Reimbursement/Billing Policy

PARAMOUNT

HMO AND PPO
ELITE (MEDICARE ADVANTAGE)
MARKETPLACE

Code Editing

Policy Number: RM013
Last Review: 02/01/2024

GUIDELINES:

- Paramount Reimbursement Policies have been developed to assist in administering proper payment under benefit contracts.
- Reimbursement policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements.
- Paramount utilizes industry standard coding methodology and claims editing in the development of reimbursement policies. Industry standard resources include, but are not limited to, CMS National Correct Coding Initiative (NCCI), Medically Unlikely Edits (MUEs), Integrated Outpatient Code Editor (I/OCE) Clinical edits, Medical Policies, Reimbursement Policies, and Administrative/Provider Manuals. Paramount will not reimburse services determined to be Incidental, Mutually Exclusive, or Unbundled.
- All health care services, devices, and pharmaceuticals must be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes and modifiers, which most accurately represent the services rendered, unless otherwise directed by the Paramount. All billed codes must be fully supported in the member's legal medical record.
- Paramount utilizes CMS pricing algorithms where appropriate based on, National Physician Fee Schedule Relative Value File (NPFSRVF) pricing rules, Inpatient Prospective Payment Systems (MS-DRG, LTC, IPF, IRF & IPSNF) and Outpatient Prospective Payment Systems (OPPS, HHA, ASC, ESRD & OPSNF).
- Paramount liability will be determined after coordination of benefits (COB) and third-party liability (TPL) is applied to the claim. Member liability may include, but is not limited to, co-payments, deductibles, and coinsurance. Members' costs depend on member benefits.
- Paramount routinely reviews reimbursement policies. Updates are published on Paramount's website https://www.paramounthealthcare.com. The information presented in this reimbursement policy is accurate and current as of the date of publication. Paramount communicates policy updates to providers via Paramount's monthly bulletin.

SCOPE:

X Professional
X Facility

DESCRIPTION:

Professional and Facility services are identified using Current Procedure Terminology (CPT) codes/modifiers, Healthcare Common Procedure Coding System (HCPCS Level II) codes/modifiers, and International Classification of Diseases,10th Revision, Clinical Modifications (ICD-10-CM). These codes/modifiers enable the accurate identification of the service or procedure.

Paramount utilizes both internal and vendor sourced HIPAA-compliant code editing software for coding verification. The claims editing software contains a comprehensive set of rules addressing coding inaccuracies such as, but not limited to unbundling, frequency limitations, up-coding, duplication, invalid codes and/or modifiers, mutually exclusive procedures, and other coding inconsistencies. The software has clinical logic based on clinical practice and reimbursement standards, along with knowledge and judgment of medical experts.

Several reference guidelines are utilized in developing the claims adjudication logic for services and procedures review, applying edits which are based on the following sources, but not limited to:

- Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) for professional and facility claims. The NCCI edits include column 1/column 2, medically unlikely edits

(MUE), mutually exclusive and outpatient code editor (OCE) edits. CMS developed these edits to control incorrect code combination billing contributing to incorrect payments.
- The American Medical Association's Current Procedural Terminology (CPT) manual
- National and State Medical Societies and Associations (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons).
- CMS Claims Processing Manual
- State Provider Manuals, Fee Schedules, Periodic Provider Updates (bulletins/transmittals)
- CMS coding resources, such as HCPCS Coding Manual, National Physician Fee Schedule, Provider Benefit Manual, Claims Processing Manual, MLN Matters and Provider Transmittals
- State-specific policies and procedures for billing professional and facility claims
- Health Plan policies and provider contract considerations
- Billing Guidelines Published by Specialty Provider Associations
    - Global Maternity Package data published by the American Congress of Obstetricians and Gynecologists (ACOG)
    - Global Service Guidelines published by the American Academy of Orthopedic Surgeons (AAOS)
- AMA resources

Modifiers can be used to describe a product or service rendered, as listed below, but not all-inclusive:
- A service or procedure has both a professional and technical component. (When both the technical and professional components of a procedure are performed by the same professional provider in a setting other than inpatient hospital, outpatient hospital, skilled nursing facility, or in an ambulatory surgical center, a single charge should be reported for the total procedure.)
- A service or procedure was performed by more than one physician and/or in more than one location.
- A service or procedure has been increased or reduced.
- Only part of a service was performed.
- A bilateral procedure was performed.
- A service or procedure was provided more than once.
- Unusual events occurred.
- A DME item is purchased or rented.

Paramount plans require the use of CPT/HCPCS modifiers when appropriate. Some modifiers are for informational purposes only, while other modifiers affect how claims are processed, how services are priced, and how payment is calculated code editing software will evaluate invalid payment modifier to procedure code combinations. Using a modifier inappropriately can result in the denial of a claim or an incorrect reimbursement for a product or service.

Revenue codes are billed by institutional providers on a UB04 or electronic equivalent and represent the location where services were performed in a hospital and the type of services received. CPT/HCPCS codes <u>are</u> required on the claim in addition to the revenue code when appropriate.

Claims editing software is updated to incorporate the most recent medical practices, coding principles, industry standards and annual changes to the CPT and CMS guidelines.

POLICY:
Providers are required to submit accurate and complete claims for all medical and surgical services, supplies and items rendered to members using industry standard coding guidelines. All claims submitted by a provider must be in accordance with the reporting guidelines and instructions contained in the most current CPT, HCPCS and ICD-10-CM publications. Hospitals and facilities must report all services, supplies and items using accurate revenue codes. The code(s) and modifier(s) must be valid for the dates of service reported. Any medical or surgical service, supply, or item, either inpatient or outpatient, reported by any code and/or modifier, must be clearly documented in an appropriate medical record. The services must also be within the scope of practice for the relevant type of provider in the State in which they are furnished and within provider's credentials/training (e.g., board certification).

As claims are adjudicated through the claims code editing cycle, each service line on the claim is processed through the code editing rules engine(s) and evaluated for correct coding. As part of this evaluation, the prospective claim is analyzed against other codes billed on the same claim, claims with the same date of service as well as previously paid claims found in the member/provider history.

Paramount applies the software rules-based logic to:

- Assess health care professional and facility claims information, including CPT and HCPCS service codes and modifiers to detect coding irregularities, conflicts, or errors;
- When necessary, stop claims processing to obtain additional documentation;
- Implement Paramount's coding guidelines, Medical Policies, and Reimbursement Policies.

Claims editing software contains a comprehensive set of rules addressing coding inaccuracies such as, but not limited to:

- Re-bundling/Unbundling
  Re-bundling is the process by which the software will take the "unbundled" procedures and re-bundle them to the more comprehensive CPT/HCPCS code. Unbundling refers to two or more procedure codes used to report a service when a single, more comprehensive code exists which more accurately represents the service performed by a provider.

- Mutually Exclusive Editing
  Mutually exclusive edits consist of combinations of procedures which differ in technique or approach but lead to the same outcome. Mutually exclusive procedures are two or more procedures which are usually not performed during the same patient encounter on the same date of service. Procedures which represent overlapping services or accomplish the same result are considered mutually exclusive. Additionally reporting an initial service and subsequent service is considered mutually exclusive.

- Global Surgical Period Editing/Medical Visit Editing
  CMS publishes rules surrounding payment of an evaluation and management (E/M) service during the global surgical period of a procedure. The global surgery data is taken from the CMS Medicare Fee Schedule Database (MFSDB).
  Procedures are assigned a 0-, 10- or 90-day global surgical period. Procedures assigned a 90-day global surgery period are designated as major procedures. Procedures assigned a 0- or 10-day global surgical period are designated as minor procedures.
  E/M services major procedure (90-day period) which are reported 1 day preoperatively on the same date of service or during the 90-day post-operative period are not recommended for separate reimbursement.
  E/M services which are reported with minor surgical procedures on the same date of service or during the 10-day global surgical period are not recommended for separate reimbursement.
  E/M services for established patients which are reported with surgical procedures which have a 0-day global surgical period is not recommended for reimbursement on the same day of surgery because there is an inherent E/M service included in all surgical procedures.

- New visit frequency edits
  This edit prevents the inappropriate reporting of a new patient E/M service and is based on following CPT guideline – A new patient is one who has not received any professional services from the physician or another physician of the same specialty which belongs to the same group practice, within the past three years

- Frequency and Lifetime Edits
  The CPT and HCPCS manuals define the number of times a single code can be reported. There are also codes which are allowed a limited number of times on a single date of service, over a given period or during a member's lifetime. State fee schedules also delineate the number of times a procedure can be

billed over a given period or during a member's lifetime. A frequency edit is applied when the procedure code is billed more than these guidelines.

- Medically Unlikely Edits (MUEs) for Practitioners, DME Providers and Facilities
  MUE for a HCPCS/CPT code is the maximum units of service which a provider would report under most circumstances for a single beneficiary on a single date of service. CPT/HCPCS modifiers should be used to report medically reasonable and necessary units of service, more than an MUE value, when appropriate.

- Duplicate Edits
  Code editing evaluates prospective claims to determine if there is a previously paid claim for the same member and provider which is a duplicate to the prospective claim. The software also looks across different providers to determine if another provider was paid for the same procedure, for the same member on the same date of service. Finally, the software analyzes multiple services within the same range of services performed on the same day.

- Correct Coding Initiative (CCI)
  The purpose of the CCI edits is to prevent improper payment when incorrect code combinations are reported. CMS developed the edit tool for coding policies based on coding conventions defined in the AMA's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices

- Age conflict
  An age conflict occurs when the provider assigns an age-specific procedure to a patient whose age is outside the age range.

- Gender conflict
  To support automated/normal claims processing, Providers must follow CMS/NCCI guidance for certain services when administered to patients where the service may not typically agree with the patient's gender.
  Claims for some services for members with transgender, ambiguous genitalia and hermaphrodite issues will be denied due to sex/diagnosis or sex/procedure NCCI edits unless the services are billed properly. At the time of this publication, modifier "KX" has been released to alert claims editing systems there is not an error in codding and allow the claim to continue with normal adjudication.

- National Coverage Determination Edits
  CMS establishes guidelines which identify whether some medical items, services, treatments, diagnostic services, or technologies can be paid under Medicare. These rules evaluate diagnosis to procedure code combinations.

Definitions

- Current Procedural Terminology (CPT)
  A medical code set maintained by the American Medical Association (AMA) which is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations. CPT is included in Level I Healthcare Common Procedure Coding System (HCPCS).

- HCPCS Level II
  A standardized coding system which is used primarily to identify medical supplies, durable medical equipment, non-physician services, and services not represented in the Level I code set CPT.

- Modifier
  A modifier is a two-character code appended to a Current Procedural Terminology (CPT®) code or Healthcare Common Procedure Coding System (HCPCS) code to clarify the services rendered without

changing the procedure code. Modifiers can facilitate editing, increase accuracy in reimbursement and improve coding consistency. Documentation of services must support a submitted modifier.

- National Correct Coding Initiative (NCCI or CCI)
  The Centers for Medicare & Medicaid Services (CMS) developed these edits to promote consistent, correct coding and appropriate payment. These coding edits are developed based on the AMA CPT Correct Coding Guidelines Definitions code set and the HCPCS code set, as well as analysis of standard medical and surgical practice and input from various groups, including specialty societies, other national healthcare organizations, Medicare contractors, providers, and consultants.

- The National Uniform Billing Committee (NUBC) and the state uniform billing committees (SUBC) Committees responsible for the revenue code definitions and requirements for use. Uniform Billing Editor (UBE) A reference tool utilized by facilities to manage the constant changes to Medicare billing and reimbursement processes. The UBE provides detailed, accurate, and timely information about Medicare and UB-04 billing rules and requirements.

- International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
  A morbidity classification system for classifying diagnoses and reason for visits in all health care settings for the purpose of coding and reporting.

- Revenue Codes (Rev Codes)
  Revenue codes are 4-digit numbers which are used on hospital bills to identify where a member was located in a facility when they received treatment or services, or what service a member received as a patient.

REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE: 03/12/2020

Date	Explanation & Changes
03/12/2020	• Reimbursement Policy created
12/01/2023	• Reimbursement Policy reviewed and updated to reflect the most current reimbursement/billing requirements • Reimbursement Policy titled changed from Claims Bundling to Code Editing • Reimbursement Policy RM015 Modifier Reimbursement combined to this policy
02/01/2024	• Reimbursement/Billing Policy updated to new template

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

National Physician Fee Schedule Relative Value File Calendar Year XXXX, Centers for Medicare & Medicaid Services (CMS) https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

NCCI Policy Manual for Medicare Services, current version, Chapter 1, General Correct Coding Policies https://www.cms.gov/files/document/medicare-ncci-policy-manual-2023-chapter-1.pdf

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services https://www.ama-assn.org/amaone/cpt-current-procedural-terminology

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

Centers for Medicare & Medicaid Services (CMS), ICD-10-CM Official Guidelines for Coding and

Reporting https://www.cms.gov/medicare/coding/icd10

Centers of Medicare & Medicaid Services (CMS), Medicare Claims Processing Manual, Chapter 23-Fee Schedule administration and coding Requirements https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf

Centers for Medicare & Medicaid Services (CMS), National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare

Center for Medicare and Medicaid Services, Medicare NCCI Medically Unlikely Edits (MUEs) https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medically-unlikely-edits

Industry Standard Review