Policy Guidelines for Denial of Redundant Services – Revised 20250826

Provider Partner Health Plan (PPHP) Policy Title: Denial of Redundant Chronic Care Management (CCM) and Advance Care Planning (ACP) Claims
Effective Date: 10/1/2025
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Purpose

To establish clear, actionable guidelines for identifying and denying claims for services deemed redundant due to the existing care model provided by PPHP-employed or contracted Nurse Practitioners (NPs). This policy promotes compliance with Medicare billing regulations, optimizes resource use, and ensures consistent, high-quality care for members while addressing patterns of fraud, waste, and abuse.

Scope

This policy applies to all CCM and ACP claims submitted to Provider Partner Health Plan for Medicare Advantage members. This policy does not apply to claims submitted by providers specializing in oncology.

Definitions

- Redundant Services: Services that duplicate care already provided by plan NPs, as identified through documentation and billing review.
- Chronic Care Management (CCM): Coordinated services for members with multiple chronic conditions requiring ongoing medical oversight.
- Advance Care Planning (ACP): Discussions and documentation regarding a member's preferences for future care in the event of serious illness or incapacity.
- Plan Nurse Practitioners (NPs): Clinicians employed or contracted by PPHP to deliver CCM and ACP services under the plan's model of care.

Policy Statement

PPHP reserves the right to deny CCM and ACP claims submitted by external providers when such services are redundant to those provided by plan NPs. These denials aim to eliminate unnecessary duplication, ensure compliance, and enhance care coordination. This policy excludes oncology providers, whose services are not subject to redundancy determinations under this policy.

Criteria for Redundancy

A CCM or ACP claim will be deemed redundant and subject to denial if all of the following conditions are met:

1. The member is actively receiving CCM or ACP services from a plan NP and
2. The external provider's services:
    - Fall within the same timeframe and scope as those of the NP and
    - Do not add materially to the member's care or address unique needs not already managed and
3. The external provider fails to justify medical necessity through documentation, or the documentation does not meet established standards (see Section 6).

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The procedure codes listed in Attachment A as subject to rejection will be auto-denied when submitted by external providers, without individualized medical necessity review, unless specifically exempted.

Collaborative care codes are not exempt and will be evaluated under the same criteria.

Denial and Appeals Process

1. Claim Review and Denial

Claims meeting redundancy criteria will be denied with appropriate CMS denial codes, such as:

- CARC 54 – "Multiple physicians/assistants are not allowed to bill separately for services that are part of the same procedure."
- RARC M86 – "Service denied because payment already made for same/similar procedure to another provider."

For codes designated in Attachment A as auto-deny, PPHP will reject the claim at initial submission without clinical review, unless the provider has demonstrated prior authorization or appeal success.

2. Provider Appeals

Denied providers may appeal by submitting documentation demonstrating:

- That services were not redundant.
- That services addressed unique member needs.
- Other justification per Medicare billing guidelines.

Appeals will be reviewed by a cross-functional committee including compliance and clinical leadership.

Documentation Standards

To support claims and avoid denials, providers must maintain:

- Detailed records of services rendered.
- Evidence of member engagement.
- Clinical justification and unique care components.
- Relevant forms (e.g., MOLST, advance directives).
- Documentation aligned with Medicare billing standards.

Communication of Denials

Denial notifications will include:

- Explanation of the redundancy determination.
- Reference to this policy and applicable documentation standards.
- Instructions for appealing the decision.

Member Communication

- Members will be informed about the role of plan NPs and the policy on redundant services at enrollment and annually.
- Members retain the right to see external providers, but redundant services may not be covered.

Compliance and Auditing

Due to high claim volumes, PPHP will apply a provider-level auditing and sampling strategy:

- Providers submitting high volumes of CCM and ACP claims may be audited.
- Noncompliance will result in inclusion on an auto-deny list, where future related claims are denied without individualized review.
- Providers may be removed from the list upon demonstration of sustained compliance through documentation audits.

Codes listed in Attachment A as denied under this policy are not subject to provider-level exception or sampling and will be systematically rejected unless PPHP authorizes an exception in writing.

The SIU will review potentially abusive or fraudulent behavior and may escalate cases to regulatory authorities.

Plan NPs are required to document services consistently to establish a strong baseline for identifying redundancy.

Policy Review

This policy will be reviewed annually or sooner if there are changes to CMS regulations or operational needs. This policy is subject to change at any time based on updates to clinical guidelines, operational procedures, regulatory requirements, or internal plan decisions intended to improve care coordination and compliance.

References

- CMS Guidelines on CCM and ACP Services
- Medicare Managed Care Manual
- PPHP Provider Manual

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Attachment A – Procedure Codes Applicable to This Policy

A. Procedure Codes That Will Be Rejected Under This Policy

The following codes will be rejected under the Redundant Services Policy when billed by external providers:

Code	Description
99424	Principal care management services first 30 minutes (physician)
99425	Principal care management services each additional 30 minutes
99426	Principal care management, first 30 minutes of clinical staff time
99427	Principal care management services each additional 30 minutes
99437	CCM, each additional 30 minutes of clinical staff time
99439	CCM, each additional 20 minutes
99453	RPM setup and education
99454	RPM device supply and transmission
99457	RPM treatment management, 20 minutes/month
99458	RPM treatment management, each additional 20 minutes
99487	Complex CCM, first 60 minutes/month
99489	Complex CCM, each additional 30 minutes
99490	CCM, first 20 minutes of clinical staff time
99491	Chronic care management by physician, 30 minutes
G0023	Principal illness navigation (PIN) – auxiliary personnel
G0024	Principal illness navigation – other provider
G0140	PIN peer support by auxiliary personnel
G0146	PIN peer support, additional 30 minutes

B. Procedure Codes Billed Internally by PPHP

The following codes are documented within PPHP's own care model and billed by plan-employed staff:

Code	Description
99426	Principal care management, first 30 minutes of clinical staff time
99490	CCM, first 20 minutes of clinical staff time

C. Procedure Codes That Will Be Allowed (with Monitoring)

These codes are allowed for external provider billing but will be monitored via a monthly report process:

Code	Description
99484	Care management for behavioral health conditions
99497	ACP, first 30 minutes
99498	ACP, each additional 30 minutes

D. Rejection Code

Comment Code U1033 "Service denied because payment already made for same/similar procedure to another provider"

- **CARC: 54** – *"Multiple physicians/assistants are not allowed to bill separately for services that are part of the same procedure. Payment has been made to another provider for this service."*
- **RARC: M86** or **N517**
    - **M86:** *"Service denied because payment already made for same/similar procedure to another provider."*