

# *Administrative* Simplification

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## Best Practice Recommendation for

### *Reconsideration of a Health Plan's Policy Regarding Code Edits*

<b>Version</b>	
<b>Issue Date</b>	<b>Explanation</b>
03-02-2010	Initial Release
06-02-2010	Amended as follows: Health Plans will have a link on their web site that describes their process. (per 01-27-10 meeting)

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## **BEST PRACTICE RECOMMENDATION**

**Topic:** Reconsideration of a Health Plan's Policy Regarding Code Edits

*Note: This Best Practice Recommendation applies to health plan policies that describe how services should be coded. Health plans may call these types of policies by different names, e.g. Code Editing Policy, Reimbursement Policy, etc. This Best Practice Recommendation applies to any such policy regardless of how a health plan refers to it. It is important to recognize that reimbursement amounts ARE NOT included in these policies and, as such, are outside the scope of this Best Practice Recommendation.*

### **Improvement Opportunity:**

Situations arise when providers use the exact same coding approach for a given service and get denials from one health plan and not from another depending upon what industry standard, i.e. source, is being used by the health plan. In these situations, providers would like the health plan to reevaluate their policy regarding the code edit. Providers would also like the reconsideration to be carried out with a spirit of collaboration where they are confident that their voice will be heard and the outcome will be formally communicated to the organization requesting the reconsideration. The opportunity is for providers and payers to be reasonable about what they do, to be willing to consider differences of opinion that are supported by credible sources and to responsibly communicate information and decisions.

### **Summary of Recommendation:**

A provider can request that a health plan reevaluate a specific policy regarding a code edit in situations where the provider's and health plan's policy sources conflict, or where the provider and the health plan have different interpretations of a common policy source. The health plan is committed to completing the reconsideration within 60 calendar days, unless additional supporting documentation is required from the provider organization.

### **Applicability:**

This Best Practice Recommendation applies in those situations when a provider is requesting a reconsideration of a health plan's policy regarding the coding of services. It does not apply when a provider is requesting reconsideration of a specific claim's adjudication of payment or benefits. This Best Practice Recommendation assumes that a health plan already has in place a process for providers to use to request reconsideration of a specific claim that has been denied. (Note: Typically, policy reconsideration is requested after the provider has already submitted numerous requests for claim reconsiderations that are related to a health plan's Code Editing policy. However, a policy reconsideration may be requested prior to any claims being submitted if the

provider is planning to do a particular procedure on a regular basis. As a general guideline, if there is a systemic coding issue related to a health plan's policy that continuously arises, policy reconsideration is the recommended course of action.)

Providers should check the adoption matrix located on the WorkSMART site at [://www.onehealthport.com/worksmart/wsadoptionmatrix.php](http://www.onehealthport.com/worksmart/wsadoptionmatrix.php) to determine which health plans have adopted these practices and when they will be fully in place. In those cases where a health plan has not adopted these practices, providers should encourage them to do so.

### **Background:**

A number of nationally recognized organizations, e.g. CMS's National Correct Coding Initiative (NCCI), American Medical Association (AMA), etc., have defined industry standard for how health care services should be coded by provider organizations and processed by health care organizations. These standards become the basis of provider and health plan policies. For each policy, the nationally recognized organization that developed the associated standard is referred to as the "source" of that policy. For a given service, different sources may recommend conflicting standards.

Provider organizations and health plans select and/or build information systems that perform their claims coding and their claims code editing functions respectively. Those systems will incorporate industry standards into their processing logic. Different systems may incorporate industry standards from different sources. As a result, situations arise where a provider codes a service according to one standard and submits the claim to a health plan that edits that service according to a conflicting standard. Situations also arise when providers and health plans adhere to the exact same standard for a given service, yet interpret the recommended standard in conflicting ways.

When the provider's and the health plan's source for coding standards conflict, or the language within the source is interpreted differently, expectations about the processing of the claims for services covered under those standards may vary. Resolution of these situations is problematic since both the provider and the health plan source is based on how they interpret language of the source.

### **Scope:**

This Best Practice Recommendation *ONLY* applies to health plan policies regarding code edits when:

- a. That policy is related to professional services (as such it applies to all organizations that bill for professional services), and
- b. There is a conflict between a provider's Coding Policy and a health plan's policy and both policies are based on a nationally recognized industry standard source such as

the American Medical Association (AMA), CPT coding guidelines and conventions, local and regional Medicare policies, nationally recognized bundling edits, including CMS's National Correct Coding Initiative (NCCI), and nationally recognized physician academy and society guidelines. The conflict may result from a difference in the two nationally recognized sources or a difference in interpretation of the same nationally recognized source.

This Best Practice Recommendation does **NOT** apply to medical policies or benefit determinations.

**In Scope:** For a health plan policy regarding code edits to be within the scope of this BPR, the applicability criteria listed above must be met. Specific examples include but may not be limited to the following:

- Bundled Services.
- Pre-post op visits in global period
- Incidental and Mutually Exclusive
- Modifier Validity
- Assistant Surgeon necessity

**Out of Scope:** Health plan policies regarding code edits are out of scope of this BPR when the applicability criteria listed above is not met. In these situations, the claim reconsideration and/or appeals process, which ever is appropriate, should be followed. Specific examples include but may not be limited to the following.

- Eligibility, Coverage and Benefits Limitations
- Medical Necessity Policy
- No Pre-Cert
  - Fee Schedule or reimbursement allowances
  - Waiting periods
  - COB Workman's Comp
  - Situations where a governing WAC is in place
  - State or Federal requirements
  - Non-FDA approved (Experimental/Investigational service)
- Contractual issues, e.g. patient cost share, referrals

### **Best Practice Recommendations**

The following outlines a set of specific practices for provider organizations and health plans. Ideally, both organizations will work together throughout the reconsideration process in a spirit of collaboration.

#### **Provider Organization**

Providers need to check with each health plan to find out any specific requirements for requesting a reconsideration of a policy regarding a code edit, e.g. how and to whom the

request should be sent. All health plans will have a process that calls for provider organizations to:

1. Submit a request for reconsideration, either as a letter or an electronic web-based form<sup>\*1</sup> as determined by the health plan. (See example letter in Appendix)

Requests should include the following information:

- a. Description of the issue that gives the health plan a clear picture of the provider's concerns
- b. Explanation of why the provider does not agree with the health plan's current policy or interpretation. Include the supporting alternative policy information and the source where it can be found
- c. Person's name/number as the point of contact within your organization
- d. As appropriate:
  - Relevant codes or code combination examples
  - Specifics about associated claims that have been denied, e.g. EOB(s). (Note: since the request is related to a policy reconsideration, health plans may not need/require claim specific information. Since Claim Numbers may be considered patient confidential information, they should not be submitted on an unsecured web site or unencrypted email.)

<sup>\*1</sup> An electronic form must provide a reasonable amount of space for providers to supply the necessary information and be printable by them so they can have a copy of the request.

2. Respond, within 15 calendar days, to requests from health plans for additional supporting documentation.

Health Plans will review the policy reconsideration request to ensure that it falls within scope of this BPR and that all necessary information is provided. If a health plan requests additional supporting materials, provider organizations should submit them within 15 calendar days. The review cannot be considered without this information.

3. Provide significantly different information when submitting subsequent requests for reconsideration of the same policy.

Once a request for reconsideration of a specific policy has been submitted and a decision has been made by the health plan, additional requests related to that same policy will no longer be processed by the health plan unless supporting documentation is submitted that provides significantly different information than was submitted with the initial request.

**Health Plan:**

Health plans will document and communicate to provider organizations their specific process for requesting a reconsideration of a policy regarding a code edit. Health Plans will have a link on their web site that describes their process.

The following are Recommended Best Practices to be included in each health plan's process.

Health plans will complete the policy reconsideration process within 60 calendar days from receipt of the request, unless additional information is needed from the provider. Providers will be given 15 calendar days to supply requested information. Unless the health plan and provider organization mutually agree to extend the process, a decision will be made within 75 calendar days of initial receipt of the request for policy reconsideration.

1. Health plans will offer a method, e.g. phone, letter, web site, etc. for providers to use to confirm that the health plan received their initial request for policy reconsideration.
2. Health Plans will review the request for policy reconsideration to make sure that the request falls within scope and that all necessary information is provided. The Health Plan will notify the requesting provider organization if the request is not in scope or if additional information is required when a request is within scope. The notification must go back to the provider point of contact that initially requested the reconsideration.

If additional information is being requested, the notification will:

- a. provide instructions for submitting the information, e.g. fax number, email address, street address, etc.
  - b. indicate that the documentation should be received within 15 calendar days.
  - c. provide a contact person's name and email address/phone number for providers to use to confirm that the information was received
3. Health plan will notify the provider of their decision within 60 calendar days of receiving the request, unless additional documentation is requested of the provider. The decision timeframe will be extended for each day that the health plan is waiting for information from the provider. If the provider takes longer than 15 calendar days to submit the information, the 60-day decision period will restart once the information is received.

There may be situations where a health plan and a provider organization are constructively engaged in a discussion about a reconsideration request, but the decision timeframe is about to end. If mutually agreed upon, a future decision date can be set.

4. If the decision is that the policy regarding a code edit WILL NOT be revised, notification will include an explanation of the rationale behind the decision.

5. If the decision is that the policy regarding a code edit **WILL** be revised, notification will include the health plan's expectations about when and how the new policy will take effect.

If the health plan must make system changes,

- The projected implementation date will be estimated (meaning that this date can be subject to change by the health plan). If the implementation date does change, the health plan will communicate the revised date to the requestor.
- The health plan will inform the provider if they intend to reprocess claims that are received prior to implementation of the system changes. If providers need to process their claims differently prior to system implementation (e.g. manual work-arounds), the health plan will communicate any special instructions. (Manual work-arounds and reprocessing of claims are not requirements of this Best Practice Recommendation.)



# APPENDIX

## Sample Letter - Request for Reconsideration

Provider Organization Name  
Request for Reconsideration of a Policy Regarding a Code Edit

September 10, 2009

Health Plan XYZ  
Address  
Town, ST 00000

RE: CPT 64612-50 (Chemodenervation of muscles; muscles innervated by facial nerve)  
CPT 64613-50 (Chemodenervation of muscles; neck muscles)  
CPT 64614-50 (Chemodenervation of muscles; extremities and/or trunk muscles)

Dear Payment Policy Manager:

We have received a number of denials when the CPT codes listed are billed as bilateral services using modifier 50. Specific claims denial examples have been attached for your review.

We disagree with your interpretation of whether these codes can actually be billed as bilateral codes and would like to request that you reconsider your coding policy for the edit that drives this denial. The following information supports our request:

The AMA CPT indicates that codes can be billed as bilateral with modifier 50 unless the code description indicates that the service is bilateral in nature. The descriptions for the CPT codes at issue do not reference that the services are described as bilateral. In addition, the description of the CPT indicates that the service can be performed on more than one muscle which, by definition, eliminates the option of using modifier 59.

The CMS MPFSDB bilateral indicator for each of these codes is "1". The definition of this indicator is: "1=150% payment adjustment for bilateral procedures applies". Based on this indicator, Medicare will allow modifier 50 on these codes. In addition, we are not seeing this denial from other health plan payers.

Thank you for reconsidering your policy for this coding edit. If you have questions or need additional information, please do not hesitate to call me at the number below.

Sincerely,

Submitter Name, CPC  
Title  
Provider Organization  
Phone  
Email Address

Attachments: Claim denials for procedures 64612-64614