Professional Pricing Policy

Subject: **Claims Editing Overview**	
Policy Number: HLAP-0001	Policy Section: **Administration**
Last Approval Date: September 1, 2020	Effective Date: October 17, 2020

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for allowed amounts for HealthLink members. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or Revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities.

If appropriate coding/billing guidelines are not followed, HealthLink and/or its Payors may:

- *Reject or deny the claim*
- *Recover and/or recoup claim payment*

These policies may be superseded by provider or State contract language, or State, Federal requirements or mandates.

We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or adjust pricing accordingly to the effective date. HealthLink reserves the right to review and revise its policies periodically when necessary. When there is an update, we will publish the most current policy to the website. Note: medical claim pricing and processing services provided by HealthLink are available to a payor; however not all payors purchase such services for the benefit plans they sponsor.

Policy

I. Documentation and Reporting

All claims submitted by a provider must be in accordance with the reporting guidelines and instructions contained in the American Medical Association (AMA) CPT codebook, "*CPT Assistant*," HCPCS, ASA Relative Value Guide, and ICD-10-CM publications. Providers are responsible for accurately reporting the medical, surgical, diagnostic, and therapeutic services rendered to a member with the correct CPT and/or HCPCS codes, and for appending the applicable modifiers, when appropriate. The code(s) and modifier(s) must be active for the date of service reported, and describe the services provided during the patient encounter.

- The member's medical records must legible and accurately describe the services that warranted the use of a specific CPT/HCPCS code.
- HealthLink reserves the right to perform audits or investigations to confirm appropriate reporting of services provided to our members.
- Based on audit findings and/or published reporting guidelines, we may update our professional pricing policies and claims editing system.
- When a denial is received on a pricing sheet/remittance, review the edit descriptions listed below and review the coding for the submitted claim prior to initiating an appeal. If an error in coding is detected, correct the information and resubmit as a corrected claim.

II. Claim Editing Software Changes

HealthLink implements claim editing software changes on a periodic basis (generally, on a quarterly basis).

- These changes will reflect the addition of new/revised CPT/HCPCS codes and HealthLink's associated edits, Correct Coding Initiative (CCI) updates and/or revisions, and changes identified through

HealthLink's regular review or due to inquiry. Additionally, these changes will include edits associated with HealthLink's professional pricing policies.

- HealthLink reserves the right to change our professional pricing policies and claim editing system without prior notice.

III. Claim Editing Rules

Many claim editing rules incorporate "same provider" editing which results in the denial of separate allowances for services rendered on the same day (or across dates of service for Pre-Op/Post Op days and Frequency Validation) by the same provider. This editing identifies "same provider" as any provider with the same tax identification number (TIN) or individual provider identification number within the same specialty. Some rules that incorporate the "same provider" identification are:

- Always Bundled Services and Supplies and Supplies for Same Day Surgery
- Pre-Op/Post-Op Days
- Base Code Validation and Base Code Quantity
- Technical/Professional Component Billing
- Frequency Validation
- Bilateral Surgical Billing
- Anesthesia

The following is a list of many of the claim editing software rules adopted by HealthLink. This list is subject to change from time to time. Also, where applicable, reference to a HealthLink Pricing Policy is indicated. This is not an exhaustive list of claim edits; refer to individual HealthLink Pricing Policies:

Age Specific: identifies when an age-specific procedure code is reported for a patient whose age is outside the designated age range. In this instance, when an inconsistency is identified, the code(s) will not be allowed.

Age to Diagnosis: identifies when an age-specific diagnosis code is reported for a patient whose age is outside the designated age range for that diagnosis. Codes with an age edit are identified in ICD-10-CM by one of the following symbols to the right of the code description: N = Newborn age: 0 years, P = Pediatric age: 0-17years, M = Maternity age: 12-55 years, and A = Adult Age: 15-124 years.

Anesthesia: identifies anesthesia services reported in the code range of 00100 – 01999 that are performed on the same date of service by the same provider. Editing for this rule is based on American Society of Anesthesiologists (ASA) billing guidelines which states: "When multiple surgical procedures are performed during a single anesthetic administration, only the anesthesia code with the highest base unit value is reported."[1] If two anesthesia services are reported, the less complex procedure(s) will not be allowed.

Assistant Surgeon: identifies procedure codes with an assistant surgeon modifier appended that do not typically require an assistant. If the procedure code is listed in our Assistant Surgery Policy as a code which does not allow surgical assistant benefits, the line item will not be allowed.

Base Code Quantity: identifies a claim reporting a primary service with a base-code that has a quantity greater than one, rather than reporting the appropriate add-on code. The line item with the base code quantity greater than one will be denied and replaced with a line item that allows payment for only one procedure. This edit also identifies multiple occurrences of a base code reported on separate lines. The additional base code line item(s) will not be allowed. See CPT Appendix D for the list of add-on codes.

Add-on code without base code: identifies add-on codes that are reported without the related primary service or procedure (base code). According to the *Current Procedural Terminology* codebook, "Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand- alone code."[2] If an add-on code is submitted without the base code, it will be denied. Therefore, it is important that the add-on code and base code be submitted on the same claim. In addition, if the base code is not allowed,

the add-on code will not be allowed.

Bilateral Surgical Billing: identifies when two claim lines are submitted with the same procedure code, and one line (or both lines) has been reported with modifier 50. When a bilateral surgical service is submitted on two lines, the two claim lines will be denied and replaced with a single line item with modifier 50, adding the charges. Allowed amount will be applied to the added line. This rule is based on CMS and HealthLink guidelines.

Bundled Services and Bundled Supplies: identifies certain services and supplies that are considered part of overall care and are not separately allowed. Editing for this rule is based on CMS, and HealthLink sourcing. For example:

- **Always Bundled Services and Supplies:** identifies all-inclusive procedure and supply codes that are not allowed even when reported alone.
- **Bundled Services and Supplies:** identifies services and/or supplies that are not allowed when billed with another specific service or supply.
- **Same Day Screening Services with Preventive or Problem Oriented E/M Services:** identifies screening services, (e. g., G0101, G0102) that are considered a component of a preventive exam and/or a problem oriented E/M service when rendered on the same date of service. Therefore, screening services are not allowed even if billed with modifier 25. Screening services should be taken into account when determining the correct level of the problem oriented E/M service.
- **Services and Supplies with Injection and Infusion Services:** identifies services and supplies not separately allowed with injection and infusion services
- **Supplies for Same Day Surgery:** identifies inclusive supply codes that are reported by the same provider reporting a surgical procedure for the same date of service. Surgical supplies and materials are not separately allowed when reported by the provider rendering the primary service.

Code and Modifier Validation: identifies if a code or modifier is valid. If an invalid procedure, diagnosis code, or modifier-procedure combination is detected, the line item will not be allowed.

- **Procedure validation:** editing for procedure code validation uses AMA as the reference source.
- **Diagnosis code validation:** ICD-10-CM validation is based on the World Health Organization (WHO) and CMS when determining additional digit requirements (4th and 5th digit).
- **Modifier to procedure code validation:** editing for validation is based on CPT, CMS and sourcing.

Correct Coding Initiative Rules: this rule identifies the CMS National Correct Coding Initiative (NCCI) edits. NCCI edits may be reviewed by visiting: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html.

NCCI edits consist of those edits listed in the CMS Column One/Column Two Correct Coding edit file (formerly, the comprehensive/component edits). Column One in this edit file represents allowed codes; Column Two represents denied codes. CMS no longer publishes a separate Mutually Exclusive edit file. The edits previously contained in the Mutually Exclusive edit file have not been deleted but have been moved to the Column One/Column Two Correct Coding edit file.

Non-site specific modifiers include 24, 25, 57, 58, 59, 78, 79, 91, XE, XP, XS, and XU:

- may override an NCCI edit with a superscript of 1 when appended to a code listed in column 2, making the column 2 code not separately allowed.
- will not override an NCCI edit with superscript of 0 when appended to a code listed in column 2 and therefore the column 2 code is not separately allowed.

NCCI edits will be applied to code pairs which, under our other pricing rules (such as procedure unbundling),

might be separately allowed but under NCCI edits are considered incorrect coding, therefore, such code pairs are not separately allowed. NCCI edits will be adjudicated after our claim editing software's unbundling edits have been completed.

Duplicate Line Items: identify a line item as a duplicate submission of a previously submitted claim. Fields that are reviewed to determine duplication are Member ID, Provider ID, procedure code, modifier, date of service and billed amount. When the same procedure is performed more than one time per date of service, the subsequent procedure(s) must be reported on the same claim as the first procedure. Appropriate modifiers must be appended, when applicable.

Frequency/Maximum Occurrences: identifies when a procedure code is reported either more than once per date of service, or across dates of service which exceeds the number of times its verbiage indicates, when it exceeds the number of times it is clinically appropriate or possible to perform, or when a code that is listed on the CMS Medically Unlikely Edit (MUE) listing has a per day MUE Adjudication Indicator (MAI) of "2."

- When inappropriate units or line items are identified, our claim editing software will either default multiple units to one unit; deny the multiple line items, and replace the line with the appropriate number of units or a more comprehensive code; or deny the claim for corrected billing.
- In the case of procedures that are allowed with more than one unit per date of service (DOS), the line item that exceeds the maximum allowed per DOS will be denied and replaced with a new corrected line item showing the appropriate number of units.

Laboratory Multi-code Rebundling: identifies when codes that are part of a comprehensive multiple component blood test, described in the Laboratory section of CPT, are reported separately. Either the individual codes will be denied and the code representing the comprehensive code will be added to the claim for allowance; or the total allowed amount for the separately reported codes will not exceed the maximum allowance for the single comprehensive code.

Multiple Evaluation and Management Services: identifies claim lines containing multiple E/M services (same or different E/M visit codes) provided on the same day, for the same patient, by the same provider. Only one E/M service is allowed per day.

Multiple Surgeries: identifies multiple surgical procedures that are subject to multiple surgery reimbursement rules. Standard multiple surgery allowance is 100% of the maximum allowance for the procedure with the highest (RVU) based on the CMS NPFSRVF maximum allowance for the date of service and 50% of the second highest RVU for the date of service for the second and each subsequent procedure.

New Patient Evaluation and Management: identifies new patient E/M procedure codes that are submitted for established patients. According to the AMA, "A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the last three years."[2 or 3] Based on this AMA guideline, when a professional service is identified as reported within the last year by the same physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, the current new patient E/M code will not be allowed.

Obstetric Services: ***HMO ONLY*** identifies when a physician or other provider with the same tax ID has reported a routine maternity E/M or antepartum care service within 270 days of a global maternity delivery code. If detected, the additional E/M and antepartum care services may not be allowed based on CPT coding guidelines on what is included in the total obstetric package.

Place of Service: identifies the reporting of an inappropriate place of service for a particular procedure, either due to the code description or due to published CPT coding guidelines that indicate that a specific procedure is not intended to be reported in a certain setting.

For example:

- When an after-hours office visit (99050) is reported in a facility setting, the service will not be allowed.
- When intravenous infusion hydration (96360) is reported in a facility setting, the service will not be allowed.

Pre-Op/Post Op: identifies E/M visits that are reported one day prior to a 90-day surgical procedure or during the 10 or 90-day aftercare period. When the E/M code is reported within the global surgery period, then the E/M code will not be allowed. The E/M service will be denied as part of the global surgical allowed amount.

Procedure to Diagnosis: identifies certain procedures that are not allowed with the reported diagnosis code in accordance with HealthLink's professional pricing policy and/or correct coding guideline. For example:

- 99050 (services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service) reported with a preventive diagnosis
- 99140 (anesthesia complicated by emergency conditions) reported with a routine pregnancy and/or delivery diagnosis

Procedure Unbundling: occurs when two or more procedure codes are used to describe a service when a single, more comprehensive procedure code exists that more accurately describes the complete service performed. Additional details regarding unbundling rules are described by the following edits.

- **Incidental/Integral**: "An *incidental* procedure is one that is performed at the same time as a more complex primary procedure and is clinically *integral* to the successful outcome of the primary procedure." A procedure determined to be incidental/integral to another procedure will not be allowed.
- **Mutually Exclusive/Redundant:** "*Mutually exclusive* edits consist of combinations of procedures that differ in technique or approach but lead to the same outcome. In some instances, the combination of procedures may be anatomically impossible. Procedures that represent overlapping services or accomplish the same result are considered *mutually exclusive.* In addition, reporting an initial service and subsequent service is considered *mutually exclusive*." A procedure determined to be mutually exclusive to another procedure will not be separately allowed.
- **Procedure Rebundling:** identifies unbundled procedure codes used to describe a procedure (e.g., a blood panel) when a single more comprehensive code exists. The correct procedure code that most accurately represents the service will be added to the claim. The identified unbundled procedures will be denied, and the appropriate added code may be allowed.

Same Day Medical Visit: identifies when an E/M visit is reported on the same day as a surgical or substantial diagnostic or therapeutic (such as dialysis, chemotherapy and osteopathic manipulative treatment) procedure by the same provider. HealthLink Pricing policies state that when the same provider reports an E/M visit and a procedure on the same day the E/M service is included within the global allowed amount for the procedure.

Technical/Professional Component and Global Billing: identifies proper coding of professional, technical, and global procedures. Modifier 26 signifies the professional component and Modifier TC signifies the technical component.

When the CMS NPFSRVF designates that modifier 26 is applicable to a procedure code (PC/TC indicator of 1 or 6), and the procedure code (e.g. radiology, laboratory, or diagnostic) has been reported by a professional provider with a facility place of service, the procedure code must be reported with modifier 26 or it will not be allowed.

When the CMS NPFSRVF designates that the concept of a separate professional and technical component does not apply to a laboratory procedure (PC/TC indicator of 3 or 9), and a professional provider has reported the laboratory procedure code with a modifier 26, the laboratory procedure code will not be allowed. When a laboratory procedure with a PC/TC indicator of 3 or 9 is reported by a professional provider with a facility place of service, the laboratory procedure code will be denied since the facility will bill for performing the laboratory procedure.

A global procedure code includes reimbursement for both the professional (PC) and technical components (TC), therefore:

- When both components are performed by the same provider or by associated providers within the same group/TIN, the appropriate code must be reported without the 26/TC modifiers.
- When a provider reports a global procedure and the same procedure with a professional (26) or technical (TC) component modifier on a different line or claim, the procedure reported with component modifier will not be allowed.
- When a provider reports the global code (no modifiers) with a facility place of service, the code will not be allowed.

In addition, when one provider reports a global procedure and a different provider reports the same procedure with a professional (26) or technical (TC) component modifier [or as a global procedure], the first charge processed by HealthLink will be allowed and any subsequent charge processed will not be separately allowed.

Related Coding

Code	Description	Comments
N/A	N/A	Standard correct coding applies.

Exemptions

Definitions

Customized Claim Edit	An edit that is added or modified for the commercially available claims editing software product in use by HealthLink.
Editing	The practice or procedure pursuant to which one or more adjustments are made to CPT codes or HCPCS codes in a claim that result in the following: • payment being made based on some, but not all, of the CPT/HCPCS codes included in the claim • payment being made based on different CPT/HCPCS codes than those included in the claim • payment for one or more of the CPT/HCPCS codes included in the claim being lowered by application of multiple procedure logic • payment for one or more of the CPT/HCPCS codes being denied, or any combination of the above

History Editing	Identifies historical claims that are related to current claim submissions, resulting in adjustments to the previously processed historical claim(s). History editing capability can auto-adjudicate reimbursement policies including, global surgery, same day multiple evaluation and management visits, pre-post-operative visits, new patient visits, frequency rules, incidental, mutually exclusive and rebundle edits and maternity services.
Significant Edit	An edit based on experience with submitted claims, will cause, on initial review of submitted claims, the denial or reduction in payment for a particular CPT/HCPCS code more than two-hundred and fifty (250) times per year in any state in which HealthLink operates.

Related Policies and Materials

Anesthesia Services
Assistant Surgeon Services
Bundled Services and Supplies
Evaluation and Management Services and Related Modifiers -25 and -57
Frequency Editing
Global Surgery
Health and Behavior Assessment/Intervention
Laboratory and Venipuncture Services
Modifier Rules
Multiple and Bilateral Surgery Processing
Multiple Diagnostic Cardiovascular Procedures
Multiple Diagnostic Ophthalmology Procedures
Place of Service
Screening Services with Related Evaluation and Management Services

Use of Pricing Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Pricing Policy is constantly evolving and we reserve the right to review and update these policies periodically.