



| PAYMENT POLICY                                                                                             |                |               |
|------------------------------------------------------------------------------------------------------------|----------------|---------------|
| General Coding and Billing                                                                                 |                |               |
| Original Date Approved                                                                                     | Effective Date | Revision Date |
| 10/1/2021                                                                                                  | 3/28/2025      | 1/8/2025      |
| Applies to Products:                                                                                       |                |               |
| <input checked="" type="checkbox"/> Senior Care Options MA <input checked="" type="checkbox"/> One Care MA |                |               |

#### **PAYMENT POLICY STATEMENT:**

Commonwealth Care Alliance, Inc. (CCA) has established a payment policy that outlines the coding and billing guidelines utilized for all CCA products to demonstrate compliance with industry standards.

#### **DEFINITIONS:**

**Health Information Portability and Accountability Act of 1996 (HIPAA):** Establishes federal standards for protecting patient's health information from disclosure their consent.

**Current Procedural Terminology (CPT):** A numerical or alphanumeric five-digit code used to classify medical services and procedures to help report information more accurately and efficiently.

**Healthcare Common Procedure Coding System (HCPCS):** (Also known as HCPCS Level II) An alphanumeric code starting with an alphabetical letter followed by 4 numeric digits; it is used to identify medical related products, supplies, and services not included in the CPTS codes for billing purposes.

**Current Dental Terminology (CDT):** A 5-digit alphanumeric procedure code that starts with the letter D followed by 4 numeric digits used for dental services and procedures.

**Revenue Codes:** A 4-digit number that is used on facility claims to tell where the patient was when they received treatment, or what type of item a patient may have received.

**International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM):** A standardized system used to code diseases and medical conditions when diagnosing patients.

**International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS):** A procedure classification used for classifying procedures performed in hospital inpatient health care settings.



**National Drug Code (NDC):** A universal product identifier made up of 11-digit number that appears on all prescription and non-prescription medication packages/inserts used to identify the manufacturer/distributor, formulation, strength, and dosage of a drug.

**American Medical Association (AMA):** An organization of medical professionals whose objective is to promote the science and art of medicine and betterment of public health.

**American Dental Association (ADA):** An organization of dental professionals dedicated to serving the public and the profession of dentistry.

**Centers for Medicare & Medicaid Services (CMS):** A federal agency that is part of the U.S. Department of Health and Human Services responsible for administering and managing the Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), HIPAA, and the Clinical Laboratory Improvement Amendments (CLIA) programs.

**National Uniform Billing Committee (NUBC):** An organization established to develop and maintain a single billing form and standard data set to be used nationwide by institutional, private and public providers, and payers for handling health care claims.

**National Correct Coding Initiative (NCCI):** A program implemented to promote national correct coding methodologies and reduce improper coding to avoid inappropriate payments of Medicare and Medicaid claims.

**National Coverage Determination (NCD):** Indicates whether a specific medical item, service, treatment procedure, or technology can be paid under Medicare.

**Local Coverage Determination (LCD):** Established for specified geographic area and must be consistent with national policies and developed according to scientific evidence and clinical practice.

#### **AUTHORIZATION REQUIREMENTS (If applicable):**

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N/A

#### **REIMBURSEMENT GUIDELINES:**

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##### **General Coding**

CCA follows the current industry standard coding guidelines set forth by AMA, CMS, ADA, and state and federal governments. CCA will accept only standard diagnosis and procedure codes that comply with HIPAA transaction code set standards.

Standard coding types include:

- **CPT (Level I Codes):** These codes are maintained by AMA and range from 00100 – 99499, with each range being broken down into categories and sub-categories based on the procedure or service type.



- **HCPCS (Level II Codes):** These codes are maintained by CMS and are used to identify products, supplies, and services not included in Level I CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.
- **CDT:** These codes are maintained by ADA used for recording dental services on patient records and for reporting to dental plans.
- **ICD-10-CM:** These codes are used to indicate a diagnosis or condition and are required on all claims. CCA follows ICD-10-CM Official Guidelines for Coding and Reporting and will deny claims when billed inappropriately.
- **ICD-10-PCS:** These codes are 7-digit alphanumeric codes maintained by CMS and associated with hospital utilization. They are used on inpatient claims.
- **NDC:** The 11-digit code is made up of three segments in a 5-4-2 format that is found on the package or vial of the medication. The hyphens included in the code is not required in claims billing. These codes are required for drugs dispensed by a pharmacy or medical supplier, and for physician administered drugs provided in an office or facility setting.
- **Revenue Codes:** These codes are typically maintained by the National Uniform Billing Committee (NUBC). A revenue code is required on all institutional (facility) claims. In some instances, a corresponding HCPCS or CPT code may be required in addition to specific revenue code to describe the services rendered.

All standard coding rules and procedures are updated and published on a quarterly and annual basis. As these revisions are released, CCA will update its systems and any related payment policies as necessary. Providers are responsible for monitoring and reviewing all updates to ensure that claims are coded accurately. If providers receive improper payments due to coding errors, this should be reported to CCA for review and validation. Any identification of improper coding or billing may result in audits and recoupment of payment.

### **Claims Editing and Application Overview**

CCA uses claims editing software to ensure claims are processed in compliance with government and industry standards. This software is set up with rules that align with the standard coding and billing regulations and is updated regularly to guarantee that recent coding and policy changes are incorporated into the system accurately.

The application allows for consistent and objective claims review by:



- Accurately applying coding criteria based on nationally recognized sources such as AMA CPT guidelines, specialty society recommendations, NCCI, and current medical practices for professional claims.
- Accurately applying coding criteria from Outpatient Code Editor (OCE), Medicare Code Editor (MCE), NCCI, and LCD/NCD guidelines for facility claims.
- Detecting coding errors related to coding status (valid or invalid), unbundling of procedure codes, modifier appropriateness, mutually exclusive procedures, incidental procedures, bilateral procedure reductions, anesthesia processing, and duplicate claims.
- Evaluating diagnosis codes (ICD-10-CM) to validate code status (valid or invalid related to active date, gender, procedure code combination, etc.), digit appropriateness, and correct level of specificity.
- Incorporating historical claims auditing functionality, which links multiple claims found in patient's claims history to current claims to ensure consistent review across all dates of service.

## Claims Editing Details

**NCCI Edits:** NCCI edits are developed by CMS and utilize coding conventions defined in the AMA CPT manual, national and local policies, national societies coding guidelines, standard medical and surgical practices analysis, and current coding practices. NCCI edits include Procedure-to-Procedure (PTP) code pair edits and Medically Unlikely Edits (MUEs).

**Procedure-to-Procedure (PTP):** PTP edits are automated prepayment edits that prevent improper payment when certain codes are submitted/reported together for covered services on the same date of service by the same provider for the same patient. PTPs contain two categories, Practitioner PTP edits which apply to physician and ambulatory surgical center (ASC) claims and Hospital PTP edits which apply to facility services including outpatient hospital services. CMS identifies which code pairs can bypass code editing when reported with an appropriate modifier.

**Medically Unlikely Edits (MUE):** MUE edits establish the maximum units of service allowed for a single procedure code (HCPCS/CPT) billed by a provider on a date of service for a patient. Providers that bill more than the maximum units allowed will only be reimbursed up to the limit; units billed over the limit will be denied.



**Unbundling:** Unbundling occurs when multiple procedure codes are billed/reported for a service that could be represented using a single code and can result in improper or inflated payment. Services identified as unbundled may be denied or re-bundled and processed as the single comprehensive procedure code.

**Mutually Exclusive Procedures:** Procedure codes are considered mutually exclusive when the procedures cannot be performed at the same anatomic site or patient encounter. If it is identified that the codes are mutually exclusive, only the primary service will be considered for reimbursement.

**Incidental Procedures:** When a procedure that is not essential to the primary procedure is performed at the same time as the primary procedure, it is considered incidental and is not reimbursed separately.

**Separate Procedures:** A separate procedure should not be reported with a related procedure. A procedure code classified as a “separate procedure” is eligible for separate reimbursement when the service performed on the same day is for a different session, for a separate distinct condition, or at an anatomically unrelated site. The procedure will need to be reported with an appropriate modifier and supporting medical documentation to be considered for the separate reimbursement.

**Bilateral Procedures:** Bilateral procedures are defined as procedures performed on both sides of the body during the same session or on the same day. Bilateral procedures that are performed must be reported with modifier 50 unless the procedure code is defined as a bilateral procedure within the code description.

**Add-on Code:** An add-on code is a service that is performed in conjunction with the primary service by the same provider. An add-on is only eligible for reimbursement when billed with the primary code that is eligible for payment for the same provider on the same date of service for the same patient.

**Outpatient Code Editor (OCE):** OCE is an editing system created and maintained by CMS that is used to process all outpatient facility claims to ensure accurate coding. OCE edits help identify incorrect and inappropriate claims coding and does incorporate NCCI edits within the logic.

**LCD:** LCD is a determination by a Medicare Administrative Contractor (MAC) on whether a specific item or service is covered or not covered within the specific geographic area based on Section 1869(f)(2)(B) of the Social Security Act. LCDs are developed using scientific and clinical evidence and are consistent with national policies.

**NCD:** NCDs are developed by CMS and apply to all states. They are made through an evidence-based process and indicate the specific services, items, procedures, or technologies that will be covered under Medicare on a national basis. If an NCD does not exclude or limit a circumstance or does not mention the service or item, the service



or item may be covered on an LCD at the discretion of the MAC. LCDs cannot contradict an NCD but should clarify it.

## **RELATED SERVICE POLICIES:**

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Add-on

Distinct Procedural Services (Modifier 59)

Evaluation and Management Services Policy

Global Days

Medically Unlikely

Modifier Policy

## **AUDIT and DISCLAIMER:**

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As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management guidelines when applicable and adherence to plan policies and procedures and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure accuracy and compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, CCA has the right to expect the provider/facility to refund all payments related to non-compliance. CCA reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated as applicable; please adhere to the most recent CPT and HCPCS coding guidelines.

## **REFERENCES:**

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Centers for Medicare & Medicaid Services

<https://www.cms.gov/>

CMS National Correct Coding Initiative (NCCI)

<https://www.cms.gov/medicare/coding-billing/ncci-medicare>

CMS Medicare Coverage Determination Process

<https://www.cms.gov/medicare/coverage/determination-process>

CMS Local Coverage Determinations

<https://www.cms.gov/medicare/coverage/determination-process/local>

AMA CPT Overview and Code Approval

<https://www.ama-assn.org/practice-management/cpt/cpt-overview-and-code-approval>

CMS Healthcare Common Procedure Coding System (HCPCS)

<https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system>

ADA The Code on Dental Procedures and Nomenclature



<https://www.ada.org/publications/cdt>

National Uniform Billing Committee | NUBC

<https://www.nubc.org/>

CMS ICD-10-PCS Official Guidelines for Coding and Reporting

<https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2020-ICD-10-PCS-Guidelines.pdf>

CDC ICD-10-CM Classification of Diseases, Functioning, and Disability

<https://www.cdc.gov/nchs/icd/icd-10-cm/index.html>

CES Professional Fact Sheet

<https://www.optum.com.br/content/dam/optum3/optum/en/resources/sell-sheet/wf3953971-ces-professional-claims-sell-sheet.pdf>

CES Facility Fact Sheet

<https://www.optum.com.br/content/dam/optum3/optum/en/resources/sell-sheet/wf3953971-ces-facility-claims-sell-sheet.pdf>

## **POLICY TIMELINE DETAILS:**

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1. Effective: October 2021
2. Revision: April 2022, formatting and corrected/updated link to CMS NCCI
3. Revision: June 2022, updated formatting
4. Revision: May 2023, add Medicare Premier – (PPO) MA\* product, added National and Local Coverage Determination information, (NCD and LCD), expanded the title Medically Unlikely Edits (MUE) to include for Practitioners, DME Providers and Facilities
5. Revision: January 2025, updated template, added definitions, added descriptions for coding types and code edits, removed modifiers under Separate Procedures, added claims editing software language