Martin's Point

Policy

Policy Title: General Billing and Coding Policy	**Policy Number:** HP.CA.001
Date Last Modified: 09/10/2025	**Effective Date:** 09/12/2025
Issuing Department: Claims Administration	**Approved By:** Jennifer Bullock (VP Health Plan Operations)

Purpose:

This General Billing and Coding Policy ("Policy") sets forth the Martin's Point reimbursement policy for both participating (PAR) and non-participating (non-PAR) providers and sets forth an overview of coding and reimbursement guidelines as they pertain to claims submitted to Martin's Point. These guidelines follow correct coding guidelines such as National and Regional Centers for Medicare and Medicaid Services (CMS) (including DMEMAC), CMS Claims Processing Manual, American Medical Association (AMA) guidelines, National Specialty Academy guidelines, knowledge of anatomy, and the standards of medical practice.

This Policy is designed to ensure transparent, timely, and accurate reimbursement practices that aligns with regulatory requirements and industry standards. This Policy is designed to assist providers in understanding the processes and expectations surrounding claims submission and review, as well as applicable compliance requirements. Unless listed in a specific payment policy, in cases where coding guidance from the AMA, CPT manual and/or AMA CPT Assistant conflicts with the CMS National Correct Coding Initiatives (NCCI) Policy Manual and edits, Martin's Point will adhere to the NCCI manual and edits. NCCI guidance will take precedence over AMA CPT coding recommendations.

By adhering to both published reimbursement policies and external regulatory requirements, Martin's Point aims to foster an efficient billing and reimbursement process, minimizing administrative burdens and promoting a streamlined partnership between providers and Martin's Point. Providers are encouraged to review this Policy thoroughly and contact Martin's Point with any questions.

This Policy serves as a resource to support adherence to best practices in claims management, regulatory compliance, and to help avoid potential reimbursement delays or adjustments due to incomplete, incorrect, or untimely submissions. Martin's Point reimbursement policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Scope:

This Policy applies to:

☒ Martin's Point Generations Advantage
☒ Martin's Point US Family Health Plan

Policy Amendments: This Policy is subject to review and amendment at the sole discretion of Martin's Point. Amendments to this Policy will be posted and highlighted on the Martin's Point "Policies" website

page. Providers are expected to check our website regularly for the most up-to-date version of reimbursement policies.

Benefit and Cost Share Verification: Martin's Point will reimburse providers based on member benefits and eligibility on the date of service, subject to applicable member out-of-pocket cost (e.g., copayment, coinsurance, deductible). Providers are responsible for verifying member eligibility and benefit specifics prior to initiating services

Policy:

Martin's Point follows the current industry standard coding guidelines set forth by AMA, CMS, ADA, and state and federal governments. Martin's Point will accept only standard diagnosis and procedure codes that comply with HIPAA transaction code set standards.

Standard coding types include:

- **Current Procedural Terminology (CPT) (Level I Codes)**: These codes are maintained by AMA and range from 00100 – 99499, with each range being broken down into categories and sub-categories based on the procedure or service type.

- **Healthcare Common Procedure Coding System (HCPCS) (Level II Codes)**: These codes are maintained by CMS and are used to identify products, supplies, and services not included in Level I CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.

- **Current Dental Terminology (CDT)**: These codes are maintained by ADA used for recording dental services on patient records and for reporting to dental plans.

- **International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)**: These codes are used to indicate a diagnosis or condition and are required on all claims. "Martin's Point" follows ICD-10-CM Official Guidelines for Coding and Reporting and will deny claims when billed inappropriately.

- **International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS)**: These codes are 7-digit alphanumeric codes maintained by CMS and associated with hospital utilization. They are used on inpatient claims.

- **National Drug Code (NDC)**: The 11-digit code is made up of three segments in a 5-4-2 format that is found on the package or vial of the medication. The hyphens included in the code is not required in claims billing. These codes are required for drugs dispensed by a pharmacy or medical supplier, and for physician administered drugs provided in an office or facility setting.

- **Revenue Codes**: These codes are typically maintained by the National Uniform Billing Committee (NUBC). A revenue code is required on all institutional (facility) claims. In some instances, a corresponding HCPCS or CPT code may be required in addition to specific revenue code to describe the services rendered.

All standard coding rules and procedures are updated and published on a quarterly and annual basis. As these revisions are released, Martin's Point will update its systems and any related payment policies as

necessary. Providers are responsible for monitoring and reviewing all updates to ensure that claims are coded accurately. If providers receive improper overpayments due to coding errors, such overpayments must be reported to Martin's Point within thirty (30) days for review and validation. Any identification of improper coding or billing may result in audits and recoupment of payment.

Procedure:

Claims Editing and Application Overview

Martin's Point uses industry standard claims editing software and editing vendor(s) to ensure claims are processed in compliance with government and industry standards. All applicable rules align with the standard coding and billing regulations and are updated regularly to guarantee that recent coding and policy changes are incorporated into the system accurately. The edits allow for consistent and objective claims review by:

- Accurately applying coding criteria based on nationally recognized sources such as AMA CPT guidelines, specialty society recommendations, NCCI, and current medical practices for professional claims.

- Accurately applying coding criteria from Outpatient Code Editor (OCE), Medicare Code Editor (MCE), National Correct Coding Initiative (NCCI), and Local Coverage Determination (LCD)/National Coverage Determination (NCD) guidelines for facility claims.

- Detecting coding errors related to coding status (valid or invalid), unbundling of procedure codes, modifier appropriateness, mutually exclusive procedures, incidental procedures, bilateral procedure reductions, anesthesia processing, and duplicate claims.

- Evaluating diagnosis codes (ICD-10-CM) to validate code status (valid or invalid related to active date, gender, procedure code combination, etc.), digit appropriateness, and correct level of specificity.

- Incorporating historical claims auditing functionality, which links multiple claims found in patient's claims history to current claims to ensure consistent review across all dates of service.

Providers are expected to adhere to correct coding guidelines. Claims are screened appropriately for patient and/or provider information conflicts. Reimbursement will not be made for claims where procedure or diagnosis codes conflict with common core data, including but not limited to:

- Place of service with procedure
- Patient age with procedure
- Patient age with diagnosis
- Diagnosis with procedure
- Provider with procedure

Claims Edits are updated regularly to incorporate the most recent medical practices, coding practices, annual changes to the AMA's CPT manual and other industry standards.

Claims Editing Details

NCCI Edits: NCCI edits are developed by CMS and utilize coding conventions defined in the AMA CPT manual, national and local policies, national societies coding guidelines, standard medical and surgical practices analysis, and current coding practices. NCCI edits include Procedure-to-Procedure (PTP) code pair edits and Medically Unlikely Edits (MUEs).

- ***Procedure-to-Procedure (PTP)***: PTP edits are automated prepayment edits that prevent improper payment when certain codes are submitted/reported together for covered services on the same date of service by the same provider for the same patient. PTPs contain two categories, Practitioner PTP edits which apply to physician and ambulatory surgical center (ASC) claims and Hospital PTP edits which apply to facility services including outpatient hospital services. CMS identifies which code pairs can bypass code editing when reported with an appropriate modifier.
- ***Medically Unlikely Edits (MUE)***: MUE edits establish the maximum units of service allowed for a single procedure code (HCPCS/CPT) billed by a provider on a date of service for a patient. Providers that bill more than the maximum units allowed will only be reimbursed up to the limit; units billed over the limit will be denied.

Unbundling: Unbundling occurs when multiple procedure codes are billed/reported for a service that could be represented using a single code and can result in improper or inflated payment. Services identified as unbundled may be denied or re-bundled and processed as the single comprehensive procedure code.

Mutually Exclusive Procedures: Procedure codes are considered mutually exclusive when the procedures cannot be performed at the same anatomic site or patient encounter. If it is identified that the codes are mutually exclusive, only the primary service will be considered for reimbursement.

Incidental Procedures: When a procedure that is not essential to the primary procedure is performed at the same time as the primary procedure, it is considered incidental and is not reimbursed separately.

Separate Procedures: A separate procedure should not be reported with a related procedure. A procedure code classified as a "separate procedure" is eligible for separate reimbursement when the service performed on the same day is for a different session, for a separate distinct condition, or at an anatomically unrelated site. The procedure will need to be reported with an appropriate modifier and supporting medical documentation to be considered for the separate reimbursement.

Bilateral Procedures: Bilateral procedures are defined as procedures performed on both sides of the body during the same session or on the same day. Bilateral procedures that are performed must be reported with modifier 50 unless the procedure code is defined as a bilateral procedure within the code description.

Add-on Code: An add-on code is a service that is performed in conjunction with the primary service by the same provider. An add-on is only eligible for reimbursement when billed with the primary code that is eligible for payment for the same provider on the same date of service for the same patient.

Outpatient Code Editor (OCE): OCE is an editing system created and maintained by CMS that is used to process all outpatient facility claims to ensure accurate coding. OCE edits help identify incorrect and inappropriate claims coding and does incorporate NCCI edits within the logic.

Local Coverage Determination (LCD): LCD is a determination by a Medicare Administrative Contractor (MAC) on whether a specific item or service is covered or not covered within the specific geographic

area based on Section 1869(f)(2)(B) of the Social Security Act. LCDs are developed using scientific and clinical evidence and are consistent with national policies.

National Coverage Determination (NCD): NCDs are developed by CMS and apply to all states. They are made through an evidence-based process and indicate the specific services, items, procedures, or technologies that will be covered under Medicare on a national basis. If an NCD does not exclude or limit a circumstance or does not mention the service or item, the service or item may be covered on an LCD at the discretion of the MAC. LCDs cannot contradict an NCD but should clarify it.

Surgical Services: Reimbursed Outside of the Global Rate when billed with appropriate modifier(s):

- Services rendered for post-operative complications requiring a return trip to the operating room.
- Services of another physician, unless the physician is part of the same specialty group service.
- If one physician performs the surgery but a different physician renders post-operative care, each service is reimbursed separately
- For surgical procedures with zero days assigned as a global period, post-operative visits are reimbursed
- Visits unrelated to the diagnosis - Treatment for an underlying condition - An added course of treatment not related to the surgery
- Diagnostic tests and procedures, including radiological procedures

Unlisted Codes: Unlisted CPT codes are reimbursed after individual consideration and review of the operative notes. When submitting supporting documentation, underline the portion of the report that identifies the test or procedure associated with the unlisted procedure code. Required information must be legible and clearly marked.

340-B Acquired Drugs: For CY2023, CMS maintains the requirement for 340B providers to report the JG and TB modifiers for informational purposes. Under the OPPS, select entities including rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals should continue to bill the modifier TB on claim lines for drugs acquired through the 340B program. All other 340B providers should continue to report the modifier JG.

Modifiers: Modifiers can be two digit numbers, two character modifiers, or alpha-numeric indicators. Modifiers provide additional information to make sure providers are reimbursed correctly for services rendered. If appropriate, more than one modifier may be used with a single procedure code; however, modifiers are not applicable for every category of the CPT codes. Some modifiers can only be used with a particular category, and some are not compatible with others.

Providers are required to reference the most updated industry standard coding guidelines for a complete list of modifiers and their usage. In instances when a modifier is submitted incorrectly with the procedure code, Martin's Point will deny the claim line for incorrect use of modifier. Examples of when modifiers may be used:

- Identification of professional or technical only components
- Repeat services by the same or different provider
- An increased, reduced, or unusual service
- Billing for components of a global surgical package
- Identification of a specific body area
- To designate a bilateral procedure
- Identification of service in a clinical trial

Some modifiers cause automated pricing changes, while others are used for information only. When selecting the appropriate modifier to report on the claim, please ensure that it is valid for the date of service billed. Commonly used modifiers are outlined below –

Type of Modifier	Modifiers Listed
Additional HCPCS Modifiers	AB, AE, AF, AG, AI, AK, AM, AO, AT, AZ, BL, CA, CB, CG, CR, CS, CT, DA, ER, ET, FB, FC, FS, FX, FY, G7, GC, GE, GG, GJ, GU, J1, J2, J3, JC, JA, JB, JC, JD, JG, JW, JZ, KX, L1, LU, M2, PD, PI, PO, PN, PS, PT, Q0, Q1, Q3, Q4, Q5, Q6, QJ, QQ, RD, RE, SC, SF, SS, SW, TB, TC, TS, UJ, UN, UP, UQ, UR, US, X1, X2, X3, X4, X5, XE, XP, XS, XU
Advance Beneficiary Notice of Noncoverage (ABN) modifiers	GA, GX, GY, GZ
Advanced Diagnostic Imaging Modifiers	MA, MB, MC, MD, ME, MF, MG, MG, MH, QQ
Ambulance Modifiers	D, E, G, H, I, J, N, P, R, S, X, GM, QL, QM, QN
Anatomical Modifiers (coronary artery, eye lid, finger, side of body, toe)	E1, E2, E3, E4, FA,F1,F2,F4, F5, F6, F7, F8, F9, LC, LD, LM, LT, RC, RI, RT, TA, T1, T2, T3, T4, T5, T6, T7, T8, T9
Anesthesia Modifiers	AA, AD, G8, G9, P1, P2, P3, P4, P5, P6, QK, QS, QY, QX, QZ, 23, 33
Assistant at Surgery Modifiers	AS, 80, 81, 82
End Stage Renal Disease (ESRD) and Erythropoiesis Stimulating Agent (ESA) Modifiers	AX, EA, EB, EC, AY, ED, EE, EJ, EM, G1, G2, G3, G4, G5, G6, GS, JA, JB, JE, V5, V6, V7, V8, V9
Global Surgery Modifiers	24, 25, 54, 55, 57, 58, 78, 79, FT **Note:** Modifiers 24, 25, 57 and FT apply to evaluation and management services
Hospice Modifiers	GV, GW
Laboratory Modifiers	90, 91, 92, LR, QW
Other CPT Modifiers	26, 27, 33, 59, 76, 77, 96, 97
Podiatry Modifiers	Q7, Q8, Q9
Quality Reporting Incentive Programs Modifiers	1P, 2P, 3P, 8P, AQ, AR, MA, MB, MC, MD, ME, MF, MG, MH, X1, X2, X3, X4, X5
Surgical Modifiers	22, 50, 51, 52, 53, 62, 66, 73, 74, PA, PB, PC
Telehealth Services Modifiers	93, 95, FQ, GQ, GT, G0 (zero)
Therapy Modifiers	GN, GO, GP, KX, CO, CQ

Sources:

1. National Uniform Billing Committee National Uniform Billing Committee | NUBC
2. CDC ICD-10-CM Classification of Diseases, Functioning, and Disability ICD-10-CM | Classification of Diseases, Functioning, and Disability | CDC
3. Medicare National Correct Coding Initiatives NCCI for Medicare | CMS
4. Medicare Coverage Determinations Medicare Coverage Determination Process | CMS
5. Local Coverage Determinations Local Coverage Determinations | CMS
6. American Medical Association, *Current Procedural Terminology (*CPT®) and associated publications and services.
7. Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
8. Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
9. Centers for Medicare and Medicaid Services, National Correct Coding Initiative (NCCI) Policy Publications
10. Centers for Medicare and Medicaid Services, Billing Guidelines for 340B Drugs Medicare-FFS Program Billing 340B Modifiers under the Hospital Outpatient Prospective Payment System (OPPS)