General Coding and Claims Editing Payment Policy

Applies to the following CarePartners of Connecticut products:

☒ CareAdvantage Preferred

☒ CarePartners Access

The following payment policy applies to providers who render ambulance and transportation services to members of the CarePartners of Connecticut plans selected above.

Note: Audit and disclaimer information is located at the end of this document.

General Benefit Information

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting CarePartners of Connecticut Provider Services at 888-341-1508.

CarePartners of Connecticut follows Medicare coverage guidelines and also offers a limited number of non-Medicare-covered items as supplemental benefits. CarePartners of Connecticut cannot cover items and services not covered under the member's benefit plan.

Note: Supplemental benefits are subject to change each calendar year.

General Coding and HIPAA Compliance

CarePartners of Connecticut will accept only standard diagnosis and procedure codes that comply with HIPAA (Health Information Portability and Accountability Act) transaction code set standards. Refer to current industry standard coding guidelines for a complete list of CPT/ HCPCS, ICD-10 codes, revenue codes, modifiers, and their usage, as well as specific payment policies for additional information. CarePartners of Connecticut complies with all applicable state and federal laws regarding coverage of healthcare services, including mental health parity requirements.

Specific types of standard coding include:

- CPT Level I codes- 5-digit numeric codes maintained by the American Medical Association (AMA). These codes have descriptors that correspond to a procedure or service. Codes range from 00100–99499 and are generally ordered into sub-categories based on procedure/service type and anatomy.
- HCPCS Level II codes- Alpha-numeric (1 letter followed by 4 numbers) codes, which are used to identify products, supplies and services not included in Level I CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.
- C codes are temporary HCPCS codes established by CMS for use under the Hospital Outpatient Prospective Payment System (OPPS). CarePartners of Connecticut will reimburse some 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 payor use. Providers may only bill procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules
- 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. CarePartners of Connecticut follows ICD-10-CM Official Guidelines for Coding and Reporting and may deny claims when billed inappropriately.
- NDC (National Drug Code) codes- A universal number that identified a drug. The NDC number consists of 11 digits in a 5-4-2 format (Do not bill with hyphens, only 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.

Quarterly and annual revisions are made to CPT, HCPCS, and ICD-10-CM codes by CMS and AMA. This can include adding, deleting, or redefining the description of applicable codes. As these revisions are released, CarePartners of Connecticut will update its systems and any related payment policies.

Claims Editing Overview

CarePartners of Connecticut uses claims editing software for automated claims coding verification and to ensure that CarePartners of Connecticut 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 CarePartners of Connecticut.

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.
- Reviewing ICD-10 codes to ensure ICD-10-CM manual guidelines are followed by detecting incorrect or inaccurate coding (e.g., ICD-10 code not coded to the highest level of specificity). This may also be in conjunction with CPT or HCPCS codes and modifiers (e.g., claim lines where a diagnosis code indicates right side but a left side modifier is billed).
- Incorporating historical claims auditing functionality, which links multiple claims found in patient's claims history to current claims to ensure consistent review across all dates of service.

Claims Editing Determination

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

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

Claims Editing Updates

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

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 date, including but not limited to:

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

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 patient encounter. These coding combinations are deemed submitted in error and only the primary service is considered for reimbursement.

Separate Procedures

Procedure codes that include the term "separate procedure" should not be reported with a related procedure. Separate procedure codes 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 when applicable:

- XE- Separate encounter

- XS- Separate organ/ structure

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.

Professional/Technical Component

CarePartners of Connecticut 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 (CPT/HCPCS) is eligible for separate professional and technical service reimbursement.

Other Coding Guidance

Add-on Codes

- Add-on codes are only those codes designated by CPT and identified by a specified 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.

Bilateral Services

Bilateral services are procedures performed on both sides of the body during the same session or on the same day. As defined in the CPT manual, modifier 50 is used to identify a bilateral procedure. Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5-digit code.

- Modifier 50 is used to report diagnostic, radiological, and surgical procedures.
- HCPCS modifiers LT and RT are used when the procedure is valid for a modifier 50 procedure but was only performed on one side.
- Do not use modifiers RT and LT when modifier 50 applies. A bilateral procedure is reported on one line, using modifier 50.
- Modifier 50 is not applicable to:
    - Procedures that are bilateral by definition
    - Procedures with descriptions including “bilateral” or “unilateral”

Bilateral services performed on both sides of the body during the same session or on the same day, when billed with modifier 50, are reimbursed at 150% of the fee schedule allowed amount.

- Modifiers that reduce the fee schedule/allowed amount must be billed in the primary modifier position, and modifier 50 in the secondary position (e.g., for professional component of a bilateral procedure, bill modifier 26 in the primary modifier position and modifier 50 in the secondary position).

Refer to the Medicare Physician Fee Schedule (MPFS) database to determine when modifier 50, RT, or LT is applicable for a procedure code.

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 service.
- 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
    - Treatment for an underlying condition
    - An added course of treatment not related to the surgery
- Diagnostic tests and procedures, including radiological procedures

Multiple Procedures Reductions

Endoscopy Services

- Compensation is based on a percentage methodology, whereby the endoscopy with the highest allowed amount is determined and secondary endoscopies are reduced by the percentage that is representative of the value of the base endoscopy.

Ophthalmology Services

- Certain clinical activities and supplies are not duplicated when multiple diagnostic ophthalmology services are performed. The service or study with the highest technical component is compensated at 100% and all other subsequent technical components are reduced to 80%, in accordance with CMS.

Cardiovascular Services

- Certain clinical activities and supplies are not duplicated when multiple diagnostic cardiovascular services are performed. The service or study with the highest technical component is compensated at 100% and all other subsequent technical components are reduced to 75%, in accordance with CMS.

Surgical Procedures

- The surgical procedure code with the highest allowable compensation is compensated at 100% of the allowed amount. Subsequent surgical procedure code(s) that are subject to reduction logic are compensated at 50% of the allowed amount.

Multiple and Bilateral Surgical Procedures Performed in the Same Operative Session

- When a bilateral procedure code and surgical procedure code(s) are submitted together and both the bilateral and surgical procedure code(s) are eligible for multiple procedure reduction, the bilateral adjustment is applied first.
- The surgical procedure code(s) with the highest allowable compensation (after the bilateral adjustment) are compensated at 100 percent. Other surgical procedure code(s) subject to reduction logic are compensated at 50 percent of the allowed amount (after bilateral adjustment), as appropriate.

Unlisted Codes

Unlisted 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.

Medical Record Documentation and Physician Queries

CarePartners of Connecticut will not accept retrospectively amended medical records or physician queries beyond 30 days from the date of service. CarePartners of Connecticut 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.

Self-Treatment or Treatment of Immediate Family Members

CarePartners of Connecticut 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 family member:

- Husband or wife
- Natural or adoptive parent, child, or sibling
- Stepparent, stepchild, stepbrother, or stepsister
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law
- Any other relative(s) residing in the same residence as the licensee

Provider Billing Guidelines and Documentation

- Services should only be billed once they have been provided to the member
- Refer to the CarePartners of Connecticut Provider Manual for additional claims submission guidance

Document History

- January 2024: Created new policy; replaces archived Professional Services and Facilities and Bilateral and Multiple Surgical Procedures policies

Audit and Disclaimer Information

CarePartners of Connecticut reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy,

CarePartners of Connecticut will expect the provider/facility to refund all payments related to noncompliance. For more information about CarePartners of Connecticut's audit policies, refer to the CarePartners of Connecticut public Provider website.

This policy provides information on CarePartners of Connecticut claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication 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 requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the CarePartners of Connecticut products identified by the checkboxes on page one. CarePartners of Connecticut reserves the right to amend a payment policy at its discretion.