Reimbursement Policy designation of Professional or Facility application is respective to how the provider is contracted with The Plan. Provider contractual agreement terms in direct conflict with this Reimbursement Policy may supersede this Policy’s direction and regional applicability. This policy supersedes and replaces any prior Plan guidance, including bulletins, in direct conflict with the guidance provided in this Reimbursement Policy.

PURPOSE:

This policy outlines the systems and sources of coding information used to appropriately adjudicate claims.

REIMBURSEMENT GUIDELINES:

The Plan coding rules are based on but are not limited to the following guidelines and resources:

- National Correct Coding Initiative (NCCI) including Medically Unlikely Edits (MUE)
- American Medical Association (AMA)
- Healthcare Common Procedure Coding System (HCPCS)
- Current Procedure Terminology (CPT)
- World Health Organization (WHO) ICD-10
- The National Center for Health Statistics (NCHS) ICD-10-CM
- Centers for Medicare and Medicaid Services (CMS) ICD-10-PCS
- National and State Medical Societies and Associations
- The Plan enhanced clinical editing processes
- American Hospital Association (AHA)

Note: The Plan reserves the right to customize these coding edits due to mandates and other business reasons.

Medically Unlikely Edits
MUE edits are applied to claims based on the values posted by CMS. The Plan reserves the right to apply MUE edits outside of the CMS values when it is deemed clinically appropriate or use statistical methods to determine MUEs when no industry standard MUEs are available.

**ICD-10**

The Plan applies the ICD-10-CM Excludes 1 and Excludes 2 guidelines in its claims adjudication process. Definitions are as follows:

**Excludes 1**

A type 1 Excludes note is a pure excludes note. It means "Not coded here." An Excludes 1 note indicates the code excluded should never be used at the same time as the code above the Excludes 1 note. An Excludes 1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

**Excludes 2**

A type 2 Excludes note represents "Not included here". An Excludes 2 note indicates the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes 2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate.

**Custom Edits**

The Plan operationalizes the following custom editing procedures based off national coding standards:

**Similar Codes**

When two or more procedure codes represent services considered to be similar in nature to one another, the procedure codes are identified as “similar codes” in The Plan’s processing system. “Similar codes” are defined as any code(s) that should not be reported with or appended to another code on the same date of service when:

1. The codes are clinically duplicative; **or**
2. When there is an AMA CPT parenthetic note indicating, “Do not report (code) in addition to (code).”

*Example:* It is not appropriate to bill an obstetrical ultrasound and a non-obstetrical ultrasound on the same date of service.

*Note:* This is not applicable to UB claims.
The Plan’s claim processing system contains various edits used to appropriately adjudicate claims. One example of these edits is procedure code combinations. Based on code terminology and/or guidelines from the applicable governing entity, some codes represent a combination of two or more components. These components may also be represented by individual codes. If component codes are reported separately, they may be combined into the combination or “total” procedure code.

**Note:** This is not applicable to UB claims.

**Claim Submission of Services Guidelines**

**Reporting Place of Service**

Physicians are instructed to report the most specific Place of Service code when describing where the patient was physically located when the services were rendered. The Place of Service Code reported by the physician and other supplier should be assigned based on the same setting in which the patient received the face to face service.

**Note:** This is not applicable to UB claims.

**Reporting Services Rendered**

Professional Billers: Services rendered to a patient on the same day by the same performing provider **must** be reported on a single claim. This requirement will limit the amount of claim inquiries providers may find necessary and post-pay adjudication corrections made by The Plan either through audit or other means.

Facility Billers: Services rendered to a patient on the same day in the same facility **must** be reported on a single claim. This requirement will limit the amount of claim inquiries providers may find necessary and post-pay adjudication corrections made by the Plan either through audit or other means.

**APPLICATION:**

If appropriate coding guidelines and policies are not followed, The Plan may:

- Reject or Deny the claim
- Recover and/or recoup claim payment

**ADDITIONAL BILLING INFORMATION, REFERENCES AND GUIDELINES:**


POLICY UPDATE HISTORY INFORMATION:

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>05 / 2018</td>
<td>Implementation</td>
</tr>
<tr>
<td>08 / 2018</td>
<td>Added example on OB vs. non OB for similar codes.</td>
</tr>
<tr>
<td>05 / 2019</td>
<td>Added AHA under Reimbursement Guidelines/Claims Submission of Services Guidelines.</td>
</tr>
</tbody>
</table>