Correct Coding Guidelines

Origination Date: 05/28/2024
Last Review: 05/28/2024
Next Review: 05/2025

Description

Providers are required to submit accurate and complete claims for all medical and surgical services, supplies and items rendered to members using industry standard coding guidelines. Coding guidelines include, but are not limited to, American Medical Association (AMA), Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), CMS Coding Initiatives, Uniform Billing Editor (UBE), and International Classification of Diseases, 10th Revision (ICD-10).

Current Procedural Terminology (CPT®)
A medical code set maintained by the American Medical Association (AMA) that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations. CPT is included in Level I Healthcare Common Procedure Coding System (HCPCS).

HCPCS Level II
A standardized coding system that is used primarily to identify medical supplies, durable medical equipment, non-physician services, and services not represented in the Level I code set CPT.

National Correct Coding Initiative (NCCI or CCI)
The Centers for Medicare & Medicaid Services (CMS) developed these edits to promote consistent, correct coding and appropriate payment. These coding edits are developed based on the AMA CPT code set and the HCPCS code set, as well as analysis of standard medical and surgical practice and input from various groups, including specialty societies, other national healthcare organizations, Medicare contractors, providers, and consultants.

The National Uniform Billing Committee (NUBC) and the state uniform billing committees (SUBC)
Committees responsible for the revenue code definitions and requirements for use.

Uniform Billing Editor (UBE)
A reference tool utilized by facilities to manage the constant changes to Medicare billing and reimbursement processes. The UBE provides detailed, accurate, and timely information about Medicare and UB-04 billing rules and requirements.

International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
A morbidity classification system for classifying diagnoses and reason for visits in all health care settings for the purpose of coding and reporting.

Revenue Codes (Rev Codes)
Revenue codes are 4-digit numbers that are used on hospital bills to identify where a member was located in a facility when they received treatment or services, or what service a member received as a patient.

Policy

Oscar will not allow reimbursement for incorrectly reported codes and modifiers, including revenue codes, for medical and surgical services and supplies and items, for professional, inpatient or outpatient facility claims.

The services must also be within the scope of practice for the relevant type of provider in the State in which they are furnished and within the provider's credentials/training (e.g., board certification).

References

1. Centers for Medicare & Medicaid Services (CMS), ICD-10-CM Official Guidelines for Coding and Reporting
2. Centers for Medicare & Medicaid Services (CMS), Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements.
3. Centers for Medicare & Medicaid Services (CMS), National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services
4. Centers for Medicare & Medicaid Services (CMS), Medicare Learning Network, Proper Use of Modifiers 59 & X
5. National Uniform Billing Committee (NUBC)
6. Centers for Medicare & Medicaid Services (CMS), Medicare Learning Network Evaluation and Management Services guide; E/M Service Providers
7. American Medical Association. Current Procedural Terminology. AMA Press
8. Centers for Medicare & Medicaid Services (CMS), HCPCS
9. American Academy of Professional Coders (AAPC). HCPCS Level II Expert Codebook.

Publication History

Date	Action/Description
05/28/2024	Policy Developed and Reimbursement Policy Committee Approved.