

CODING

Policy

The terms of this policy set forth the guidelines for reporting the provision of care rendered by NHP participating providers, including but not limited to use of standard diagnosis and procedure codes in compliance with HIPAA (Health Information Portability and Accountability Act) medical transaction code set standards.

Definitions

CDT Codes: Current Dental Terminology, Code on Dental Procedures and Nomenclature, version 3, as maintained by the American Dental Association for dental services.

CPT Codes: A set of five digit codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care providers, uniquely identified by the American Medical Association (AMA) Current Procedural Terminology (CPT-4) nomenclature.

- Category I CPT Codes - Procedures

The inclusion of a descriptor and its associated specific five-digit identifying code number in this category of CPT codes is generally based upon the procedure being consistent with contemporary medical practice and being performed by many physicians in clinical practice in multiple locations.

- Category II CPT Codes – Performance Measurement

Supplemental tracking codes used for performance measurement that will decrease the need for record abstraction and chart review, and thereby minimize administrative burdens on physicians and other health care professionals. These codes are intended to facilitate data collection about quality of care by coding certain services and/or test results that support performance measures and that have been agreed upon as contributing to good patient care. Some codes in this category may relate to compliance by the health care professional with state or federal law. This category of codes makes use of alpha characters as the 5th character in the string (i.e., 4 digits followed by an alpha character such as: 3045F).

The use of these codes is *optional*. The codes are *not required for correct coding*, many *not be used as a substitute for Category I codes*, and do *not* have a relative value associated with them.

- Category III CPT Codes – Emerging Technology

A temporary set of tracking codes for new and emerging technologies, intended to facilitate data collection on and assessment of new services and procedures. The Category III codes are intended for data collection purposes in the FDA approval process or to substantiate

widespread usage. As such, the Category III codes may not conform to the usual CPT code requirements for Category I.

No relative value units (RVUs) will be assigned to Category III codes. Payment for these services/procedures is based on the policies of payers and local Medicare Carriers. The assignment of a CPT Category III code to a service does not indicate that it is experimental or of limited utility, but only that the service or technology is new and is being tracked for data collection. Since Category III codes are part of the CPT code set, all health care payers must be able to accept Category III codes into their systems to comply with the standards for transactions and code sets under HIPAA.

These codes will be assigned a numeric-alpha identifier (e.g., 1234T), and located in a separate section of CPT, following the "Category II" section.

In general, these codes will be archived 5 years from the date of implementation; if the code has not been accepted for placement in the Category I section of CPT. The code number will not be reused.

DRG Codes: Diagnosis-related groups (DRGs) are a patient classification scheme which provides a means of relating the type of patient a hospital treats to the costs incurred by the hospital, and provides a framework for Medicare's hospital reimbursement system.

HCPCS Level II Codes: A set of alpha-numeric codes, consisting of a single alphabetical letter followed by 4 numeric digits, used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. These codes are commonly referred to as "HCPCS" codes.

Global Period: The period of time immediately prior to or after a surgical procedure in which all routine pre and follow-up care is included in the original charge amount. The global period assigned to a procedure, 0, 10, or 90 days, is assigned by CMS based on the complexity of the procedure.

ICD-9 CM Volumes 1 & 2: The International Classification of Diseases, Ninth Revision, Clinical Modification, set of codes with either 3, 4, or 5 digits, as maintained by HHS for the below listed conditions. The code is invalid if it is not coded to the *full* number of digits required for that code.

- Diseases
- Injuries
- Impairments
- Other health problems and their manifestations
- Causes of injury, disease, impairment, or other health problems

ICD-9 CM Volume 3: The International Classification of Diseases, Ninth Revision, Clinical Modification, Volume 3 Procedures, set of codes with either 2, 3, or 4 digits, as maintained by HHS for the below listed procedures or other actions taken for diseases, injuries, and

impairments on *hospital* patients. The code is invalid if it is not coded to the *full* number of digits required for that code.

- Prevention
- Diagnosis
- Treatment
- Management

ICD-9 “V” Codes: Supplementary classification of factors influencing health status and contact with health services, reported with codes V01. through V 86. delineated in ICD-9 reporting guidelines.

ICD-9 “E” Codes: Supplementary classification of external causes of injury and poisoning, reported with codes E8000-E999, delineated in ICD-9 reporting guidelines.

Medical code sets: Clinical codes used in transactions to identify what procedures, services and diagnosis pertain to a patient encounter. The codes characterize a medical condition or treatment and are usually maintained by professional societies and public health organizations.

Modifiers: Modifiers indicate that a service was altered in some way from the stated code descriptor without changing the definition. The American Medical Association (AMA) CPT modifiers are two-digit numeric codes listed after a procedure code and separated from the CPT code by a hyphen. The HCPCS Level II modifiers are two- alpha character codes listed after a procedure code and separated from the HCPCS code by a hyphen.

NDC Codes: National Drug Codes as maintained and distributed by HHS, in collaboration with drug manufacturers for the following:

- Drug and Biologicals on retail pharmacy drug transactions

Revenue Codes: Four digit codes configured to identify specific accommodations, ancillary services and billing calculations as determined by the National Uniform Billing Committee reported in conjunction with the UB 04 (facility) uniform billing form. HCPCS codes must be reported in conjunction with specific revenue codes to describe the services rendered. The COBRA act of 1986 requires hospital outpatient billing (acute-care, long-term care, rehab and psychiatric hospitals, and hospital-based rural health clinics) to make use of HCPCS coding.

Coding

For professional services use the following code sets:

Professional Service Codes	Service
CPT-4, Category I codes must be used as the first line of coding when an appropriate code exists	Professional services and services uniquely identified by CPT such as surgery, radiology, laboratory, pathology, therapies
HCPCS Level II codes	Ambulance, durable medical equipment (DME), pharmacy and other specifically approved services
CDT- D Codes- when an appropriate CPT code does not exist for oral surgery	Dental services (when available, report oral surgery with a CPT code)
NHP does not accept “S” codes, (HCPCS private payer codes), except for a limited number of provider contracts.	

For Facility (Technical) services use the following code sets:

Facility (Technical) Codes	Service
Revenue (REV) codes	Facility (technical) services
CPT-4 codes	Professional services and services uniquely identified by CPT such as surgery, radiology, laboratory
Diagnostic Related Groupings (DRG) codes	As contractually required
NHP does not accept "C" codes (HCPCS hospital outpatient PPS codes)	

For diagnosis codes on all claims, including but not limited to inpatient admissions and outpatient services, use the following code sets:

Diagnosis Codes	Service
ICD-9-CM code	A diagnosis code with every claim
ICD-9-CM "V" codes	Per ICD-9 guidelines
ICD-9-CM "E" codes	E codes are required on all motor vehicle and other accident claims

General Coding Guidelines

Modifiers

When applicable, the appropriate CPT-4 or HCPCS modifiers are required. Please note that inappropriate use of modifiers may result in the specific service or services being denied by NHP.

Unlisted Services and Procedures

Unlisted CPT codes are not recognized by NHP, unless prior authorization has been granted. The reporting of an unlisted CPT code with prior-auth requires submission of supporting clinical documentation, without which the code will deny.

Global Surgical Period

The fee schedule for most surgical procedures allows a global payment that includes the surgery and all routine pre-operative and post-operative care. The surgeon's inpatient hospital visits during an inpatient stay are included in the global allowance. The global fee allowable for the surgeon includes the following:

Service	Global Period	Comments
Routine Pre-operative Care	Visit up to 1 day prior to the procedure	Additional reimbursement allowed for evaluation and management service resulting in decision for <i>major</i> surgery when submitted on the same day as, or the day prior to a <i>major</i> surgical procedure, identified by appendage of modifier 57 (decision for surgery) to the appropriate level E & M service.
Surgery		Includes the surgery itself, local, topical, or digital metacarpal block anesthesia, and any biopsy related to the surgery on the same day as the surgery.
Routine Post-operative Care	10 days (<i>minor</i> surgery) or 90 days (<i>major</i> surgery)	Includes follow-up visits within the global period. Each procedure is assigned a specific global period.

Incidental Global Procedures

Incidental global procedures are procedures that clinical practice standards, such as promulgated by professional medical societies, suggest are normally included as a part of the definitive procedure and would not be separately reimbursed.

Unbundling

When a procedure with multiple components, described by CPT to be reported with a single code, is reported with individual codes for each of the components, the unbundled procedure codes are re-bundled and reimbursed as a single procedure.

To reduce the occurrence of post-payment adjustments, NHP utilizes McKesson's *ClaimCheck* software. *ClaimCheck* reviews claims for accuracy of CPT and HCPCS coding submission against standard coding rules, including but not limited to unbundling, upcoding, fragmentation, duplicate coding, use of invalid codes, and mutually exclusive edits, but **not** for medical necessity.

Related NHP Payment Guidelines

NHP Modifier Provider Payment Guidelines

References

American Medical Association (AMA) Current Procedural Terminology (CPT) 2011

HCPCS Level II, 2011

CMS/HIPAA Information Series 4. Overview

Publication History

Topic: Coding	Owner: Provider Network Management
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This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Neighborhood Health Plan utilizes McKesson's claims editing software, ClaimCheck, a clinically oriented, automated program that identifies the "appropriate set" of procedures eligible for provider reimbursement by analyzing the current and historical procedure codes billed on a single date of service and/or multiple dates of service, and also audits across dates of service to identify the unbundling of pre and post-operative care. Please refer to Neighborhood Health Plan's Provider Manual Billing Guidelines section for additional information on NHP's billing guidelines and administration policies. Questions may be directed to Provider Network Management at prweb@nhp.org.