Potential Upcoding of Surgical Services

Payment Policy ID: MPR.0100

Recent review date: 12/2021

Next review date: 12/2022

AmeriHealth Caritas Louisiana's claim payment policies and the resulting edits are based on guidelines from established industry sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), State regulatory agencies, and medical specialty professional societies. In making claim payment determinations, the health plan also uses coding terminology and methodologies that are based on accepted industry standards, including the Healthcare Common Procedure Coding System (HCPCS) manual, the Current Procedural Terminology (CPT) codebook, the International Statistical Classification of Diseases and Related Health Problems (ICD) manual, and the National Uniform Billing Code (NUBC).

Other factors affecting reimbursement may supplement, modify, or in some cases supersede medical/claim payment policy. These factors may include but are not limited to: legislative or regulatory mandates, a provider's contract, and/or a member's eligibility to receive covered health care services.

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Policy Overview

The purpose of this policy is to outline circumstances where suspected upcoding may have occurred related to surgical services which will prompt AmeriHealth Caritas to require a provider submit medical records to support billed services.

This policy applies to all AmeriHealth Caritas Louisiana network and non-network providers, including but not limited to non-network authorized and percent-of-charge contract providers.

AmeriHealth Caritas Payment Policies are intended to guide providers in submission of accurate claims and to summarize the conditions for reimbursement of services covered by a member's health plan. Claims submitted to AmeriHealth Caritas must meet published medical necessity and prior

authorization requirements and providers are expected to adhere to industry standard billing and coding guidelines when reporting services, items, and supplies to AmeriHealth Caritas for reimbursement.

AmeriHealth Caritas Louisiana will follow *Current Procedural Terminology* (CPT©), *Healthcare Common Procedure Coding System* (HCPCS©), *International Statistical Classification of Diseases and Related Health Problems* (ICD©), and associated publications for reimbursement of professional and facility claims.

Reimbursement Guidelines

AmeriHealth Caritas Louisiana will reimburse professional and facility claims according to the provider's contract and applicable section(s) of the AmeriHealth Caritas Louisiana Provider Handbook (See Edit Sources below).

All services reported to AmeriHealth Caritas must be supported in the medical record. The following items will require medical records prior to claim adjudication to prevent upcoding of surgical services.

1. **Professional and outpatient claim surgical procedure code mismatches, where similar services were provided to the same patient on the same date of service.**

2. **Percutaneous nephrolithotomy (PCNL) procedures when claim level diagnosis codes suggests a smaller classification of kidney stone removal related to size, impact and number of stones.**

3. **Complex cataract surgery codes when claim level diagnosis codes suggests upcoding from a standard cataract surgery code was performed instead.**

4. **Superficial and Deep Implant removal related to multiple units, location of service, billing during global surgery period, or no prior history of implant.**

5. **Professional and outpatient claim add on procedure code mismatches, where similar base procedures were provided to the same patient on the same date of service.**

6. **Musculoskeletal excision procedures claim level diagnosis codes suggests the primary issue likely relates to the cutaneous layer.**

7. **Adjacent tissue transfer codes for defects that exceed the anticipated size needed to accomplish the repair based on claim level diagnosis codes and wound history.**

After a review of whether services are billed/coded appropriately, AmeriHealth Caritas Louisiana may:

- **Pay the claim based on review of medical records**
- **Deny the claim due to the fact that medical records fail to support coding.**
- **Deny the claim for lack of medical records.**
- **Pay the claim if medical records are provided after the original claim adjudication and support code**

Exceptions

None

Definitions

Add-on Code
An add-on code describes additional work associated to and performed in conjunction with another primary procedure

Global Period
The period of time encompassing:

- **The Pre-operative Period as applicable,**
- **The Day of Surgery, and**
- **The Post-Operative Period (0, 10, or 90 days).**

Modifier: A one or two character code used to indicate that a service has either been altered in some way or that a significant circumstance surrounds that service and that this information needs to be taken in to account for claims processing.

***CPT*© Appendix A and *HCPCS*© Appendix 2 provide comprehensive lists of procedure code modifiers.**

National Correct Coding Initiative (NCCI)
The Center for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) promotes national correct coding methodologies and reduces improper coding which may result in inappropriate payments of Medicare Part B claims and Medicaid claims.
The NCCI contains two types of edits:

1. **NCCI procedure-to-procedure (PTP) edits that define pairs of Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported.**
2. **Medically Unlikely Edits (MUEs) define for each HCPCS/CPT code the maximum units of service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service.**

New Patient
A new patient is one who has not received any professional services from the same physician/provider or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three (3) years.

Unbundling (a.k.a. Fragmented Billing)
Billing of multiple procedure codes for a group of procedures ordinarily included in a single, comprehensive code, either due to misinterpretation, or to maximize reimbursement. Reporting of procedures that are Mutually Exclusive or Incidental to the primary procedure are examples of Unbundling.

Edit Sources

I. ***Current Procedural Terminology*** **(CPT©),** ***Healthcare Common Procedure Coding System*** **(HCPCS©),** ***International Statistical Classification of Diseases and Related Health Problems*** **(ICD©), and associated publications and services.**
II. **CPT Assistant, September 2018 Code Selection for Lesion Excision: Integumentary vs Musculoskeletal System**
III. **Centers for Medicare and Medicaid Services (CMS).**
IV. **The National Correct Coding Initiative (NCCI) in Medicaid. NCCI Policy Manual CHAPTER III - Surgery: Integumentary System**
V. **Coding guidelines from Specialty Societies (e.g. American Society for Radiation Oncology (ASTRO), American Academy of Pediatrics (AAP), American Congress of Obstetricians and Gynecologists (ACOG), American Academy of Family Practitioners (AAFP), etc.).**
VI. **Applicable Louisiana Medicaid Fee Schedule(s).**
VII. **AmeriHealth Caritas Louisiana Provider Handbook**
VIII. **American Academy of Ophthalmology Coding Complex Cataract Surgery With Confidence**

Affected Claim Types

Edits related to this policy apply to claims for Professional services.

Policy History Abstract

Original Effective Date: TBD