Review for Potential Upcoding of Services

Reimbursement Policy ID: RPC.0084.5400

Recent review date: 09/2024

Next review date: 09/2026

AmeriHealth Caritas District of Columbia reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas District of Columbia may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

Policy Overview

This policy outlines circumstances under which AmeriHealth Caritas District of Columbia may require a provider to submit medical records to support billed services when claim data suggests possible upcoding of surgical or other services.

Exceptions

N/A

Reimbursement Guidelines

Claims submitted to AmeriHealth Caritas District of Columbia must comply with industry standard coding guidelines, and all reported services must be supported in the medical record. AmeriHealth Caritas District of Columbia conducts periodic analysis of current and historical claim data and may request medical records to ensure accurate and appropriate reimbursement for services that are frequently miscoded or upcoded. Examples include but are not limited to:

- Evaluation and management services (e.g., New versus established patient services, neonatal and/or pediatric critical care, consultation services provided to established patients, use of modifier 25)
- Complex surgical procedures (e.g., cataract surgery, surgical debridement, musculoskeletal excisions, dermatology procedures, selective endovascular catheterization)
- Use of modifier 59
- Use of add-on codes
- Custom-fitted and custom-fabricated prosthetics and orthotics
- Procedure or procedure component(s) incident to a reported professional service.

Definitions

Add-on code
An add-on code describes additional intra-service work associated with the primary service or procedure.

Established patient
An established patient is one who has received face-to-face professional services from the same individual physician or other qualified health care professional within the last three years.

Evaluation and management
Evaluation and management (E/M) codes represent services by a physician (or other health care professional) in which the provider is either evaluating or managing a patient's health. Procedures such as diagnostic tests, radiology, surgery, and other particular therapies are not considered evaluation and management services.

Incident to
"Incident to" a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness.

Modifier 25 — significant, separately identifiable E/M service
Modifier 25 indicates a significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.

Modifier 59 – distinct procedural service
Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. However, when another already established modifier (XE-XU) is appropriate, it should be used rather than modifier 59. Modifier 59 should not be appended to an E/M service. XE-XU modifiers are defined as follows:

> XE — Separate encounter. A service that is distinct because it occurred during a separate encounter. Only use XE to describe separate encounters on the same date of service.

XS — Separate structure. A service that is distinct because it was performed on a separate organ/structure

XP — Separate practitioner. A service that is distinct because it was performed by a different practitioner

XU — Unusual non-overlapping service. The use of a service that is distinct because it does not overlap usual components of the main service

New patient
A new patient is one who has not received any professional services, [e.g., E/M service or other face-to-face service (e.g., surgical procedure)] from the physician or physician group practice (same physician specialty) within the previous three years.

Unbundling
Billing multiple procedure codes for a group of procedures ordinarily included in a single, comprehensive code, either due to misinterpretation, or to maximize reimbursement.

Upcoding
Upcoding occurs when a health care provider has submitted codes for more severe conditions than are diagnosed to receive higher reimbursement.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI).
VI. District of Columbia Medicaid Fee Schedule(s).

Attachments

N/A

Associated Policies

RPC.0007.5400 Add-On Codes

RPC.0022.5400 Bundling (Status B, P, T)

RPC.0066.5400 Evaluation and Management

RPC.0074.5400 DMEPOS

RPC.0014.5400 Incident To

RPC.0009.5400 Significant, Separately Identifiable Evaluation and Management Service (Modifier 25)

RPC.0010.5400 Distinct Procedural Service (Modifier 59, X {EPSU})

Policy History

09/2024	Reimbursement Policy Committee Approval
04/2024	Revised preamble
08/2023	Removal of policy implemented by AmeriHealth Caritas District of Columbia from Policy History section
01/2023	Template Revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section