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# HIGHMARK CODING TIPS

## Reporting Services Defined as Per Calendar Month

Some services contain frequency restrictions defined in the definition of the procedure code as *"per calendar month"*, *"in a month"*, or *"per month."* It is important to know that the Plan will allow such services as a "floating" 30-day period. In other words, if a service is performed in March and April, the Plan will require 30 days within the services billed.

Examples of services that commonly fall into this scenario are Care Management codes such as: 990487-99494, 99439, 99484, G2064, G2065, and G2214.

If reporting these services within 30 days from the previous or subsequent service, the Plan may reject an eligible and separately reimbursable service. Services that are considered eligible would be those that correctly and accurately follow the CPT guidelines and definitions of the procedure codes. The medical record should include documentation in support of all services performed within the 30-day period.

For more information on Care Management reporting and payment, please reference RP-043; Care Management Services, on the Provider Resource Center.

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