curative

TITLE:	CORRECT CODING GUIDELINES
DEPARTMENT:	PAYMENT INTEGRITY
ORIGINAL EFF. DATE:	05/01/2025
REVISION DATE:	06/10/2025

1. PURPOSE

This Payment Policy outlines clear and consistent reimbursement guidelines to ensure compliant, transparent, and timely payment for medically necessary, cost-effective care.

2. SCOPE

This policy applies to the reimbursement of covered services for all members and providers, consistent with plan benefits, contractual agreements, and regulatory requirements.

3. DEFINITIONS

The following terms are defined as follows in regard to this P&P and/or SOP.

3.1. **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).

3.2. **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.

3.3. **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.

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

3.5. **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.

3.6. **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.

3.7. **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.

4. POLICY

These payment policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a Curative member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our payment policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current payment policies are not followed, Curative may:

1. Reject or deny the claim.
2. Recover and/or recoup claim payment.

Refer to the Provider Manual for claim reconsideration, appeals, and dispute resolution processes.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

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.

The Health Plan applies Code and Clinical Editing Guidelines (CCEG) to evaluate claims for accuracy and adherence to accepted national industry standards and plan benefits unless provider, state, federal contracts and/or mandates indicate otherwise. The Health Plan uses software products that ensure compliance with standard code edits and rules. These products increase consistency of payment for providers by ensuring correct coding and billing practices and may automatically apply edits using the software's editing logic. CCEG consists of the following measures:

1. Code editing software, CMS National Correct Coding Initiative (NCCI) edits, and Outpatient Code Edits (OCE)
    a. Code editing software is updated to conform to changes in coding standards
    b. National Correct Coding Initiative (NCCI) edits are updated according to CMS published updates:
        i. PTP (procedure to procedure)
        ii. MUE (Medically Unlikely Edits)

2. Clinical criteria
3. Claims processing platform
4. Per state requirements, the Health Plan publishes the use of specific commercial code editing software
5. The Health Plan only customized applicable CCEG measures due to compelling business reasons.

Providers must code their claims to the highest level of specificity in accordance with industry standard coding guidelines, such as ICD-10-CM coding guidelines and reporting. When an ICD-10-CM diagnosis code has a specified anatomical laterality within the code description, the anatomical modifier that is appended to a CPT ® or HCPCS code must correspond to the laterality within the ICD-10-CM description to identify different areas of the body that were treated. Proper application of the anatomical modifiers helps ensure the highest level of specificity on the claim and can help show that different anatomic sites received treatment.

Curative Health will apply these correct coding ICD-10-CM guidelines and deny claim lines that have a laterality diagnosis submitted with a CPT or HCPC modifier that does not correspond to the diagnosis. Additionally, the ICD-10-CM diagnosis code should correspond to the medical record, CPT, ® HCPCS code(s), and/or modifiers billed.

5. REFERENCE DOCUMENTS AND MATERIALS

5.1. Regulatory References

5.1.1. Centers for Medicare & Medicaid Services (CMS), ICD-10-CM Official Guidelines for Coding and Reporting

5.1.2. Centers for Medicare & Medicaid Services (CMS), Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements.

5.1.3. Centers for Medicare & Medicaid Services (CMS), National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services

5.1.4. Centers for Medicare & Medicaid Services (CMS), Medicare Learning Network, Proper Use of Modifiers 59 & X

5.1.5. National Uniform Billing Committee (NUBC)

5.1.6. Centers for Medicare & Medicaid Services (CMS), Medicare Learning Network Evaluation and Management Services guide; E/M Service Providers

5.1.7. American Medical Association. Current Procedural Terminology. AMA Press

5.1.8. Centers for Medicare & Medicaid Services (CMS), HCPCS

5.1.9. American Academy of Professional Coders (AAPC). HCPCS Level II Expert Codebook.

6. COLLABORATING DEPARTMENTS

6.1. Claims

6.2. Medical Management

6.3. Network

6.4. Compliance

6.5. System Configuration

7. POLICY & PROCEDURE CONTROL

This Policy will be reviewed at least annually and as necessary.

REVISION HISTORY			
Date	**Author**	**Version**	**Comments**
2025-05-01	CJ Wisecarver	001	Initial Version
2025-06-10	CJ Wisecarver	002	Added Dx to Modifier Clarification. Policy Reviewed and Approved by Payment Policy Committee. Effective 6/10/2025.