Administrative Simplification

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Best Practice Recommendation
for

Claim Coding Policy and Edits: Standardization & Transparency

Version 1.3

Version	
Issue Date	**Explanation**
04-14-2009	Version 1.0 /Rev 022109a
01-05-2010	Minor Edits
06-02-2010	Amended as follows: "Health Plans will have a link on their web site that informs providers that they follow industry standards and describes to providers how they will make any variations to those standards known. (per 01-27-10 meeting)

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BEST PRACTICE RECOMMENDATION

Topic: Claim Coding Policy and Edits: Standardization and Transparency

Improvement Opportunity:

Non-standard coding practices by providers and non-standard coding edits by health plans lead to unexpected claim denials and costly appeals. Providers spend time researching these denials and working with health plans to resolve them. Health plans spend time reviewing and responding to reconsideration requests.

Development of and adherence to recommended best practices for a) adopting industry standard claim coding policies and b) publishing variations from these standards, is intended to:

- Increase number of claims coded in accordance with industry standards
- Enhance visibility of health plan specific variations to standard coding policies and edits
- Reduce unexpected denials and the associated work
- Enhance communication between providers and health plans regarding claims coding policy and edits.

Summary of Recommendation:

This document outlines a set of recommended best practices for adopting industry standard coding policies and publishing variations from those standards. More specifically,

1. Health plans and provider organizations will adopt and appropriately implement:
   - Industry standard National Correct Coding Initiative (NCCI) policy and guidelines, including CCI code edits.
   - Industry standard payment rules and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB)

2. Where a health plan varies from the general NCCI policy, the CCI code edits, and/or the defined set of payment rule indicators in the MPFSDB, these variations will be made transparent by the respective health plan in a manner that allows contracted providers to easily retrieve them.

Applicability:

Though the general principles of Standardization and Transparency apply to all billing practices, this BPR is specifically focused on coding practices for professional services. As such it applies to clinics, private practices, Ambulatory Surgery Centers, Hospitals and all other organizations that bill for professional services. All provider organizations that bill for professional services and health plans that process claims for professional services are encouraged to adopt and appropriately implement these Best Practice Recommendations as soon as practical.

Providers should check with the health plan to determine if they have implemented these and encourage the health plan to adopt them if they have not yet put them in place.

Background:

Industry standard coding and payment policies and guidelines encourage consistent coding practices by providers when billing for care services and consistent adjudication practices by health plans.

There are, however, situations when industry standards do not exist or apply:

- There are situations where no industry accepted single coding standard exists (e.g. CMS doesn't address the situation, existing coding standards have not addressed a new technology, etc.)
- There are situations where health plans vary from an industry standard or convention due to specific benefit structure, provider contracts, etc. These variations may be advantageous to the provider and/or patient.

Commonly accepted practices need to be put in place for those situations when standards do not exist and/or when health plans vary from standards.

Cost and complexity is introduced into the provider environment when health plans do not adopt industry standard coding policy and guidelines or do not make transparent their alternative(s) to policy standards. These situations cause costly unexpected denials of codes/claim lines for the providers. Providers are burdened with trying to anticipate the health plan's unique adjudication practices, customizing their own billing/remittance posting software, and/or working through a costly process of researching and handling those unexpected denials through provider reconsideration requests, etc.

Cost and complexity is introduced into the health plan environment when providers do not adopt industry standard coding policy and guidelines or implement a health plan's variations to that policy. The absence of standards or competing standards is even more problematic as it leads to differences of opinion between providers and health plans and repeated appeals. In all these situations, health plans are burdened with increased claims cycle time and/or working through a costly process of researching and handling reconsideration requests.

Industry Standards and Transparency:

The National Correct Coding Initiative (NCCI) Policy is a nationally recognized and published standard for coding policies and guidelines. The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment. The coding policies are based on coding conventions defined in the American Medical Association's *Current Procedural Terminology (CPT) Manual*, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice. Since the NCCI is a CMS program, its policies and edits represent CMS national policy (although it doesn't supersede any other CMS coverage or payment policies).

The *National Correct Coding Initiative Policy Manual for Medicare Services* is published by CMS. The policy and related CCI code edits are updated quarterly and can be found on the CMS websites:

- http://www.cms.hhs.gov/NationalCorrectCodInitEd/
- http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/

The Medicare Physician Fee Schedule Database (MPFSDB) contains a set of rules and guidelines for payment under Medicare Part B. The database includes more than 10,000 Health Care Procedure Coding System (HCPCS) and Current Procedural Codes (CPT) codes that are included on the CMS physicians' fee schedule. The Centers for Medicare and Medicaid Service (CMS) assigns various payment policy indicators to each code within the Medicare Physician Fee Schedule Database (MPFSDB). The Database is available to all carriers nationally to assure consistent claims processing for the Centers for Medicare & Medicaid Services (CMS). The MPFSDB is updated quarterly.

The MPFSDB can be found on the CMS website:

http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp?listpage=3

Ideally, health plans that implement coding policy and edits will do so in a manner that follows NCCI & MPFSDB policy standard(s) where they exist and are applicable. In cases where health plans vary from NCCI & MPFSDB industry accepted policy and edits standards, their alternative edits and corresponding policy source(s) should be visible to providers so that providers can adjust their billing practices accordingly. Making these alternative edits/sources visible is referred to as Transparency.

The practice of using NCCI & MPFSDB standards in conjunction with transparency of health plan-specific variations to those standards will improve and simplify the process of claims coding and adjudication. Adoption of this practice will enable the following benefits:

- Provider time and costs are not wasted appealing unexpected coding denials.
- Health Plan time and costs are not wasted researching and resolving provider reconsideration requests

- Conversations between providers and health plans can be constructively focused on understanding and resolving conflicts regarding alternative edits/sources

Providers may or may not choose to implement billing practices that are consistent with existing NCCI & MPFSDB (or health plan specific) payment policy and edit standards for coding. In those cases where providers ***do not agree with NCCI standards and/or a health plan's variation and would like to see the standard changed***, providers have these options:

- Regarding NCCI policy/edits, comments should be submitted in writing to:

  National Correct Coding Initiative
  Correct Coding Solutions LLC
  P.O. Box 907
  Carmel, IN 46082-0907

- For health plan variations to NCCI & MPFSDB policy/edits, providers may chose to continue to submit claims even though they know they will be denied. By submitting claims in these situations, providers are building the case for changing the health plan's policy. Providers can further support their case by:
  - Sending feedback with documentation supporting their position to the health plan
  - Submitting a request for reconsideration of the denial along with their supporting coding policy source information

  These efforts may result in that edit being removed from the "variation" list and payment ultimately allowed.

Coding Edits Currently Within Scope:

Interviews with provider organizations, health plan customer service phone calls and workgroup discussion suggest that non-compliance with the following coding policies is highly problematic for both providers and health plans. Issues result in a high volume of incorrectly coded claims, unexpected claim denials and provider requests for reconsideration. As such, this Best Practice Recommendation addresses the specific policies listed below. Over time, other policies may be added and addressed as they are identified to be problematic.

1. CCI Edits

Within NCCI there is an extensive set of tables of Correct Coding Initiative (CCI) edits which were created to clarify practices related to bundling/unbundling. There are over 140,000 pairs of Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) Level II codes that are not separately payable services and should not be reported together except under certain

circumstances. The edits are applied to services billed by the same provider for the same patient on the same date of service.
CCI code edits fall into two categories:

a) "Column One/Column Two Correct Coding Edit Table" (formerly Comprehensive/ Component Edit Table)

This table contains 'edit pairs' of CPT/HCPCS codes that, in general, should not be reported together. Each 'edit pair' has a column one and column two CPT/HCPCS code. If a provider bills the two codes of an 'edit pair', without the appropriate modifier, the column two code is denied, and the column one code will be adjudicated.

Although the column two code is often a component of a more comprehensive column one code, this relationship is not true for many edits and, in these cases, the 'edit pair' simply represents two codes that should not be reported together.

Note: It may be clinically appropriate to utilize an NCCI-associated modifier. In these limited circumstances, the column two code may be reported (with the modifier) on the same date of service as the column one code and both will be adjudicated.

b) "Mutually Exclusive Edit Table"

This table contains 'edit pairs' of CPT/HCPCS codes that are mutually exclusive of one another based either on the CPT/HCPCS code descriptors or the medical impossibility/improbability that the two procedures could be performed at the same anatomical site or the same patient encounter.

Note: many edits in the Mutually Exclusive edit table allow the use of NCCI-associated modifiers when, for example, the two procedures of a code pair edit may be performed at different anatomic sites or separate patient encounters on the same date of service.

2. MPFSDB Indicators

The Centers for Medicare and Medicaid Service (CMS) assigns various payment policy indicators to each code within the Medicare Physician Fee Schedule Database (MPFSDB). The following indicators are included within the scope of this BPR. The full definition & use of these indicators and be found in the prologue section of the Database.

Note: This BPR references the MPFSDB as the source document that defines the set of indicators and their appropriate usage for coding. It is not intended to define how health plans administer reimbursement.

Indicator Name	Brief Description
Status Code	Indicates whether the code is in the fee schedule and whether it is separately payable if the service is covered. *Note*: Only codes with a status of 'B' = Bundled Code ("Payment for covered services are always bundled into payment for other services") is generally applicable across providers and health plans and as such falls within the scope of this BPR .
Global Surgery	Provides time frames that apply to each surgical procedure if concept applies
Multiple Procedures (Modifier 51)	Indicates applicable payment adjustment rule for multiple procedures performed on the same day
Bilateral Surgery (Modifier 50)	Indicates whether payment adjustment for bilateral procedures apply
Assistant at Surgery	Indicates services for which an assistant at surgery is paid
Co-surgeons (Modifier 62)	Indicates services for which two surgeons, each in a different specialty, may be paid
Team Surgery (Modifier 66)	Indicates services for which team surgeons may be paid
Endoscopic Base Codes (Indicator 3)	Used to identify and apply multiple endoscopic reductions following CMS policy.

Best Practice Recommendations:

As outlined below, health plans and providers will adopt and implement industry policy standards as outlined in the above section, 'Coding Edits Currently Within Scope'. When health plans vary from these standards, they will make their variation(s) available to contracted providers.

Health Plans will have a link on their web site that informs providers that they follow industry standards and describes to providers how they will make any variations to those standards known.

Health Plans

Adherence to these practices will help to a) decrease work and claim cycle time spent reviewing provider's coding and b) reduce the manual processing work related to researching and processing claim reconsiderations from providers.

1. Adopt and implement National Correct Coding Initiative Policy and Guidelines (NCCI), with specific focus on the rules surrounding the CCI Code Edits referenced above in the section 'Coding Edits Currently Within Scope'.

2. Implement coding logic consistent with CMS MPFSDB indicators referenced above in the section 'Coding Edits Currently Within Scope'.
3. Implement updates to these rules/edits within 30 days of their release by CMS or as soon thereafter as is reasonably practical.

4. In situations when there is variation from NCCI policy, CCI code edits or MPFSDB guidelines (referenced above in the section 'Coding Edits Currently Within Scope'), make the following information available to providers on the health plan's web site . . .
   - Specific variations to general coding guidelines, code pair edits or MPFSDB guidelines
   - Source that you use to support the variation from standard. (A source is only required if the variation results in less reimbursement to the provider.)

   This information can be made available on the web site in any one of the following ways, as determined by the health plan, a) part of general policy or contracting information, b) a current list of variations, and/or c) an interactive process where the provider can enter specific billing and coding scenarios to see how they will be processed by the health plan. This information should be updated on a quarterly basis.

Providers

Adherence to these practices will help to a) assist in billing clean claims, b) decrease unexpected claim denials resulting from claim coding edits, and c) reduce claim reconsideration/appeal requests sent to health plans.

1. Adopt and implement National Correct Coding Initiative Policy and Guidelines (NCCI), with specific focus on the rules surrounding the CCI Code Edits referenced above in the section 'Coding Edits Currently Within Scope'.

2. Implement coding logic consistent with CMS MPFSDB indicators referenced above in the section 'Coding Edits Currently Within Scope'.

3. Implement updates to these rules/edits within 30 days of their release by CMS or as soon thereafter as is reasonably practical.

4. Regularly (not less then once per quarter) check health plan web sites for updates to their list of variations and alternative policy sources. Research those sources, discuss with the health plan as necessary and implement them within your system.