PROFESSIONAL NETWORK REIMBURSEMENT POLICY

POLICY TITLE	**General Coding Guidelines**
POLICY NUMBER	**NR- 30.001**

Health care benefit programs issued or administered by Capital Blue Cross and/or its subsidiaries, Capital Advantage Insurance Company®, Capital Advantage Assurance Company® and Keystone Health Plan® Central. Independent licensees of the Blue Cross Blue Shield Association. Communications issued by Capital Blue Cross in its capacity as administrator of programs and provider relations for all companies.

Original Issue Date (Created):	**07/01/2005**
Most Recent Review Date (Revised):	**07/28/2022**
Effective Date:	**09/1//2022**

I. DESCRIPTION/BACKGROUND TOP

This policy contains common coding instructions for reporting CPT, HCPCS and ICD-10-CM codes.

Note: This policy is not inclusive of all coding situations and is meant to serve as a guide.

II. DEFINITIONS TOP

American Medical Association (AMA) **–** An organization whose missions is to promote the Art and Science of Medicine and the Betterment of Public Health. The AMA speaks out on issues important to patient and the nation's health and exercises a strong advocacy agenda on behalf of patients and provider. The AMA is also committed to providing timely information on matters important to the health of America and includes the development and promotion of standards in medical practice, research and education.

Centers for Medicare and Medicaid Services (CMS) –The Centers for Medicare & Medicaid Services (CMS) is the agency within the U.S. Department of Health and Human Services (HHS) that administers the nation's major healthcare programs. CMS oversees programs including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the state and federal health insurance marketplaces.

Current Procedural Terminology (CPT) – A set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care professionals. Each procedure or service is identified with a five-digit code. The use of CPT codes simplifies the reporting of procedures and services.

Healthcare Common Procedure Coding System (HCPCS) - A national standard, alphanumeric coding system established by the Centers for Medicare and Medicaid Services. It standardizes billing and payment for certain covered services (for example, medical supplies, prosthetics and durable medical equipment). HCPCS Level I codes are copyrighted by the American Medical Association (CPT). Level II codes are five-position alphanumeric codes maintained jointly by the Alpha-Numeric Panel (consisting of the Centers for Medicare and Medicaid Services (CMS), the Health Insurance Association of America, and the BlueCross and BlueShield Association). The American Dental Association copyrights the D-code series in Level II HCPCS.

Health Insurance Portability and Accountability Act (HIPAA) – The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers, as well as addressing the security and privacy of health data.

ICD-10-CM – The International Classification of Diseases, Tenth Revision, Clinical Modification is based on the official version of the World Health Organization's International Classification of Diseases. ICD-10-CM classifies morbidity and

mortality information for statistical purposes, indexing of hospital records by disease and operations, data storage, and retrieval. Medicare has designated ICD-10-CM as the coding system physicians must utilize to report appropriate diagnosis codes when billing for services provided to beneficiaries on or after October 1, 2015. ICD-10-CM code revisions become effective October 1st of each year.

Modifier – A two-digit numeric, alphanumeric or alphabetic code appended to a CPT or HCPCS code, which indicates that a service or procedure has been altered by some specific circumstances but not changed in its definition or code. This information is important because it provides payors with additional information to process a claim. There are three levels of modifiers: Level I (CPT) modifiers are developed by the American Medical Association; Level II (HCPCS) modifiers are developed by the Centers for Medicare and Medicaid Services; Level III modifiers are unique to each Medicare Part B carrier and begin with an alpha prefix of S, W, X, Y or Z.

Place of Service Codes – Codes reported on professional claims to specify the entity where service(s) were rendered.

III. POLICY

TOP

Capital Blue Cross requires that each code and modifier submitted for reimbursement consideration is the most appropriate code, coded to the highest level of specificity, for that procedure, item or diagnosis. In addition, the code reported by the provider must be valid for the date of service on which the service or supply was performed or distributed. Submission of discontinued procedure codes, diagnosis codes and/or modifiers to report services provided after the date on which the codes/modifiers are discontinued will cause the service to be rejected or denied reimbursement. The provider will be advised that a deleted code/modifier has been used in error and a corrected claim will be required for reimbursement consideration.

POLICY TITLE	General Coding Guidelines
POLICY NUMBER	NR- 30.001

Unlisted and Not Otherwise Classified Codes (NOC)

It is not appropriate to report a CPT or HCPCS that approximates the service provided. If a specific CPT or HCPCS is not available to identify the service, the provider should report the appropriate unlisted CPT or HCPCS code. In addition to the unlisted code, a literal description of the service as well as supporting medical documentation detailing the service(s)/procedure(s) provided must be included. The description and/or supporting medical documentation must include all aspects of the service(s)/procedure(s) performed. Therefore, it is not appropriate to append a modifier(s) to an unlisted code. If a modifier(s) is appended to an unlisted code, the claim line including the unlisted code will be denied.

Injectable Drug(s) or Immunization/Vaccine(s) Reported with Unlisted and Not Otherwise Classified Codes (NOC)

Paper claims will be denied if in addition to the drug description for each NOC code reported for an injectable drug(s) or immunization/vaccine(s), the following information is not documented in the red shaded area of the service lines in Field 24 of the paper CMS1500 Claim Form:

- Qualifier N4 to identify the number as an NDC
- The 11-Digit NDC (without hyphens or spaces between the segments, followed by one (1) space
- The NDC unit of measure (two digits)
    - F2 - International Unit
    - GR – Gram
    - ME – Milligram
    - ML – Milliliter
    - UN – Unit
    - The numeric quantity administered to the patient.

Electronic claims will be denied, if, when reporting a NOC code for an injectable drug(s) and the drug description, the following elements are not reported on the 837P: (1) National Drug Code, (2) National Drug Unit Count (Quantity), and (3) unit or basis of measurement (i.e. ML, UN, GR).

Paper and electronic claims will also be denied if, when reporting the administration of a compound drug, each drug component and corresponding Prescription or Compound Drug Association Number is not reported on separate service lines. The HCPCS code should be repeated as necessary to cover each unique NDC.

Medical Record

In all instances, documentation within the medical record must support all services reported and must be consistent, complete and legible.

Time Based Codes

Certain procedure codes include time in the description of the service or procedure performed. The number of units reported is dependent upon the increments of time documented in the code description.

Units

In certain circumstances, it is appropriate to report more than one (1) unit of a procedure or service. However, the number of units reported must be consistent with the procedure(s) or service(s) provided and the description of the appropriate CPT or HCPCS procedure code(s).

Combination Codes

Certain CPT codes include multiple components in their code description. When a combination code exists, it is inappropriate to report each component of a combination code separately.

Diagnosis Pointer

In addition to reporting the most appropriate diagnosis code, coded to the highest level of specificity, each diagnosis code must be appropriately cross-referenced to the procedure/supply for which it pertains, using the 'Diagnosis Pointer' (Block 24E of the CMS 1500 claim form). Failure to correctly cross-reference the diagnosis code to the procedure/supply may result in a denial of the service.

POLICY TITLE	General Coding Guidelines
POLICY NUMBER	NR- 30.001

In addition to the criteria and conditions contained in this policy, the service, procedure or item must be deemed medically necessary, must be a covered member benefit and is subject to member cost sharing provisions.

IV. EXCLUSIONS

TOP

V. VARIATIONS

TOP

This policy is applicable to all programs and products administered by Capital Blue Cross unless otherwise indicated below.

VI. REFERENCES

TOP

Capital Blue Cross 2022 Provider Manual

CPT 2022 Professional Edition
American Medical Association

EncoderPro for Payers
OptumTM 2022

HCPCS Level II Expert
Optum™ 2022

ICD-10-CM Expert for Physicians
Optum 360°™ 2022