Code Review Payment Policy

Policy

The Plan will review and assign the appropriate coverage and determine prior authorization requirements for all new and revised industry standard code sets, including but not limited to CPT, HCPCS, ICD, DRG, and Revenue codes. The Plan will notify all contracted providers of this determination via the Connection newsletter and on the Plan website in the Provider Manual.

Consistent with industry standards, the Plan will update coverage determinations as necessary unless otherwise directed by CMS, Masshealth, Massachusetts Division of Insurance, or New York State Medicaid.

Definitions

This policy applies to the standard code set review process to ensure proper coverage assignments for all new and revised codes in a calendar year. Deleted codes will be deactivated and not be reimbursed for dates of service after the deletion date.

Reimbursement

Reimbursement will be according to contract.

Referral/notification/prior authorization requirements

All new procedure codes will require prior authorization until a formal review is performed by The Plan.

Billing/coding guidelines

The Plan will use current industry standard codes throughout our processing systems.

The Health Insurance Portability & Accountability Act (HIPAA) Transaction & Code Set Rule requires providers to use the codes that are valid at the time the service is provided. The Plan adheres to HIPAA standards.

Providers must only use industry-standard code sets.

Place of service

This policy applies to services rendered in all settings.

Policy history

Origination date:	11/23/03
Previous revision date(s):	08/04/04, 08/03/05, 07/19/06, 09/12/07 01/1/09 – Add statement that providers may only use industry standard codes; retire Home Grown Codes Payment Policy. 03/01/2011 - Changed name Procedure Code Review to Code Review and expanded discussion to include all standard code sets. 09/01/2015 – Annual review and moved to new Plan template. 05/01/2016 - Annual review.
Connection date & details:	March 2017 – Annual review. April 2018 – Annual Review, no updates. April 2019 – Annual Review, no updates. April 2020 - Clarified policy section.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.