Coding Guidelines for Claims Editing (Line Item Bill Auditing)

State(s):	LOB(s):
☒ *Idaho* ☒ *Montana* ☒ *Oregon* ☒ *Washington* ☐ *Other:*	☒ *Commercial* ☒ *Medicare* ☒ *Medicaid*

Enterprise Policy

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

Providers are responsible for accurately, completely, and legibly documenting the services they perform. The billing office is expected to submit claims for services rendered using valid codes from HIPAA approved code sets. Claims should be coded appropriately according to industry standard coding guidelines (including, but not limited to: UB Editor, AMA, CPT, COT Assistant, HCPCS, DRG guidelines, CMS National Correct Coding Initiative (NCCI) Policy Manual, NCCI Table Edits and MUEs (units), and other CMS guidelines).

PacificSource follows CMS's Provider Reimbursement Manual Part I, chapter 22, section 2202.6, for definition of **"routine services**" as those services included by the provider in a daily service charge—sometimes referred to as the "room and board" charge. Routine services are comprised of two broad components: (1) general routine service, and (2) special care units (SCU), including coronary care units (CCU) and intensive care units (ICU). Included in routine services are the regular room/observation room, dietary services, nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not applicable"

In addition, current procedural terminology (CPT) is a set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care providers. Procedural CPT code(s) and charges include all supplies and related services. Supplies/equipment are ineligible for separate reimbursement when billed in combination with the procedure CPT code. In the case of DRG payment structures, supplies, equipment, services that are not eligible for separate reimbursement are not eligible to be included in outlier calculation.

The purpose of this policy is to set forth standards for the review of the itemized claim for covered medical and surgical services and supplies in the Inpatient/Outpatient, Observation, and Ambulatory Care settings. Routine equipment, supplies, and services are not separately reimbursable as they are

considered to be included in the room and board charges, or are part of another more comprehensive procedure or service. Determination of disallowed claim lines based on coding regulations and policy will be made by the assigned clinical and support staff. Determination of disallowed claim line based on medical necessity will be made by the Medical Director.

Procedure

On identified claims, an itemized bill of incurred charges and supporting documentation will be requested. The itemized bill will be reviewed by clinical and non-clinical staff for appropriate billing practices. In addition, any questions of medical necessity will be forwarded to a PacificSource Medical Director for determination.

In the event that disallowed claim lines are identified, the information is communicated to with the Claims Department for further processing.

Providers are granted rights to appeal coverage decisions. See the applicable (Commercial or Government) Provider Appeal policies for details.

Criteria

- **Medical Equipment/Supplies (Capital Equipment)** – Routine medical equipment/supplies are not eligible for separate reimbursement as they are packaged in the procedure or facility charge respectively (Federal Register). Medical equipment/supplies includes, but is not limited to: (*commonly associated revenue codes 260-269, 270, 279, 410, 412*)

• Ambu bags • Beds, commodes, scales, overhead frame, over-bed table, room furniture • Cameras • Cell Saver equipment and related supplies • Crash cart, defibrillator • Digital recording equipment i.e., EKG, CO2 • Fetal monitors • Flow meters • Fluoroscopy and/or Ultrasound in OR • Glucometer • Infant warmer • Incentive Spirometer • Linens – reusable sheets, blankets, pillowcases, draw sheets, under pads, washcloths, towels • Lasers	• Microscopes • Monitors (cardiac, oximetry, fetal, arterial, neurology [IONM], etc.) • NIBP machines/monitors • Perfusion equipment and supplies in OR • Pill splitter or crusher • Pressure bags/pressure infusion equipment • Procedure specific tool kits/instruments/trays • Pumps (IV, Bio, syringe, blood warmer, suction, feeding, PCA, etc.) • Rental equipment (wound vac, bariatric bed, etc.) • Scopes (bronc, colon, endo) • Stethoscopes, pin lights, flashlights (including disposable) • Traction equipment • Transport monitors, isolates, ventilators

• Machines (anesthesia, bladder scanner, blood pressure, cautery, humidifier, CPAP, ventilator, heating/cooling, hemodynamic etc.)	• Thermometers • Vascular closure devices

- **Routine Medical/Surgical Supplies** – are to be included in the general cost of the procedure or the facility. These items are considered floor stock and are generally available to all patients receiving services. Routine Supplies are not separately reimbursable. (*commonly associated revenue codes 250, 270–279*)
    - When coding for services or supplies, the most specific and comprehensive code available is to be selected to report the service or item. Unspecified codes (i.e., 99070) and any use of "miscellaneous" charge items will not be eligible for separate reimbursement consideration.

• Alcohol swabs/pads • Baby powder • Basin • Bandages/dressings (Band-Aids, 4X4, sponges, etc.) *does not include wound vac supplies • Batteries • Bedpans • Blood pressure cuff • Breast pumps • Cold/hot packs • Cotton balls (sterile or non-sterile) • Diapers • Drapes • Food thickeners • Gloves • Heat lights or pads • IV arm boards • IV solutions 50 mL – 250 mL used as vehicle to administer medication (bundled in the J code) • IV tubing, extenders, dressings • Lemon glycerin swabs • Lubricant jelly	• Oxygen • Oxygen masks, cannula, tubing • Personal items (soap, toothpaste, razors, deodorant, socks, etc.) • Preparation kits • Reusable equipment or items • Skin cleansing solutions (betadine, chlorhexidine) • Socks/slippers • Solutions (saline, sterile water, IV flushes, irrigation, etc.) • Stock or bulk supplies • Syringes and needles • Tape • Thermometers • Tubing (IV, blood, etc.) • Wall suction • Water pitcher (measuring) • Items used to obtain specimens or complete a diagnostic or therapeutic procedure (arterial blood gas kit, urine collection kits, mucus traps, etc.)

• Masks (patient or staff) • Meal trays (including guest) • Mouth care kits (excluding chlorhexidine used for VAP) • Odor eliminator/room deodorizer	

- **Nursing Care/Services** – is performed by the primary bedside nurse (RN and/or LPN), certified nursing assistants, or technicians within the scope of their daily duties. Routine nursing services are bundled under the room and board charge and not separately reimbursable. Normal scope of services include but are not limited to (Standards and Scope of Practice). (*commonly associated revenue codes 260, 300, 309, 361, 391, 460, 510, 761*)

*******routine nursing care/services DO NOT apply to specialty trained/certified nurses' providing such services as PICC insertion or wound debridement

• Administration of blood or any blood product including Intraoperative Autologous Transfusion (product is billed under laboratory services). This excluded Massive Transfusion Protocol • Administration or application of any medication, chemotherapy, and/or IV fluids including TPN) • Accessing indwelling IV catheter or port • Assisting physician or other licensed personnel in performing any procedure regardless of setting (patient room, treatment room, surgical suite, endoscopy suite, cardiac cauterization lab, or x-ray) when performed as part of the routine care provided in the specific facility region/unit • Cardiopulmonary resuscitation (management or participation in arrest event – see code blue activation below) • Dressing changes / ostomy appliances • Enterostomal services • Incentive spirometer • Incremental nursing care (1:1, 2:1 in ICU, sitter [see 023x below]) • Insertion, discontinuation, maintenance of nasogastric tubes	• Neurological status checks • Obtaining/monitoring vital signs (blood pressure, temperature, respirations, pulse, pulse oximetry) • Obtaining any bodily fluid specimen (urine, stool, sputum, blood [finger-stick glucose], venipuncture, arterial draw, line draw) • Patient/family education • Personal hygiene • Personal safety/quality care (turning) • Preoperative care • Point-of-care testing (glucose, urine dip, ABG, electrolyte) obtained at the bedside with a handheld device • Pulse oximetry (single or continuous) • Respiratory/nebulizer treatments administered by Nursing staff • Set up and/or take down of IV pumps, suction, flow meters, heating/cooling pumps, over-bed frames, traction equipment, monitoring equipment. • Scanning of the bladder for urinary retention • Suctioning or lavaging

• IV hydration at TKO/KVO rate • IV insertions/discontinuation (including use of local anesthesia) • IV maintenance (flushes, dressing changes) of peripheral or central lines • Maintenance or flushing of J-tubes, PEG tubes, or feeding tubes of any kind • Maintenance of chest tubes (dressing change, discontinuation) • Medical records documentation • Mixing, preparing, and dispensing medications (IV fluids, nutrition, etc.) • Monitoring of cardiac monitors (CVP, Swan-Ganz, arterial readings)	• Tracheostomy care (outside of ICU) • Transporting, ambulating, range-of-motion, transfers from surface to surface • Urinary catheterization • Venipuncture (venous or arterial)

- **Surgery/Procedures** – to include surgical suites, major or minor treatment rooms, endoscopy labs, cardiac catheterization labs, x-ray, pulmonary, and cardiology procedure rooms. Minor procedures can also be performed at the bedside. In addition to the above list of equipment, supplies, and nursing personnel services, the following list of services are included in the surgical room rate (not all inclusive) (*commonly associated revenue codes 27X, 270-279, 300-370*)
    - When coding for services or supplies, the most specific and comprehensive code available is to be selected to report the service or item. Unspecified codes (i.e., 99070) and any use of "miscellaneous" charge items will not be eligible for separate reimbursement consideration.

• Air conditioning and filtration • All reusable instruments charged separately (e.g., forceps/scissors) • Anesthesia equipment and monitors • Anesthesia gases • Any automated blood pressure/vital sign equipment (e.g., Dinamap) • Blankets (e.g., Bair Hugger) • Batteries for any equipment • Cardiac monitors • Cardiopulmonary bypass equipment • Cautery Equipment monopolar and bipolar electrosurgical/bovie	• Procedure-specific reusable tools/instruments (broaches, extractors, drill, drill bits, osteotomes, reamers, retractors, etc.) • Power equipment • Room heating and monitoring equipment • Room set-ups of equipment and supplies • Saline infusion sonogram (SIS equipment) • Saline slush machine • Solution warmer ex. warms IV fluid or solution used to warm scopes • Surgeons' loupes or other visual assisting devices

• Cell Saver equipment and supplies • CO2 monitors • Crash carts • Digital recording equipment and printouts • Fracture tables • Grounding pads • Hemochron/supplies • Hemoconcentrator • Laparoscopes, bronchoscopes, endoscopes and accessories • Lights; Light handles; light cord, fiber optic Microscopes • Local anesthesia • Midas Rex (high speed pneumatic drill) • Obtaining laboratory specimens (biopsies, tissue samples, etc.)	• Trocars • Transport monitor to include intra hospital transport and bedside monitoring • Video camera and tape • Wall suction equipment ******in addition, when a procedure CPT code is billed, all usual and customary supplies/equipment required to complete the procedure is considered bundled to the procedure and is not separately reimbursable.

- **C-codes**
  - Each year, CMS makes C codes separately payable or packaged into the payment for the procedure. Each have unique costs and thus are reported separately. Separate payment is based on the C code, the CMS change, and the APC update. For specific C-code allowable, refer to Optum 360 Medical Reference Engine (MRE) https://www.medicalreferenceengine.com/mre/index.jsp or facility specific coding reference.
  - Examples of "Packaged service/item; no separate payment made" for Cardiac Catheterization procedures.

C1730	C1766	C1782	C2630
C1731	C1759	C1893	
C1732	C1769	C1894	

- **Code Blue activation**
  - Advanced Life support (CPT 99288) is allowable when accompanied by documentation to support the patient received at least 30 minutes of critical care (CPT 99291).
- **Computer aided navigational** is considered bundled into the primary procedure and not eligible for separate reimbursement.
- **Emergency charges (other)**

- No separate reimbursement will be provided for callback, emergency, standby, urgent attention, ASAP, STAT, or portable services.

- **Imaging**
  - Low-osmolar imaging contrast is included in the imaging charge (i.e., CT abdomen w/contrast).
  - Chest x-ray to confirm placement of central lines is packaged into the insertion procedure code and not separately reimbursable.
  - 3D rendering is considered a packages service with the primary imaging study and not separately reimbursable.

- **Implants** (commonly associated revenue code 272-278)
  - Will require an implant log that clearly indicates the vendor, the implant description, and units used.
  - May require a vendor's invoice to support supplies used that correspond to the services rendered.
  - If supplies are purchased in bulk, the units that apply to the claim billed must be noted on the invoice.
  - If not specifically approved by prior authorization (PA), will be reviewed for experimental/investigational/unproven (E/I/U) designation.

- **Incremental Nursing** (commonly associated revenue code 023x)
  - Is allowable when accompanied by documentation supporting extraordinary service that goes above and beyond the customary and routine care of the primary nurse.
  - Payment for incremental nursing charges will take into consideration the average usual and customary room and board charges for the specific region in which the care was provided. Routine nursing charges unbundled from standard room and board will not be reimbursed.

- **MUE's**
  - MUE for Inpatient services is tied to the CPT/HCPC code.
  - MUE for Government outpatient services can be found at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE
  - MUE for Commercial outpatient services can be found at Multiple Frequency per day (MFD) housed within the Optum 360 Medical Reference Engine (MRE) product:
    - Maximum Frequency Per Day CPT List
    - Maximum Frequency Per Day HCPC List

- **Multiple procedures**
  - Multiple procedure rule assigns a lesser payment for the second and subsequent procedures performed during the same patient encounter than would be allowable when the procedures have been performed under separate encounters (laparoscopic cholecystectomy/umbilical hernia, MRI/MRA, CT/CTA).

- **Pharmacy**
  - Disposable drug delivery systems (CPT A4305, A4306) are considered a packaged service and not separately reimbursable.

- **Respiratory** (commonly associated revenue codes 410, 412, 419, 460)
  - Ventilator or CPAP (facility owned) management are allowed one (1) unit per day.
    - O2, CPAP, PEEP changes, endotracheal suctioning, weaning, and extubation are included in the daily ventilator management charge.
  - Patient's own CPAP/BiPAP machine services
  - Pressurized or non-pressurized inhalation treatment for acute airway obstruction describes either treatment of acute airway obstruction with inhaled medication or the use of an inhalation treatment to induce sputum for diagnostic purposes. CPT code 94640 shall only be reported once during an episode of care regardless of the number of separate inhalation treatments that are administered. (bundled into the J code) https://www.cms.gov/files/document/chapter11
  - Blood draws from capillary, arterial, or vascular access devices, regardless of the practitioner performing the draw is an integral part of the laboratory test and not separately reimbursable.

- **Room & Board**
  - Post-operative surgical or procedural recovery services are performed in the ICU setting (outside the PACU), the critical care daily room charge will cover the recovery services charges.
  - Room and board charges will be for a semi-private room unless medically indicated (isolation).

- **Trauma team activation**
  - Activation of Trauma teams is allowable when: (1) billed by a designated trauma center; and (2) accompanied by documentation to support the patient received at least 30 minutes of critical care (CPT 99291).

Definitions

Ancillary Services – includes laboratory, radiology, pharmacy, delivery room (including maternity labor room), operating room (including post-anesthesia and post-operative recovery rooms), and therapy services (physical, speech, occupational). Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge.

Nursing services - means health care services provided to a patient by a registered professional nurse or a licensed practical nurse under the direction of a licensed professional within the scope of practice as defined by state law. Certified Nursing Assistants and technicians provide nursing services under the direction and supervision of the professional nurse.

Medical Equipment/Supplies – any device that is used in the rendering of patient care to include: capital, minor, and other hardware (tools, machinery, instruments, apparatuses) that is owned (leased, rented, or purchased) for diagnostic or therapeutic purposes.

MUE - for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date.

Routine Services – services to be included in the room and board charges. Routine services are composed of two components; 1) general routine services, and 2) special care units (SCU, CCU, ICU, and NICU). Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customary.

Unbundling - can occur in a couple of ways: 1) Submission of revenue codes for payment of routine supplies/equipment/nursing care that are considered "bundled" into the room and board charges and 2) Submission of revenue codes for payment for individual parts of a procedure in addition to charges for CPT procedure code.

Related Policies

****** In the event of conflict between a Clinical Payment and Coding Policy and any provider contract pursuant to which a provider participates in and/or provides services to eligible member(s) and/or plans, the provider contract will govern.**

Durable Medical Equipment, Prosthetic Orthotics and Supplies (DMEPOS)

Enteral Nutrition and Pumps

Global Period

Hospital Observation Services Reimbursement

Inhaled Nitric Oxide (iNO)

Intraoperative Neurophysiologic Monitoring

Line Item Claim Audit for Determinations of Non-coverage for Reimbursement Purposes

Neonatal Levels of Care and Inpatient Management

New and Emerging Technologies – Coverage Status

Provider Appeals – Commercial

Provider Appeals - Government

Robotic – Assisted Surgery

References

American Medical Association (AMA). "Introduction – Instructions for Use of the CPT codebook"

CMS. Code Sets Overview (HIPAA approved code sets)

CMS. Medicare Benefit Policy Manual. Chapter(s) 1, 6

CMS. Coding and Billing Guidelines

CMS. Costs related to Patient Care. Chapter(s) 21

CMS. Medically Unlikely Edits (MUEs)

CMS. Medicare Claims Processing Manual. Chapter(s) 4, 10, 16, 20, 21

CMS. National Correct Coding Initiative Policy Manual. Chapter(s) 1, 9, 11, 12

CMS. Physicians/Non-physician Practitioners Medicare Claims Processing Manual. Chapter 12.

CMS. Provider Reimbursement Manual Part I, chapter 22

CMS. Provider Reimbursement Manual, Determination of Cost of Services to Beneficiaries. Chapter(s) 22

Federal Register, Health Care Financing Administration (HCFA, 65 FR 18433, Medical Devices.

Noridian Administrative Services – Routine Hospital Supplies and Services (Not Separately Billable)

Nurse Practice Act. Standard and Scope of Practice. Montana, Oregon, Idaho & Washington State Board of Nursing

Oregon Health Authority. Hospital Services Provider Guide. Chapter 410, Division 130.

Optum360 Medical ReferenceEngine.com. Optum360, LLC, 2022.

- Medicare Desk Reference for Hospitals
- Multiple Frequency per day (MFD) list

Washington Apple Health. Inpatient Hospital Services Billing Guide.

Appendix

Policy Number:

Effective: 4/9/2022 **Next review:** 12/1/2022

Policy type: Enterprise

Author(s):

Depts.: Health Services

Applicable regulation(s):

Commercial Ops: 4/2022

Government Ops: 4/2022