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Dear Provider,

Thank you for your continued partnership with Meridian. As you know, we continually review and update our payment and utilization policies to ensure that they comply with industry standards, while delivering the best patient experience to our members. We are writing today to inform you of the new policies Meridian will be implementing and going into effect on April 1, 2022.

For detailed information about the policies, please refer to our website at **www.mimeridian.com**. If you have questions, please call Provider Services at **888-437-0606**.

Sincerely,

Meridian

Policy Number	Policy Name	Policy Description
CC.PP.500	Three Day Payment Window	All hospitals (other than non-IPPS hospitals) are subject to a three day bundling requirement when they furnish preadmission diagnostic services or non-diagnostic services that are related to the member's inpatient admission, on the date of the inpatient admission or within three calendar days prior to the date of the inpatient admission.
CC.PP.071	Evaluation and Management Services Billed with Treatment Rooms	Disallows Evaluation and Management (E/M) services in treatment rooms, as this does not represent a treatment type of service.
CC.PP.066	Leveling of Care: Evaluation and Management Over Coding	Meridian will provide an automated pre-payment (after services are rendered, but prior to claims payment), claims review process for determining the correct level of evaluation and management service. The coding algorithm will evaluate each diagnosis code billed in the claim header, along with historical claims and other claim information (including additional testing/procedures), to determine if the level of the E/M service billed is appropriate for the services rendered. When multiple diagnosis codes are billed, the algorithm will evaluate each code and other claims information and assign a maximum level of service to each diagnosis. The minimum level of service is 3 for E/M services with 5 levels and a level 2 for E/M services with 3 levels.
CC.PP.065	Multiple Diagnostic Cardiovascular Procedure Payment Reduction	This policy is based on CMS reimbursement methodologies for MPPR and applies a multiple diagnostic cardiovascular procedure reimbursement reduction (MDCR) to procedures assigned a multiple procedure indicator (MPI) of 6 on the CMS

		National Provider Fee Schedule (NPFS). When this occurs, only the highest-valued procedure is reimbursed at the full payment allowance (100%) and payment for subsequent procedures/units is reimbursed at 75% of the allowance.
CC.PP.068	Multiple Procedure Payment Reduction for Therapeutic Services	When two or more 'always therapy' procedures with an MPI of 5 are performed by the same provider, or by providers within the same group practice, on the same day, the policy will allow 100% of the maximum allowance for the therapeutic procedure with the highest cost per until and 90% of the allowance for each subsequent therapeutic procedure.
CC.PP.069	Multiple Procedure Reduction: Ophthalmology	When two or more diagnostic ophthalmology procedures with an MPI of 7 are performed by the same provider, on the same patient, on the same day, the policy will allow 100% of the maximum allowance for the first diagnostic procedure with the highest cost per unit and 80% of the allowance for each subsequent procedure, unless the modifier -26 is present.
CC.PP.053	Non-Emergent ER Services	When a hospital, freestanding emergency center, or provider bills a level 4 (CPT 99284) or level 5 (CPT 99285) emergency room service, with a diagnosis indicating a lower level of complexity or severity, Meridian will reimburse the provider at a level 3 (CPT 99283) reimbursement rate. The patient's primary discharge diagnosis should be billed in the first diagnosis position on the emergency room claim form.
CC.PP.061	Non-OB and OB Pelvic and Transvaginal Ultrasounds	Revision to the existing CC.PP.061 policy to include a multi-procedure reduction for transvaginal and first trimester abdominal ultrasound performed on the same day. The transvaginal ultrasound would be paid at 100% and the abdominal ultrasound will be reduced by 50%.
CC.PP.054	Provider's Consultation Services	Meridian will reimburse consultation codes at the corresponding E/M visit level. The provider should bill the E/M code, other than the consultation code, that describes the service provided. The table above shows identified consultation codes and crosswalks them to the more appropriate level of office visit, initial inpatient visit, or emergency department procedure code. The provider will be paid according to the fee schedule for the equivalent procedure code.
CC.PP.055	Provider's Office Lab Testing	Only in-office laboratory procedures that are to be used in establishing a diagnosis and/or to select the best treatment options to manage the patient's care will be reimbursed and the higher quality laboratory tests which are performed in the correct setting. The only in-office laboratory tests allowed are those on the Short Turnaround Time (STAT) laboratory code list, included in the policy.
CC.PP.057	Problem-Oriented Visits with Preventative Visits	A provider or other qualified healthcare professional may submit both a preventative E/M Current Procedural Terminology (CPT®) code and a problem-oriented E/M CPT code on the same date of service for the same patient. Once clinically validated, (see CC.PP.013), if the problem-oriented E/M represents a significant

		and separately identifiable E/M procedure or service, the problem-oriented procedure code will be reimbursed at a reduced rate.
CC.PP.052	Problem-Oriented Visits with Surgical Procedures	A provider or other qualified healthcare professional may submit both a problem-oriented E/M CPT code and a surgical procedure code on the same date of service for the same member. Once clinically validated (see CC.PP.013 "Clinical Validation of Modifier -25") if the problem-oriented E/M represents a significant and separately identifiable E/M procedure or service, the problem-oriented procedure code will be reimbursed at a reduced rate.
CC.PP.067	Renal Hemodialysis	Hemodialysis will be denied in excess of 3 units or visits during any calendar week.
CC.PP.050	Robotic Surgery	Code S2900 will not be paid because it is an add-on code billed in addition to the primary surgical procedure code and it denotes separate reimbursement for the robotic technique.
CC.PP.035	Sleep Studies Place of Service	Meridian's code editing software will evaluate claim lines to determine if the place of service submitted for a sleep study is consistent with the definition of the sleep study procedure code billed. If the place of service is incorrect, the sleep study will be denied. (i.e., an attended sleep study with the place of service as 'home' would not be appropriate).
CC.PP.056	Urine Specimen Validity Testing	Separate reimbursement for testing to confirm that a urine drug specimen is unadulterated is disallowed because validity testing is an internal control process that is not separately reportable according to the CMS guidelines for Drug Testing documented in the National Correct Coding Initiative Policy Manual.
CC.PP.502	Wheelchair Accessories	Special wheelchair accessories are allowed based on the indications outlined in the policy.