Enhanced Correct Coding Guidelines

Buckeye Community Health Plan is committed to continuously improving its claims review and payment processes.

Effective **10/01/2021** for Medicaid, Marketplace and Medicare lines of business, we will enhance several correct coding edits based on industry standards and coding rules published within the:

- Centers for Medicare & Medicaid Services' (CMS)
- National Correct Coding Initiative (NCCI) for professional and facility claims (Medicare and Medicaid)
- Medically Unlikely Edits (MUE)
- Mutually Exclusive and Outpatient Code Editor (OCE) edits
- State Provider Manuals, Fee Schedules, Periodic Provider Updates (bulletins/transmittals)
- CMS coding resources, such as HCPCS Coding Manual, National Physician Fee Schedule, Provider Benefit Manual, Claims Processing Manual, MLN Matters and Provider Transmittals
- AMA resources: CPT Manual, AMA Website, Principles of CPT Coding, Coding with Modifiers, CPT Assistant, CPT Insider's View, CPT Assistant Archives, CPT Procedural Code, definitions, HCPCS Procedural Code Definitions
- Billing Guidelines Published by Specialty Provider Associations: Global Maternity Package data published by the American Congress of Obstetricians and Gynecologists (ACOG) and Global Service Guidelines published by the American Academy of Orthopedic Surgeons (AAOS)
- State-specific policies and procedures for billing professional and facility claims
- Health Plan policies and provider contract considerations
- Centene Policy CC.PP.011

These are the same rules used by most healthcare claims payers and enforced by the Centers for Medicare and Medicaid Services.

Buckeye Health Plan Claims Editing Software ensures that claims are processed and paid accurately. This helps to avoid potential waste and error. Therefore, Buckeye Health Plan may deny a claim and request medical records (or coordinate request through a third-party vendor) from the provider or supplier who submitted the claim to support the services submitted on the claim.

{Providers should submit adequate medical record documentation that supports the claim (services) billed. Once medical records are received, coding professionals will examine the documentation to determine if the services billed are supported (or not supported) as

submitted and pay (or deny) the claim accordingly. Please note that the submission of medical records is not a guarantee of payment.}

The following table outlines the enhancement to several correct coding edits.

Coding Policy	Denial Reason Code	Description
Medically Unlikely Edits (MUEs) for Practitioners, DME Providers and Facilities	xD & xH	MUEs reflect the maximum number of units that a provider would typically bill for a single member on a single date of service. These edits are based on CPT/HCPCs code descriptions, anatomic specifications, the nature of the service/procedure, the nature of the analyte, equipment prescribing information and clinical judgment. These are combinations of procedure codes that may differ in technique or approach but result in the same outcome. The procedures may be impossible to perform anatomically. Procedure codes may also be considered mutually exclusive when an initial or subsequent service is billed on the same date of service. The procedure with the highest RVU is considered the reimbursable code.
PTP Practitioner and Hospital Edits	x3	CMS has designated certain combinations of codes that should not be billed together. CMS developed the Procedure to Procedure (PTP), also known as Column I/Column II, edits to detect incorrect claims submitted by medical providers. The column I procedure code is the most comprehensive code and reimbursement for the column II code is subsumed into the payment for the comprehensive code. The column II code is considered an integral component of the column I code. While these codes should not typically be billed together, there are circumstances when an NCCI modifier may be appended to the column II code to identify a significant and separately identifiable or distinct service. When these modifiers are billed, clinical validation will be performed. PTP for practitioner edits are applied to claims submitted by physicians, non-physician practitioners and ambulatory surgical centers (ASC). PTP hospital edits apply to hospitals, skilled nursing facilities, home health agencies, outpatient physical therapy and speech-language pathology providers and comprehensive outpatient rehabilitation facilities.

Global Surgical Period Editing/Medical Visit Editing (Pre & Post Op)	x2	CMS publishes rules surrounding payment of an evaluation and management service during the global surgical period of a procedure. The global surgery data is taken from the CMS Medicare Fee Schedule Database (MFSDB). Procedures are assigned a 0-, 10- or 90-day global surgical period. Procedures assigned a 90-day global surgery period are designated as major procedures. Procedures assigned a 0- or 10-day global surgical period are designated as minor procedures. Evaluation and Management services for a major procedure (90-day period) that are reported 1 day preoperatively, on the same date of service or during the 90-day post-operative period are not recommended for separate reimbursement. Evaluation and Management services that are reported with minor surgical procedures on the same date of service or during the 10-day global surgical period are not recommended for separate reimbursement. Evaluation and Management services for established patients that are reported with surgical procedures that have a 0-day global surgical period are not recommended for reimbursement on the same day of surgery because there is an inherent evaluation and management service included in all surgical procedures
Unbundling	x9	CMS developed the correct coding initiative to control erroneous coding and prevent inaccurate claims payment. CMS NCCI edits consist of Procedure-to-Procedure (PTP) edits for physicians, hospitals, and Medically Unlikely Edits for professionals and facilities. Many specialty medical organizations and health advisory committees have developed rules around how codes should be used in their area of expertise. These rules are published and are available for use by the public domain. Procedure code definitions and relative value units are considered when developing these code sets. Rules are specifically designed for professional and outpatient facility claims editing.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.

If you have any questions or need further information, please contact our Provider Services team at 866.296.8731.