

KY New Coding Integrity Reimbursement Guidelines

WellCare Health Plans, Inc. is committed to continually improving its claims review and payment processes.

Effective **11/1/2019**, we will introduce new Coding Integrity Reimbursement Guidelines based on industry standards, coding rules published within the Medicare Claims Processing Manual, Current Procedural Terminology (CPT®) by the American Medical Association (AMA) and ICD-10-CM guidelines governed by Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS). These are the same rules used by most healthcare claims payers and enforced by the Centers for Medicare and Medicaid Services.

WellCare’s Comprehensive Payment Solution ensures that claims process and pay accurately, avoiding potential waste and error. Therefore, <WellCare Health Plans> may deny a claim and request medical records (or coordinate request through a third-party vendor) from the provider or supplier who submitted the claim to support the services submitted on the claim. Providers should submit adequate medical record documentation that supports the claim (services) billed. Once medical records are received, coding professionals will examine the documentation to determine if the services billed are supported (or not supported) as submitted and pay (or deny) the claim accordingly. Please note that the submission of medical records is not a guarantee of payment.

The following table outlines the new coding guidelines.

Coding Policy	Description
Multiple Procedure Reduction for Radiology (Multi-Procedure Indicator 4-MPFS)	<ul style="list-style-type: none"> • When any provider with the same tax ID, for the same date of service performs two or more diagnostic imaging services from the same CMS-defined code family, the procedure with the highest RVU for the technical component (TC) is reimbursed at 100% and the technical component for all secondary procedures is reduced by 50%. • Likewise, the procedure with the highest RVU for the professional component is reimbursed at 100% and the professional component (PC) for all secondary procedures is reduced by 5%.
Multiple Procedure Reduction for Diagnostic Cardiovascular Services (Multi-Procedure Indicator 6-MPFS)	<ul style="list-style-type: none"> • For cardiovascular services, the procedure with the highest RVU price (MPFS) for the technical component (TC) is reimbursed at 100% and the technical component (TC) for all secondary procedures is reduced by 25%. • The MPPRs apply to TC-only services and to the TC of global services. • This policy applies to diagnostic cardiovascular services billed by the same Tax ID and Specialty for the same date of service.

	<ul style="list-style-type: none"> When multiple diagnostic cardiovascular services are billed for the same date of service under the professional revenue codes (096X-098X).
Multiple Procedure Reduction for Diagnostic Ophthalmology Services (Multiple-Procedure Indicator 7-MPFS)	<ul style="list-style-type: none"> When providers with the same Tax ID and Specialty perform two or more CMS-defined diagnostic ophthalmology services on the same date of service, the procedure with the highest RVU price for the technical component is reimbursed at 100% under the Medicare Physician Fee Schedule (MPFS) and the technical component for all secondary procedures is reduced by 20%. This policy applies to diagnostic ophthalmology services billed by the same Tax ID and Specialty for the same date of service.
Modifier Policies	<p>Unrelated Procedure/Service by the Same Physician During the Post-op Period, Modifier 79</p> <ul style="list-style-type: none"> Claims may deny for procedures billed with modifier 79 when the same or different 0-, 10- or 90-day procedure code has not been billed on the same date of service. Alternatively, in the previous 10 days for a CPT code with a 10-day post-operative period, or in the previous 90 days for a code with a 90-day post-operative period by the same provider.
Diagnosis Code Guideline Policy	<p>ICD-10-CM Excludes 1 Notes Policy</p> <ul style="list-style-type: none"> Claims may deny when reported with mutually exclusive code combinations according to the ICD-10-CM "Excludes 1 Notes" guideline policy. <p>ICD-10-CM Laterality Policy</p> <p>"Laterality" (side of the body affected) is a coding convention added to relevant ICD-10 codes to increase specificity. Designated codes for conditions such as fractures, burns, ulcers and certain neoplasms require documentation of the side/region of the body where the condition occurs.</p> <ul style="list-style-type: none"> Claims may deny when reported with incompatible ICD-10-CM Laterality policy for Diagnosis-to-Modifier comparison.
Radiology Policy: Intracranial and Extracranial Imaging (Duplex, CT, CTA, MRA, MRI) for Simple Syncope	<p>According to the American College of Emergency Physicians, the American Heart Association and the American College of Cardiology Foundation, CT, CTA, MRA, MRI, should not be performed routinely for evaluation of syncope in the absence of related neurologic signs and symptoms. The likelihood of a central nervous system (CNS) cause of the event is extremely low, and patient outcomes are not improved with brain imaging studies.</p> <p>In addition, duplex scan of extracranial arteries, computed tomographic angiography (CTA) of the neck and magnetic resonance angiography (MRA) of the neck are not medically necessary for evaluation of syncope in patients with no suggestion of seizure and no report of other neurologic symptoms or signs.</p>

	<p>The American College of Emergency Physicians (ACEP) also indicates that it is not appropriate to perform screening with advanced imaging for syncope patients, however be guided by the patient's history and physical exam findings. A standard 12-lead electrocardiogram should be obtained first for patients with a diagnosis of syncope and collapse before performing advanced imaging procedures.</p> <ul style="list-style-type: none"> • Claims may deny if the only reported diagnosis is syncope and collapse when any of the listed diagnostic head, brain, carotid artery or neck imaging procedures are billed. • Claims may be denied if an advanced imaging procedure is billed with a diagnosis of syncope and there is no history of a 12-lead EKG being performed/billed the same date or in the previous 90 days. • Associated CPT Procedure Codes <ul style="list-style-type: none"> ○ Computed tomography (CT) of the head or brain (CPT 70450, 70460, 70470) ○ Computed tomographic angiography (CTA) of the head (CPT 70496) ○ Magnetic resonance angiography (MRA) of the head (CPT 70544, 70545, 70546) ○ Magnetic resonance imaging (MRI) of the brain (CPT 70551, 70552, 70553) ○ Duplex scan of extracranial arteries (CPT 93880,93882) ○ Computed tomographic angiography (CTA) of the neck(CPT 70498) ○ Magnetic resonance angiography (MRA) of the neck(CPT 70547, 70548, 70549) ○ Electrocardiograms (CPT 93000-93005)
<p>Radiology Policy: Intracranial and Extracranial Imaging (Duplex, CT, CTA, MRA, MRI) for Migraine</p>	<p>According to the American College of Radiology and the American Academy of Neurology, a CT of the head or brain, CTA of the head, MRA of the head or MRI of the brain should not be performed routinely for patients with a migraine in the absence of related neurologic signs and symptoms.</p> <p>The changes in the brain that happen during a migraine cannot be seen by the imaging studies since a migraine is caused by a complicated interaction between the brain and the blood vessels in the face and head. Head imaging in the form of CT scans, MRI or MRA is allowed only when the service is medically reasonable and necessary.</p> <ul style="list-style-type: none"> • Claims may deny for a CT head or brain, CTA head, MRA head, MRI brain or CT follow-up when the only diagnosis on the claim is a migraine. • Associated CPT Procedure Codes: <ul style="list-style-type: none"> ○ CT Head or Brain: CPT 70450-70470, 76380 ○ CTA Head: CPT 70496 ○ MRA Head: CPT 70544-70546

	<ul style="list-style-type: none"> ○ MRI Brain: CPT 70551-70553 ● Associated ICD10 Diagnoses codes <ul style="list-style-type: none"> ○ ICD-10 Diagnosis codes G43.009, G43.109, G43.709, G43.809, G43.829, G43.909 ○ ICD-10 migraine diagnosis codes indicating a "routine" or "uncomplicated" migraine (i.e. not intractable and without status)
Revenue Code Policy: Revenue Code-HCPCS Code Links	<p>Medicare accepts any National Uniform Billing Committee (NUBC) approved revenue codes. The Medicare Claims Processing Manual and the UB-04 Data Specifications Manual outlines requirements for billing outpatient claims including that (HCPCS) codes are required on outpatient claims (UB-04) with related revenue codes.</p> <ul style="list-style-type: none"> ● FL 42 – Revenue Code Required. The provider enters the appropriate revenue codes to identify specific accommodation and/or ancillary charges ● FL 44 – HCPCS/Rates/HIPPS Rate Codes Required. When coding HCPCS for outpatient services, the provider enters the HCPCS code describing the procedure. <p>Based on these reimbursement guidelines, claims may deny when the following revenue codes are billed without the appropriate HCPCS code:</p> <ul style="list-style-type: none"> ● 0300-0319 (Laboratory/Pathology)
Place of Service Policy: Coding for Physician Services	<p>According to CMS Medicare Claims Processing Manual, Place of Service codes (POS) are used to identify where, i.e., physician office, inpatient hospital, a procedure or service is furnished to a patient. POS codes are required under the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).</p> <p>For example, a claim from a physician provider with place of service 11 (Office) would be considered incorrectly coded when a claim from an outpatient facility (e.g., ambulatory surgical center, outpatient hospital) exists for the same member, same date of service and the same procedure or service. Therefore, physician provider claim would deny.</p>
Anesthesia Policy: Anesthesia for Pain Management Injections	<p>According to the American Society of Anesthesiologists and the International Spine Intervention Society, minor pain procedures such as epidural steroid injections, epidural blood patch, trigger point injections, sacroiliac joint injection, bursal injections, occipital nerve block and facet injections under most routine circumstances, require only local anesthesia.</p> <ul style="list-style-type: none"> ● Anesthesia and moderate sedation services billed with pain management services for a patient age 18 or older may deny unless a surgical procedure CPT code range 10021-69990 (other than pain management procedures) is also billed on the claim.

	<ul style="list-style-type: none"> • An exception will apply for anesthesia services billed with modifiers indicating severe systemic disease (Physical status modifiers P3, or P4, or monitored anesthesia care modifier G9). • Associated CPT Procedure Codes <ul style="list-style-type: none"> ○ Anesthesia and Moderate Sedation Services – CPTs 00300, 00400, 00600, 01935-01936, 01991-01992, 99152-99153, 99156-99157 ○ Pain Management Services – CPTs 20552, 20553, 27096, 62273, 62320-62323, 64405, 64479, 64480, 64483, 64484, 64490-64495, 0228T, 0229T, 0230T, 0231T, G0260
<p>Neurology Policy: Nerve Conduction Studies (NCS) and Electromyography (EMG) for Radiculopathy</p>	<p>According to the American Association of Neuromuscular & Electro-Diagnostic Medicine and CMS Policy, nerve conduction studies and a needle electromyography (EMG) must both be performed in order to diagnose radiculopathy (pinched nerve in back or neck).</p> <ul style="list-style-type: none"> • When the nerve conduction study or the needle EMG is performed on its own, the results can be misleading and important diagnoses may be missed. Claims may deny when a nerve conduction study is billed without a needle EMG, or a needle EMG is billed without a Nerve conduction study, and the only diagnosis is radiculopathy (ICD-10 codes M50.1-M50.23, M51.1-M51.27, M51.9, M53.80, M54.10-M54.18, M54.30-M54.42, and M79.2). • Associated CPT Procedure Codes <ul style="list-style-type: none"> ○ Nerve Conduction Studies – CPT 95907-95913 ○ Needle electromyography (EMG) – CPT 95885, 95886
<p>Radiology Policy: Dual-Energy X-Ray Absorptiometry (DXA) Bone Density Screening</p>	<p>According to the American College of Radiology and the International Society for Clinical Densitometry, dual-energy X-ray absorptiometry (DXA) bone density screening (77080 or 77081) is not indicated for women under age 65 or men under age 70 without risk factors for osteoporosis.</p> <ul style="list-style-type: none"> • Claims may deny when DXA bone density studies (CPT 77080 or 77081) are billed and the only diagnosis on the claim is osteoporosis screening (ICD-10 code Z13.820) for a woman who is under age 65 or for a man who is under age 70.

The proper reporting of CPT® procedure codes enables <WellCare Branding> to more precisely apply reimbursement guidelines and ensure that an accurate record of patient care history is maintained.

Thank you for helping <WellCare Branding> members live better, healthier lives. If you have any questions or need further information, please contact your Provider Relations Representative.