Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-035		
Subject:	Correct Coding Guidelines		
Effective Date:	May 1, 2018	**End Date:**	
Issue Date:	March 18, 2024	**Revised Date:**	March 2024
Date Reviewed:	February 2024		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY** ☐
Applicable Claim Type	**UB**	☒	**1500**	☒			

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

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

REIMBURSEMENT GUIDELINES:

The Plan's 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)
- American Medical Association (AMA) Current Procedural Terminology (CPT) Assistant

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

AMA and CMS Code Updates

The Plan follows AMA and CMS guidance when new direction is provided concerning the retiring of codes, alterations of existing codes, and issuance of new codes. Advance notice to providers may not always be possible to accommodate these changes. Providers should follow AMA, or CMS, guidance as issued regarding correct coding for services. The Plan will use best efforts to update its policies to reflect current guidelines.

Medically Unlikely Edits and National Correct Coding Initiative

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.

NCCI edits are used to prevent improper payment when incorrect code combinations are reported. The NCCI contains one table of edits for physicians/practitioners and one table of edits for outpatient hospital services. The NCCI Policy Manual is available for as a reference tool for correct coding and to provide rationale for edits. Each chapter within the manual corresponds to a separate section of the CPT manual, it is suggested to review chapter specific guidelines that pertain to specific procedure code ranges.

Add-on Code

Add-on procedures reported without a primary procedure will be denied as non-billable to the member by a participating, preferred, or network provider.

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.

Procedure Terminology Combinations

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.

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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 inquires providers may find necessary and post-pay adjudication corrections made by the Plan either through audit or other means.

POLICY APPLICATION:

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

1. Reject or Deny the claim
2. Recover and/or recoup claim payment

REFERENCES:

- Payment Policy and Reimbursement Management; (2017) Hospital Outpatient Prospective Payment System (OPPS) Based Payment Method. https://www.highmark.com/health/pdfs/facility/hosp-opps-manual-2017-q3.pdf
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POLICY UPDATE HISTORY INFORMATION:

5 / 2018	Implementation
8 / 2018	Added example on OB vs. non OB for similar codes
5 / 2019	Added AHA under Reimbursement Guidelines/Claims Submission of Services Guidelines
9 / 2020	Removed ICD-10 information and resource
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added NCCI information
6 / 2022	Added AMA and CMS code updates information
8 / 2023	Administrative policy review with no changes in policy direction
3 / 2024	Added AMA CPT Assistant as a resource under Reimbursement Guidelines

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HISTORY VERSION

Bulletin Number:	RP- 035		
Subject:	Correct Coding Guidelines		
Effective Date:	May 1, 2018	**End Date:**	
Issue Date:	August 14, 2023	**Revised Date:**	August 2023
Date Reviewed:	July 2023		
Source:	Reimbursement Policy		

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HISTORY VERSION

Bulletin Number:	RP- 035		
Subject:	Correct Coding Guidelines		
Effective Date:	May 1, 2018	**End Date:**	
Issue Date:	June 20, 2022	**Revised Date:**	June 2022
Date Reviewed:	May 2022		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
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HISTORY VERSION

Bulletin Number:	RP- 035		
Subject:	Correct Coding Guidelines		
Effective Date:	May 1, 2018	**End Date:**	
Issue Date:	January 31, 2022	**Revised Date:**	January 2022
Date Reviewed:	January 2022		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
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Issue Date:	November 1, 2021	**Revised Date:**	July 2021
Date Reviewed:	July 2021		
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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 inquires providers may find necessary and post-pay adjudication corrections made by the Plan either through audit or other means.

POLICY APPLICATION:

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

1. Reject or Deny the claim
2. Recover and/or recoup claim payment

REFERENCES:

- Payment Policy and Reimbursement Management; (2017) Hospital Outpatient Prospective Payment System (OPPS) Based Payment Method. https://www.highmark.com/health/pdfs/facility/hosp-opps-manual-2017-q3.pdf
- MLN Matters; (2014) Update to 2014 Hospital Outpatient Clinical Diagnostic Laboratory Test Payment and Billing. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1412.pdf
- MLN Booklet Hospital Outpatient Prospective Payment System. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf
- Centers for Medicare & Medicaid Services; National Correct Coding Edits. https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
- American Medical Association. https://www.ama-assn.org/
- Center for Disease Control and Prevention. https://www.cdc.gov/nchs/index.htm
- World Health Organization. http://www.who.int/en/

POLICY UPDATE HISTORY INFORMATION:

5 / 2018	Implementation
8 / 2018	Added example on OB vs. non OB for similar codes.
5 / 2019	Added AHA under Reimbursement Guidelines/Claims Submission of Services Guidelines.
9 / 2020	Removed ICD-10 information and resource.
11 / 2021	Added NY region applicable to the policy

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-035		
Subject:	Correct Coding Guidelines		
Effective Date:	May 1, 2018	**End Date:**	
Issue Date:	August 1, 2020	**Revised Date:**	July 2020
Date Reviewed:	July 2020		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE** ☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	
Applicable Claim Type	**UB**	☒	**1500**	☒	

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this 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.

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.

Procedure Terminology Combinations

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 inquires 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

REFERENCES:

Payment Policy and Reimbursement Management; (2017) Hospital Outpatient Prospective Payment System (OPPS) Based Payment Method.
https://www.highmark.com/health/pdfs/facility/hosp-opps-manual-2017-q3.pdf

MLN Matters; (2014) Update to 2014 Hospital Outpatient Clinical Diagnostic Laboratory Test Payment and Billing.
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1412.pdf

MLN Booklet Hospital Outpatient Prospective Payment System.
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf

Centers for Medicare & Medicaid Services; National Correct Coding Edits.
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

American Medical Association.
https://www.ama-assn.org/

Center for Disease Control and Prevention.
https://www.cdc.gov/nchs/index.htm

World Health Organization.
http://www.who.int/en/

POLICY UPDATE HISTORY INFORMATION:

05 / 2018	Implementation
08 / 2018	Added example on OB vs. non OB for similar codes.
05 / 2019	Added AHA under Reimbursement Guidelines/Claims Submission of Services Guidelines.
09 / 2020	Removed ICD-10 information and resource.

Highmark Reimbursement Policy Bulletin

CLICK HERE FOR HISTORY VERSION

Bulletin Number:	RP-035		
Subject:	Correct Coding Guidelines		
Effective Date:	May 1, 2018	**End Date:**	
Issue Date:	June 17, 2019	**Revised Date:**	June 2019
Date Reviewed:	May 2019		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE** ☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	
Applicable Claim Type	**UB**	☒	**1500**	☒	

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.

Procedure Terminology Combinations

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.

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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.

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APPLICATION:

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ADDITIONAL BILLING INFORMATION, REFERENCES AND GUIDELINES:

https://www.highmark.com/health/pdfs/facility/hosp-opps-manual-2017-q3.pdf

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1412.pdf

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https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

https://www.ama-assn.org/

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POLICY UPDATE HISTORY INFORMATION:

05 / 2018	Implementation
08 / 2018	Added example on OB vs. non OB for similar codes.
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Highmark Reimbursement Policy Bulletin

Bulletin Number:	RP-035		VIEW HISTORY
Subject:	Correct Coding Guidelines		
Effective Date:	May 1, 2018	**End Date:**	
Issue Date:	August 27, 2018		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV** ☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☐	**WV** ☐		
Applicable Claim Type	**UB**	☒	**1500** ☒		

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- National and State Medical Societies and Associations
- The Plan enhanced clinical editing processes

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

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APPLICATION:

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Highmark Reimbursement Policy Bulletin

Bulletin Number:	RP-035		
Subject:	Correct Coding Guidelines		
Effective Date:	May 1, 2018	**End Date:**	
Issue Date:	May 1, 2018		
Source:	Reimbursement Policy		

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APPLICATION:

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REFERENCES:

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