CONSISTENCY GUIDELINES

File Name: consistency_guidelines_MA
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Last Review: 12/2022
Next Review: 12/2023

Description

Claims are reviewed for consistency between the services provided, diagnoses, modifiers, and units of service based on several sources, including but not limited to: procedure and diagnosis code definition, nature of the procedure, associated diagnoses, CMS policy, and select FDA approved package insert/prescribing information.

This policy highlights correct coding guidelines for consistency regarding age.

Claims review for age consistency:

Certain diagnoses codes have been identified as being specific to certain age groups. When one of these diagnoses is billed, it must match the age of the patient on the claim for that date of service.

Certain procedure codes, by definition or nature of the procedure, are limited to the treatment of a specific age or age group. When a specific age is not indicated in the procedure description, the following age definitions are used for determining procedural appropriateness.

The age groups are:

- Newborn/Neonatal: < 29 days
- Infant: < 1 year (Includes newborn/neonatal)
- Child: 1-17 years
- Junior: 11-18 years
- Adolescent: 12-17 years
- Pediatric: 0-17 years (Includes newborn/neonatal, infant, child and adolescent)
- Adult: 15 years and above
- Elder: 65-124 years
- Maternity: 9-64 years
- Geriatric: 70 years and above

Policy

Blue Cross Blue Shield North Carolina (Blue Cross NC) will review claims for appropriateness of member's age according to the criteria outlined in this policy.

Reimbursement Guidelines

Age-specific procedures provided for a member in the appropriate age range will be allowed.

Claims for services will not be allowed if the claim indicates that age-specific services have been provided to a member who was not in the appropriate age group on that particular date of service.

Rationale

Whenever possible, if a claim is filed with a code that conflicts with the member's age, the correct code for the member's age will be added to the claim.

Services incorrectly coded for the member's age will not be reimbursed.

When an age-specific diagnosis is billed as the only diagnosis on a claim and it does not match the age of the patient on the claim for that date of service, all services on the claim will be denied. This policy includes all diagnoses on a claim.

Billing and Coding

Applicable codes are for reference only and may not be all inclusive. For further information on reimbursement guidelines, please see the Blue Cross NC web site at www.bcbsnc.com.

Claims denied due to conflict between the services provided and the member's age must be resubmitted with the correct procedure codes.

Related policy

Diagnosis Validity & Coding Guidelines

Once In A Lifetime

References

American Medical Association, Current Procedural Terminology (CPT®)

Centers for Disease Control and Prevention, International Classification of Diseases, 10th Revision

Centers for Medicare & Medicaid Services, CMS Manual System, and Medicare Claims Processing Manual 100-04

Healthcare Common Procedure Coding System

History

Date	Description
6/1/2022	New policy developed. Medical Director approved. **Notification on 3/31/2022 for effective date 6/1/2022.** (eel)
12/31/2022	Routine Policy Review. Minor revisions only. (cjw)

Application

These reimbursement requirements apply to all Blue Medicare HMO, Blue Medicare PPO, Blue Medicare Rx members, and members of any third-party Medicare plans supported by Blue Cross NC through administrative or operational services.

This policy relates only to the services or supplies described herein. Please refer to the Member's Evidence of Coverage (EOC) for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this policy.

Legal

Reimbursement policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and Blue Cross NC reserves the right to review and revise its medical and reimbursement policies periodically.

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