BlueCross BlueShield of Texas

Implementation of Outpatient Payment Policy

Effective August 1, 2020 we will enhance the method used to process claims for outpatient services. To provide greater consistency in claims processing and more accurate payment determination, we will enhance our application of nationally and locally supported payment policies which are designed to support correct coding standards. These enhancements will occur in addition to the policies already in effect and will be implemented for the Medicaid lines of business. Where applicable, outpatient payment policies are aligned with existing professional policies.

Summary of Edits

Policies where similar professional policy are currently in place.

National Coding Policies and Guidelines

Several policies being instituted are based on Centers for Medicare & Medicaid Services (CMS) and American Medical Association (AMA) Policies and Guidelines. In most cases these policies are the same as or similar to the policies already effective for professional claims. We are highlighting some of the more frequently encountered policies.

National Correct Coding Initiative (CCI)

The National Correct Coding Initiative (CCI) is a collection of bundling policies created and sponsored by CMS. Correct Coding Initiative policies are for services performed by the same facility on the same date of service only. Please note that the CCI policies that are applicable to outpatient hospitals services are one version behind the CCI policies applicable to professional claims due to a delayed release from CMS.

- CCI Example
  - A facility bills 74245 (X-ray of the upper GI tract) with 74240 (X-ray; upper GI tract with small intestine). Code 74240 is considered a component of 74245 when performed during the same session and will be denied as such. Modifier exceptions are allowed for unrelated procedures.

- Evaluation and Management (E/M) Services the Same Day as a Medical or Surgical Service
  - Evaluation and Management services billed the same day as a medical or surgical service are included in the payment for the medical or surgical service unless the facility indicates that the Evaluation and Management service is separate and distinct from the medical or surgery and is therefore separately payable.

  - Example: On the same day 66984 (Cataract Removal) is performed, the facility also bills 99213 (Evaluation and Management Service). The E/M service would be denied as part of the surgical fee.

- CMS Bundling Rules
  - There are a number of services/supplies which are covered by CMS but are bundled into the facility payment.
  - Example: 36000 (Insert needle into vein), when billed the same date of service as 29888 (Knee Arthroscopy), will be packaged into the payment for 29888

- AMA Code definitions and appropriateness of codes when used together
    - Throughout the AMA CPT-4 Manual and CMS HCPCS Manual, the publishers have provided instructions on code usage. Blue Cross and Blue Shield of Texas has adopted policies that support correct coding based on the definition or nature of a procedure code or combination of procedure codes. These policies will either bundle or recode procedures based on the appropriateness of the code selection.
    - Example: CPT code 73510 (X-ray, hip, unilateral complete) billed on one line with modifier LT (left side) and on a second line with modifier RT (right side) will be replaced with 73520 (X-ray, hips, bilateral)

CMS's Outpatient Claims Editor (OCE) Policies

The OCE is a software package supplied to Medicare Intermediaries by CMS to edit hospital outpatient claims (bill types 12X, 13X, or 14X). The OCE detects incorrect billing data (e.g., accuracy of units of service, correct modifiers) and reviews each HCPCS and ICD-10-CM code for validity and coverage. Some OCE policies are incorporated into Blue Cross and Blue Shield of Texas current professional claim adjudication process and are already being applied to claims submitted by providers.

CMS releases quarterly updates to the OCE and program memorandums that detail the application of the OCE. For more information about OCE edits, visit the CMS website.

Policies unique to Outpatient Claims

Revenue Code Validation

Revenue codes are 4-digit codes used to classify types of service. They are required for accurate hospital outpatient claims processing. Revenue codes are required for processing of all outpatient facility claims, therefore if revenue codes are not present on a claim line, then the entire claim will be denied. There are also additional rules regarding the appropriate use of revenue codes on outpatient facility claims.

- Many revenue codes are required to be billed with a CPT/HCPCS code. If these revenue codes are not submitted with a valid CPT/HCPCS code, the charges will be denied.
    - Example: Revenue code 510 (clinic) is required to be billed with a HCPCS code. If billed without one, the charges will be denied.

- Alternatively, the CPT/HCPCS codes must be used appropriately with the billed revenue code. If the codes do not match, the charges will be denied.

- Certain revenue codes are not appropriate for use with outpatient hospital claims billed by facilities. If these revenue codes are billed by facilities for outpatient claims, the claims will be denied: Specifically, Room and Board revenue codes 010X-021X are intended to be used only in the inpatient hospital setting. It is inappropriate for these codes to be billed will outpatient hospital bills (bill types 12X, 13X, 14X).

CMS Coverage Rules

CMS also enforces a number of other restrictions before providing reimbursement for services. Some of the policies adopted by Blue Cross and Blue Shield of Texas include:

Questionable Services

- CMS has identified a list of services that it considers questionable, but may be covered depending on the medical circumstances. The majority of the services in this category are services that might be considered cosmetic or elective in a nature. When these services are billed, the service will be denied.

- Examples of questionable services include 15775 (Hair transplant punch grafts) and 58600 (Division of fallopian tube).

Services Not Included in OPPS

- CMS has identified a list of services that are not payable under the OPPS program. These services are primarily excluded because the place of service that these codes would normally be rendered in does not include the outpatient hospital setting. When these services are billed, the service will be denied.
- Examples of services not included in OPPS are 59425 (Antepartum care only) and 99221 (Initial hospital care).

Services Not Recognized by Medicare

- CMS has identified a list of codes that are not recognized under the Medicare program. Some of the codes in this list are reportable through other codes (i.e. C or G codes). When these services are billed, the service will be denied.
- An example of services not recognized by Medicare is 90921 (ESRD services, per month; for patient's age 20 and over) services which should be reported by an outpatient hospital as G0317-G0319 (ESRD services, per month; for patient's age 20 and over, specific number of visits).

Non-Recognized Revenue Codes

- Certain revenue codes are not recognized by CMS. When these revenue codes are billed, the line will be denied.
- An example of this is revenue code 310X (Adult Care).

Important Notes

- These changes will begin for any claims processed on or after May 31, 2020.
- These edits will not affect the provider reimbursement rate. Services will be paid at the same rates as they previously were.
- There are no changes to any other processes, including claims submission, customer service and support, or grievances and appeals.

What to Do if You Have Questions

If you have questions about the information in this document, please contact your provider representative or our provider representative line at (855) 212-1615.

BlueCross BlueShield of Texas

Policy	Description
Add-on Code Policy	Certain procedure codes are commonly carried out in addition to the performance of a primary procedure. These additional or supplemental procedures are referred to as "add-on" procedures and describe additional service associated with the primary procedure. These codes are identified in the AMA CPT Manual with a plus mark ("+") symbol and are also listed in Appendix D of the CPT Manual. Add-on codes in the HCPCS Level II Manual and the ADA Dental Services Manual are identified with "list separately in addition to code for primary procedure" or "each additional" language within the code description. Add-on codes are always performed in addition to a primary procedure and should never be reported as a stand-alone service. When submitting an add-on code and the primary procedure has not been identified on either the same or different claim, then we will not recommend the add-on code for payment as an inappropriately coded procedure. If the primary procedure is not paid for any reason, then we will also not reimburse the add-on code will not be reimbursed also. For example, if 11045 (Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)) is reported, then it is also expected that 11042 (Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less) has also been reported on the same day.
Co-Surgeon Policy	Co-Surgeons are two physicians (from different specialties or subspecialties) working together as primary surgeons, performing distinct parts of a procedure. The modifier used to indicate the services of a co-surgeon is modifier 62 (Two surgeons). Only surgical codes identified by CMS as requiring a co-surgeon will be allowed when reported with modifier 62.

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Policy	Description
National Correct Coding Initiative Policy	The National Correct Coding Initiative (NCCI) for Medicaid is a collection of bundling edits created and sponsored by CMS that fall into two major categories: Column I and Column II procedure code edits (previously referred to as "Comprehensive" and "Component"), and Mutually Exclusive procedure code edits. CCI edits are for services performed by the same provider on the same date of service only and do not apply to services performed within the global surgical period. Each CCI code pair edit is associated with a policy as defined in the National Correct Coding Initiative Policy Manual. **Examples**: **Column I and Column II code pair edit:** 77610 (Hyperthermia generated by interstitial probes(s) billed with 96365 (Intravenous infusion, for therapy, prophylaxis or diagnosis denies 96365 based on standards of medical/surgical practice since IV infusion is routinely given when performing hyperthermia. **Mutually Exclusive procedure code pair edit:** 77610 (Hyperthermia generated by interstitial probes(s) billed with 77620 (Hyperthermia generated by intracavitary probe(s) denies 77620 as mutually exclusive since they are different techniques to produce the same result.

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Policy	Description
National Correct Coding Initiative Supplemental Policy	Some CPT and HCPCS codes are not addressed in the National Correct Coding Initiative (CCI). This omission is primarily because CMS either does not recognize the CPT or HCPCS code or because the service is excluded from the Medicare program. In some cases, CMS instructs providers to utilize a different code in place of a code not recognized by CMS. In instances where CMS does not address specific codes, CCI-equivalent policies have been created to capture inappropriate utilization. **Example:** CMS considers 97014 (Application of a modality to one or more areas; electrical stimulation) to be Invalid for Medicare. Instead, CMS wants providers to bill G0283 (Electrical Stimulation [unattended], to one or more areas for indication[s]) other than wound care, as part of a therapy plan of care). CMS has CCI edits to deny G0283 when billed with G0151 (Services of physical therapist in home health setting, each 15 minutes). Since some providers will still be billing 97014 to commercial health plans, **HCSC** has edits to deny 97014 when submitted with G0151.

BlueCross BlueShield of Texas

Policy	Description
Assistant Surgeon Policy	The modifiers used to indicate the services of an assistant surgeon are: 80 (Assistant Surgeon), 81 (Minimal Assistant Surgeon), 82 (Assistant Surgeon [when qualified resident surgeon not available]), and AS (Physician Assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery). We will deny surgical codes identified by CMS or by the American College of Surgeons (ACS) as not requiring an assistant surgeon. In addition, CMS indicates procedures where assistant surgeons are not allowed unless documentation supports the need for an assistant surgeon.
Anesthesia Policy	When anesthesiologists report surgical claims, the services will be cross-walked to the appropriate general anesthesia service code. When reporting multiple anesthesia services for the same day and for the same patient, the anesthesiologist should report only the general anesthesia service for the procedure with the highest base value, plus the time for all anesthesia services combined. Multiple anesthesia service codes will be processed according to the highest submitted charge as the primary procedure. We will deny the secondary anesthesia services. The HCPCS Manual identifies certain modifiers that indicate the number of qualified individuals for which an anesthesiologist is providing medical direction. When a CRNA or other qualified individual rendering anesthesia services submits a claim, both the anesthesiologist and the CRNA are required to use appropriate modifiers indicating medical direction was provided. The daily hospital management of epidural or subarachnoid continuous drug administration is limited in frequency and duration following a general anesthesia service.

BlueCross BlueShield of Texas

Policy	Description
Bilateral Procedures Policy	A bilateral procedure is a procedure that is performed on both sides of the body at the same session or on the same date of service. Procedures reported with a 50 modifier should only be reported with one unit of service. Some payors may require bilateral procedures to be reported on two lines - one with a 50 modifier and one without, and each with one unit of service. Report procedures that are bilateral in nature on a single claim line, without any modifiers, and with one unit of service.
Bundled Services Policy	There are several services/supplies for which payment is bundled into the payment for other related services, whether specified or not. The list of bundled services is based on CMS National Physician Relative Value File.
Deleted HCPCS Codes Policy	Procedure codes, such as Level II HCPCS and AMA CPT-4 codes, undergo revision by their governing entities on a regular basis. Revisions typically include adding new procedure codes, deleting procedure codes, and redefining the description or nomenclature of existing procedure codes. These revisions are normally made on an annual basis by the governing entities with occasional quarterly updates. Claims received with deleted procedure codes will be validated against the date of service. If the procedure code is valid for the date of service, then the claim will continue processing. If the procedure code is no longer valid for the date of service, then the claim will be processed in one of two ways: mapping to the comparable new code or denying.
Duplicate Services Policy	In alignment with our existing policy, editing for duplicate services will be enhanced to review claims submitted on both the CMS 1450 and CMS 1500 form for Ambulatory Surgical Center (ASC) claims.
Diagnosis-Gender Policy	Certain diagnosis codes are gender specific. When reporting one of these diagnoses and it does not match the gender of the patient, then we will deny all services on the claim. For example, a cyst of the prostate (ICD-10 code N42.83) is restricted to male patients.

BlueCross BlueShield of Texas

Policy	Description
Diagnosis Procedure Policy	Certain sources such as National CMS policies (i.e., National Coverage Determinations [NCDs]), Regional CMS policies (i.e. Local Coverage Decisions [LCDs]), industry publications, and other clinical expertise sources publish appropriate indications for procedures. We will not consider procedures reported with an inappropriate diagnosis for reimbursement.
Evaluation and Management Services Policy	The American Medical Association defines a new patient as "one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years". Otherwise, the patient is considered an established patient. You should bill only one Evaluation and Management (E/M) code for a single date of service by the same provider group and specialty, regardless of place of service. Gynecologic screening services are included in preventive medicine visits. Peak expiratory flow rate and visual function screening are components of E/M services and eye exam codes. You should report annual exams or screening services as new or established patient preventative medicine visits, not as consultations. Only one inpatient admission or inpatient consultation service is allowed per week by the same provider group and specialty. An initial E/M service for patients with diabetic loss of protective sensation (LOPS) is required if follow-up E/Ms are to be considered for reimbursement and are only to be reported once per group practice.

BlueCross BlueShield of Texas

Policy	Description
Global Surgery Policy	The Global Surgery Package includes all necessary services normally furnished by the surgeon before, during and after a surgical procedure. The Global Surgery Package applies only to surgical procedures that have post-operative periods of 0, 10 and 90 days. The global surgery concept applies only to primary surgeons and co-surgeons. The following items are included in the Global Surgery Package: preoperative and same day E/M visits after the decision is made to operate; all post-operative E/M visits and services for 10-day and 90-day surgeries related to the primary procedure in accordance with CMS guidelines.
Diagnosis Validity Policy	Diagnosis (ICD) codes undergo revision by their governing entities on a regular basis. Revisions typically include adding new diagnosis codes, deleting codes, and redefining the description or nomenclature of existing diagnosis codes. These revisions are normally made on an annual basis (October 1) by the governing entities. Claims received with invalid diagnosis codes will be corroborated with the date of service. If the diagnosis code is valid for the date of service, then the claim will continue processing. If the diagnosis code is invalid for the date of service, then the claim line will be denied.
Incident To Services Policy	Incident To services are those services furnished as an integral, although incidental, part of the physician's personal professional services during diagnosis or treatment of an illness or injury according to CMS guidelines. Incident To services should not be reported in an inpatient hospital, outpatient department (including the emergency department), military treatment facility setting, or other facility.
Maximum Units Policy	All procedure codes have been assigned a maximum number of units that may be reported per day for a member, regardless of the provider, based upon on criteria such as, procedure code definition or nomenclature, anatomical site, CMS sources, clinical guidelines, or state sources. For example, some fetal procedures are limited to 1 per day, due to there being a single gestation. Additional units are allowed for multiple gestations. Other codes allow more than 1 unit, based on the diagnostic indication. For instance, level IV surgical pathology is allowed differing units, based on the condition that is reported.

BlueCross BlueShield of Texas

Policy	Description
Once Per Lifetime Services Policy	Certain procedures would be inappropriate to be reported more than once per lifetime due to anatomical and other considerations (e.g. appendectomy).

BlueCross BlueShield of Texas

Policy	Description
Global Obstetrical Policy	The American Medical Association and the American College of Obstetricians and Gynecologists define the global obstetrical package for uncomplicated maternity cases as including the following services: **Antepartum Care (approximately 13 visits)** • Initial and subsequent history • Physical examinations • Recording of weight, blood pressure and fetal heart tones • Routine urine dipstick analysis • Monthly visits up to 28 weeks gestation • Biweekly visits up to 36 weeks gestation • Weekly visits from 36 weeks gestation until delivery **Delivery Services** • Admission to the hospital • Admission history and physical examination • Management of uncomplicated labor • Vaginal or cesarean delivery **Postpartum Care** • Routine hospital visits • Routine office visits during global period Separate reimbursement for those services which are included in the global obstetrical package for uncomplicated maternity cases is not allowed. Evaluation and Management services or Postpartum care is not allowed by the same provider that performed the delivery within the 6 weeks following the delivery. If a provider provides all or part of the antepartum care but does not perform the delivery due to reasons such as termination of pregnancy by abortion or referral to another provider for delivery, then the provider should bill the antepartum care using the appropriate E/M or antepartum care only code. It is not appropriate for a single provider to bill more than one antepartum care code in any combination during the antepartum period. Cerclage removal is included in the delivery fee.

BlueCross BlueShield of Texas

Policy	Description
Procedure Code Definition Policy	The AMA CPT Manual assigns specific definitions to describe each procedure code. To support correct coding, these policies will either deny or change procedure codes based on the appropriateness of the code selection as directed by the definition and nature of the procedure code.
Procedure Code Guideline Policy	The AMA CPT Manual includes specific reporting guidelines which are located throughout the Manual and at the beginning of each section. To ensure correct coding, these guidelines provide reporting guidance and should be followed when submitting specific procedure codes.
Procedure-Age Policy	Certain procedure codes, by definition or nature of the procedure, are limited to the treatment of a specific age or age group. For example, preventive medicine services code 99382 is limited to patients 1 through 4 years of age.
Procedure-Gender Policy	Certain procedure codes, by definition or nature of the procedure, are limited to the treatment of one gender. For example, code 58150 (Total abdominal hysterectomy) is limited to female patients.

BlueCross BlueShield of Texas

Policy	Description
Professional, Technical, and Global Services Policy	Diagnostic tests and radiology services are procedure codes that include two components: professional and technical. The professional component describes the physician work portion of a procedure which consists of interpretation and a report and is represented by a procedure code with a modifier 26. The technical component describes the technical portion of a procedure, such as the use of equipment and staff needed to perform the service and is represented by a procedure code with modifier TC. The global service represents the sum of both the professional and technical components and is represented by the CPT/HCPCS code for the service without modifiers 26 and TC. Only procedure codes designated as diagnostic tests or radiology services have the two individual components. Reimbursement of diagnostic tests and radiology services is limited to no more than the amount for the global service. Diagnostic tests or radiology services submitted with a place of service outside of the office setting should be reported using the appropriate professional component modifier. Professional radiology services should not be reported by a non-radiologist in the inpatient or outpatient hospital setting. Professional radiology services should not be reported in the office setting in conjunction with an evaluation and management service when reading or overreading of outside films was the service performed. Professional Component Only services are stand-alone procedures that describe only the professional component of a given procedure (e.g., interpretation and report only). These codes identify the physician work portion of selected diagnostic procedures that have associated codes to describe the technical and global components of these procedures. It is inappropriate to bill these procedure codes with professional or technical component modifiers as neither of these modifiers is applicable to this group of procedure codes. Technical Component Only services are those that are stand-alone and describe only the technical component of a given procedure without the use of the technical component modifier. Procedures should not be reported in the inpatient hospital, outpatient hospital, emergency department, or ambulatory surgical center using a technical component modifier. The technical component of diagnostic tests and radiology services will be reported by the facility in these settings.

BlueCross BlueShield of Texas

Policy	Description
Professional, Technical, and Global Services Policy (continued)	Many clinical laboratory services do not have associated professional components. When a provider bills for one of these clinical laboratory services with a professional component modifier, the clinical laboratory service will be denied. The interpretation of laboratory results is included in the payment for E/M services. It is inappropriate for pathologists to bill for laboratory oversight and supervision through use of this modifier. Reimbursement for laboratory oversight and supervision is obtained through the hospital or independent laboratory. Certain procedure codes, such as office visits and surgical procedures, describe physician services. These services do not have separate professional and technical components. Therefore, it is inappropriate to use professional and/or technical component modifiers with these procedure codes.
Split Surgical Care Policy	Split surgical care occurs when different physicians furnish either the pre-operative, intra-operative or post-operative portions of the global surgical package. Split surgical care is only applicable to providers of different Tax ID groups or providers within the same Tax ID group but with different specialties. Providers within the same Tax ID group and same specialty are treated as a single entity and may not bill split surgical care. When split surgical care occurs, each provider is reimbursed according to the portion of surgical care they provided. The three portions of surgical care are: Preoperative; Intraoperative (or Surgical Care Only); and Postoperative. Modifiers 54, 55 and 56 are appropriate for use only with procedure codes that have a 10-day or 90-day postoperative period. It is not appropriate to append these modifiers to E/M services, 0-day surgical services, or any other service that does not have a 10-day or 90-day postoperative period.
Separate Procedures Policy	The description for many CPT codes includes a parenthetical statement that the procedure represents a "separate procedure". The inclusion of this statement indicates that the procedure should not be reported when it is performed in conjunction with, and related to, a major service.

BlueCross BlueShield of Texas

Policy	Description
Diagnosis-Age Policy	Certain diagnosis codes are age specific. When one of these diagnoses is reported and it does not match the age of the patient for that date of service, then all services on the claim will be denied. For example, a newborn diagnosis must be associated with a member less than 30 days old.
Place of Service Policy	Certain codes are allowable only in specific places of service. For example, hospital admission codes (99221-99223) can only be reported for hospital places of services such as POS 21 (Inpatient hospital), or POS 51 (Psychiatric inpatient facility).
Frequency Policy	Services should be reported with appropriate frequency.
Observation Services Policy	Observation services are services furnished on an outpatient basis on a hospital's premises and include the use of a bed and periodic monitoring by nursing or other staff. Such services are necessary to evaluate a patient's condition to determine the need for possible admission. Observation services are only covered when ordered by a physician and usually do not exceed one day. However, a second day may be required. These observation services should be reported with the appropriate bill types and revenue codes.
Revenue Code Policy	Revenue codes are 4 digits in length and are used to identify a specific accommodation, ancillary service or billing calculation. The National Uniform Billing Committee (NUBC) defines the use of revenue codes. Certain revenue codes are required to be accompanied by a HCPCS code.
Device and Supply Policy	CMS has established a device/implant procedure link and an implant procedure/device link. A device/implant should be reported with an appropriate procedure and vice versa.
CMS Coverage Policies	CMS has established several items and services that require specific reporting guidelines. These guidelines are based on specific CMS requirements such as published in the Internet Only Manuals, Physician Fee Schedules, and/or the Outpatient Prospective Payment System.

BlueCross BlueShield of Texas

Policy	Description
Partial Hospitalization Policy	Partial hospitalization is a distinct and organized intensive outpatient day treatment. Partial hospitalization services are furnished by a hospital or community mental health center (CMHC). CMS reimburses partial hospitalization services on a per diem basis. These services should be reported with the appropriate condition codes and bill types. A mental health diagnosis code is also required.
Modifier Processing Policy	Modifiers play a significant role in claims processing. They are used to convey that a service has either been altered in some way or that a significant circumstance surrounds that service and that this information needs to be considered for claims processing. Absence of an appropriate modifier or presence of an inappropriate modifier does not support correct coding.
Modifier Policy	Most modifiers have descriptions indicating that the procedure applies to a specific anatomic site, that the services were performed distinctly from other services, or that there were special circumstances surrounding the performance of the services. Inappropriate procedure-modifier combinations will not be considered for reimbursement. For example, procedural modifiers would be inappropriately reported on evaluation and management codes.
Team Surgery Policy	Under some circumstances, highly complex procedures are carried out by a team of physicians. In a team surgery setting, the physicians are typically of different specialties and include other highly skilled specially trained personnel. Only surgical codes identified by CMS as requiring a team to complete the procedure will be allowed when reported with modifier 66.

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Policy	Description
Ambulatory Surgical Center (ASC) Policy	CMS has established a list of procedures that may be performed safely in an ASC setting. These procedures are those that generally do not exceed 90 minutes in length and do not require more than four hours recovery or convalescent time. Physician services are covered separately and should be submitted to the Part B Carrier. According to CMS policy, separate payment may be made for certain drugs and biologicals, certain radiology services, certain devices, and certain brachytherapy sources that are provided integral to a covered surgical procedure in an ASC. These services will be denied when billed without an ASC surgical procedure for the same date of service. In addition, payment is only allowed for the insertion of new technology intraocular lenses (NTIOLs) when performed in the ASC setting.
CMS National Coverage Determinations (NCD) Policy	CMS limits reimbursement of certain items and services to those that are reasonable and necessary for the treatment of an illness or injury. The policies that include what is reasonable and necessary are known as National Coverage Determinations (NCD's). Each NCD is created through an evidence-based process and are published by CMS.
Claims Processing Parameters Policy	According to CMS policy, providers must have valid and active billing privileges at the time that services are rendered to receive Medicare payments. A provider may have his or her National Provider Identifier (NPI) deactivated under certain circumstances, such as when a provider is deceased or out of business.