Coding Overview

Policy[1]

The purpose of this policy is to serve as a reference guide for general coding and claims editing information.

General Coding and HIPAA Compliance

Harvard Pilgrim will accept only standard diagnosis and procedure codes that comply with HIPAA (Health Information Portability and Accountability Act) transaction code set standards.

Specific types of standard coding include:

- CPT Level I Codes — 5-digit numeric codes maintained by the American Medical Association. Used to describe medical, surgical, and diagnostic services, including radiology, anesthesiology, and evaluation/management services of physicians, hospitals, and other healthcare providers.
- HCPCS Level II Codes — alpha-numeric (1 letter followed by 4 numbers) codes for medical services not included in Level I, for example, durable medical equipment, ambulance services, drugs and supplies.
- C codes are temporary HCPCS codes established by CMS for use under the Hospital Outpatient Prospective Payment System (OPPS). Harvard Pilgrim will reimburse most C codes to outpatient facilities and ambulatory surgery centers only. They will not be reimbursed to professional providers.
- HCPCS Temporary National “S” codes are temporary codes for private payer use. Harvard Pilgrim does not reimburse “S” codes except for a limited number of contracts.
- Current Dental Terminology (CDT) Codes — Dental codes maintained by the American Dental Association (ADA)
- International Classification of Diseases, ICD-10-CM codes — Used to indicate diagnosis or condition. ICD-10 codes are required on all claims.
- NDC codes — a universal number that identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. (Harvard Pilgrim does not allow the hyphens, only bill the 11-digit NDC).
- Revenue Codes — 4-digit numeric codes used by institutional providers. HCPCS or CPT codes may be required in addition to specific revenue codes to describe the services rendered.

Claims Editing Overview

Harvard Pilgrim uses claims editing software for automated claims coding verification and to ensure that Harvard Pilgrim is processing claims in compliance with general industry standards. The policies and procedures included in the claims editing software are incorporated herein by reference as policies and procedures of Harvard Pilgrim.

Claims Editing Background

Claims editing evolved through the collaborative efforts of medical directors and review nurses who developed rules for appropriate coding. In addition, a consensus panel of specialty physician consultants developed the rules that apply to various specialties. Claims editing takes into consideration the conventions set forth in the health care insurance industry, such as Centers for Medicare & Medicaid Services (CMS) policies, current health insurance and specialty society guidelines and the American Medical Association’s CPT Assistant newsletter.

Claims Editing Software Application

Using a comprehensive set of rules, claims editing provides consistent and objective claims review by:

- Accurately applying coding criteria for the clinical areas of medicine, surgery, laboratory, pathology, radiology and anesthesiology as outlined by the American Medical Association’s (AMA) Current Procedural Terminology (CPT) manual.
- Evaluating the CPT and HCPCS codes submitted by detecting, correcting and documenting coding inaccuracies including, but not limited to, unbundling, up-coding, fragmentation, duplicate coding, invalid codes and mutually exclusive procedures.
- Incorporating historical claims auditing functionality, which links multiple claims found in a patient’s claims history to current claims to ensure consistent review across all dates of service.

Claim Editing Determination

Claim editing does not affect claims submission or Explanation of Payment (EOP) statements.

- A claim edit determination may be appealed due to unusual clinical circumstances; separate reimbursement may be considered upon medical record review.
- Claim appeals resulting from the claim-editing determinations are treated the same as any other provider claim appeal.

Claims Editing Updates

The claims editing software is updated regularly to incorporate the most recent medical practices, coding practices, annual changes to the AMA's CPT manual and other industry standards.

Claims Editing Principles

Unbundling

Unbundling occurs when two or more procedures are reported separately when a single, comprehensive code exists that accurately describes the service performed.

- Services should not be unbundled into multiple procedure codes but should be reported as a single comprehensive code.
- Unbundled procedure codes may be denied or re-bundled and processed as the more accurate, single, comprehensive procedure code.
- When all individual laboratory component codes, which together make up a laboratory panel code, are submitted, they will be combined into and reimbursed as the more comprehensive laboratory panel code.

Incidental Procedures

Procedures that are performed at the same time as a primary procedure are considered incidental if clinical practice standards indicate they are normally included as part of the primary procedure. Incidental procedures are not reimbursed separately.

Mutually Exclusive Procedures

Two or more procedures are considered mutually exclusive if they cannot reasonably be performed at the same anatomic site or same patient encounter. These coding combinations are deemed submitted in error and only the primary service is considered for reimbursement.

Separate Procedures

Procedure codes include the term "separate procedure" should not be reported with a related procedure. Procedure codes designated as a "separate procedure" are eligible for separate reimbursement when they are performed on the same day but at a different session, or at an anatomically unrelated site.
If appropriate and supported by the medical documentation, report the separate procedure by appending either of the following modifiers where applicable:

- XE-Separate Encounter
- XS-Separate Organ/Structure

Surgical Services Reimbursed Outside of the Global Rate When Billed with Appropriate Modifier

- Services rendered for post-operative complications requiring a return trip to the operating room.
- Services of another physician, unless the physician is part of the same specialty group practice.
- If one physician performs the surgery but a different physician renders post-operative care, each service is reimbursed separately.
- For surgical procedures with zero days assigned as a global period, post-operative visits are reimbursed
- Visits unrelated to the diagnosis (see below for same day significant E&M with global day service)
  - Treatment for an underlying condition
  - An added course of treatment not related to the surgery
- Diagnostic tests and procedures, including radiological procedures

Add-on Codes

- Add-on codes are reimbursed at 100% of the allowable rate and are not subject to the multiple procedure reduction.
- Add-on codes are only those codes designated by CPT and identified by a specific descriptor that includes the phrase “each additional” or “list separately in addition to the primary procedure.”
- Add-on codes are reimbursable only when billed with their primary procedure.

Unlisted Codes

Unlisted surgical CPT codes are reimbursed after individual consideration and review of the operative notes. When submitting supporting documentation, underline the portion of the report that identifies the test or procedure associated with the unlisted procedure code. Required information must be legible and clearly marked.

Conflicts with Other Common Core Data

Providers are expected to adhere to correct coding guidelines.
Claims are screened for patient and/or provider information conflicts. Reimbursement will not be made for claims where procedure or diagnosis codes conflict with common core data, including but not limited to:

- Diagnosis with procedure
- Patient age with diagnosis
- Patient age with procedure
- Place of service with procedure
- Provider with procedure

Code Auditing Reference Tool (professional claims)

For CMS 1500 claims, Harvard Pilgrim offers the Code Auditing Reference Tool, a Web-based software application designed to enable providers to gain a better understanding of code auditing rules including, but not limited to, incidental procedures, mutually exclusive procedures, bundling/unbundling procedures and codes in conflict with age. The Code Auditing Reference Tool can increase your administrative efficiency by reducing manual inquiries, claim appeals, and misunderstandings regarding claim edits. Providers and their office staff registered with HPHConnect can review the claim payment methodology and reimbursement policies behind coding edits. To access Harvard Pilgrim's Code Auditing Reference Tool, please login into *HPHConnect*.

Professional/Technical Component

Harvard Pilgrim uses the Center for Medicare and Medicaid Services (CMS) Professional Component/Technical Component (PC/TC) indicators in the National Physician Fee Schedule (NPFS) Relative Value File to determine whether a procedure code (CPT/HCPCS) is eligible for separate professional and technical service reimbursement.
www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html

PC/TC Indicators	
0	Physician service only codes. The concept of PC/TC does not apply.
1	Diagnostic tests for radiology services. Both modifiers 26 and TC can be used with these codes.
2	Professional component only codes. Modifiers 26 and TC cannot be used with these codes.
3	Technical component only codes. Modifiers 26 and TC cannot be used with these codes
4	Global test only codes. These are selected diagnostic tests that describe a) the professional component of the test only, and b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes.
5	Incident to codes. These are services covered incident to a physician's service when provided by auxiliary personnel employed by and working under physician. Modifiers 26 and TC cannot be used. Services cannot be paid when they are rendered to patients in inpatient or outpatient hospital setting.

PC/TC Indicators	
6	Laboratory physician interpretation codes. Actual performance of the test is paid under the lab fee schedule. Modifier TC cannot be used. Physician performing interpretations of these codes must be billed with modifier 26. These services can be paid under the physician fee schedule if they are furnished to a patient by a hospital pathologist or an independent laboratory.
7	Physician therapy service, for which payment may not be made when the service is billed by an independently practicing physical or occupational therapist to a patient in an inpatient or outpatient hospital setting.
8	Physician interpretation codes. This is for physician interpretation of an abnormal smear for hospital inpatient. No TC billing is recognized. The actual test is paid through inpatient PPS rate.
9	Not applicable. The concept of TC/PC does not apply.

Self-Treatment or Treatment of Immediate Family Members

Harvard Pilgrim does not reimburse contracted providers for treatment or service rendered to immediate family members or for self-treatment.

The following degrees of relationship are included within the definition of immediate relative:

- Husband and wife
- Natural or adoptive parent, child, and sibling
- Stepparent, stepchild, stepbrother, and stepsister
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law
- Grandparent and grandchild
- Spouse of grandparent and grandchild

Medical Record Documentation and Physician Queries

Harvard Pilgrim will not accept retrospectively amended medical records or physician queries beyond 30 days from the date of service. Harvard Pilgrim considers medical record documentation and/or physician queries upon review as the official record to support services provided for the basis of coverage or reimbursement determination. Clinical documentation or physician queries amended over 30 days from the date of service will not be accepted to defend reimbursement, increase reimbursement, or for consideration of a previously denied claim.

A late entry, an addendum or a correction to the medical record, must bear the current date of that entry and should be signed by the person making the addition or change.

Provider Billing Guidelines and Documentation

Services should only be billed once they have been provided to the member.

Related Policies

Payment Policies

- Non-covered Services

PUBLICATION HISTORY

05/15/09	annual review; minor edits to the Unlisted Service/Procedures and DRG sections
02/15/10	revised schedule of coding software update to quarterly
05/15/10	annual review; minor edits for clarity
04/15/11	annual review; minor edits for clarity
01/01/12	removed First Seniority Freedom information from header
09/15/12	revised format; annual review
10/15/13	annual review; update to C codes
09/15/14	annual review; no changes
06/15/15	added ICD-10 information

10/15/15	annual review; added NDC codes
10/15/16	annual review; removed references to gender; administrative edits
10/15/17	annual review; no changes
05/01/18	added PC/TC indicators
10/01/18	annual review; added definition of “immediate family member;” removed references to ICD-9
03/01/19	added definition of Separate Procedures
10/01/19	annual review; added information regarding late entries to medical documentation
10/01/20	annual review; no changes
10/01/21	annual review; added information from the surgery policy

[1]This policy applies to the products of Harvard Pilgrim Health Care and its affiliates—Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England, and HPHC Insurance Company—for services performed by contracted providers. Payment is based on member benefits and eligibility, medical necessity review, where applicable, and provider contractual agreement. Payment for covered services rendered by contracted providers will be reimbursed at the lesser of charges or the contracted rate. (Does not apply to inpatient per diem, DRG, or case rates.) HPHC reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated annually. Always use the most recent CPT and HCPCS coding guidelines.