WellSense HEALTH PLAN

Payment Policy

General Billing and Coding Guidelines

Policy Number: WS 4.17
Version Number: 9
Version Effective Date: 03/01/2022

Impacted Products

- ☐ **All Products**
- ☒ NH Medicaid
- ☐ NH Medicare Advantage
- ☐ MA MassHealth ACO
- ☐ MA MassHealth MCO
- ☐ MA Qualified Health Plans/Employer Choice Direct
- ☐ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan reimburses covered services based on the provider's contractual rates with the Plan and the terms of reimbursement identified within this policy.

The Plan requires that CMS-1500 and UB-04 paper claim forms, or the electronic equivalent, be submitted using proper coding according to the HIPAA transaction code set guidelines. All claims must be submitted with the minimum claim requirements. Claims submitted without the minimum claim requirements will be returned to providers for correction and resubmission.

Prior-Authorization

Please refer to the Plan's Prior Authorization Requirements Matrix at www.wellsense.org.

Definitions

CPT – Current Procedural Terminology 4th Edition; an American Medical Association (AMA) maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. There are three types of CPT codes:

- Category I Code – Procedures/Services
- Category II Code – Performance Measurement
- Category III Code – Emerging Technology

HCPCS – HealthCare Common Procedural Coding System; a Centers for Medicare and Medicaid Services (CMS) maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify procedure, supply and durable medical equipment codes furnished by physicians and other health care professionals.

ICD-10-CM – International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM diagnosis codes are maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).

ICD-10-PCS - International Classification of Diseases, 10th revision, Procedure Coding System used to report procedures for inpatient hospital services.

Minimum Requirements for Claim Submission

- Member demographics (i.e., Member name, sex, date of birth)
- Member's ID number
- Member's Signature
- Provider's National Provider Identifier (NPI)
- Billing provider, group, or facility NPI
- Referring provider's NPI
- Ordering physician's NPI (If applicable)
- Provider's tax ID number (TIN)
- Revenue Codes
- Place of service (POS) or type of bill (TOB)
- Appropriate coding (CPT, HCPCS, ICD-10-CM/PCS)
- Principal/Admitting diagnosis
- Units of service
- Line item and total charges
- Date of service (Do not use date spans for professional services at the line level)
- Statement covers period, (UB-04 only)
- Admission/Start of care date, (Inpatient or Home Health only)

- Admission time (Inpatient or Observation only)
- Discharge date and time (Inpatient or Observation only)
- Observation start/end time
- Discharge status
- Diagnosis related group (DRG - DRG contracted providers only)
- Present on admission (POA) indicator, (reference the Plan's reimbursement policy, *Hospital, WS 4.21*.)
- Provider Signature
- Provider billing address

General Coding Requirements

CPT and HCPCS Codes

Codes must be submitted in accordance with the chapter and code-specific guidelines set forth in the current/applicable version of the AMA CPT and HCPCS codebooks. In order to ensure proper and timely reimbursement, codes must be effective on the date of service (DOS) for which the procedure or service was rendered and *not* the date of submission.

Modifiers

For guidance related to modifier usage see the Plan's reimbursement policy, *CPT and HCPCS Level II Modifiers Reported on CMS-1500 Claims, WS 4.23*.

ICD-10-CM/PCS codes

The Plan utilizes ICD-10-CM and PCS billing rules, and will deny claims that do not meet the Plan's ICD-10 Claim Submission Guidelines. In order to ensure proper and timely reimbursement, codes must be effective on the dates of service (DOS) for which the procedure or service was rendered and *not* the date of submission. The Plan will deny all claims that are billed with both ICD-9 and ICD-10 diagnosis codes on the same claim. The Plan will only accept ICD-10 codes comprised of upper case characters. Any claim submitted with ICD-10 codes comprised of lower case characters will be denied.

Refer to the ICD-10 CM/PCS Official Guidelines for Coding and Reporting on the proper assignment of principal and additional diagnosis codes. For further information reference the Plan's ICD-10 Submission Guidelines which can be found on the Plan's provider webpage.

Place of Service Codes

Place of Service Codes are two-digit codes placed on health care professional claims (CMS 1500) to indicate the setting in which a service was provided. The Centers for Medicare & Medicaid Services (CMS) maintain POS codes used throughout the health care industry. If billing multiple lines, each line should indicate the POS for the procedure/service on that line.

Type of Bill

Type of bill is a four-digit alphanumeric code that gives three specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The

fourth indicates the sequence of this bill in this particular episode of care, also referred to as a "frequency" code. For a complete list of codes, reference the National Uniform Billing Committee's (NUBC's) Official UB-04 Data Specifications Manual.

Revenue Codes

Revenue codes are four-digit codes used to identify specific accommodation and/or ancillary charges. There are certain revenue codes that require CPT/HCPCS codes to be billed. For a complete list of codes, reference the National Uniform Billing Committee's (NUBC's) Official UB-04 Data Specifications Manual and the Plan's reimbursement policy, *Hospital, WS 4.21*.

Diagnosis Related Group (DRG)

The Plan processes DRG claims through DRG software. If the submitted DRG and system-assigned DRG differ, the Plan-assigned DRG will take precedence. Providers may appeal with medical record documentation to support the ICD-10-CM principal and secondary diagnoses (if applicable) and/or the ICD-10-PCS procedure codes (if applicable). If the claim cannot be grouped due to insufficient information, it will be assigned an ungroupable DRG 998 or 999 and no payment will be made. In these instances a corrected claim containing all required data elements must be submitted.

National Drug Code (NDC) Reporting

A valid, 11 digit NDC number is required when submitting claims for physician administered drugs reported with a J, Q or S HCPCS drug procedure code and/or revenue codes 0250-0252, 0257-0259, and 0631-0637. This requirement applies to all professional and outpatient claims when submitted on the CMS-1500 claim form, UB-04 or its electronic equivalent. Crossover claims are included in this requirement. Providers must report the HCPCS code, the exact NDC that appears on the medication packaging in the 5-4-2 digit format (i.e. xxxxx-xxxx-xx), as well as the NDC units and descriptors. Claims submitted without this information will be denied.

Any claim type that is submitted with an invalid NDC code will deny.

340B Drug Billing

In accordance with NH Medicaid 340B covered entities are not allowed to bill the Plan for drugs purchased through the 340B drug program.

Timed Based Procedure Codes

For any single timed procedure code, a provider may only bill one unit if the direct treatment time provided is at least 51% of the time designated in the code's description.

- Example: 97530 - Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes. Provider must render direct treatment for 8 or more minutes to bill one unit of 97530.

Policy History

Original Approval Date	Original Effective Date and Version Number	Policy Owner	Original Policy Approved by
04/02/2012	12/01/2013	Payment Policy	Payment Policy Committee

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
11/20/2013	Added Section 1202 billing requirements	11/20/2013	Payment Policy Committee
02/28/2014	Updated NDC billing requirements	05/01/2014	Payment Policy Committee
12/22/2014	Annual review	12/22/2014	Payment Policy Committee
05/21/2015	Removed ICD-9 guidelines and included ICD-10 guidelines, new template	10/01/2015	Payment Policy Committee
08/01/2015	Updated ICD-10 guidelines to clarify codes must be submitted only with upper case characters	10/01/2015	Payment Policy Committee
05/15/2018	Annual review, removed Section 1202 billing requirements, added section about timed procedure codes, updated modifier section and clarified NDC reporting.	06/01/2018	Payment Policy Committee
05/21/2019	Added section stating 340B drugs should not be billed to the Plan	09/01/2019	Payment Policy Committee
02/16/2021	Annual review, clarified ungroupable DRGs, added revenue codes to NDC section, added reference to hospital reimbursement policy to revenue code section.	05/01/2021	Payment Policy Committee
02/15/2022	Annual review. Updated product applicability box.	03/01/2022	Payment Policy Committee

Other Applicable Policies

- All Plan reimbursement policies

References

- Contract between New Hampshire Medicaid Care Management, and Boston Medical Center Health Plan, Inc.
- HIPAA Transaction Code Set Regulations
- Centers for Medicare and Medicaid Services, Medicare Claims Processing Manual 100-04, Chapter 25 Completing and Processing Form CMS-1450 Data Set
- Centers for Medicare and Medicaid Services, Medicare Claims Processing Manual 100-04, Chapter 26 Completing and Processing Form CMS-1500 Data Set
- Medicare Claims Processing Manual 100-04, Chapter 1, General Billing Guidelines
- NH Medicaid General Billing Provider Manual, Volume 1, December 2018
- NH Medicaid Provider Notice- Implementation of the National Drug Code (NDC) and Present on Admission (POA) Indicator, October, 2008
- ICD-10-CM/PCS Official Guidelines for Coding and Reporting

Disclaimer Information

Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. This Policy provides information about the Plan's reimbursement/claims adjudication processing guidelines. The use of this Policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement. Member cost-sharing (deductibles, coinsurance and copayments) may apply – depending on the member's benefit plan. Unless otherwise specified in writing, reimbursement will be made at the lesser of billed charges or the contractual rate of payment. Plan policies may be amended from time to time, at Plan's discretion. Plan policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization guidelines (including NCQA). The Plan reserves the right to conduct Provider audits to ensure compliance with this Policy. If an audit determines that the Provider did not comply with this Policy, the Plan will expect the Provider to refund all payments related to non-compliance. For more information about the Plan's audit policies, refer to the Provider Manual.