PolicyStat ID 14178873

Last Approved	8/11/2023	Area	Provider Payment Policies
Effective	10/2/2023	Lines Of Business	All Lines of Business
Next Review	8/10/2024		

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	A federal agency that provides health coverage to more than

Medicaid Services (CMS)	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 on-line 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 exclude coverage if such excluded coverage is agreed upon contractually, nor does it take the place of medical necessity or utilization management reviews.

Commercial, Medicare Advantage, Self-Funded (ASO), and WV PEIA Reimbursement Guidelines:

THP references CMS' fee schedules as guides to determine covered codes for all Commercial, Medicare Advantage, Self-Funded (ASO), and WV PEIA lines of business (LOB) per each plan design.

CMS' fee schedules can be accessed on line 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 on line at: https://dhhr.wv.gov/bms/FEES/Pages/default.aspx.

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 Links:

Ambulance Fee Schedule and Public Use Files

Clinical Laboratory Fee Schedule

Durable Medical Equipment (DME), Prosthetic/Orthotics & Supplies Fee Schedules:

- CMS DME Fee Schedule Information
- Noridian DME MAC- Jurisdiction A
- CGS DME MAC- Jurisdiction B
- CGS DME MAC- Jurisdiction C
- Noridian DME MAC- Jurisdiction D

CMS Physician Fee Schedule

All Fee-for-Service Providers fee schedule

- Information related to Medicare fee-for-service payment for services not mentioned above can be found in the "Special Links" section.

BMS Fee Schedules:

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

- Non-covered/non-reimbursable (not separately billable) codes are noted in BMS' fee schedules.
- More billing information may be found in The Health Plan's Provider Manual located at healthplan.org "For Providers," "Resources."

Post-payment Review:

The claim and record must include documentation that reflects the criteria of this policy, and is subject to audit by THP at any time pursuant to the terms of your provider agreement.

Review/Revision History:

	Date	Action
Policy Issue Date	07/30/2021	
Date Revised	12.3.21	Added detailed fee schedule searches for Ambulance, Clinical Laboratory, DME, Physician and All Fee-For-Service Providers under the "CMS Fee Schedules" subsection in the Billing and Information Guidelines section.
	12.3.21	Added detailed fee schedule searches for Clinical Diagnostic Lab, DME, Home Health and Physician (RBRVS) fee schedules under the "BMS Fee Schedules" subsection in the Billing and Information Guidelines section.
Annual Review	5/11/2022	Condensed sections for Commercial, Medicare Advantage, Self-Funded (ASO), and WV PEIA into one section as criteria was the same for each of those LOBs. Reviewed links, criteria, and references.
Update	11/11/2022	Under Policy Description "or lack thereof" was changed to "exclude coverage if such excluded coverage is agreed upon contractually".
Annual Review	7/26/2023	Annual Review: Removed BMS fee schedule update calendar as it no longer applies. Removed web-page navigation directions for all LOBs and replaced with "CMS Fee Schedule Links" section. Updated formatting and references. Corrected typos.

References and Research Materials:

Centers for Medicare and Medicaid Services(CMS). Fee Schedule - General Information. Last updated November 15, 2022. https://www.cms.gov/medicare/medicare-fee-for-service-payment/feeschedulegeninfo

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

WV Medicaid Physician's Fee Schedules. WV Bureau for Medical Services. Available on-line 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 judgment. 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.

All Revision Dates

8/11/2023, 1/10/2023, 9/13/2022, 6/17/2022, 7/30/2021