PROVIDER REIMBURSEMENT GUIDANCE		
General Coding		
Original Date Approved	Effective Date	Revision Date
10/01/2021	06/10/2022	05/09/2023

Scope: Commonwealth Care Alliance (CCA) Product Lines

☒ Senior Care Options MA ☒ One Care MA

PAYMENT POLICY SUMMARY:

Commonwealth Care Alliance (CCA) follows AMA CPT, HCPCS, ICD-10-CM, ICD-10-PCS, and all industry standard guidelines with respect to coding. CCA also follows the directive of the National Correct Coding Initiative (NCCI) edits to ensure no improper payment is issued. It is imperative that providers note that NCCI files may not capture all existing NCCI edits for each code pairing of unbundling that exists.

AUTHORIZATION REQUIREMENTS:

Applicable CCA notification and authorization policies and procedures apply. For more information on prior authorizations, please refer to the Prior Authorization Requirements in the plan specific Provider Manual.

Providers are responsible for reviewing CMS NCCI files prior to claims submission. CCA is not responsible for notifying providers of NCCI edit updates as these are industry standard and the file replacements are published by CMS on a quarterly basis.

REIMBURSEMENT GUIDELINES:

Coding rules for current year AMA CPT, HCPCS, ICD-10-CM, and ICD-10-PCS rules should be adhered to and followed in claims submission. Providers have a duty to report any incorrect or improper billing to CCA that results in additional unwarranted payment. Identification of improper coding/billing will result in recoupment of payment and possible further audit action.

National Coverage Determination Edits (NCD): CMS establishes guidelines that identify whether some medical items, services, treatments, diagnostic services, or technologies can be paid under Medicare. These rules evaluate diagnosis to procedure code combinations. To ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs edits applied. National coverage determinations (NCDs) are made through an evidence-based process, with opportunities for public participation. In some cases, CMS' own research is supplemented by an outside technology assessment and/or consultation with the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC). In the absence of a national coverage policy, an item or service may be covered at the discretion of the Medicare contractors based on a local coverage determination (LCD).

Local Coverage Determination Edits (LCD): Local coverage determinations (LCDS) are defined in Section 1869(f)(2)(B) of the Social Security Act (the Act). This section

states: “For purposes of this section, the term ‘local coverage determination' means a determination by a fiscal intermediary or a carrier under part A or part B, as applicable, respecting whether or not a particular item or service is covered on an intermediary- or carrier-wide basis under such parts, in accordance with section 1862(a)(1)(A).”

National Correct Coding Initiative (NCCI) Edits: NCCI Edits are in place to capture incorrect coding that leads to improper payment. There are Procedure to Procedure (PTP) edits, Medically Unlikely Edits (MUE) edits, and Add-On Coding (AOC) edits. These pre-payment edits are in place to deny incorrect code combinations that may result in improper payment. The tables are maintained by CMS and are updated on a quarterly basis for both Practitioner and Hospital Facility Column 1/Column 2 edits.

The NCCI has established tables that are made up of code pairs and code combinations. The combinations listed within the tables identify certain procedures/services that would not be performed on the same day or during the same session and therefore, should not be reported together. Codes that appear on claims submitted to CCA are compared with the computerized NCCI coding edits. If a code combination on the claim form matches a code combination in the NCCI edits, a denial of the procedure or service will occur. Incidental is defined as a procedure carried out

REIMBURSEMENT GUIDELINES (cont.):

at the same time as a primary procedure but is not clinically integral to the performance of the primary procedure and therefore, should not be reimbursed separately. Incidental procedures require little additional provider resources and are not considered necessary to the performance of the primary procedure. An incidental procedure is not reimbursed separately on a claim. Incidental services include procedures that can be performed along with the primary procedure but are not essential to complete the procedure. They do not typically have a significant impact on the work and time of the primary procedure. Incidental procedures are not separately reimbursable when performed with the primary procedure. Modifiers to bypass edits should never be submitted on incidental procedures

Mutually Exclusive procedures: Two or more procedures are considered mutually exclusive if they cannot reasonably be performed at the same anatomic site or same patient encounter. These coding combinations are deemed submitted in error and only the primary service is considered for reimbursement

Separate Procedures: Procedure codes include the term “separate procedure” should not be reported with a related procedure. Procedure codes designated as a “separate procedure” are eligible for separate reimbursement when they are performed on the same day but at a different session, or at an anatomically unrelated site. If appropriate and supported by the medical documentation, report the separate procedure by appending either of the following modifiers where applicable:

- XE-Separate Encounter
- XS-Separate Organ/Structure

Procedure to Procedure (PTP) Edits: CMS developed Procedure to Procedure (PTP), also known as Column I/Column II, edits to detect incorrect claims submitted by providers. There are two types of PTP Edits:

- The PTP Practitioner edit files are applicable to claims that are submitted by practitioners, non-physician practitioners, and Ambulatory Surgical Centers (ASC).
- PTP edits for Hospital edits applicable to Types of Bills (TOB's) that are conditional on the Outpatient Coding Editor (OCE) for the Outpatient Prospective Payment System (OPPS) payment methodology. The facility types include (and are not limited to) certain therapy providers and certain Home Health Agencies under TOB's 22X, 23X, 74X, 75X, and 34X

REIMBURSEMENT GUIDELINES (cont.):

Providers must review all modifier indicators and rationale for Column 1/Column 2 coding edits:

- "0" – Modifier not allowed
- "1" – Modifier allowed
- "9" – Not applicable

If a code pairing modifier indicator is "0", no modifier is allowed and there should not be a modifier appended to bypass the edits. The procedures are considered "Misuse of a column 1 procedure with a column 2 procedure". If the indicator is "1", the provider must select the appropriate modifier based upon that rationale. If a code pairing indicator is "9" the rationale is that the PTP edit was deleted retroactive to the implementation date.

PTP edits for practitioner and hospital services are separate documents and the Column 1/Column 2 rationale may differ based upon the procedures performed in professional or facility settings

Medically Unlikely Edits (MUE) for Practitioners, DME Providers and Facilities: MUE's are in place to prevent improper payment for possible excessive units of service. The tables consist of the maximum number of units for a procedure code that are typical for the service/item rendered to the member. MUE rationale is contained within the table for review. There are different forms of MUE's:

- Practitioner MUE's – applicable to practitioners and physicians
- Durable Medical Equipment DME's – applicable to HCPCS A-B codes, E-V codes, and other codes under the MAC or jurisdiction
- Facility Outpatient MUE's – applied to the TOB's including but not limited to 13X, 14X, and 85X

The values for the units under this table are not utilization guidelines. However, providers must substantiate medical necessity for the units of service within their documentation regardless of whether the value of the unit is less than or equal to the MUE value within the table. Providers/suppliers should never submit more units of service than are reasonable and necessary. CCA members may not be billed for units of service denied because of MUE edits.

Add-On Coding (AOC) Edits: An AOC is a HCPCS/CPT code that describes a service that, with rare exception, is performed in conjunction with another primary service by the same practitioner. An AOC is rarely eligible for payment if it is the only procedure reported by a practitioner.

BILLING and CODING GUIDELINES: The following code ranges are found within the NCCI file tables:

Code Range	Description
00000-09999	Anesthesia Services
10000-19999	Surgery (Integumentary System)
20000-29999	Surgery (Musculoskeletal System)
30000-39999	Surgery (Respiratory, Cardiovascular, Hemic and Lymphatic Systems)
40000-49999	Surgery (Digestive System)
50000-59999	Surgery (Urinary, Male Genital, Female Genital, Maternity Care and Delivery Systems)
60000-69999	Surgery (Endocrine, Nervous, Eye and Ocular Adnexa, and Auditory Systems)
70000-79999	Radiology Service
80000-89999	Pathology/Laboratory Services
90000-99999	Medicine, Evaluation and Management Services
A0000-V9999	Supplemental Services
0001T-0999T	Category III Codes
0001M-0010M	MAAA Codes
0001U-0034U	PLA Codes

Modifier Utilization: Under the correct circumstances, the modifiers below may be used to bypass NCCI edits for code pairings that are appropriate based upon the clinical circumstances:

Description	Code Range
Anatomic Modifiers	E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI
Global Surgery	24, 25, 57, 58, 78, 79
Other Modifiers	27, 59, 91

Any procedure or modifier submitted should always be reasonable and necessary. The documentation should always support the services billed, including the rationale for modifier usage. CCA reserves the right to audit providers under any circumstance for NCCI edits.

ICD-10-CM: Diagnosis guidelines for ICD-10-CM are updated and released by the World Health Organization (WHO) annually October 1st. Diagnosis code guidelines should be followed in addition to coding notes. October 1, 2016, marked the end of the ICD-10-CM grace period allowed by CMS, which allows for denial due to lack of coding specificity. Providers should be mindful of diagnosis code sequencing and that the correct diagnosis has been submitted for the date of service. ICD-10-CM contains guidance for each body/organ system chapter and applicable guidance should always be followed.

RELATED SERVICE POLICIES:

Add-on

Distinct Procedural Services (Modifier 59)

Evaluation and Management Services Policy

Global Days

Medically Unlikely

Modifier Policy

AUDIT and DISCLAIMER:

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. Please refer to CPT/HCPCS for a complete and updated list of codes. 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, procedures, and claims editing logic. CCA has the right to conduct audits on any contracted provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, CCA has the right to expect your office/facility to refund all payments related to non-compliance.

REFERENCES:

- CMS National Correct Coding Initiative (NCCI)
- CMS Medicare Coverage Determination Process https://www.cms.gov/Medicare/Coverage/DeterminationProcess
- CMS Medicare Coverage Determination Process Local Coverage Determinations https://www.cms.gov/medicare/coverage/determinationprocess/lcds

POLICY TIMELINE DETAILS:

1. Effective: 10/01/2021
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