healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	By Report (BR)		
Policy Number:	PO-RE-112v1		
Effective Date:	1/01/2025	**Last Approval Date:**	11/18/2024

I. Policy Description

The By Report (BR) reimbursement policy outlines the guidelines for reimbursing Medicaid service codes that are designated "By Report" ("BR") on the NYS Medicaid Physician Manual Fee Schedule and on the Ordered Ambulatory Fee Schedule. Healthfirst is committed to ensuring fair and transparent reimbursement processes for healthcare providers, and this policy provides clarity on how reimbursement for BR service codes are determined.

The information below applies to the following lines of business:

- Child Health Plus
- Medicaid Managed Care
- Health & Recovery Plan (HARP)

Reimbursement Guidelines

1. Providers must obtain prior authorization for services that have a By Report "BR" indicator
2. Appropriate documentation (e.g., operative report, procedure description, and/or itemized invoices) should accompany all claims submitted.
3. Itemized invoices must document the acquisition cost, line-item cost from a manufacturer or wholesaler net of any rebates, or other valuable considerations.
4. Providers are required to report the National Drug Code (NDC) for all drugs, if the NDC is not referenced on a claim, Healthfirst will not provide reimbursement for the drug.
5. Healthcare Providers and billing staff are responsible for ensuring accurate coding and billing practices.

Adjudication and Appeal Process

1. Reimbursement for services with a status indicator of By Report "BR" will be based on the provider's contract with Healthfirst or at the Healthfirst Standard Fee Schedule rate.

2. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst*

Provider Manual Subsection 17.6, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.

This policy is not an authorization or guarantee of payment. Reimbursement is subject to member eligibility, program coverage, and medical necessity at the time the service is provided.

II. Applicable Codes

Code	Description	Comment

III. Definitions

Term	Meaning

IV. Related Policies

Policy Number	Policy Description
PO-RE-088	Reimbursement-Policy-PO-RE-088v1 National Drug Code (NDC)

Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

New York State Medicaid Update - July 2022 Volume 38 - Number 8 (ny.gov)

VI. Revision History

Revision Date	Summary of Changes

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.