**Revenue Code Validation**

Revenue codes are 4-digit codes used to classify types of service. They are required for accurate hospital outpatient claims processing. Revenue codes are required for processing of all outpatient facility claims.

| DHP Processing | Additional Detail | Source | LOB |
|---|---|---|---|
| Revenue codes received without a required HCPCS code will not be reimbursed. | Certain revenue codes lack sufficient detail to determine what specific services and procedures were performed. The Omnibus Budget Reconciliation Act (OBRA) passed in 1986 requires that hospitals report HCPCS codes for all outpatient services.<br><br>Examples of revenue codes that require a corresponding HCPCS include: 450, 360, 636, 761, and 490.<br><br>A HCPCS code is also required for claims submitted with Bill Type 12X or 14X, when billed without condition code 41 (Partial hospitalization) | CMS | Commercial Medicare |
| CPT, HCPCS and modifier codes billed with inappropriate revenue codes will not be reimbursed. | CPT, HCPCS and modifier codes must be appropriate for use with the billed revenue code. For example:<br>• Medical/surgical supplies would not be reported under professional revenue codes 0960-0989.<br>• Modifier 26 should be appended to diagnostic and radiologic services reported with revenue codes 0960-0989 (professional services) | CMS | All lines |
| Revenue codes that are not appropriate for use with outpatient hospital claims will not be reimbursed when billed. | It is inappropriate for certain revenue codes to be billed with outpatient hospital bills (bill types 12X, 13X, 14X). For example, Room and Board revenue codes 010X-021X are intended to be used only in the inpatient hospital setting | CMS | All lines |

**Modifier Policy**

Modifiers are used to add additional specificity to a procedure or service without changing the meaning of the associated CPT or HCPCS code. Special care should be used to ensure that the modifier reported is appropriate for both the code and the clinical scenario.

| DHP Processing | Additional Detail | Source | LOB |
|---|---|---|---|
| Procedures billed with modifier 53 will not be reimbursed when billed by an outpatient hospital facility or ambulatory surgical center. | CPT has developed modifiers 73 and 74 for hospital outpatient use | CPT<br>CMS | All lines |
| Reimbursement for procedures billed with modifier 73 will be reduced by 50%. | According to CMS policy, procedures that are discontinued prior to the administration of anesthesia are reimbursed at 50% of the allowed amount | CMS | All lines |

| | | | |
|---|---|---|---|
| Items billed with modifiers FB (Item provided without cost) or FC (Partial credit received for replaced device) will not be reimbursed when appended to a code with an OPPS status indicator other than S, T, V, and X. | According to CMS policy, modifiers FB and FC are for use in the Outpatient Hospital and Ambulatory Surgical Center settings | CMS | All lines |
| Reimbursement for items billed with modifiers FB or FC will be reduced by the CMS offset percentage. | According to CMS policy, modifiers FB and FC indicate that full or partial credit for a device was provided to the provider | CMS | All lines |
| Non-inpatient only services billed with Modifier CA will not be reimbursed. | Modifier CA is allowed once per date of service when appended to inpatient only procedures performed emergently on an outpatient who expires before admission | CMS | All lines |

**National Correct Coding Initiative (NCCI)**

Dean Health Plan employs CMS NCCI tables for Hospital Outpatient PPS in its processing of outpatient facility claims. According to CMS, these policies are based on a number of sources including; AMA coding conventions as defined in the CPT manual, national and local CMS policies, coding guidelines developed by national societies, analysis of standard medical and surgical practices and a review of current coding practices.

The NCCI tables for Hospital Outpatient PPS are available at the CMS website at http://www.cms.gov/NationalCorrectCodInitEd/NCCIEHOPPS/list.asp

| DHP Processing | Additional Detail | Source | LOB |
|---|---|---|---|
| Column II procedure codes will not be reimbursed when submitted with a code from Column I. | The Column II code is considered the component code. | CMS | All lines |

**Maximum Units Policy**

Each CPT/HCPCS code has been assigned a maximum number of units that may be billed per day for a member. Where available, DHP has accepted the CMS Medically Unlikely Edit (MUE) value. All other codes have been assigned a maximum-unit-of-service based on the code definition, anatomical site, clinical guidelines and industry standards.

| DHP Processing | Additional Detail | Source | LOB |
|---|---|---|---|
| Procedures and services billed with a unit amount that is in excess of the assigned value, will not be reimbursed. | Each CPT/HCPCS code has been assigned a maximum number of units that may be billed per day for a member. | CMS | All lines |

**Multiple Procedure Reduction**
Multiple Procedure Reduction rules apply when a facility performs two or more surgical procedures, identified by CMS as subject to multiple surgery guidelines, on the same date of service.

| DHP Processing | Additional Detail | Source | LOB |
|---|---|---|---|
| Covered procedures with the highest ASC fee schedule price will be reimbursed as the primary service. | Primary procedures are reimbursed at 100%. Subsequent procedures are reimbursed at 50%. | CMS | All lines |

**Global Surgical Package / Global Period**
Dean Health Plan has adopted the CMS definition and processing logic for the global surgical package.

| DHP Processing | Additional Detail | Source | LOB |
|---|---|---|---|
| E/M services are not separately reimbursed when billed with a procedure assigned a Status Indicator of "T" (Surgical services to which the multiple procedure reduction applies). | Unless significant and separately identifiable, payment for E/M services is included in procedures assigned a Status Indicator of "T". | CMS | All lines |

**Professional, Technical and Global Services Policy**
Certain procedures are comprised of a professional (physician) component and a technical (facility) component. The combination of the professional and technical component is considered the global service.

- **Modifier -26** – "Professional Component". Modifier -26 is appended to the procedure when only the professional component is performed.
- **Modifier -TC** – "Technical Component". Modifier -TC is appended to the procedure when only the facility component is performed.

| DHP Processing | Additional Detail | Source | LOB |
|---|---|---|---|
| Only one professional component will be reimbursed per diagnostic test when billed with Professional-Fee Revenue Codes 0960-0989. | DHP will reimburse up to the global amount for covered procedures. Modifiers should be used to indicate a repeat procedure or one that was performed by a different physician so that the appropriate additional reimbursement can be made. | CMS | All lines |

**CMS Coverage Policies**

| DHP Processing | Additional Detail | Source | LOB |
|---|---|---|---|
| CPT codes will not be reimbursed when used to report a service for which CMS requires a Medicare-specific HCPCS code. | To ensure appropriate reimbursement under the Medicare program, CMS has instructed hospitals to report certain services with HCPCS codes rather than CPT. For example, when performing radiation treatment delivery, CMS requires G0173 rather than 77372 | CMS | Medicare only |

## Evaluation and Management (E/M) Services

| DHP Processing | Additional Detail | Source | LOB |
|---|---|---|---|
| A new patient E/M will not be reimbursed when used to report services for an established patient. | Under the OPPS, an established patient is one that has been registered as an inpatient or outpatient of the hospital within the past 3 years. The same patient may be ``new'' to the physician but ``established'' to the hospital. | CMS | All lines |
| Only one E/M is allowed per day per outpatient hospital facility/revenue center. | Multiple outpatient hospital E/M encounters on the same date may be reimbursed separately when billed with the appropriate modifier. | CMS | All lines |

## Device and Supply Policy

| DHP Processing | Additional Detail | Source | LOB |
|---|---|---|---|
| Nuclear medicine procedures will not be reimbursed when billed without the appropriate radiopharmaceutical imaging agent. | Certain imaging agents are only appropriate for use with specific therapeutic imaging procedures or studies. For example, a vitamin B12 absorption study will not be reimbursed if billed without A9546 or A9559 (cyanocobalamin). | CMS | All lines |
| Brachytherapy source will not be reimbursed when billed without an appropriate surgical procedure in the ASC. | According to CMS policy, separate payment may be available for certain brachytherapy sources that are provided in conjunction with specific, covered surgical procedures. The source will not be reimbursed if it is billed without this procedure. For example, C1717 (brachytherapy) will not be reimbursed if billed without 55875. | CMS | All lines |

## End Stage Renal Disease (ESRD) Policy

| DHP Processing | Additional Detail | Source | LOB |
|---|---|---|---|
| CPT 90999 (unlisted dialysis procedure) will not be reimbursed when billed without modifier G1-G6 with bill type 72X (renal dialysis facility) | According to CMS policy, modifiers G1-G6 are used to indicate the most recent URR reading | CMS | All lines |