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DIVISION OF INSURANCE

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COMMISSIONER OF INSURANCE

Bulletin 2010-08

TO: Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc. and Health Maintenance Organizations
FROM: Joseph G. Murphy, Commissioner of Insurance
DATE: June 29, 2010
RE: Policies and Procedures for Uniform Coding and Billing Compliance Monitoring

The Division of Insurance (the "Division") issues this Bulletin to describe the policies and procedures for commercial health insurers, Blue Cross and Blue Shield of Massachusetts, Inc. and Health Maintenance Organizations (collectively, "managed care companies") to report compliance with requirements for uniform coding and billing.

Chapter 176O, § 5A of the Massachusetts General Laws requires managed care companies doing business in Massachusetts, and their subcontractors, to accept and recognize patient diagnostic information and patient care service and procedure information consistent with the current Health Information Portability and Accountability Act (HIPAA) compliant code sets. The HIPAA compliant code sets included are:

1. International Classification of Diseases (ICD);
2. American Medical Association's (AMA) Current Procedural Terminology (CPT) codes, reporting guidelines and conventions; and
3. Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS).

Managed care companies must also use the standardized claim formats for processing health care claims as adopted by the:

- National Uniform Claim Committee (NUCC); and
- National Uniform Billing Committee (NUBC).

Codes and formats must not be subject to any local or unique customization and must be effective on the same date as the implementation date established by the entity implementing the codes or formats.

Compliance Standards

Only Official Code Sets and Guidelines shall be recognized for purposes of measurement and compliance. The code sets and guidelines[1] to be adhered to are as follows:

1. The current version of the ICD and the official guidelines for coding and reporting as defined by the CMS and NCHS source:ICD-9, Clinical Modification, Sixth Edition or its successor (http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm) and AHA Coding Clinic for ICD-9 or its successor (http://www.ahacentraloffice.org/ahacentraloffice/files/CodingClinicAlphaIndex2008.pdf)
2. The current version of the CPT codes and reporting guidelines as defined by the AMA
   a. CPT Manual- chapter notes, section and subsection notes, parenthetical notes. Source: AMA CPT Manual : https://catalog.ama-assn.org/Catalog/product/product_detail.jsp?productId=prod1170002
   b. CPT Assistant Newsletter. Source: AMA's CPT Assistant : https://catalog.ama-assn.org/Catalog/product/product_detail.jsp?productId=prod170136
   c. CPT Changes, an Insider View. Source: CPT Changes, an Insider View: https://catalog.ama-assn.org/Catalog/product/product_detail.jsp?productId=prod1170011
3. The current version of the HCPCS. Level I codes (CPT) shall follow the official codes and reporting guidelines as maintained by the AMA. Level II codes shall follow the official codes and reporting guidelines as maintained by CMS. Source: HCPCS Level I codes and guidelines. (CPT) – See Section b. HCPCS Level II codes and guidelines refer to the HCPCS Quarterly Update Update and AHA Coding Clinic for HCPCS http://www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp http://www.customcodingbooks.com/index.asp?PageAction=VIEWPROD&ProdID=966

All above standards must be effective on the national implementation date established by the entity implementing the coding standards. Any standard that is not identified in the standard coding guidelines referenced above may be administered according to the managed care company's contract and payment policies.

[1] Versions listed are current as of the date this document was prepared; future versions be must be adhered to immediately upon the date implemented by the responsible entity.

Compliance Enforcement

Chapter 176O, § 5B requires the Bureau of Managed Care (BMC) within the Division to adopt policies and procedures to enforce the above requirements. In order to demonstrate compliance, managed care companies will provide periodic reports to the BMC on coding errors and on the managed care company's compliance status in relation to certain identified coding issues.

If the BMC has evidence that a managed care company is non-compliant in its acceptance and/or recognition of one or more codes or formats, the BMC will require the managed care company to submit a corrective action plan, subject to the approval of the BMC, to correct such noncompliance. If the BMC has reason to believe that a managed care company demonstrates a pattern of noncompliance in the managed care company's claims payment system, the BMC may call for a targeted review of that managed care company's system to determine whether it meets acceptable levels of compliance with the standards. If, based on that review, the managed care company is found to be noncompliant in any area, the managed care company will be expected to submit a corrective action plan, subject to the approval of the BMC, to correct such noncompliance.

If the BMC finds that a managed care company has not submitted the required reports or has not submitted an acceptable corrective action plan, when necessary, the BMC may issue a finding of neglect on the part of the managed care company, where the BMC notifies the managed care company in writing that the managed care company has failed to make and file the materials required by Chapter 176O, *et seq.* or 211 CMR 52.00 in the form and within the time required. The notice shall identify all deficiencies and the manner in which the neglect must be remedied. Following the written notice, the managed care company shall be fined $5,000 for each day during which the neglect continues. Following notice and hearing, the Commissioner of Insurance (Commissioner) shall suspend the managed care company's authority to do new business until all required reports or materials are received in a form satisfactory to the Commissioner and the Commissioner has determined that the finding of neglect has been appropriately addressed.

Compliance Reports

Managed care companies must submit the following reports to the BMC:

A. Coding Reports:
   1. Line Level Denials:
      a. Total # of finalized lines received
      b. Total # of line denials for the following reasons related to above-referenced code structures
         i. Service code does not accurately reflect service performed
         ii. Service code/diagnosis code not appropriate for age
         iii. Service code/diagnosis not appropriate for gender
         iv. Service code not appropriate for setting or place of service
         v. Service code/diagnosis does not support member benefit
         vi. Diagnosis code(s) does not support service code
         vii. Service code modifier required

viii. Service code modifier not appropriate for service
ix. Invalid code (ICD, CPT/HCPCS, Rev.)
x. Unlisted code

c. Total # of lines appealed related to above-referenced code structures
d. Total # of line denials related to above-referenced code structures overturned on appeal
e. Total # of lines denied incorrectly due to a coding recognition error
f. Narrative with additional comments on issues not captured above

2. DRG Audits
   a. Total # of DRG claims
   b. Total # of DRG claims reassigned from audit related to above-referenced code structures
   c. Total # of DRG audit reassignments appealed by provider related to above-referenced code structures
   d. Total # of overturned audit reassignments related to above-referenced code structures

B. Status Reports:
1. Detailed status report of managed care company's compliance with certain identified coding issues. The coding issues are those issues for which compliance is required by Chapter 176O, § 5A and agreed upon by the Advisory Committee created by Chapter 305 of the Acts of 2008. The Advisory Committee may update, from time to time, the identified coding issues, including removal or addition of issues. The status report should include:
   a. Managed care company's current status of compliance/noncompliance with each issue listed
   b. Corrective action(s) undertaken to address each issue listed
   c. Description of any known barriers to correction of noncompliance
   d. Timeline for completion for each corrective action undertaken

C. Reporting Timelines:
1. Coding Reports due:
   a. September 15, 2010, for denials between January 1, 2010 and June 30, 2010
   b. February 15, 2011 for denials between July 1, 2010 and December 31, 2010
   c. August 15, 2011 for denials between January 1, 2011 and June 30, 2011
   d. Annually beginning February 15, 2012, and annually thereafter, for the previous calendar year
2. Status Reports due:
   a. First report due September 15, 2010 and thereafter quarterly on February 15, May 15, August 15 and November 15 of each year

Managed care companies must use the Uniform Coding and Billing Compliance Report Form attached to this Bulletin.

Uniform Coding and Billing Compliance Report[1]

Payer Name	Report Date
Street address	Period Start
City, State, Zip	Period End

Statistics should be reported as follows:

1. Include – Fully insured HMO, PPO, POS (dual certificate), EPO, and Indemnity product lines
2. Exclude – Self-insured, Medicare Advantage, Medicare Supplement, Other Medicare, and Medicaid product lines

Section A. Coding report

1. Line level denials for the following reasons related to itemized code structures.	**1. Compliance Measures**		
	a. Total # of finalized lines		
	b. Total # of line denials		% of 1a.
	c. Total # of appeals		% of 1b.
	d. Total # of denials overturned on appeal		% of 1b.
	e. Total # of incorrect denials		% of 1a.
	Summary of issues identified in 1e.		
	Code from 1b (i. – x.)	**Issue identified**	**Corrective Action Plan**
1.1 Line level code structure issues not reportable under A.1.	**1.1 Compliance Measures**		
	f. Total # of line issues		% of 1a.
	Summary of issues identified in 1f.		
	Code from 1b (i. – x.)	**Issue identified**	**Corrective Action Plan**
TOTAL	g. Total # of line denials (1e) plus line issues (1f)		% of 1a.

2. DRG Claims.	**2. Compliance Measures**		
	a. Total # of DRG Claims		
	b. Total # of DRG Claims reassigned from audit		% of 2a.
	c. Total # of DRG Claims reassigned appealed		% of 2b.
	d. Total # of overturned audit reassignments		% of 2a.
	Summary of issues identified in 2d.		
	Code from 1b (i. – x.)	**Issue identified**	**Corrective Action Plan**

[1] Please see Bulletin2010-xx for more details on the Uniform Coding and Billing Compliance Report.