Capital

PROFESSIONAL NETWORK REIMBURSEMENT POLICY

POLICY TITLE	Correct Coding and Reimbursement Methodology
POLICY NUMBER	NR- 30.019

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I. DESCRIPTION/BACKGROUND TOP

This policy documents the basis for the application of correct coding guidelines and reimbursement methodology for professional provider claims submitted for reimbursement consideration.

II. DEFINITIONS TOP

American Medical Association (AMA) **–** An organization whose missions is to promote the science and are of medicine and the betterment of public health. The AMA speaks out on issues important to patient and the nation's health and exercises a strong advocacy agenda on behalf of patients and provider. The AMA is also committed to providing timely information on matters important to the health of America and includes the development and promotion of standards in medical practice, research and education.

Current Procedural Terminology (CPT) – A set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care professionals. Each procedure or service is identified with a five-digit code. The use of
CPT codes simplifies the reporting of procedures and services.

Healthcare Common Procedure Coding System (HCPCS) - A national standard, alphanumeric coding system established by the Centers for Medicare and Medicaid Services. It standardizes billing and payment for certain covered services (for example, medical supplies, prosthetics and durable medical equipment). HCPCS Level I codes are copyrighted by the American Medical Association (CPT). Level II codes are five-position alphanumeric codes maintained jointly by the Alpha-Numeric Panel (consisting of the Centers for Medicare and Medicaid Services (CMS), the Health Insurance Association of America, and the BlueCross and BlueShield Association). The American Dental Association copyrights the D-code series in Level II HCPCS.

Centers for Medicare and Medicaid Services (CMS) –The Centers for Medicare & Medicaid Services (CMS) is the agency within the U.S. Department of Health and Human Services (HHS) that administers the nation's major healthcare programs. The CMS oversees programs including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the state and federal health insurance marketplaces.

ICD-10-CM – *The International Classification of Diseases, Tenth Revision, Clinical Modification* is based on the official version of the World Health Organization's International Classification of Diseases. ICD-10-CM classifies morbidity and mortality information for statistical purposes, indexing of hospital records by disease and operations, data storage, and retrieval. Medicare has designated ICD-10-CM as the coding system physicians must utilize to report appropriate diagnosis codes when billing for services provided to beneficiaries on or after October 1, 2015. ICD-10-CM code revisions become effective October 1st of each year.

Modifier – A two-digit numeric, alphanumeric or alphabetic code appended to a CPT or HCPCS code, which indicates that a service or procedure has been altered by some specific circumstances but not changed in its definition or code. This information is important because it provides payors with additional information to process a claim. There are three levels of modifiers: Level I (CPT) modifiers are developed by the American Medical Association; Level II (HCPCS) modifiers are developed by the Centers for Medicare and Medicaid Services; Level III modifiers are unique to each Medicare Part B carrier and begin with an alpha prefix of S, W, X, Y or Z.

Place of Service Codes – Codes reported on professional claims to specify the entity where service(s) were rendered.

III. POLICY

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Capital Blue Cross utilizes the Optum™ Claims Edit System (CES) as the primary software resource for the application of reimbursement methodology and the validation of correct coding during the adjudication process of professional provider claims. The CES software system is updated on a quarterly basis to recognize the most recent Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes and changes from the National Physician Fee Schedule Relative Value Units (RVU) File. Capital Blue Cross will implement quarterly updates to edits approximately one month after the effective date retroactive to the 1st day of the quarter. Claims received before our systems are updated will not be adjusted.

The CES software of reimbursement methodology is derived from nationally accepted standards including, but not limited to:

- Centers for Medicare and Medicaid Services (CMS) guidelines
  - National Correct Coding Initiative (NCCI)
  - Medically Unlikely Edits (MUE)
  - National Physician Fee Schedule Relative Value Files
  - Medicare Claims Processing Manual
  - CMS Program Memorandums and Transmittals
  - Healthcare Common Procedure Coding System (HCPCS)
- American Medical Association (AMA)
  - Current Procedural Terminology (CPT®) Manual
  - CPT® Assistant
  - CPT® Clinical Examples
- Coding guidelines published by medical societies/associations,
  - American Society of Anesthesiologists (ASA)
  - American College of Obstetricians and Gynecologists (ACOG)
  - American Academy of Orthopaedic Surgeons (AAOS)

The CES validation of coding edits is derived from nationally recognized standards, including but are not limited to:

- The CPT, HCPCS, /ICD-10, Modifiers, Place of Service are valid for the date of service
- CPT, HCPCS, /ICD-10, Modifiers, Place of Service coded to the highest level of specificity
- Valid code relationships (e.g. Modifier to Procedure Code, Add-on to Primary Code Procedure)
- Identification of:
  - Modifier 51 Exempt Procedures
- Identification of Bundling/Unbundling scenarios
- Eligibility of services for Assistant Surgery, Co-Surgery and Team Surgery
- Application of the Global Surgery Period
- Unit Limitation
- Correct reporting of Professional and Technical Components

Providers are able to view rationale supporting the applied methodology for each claim line processed by accessing the Claims Coding and Lookup tool located on the Capital Blue Cross health plan home page via Availity .

In most instances, Capital Blue Cross will apply these rules/guidelines/edits during the initial claims adjudication process. However, in some instances, it is necessary to apply the rules/guidelines/edits during the retrospective audit process when all associated claims are processed.

In addition to the criteria and conditions contained in this policy, the service, procedure or item must be deemed medically necessary, must be a covered member benefit and is subject to member cost sharing provisions.

IV. EXCLUSIONS TOP

N/A

V. VARIATIONS TOP

This policy is applicable to all programs and products administered by Capital BlueCross unless otherwise indicated below.

VI. REFERENCES

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CPT 2021 Professional Edition
American Medical Association

EncoderPro for Payers
Optum™ 2021

Current and historical versions of the National Physician Fee Schedule Relative Value File can be located by accessing the CMS website.

The current version of the National Correct Coding Initiative (NCCI) edits can be located by accessing the CMS website.

Current and historical versions of the Medically Unlikely Edits can be located by accessing the CMS website.