Priority Health	BILLING POLICY No. 022
GENERAL CODING	
Date of origin: Mar. 2024	**Review dates: 11/2024, 2/2025, 5/2025, 6/2025**

APPLIES TO
All plans

DEFINITION
We use several coding and billing resources to align correct coding guidelines for accurate claims processing. These criteria may be defined by multiple sources and applicable to professional, facility, ambulatory surgical center, etc. claim types or may be standard across all these claim types. Clinical edits are controls aligned with coding guidelines or industry standard principles to flag inappropriate coding practices, inaccurate billing or duplication of services.

All services coded on a claim should be supported within the medical record and clinically appropriate. In addition, whether a contracted or non-contracted provider or facility, correct coding guidelines should be followed for accurate claim submissions and claims are subject to correct coding editing. It's important to note that codes are released on an ongoing basis and defined guidelines may change. ***Our controls to adhere to correct and standard coding guidelines may change in accordance with the published updates. Prior notification of edit logic in accordance with these guidelines won't be provided. The provider, provider group, ancillary group or facility is responsible for remaining up to date with correct coding guidelines.***

POLICY SPECIFIC INFORMATION
This isn't an all-inclusive list of criteria applied in the claims editing process. Additional criteria may be defined within our Provider Manual under specific policy guidelines. We also detail clinical edit rationale on our clinical edit page.

Controls are applied to claims to support accurate coding. Appealing claims without an accurately coded claim in our system will result in upholding the denied claim.

General coding resources
Below are multiple resources and criteria used to create controls for managing correct coding and accuracy in claims submission:

- Current Procedural Technology (CPT) guidelines as defined by American Medical Association (AMA)
- National Correct Coding Initiative (NCCI) guidelines include Medically Unlikely Edits (MUE)
- HCPCS II Procedures
- ICD-10 guidelines
- Integrated OCE guidelines
- Uniform Billing Guidelines from American Hospital Associates (AHA)
- Guidance supplied by state medical societies
- State specific reimbursement guidance
- Other coding guidelines defined by industry-standard and recognized resources
- Place of service
- Duplicate
- Frequency
- Global Surgical Package
- Food and Drug Administration (FDA)

Current Procedural Technology (CPT) guidelines as defined by American Medical Association (AMA)

Current Procedural Terminology (CPT) 4th Edition is an American Medical Association (AMA) that maintains a uniform coding system consisting of descriptive terms and codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. There are three types of CPT codes:

- Category I Code – Procedures/Services
- Category II Code – Performance Measurement
- Category III Code – Emerging Technology

The AMA creates and manages the CPT codes as a standardized code set for professional and outpatient billing. CPT defines guidelines for each code, parenthetical statements on appropriate use and guidance for modifier use. We apply controls to claims to support accurate coding. Below are a few examples where logic may be applied (this isn't all inclusive).

- General CPT description
- CPT age specific
- CPT definition gender specific (see exceptions)
- CPT parenthetical criteria
- Guidelines defined in AMA CPT
- Laterality
- Add on codes
- Frequency
- Unlisted codes
- Modifier use
- Separate procedures

CMS guidelines

CMS defines various guidelines within their Medicare Claims Processing Manual, Medicare Managed Care Manual and reimbursement criteria associated with their fee schedules. We may adopt or adhere to these guidelines to process claims according to industry standards.

- Inclusive or bundles services
- Status indicators
- Requirements or limitations for various providers or institutions

CMS driven National Correct Coding Initiative (NCCI) guidelines

The Centers for Medicare and Medicaid (CMS) created the NCCI guidelines to promote correct coding for Medicare claims, which has been adopted across the industry as a standard for coding policies. In alignment with this General Coding Policy, NCCI utilizes multiple sources to define content for these guidelines.

Modifiers shouldn't be appended to a HCPCS/CPT code to solely bypass an NCCI edit if the clinical circumstances don't justify its use. Documentation must support coding and modifier use. Claim lines containing modifiers deemed inappropriate may be denied.

Examples of NCCI logic include:

- Pair to Pair edits (PTP)
- Mutually exclusive code combination
- Medically Unlikely Edits (MUE)
- Medical Adjudication Indicator (MAI)
- Once in a lifetime codes
- Edits may also be derived from written logic detailed throughout the NCCI guideline criteria

Outpatient Code Editor (OCE) edits

The Outpatient Code Editor (OCE) is an editing system created and maintained by CMS to process outpatient facility claims. The OCE edits identify incorrect and inappropriate coding of these claims. Priority Health reserves the right to implement OCE edits to apply correct coding guidelines for claims without prior notification.

- Facility status indicators
- Condition code use
- Medically Unlikely Edits (MUE)
- PTP Codes

HCPCS procedure codes

HCPCS level II codes are standardized code sets to identify items such as ambulance, drugs, dental, biologicals, supplies, durable medical equipment, prosthetics, orthotics and various other supplies and items. Below are a few examples where logic may be applied (this isn't all inclusive).

- Drug descriptions and dosage for drugs and biologicals when applicable
- Listing accurate NDC to HCPCS code
- Description for unlisted codes
- Unbundling of services rendered or supplied
- Reporting HCPCS II in addition to comparable CPT code
- Accurate reporting of units to DME, P&O, supply, etc.
- Accurate modifier use

ICD-10 guidelines

The International Classification of Diseases (ICD) is utilized to classify and code all diagnoses, signs and symptoms and inpatient procedures through a standardized code set. Accurately reporting these ICD-10 codes allows for collection of data, management of acute or chronic conditions and application of benefits as defined by plan documents. This requires coding to the highest level of specificity and accurately assigning all applicable codes for services rendered. Controls (or edits) are applied for accuracy in ICD-10 coding in the areas detailed below but not an all-inclusive listing. Adhere to guidelines defined in the ICD-10 coding manuals (CM and PCS).

- Adhere to guidelines defined in the ICD10 coding manuals (CM and PCS)
- Diagnosis codes should be coded to the highest level of specificity. Failure to code to the highest level may result in a line level or claim level denial.
- Manifestation codes should not be submitted as the only diagnosis codes on the claim.
- Priority Health follows all sequencing guidelines. Please refer to the primary diagnosis code requirements to ensure that primary diagnosis codes are correct and that the appropriate secondary diagnosis are submitted as required. Incorrectly submitted claims may result in denials.
- Sequela diagnosis codes should not be submitted as primary diagnosis codes.
- Priority Health also follows the OPPS unacceptable principal ICD 10 diagnosis codes for facility claims, including SNF. Claims submitted with unacceptable primary diagnosis codes will be denied for resubmission and may be subject to a post payment review.
- Adhere to guidelines defined in the ICD-10-CM official guidelines for coding and reporting. (Please reference CMS website for past years guidelines)
- Documentation in the medical record must support diagnosis use from both coding and clinical validation perspective
- Specificity associated with age, gender, laterality, etc. should be coded to the highest level of specificity as defined by ICD10 guidelines
- Adhere to parenthetical statements associated with primary diagnosis conditions or code also statements for secondary conditions that should be reported

National Drug Coding (NCD) reporting

A valid, 11-digit NDC number is required when submitting professional claims for physician administered drugs reported with a J, Q or S HCPCS drug procedure code.

A valid, 11-digit NDC number is required when submitting facility claims for physician administered drugs when reported with J, Q or S HCPCS drug procedure codes. Revenue codes 0250-0252, 0257-0259 and 0631-0637, billed with or without HCPCS codes, also require NDC reporting.

This requirement applies to all professional and outpatient claims when submitted on the CMS-1500 claim form, UB-04 or its electronic equivalent. Crossover claims are included in this requirement. Providers must report the HCPCS code, the exact NDC that appears on the medication packaging in the 5-4-2 digit format (e.g., xxxxx-xxxx-xx), as well as the NDC units and descriptors. Claims submitted without this information will be denied.

Any claim type that's submitted with an invalid NDC code will deny. Any claim submitted for a physician administered drug reported with a J, Q or S HCPCS code and an NDC code that doesn't appropriately crosswalk to the reported HCPCS code will deny.

Guidance supplied by specialty medical societies and state driven practices

State and medical specialty societies (examples MSMS, ACOG, AAFP, AAOS, etc.) publish various guidelines to detail standards of medical practice.

Place of service

Professional claims require reporting of a place of services (POS) on all claim lines to identify the setting a service is provided. Each claim line should accurately represent the POS in which that service was rendered. If a procedure code contains a descriptor specific to a place of service, these must align on the claim, or an edit will be applied. CMS maintains an active list that's recognized as the standard. Priority Health may recognize and apply edit logic to place of service criteria that CMS may not have in use.

Uniform billing guidelines (American Hospital Association – AHA)

Facility claims guidance for coding appropriate revenue codes, procedure, codes and UB claim specific criteria is outlined by the UB-04 manual. Failure to follow the specifications detailed in the UB-04 manual may result in claim denials. Updates to this manual are ongoing and align with our coding policy. Below are some examples but not an all-inclusive listing.

- Accurate reporting of condition codes and value codes
- Alignment of revenue code to procedure code(s) and modifiers
- Accurately reporting type of bill, including claim corrections
- Reporting
- Revenue Codes

Consistent with CMS, uniformed billing editor (UBE) and the UB-04 Manual, revenue codes that are required to be submitted with a CPT/HCPCS code will not be reimbursed if submitted without the appropriate code.

Frequency (criteria in addition to Medically Unlikely Edits/MUE)

Coding for CPT and HCPCS services with frequency that exceeds the defined quantity for that code will be denied. Criteria may be defined as daily, lifetime or periodic based on medical policy, reimbursement policy or as defined within our Provider Manual.

Global surgical package

As an industry standard, our correct coding policy adopted the CMS global surgical package guidelines. As defined by CMS Medicare Fee Schedule Database (MFSDB), services are defined for global surgical package with a 0-, 10-, or 90-day global period (10-day is minor; 90-day is major).

- Pre-operative period begins one day prior to surgical/procedural service

- Intraoperative day is day of surgical/procedural service
- Post-operative period begins day following surgical/procedural service
- Services performed in the pre/post operative period of a 10- or 90-day global code will be denied
- Complications resulting in return to the operating room may fall outside of the global surgical package. Appropriate modifiers should be appended for accurate coding
- Decision for surgery and unrelated E/M or procedural services during the global period should be coded with the appropriate modifier(s)

For more information, see specific modifier pages in our Provider Manual.

Duplicate claims

Controls are implemented to capture claims that are considered duplicate to another service billed. This may include service(s) billed by the same provider or provider group for the same service on the same date of service. ***Note, failure to apply the appropriate repeat service modifiers or correctly submitting claim as corrected claim may result in claim denial as a duplicate.*** See our guidelines for submitting corrected claims.

Other coding guidelines defined by industry-standard and recognized resources

- Diagnosis to procedure misalignment (or vice versa with procedure to diagnosis)
- Modifier misalignment
- Data driven edit logic (specific guidelines will be detailed in the provider manual)

Please follow the dispute / appeal process if you feel that a claim decision should be reviewed as outlined in the Provider Manual. Priority Health uses industry benchmarks and guidelines to make claims decisions and supporting documentation should be submitted for review. Please confirm a claim has been coded accurately prior to submitting a claim appeal.

Minimum requirements for claim submission

- Member demographics (i.e., Member name, sex, date of birth)
- Member's ID number
- Member's signature
- Provider's National Provider Identifier (NPI)
- Billing provider, group or facility NPI
- Referring provider's NPI
- Ordering physician's NPI (If applicable)
- Provider's Tax ID number (TIN)
- Provider's taxonomy
- Revenue codes
- Place of service (POS) or type of bill (TOB)
- Appropriate coding (CPT, HCPCS, ICD-10-CM/PCS, HIPPS)
- Principal/admitting diagnosis
- Units of service
- Line item and total charges
- Date(s) of service
- Statement covers period (UB-04 only)
- Admission/start of care date (inpatient or home health only)
- Admission time (inpatient or observation only)
- Discharge date and time (inpatient, observation or home health only)
- Observations start/end time
- Diagnosis related group (DRG) (inpatient only)
- Discharge status (UB-04 only)
- Condition codes (UB-04 only when required by Medicare)
- Occurrence codes (UB-04 only when required by Medicare)
- Value codes and amounts (UB-04 only when required by Medicare)

- Present on admission (POA) indicator
- Provider signature
- Provider billing address

Related denial language

- pf9 – Add-on procedure submitted w/o appropriate primary procedure
- t24 – Add-on procedure code has been submitted without an appropriate primary procedure code

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Nov. 12, 2024	• Added "Applies to", "National Drug Coding (NDC) reporting" and "Minimum requirements for claim submission" sections • Added CPT definition under "Current Procedural Technology (CPT) guidelines as defined by American Medical Association (AMA)" section

Feb. 5, 2025	Added “Disclaimer” section
May 13, 2025	Added “Related denial language” section and information on prism explanation code pf9 - Add-on procedure submitted w/o appropriate primary procedure
June 19, 2025	Added denial code t24 to the “Related denial language” section