



Effective: 8/29/2021
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 Lines Of Business:

Non-Covered/Non-Reimbursable (Not Separately Billable) Codes

Applicable Lines of Business:

- ✓ Commercial - Health Maintenance Organization (HMO), Preferred Provider Option (PPO) and Point of Service (POS)
- ✓ Medicare Advantage - SecureCare HMO (includes the Dual Eligible Special Needs Plan [DSNP]) and SecureChoice PPO)
- ✓ Mountain Health Trust (MHT) including WV Medicaid (Temporary Assistance for Needy Families [TANF], Expansion [WV Health Bridge] and Supplemental Security Income [SSI] populations) and West Virginia Children's Health Insurance Program (WVCHIP)
- ✓ Self-Funded/Administrative Services Only (ASO)
- ✓ West Virginia Public Insurance Agency (WV PEIA)

Applicable Claim Type:

- Dental
- ✓ Facility
- Pharmacy
- ✓ Professional

Definitions:

Term	Definition
Bureau for Medical Services (BMS)	BMS is the designated single state agency responsible for the administration of the State of West Virginia's Medicaid program.
Centers for Medicare and Medicaid Services (CMS)	A federal agency that provides health coverage to more than 100 million people through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace.

Current Procedural Terminology (CPT) code	CPT codes serve as the coding system by which physicians bill for the various services and procedures that they render. Also known as Level 1 HCPCS codes.
Healthcare Common Procedure Coding System (HCPCS)	A standardized code system utilized for drugs, supplies, durable medical equipment, and for filling in gaps within the CPT coding system. Also known as Level II HCPCS codes.
Medicare Physician Fee Schedule (MPFS)	An online physician fee schedule search tool developed by CMS to provide Medicare payment information.
Resource-Based Relative Value Scale (RBRVS)	A standardized physician payment system established by the federal government which bases payment on a resource-based relative value scale (RBRVS) instead of basing payments on charges. This reimbursement method is used by the Centers for Medicare & Medicaid Services (CMS) and most other payers.

Policy Purpose:

The purpose of this policy is to address general payment guidelines related to non-covered/non-reimbursable (not separately billable) codes as defined by the Centers for Medicare and Medicaid Services (CMS) and the Bureau for Medical Services (BMS).

Policy Description:

The Health Plan (THP) refers to governmental agency fee schedules to establish payment **if a service is covered by THP** under the particular group's plan design.

THP will not cover any Current Procedural Terminology (CPT) code and/or Healthcare Common Procedure Coding System (HCPCS) codes not included, not priced or indicated as non-covered per the appropriate governmental agency's guidelines that THP references.

An exception to the above statement is if benefit or contractual agreements are reached that are inclusive of negotiated rates of non-covered codes.

The presence or absence of a code or service on a reference list does not guarantee coverage, or lack thereof, nor does it take the place of medical necessity or utilization management reviews.

Commercial Reimbursement Guidelines:

THP references CMS' fee schedules as guides to determine covered codes for all Commercial lines of business (LOB) per each plan design.

CMS' fee schedules can be accessed online at: <https://www.cms.gov/medicare/medicare-fee-for-service-payment/feeschedulegeninfo>.

Medicare Advantage Reimbursement Guidelines:

THP references CMS' fee schedules as guides to determine covered codes for all Medicare Advantage LOB per each plan design.

CMS' fee schedules can be accessed online at: <https://www.cms.gov/medicare/medicare-fee-for-service-payment/feeschedulegeninfo>.

Mountain Health Trust Reimbursement Guidelines:

THP references BMS' fee schedules as guides to determine covered codes for all plans under the Mountain Health Trust (MHT) program per each plan design.

The BMS fee schedule can be accessed online at: <https://dhhr.wv.gov/bms/FEES/Pages/default.aspx>.

Self-Funded (ASO) Reimbursement Guidelines:

THP references CMS' fee schedules as guides to determine covered codes for all Self-Funded (ASO) LOB per each plan design.

CMS' fee schedules can be accessed online at: <https://www.cms.gov/medicare/medicare-fee-for-service-payment/feeschedulegeninfo>.

WV PEIA Reimbursement Guidelines:

THP references CMS' fee schedules as guides to determine covered codes for the WV Public Employees Insurance Agency (WV PEIA) LOB per each plan design.

CMS' fee schedules can be accessed online at: <https://www.cms.gov/medicare/medicare-fee-for-service-payment/feeschedulegeninfo>.

Billing Information and Guidelines:

If a provider bills THP for a non-covered/non-reimbursable (not separately billable) code the claim will deny. The member is held harmless and the provider must write off the claim.

CMS Fee Schedules

The CMS website maintains spreadsheets of billing codes of their various fee schedules on their website and they are updated quarterly.

The billing codes are listed in numerical order.

The Excel spreadsheets are search-able by pressing and holding the "Ctrl" button on your keyboard and then pressing the "F" button to display a search box.

The various fee schedules are located on tCMS' website located at: <https://www.cms.gov/medicare/medicare-fee-for-service-payment/feeschedulegeninfo>.

BMS Fee Schedules

The BMS website maintains spreadsheets of billing codes of their various fee schedules.

BMS updates their fee schedules as follows:

- **January 1st**
 - Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC)
 - The West Virginia Children's Health Insurance Program (WV CHIP)
- **April 1st**
 - Physician (RBRVS)
 - Durable Medical Equipment (DME)
 - Clinical Lab
 - Home Health
 - Ambulance
 - Ambulatory Surgical Center (ASC)
 - Dental fee schedules
- **October 1st**
 - Hospice
 - Diagnosis Related Group (DRG)
- **Quarterly**
 - Average Selling Price (ASP)

The billing codes are listed in numerical order.

The Excel spreadsheets are search-able by pressing and holding the "Ctrl" button on your keyboard and then pressing the "F" button to display a search box.

Non-covered/non-reimbursable (not separately billable) codes are noted in BMS' fee schedules.

The BMS website is located at: <https://dhhr.wv.gov/bms/FEES/Pages/default.aspx>.

More billing information may be found in The Health Plan's Provider Manual located at healthplan.org "For Providers," "Resources."

References and Research Materials:

Centers for Medicare and Medicaid Services Fee Schedule General Information. Centers for Medicare and Medicaid Services. Available online at at: <https://www.cms.gov/medicare/medicare-fee-for-service-payment/feeschedulegeninfo>

Pre-Authorization Code Look-Up Tool. The Health Plan. Available online at: <https://myplan.healthplan.org/provider>.

WV Medicaid Physician's Fee Schedules. WV Bureau for Medical Services. Available online at: <https://dhhr.wv.gov/bms/FEES/Pages/default.aspx>.

Disclaimer:

This policy is intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry standard claims editing logic, benefit design and other factors are considered in developing payment policies. This policy is intended to serve as a guideline only and

does not constitute medical advice, any guarantee of payment, plan pre-authorization, an explanation of benefits, or a contract. This policy does not govern whether a specific procedure is covered under any specific member plan or policy, nor is it intended to address every claim situation. The determination that any service, procedure, item, etc., is covered under a member's benefit plan shall not be construed as a determination that a provider will be reimbursed for services provided. Individual claims may be affected by other factors, including but not necessarily limited to state and federal laws and regulations, legislative mandates, provider contract terms, and THP's professional judgement. Reimbursement for any services shall be subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Unless otherwise noted within the policy, THP's policies apply to both participating and non-participating providers and facilities. THP reserves the right to review and revise these policies periodically as it deems necessary in its discretion, and it is subject to change or termination at any time by THP. THP has full and final discretionary authority for its interpretation and application. Accordingly, THP may use reasonable discretion in interpreting and applying this policy to health care services provided in any particular case.

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All revision dates:

7/30/2021