath* provider are payable at the *QualityPath* benefit level. These claims are forwarded to the TPA designate with a cover letter advising that charges are subject to the *QualityPath* benefit level and should be paid at 100% of the Alliance reprice.

***QualityPath* for Outpatient Procedures**

***QualityPath* Designation for Outpatient Procedures**

Hospitals and clinics that will provide outpatient CTs, MRIs and Colonoscopy through *QualityPath*.

CT Scans

Forest City Diagnostic Imaging

Fort HealthCare, Fort Atkinson, Wis.

Gundersen Health System, La Crosse, Wis.

Gundersen Health System, Onalaska, Wis.

OrthoIllinois, Rockford, Wis.

Southwest Health, Platteville, Wis.

Upland Hills Health, Dodgeville, Wis.

MRI

Forest City Diagnostic Imaging

Fort HealthCare, Fort Atkinson, Wis.

Gundersen Health System, LaCrosse, Wis.

Midwest Open MRI, Middleton, Wis.

OrthoIllinois, Rockford, Ill.

Southwest Health, Platteville, Wis.

Upland Hills Health, Dodgeville, Wis.

Colonoscopy

Upland Hills Health, Dodgeville, Wis

Changes in *QualityPath* Designation

QualityPath designation can change over time. Please check our website for a current list of *QualityPath* providers.

Understanding the Bundle for CT and MRI Scans

The bundle for Computerized Tomography (CT) and Magnetic Resonance Imaging (MRI) is designed to provide cost effective pricing for adult and pediatric imaging when the image is the primary purpose for the encounter. The image must be performed on a non-emergent outpatient basis as determined by the place of service code presented on the CMS 1500 or bill type presented on the UB04 claim. Services included in the reimbursement rate are:

- The technical and professional component(s) of the triggering CPT/HCPCs Codes
- All charges submitted on the claim
- Services defined as “packaged services” under the APC reimbursement model;
- Drugs, biologicals, and radiopharmaceuticals that function as supplies (including diagnostic radiopharmaceuticals and contrast agents)
- All supplies
- Ancillary services
- Guidance services
- Image processing services
- Observation services

In addition hospital claims using a UB04 claim that are submitted with revenue codes with no defined CPT/HCPCs code will be repriced under the bundle

There will be six pricing categories for these procedures.

Alliance bundle allowable will be applied to each claim submitted for the service.

CPT Codes that are subject to bundle repricing can be found in Appendix C or on our website.

CT and MRI Scans Warranty

The bundled reimbursement includes a warranty period of 30 days post procedure. There is no charge for a repeated image required for a period of 30 days from the initial *QualityPath* image when the additional image is performed by a *QualityPath* provider and is due to the quality of the initial scan.

Plan participants are not required to call the Alliance in order to activate the warranty provision of the plan. Plan participants are however encouraged to notify us via the Tell Us application on our website: http://www.the-alliance.org/qualitypath/tellus/

Follow up or subsequent imaging is not covered under the *QualityPath* warranty.

Plan Design for Outpatient Procedures

Services subject to the bundle will be covered at 100% of The Alliance repriced amount

For HSA plans: 100% coverage post deductible waiving any additional co-insurance for all services listed above and providing the patient with a minimum of a $100 cash incentive to be either funded in the HSA account or paid directly to the employee.

Relaying Information to TPAs Regarding CT and MRI Bundle Allowable

Claims subject to the MRI and CT bundle will be delivered to the appropriate TPA designate on a daily basis.

Status message on Alliance repricing sheet will state:

> *QualityPath* Pricing Pay Repriced amount; Not subject to Deductibles and Coinsurance

Warranty claims will reprice to zero.

Understanding the Bundle for Colonoscopy

The bundle for Colonoscopy procedures is designed to provide cost effective pricing for patients age 18 or older, when a qualified colonoscopy is the primary purpose for the encounter. The colonoscopy must be performed on a non-emergent outpatient basis as determined by the place of service code presented on the CMS 1500 or bill type presented on the UB04 claim.

The Colonoscopy is for one of the following reasons:

- Colorectal Cancer (CRC) Screening
- Colorectal Cancer Screening that Transitioned to Therapeutic Procedure
- Surveillance procedures for patients that have previously had a CRC screening.

Patients are not excluded from the bundle based on diagnosis. Patients must contact The Alliance and enroll in the *QualityPath* Colonoscopy bundle prior to receiving care.

Services below are part of the bundled payment or its warranty and will not be separately reimbursable:

Pre-Operative Services

- Pre-operative evaluations performed up to 3 days prior to procedure

Day of Services

- Colonoscopy Facility Claim
- Colonoscopy Surgeon Claim
- Monitored Anesthesia Care Claim
- Pathology Claims Technical
- Pathology Claims Professional

Post-Operative Medical Services

Post-Operative medical services include the following services rendered within 7 days of the colonoscopy

- Follow-up visits during the post-operative period of the surgery that are related to recovery from the surgery
- Tissue Exam by Pathologist

There will be two pricing categories for these procedures.

Alliance bundle allowable will be applied to each claim submitted for the service.

CPT Codes that are subject to bundler repricing can be found in Appendix D or on our website.

Colonoscopy Warranty

The bundled reimbursement includes a warranty period. Patient must notify The Alliance within 14 days post procedure of potential warranty claim. Covered Services included for consideration include are:

- Necessary repeated procedures due to incomplete procedures or poor preparation.
    - Claims for discontinued procedures will be repriced to zero
- Emergent, Urgent or Inpatient Visits at any site with capped
    - Within 7 days of the initial colonoscopy.

The following services will be determined part of the warranty as defined on a professional claim in an Emergency Room, Urgent Care or Inpatient setting.

- Gastrointestinal bleeding
- Abdominal Pain
- Perforation

Other services that the patient feels should be covered as part of a warranty service may be appealed to the payer for consideration on a case-by-case basis.

Plan Design for Outpatient Procedures

Services subject to the bundle will be covered at 100% of The Alliance repriced amount

For HSA plans: 100% coverage post deductible waiving any additional co-insurance for all services listed above and providing the patient with a minimum of a $100 cash incentive to be either funded in the HSA account or paid directly to the employee.

Relaying Information to TPAs Regarding Colonoscopy Bundle Allowable

Claims subject to the MRI and CT bundle will be delivered to the appropriate TPA designate on a daily basis.

Status message on Alliance repricing sheet will state:

> *QualityPath* Pricing Pay Repriced amount; Not subject to Deductibles and Coinsurance

Claims for incomplete procedures and warranty claims for treatment received at index provider will reprice to zero.

Other Items:

Access Fees – The *QualityPath* program is covered under standard Alliance access fees.

Appeals Process – TPA standard appeals process should be used for *QualityPath* procedures. The Alliance will work with TPA Appeals staff to develop a workflow between organizations to accommodate any appeals tied to *QualityPath* procedures.

Explanation Of Benefits (EOB) Language – No *QualityPath*-specific EOB language requirements.

ID Card – No *QualityPath*-specific ID card requirements.

Implementation Costs – None.

Patient Experience Manager – The Alliance offers the resources of our Patient Experience Manager to patients who are undergoing an inpatient surgery to assist them along their *QualityPath* care journey. In addition, the Patient Experience Manager works closely with the member, the provider and TPA designates, as well as case management and pre-authorization vendors, to ensure all parties who play a role in the delivery and payment of the member's health care claims are aware of the member's participation in the *QualityPath* program and that all plan requirements have been met to ensure a positive outcome for the plan member. The Patient Experience Manager is assisted by Member Services Representatives and Customer Service Representatives at The Alliance, as needed.

QualityPath Specific Repricing Sheet Messages

REPRICING COVER SHEET STATUS MESSAGE	PROVIDERS/LOCATIONS	ALLIANCE REPRICE APPLICABILITY
QualityPath Pricing: Pay Repriced amount; Not subject to Deductible and Coinsurance	Par providers in any location that are providing pre-surgical services for *QualityPath* eligible member	Payment should be made at the *QualityPath* level of benefits (100%) based on Alliance repriced amount
QualityPath Pricing: Pay repriced amount. Bundled pricing applied	*QualityPath* providers and their designates	Payment should be made at the *QualityPath* level of benefits (100%) based on Alliance repriced amount
QualityPath Warranty: Pay repriced amount, not subject to deductibles and coinsurance	Par providers in any location that is providing services related to a complication from a *QualityPath* procedure	Payment should be made at the *QualityPath* level of benefits (100%) based on Alliance repriced amount
QualityPath Warranty: Included in Bundle Pricing No additional payment allowed	*QualityPath* providers providing services related to a complication from a *QualityPath* procedure	Claim will be repriced to zero by The Alliance. While no payment will be issued, EOB should be generated to the provider of service

Appendix A -- Chart of Benefits Covered at 100% in *QualityPath* Inpatient Plan Design

SERVICE	COVERAGE LEVEL	REPRICING LEVEL	SPECIAL REQUIREMENTS
Presurgical Consult with *QualityPath* physician and routine pre-operative care	100%	Alliance standard provider agreement	Member must contact The Alliance Patient Experience Manager prior to initial consult with *QualityPath* provider to enroll in the program and to be eligible for the *QualityPath* level of benefits
All services related to the *QualityPath* procedure and inpatient stay	100%	*QualityPath* Bundle agreement	
Outpatient rehabilitation by a *QualityPath* Provider	100%	*QualityPath* Bundle agreement	Member must select to participate in bundle that includes rehabilitation
Outpatient rehabilitation by a non-*QualityPath* Provider	100%	Alliance standard provider agreement	Optional benefit available only if chosen by employer
Emergency room visits and treatment of post-operative complications rendered by the *QualityPath* provider	100%	*QualityPath* Bundle Agreement	Services are covered under the warranty provision of the agreement; member must contact *QualityPath* prior to receiving services
Emergency room visits and treatment of post-operative complications rendered by a non-*QualityPath* provider.	100%	Alliance standard provider agreement	Services are covered under the warranty provision of the agreement; member must contact *QualityPath* prior to receiving services
Readmissions related to the surgery during the warranty period (at *QualityPath* provider)	100%	*QualityPath* Bundle Agreement	Within 90 days for total hip and knee replacements Within 30 days for CABG
Revisions or reoperations during the warranty period (at *QualityPath* provider)	100%	*QualityPath* Bundle Agreement	

Appendix B: Additional Optional Benefits for Inpatient Plan Design

BENEFIT	ITEMS THAT MAY BE INCLUDED
Travel Benefits	**Hotel Room and travel costs** 1) Payable at a percentage of total charges 2) Payable for travel based on a travel radius from member's home 3) For plan member and traveling companion 4) To a capped limit based on: a. Dollar amount for travel b. Dollar amount for lodging c. Per procedure d. Per year e. Per lifetime 5) Mileage reimbursement at a. Standard government rate b. Rate defined by employer 6) Additional expenses including a. Tolls/parking fees b. Tax
Cash incentive/bonus program	Cash or gift card bonus for members provided upon demonstration of any of the following: 1) *QualityPath* procedure approval 2) Presentation by employee of Explanation of Benefits (EOB) 3) Notification from The Alliance that a member has completed the treatment through the warranty period

Appendix C: CT and MRI Trigger Codes

Elective CT and MRI Services where the qualified CT/MRI is the primary procedure

Level 1 CT w/ Contrast

CT HEAD/BRAIN W/DYE (70460)

CT HEAD/BRAIN W/O & W/DYE (70470)

CT ORBIT/EAR/FOSSA W/DYE (70481)

CT ORBIT/EAR/FOSSA W/O&W/DYE (70482)

CT MAXILLOFACIAL W/DYE (70487)

CT MAXILLOFACIAL W/O & W/DYE (70488)

CT SOFT TISSUE NECK W/DYE (70491)

CT SFT TSUE NCK W/O & W/DYE (70492)

CT ANGIOGRAPHY HEAD (70496)

CT ANGIOGRAPHY NECK (70498)

CT THORAX W/DYE (71260)

CT ANGIOGRAPHY CHEST (71275)

CT NECK SPINE W/O & W/DYE (72127)

CT CHEST SPINE W/DYE (72129)

CT CHEST SPINE W/O & W/DYE (72130)

CT LUMBAR SPINE W/O & W/DYE (72133)

CT ANGIOGRAPH PELV W/O&W/DYE (72191)

CT PELVIS W/DYE (72193)

CT PELVIS W/O & W/DYE (72194)

CT UPPR EXTREMITY W/O&W/DYE (73202)

CT ANGIO UPR EXTRM W/O&W/DYE (73206)

CT LOWER EXTREMITY W/DYE (73701)

CT LWR EXTREMITY W/O&W/DYE (73702)

CT ANGIO LWR EXTR W/O&W/DYE (73706)

CT ABDOMEN W/DYE (74160)

CT ABDOMEN W/O & W/DYE (74170)

CT ANGIO ABDOM W/O & W/DYE (74175)

CT ANGIO ABDOMINAL ARTERIES (75635)

Comb. CT w/o Contrast

CT ABD & PELVIS W/O CONTRAST (74176)

Level 2 CT w/ Contrast

CT THORAX W/O & W/DYE (71270)

CT NECK SPINE W/DYE (72126)

CT LUMBAR SPINE W/DYE (72132)

CT UPPER EXTREMITY W/DYE (73201)

CT ANGIO ABD&PELV W/O&W/DYE (74174)

CT ABD & PELV W/CONTRAST (74177)

CT ABD & PELV 1/> REGNS (74178)

MRI w/o Contrast

MAGNETIC IMAGE JAW JOINT (70336)

MRI ORBIT/FACE/NECK W/O DYE (70540)

MR ANGIOGRAPHY HEAD W/O DYE (70544)

MR ANGIOGRAPHY NECK W/O DYE (70547)

MRI BRAIN STEM W/O DYE (70551)

MRI BRAIN W/O DYE (70557)

MRI CHEST W/O DYE (71550)

MRI NECK SPINE W/O DYE (72141)

MRI CHEST SPINE W/O DYE (72146)

MRI LUMBAR SPINE W/O DYE (72148)

MRI PELVIS W/O DYE (72195)

MR ANGIO PELVIS W/O & W/DYE (72198)

MRI UPPER EXTREMITY W/O DYE (73218)

MRI JOINT UPR EXTREM W/O DYE (73221)

MR ANGIO UPR EXTR W/O&W/DYE (73225)

MRI LOWER EXTREMITY W/O DYE (73718)

MRI JNT OF LWR EXTRE W/O DYE (73721)

MRI ABDOMEN W/O DYE (74181)

MR ANGIOGRAPHY WITHOUT CONTRST ABD (C8901)

MR ANGIO WITHOUT CONTRST CHEST (C8910)

MR ANGIO WITHOUT CONTRST LOW EXTREM (C8913)

MRA WITHOUT CONTRAST PELVIS (C8919)

MRA WITHOUT CONTRST UPPER EXTREMITY (C8935)

MRI w/ Contrast

MRI ORBIT/FACE/NECK W/DYE (70542)

MRI ORBT/FAC/NCK W/O &W/DYE (70543)

MR ANGIOGRAPHY HEAD W/DYE (70545)

MR ANGIOGRAPH HEAD W/O&W/DYE (70546)

MR ANGIOGRAPHY NECK W/DYE (70548)

MR ANGIOGRAPH NECK W/O&W/DYE (70549)

MRI BRAIN STEM W/DYE (70552)

MRI BRAIN STEM W/O & W/DYE (70553)

MRI BRAIN W/DYE (70558)

MRI BRAIN W/O & W/DYE (70559)

MRI CHEST W/DYE (71551)

MRI CHEST W/O & W/DYE (71552)

MRI ANGIO CHEST W OR W/O DYE (71555)

MRI NECK SPINE W/DYE (72142)

MRI CHEST SPINE W/DYE (72147)

MRI LUMBAR SPINE W/DYE (72149)

MRI NECK SPINE W/O & W/DYE (72156)

MRI CHEST SPINE W/O & W/DYE (72157)

MRI LUMBAR SPINE W/O & W/DYE (72158)

List continues on next page

MRI PELVIS W/DYE (72196)

MRI PELVIS W/O & W/DYE (72197)

MRI UPPER EXTREMITY W/DYE (73219)

MRI UPPR EXTREMITY W/O&W/DYE (73220)

MRI JOINT UPR EXTREM W/DYE (73222)

MRI JOINT UPR EXTR W/O&W/DYE (73223)

MRI LOWER EXTREMITY W/DYE (73719)

MRI LWR EXTREMITY W/O&W/DYE (73720)

MRI JOINT OF LWR EXTR W/DYE (73722)

MRI JOINT LWR EXTR W/O&W/DYE (73723)

MR ANG LWR EXT W OR W/O DYE (73725)

MRI ABDOMEN W/DYE (74182)

MRI ABDOMEN W/O & W/DYE (74183)

MRI ANGIO ABDOM W ORW/O DYE (74185)

MR ANGIOGRAPHY W/CONTRAST ABDOMEN (C8900)
MR ANGIO W/O CONTRST W/CONTRST ABD (C8902)
MR ANGIOGRAPHY WITH CONTRAST CHEST (C8909)
MR ANGIO NO CONTRST FLW CNTRST CHST (C8911)
MR ANGIO W/CONTRST LOWER EXTREMITY (C8912)
MR ANGIO NO CNTRST FLW CON LW EXTRM (C8914)
MR ANGIOGRAPHY WITH CONTRAST PELVIS (C8918)
MRA NO CONTRST FLWED W/CONTRST PELV (C8920)
MRA WITH CONTRAST UPPER EXTREMITY (C8934)
MRA NO CONTRST FLW W/CONTRST UP EXT (C8936)

Appendix D – Colonoscopy Trigger Codes

Triggering Code: The following CPT/HCPCS codes are considered triggering codes:

Code	Description
44388	COLONOSCOPY THRU STOMA SPX
44389	COLONOSCOPY WITH BIOPSY
44392	COLONOSCOPY & POLYPECTOMY
44394	COLONOSCOPY W/SNARE
44401	COLONOSCOPY WITH ABLATION
45378	DIAGNOSTIC COLONOSCOPY
45380	COLONOSCOPY AND BIOPSY
45381	COLONOSCOPY SUBMUCOUS NJX
45382	COLONOSCOPY W/CONTROL BLEED
45384	COLONOSCOPY W/LESION REMOVAL
45385	COLONOSCOPY W/LESION REMOVAL
45386	COLONOSCOPY W/BALLOON DILAT
45388	COLONOSCOPY W/ABLATION
45390	COLONOSCOPY W/RESECTION
45392	COLONOSCOPY W/ENDOSCOPIC FNB
45398	COLONOSCOPY W/BAND LIGATION
G0105	COLOREC CANCR SCR; COLNSCPY HI RISK
G0121	COLOREC CNCR SCR;COLNSCPY NO HI RSK

- Colonoscopy is for one of the following reasons
    - Colorectal Cancer (CRC) Screening:
    - Colorectal Cancer Screening that Transitioned to Therapeutic Procedure
    - Surveillance procedures for patients that have previously had a CRC screening.

These may be determined in one of three ways:

1. A primary or secondary diagnosis on the **Surgeon's** or **Facility's Claim** indicating an appropriate diagnosis

ICD10_CODE	SHORT_DESCRIPTION
Z1211	Encounter for screening for malignant neoplasm of colon
Z800	Family history of malignant neoplasm of digestive organs
Z8371	Family history of colonic polyps
Z85038	Personal history of malignant neoplasm of large intestine
Z86010	Personal history of colonic polyps
Z08	Encounter for follow-up exam after treatment for malignant neoplasm
Z09	Encounter for f/u exam after treatment for condition other than malignant neoplasm

2. The **Triggering Code** indicates the colonoscopy is for screening

Code	Description
G0105	COLOREC CANCR SCR; COLNSCPY HI RISK
G0121	COLOREC CNCR SCR;COLNSCPY NO HI RSK

3. A modifier on a **Triggering Code** indicating a preventative or transitioned procedure

Modifier	Description
33	Preventive Services
PT	Colorectal cancer screening test; converted to diagnostic test or other procedure