Outpatient & Professional Services Claim Edits

Reimbursement Policy

Purpose

Community Health Options utilizes claim editing rules in processing outpatient and professional services claims that are integrated into the claims processing system for all Health Options plans and products. The use of these provides code editing rules that are consistent with standard commercial health insurance business practices and allows Health Options to accurately and efficiently process medical claims.

Policy

Community Health Options uses several reference guidelines in developing logic related to claims adjudication for outpatient and professional services and procedures. Rules are developed from clinical and rules-based logic to assess submitted claims information against a series of edit programs that include, but are not limited to: age specific procedures; gender specific procedures; duplicate codes; unbundled/rebundled procedures; mutually exclusive and/or redundant procedures; incidental procedures; incorrect coding of specific codes; services related to a surgery (global surgery); assistant surgeon use; time, type and place of service requirements; service utilization requirements (such as anesthesia administration); and other custom code edits that Health Options may develop from time to time (any such edits that are significant in nature will result in communication and publication of details in advance of utilization).

Edits and rules include those derived from, but not limited to, National Correct Coding Initiative (NCCI), the Centers for Medicare and Medicaid Services (CMS), Healthcare Common Procedure Coding System (HCPCS®), American Medical Association Complete Procedural Terminology (CPT®), American Society of Anesthesiology (ASA), coding guidelines from national medical specialty societies and Change Healthcare physician consultants, and Community Health Options guidelines. Community Health Options utilizes Change Healthcare ClaimsXten (CXT) claim editing software as one of its editing tools during the adjudication process.

Historical claims editing may also result from CXT rules that review previously submitted claims within our claims processing system that may be related to new claim submissions.

Definitions

Editing: Application of one or more rule recommendations to Current Procedural Terminology (CPT®) codes or HCPCS Level II codes presented on a claim that result in reimbursement that may:
a) be based on some, but not all of the included CPT/HCPCS codes
b) be based on different CPT/HCPCS codes than were included on the claim
c) be denied for one or more of the included CPT/HCPCS codes
d) be decreased for one or more included CPT/HCPCS codes through application of multiple procedure logic.

Historical Editing: CXT will review and identify previously submitted claims in our processing system that may be related to newly submitted claims and may result in reimbursement adjustments to previously processed claims.

Procedure

Providers are responsible for determining appropriate codes to use in billing for health care services or supplies they provide. Codes may include CPT, HCPCS, applicable modifiers, ICD-10, and must: be valid for the date(s) of service being reported, and accurately describe the services or supplies provided.

Member medical records must support the services or supplies reported on the claim by CPT/HCPCS code(s). Community Health Options reserves the right to investigate or perform audits to validate appropriateness of billed services or supplies provided to our members.

Updates to claim editing rules and/or CXT may include adding new CPT and HCPCS codes, NCCI edits, and claim editing information additions or revisions based on Change Healthcare's ongoing review of the CXT knowledge base.

Following is a list of ClaimsXten Rules adopted by Community Health Options and is not considered a full or comprehensive list of claim edits utilized by Health Options; it only details those from CXT. Refer to other Community Health Options reimbursement policies for additional information regarding other Health Options claim edits.

ClaimsXten Rules

Age and Gender-Specific Codes Rule: Identifies claim lines where an age-specific procedure code is reported for a patient whose age is outside of the associated age range, or when a gender specific diagnosis and/or procedure code is submitted that is inconsistent with the member's gender. Designations for age and gender may be based on code descriptions or publications from other sources like CMS, professional specialty societies, and the AMA.

Codes that are inconsistent with the age or gender of the member may be denied or replaced (when an appropriate replacement code exists) with this claim edit.

Assistant Surgeon Rule: Identifies claim lines containing procedure codes billed with an assistant surgeon modifier (80, 81, 82, AS) that typically do not require an assistant surgeon. This rule follows the American College of Surgeons (ACS) "Always Pay/Never Pay" guidelines for primary editing and may further refer to CMS guidelines and Change Healthcare guidelines as needed (generally in a case where ACS indicates "Sometimes Pay".

Base Code Quantity Rule: Identifies claim lines where a provider is billing a primary service or procedure with a quantity greater than one, rather than billing an appropriate add-on ("each additional") code(s).
Claim lines with an identified base code billed with a quantity greater than one will be denied and replaced with a new line with the same procedure code and a quantity of one.
This rule will also identify multiple occurrences of a base code when billed on separate lines. Additional base code line item(s) or claims will be denied.
Submit appropriate add-on codes for services that are performed in conjunction with the primary procedure.
Add-on Code without Base Code Rule: Identifies claim lines containing a CPT or HCPCS assigned add-on code billed without the presence of one or more related primary service/base procedure(s). This rule also contains content related to vaccine and immunoglobulin administration requirements.
Add-on codes submitted without a designated primary service or procedure code will be denied. If the primary service or procedure code is submitted and denied, the related add-on code will also be denied. It is expected that add-on codes will be billed on the same claim as the primary service/base procedure code, however this rule will also look for base codes for the same member by the same provider for the same date of service associated with the add-on code in the member's claim history.
Immune globulin product codes will be denied when submitted without the applicable, associated immune globulin administration code.

Vaccine administration codes will be denied when submitted without their primary vaccine or toxoid supply code.

Bilateral Billing Rule: Identifies claim lines where the submitted procedure code has already been billed with a modifier -50 for the same date of service.
A service performed bilaterally should not be billed twice when reimbursement guidelines require the code to be billed once with a bilateral modifier.
This rule identifies the same code billed twice for the same date of service, where the first code has modifier -50 appended, and will deny the second submission of the procedure code whether it is submitted with or without a bilateral modifier.

Deleted Code Rule: Identifies claim lines containing deleted procedure codes for services rendered on dates that are after the procedure code's deletion date.
Claim lines with procedure codes that are deleted for the date of service being billed will be denied.

Frequency Validation – Alternate Procedure Code Recommended Rule: Identifies claim lines containing procedure codes with "single" or "unilateral" in the description that have been submitted more than once per date of service and replaces all occurrences of the "single/unilateral" with the corresponding "multiple" or "bilateral" code. If both the multiple/bilateral code and the single/unilateral code are submitted for the same date of service, the single/unilateral code will be denied. This rule looks across claim history for same member, same date of service, same provider.

Modifier to Procedure Validation Rule: Identifies claim lines with invalid modifier to procedure code combinations. Most modifiers apply to a specific group of procedure codes and may only be reported in conjunction with those codes.
Claim lines with invalid procedure code and modifier combinations will be denied.

Multiple Code Rebundling Rule: Identifies claims containing two or more procedure codes used to report a service when a single, more comprehensive procedure code exists that more accurately represents the service performed. Typically, this is identified by the CPT code description or each code.
If the more comprehensive procedure code is billed by the same provider for the same date of service on this claim or a separate claim, this rule will deny the component codes.
Unbundled procedure codes will be re-bundled to the more comprehensive procedure code, and the component codes will be denied.

Pre-Op and Post-Op Rule: Identifies E&M procedure codes billed by the same provider within a procedure's pre-operative and/or post-operative period. If an E&M service date is within the global surgical period, the claim will be denied as part of the global surgical reimbursement. Global surgery indicators are available from the CMS website as part of the MPFS lookup.

Procedure Unbundling Rule: Identifies claim lines containing procedure codes typically not recommended for reimbursement when submitted with certain other procedure codes on the same date of service. Unbundling describes billing for services with two or more procedure codes when a single, more comprehensive procedure code exists to better describe the complete services performed. This rule will deny claim lines where a more comprehensive procedure, a procedure that results in overlap of services, or procedures that are medically impossible or improbable to be performed together on the same date of service are identified on a submitted claim.

Unbundling may be related to procedures that are incidental or mutually exclusive, and procedures identified as incidental or mutually exclusive will be denied.
Incidental procedures are ones that are performed at the same time as a more complex primary procedure, and generally are integral to successful outcome of the primary procedure or do not represent significant additional work for the physician.

Mutually exclusive procedures are ones where two procedures could not be performed at the same patient encounter because they may differ in technique or approach but result in the same outcome or are anatomically impossible.

Same Day Visit Rule: Identifies procedure codes billed by the same provider on the same date of service as a code with a global period. An E&M code billed by the same provider on the same date of service as a procedure that has a global period will be denied.

CMS Correct Coding Initiative Rule: Identifies claims containing code pairs found to be unbundled according to the CMS National Correct Coding Initiative (NCCI). This rule will deny claim lines for which the submitted procedure is not recommended for reimbursement when submitted with another procedure as defined by a code pair in the NCCI. Claims history is reviewed for same provider and same date of service.

Outpatient Code Editor (OCE) CMS Correct Coding Initiative (CCI) Bundling Rule: Identifies claims containing code pairs found to be unbundled according to CMS Integrated Outpatient Code Editor (I/OCE). Claim lines that contain a procedure that is not recommended for reimbursement when submitted with another procedure as defined by a code pair found in the I/OCE will be denied. Claims history is reviewed for same provider and same date of service.

Unbundled Pairs Outpatient Facility Rule: Identifies the unbundling of multiple surgical codes when submitted on facility claims. This rule detects surgical code pairs where either one code is a component of the other code or that these codes would not reasonably be performed together on the same date of service. The selection of code pairs is based upon the standard physician coding guidelines and not standard facility coding guidelines.

Claim lines will be denied when identified with procedures that are not recommended for reimbursement due to being submitted with one of the following: a more comprehensive procedure, a procedure that results in overlap of services, procedures that are medically impossible or improbable to be performed together on the same date of service.

Anesthesia Crosswalk Rules: Effective for dates of service on and after October 1, 2019, three anesthesia claim editing rules will be implemented.

The first is a standard anesthesia crosswalk rule: for claim lines submitted by anesthesiologists for non-anesthesia services, if a one-to-one crosswalk between a non-ASA submitted procedure code and an ASA procedure code exists, the non-ASA code will be denied, and the appropriate crosswalk code will be added on a new claim line for further processing.

The second rule identifies claim lines submitted by anesthesiologists for non-anesthesia procedure codes that are not eligible to be cross walked to an anesthesia code. This typically occurs for one of the following reasons: it is not a primary procedure code, anesthesia care is not normally required, it is a radiology service related to a diagnostic or therapeutic service, the CPT book states the procedure is performed without anesthesia, or it is a non-specific unlisted procedure code. Claim lines with codes that fall into this class will be denied.

The third rule identifies claim lines submitted by anesthesiologists for non-anesthesia services that have a one-to-many relationship with anesthesia services. The claim line(s) with the procedure code will be denied and must be resubmitted with the appropriate ASA procedure code.

Consultation Rules: Effective for new dates of service on and after October 1, 2019, this new rule will review claim lines containing procedure codes identified as consultations in the code definition. According to the AMA, "A consultation is a type of service provided by a physician at the request of another physician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care of for the care of a specific condition or

problem. If subsequent to the completion of the consultation, the consultant assumes responsibility for the management of a portion or all of the patient's condition(s), the appropriate Evaluation and Management services code for the site of service should be reported."

Inpatient Consultations: this rule will identify claim lines containing inpatient consultations that should have been billed with the appropriate level of subsequent hospital care. CPT guidelines for inpatient consultations include the following, "Only one consultation should be reported by a consultant per admission." Claim lines that contain an inpatient consultation that was billed for the same provider for the same member with at least one matching diagnosis within the previous 5-day period will be denied and replaced with a crosswalk code replacement.

Outpatient Consultations: this rule will identify claim lines containing office or other outpatient consultations billed within six months of another consultation, that should have been billed instead at the appropriate level of office visit, established patient or subsequent hospital care. Claim lines that contain an outpatient consultation that was billed for the same provider for the same member with at least once matching diagnosis within the previous six months will be denied and replaced with a crosswalk code replacement.
These rules will review claims history to determine if a consultation was billed in the six months prior to the new service being billed, including consultations billed in claims history six months before October 1, 2019.

CMS Always Bundled Procedures Rule: Effective for dates of service on and after October 1, 2019, this rule identifies claim lines containing procedure codes indicated by the CMS to be always bundled when billed with any other procedure.

According to the CMS National Physician Fee Schedule Relative Value File, the procedures identified by this editing rule have a status code indicator of "B", which is defined as: "Payment for covered services is always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident."

This rule will deny claim lines containing procedure codes indicated by CMS as always bundled when billed with any other procedure not indicated as always bundled for the same member for the same provider on the same date of service.

Frequency Validation – Allowed Once or Multiple Times per Date of Service Rules: Effective for dates of service on and after October 1, 2019, this rule identifies claim lines that contain procedure codes that have been submitted more than once per date of service, or that contain procedure codes that have exceeded the maximum number of times allowed for a single date of service. Values for frequency validation are based on anatomic considerations, CPT/HCPCS code descriptors, CPT instructions, CMS policies/Medically Unlikely Edit values, the nature of a service/procedure, nature of analyte, nature of equipment, and clinical judgment.

Missing Professional Component Modifier Rule: Effective with dates of service on and after October 1, 2019, identifies claim lines where a modifier -26, denoting professional component, should have been reported for the procedure performed at the noted place of service. CMS guidelines establish that certain procedures, when performed in certain settings, require the billing of the professional component modifier. Procedure codes with a modifier -26 line in the National Physician Fee Schedule Relative Value File are included in this list of procedures.

If a procedure code is designated as one that modifier -26 may be applicable, and it has been reported by a professional provider with a facility-based place of service but does not include the -26 modifier, the claim line may be denied or replaced with a line that contains the modifier -26, following a review of other claims in history for the same member and same date of service.

New Patient Code for Established Patient Rule: Effective with dates of service on and after October 1, 2019, identifies claim lines containing new patient codes that are submitted for established patients. The AMA states,

"A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years." Claim lines identified with new patient codes where claims history contains a claim that meets the standards set by the AMA will be denied and/or cross-walked to the appropriate established patient visit code.

Obstetrics Package Rule: Effective with dates of service on and after October 1, 2019, evaluates claim lines to determine if any global obstetric care codes (defined as containing antepartum, delivery and postpartum services) were submitted with another global OB care code or a component code such as the antepartum care, postpartum care, or delivery only services, during the average length of time of the typical pregnancy (and postpartum period as applicable), 280 days (expected length of a normal pregnancy) and 322 days (expected length of pregnancy with postpartum period).

When the current billed code is considered a maternity care code and there is a global obstetrical code found in claims history within 280 or 322 days, the current billed code will be denied.

Pay Percent Multiple Surgeries Rule: Effective for dates of service on and after October 1, 2019, identifies claim lines that are eligible for Pay Percent adjustments for bilateral, multiple quantity and/or payment modifiers.
CMS rules advise that when more than one surgical procedure is performed on the same patient, by the same physician, on the same day, the fee schedule amount for the second and each additional procedure will be 50 percent of the fee schedule amount that otherwise would have applied for that procedure.

The procedure with the highest RVU will be considered the primary procedure and have a Pay Percent value of 100% assigned with all other procedures assigned a Pay Percent value of 50%. All values remain subject to fee schedule and contract rate calculations, along with benefit and cost-sharing provisions.

Claims for multiple surgeries performed with an Assistant Surgeon or Assistant at Surgery are subject to these Pay Percent considerations in addition to standard Assistant fee schedule reductions.

If a subsequent claim is received from the same provider for a primary procedure on the same date of service, the previously processed claim will be audited and may be adjusted based on the RVU of all reported surgical procedures.

Pay Percent Multiple Cardiology Rule: Effective for dates of service on and after October 1, 2019, identifies claim lines that are eligible for a Multiple Procedure Payment Reduction (MPPR) for the technical component (TC) of Diagnostic Cardiovascular Procedures; assigns appropriate pay percentage to the eligible line(s), including adjustments for multiple procedure, bilateral, multiple quantity, and additional payment modifiers. Editing will follow CMS guidelines for MPPR, and will occur across claims, following applicable guidelines based on the date of service.

Pay Percent Multiple Ophthalmology Rule: Effective for dates of service on and after October 1, 2019, identifies claim lines that are eligible for a Multiple Procedure Payment Reduction (MPPR) for the technical component (TC) of Diagnostic Ophthalmology Procedures; assigns appropriate pay percentage to the eligible line(s), including adjustments for multiple procedure, bilateral, multiple quantity, and additional payment modifiers. Editing will follow CMS guidelines for MPPR, and will occur across claims, following applicable guidelines based on the date of service.

Pay Percent Multiple Radiology Rule: Effective for dates of service on and after October 1, 2019, identifies claim lines that are eligible for a Multiple Procedure Payment Reduction (MPPR) for Diagnostic Imaging services. Editing will follow CMS guidelines for MPPR, and will occur across claims, following applicable guidelines based on the date of service.

Pay Percent Multiple Therapy Rule: Effective for dates of service on and after October 1, 2019, identifies claim lines that are eligible for a Multiple Procedure Payment Reduction (MPPR). According to CMS, when multiple therapy procedures are performed, secondary and subsequent procedures performed by the same provider on the same date of service should have the non-facility Practice Expense RVU reduced by 50%. CXT editing will identify procedure codes eligible for the MPPR and apply the related reduction.

The MPPR will apply to codes contained on the list of "always therapy" services paid under the Medicare Physician Fee Schedule, regardless of the type of provider or supplier that furnishes the services.

Pay Percent Multiple Endoscopies / Multiple Endoscopies Assistant Surgeon Rule: Effective with dates of service on and after October 1, 2019, identifies claim lines where multiple endoscopy procedures within the same family are reported that are eligible for a multiple endoscopy reduction per CMS guidelines. Additionally, if more than one endoscopy family is reported and/or surgery procedures are reported, the rule will apply to those that are eligible for a multiple endoscopy reduction per CMS guidelines.

This rule will also apply to claim lines submitted with Assistant Surgeon or Assistant at Surgery modifiers, other payment modifiers, bilateral procedures, and those billed with multiple quantity, and apply the multiple endoscopy reduction per CMS guidelines.

Related Services Rule: Effective with dates of service on and after October 1, 2019, identifies procedure codes or revenue codes billed by the same or a different provider ten days prior to, the same day as, or within seven days after a non-covered service. Claim lines containing procedure codes that meet these conditions and that are related to the non-covered service, identified by reviewing the diagnosis code(s) for the non-covered denied service, will be denied.

Supplies - Same Day Surgery Inclusive Rule: Effective with dates of service on and after October 1, 2019, identifies claim lines containing supplies that have been submitted for the same date of service as a surgical procedure. Supply codes are established by the CMS, and claim lines containing identified supplies will be denied.

Duplicate Component Billing Rule: Effective with dates of service on and after October 1, 2019, identifies when a professional or technical component of a procedure is submitted, and the same global procedure was previously submitted by the same provider for the same member for the same date of service.
The CMS National Physician Fee Schedule Relative Value File directs that a global procedure includes reimbursement for both the professional and technical components of certain procedures.
Submitted claim lines that contain procedure codes billed with a professional or technical modifier when the procedure code was previously submitted as a global procedure by the same provider for the same member on the same date of service will be denied.

Global Component Rule: Effective with dates of service on and after October 1, 2019, identifies claim lines with procedure codes which have components (professional and technical) to prevent overpayment for either the professional or technical components or the global procedure. This rule also detects duplicate submissions of the total global procedure or its components across different providers for the same date of service.
The CMS National Physician Fee Schedule Relative Value File directs that a global procedure includes reimbursement for both the professional and technical components of certain procedures. A single provider can bill for both components (global procedure), or different providers can each bill for different components. Any submission of the same procedure will be evaluated against previous submissions to determine if any or all components of the procedure (same date of service) have already been paid, and the current claim is adjusted accordingly.

Document Publication History

8/25/2021 Annual review: removed sources from each rule as duplicative to Policy section, added full name for abbreviation NCCI.
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This policy provides information on Community Health Options' claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management guidelines when applicable, adherence to plan policies and procedures, and claims editing logic. Community Health Options reserves the right to amend a payment policy at its discretion. Policies are enforced unless underpinning direction stated otherwise.