General coding policy

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.***

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.

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

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

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 or gender specific
- CPT parenthetical criteria
- Guidelines defined in AMA CPT
- Laterality
- Add on codes
- Unlisted codes

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. Pair to Pair edits (PTP)
- Mutually exclusive code combination
- Medically Unlikely Edits (MUE)
- Edits may also be derived from written logic detailed within the NCCI guideline criteria

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 ICD-10-CM official guidelines for coding and reporting. (Reference the 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 ICD-10 guidelines
- Adhere to parenthetical statements associated with primary diagnosis conditions or code also statements for secondary conditions that should be reported

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

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)