CONSISTENCY GUIDELINES

File Name: consistency_guidelines
Origination: 1/2000
Last Review: 4/2021
Next Review: 12/2021

Description

Claims review for appropriateness of member age with the services provided:

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: 1-11 years
- Adolescent: 12-17 years
- Pediatric: 0-17 years (Includes newborn/neonatal, infant, child and adolescent)
- Adult: 15 years and above
- Maternity: 12-55 years
- Geriatric: 70 years and above

Claims review for lifetime procedure duplication:

Certain procedures, by definition or nature of the procedure, can only be performed once in a member's lifetime.

Policy

Claims for services will be reviewed for appropriateness of member's age.

Addition of Alternate Code; if a conflict is noted between the member's age and the services provided, the incorrect procedure is assigned a denial status code of 'AGE' and the appropriate procedure code for the member's age will be added whenever possible.

Services provided will be reviewed for history of similar procedure.

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.

Services will not be allowed if the claim indicates that a surgical procedure was performed on a patient who previously had that organ removed. (e.g., cholecystectomy, hysterectomy).

Rationale

Whenever possible, the correct code for the member's age will be added when claims are filed with conflicts with the member's age.

Services inappropriate for the member's age will not be allowed.

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 looks at all diagnoses on a claim.

Claims for services performed on individuals who have previously had that organ removed will not be allowed.

Billing and Coding

Applicable codes are for reference only and may not be all inclusive. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross NC web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

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

Related policy

n/a

References

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)

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.