CONSISTENCY GUIDELINES

File Name: consistency_guidelines
Origination: 1/2000
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 Blue Cross NC.

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

Medical Policy Advisory Group - 9/2001

Medical Policy Advisory Group - 10/2003

Medical Policy Advisory Group - 03/10/2005

Medical Policy Advisory Group - 03/24/2006

Payment Policy Governance Committee – 10/14/2013

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Commercial Reimbursement Policy

Reimbursement Policy Oversight Committee review – 9/2016

History

1/00	Implementation
3/00	Reference to Blue Edge removed.
5/01	Changes in formatting.
9/01	Medical Policy Advisory Group review. No changes in policy.
11/01	Coding format change.
11/02	Policy reviewed. No changes in policy.
12/02	Policy reviewed and typo's corrected.
10/03	Medical Policy Advisory Group review. Information added to Billing and Coding section and to Benefit Application section. Information added regarding when codes may be added to the claim for inappropriate code submission.
11/03	Corrected Benefit Application section. Added information regarding services provided for patients who have previously had that organ removed.
4/07/05	Medical Policy Advisory Group reviewed policy on 03/10/2005. No changes in policy.
5/08/06	Medical Policy Advisory Group review 3/24/06. No change to policy criteria. Policy number added to the Key Words Section.
3/26/07	Under the section, "Policy for", added Blue Advantage. Medical Policy reviewed by Senior Medical Director of Network Support. Policy status changed to: "Active policy, no longer scheduled for routine review".
6/22/10	Policy Number(s) removed (amw)
10/29/13	Policy re-activated and reformatted. Description section updated for clarity. Guidelines reviewed and approved by Payment Policy Governance Committee. (adn)
5/13/14	Policy category changed from "Corporate Medical Policy" to "Corporate Reimbursement Policy". No changes to policy content. (adn)
4/28/15	Routine policy review. No changes to policy content. (adn)
12/30/16	Routine policy review. All references to gender removed. (an)
12/29/17	Routine policy review. No changes to policy content. (an)
12/14/18	Routine policy review. No changes to policy content. (an)
1/14/20	Routine policy review. Senior medical director approved 12/2019. No changes to policy statement. (an)
12/31/20	Routine policy review. Medical director approved 12/2020. No change to policy statement. (eel)
4/20/21	Policy format update. No changes to policy statement. (eel)
12/30/21	Routine policy review. Medical Director approved. (eel)
6/1/22	Policy language updated throughout. Age group definitions updated. Medical Director approved. **Notification on 3/31/2022 for effective date 6/1/2022**. (eel)
12/31/2022	Routine policy review. Minor revisions only. (ckb)

Application

These reimbursement requirements apply to all commercial, Administrative Services Only (ASO), and Blue Card Inter-Plan Program Host members (other Plans members who seek care from the NC service area). This policy does not apply to Blue Cross NC members who seek care in other states.

This policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet 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.