Policy and Procedure

Subject: Claim Processing Edits	**Policy Manual:** NAMM California Corporate
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Last Revised By:	**Approval Signature on File:**

SCOPE

All employees of NAMM California, PMNI, and its affiliated entities, globally referred to as "the Company" shall follow the procedures set forth in this policy.

PURPOSE

To define the manner in which Company identifies acceptable billing practices, manages and applies Industry Standard Claims edits to Provider, Vendor and Facility Payments whereby promoting correct coding methodologies and controlling improper coding and inappropriate payment. This Policy is intended to reduce delays in processing claims, as well as avoid rebilling. Also to ensure that one is reimbursed based on code or codes that correctly describe the health care services provided.

POLICY

Company periodically updates its policies and claims payment systems to be aligned with the following:

- Centers for Medicare & Medicaid Services (CMS) guidance, including but not limited to Medicare Provider Reimbursement Manual (PRM) - relating to charge and cost reporting guidelines. Internet-only manuals (IOM) relating to Medicare coverage, benefits, coding, billing and payment, CMS Transmittals, MLN Matters Articles, Frequently asked questions, Medicare contractors, National Correct Coding Initiative (NCCI), Medically unlikely Edits (MUE), National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).
- National benchmarks & industry standards
- National uniform Billing Committee (NUBC) Guidelines.
- American Medical Association (AMA)/Current Procedural Terminology (CPT®)
- Healthcare Common Procedure Coding System (HCPCS).
- International Classification of Disease, 9th edition/Revision (ICD-9) code sets.
- Diagnosis Related Group (DRG)
- National Drug Codes (NDC).

- National Health Care Billing Audit Guidelines.
- American Hospital Association (AHA) Coding Clinic Guidelines.
- Charge Master Guidelines as they relate to and define services billed.
- UB-04 Data Specifications Manual ICD-9-CM Official Guidelines for Coding and Report
- Uniform Billing (UB) Editor.
- American Society of Anesthesiologists (ASA) relative values for the basic coding, regarding Provider, Vendor and Facility claims.

This policy applies to all Health Care Services billed on either a CMS 1500 / UB 04 form, 837p/837i or future claim form.

DEFINITIONS

NCCI – National Correct Coding Initiatives comprised of three types of edits: NCCI Procedure to Procedure (PTP), Medically Unlikely Edits (MUE) & Add-on Code edits.

PTP – (Procedure to Procedure) Identification of services not appropriately billed together. If a provider reports the two codes of an edit pair for the same beneficiary on the same date of service, the column one code is eligible for payment but the column two code is denied unless a clinically appropriate NCCI-associated modifier is billed.

Modifiers – Company recognizes the following NCCI designated modifiers as it relates to Medicare PTP edits: 24,25, 27, 58, 59, 78, 79, 91, LT, RT, LM, E1, E2, E3, E4, FA, F1, F2, F3, F4, F5, F6, F7, F8, F9, LC, LD, RC, RI, TA, T1, T2, T3, T4, T5, T6, T7, T8,T9, E1, E2, E3, E4, F1, F2, F3, F4. *Modifiers offer specific information and should be used appropriately.

MUE - A unit of service edit applied to both HCPCS and CPT codes and defines the maximum units of service that a single provider/supplier would report under most circumstances for an individual one single date of service.

Medically Unlikely Edits (MUE) – these are units-of-service edits for practitioners, ambulatory surgical centers, outpatient hospital services, and durable medical equipment. This component defines for each HCPCS/CPT code the number of units of service that is unlikely to be correct.

Add-on code edits - consist of a listing of HCPCS and CPT add-on codes with their respective primary codes. An add-on code is eligible for payment if and only if one of its primary codes is also eligible for payment

ME Edits – Many procedure codes cannot be reported together because they are mutually exclusive of each other. Mutually exclusive procedures cannot reasonably be performed at the same anatomic site or same patient encounter.

Charges – Medicare Provider Reimbursement Manual, section 2202.4 states:

Charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient. All patients'

charges used in the development of apportionment rations should be recorded at the gross value; i.e., charges before the application of allowances and discounts deductions.

Routine Services – Medicare Provider Reimbursement Manual, section 2202.6 states:

"Inpatient routine services in a hospital or skilled nursing facility generally are those services included in the daily service charge-sometimes referred to as the "room and board" charge. Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made."

Routine medical/surgical Supplies – Considered to be packaged into the procedure or room charge and should not be separately billable to Company. These items are customarily used during the course of treatment as needed, are stocked at the nursing station or in floor bulk stock and generally available to all patients receiving supplies in that location and are not tracked individually. (e.g., alcohol preps, applicators, band-aids, Maalox, aspirin and other non-legend drugs ordinarily kept on hand, suppositories and tongue depressors, gloves, paper masks, chux/linen savers, cotton balls).

Routine Nursing Services – All general nursing services, including administration of oxygen and related medications, monitoring patients, hand feeding, incontinency care, tray service, enemas, and other bedside nursing services.

Routine Laboratory Services – Routine specimen collections.

Routine Pharmacy Services – Flush and Irrigation supplies.

Ancillary Services - Medicare Provider Reimbursement Manual, section 2202.8 states:

Ancillary services in a hospital or SNF include laboratory, radiology, drugs, delivery room (including maternity labor room), operation room; including post anesthesia and postoperative recovery rooms), and therapy services (physical, speech, occupational). Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge.

Capital Equipment & Monitors/Pumps – Equipment commonly available to patients in a particular setting or ordinarily furnished during the course of a procedure is considered routine and not billed separately. Supplies used in conjunction with the equipment are also considered routine. The cost of the equipment should be incorporated into the charge for the procedure.

Dietary Services – dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as prescription items by a physician.

Patient Convenience Items – Items that do not meaningfully contribute to the treatment of patient's illness or injury or the functioning of a malformed body member.

Supplies – Items which are utilized by individual recipients but which are reusable and expected to be available in an institution providing a skilled level of care; e.g., ice bags, bedrails, canes, crutches, walkers, wheelchairs, IV poles and pumps, traction equipment and other durable medical equipment.

Criteria for Billing Services:

- Must be medically necessary and furnished at the direction of a physician. Documentation in the patients' medical records must be provided.
- Must be covered in accordance with current Medicare regulations and guidelines.
- Uses of non-FDA-approved procedure/drug/services are considered investigational and are non-covered services

Billed Charges – Represent allowable charges for billable items that are in accordance with all regulatory agencies or coding references listed above. Routine and non-chargeable items shall be eliminated from the itemized statement.

PROCEDURE

1. The Company's Claims department reviews claim, including any attachments of Itemization, medical records, etc. against correct coding standards, the definitions as identified above while in conjunction with affiliated or non-affiliated fee schedule(s) for accurate reimbursement. Any billed charges not in alignment with the billing and coding standards as referenced will result in a reduction or denial of payment for specific charges prior to payment calculation.

2. Company or its contracted vendors may conduct claim, billing and medical record reviews pre or post payment. An itemized bills or medical records will be requested as supported by Section 1815 (a) and Section 1833 (e) of the Social Security Act, Section 422.214 (a)(2) of Title 42 of the Code of Federal Regulations, contract provisions, and other relevant guidance in support of these reviews to make an initial proper payment determination. Such review includes but is not limited to identifying errors, duplicate charges, capital equipment, nursing functions, and redundant/unbundled charges.

3. Providers will need to send copies of the itemized bill or medical records within 30 days of request or within the appropriate federal- or state-mandated guidelines.

4. In the event a provider does not submit requested documentation by state/federal time frames, the provider may receive a rejected claim for lack of information.

5. Providers are responsible for applying correct coding standards that integrate nationally accepted guidelines including Current Procedural Terminology (CPT) logic as documented by American Medical Association and National Correct Coding Initiatives (NCCI) and Medically Unlikely edit (MUEs) guidelines as outlined by the Centers for Medicare Services. Codes determined to be included in or incidental to another procedure will be replaced with the more comprehensive code. Services and items, subject to MUEs, will be reimbursed up to the maximum units allowed per individual code. NCCI-associated modifier shall be used when the appropriate clinical circumstances are met.

6. Providers should report AMA CPT Codes consistent with their descriptors, CPT book instructions and correct coding principles.

7. All services/procedures performed on the same day for the same beneficiary by the physician/provider should be billed on the same claim.

8. Company and/or Group reserves the right to re-bundle claims for Covered Services according to the guidelines established by the Centers for Medicare and Medicaid Services, and where permitted by CMS guidelines,. The CMS guidelines shall apply to the processing of claims for Covered Services, regardless of the payment method.

9. Any overlapping charges exceeding 24 hours per day may be denied requesting supporting documentation.

10. CPT codes representing services denied based on NCCI edits may not be billed to Medicare and or Commercial beneficiaries.

11. Modifiers may be appended to Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes only when clinical circumstances justify the use of the modifier. Institutional claims must incorporate the correct use of modifiers. A modifier should not be appended to an HCPCS/CPT code solely to bypass Component Re-bundling auditing. The use of modifiers affects the accuracy of claims billing, reimbursement, and Component Re-bundling auditing. If multiple units of the same procedure are performed during the same session, the provider should roll all the units to a single line.

12. Routine and non-chargeable supplies as listed under HHPPS non routine medical supplies shall either be eliminated from the bill or zero priced if statistics on usage are necessary for management reporting purposes.

13. Durable Medical Equipment (e.g., crutches, canes, walkers, wheelchairs, bedside commodes) is not billable by a hospital unless the hospital has a DME provider number.

14. Outpatient services that occur within three days preceding an inpatient admission to the same facility for the same or related diagnosis are considered part of the corresponding inpatient admission. Providers are required to submit an inpatient claim only when the services, outpatient and inpatient, occur at the same facility.

15. ICU/CCU areas must house specific equipment. The unit must be equipped, or have available for immediate use, life-saving equipment necessary to treat the critically ill patients for which it is designed. This equipment may include, but is not limited to, respiratory and cardiac monitoring equipment, respirators, cardiac defibrillator, and wall or canister oxygen and compressed air. This equipment is not charged in addition to the ICU/CCU daily rate. See PRM 2202.7.

16. Company's review of such claims shall be consistent for all Lines of Business, including but not limited to both Commercial and Senior Members.

17. Company may utilize external resources and or software for such reviews, i.e. Flashcode, CES, Encoder Pro.

18. The provider will be informed via letter and /or Explanation of Benefit / Remittance Advice should Company find a coding and/or billing error that is resulting in a payment reduction. Should provider disagree with the adjustment, provider may follow State and Federal regulatory guidelines for submitting a dispute. Dispute language and timeframes are also posted on Company's website at NAMMCAL.com

19. Company periodically updates its policies and claims payment systems to be aligned with the regulatory agencies, national benchmarks and industry standards in an effort to continue processing claims accurately.

Disclaimer: This policy is made available to provide information on certain Company claims payment processes. This policy is intended to serve only as a guide and to provide general information. It does not constitute medical advice, guarantee of payment, plan pre-authorization, explanation of benefits, or a contract. This policy does not address every claim situation. Claims may be affected by other factors, such as: state and federal laws and regulations, provider contract terms. This policy is subject to change or termination by Company. Any items not listed herein are subject to review for inclusion per Medicare Provider Reimbursement Manual, section 2202.6