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Description

Blue Cross and Blue Shield of Vermont (Blue Cross VT) utilizes clinical claims editing software to facilitate accurate claim processing for claims for services provided to members of Blue Cross VT commercial health plans. This policy provides an overview of the system as well as a description of the edits.

As used in this policy, an "edit" refers to the practice by which one or more rule recommendations are made to CPT® or HCPCS Level II codes included in a claim that result in: (1) reimbursement being made based on some, but not all, of the CPT®/HCPCS codes included in the claim, (2) reimbursement being made based on different CPT®/HCPCS codes than those included in the claim, (3) reimbursement for one or more of the CPT®/HCPCS codes included in the claim being decreased by application of multiple procedure logic, and (4) reimbursement for one or more of the CPT®/HCPCS codes being denied, or any combination of the above. Where an appropriate replacement procedure code or quantity exists, an edit may also involve denial of the incorrect procedure code or quantity and addition of a new claim line with the appropriate procedure code or quantity for processing.

Legislative and Regulatory Guidelines

18 V.S.A. § 9418a as amended by Vt. Act 111 effective January 1, 2025

Related Policies

CPP_22 Modifiers -52, -53, -73, -74 Reduced, Discontinued Services Payment Policy

CPP_50 Modifier -62 Two Surgeons Payment Policy

CPP_51 Modifiers -76, -77, -78, -79 Repeat, Unplanned & Unrelated Procedures Payment Policy

Policy Implementation/Update Information

This policy was originally implemented on January 1, 2021

Date of Change	Effective Date	Overview of Change
December 9, 2022	December 9, 2022	Added (1) Document Precedence details (2) Cotiviti, Inc., information to the Overview (3) Cotiviti, Inc., claim edits as noted in the effective date field of each edit and (4) removed three ClaimsXten-Select™ Anesthesia claim edits; Anesthesia Multiple Crosswalk, Anesthesia Not Eligible to Bill and Anesthesia Standard Crosswalk as they were implemented and retracted retroactively to January 1, 2021.
December 5, 2022	January 1, 2023	The Consultations Outpatient Edit removed code 99241 as it is an expired code as of January 1, 2023. The Cotiviti, Inc., Edits were moved to a January 13, 2023, effective date. The Inpatient Only Services Edit had a note added for the use of place of service 22 (outpatient).

January 23, 2023	April 1, 2023	Added the following new code edits:
		• Durable Medical Equipment (DME) Maximum Units Over Time
		• Evaluation and Management
		  ○ Note: the edit for Multiple Evaluation and Management Services on the Same Date has been in effect since January 13, 2023.
		• Multiple Endoscopy
		• Multiple Procedure Reduction (MPR)
		• Multiple Procedure Reduction (MPR) for Cardiovascular Services
		• Multiple Procedure Reduction (MPR) for Ophthalmology Services
		• Place of Service
		  ○ Note: the following edits have been in effect since January 13, 2023, however, just recategorized under Place of Service Code edit category—(1) Inpatient Only Services (2) Physician Fee Schedule Non-Facility NA

		Indicator (3) Laboratory Services billed by a Physician and (4) Professional Component of Radiology Services in Facility Place of Service • Revenue Code Implant Procedures Requires Implant Devices Edit • Added additional Source—Expert Specialty Review Panel • Added to Definition—Implant device(s) billed without an associated implant procedure are denied • Added a note to refer to Revenue Code section as well for further details Bundled Services (Cotiviti, Inc.) Edit clarified the definition Removed the red font from the Cotiviti code edits that are effective January 1, 2023, to Blue.
October 5, 2023	October 5, 2023	• Bundled Services (Cotiviti, Inc.) ○ Revised Claim Type reference to remove outpatient and clarify it is only for Comprehensive Outpatient Rehabilitation Facilities and Outpatient Physical Therapy ▪ Updated Claim Type: Professional claims, billed on a CMS 1500 form, Comprehensive Outpatient Rehabilitation Facilities (CORF), Outpatient Physical Therapy (OPT), and Ambulatory Surgical Centers (ASC) ○ Revised description to clarify how the edit works for each claim type • Cotiviti claim validation in the overview section and under each CV edit revised to provide clarity of process
November 8, 2023	November 3, 2023	Added reference to coding tip sheet that are available on the provider website.
November 14, 2024	January 01, 2025	Update to remove mention to the pre-payment Coding Validation (CV) program to comply with Act 111. Added clarifying language and updated verbiage as

		appropriate to the following edits:
		
		• Ambulatory Surgical Center (ASC) – Cotiviti, Inc.
		  ○ Added language to clarify that other edits do apply to ASC facilities such as modifier edits, maximum units edits, bundled services, professional and technical component edits, global services and multiple procedure reduction edits.
		• Anatomical Modifiers – Cotiviti, Inc.
		  ○ Only applies to professional claims
		  ○ Sourced from AMA CPT® Manual
		  ○ Clarified language in the modifier grid
		  ○ Added language relating to maximum units edit as related to anatomical modifiers
		• Assistant Surgeon – Cotiviti, Inc.
		  ○ Modifier AS reimbursed at 13.6% of the allowed amount (to match Provider Handbook language)
		• Assistant Surgeon Modifiers - ClaimsXten-Select™
		  ○ Spelled out American College of Surgeons (ACS). Deleted AMA.
		• Consultations Outpatient
		  ○ Updated codes within the grid (deleted 99212, added 99215)
		• Clarified language in Device and Supply – Brachytherapy Source – Cotiviti, Inc.
		• Clarified language in Frequency Additional Services – Cotiviti, Inc.
		  ○ Deleted “Preventive Services”
		  ○ Added Definition language
		  ○ Added frequency to “Not Pre-Diabetic” screening
		  ○ Added Presumptive drug testing
		  ○ Added Definitive drug testing
		
		Deleted the following edits that were deactivated in the course of 2024:
		• Bundled Facility Services – Cotiviti, Inc./ Deactivated **Only** the following modules within this edit:

		○ Pre-Admission Diagnostic Services ○ Nondiagnostic Services ○ Durable Medical Equipment (DME) • Durable Medical Equipment (DME) Maximum Units Over Time • Under Evaluation and Management – Cotiviti, Inc. Deactivated and deleted **Only** the following module**:** ○ X. Transitional Care Management (TCM) Services, Inpatient Neonatal and Pediatric Critical Care and Intensive Care Services, Newborn Care Services, Pediatric Interfacility Transport Services and Critical Care Services. • Under Place of Service – Cotiviti, Inc. Deactivated and deleted **Only** the following modules: ○ XII. Laboratory Services billed by Physicians ○ XV. Professional Component of Radiology Services in Facility Places of Service • Pre-Admission Outpatient Services Inclusive to an Admission
July 17, 2025	October 1st, 2025	• Removed Specialty Review Panel Content from all edits that had this component. Clarified and/or added verbiage to the following Cotiviti Edits: • Clarified the Co-surgeon edit by adding Outpatient Facility Claims submitted on a UB-04 as a claim type. • Added verbiage regarding Split Surgical Care edit. • Added verbiage regarding the Modifier edit. • Clarified source in Place of Service edit to CMS only. • Clarified source in Duplicate Services edit by adding CMS. • Added verbiage to define Multiple Procedure Reduction for Radiology edit.
September 15, 2025	December 1st, 2025	Code Edits being deactivated: • Multiple Inpatient Admission or Consultation From Maximum Units Policy: • Daily Maximum Units • Excess units when the same provider bills a certain number of units of team surgery or co-surgery that

		exceed the daily assigned allowable unit(s) for that procedure for the same member • Annual Maximum Units • Maximum Units Per Day for Outpatient Hospitals From Place of Service Policy: • Special Services, Procedures and Reports From Device and Supply Policy: • Brachytherapy Source • Diagnostic and therapeutic Add-on Code Policy From Frequency Policy: • Ocular photography more than twice a year Added verbiage for Device and Supply Policy – Implant Procedure Requires Implant Device From Revenue Code Policy: • 0300 0319 (Laboratory/Pathology) • 0320 0359, 0400 0409, 0610 0619 (Radiology) • 0636 (Drugs requiring detailed coding) From Anesthesia Policy: • Anesthesia for vaginal or cesarian delivery (01961, 01968 or 01969) when anesthesia for cesarian delivery has been billed in the past 240-day period. <u>Exception:</u> Anesthesia for a subsequent vaginal delivery or cesarean delivery reported within an 8-month period following anesthesia reported for a for a cesarean delivery and modifier -52 or -53 is appended to the service. Verbiage added for: • Code Edit - Global Obstetrical
January 1, 2026	October 16, 2025	Policy reviewed. Minor formatting changes for clarity and consistency. Added Related Policies in policy section.
October 1, 2026	January 1, 2027	Deleted the following edits that correspond to expired Global Maternity codes: • Global Obstetrical • Obstetrics Package Removed the following references to expired global maternity codes in Assistant Surgeon edit: • CPT® 59510 (global obstetrical care, cesarian delivery) is denied when billed with an assistant surgeon modifier

		• CPT® 59618 (global obstetrical care, cesarean delivery, following failed VBAC) is denied when billed with an assistant surgeon modifier
		Removed following sections which are represented in the Payment Policy Guideline Document • Benefit Determination Guidance, Eligible Providers, Audit Information and Document Precedence Deleted the following edits that correspond to expired Global Maternity codes: • Global Obstetrical • Obstetrics Package Removed the following references to expired global maternity codes in Assistant Surgeon edit: • CPT® 59510 (global obstetrical care, cesarian delivery) is denied when billed with an assistant surgeon modifier • CPT® 59618 (global obstetrical care, cesarean delivery, following failed VBAC) is denied when billed with an assistant surgeon modifier Information regarding vendors has been removed from the payment policy and has been posted to the website

Approved by:

Tom Weigel, MD 10/19/2026

Tom Weigel, MD Date
Chief Medical Officer

Margaret Pinello-White 10/19/2026

Margaret Pinello-White Date
Chief Administrative Officer

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Code Edit: Age Code Replacement

Effective Date: January 1, 2021
Claim Type: Professional Claims, CMS 1500
Source: AMA, CMS

Definition: Identifies claim lines containing procedure codes that are inconsistent with the member's age for which an alternative code is more appropriate for the age.

When an age inconsistency is identified on a claim, the code(s) in question are denied.

Where an appropriate replacement procedure code exists, the inappropriate procedure code is denied and a new claim line with the appropriate procedure code may be added to the claim and processed accordingly.

Code Edit: Ambulatory Surgical Center (ASC)

Effective Date: January 13, 2023
Claim Type: Ambulatory Surgical Claims
Source: CMS, Provider Contract

Definition: An ASC is a distinct entity that operates exclusively to furnish same-day surgical care to patients who do not require hospitalization. This edit addresses procedures that are not listed on the ASC approved procedure list for claims submitted with an ASC bill type (083x) and Place of Service 24.

This edit identifies procedures and ancillary services that are covered or not covered when performed in an ASC.

Other edits apply to ASC facilities as appropriate and outlined in this document such as appropriate usage of modifiers, maximum units policy, bundled services, professional, technical, and global services policy and multiple reduction policy.

Code Edit: Anesthesia

Effective Date: January 13, 2023

Claim Type: Professional Claims, CMS 1500 and Outpatient Facility Clams submitted on a UB-04
Source: CMS Correct Coding Initiative (CCI), HCPCS Level II Manual, ASA Relative Value Guide, American Society of Anesthesiologists

Definition: Multiple General Anesthesia Services on the same Day: Only one anesthesia code should be reported for a single date of service unless the second anesthesia code is an add-on code or has an appropriate modifier attached. When multiple general anesthesia services are performed on the same day, only the procedure with the highest base value should be reported, plus the time for all anesthesia services combined. Therefore, when multiple general anesthesia services (00100 through 01999) are billed for the same day, the highest submitted charge amount is paid, and the secondary anesthesia services are denied.

Additionally, when multiple Certified Registered Nurse Anesthetists (CRNA) services (00100 through 01999) identified by modifiers -QX (CRNA services with medical direction by a physician) or -QZ (CRNA services without medical direction by a physician) are submitted, the highest submitted charge is paid, and the secondary services are denied.

The following anesthesia services are excluded:

- 01953 (Anesthesia, burn, each additional 9 percent)
- 01968 (Anesthesia cesarean delivery add-on)
- 01969 (Anesthesia cesarean hysterectomy add-on)
- 01996 (Hospital Management Continuous Drug Administration and IV PCA)

Procedures containing a modifier that indicates separate and distinct services are allowed separately.

<u>Anesthesia Policy Edits also audit the following scenarios for coding appropriateness</u>

- Out of Sequence for Multiple General Anesthesia Services on the Same Day (Bundled Edits)
- Certified Registered Nurse Anesthetist (CRNA). Services billed without the appropriate CRNA modifier (-QX, or -QZ) are denied
- Medical Supervision and Medical Direction of Anesthesia Services. (Example: Anesthesiologist's claim without medical supervision/direction modifiers is denied if a CRNA claim with medical direction exists. CRNA claim billed without medical direction is denied if an anesthesiologist’s claim with a medical direction or medical supervision modifier exists)
- Daily Management of epidurals or subarachnoid continuous drug administration (01996) is edited when billed with anesthesia qualifying circumstance codes (99100 through 99140) and billed without an anesthesia procedure code (00100 through 01992). Physical status modifier codes are also edited in these circumstances (-P1, -P2, -P3, - P4, -P5 and -P6)
- Anesthesia services billed without the appropriate anesthesia modifiers

- Anesthesia services when billed with multiple anesthesia modifiers on the same claim line. Mutually exclusive edits.
- Anesthesia for gastrointestinal endoscopic procedures and monitored anesthesia services (see our Corporate Medical Policy for Monitored Anesthesia Care (MAC) during Gastrointestinal Endoscopy, Bronchoscopy, or Interventional Pain Procedures in Outpatient Settings for additional information and Prior Approval requirements)
- Anesthesia for pain management injections
- Reimburse modifiers -AD, -QK, -QX and -QY reimbursed at 50% of the fee schedule payment (See Provider Handbook for additional information)

Code Edit: Assistant Surgeon

Effective Date: January 13, 2023
Claim Type: Professional Claims, CMS 1500 and Outpatient Facility Clams submitted on a UB-04
Source: CMS, AMA CPT® Manual, American College of Surgeons

Definition: Applies to assistant surgeons whether physicians or non-physicians.

This edit applies to the following scenarios but not limited to:

- Procedures where typically assistant surgeons are not allowed
- CPT® 59622 (cesarean delivery only, following failed VBAC, including postpartum care) is denied when billed with an assistant surgeon modifier
- Non-physician claims billed with modifiers -80, -81 or -82 are denied
- Reimburse modifiers -80, -81, -82 at 16% of the allowed amount (see Provider Handbook for additional information)
- Reimburse modifier AS at 13.6% of the allowed amount (see Provider Handbook for additional information)

Code Edit: Assistant Surgeon Modifiers

Effective Date: January 1, 2021
Claim Type: Professional Claims, CMS 1500
Source: CMS, American College of Surgeons (ACS)

Definition: Identifies claim lines containing procedures billed with an assistant surgeon modifier (-80, -81, - 82, -AS) that typically do not require an assistant surgeon. Claim line denies.

Code Edit: Bilateral Procedures

Effective Date: January 13, 2023
Claim Type: Professional Claims, CMS 1500, Outpatient Facility Claims submitted on a UB-04 and Ambulatory Surgical Centers (ASC)
Source: AMA Principles of CPT® Coding, AMA CPT® Manual, CMS, and OCE Edits

Definition: Applies the current bilateral coding principals and guidelines as well as current claim processing logic for reimbursement of bilateral procedures reported with modifier -50 or -LT and -RT.

In addition to current bilateral logic this edit applies the five CMS classifications of bilateral procedures and process claims accordingly.

The five CMS classifications of bilateral procedures are as noted below:

- Procedures that are not payable at 150% when billed bilaterally (Bilateral Indicator 0)
- Procedures that are payable at 150% when billed bilaterally (Bilateral Indicator 1)
- Procedures that are bilateral in nature (Bilateral Indicator 2)
- Procedures that are payable at 100% for each side (Bilateral Indicator 3)
- Procedures to which the bilateral concept does not apply (Bilateral Indicator 9)

Additionally

Claims billed with modifier -LT (left side) or- RT (right side) when billed on the same line with modifier -50 are denied as not necessary or appropriate for a provider to append modifiers -LT and/or -RT on the same line as modifier -50.
Claims billed with a bilateral in nature service and reported with -RT or -LT modifier are denied for inappropriate coding.

Planned bilateral procedures that have a reduced service (modifier -52) or are discontinued prior to administration of anesthesia (modifier -Column) are not entitled to be reimbursed at 150% by CMS guidelines.

Services billed with both modifiers -50, -52 and -73 on the same line are denied.

Services billed on two lines, one with modifier -50 and one without modifier -50, with modifier -52 or -73 appended to either line, results in the denial of one of the lines.

These actions ensure that no more than 50% is reimbursed for the discontinued services.

If the service with modifier -52 or -73 is submitted after the service has been previously processed on a different claim without modifier -52 or -73 (paid historical claim), then the service with modifiers -52 or -73 are denied. This action prevents additional payment for a discontinued service if the services are billed out of sequence.

Additional Source

Please refer to Blue Cross VT's Corporate Payment Policy for Modifier -52 (CPP_22) for reporting and reimbursement information along with Provider Handbook information.

Code Edit: Bundled Services

Effective Date: January 1, 2021
Claim Type: Professional Claims, CMS 1500
Source: CMS

Definition: Certain procedure codes are designated by CMS as "bundled" by a status code indicator of "B" on the CMS National Physician Fee Schedule Relative Value File. When billed with any other procedure code that is not indicated as a "bundled" service, these procedures are considered a component of, or incident to, the overall service provided, and separate reimbursement is not warranted.

Code Edit: Bundled Services

Effective Date: January 13, 2023
Claim Type: Professional Claims, billed on CMS 1500 forms, Comprehensive Outpatient Rehabilitation Facilities (CORF)/Outpatient Physical Therapy (OPT), and Ambulatory Surgical Center (ASC)
Source: CMS

Definition: Any professional claim billed on a CMS 1500 are reviewed by the Bundled Services edit. ASC facility claim types defined in this edit have a status indicator of "N1" or "L1" and are not separately reimbursable items. Supplies other than HCPCS Level II codes Q4001 and Q4049 should not be billed by CORFs/OPTs with revenue code 0270 as these are taken into account under the practice expense relative values (RVUs).

Code Edit: Bundled Facility Services

Effective Date: January 13, 2023
Claim Type: Professional Claims, CMS 1500
Source: CMS

Definition: According to CMS policy*, certain outpatient services and home health services provided during an inpatient admission prior to the discharge date are not separately billable.

- Outpatient services other than ambulance, rendered by an outpatient hospital and the date of service falls after the inpatient admission date and prior to the discharge date by any provider will be denied (CMS-1450). Separate payment is not made for any services provided by an outpatient hospital (Bill Type 0130-013Z or 0140-014Z or Outpatient Hospital specialty in POS 22) during an inpatient admission.
- Home Health services provided when the date of service falls after the admission date and prior to the discharge date for any inpatient hospital, skilled nursing facility, or swing bed hospital admission will be denied. Separate payment is not made for any services reported with Place of Service 12, or Bill Type 032X, or Bill Type 034X, while a member is confined to an inpatient hospital, skilled nursing facility, or swing bed hospital.

Additionally, the following services are considered bundled facility services during an inpatient admission and are not separately reimbursed when provided after the admission date and/or prior to the discharge date:

- Home Infusion/home therapy services
- Professional services billed by a DME supplier, physical therapy or speech-language pathologist when there exists an institutional claim for hospice care and the professional service falls on or between the institutional claim from and to service dates. Exception is made for modifiers GV (Attending physician not employed or paid under arrangement by the patient's hospice provider) or GW (Service not related to the hospice patient's terminal condition).
- Transportation and/or set up of portable x-ray equipment and personnel in home or nursing home (HCPCS R0070, R0075, or Q0092).

Code Edit: CMS Correct Coding Initiative

Effective Date: January 1, 2021
Claim Type: Professional Claims, CMS 1500 and Outpatient Facility Claims submitted on a UB-04
Source: CMS

Definition: Identifies claims containing code pairs found to be unbundled according to the CMS NCCI. The CMS NCCI coding policies are based on coding conventions defined in the CPT® manual, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice and/or current coding practice.

This rule recommends the denial of claim lines for which the submitted procedure is not recommended for reimbursement when submitted with another procedure as defined by a code pair found in the NCCI. Both codes must have same provider ID, same member, and same date of service.

NCCI code pair edits may be reviewed online at www.cms.gov.

Code Edit: CMS Unbundling

Effective Date: January 1, 2021
Claim Type: Professional Claims, CMS 1500
Source: CMS

Definition: Identifies claim lines containing procedure codes typically not recommended for reimbursement when submitted with other procedure codes on the same date of service for the same member.

Identifies code pairs that are created based on coding standards such as to procedure codes not reasonably performed on the same date of service or procedure codes that are a component of another procedure code.

This rule recommends the denial of claim lines where the submitted procedure is not recommended for reimbursement when submitted with one of the following: a more comprehensive procedure, a procedure that results in overlap of services, or procedures that are medically impossible or improbable to be performed together on the same date of service.

There are three sub-rules within the CMS_UNBUN_PAIRS rule, each with its own specific clinical justification. Each sub-rule is identified using the following acronyms:

- ULT_PARENT: Ultimate Parent
- ME: Mutually Exclusive
- INC: Incidental

Code Edit: Consultations Outpatient

Effective Date: January 1, 2021
Claim Type: Professional Claims, CMS 1500
Source: CMS

Definition: This rule recommends the denial of claim lines containing an outpatient consultation when another outpatient consultation was billed for the same member by the same Provider ID with at least one matching diagnosis within a 6-month period.

Outpatient Consultation Code	Established Patient
99242	99213
99243	99214
99244	99215
99245	99215
Telehealth Consultation Critical Care-Initial	Telehealth Consultation Critical Care-Subsequent
G0508	G0509

The rule adds the claim line with the appropriate level of office visit, established patient.

Code Edit: Co-Surgeon

Effective Date: January 13, 2023
Claim Type: Professional Claims, CMS 1500, Outpatient Facility Claims submitted on a UB-04
Source: CMS

Definition: Denies claim lines submitted with modifier -62 (co-surgeon) when the procedure code typically does not require co-surgeons as determined by the sources in this document.

Reimburse modifier -62 at 62.5% of the allowed amount

Refer to Provider Handbook for additional Modifiers information.

Code Edit: Continuous Positive Airway Pressure or Bilevel Positive Airway Pressure (CPAP/BIPAP) Frequency

Effective Date: January 1, 2021
Claim Type: Professional Claims, CMS 1500
Source: CMS

Definition: Identifies supply codes associated with CPAP/BIPAP therapy that are being submitted at a rate that exceeds our standard allowance.

Many CPAP/BIPAP supplies associated with sleep therapy are designed to be disposable. Masks, tubing, filters, and headgear are not designed to last extreme amounts of time. Based on the recommended replacement schedule for CPAP/BIPAP supplies from Medicare, this rule fires when the current claim for the submission of an associated CPAP/BIPAP supply is being submitted at a rate that exceeds the recommended replacement schedule.

The history line and the current line quantities are summed for the same date of service and provider. If the total quantity exceeds the recommended replacement rate, only the incorrect line is denied (all current lines are not denied). A new line may be added with the allowed quantity and processed accordingly.

Please Refer to the Corporate Payment Policy 33 Frequency of Supplies (Diabetic and Positive Airway Pressure (PAP) Supplies) for additional information.

Code Edit: Deleted HCPCS Code

Effective Date: January 13, 2023
Claim Type: Professional claims, CMS 1500 Source: AMA CPT® Manual

Definition: Denies claim lines with a HCPCS code that the AMA has deleted and is no longer in effect. The provider needs to resubmit the claim as a corrected claim with the correct current HCPCS code.

Code Edit: Device and Supply – Blood

Effective Date: January 13, 2023
Claim Type: Professional claims, CMS 1500
Source: CMS, OCE Edits

Definition: Transfusion services are expected to be accompanied by blood products. Transfusion services billed without blood products are denied.

Applicable bill types are:

- 0120 through 012Z
- 0130 through 013Z
- 0140 through 014Z

Codes 86890 through 86891 are used when autologous blood products are collected and stored but not transfused.

Providers should be certain that the blood is not transfused on the same day it is collected. If so, the collection and storage charge is denied.

If a blood product transfusion is billed with a blood administration charge, and an autologous blood collection and storage charge has already been paid for the same date of service, then the blood product is denied.

Code Edit: Device and Supply – Implant Procedure Requires Implant Device

Effective Date: January 13, 2023
Claim Type: Outpatient, Inpatient Facility Claims Submitted on a UB-04
Source: CMS, OCE Edits

CMS policy requires the presence of a qualifying device when a device-dependent procedure is billed. This edit will deny a device-dependent procedure when billed without any qualifying device code based on CMS guidelines.

Code Edit: Device and Supply – Drugs

Effective Date: January 13, 2023
Claim Type: Outpatient Facility Claim Submitted on a UB-04
Source: OCE Edits

Definition: According to CMS policy and based on I/OCE specifications, claims containing drug and biological codes with pass through status or non-pass-through status must be reported with a payable procedure, or the drug and biological code is denied.

Radiopharmaceuticals further require that the payable procedure be reported on the same claim, while the remaining drug and biologicals are edited for the same date of service.

Code Edit: Diabetic Supply Frequency

Effective Date: January 1, 2021
Claim Type: Professional Claims, CMS 1500
Source: CMS

Definition: Identifies claim lines submitted with diabetic supply codes when the utilization of these supplies is at a frequency over the usage defined by over the usage by CMS, industry standard or other health plan policies. This rule distinguishes the quantity of supplies necessary for those patients that are insulin dependent and those that are non-insulin dependent. The rule also provides an option to perform a diagnosis validation check on the claim containing the supply code as ICD-10-CM diagnosis code(s) describing the condition that necessitates glucose testing must be included on each claim for the supplies. The default rule checks both claim and line level diagnosis.

This rule allows for a grace period to be applied to eligible claim lines submitted with diabetic supply codes. For example, if a diabetic supply code has a limitation of 1 every 90 days and a refill is shipped on the 91st day, i.e., the end date of the current supply usage, delivery time needs to be considered. Applying the grace period ensures there is no gap due to delivery time. (Medicare also allows the grace period for this reason.)

The history line and the current line quantities are summed for the same date of service and provider. If the total quantity exceeds the recommended usage rate, only the incorrect line is denied (all current lines are not denied). A new line may be added with the allowed quantity and processed accordingly.

Please Refer to the Corporate Payment Policy 33 Frequency of Supplies (Diabetic and CPAP/BIPAP) for additional information.

Code Edit: Diagnosis-Age Consistency

Effective Date: January 13, 2023
Claim Type: Professional claims, CMS 1500
Source: ICD-10-CM

Definition: Certain diagnosis codes have been identified as being specific to certain age groups. When one of these diagnoses is billed, it is the only diagnosis on a claim, and it does not match the age of the patient on the claim for that date of service, then all services on the claim is denied. This edit looks at all diagnoses on a claim.

Code Edit: Diagnosis Code Guideline

Effective Date: January 13, 2023
Claim Type: Professional claims, CMS 1500 and Outpatient Facility Claim Submitted on a UB-04
Source: CMS

Definition: Identifies when diagnosis codes were not submitted in accordance with ICD-10-CM coding guidelines and CMS policies.

ICD-10-CM coding guidelines provides a step-by-step tutorial and full official conventions and guidelines regulating the appropriate assignment and reporting of ICD-10-CM codes. As such

we expect providers bill with the highest level of accuracy and compliance with official coding sources and guidelines. The Diagnosis Code Guideline Policy identifies scenarios within ICD-10-CM where a diagnosis code submitted for a procedure or service is reported inappropriately or in an inaccurate position on a Professional and/or Facility claim line(s). Examples of ICD-10-CM coding guidelines edit will help identify: Primary or Principal Diagnosis or the ONLY diagnosis:

The following groups of diagnosis codes are not allowed to be reported as the ONLY diagnosis on the claim or claim line, the principal or primary diagnosis on a professional claim:

- Diagnosis of external causes
- Manifestation codes
- Secondary diagnosis codes
- ICD-10-CM Sequela (7th character "S") codes
- Principal or primary diagnosis for chemotherapy administration. Specified chemotherapy administration procedure codes are required to have Z51.11 and Z51.12 as the primary or principal diagnosis. In addition, ICD-10-CM guidelines state when a patient's encounter is solely to receive chemotherapy for the treatment of neoplasm, two diagnosis codes are required
- Factors Influencing Health Status and Contact with Health Services Diagnoses and Non-Routine Examinations
- Health services for specific procedures and treatment- not carried out
- ICD-10-CM excludes 1 Notes
- ICD-10-CM Laterality

Code Edit: Diagnosis Procedure

Effective Date: January 13, 2023
Claim Type: Professional claims, CMS 1500 and Outpatient Facility Claim Submitted on a UB-04
Source: Corporate Medical Policy for Clinical Trials

Definition: Billing Requirements for Clinical Trials, see below

Modifier Requirements

According to CMS policy, any service identified as part of a clinical trial must be billed with modifier -Q0 (investigational clinical service provided in a clinical research study that is in an approved clinical (research study), or -Q1 (routine clinical service provided in a clinical research study that is in an approved clinical research study). Additionally, the billed service must be accompanied by ICD-10-CM code Z00.6 (encounter for examination for normal comparison and control in clinical research program) on the claim. Therefore, failure to include the requisite diagnosis results in a claim denial.

Diagnosis Requirements

According to CMS policy, HCPCS codes G0293 (non-covered surgical procedure using conscious sedation, regional, general, or spinal anesthesia in a Medicare qualifying clinical trial) and G0294 (non-covered procedure using no anesthesia or local anesthesia only in a Medicare qualifying clinical trial) are to be used specifically during clinical trials. The appropriate diagnosis to accompany these HCPCS codes is ICD-10-CM code Z00.6 (encounter for examination for normal comparison and control in clinical research program). Therefore, G0293 and G0294 billed without Z00.6 results in a denial.

*Note: This edit also follows Blue Cross VT Clinical Trials Corporate Medical Policy. Refer to the policy for more information on allowed and non-covered services.

- Ulcer Debridement and Ulcer Stages

According to the ICD-10-CM Manual, there are specific diagnosis codes that reflect the stage of a pressure ulcer. When debridement of a pressure ulcer is performed, the procedure code should also reflect the stage of the pressure ulcer.

- Procedures that do not remedy a health state

According to CMS policy, services which are elective in nature (ICD-10-CM codes Z40.8-Z40.9, Z41.1, Z41.3, Z41.9) and do not remedy a health state are considered noncovered. Therefore, any procedure billed with these diagnosis codes are denied.

- Multiplex Nucleic Acid Amplified Tests for Respiratory Viral Panels

According to CMS policy, the test to detect a respiratory infectious agent by nucleic acid (87631, 87636- 87637, 0240U, 0241U) must include an approved secondary diagnosis indicating the pathogen detection and immunocompromised condition in addition to the sign or symptom for the suspicion of the respiratory illness. This edit denies claim lines billed with 87631, 87636-87637, 0240U, or 0241U (respiratory infectious agent detection by nucleic acid) without an approved secondary diagnosis.

<u>Examples of signs and symptom diagnoses:</u>

- Acute upper respiratory infection (ICD-10-CM code J06.9)
- COVID-19 (ICD-10-CM code U07.1)
- Influenza (ICD-10-CM codes J09.X1-J09.X9)

<u>Examples of approved secondary diagnoses:</u>

- Acute bronchitis (ICD-10-CM code J20.8)
- Coronavirus (ICD-10-CM code B97.29)
- Pneumonia (ICD-10-CM codes J12.0-J12.9, J15.8, J16.8, J18-J18.9)

Code Edit: Diagnosis Validity

Effective Date: January 13, 2023
Claim Type: Professional claims, CMS 1500 and Outpatient Facility Claim Submitted on a UB-04

Source: ICD-10-CM and CMS

Definition: Annually, diagnosis (ICD-10-CM) codes undergo revision by the governing entity. Revisions typically include adding new diagnosis codes, deleting diagnosis codes, and redefining the description or nomenclature of existing diagnosis codes. As these revisions are made public, our secondary claims editor updates its database to reflect these changes. Based on CMS policy, we will not allow a grace period for reporting deleted codes. Claims submitted with deleted ICD-10-CM codes are denied. The provider needs to resubmit the claim as a corrected claim with a valid ICD-10-CM code at the highest level of specificity.

This edit is applied:

Diagnosis Specificity

Claims received with **any** diagnosis code not coded to the highest level of specificity are denied. The provider needs to resubmit the claim as a corrected claim with an updated ICD-10-CM code at the highest level of specificity.

Invalid Diagnosis

Invalid diagnosis codes are defined as codes submitted by a provider that cannot be correlated to a diagnosis code that was valid at any point in time. When a claim is received with **any** invalid ICD-10-CM code, then it is denied. Deleted diagnosis codes are defined as diagnoses that have been valid at some point in the past but have either been deleted by the governing entity or have been modified with either greater or lesser specificity. All diagnosis codes are assigned an effective date and a termination date by the governing body. Claims received with deleted diagnosis codes are validated against the date of service. Therefore, **any** deleted ICD-10-CM code corresponding to the date of service is considered as invalid and the claim denied.

Code Edit: Duplicate Services

Effective Date: January 13, 2023
Claim Type: Professional Claims, CMS 1500 and Outpatient Facility Claim Submitted on a UB-04
Source: CMS, Administrative Claims Processing Rules

Definition: Claims are edited against basic administrative processing rules. This edit compares new claims and claim lines in both history and in the same new claim. Primary elements considered for duplicate claim logic include but are not limited to:

- Subscriber Identification
- Dependent Identification
- Date of Service
- Procedure Code
- Modifiers

- Units
- Claim Type
- Tax ID
- Specialty

Note: BlueCard claims are excluded from this edit.

Code Edit: Evaluation and Management (E/M)

Effective Date: April 1, 2023 (except Multiple E/M Services on the same day, effective January 13, 2023)
Claim Type: See each edit for specifics
Source: See each edit for specifics

I. New Patient Visits

Claim Type: Professional Claims, CMS 1500, Ambulatory Surgical Center (ASC) and Outpatient Facility Claim Submitted on a UB-04
Source: AMA CPT® Manual, Pub 100-2 Medicare Benefit Policy, and Federal Register

Definition: Denies a new patient visit when any face-to-face service has been previously billed within the last three years. This edit will apply to the following on **professional** claims:

- Same provider ID, same Tax ID (same group practice), same specialty or subspecialty
- Same provider ID, regardless of Tax ID, or specialty
- Non-physician practitioner's (i.e., certified nurse midwife, clinical nurse specialist, nurse practitioner, or physician assistant) new patient visit are denied if any face-to-face service has been billed in the previous three years by the same Tax ID and any specialty, with diagnosis match

New Patients in Facility and ASC Billing – New patient is a patient who has not been registered as an inpatient or outpatient of the hospital or ambulatory surgery center within the past three years. If a facility bills a new patient visit and the same facility provider has performed any service in the previous three years, the second new patient visit is denied.

II. Consultation with Annual Exam or Screening Diagnoses

Claim Type: Professional Claims, CMS 1500
Source: ICD10 Manual and AMA CPT® Manual

Definition: Office consultation codes or interprofessional telephone/internet consultation are not to be billed with a health supervision diagnosis, or routine examination diagnosis that indicates a preventive medicine service was performed.

III. Discharge Services

Claim Type: Professional Claims, CMS 1500
Source: AMA CPT® Manual and Pub 100-4 Medicare Claims Processing

Definition: Only one hospital discharge day management service is payable per patient per hospital stay, regardless of the order that the discharge management services are received. If an inpatient discharge service has already been processed, the subsequent discharge service submitted is denied.

IV. Observation Services

Claim Type: Professional Claims, CMS 1500
Source: AMA CPT® Manual and Pub 100-4 Medicare Claims Processing

Definition: Initial observation services are to be reported for the first day of treatment. Subsequent day of treatment should be reported with the appropriate codes. When an initial observation care service is reported and there is another initial observation care service reported by any provider for the previous day, the service is denied. Observation services claims will also be validated through editing on the following instances:

- Initial observation and discharge service followed by discharge service
- Observation care discharge service and initial hospital care for the same date of service
- Observation discharge services when initial hospital care was billed the previous day Initial hospital care when observation care discharge has already been paid for the subsequent day
- Initial/Subsequent observation services for the same date of service
- Physician billing for inpatient hospital care following initiation of observation services for the same date of service

V. Initial Critical Care

Claim Type: Professional Claims, CMS 1500
Source: Pub 100-4 Medicare Claims Processing

Definition: Initial critical care should not be reported with more than one unit per date of service by the same provider Tax ID and specialty.

VI. Prolonged Services

Claim Type: Professional Claims, CMS 1500
Source: AMA CPT® Manual

Definition: Prolonged services in the inpatient or observation setting when billed with any other place of service other than inpatient or observation facility setting is denied.

Indirect contact prolonged E/M service before and/or after direct patient care when billed with a hospital discharge day management service on the same claim and for the same date of service is denied.

VII. Care Management Services

Claim Type: Professional Claims, CMS 1500 and Outpatient Facility Claim Submitted on a UB-04
Source: AMA CPT® Manual

Definition: Identifies claim lines containing Care Management Services and edits in accordance with AMA CPT® Manual guidelines. CPT® codes and diagnoses improperly coded are denied. This edit will look at the following:

- Chronic and complex care management services
- Care Management Services reported with end-stage renal disease related services (ESRD)
- Behavioral and Psychiatric Care Management Services
- Multiple Psychiatric Care Management Services

VIII. Interprofessional Telephone/Internet Consultations

Claim Type: Professional Claims, CMS 1500
Source: AMA CPT® Manual

Definition: Identifies claims where Interprofessional telephone/Internet consultation services are not billed in accordance with AMA CPT® Manual coding guidelines. This edit will look through claim history and validate the following:

- Interprofessional telephone/Internet consultation services billed on the same date or in the previous 14 days of the current interprofessional consultation
- Interprofessional telephone/Internet consultation services in any combination have been billed more than one unit in seven days
- E/M service billed on the same day, previous seven days, or following day with the same primary diagnosis as a telephone E/M services, remote evaluation of recorded video and/or image, or brief check in by physician or qualified health care professional (QHP)
- Telephone E/M services billed when a related online digital E/M service was reported in the previous seven days for the same diagnosis and the same provider

IX. Transitional Care Management (TCM) Services, Inpatient Neonatal and Pediatric Critical Care and Intensive Care Services, Newborn Care Services, Pediatric Interfacility Transport Services and Critical Care Services

Claim Type: Professional Claims, CMS 1500 and Outpatient Facility Claim Submitted on a UB-04

Source: AMA CPT® Manual

Definition: This edit will identify claim lines where services for these specific topics were not reported in accordance with the AMA CPT® Manual guidelines, definitions, and limitations.

X. Evaluation and Management Services with Critical Care

Claim Type: Professional Claims, CMS 1500

Source: Pub 100-4 Medicare Claims Processing

Definition: E/M services billed in conjunction with critical care services in the same place of service are considered inclusive to the critical care services. Modifier -25 can be reported if appropriate and supported by the medical record.

XI. Multiple Evaluation and Management Services on the Same Day

Effective Date: January 13, 2023

Claim Type: Professional claims, CMS 1500

Source: CMS, AMA CPT® Manual

Definition: Provider should only bill a new patient exam or initial care visit for one date of service. Additional visits should be submitted with the appropriate established patient or facility codes.

New patient or initial care visit codes billed with units that are greater than one per date of service are denied.

Multiple E/M Services on the Same Day:

Only one E/M code is allowed for a single date of service for the same provider group and specialty. If multiple E/M services are performed, then the E/M services are ranked by RVU price unless billed with a -25 modifier.

Separate and Distinct E/M Services:

Separate and distinct E/M services that are reported with a modifier -25 are allowed with one unit for the same date of service when reported by the same provider ID.

XII. Additional E/M Services Edits

Claim Type: Professional Claims, CMS 1500 and Outpatient Facility Claim Submitted on a UB-04 (when applicable)
Source: AMA CPT® Manual, AMA CPT® Assistant, ICD-10 CM, HCPCS Level II Manual, Pub 100-4 Medicare Claims Processing, American Academy of Pediatrics, American Academy of Family Physicians, CMS's CCI Edits and Policy Manual, Regional CMS Policy (Local Coverage Determination [LCD])

Definition: Additional E/M coding and billing edits will identify additional circumstances, including but not limited to:

- Multiple preventive medicineE/Mservices billed on the same day
- Problem-oriented E/M services billed with preventive medicine services without modifier -25
- Pediatric preventive medicine services not billed in accordance with the American Academy of Pediatrics standards using age-appropriate codes and frequency
- Unbundling codes that should be inclusive to the E/M
- Reporting of services with a frequency that is not supported by AMA CPT® Manual and HCPCS Level II Manual definitions

Note: The use of modifier -25 to indicate that the E/M services were significant, separately, and identifiable on the same day of a procedure or other service should be appropriate and supported.

Code Edit: Frequency- Additional Services

Effective Date: January 13, 2023
Claim Type: Professional claims, CMS 1500
Source: CMS, AMA CPT® Changes, CMS's Correct Coding Initiative (CCI) and Policy Manual

Definition: According to CMS guidelines the following services are limited to the frequency noted below:

Diabetes Screening

- Non-Pre-Diabetic – once every year
- Pre-diabetic – every 6-months
- Cardiovascular Disease screening

Cardiovascular screening when billed with laboratory services are reimbursed once in a 5-year period

Allergen extract 30 units per year

Integumentary photo once a year

Drug Testing

- Presumptive drug testing
  80305, 80306, 80307 –one combined unit per day
- Definitive drug testing
  G0480, G0481, G0482, G0483, G0659 – one combined unit per day

Code Edit: Frequency - Other Services

Effective Date: January 13, 2023
Claim Type: Professional claims, CMS 1500
Source: CMS HCPCS Level II Manual, Regional CMS Policy (local coverage determination), CMS Transmittals, Memos, and Publications

Definition:

- Home Health Recertification - G0179 – once every 2-months
- Care Plan Oversite - care coordination services are denied when billed in the same calendar month of a monthly ESRD service
- Chiropractic Manipulation - 98940-98942 – one per day
- Emergency Response System - S5161 – once per month
- Peripheral Nerve Stimulation - 64555 – twice per year
- Psychiatric Diagnostic Evaluation - any combination of 90791 or 90792 – three units per year
- Telehealth – Nursing Facility - 99307, 99308, 99309, 99310 (appended with Modifier -GT or -GQ) – one visit every 2-weeks

Code Edit: Global Comp

Effective Date: January 1, 2021
Claim Type: Professional Claims, CMS 1500 and Outpatient Facility Claim Submitted on a UB-04
Source: CMS

Definition: Identifies claim lines with procedure codes which have components (professional and technical) to prevent overpayment for either the professional or technical components or the global procedure. The rule also detects when duplicate submissions occurred for the total global procedure or its components across different providers.

The following scenarios are audited:

- Global vs. Global
- Global vs. Professional
- Global vs. Technical
- Professional vs. Global
- Technical vs. Global
- Professional vs. Professional
- Technical vs. Technical

Code Edit: Global Surgery

Effective Date: January 13, 2023
Claim Type: Professional claims, CMS 1500
Source: CMS, AMA CPT® Manual

Definition: CMS defines the global surgical package, also called global surgery as all the necessary services normally furnished by a surgeon before, during and after a procedure. The Global Surgery Package applies only to surgical procedures that have postoperative periods of 0, 10 and 90 days, as defined by CMS. The global surgery concept applies only to primary surgeons and co-surgeons.

This edit follows CMS and national guidelines for items that are included in the Global Surgery Package such as:

- Preoperative (E/M visits after the decision is made to operate one day prior to major surgery and on the same day a major or minor surgery is performed.
- Postoperative E/M's that are related to the surgery. Unrelated services should be reported with the appropriate modifiers.
- Intra-operative services that are a usual and necessary part of the surgical procedure.
- Supplies including surgical trays
- All additional medical or surgical services required of the surgeon during the postoperative period because of complications.
- Anesthesia or postoperative pain management by the surgeon.
- Dressing changes; local incisional care; removal of operative packs; removal of cutaneous sutures, staples, lines, wires, tubes, drains, and splints; insertion, irrigation, and removal of urinary catheters; routine peripheral intravenous lines; nasogastric and rectal tubes; change and removal of tracheostomy tubes.

Report the appropriate modifiers to reflect services in connection with or distinct from the Global Surgical Package when applicable. Modifiers include but are not limited to:

- -47 Anesthesia by surgeon
- -57 Decision for surgery
- -58 Staged procedure
- -78 Unplanned return to operating room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period
- -79 Unrelated procedure or service by the same physician or other qualified health care professional during postoperative period
- -24 Unrelated E/M service by the same physician or other qualified health care professional during a postoperative period

- -25 Significant, separately identifiable E/M by the same physician or other qualified health care professional on the same day of the procedure or other service

*Note: Modifiers should be reported when appropriate and supported by the medical record.

Code Edit: Implant Procedures Requires Implant Device

Effective Date: January 13, 2023
Claim Type: Outpatient Facility Clam Submitted on a UB-04 Source: CMS

Definition: Procedures that require one or more implant device(s) are required to be billed. If the implant device is not present than the services are denied. Implant device(s) billed without an associated procedure are denied.

Note: Please refer to the following edits under the Revenue Code section: Revenue code requires HCPCS and Revenue Code – HCPCS Code Links for additional information on Revenue Code Editing.

Code Edit: Lifetime Event

Effective Date: January 1, 2021
Claim Type: Professional Claims, CMS 1500
Source: AMA

Definition: Audits claims to determine if a procedure code(s) has been submitted more than once or twice on same date of service or across dates of service when it can only be performed once or twice in a lifetime.

The Lifetime Value is the total number of times that a given procedure may be appropriately submitted in a lifetime. This is reflective of the total number of times it is clinically possible or clinically reasonable to perform a given procedure on same date of service or across dates of service. After the maximum number of times is reached, additional submissions of the procedure are not recommended for reimbursement. Lifetime values are assigned according to anatomic sites and AMA/CMS guidelines associated with each procedure.

This rule denies a claim that contains a procedure code that has been submitted more than once or twice on same date of service or across dates of service because it has been identified as a procedure that can only be performed once or twice in a lifetime.

Code Edit: Maximum Units

Effective Date: January 13, 2023

Claim Type: Professional claims, CMS 1500 and Outpatient including Ambulatory Surgical Centers (ASC)
Source: CMS, AMA CPT® Manual, ICD-10-CM, American College of Surgeons

Definition: All procedure codes have been assigned a maximum number of units that may be billed per day and/or per year for a member.

When a provider bills a certain number of units that exceed the assigned allowed for that procedure, then the total number of units is adjusted to the assigned allowed amount and the excess units are denied. Modifiers are taken into consideration during the processing of this edit. The maximum units logic only apply to procedures with like modifiers.

The Maximum units Edit applied:

- Anatomical Modifiers (-E1, through -E4, -FA- through -F9, -TA through -T9)
- Certain obstetrical diagnostic services with maximum units per day restrictions based on diagnosis code (Ex: Twin pregnancy ICD-10-CM codes O30.009, O30.099)
- Daily units for certain procedures are limited to one unit per day regardless of modifier according to the AMA CPT® Manual and the HCPCS Level II Manual code descriptors
- Daily maximum units for surgeries that allow multiple assistant surgeons
    -

Code Edit: Medicare Medically Unlikely Edits (MUE) Durable Medical Equipment (DME)

Effective Date: January 1, 2021
Claim Type: Professional Claims, CMS 1500
Source: CMS

Definition: This rule identifies claim lines where the MUE has been exceeded for a CPT®/HCPCS code with MUE adjudication indicator (MAI) = 1, 2 or 3, reported by the same provider or across providers (depending on the provider setting configuration), for the same member, on the same date of service. This rule evaluates date ranges to determine if the MUE has been met or not.
- MAI = 1 claim line edit
- MAI = 2 date of service edits (based on policy)
- MAI = 3 date of service edits (based on clinical benchmarks)

MUE for a HCPCS/CPT® code is maximum units of service that a provider would report under most circumstances for a single member on a single date of service. The MUE values are based upon anatomic considerations, HCPCS/CPT® code descriptors, HCPCS/CPT® instructions, CMS policies, nature of the analyte, nature of service/procedure, nature of the equipment, and/or clinical judgment prescribing information and claims data.

The history line and the current line quantities are summed for the same date of service and provider. If the total quantity exceeds the recommended value, only the incorrect line is denied (all current lines are not denied). A new line may be added with the allowed MUE and processed accordingly.

Code Edit: Medicare Medically Unlikely Edits (MUE) Outpatient Hospital DOS

Effective Date: January 1, 2021
Claim Type: Outpatient Facility Claim Submitted on a UB-04
Source: CMS

Definition: Identifies claim lines where the MUE has been exceeded for a CPT®/HCPCS code with MUE adjudication indicator (MAI) = 1, 2 or 3, reported by the same provider, for the same member, on the same date of service.

Guidelines found in the National Correct Coding Initiative Policy Manual for Medicare Services, Chapter I, General Correct Coding Policies, under Section V for Medically Unlikely Edits (MUEs) state: "To lower the Medicare Fee-For-Service Paid Claims Error Rate, CMS has established units of service edits referred to as Medically Unlikely Edit(s) (MUEs). An MUE for a HCPCS/ CPT® code is the maximum number of Units of Service (UOS) under most circumstances allowable by the same provider for the same [member] on the same date of service. The ideal MUE value for a HCPCS/ CPT® code is the unit of service that allows the vast majority of appropriately coded claims to pass the MUE."

The MUE values are based upon anatomic considerations, HCPCS/CPT® code descriptors, HCPCS/CPT® instructions, CMS policies, nature of analyte, nature of service/procedure, nature of equipment, and/or clinical judgment prescribing information and claims data. In addition to the MUE value assigned to each procedure code in the MUE table, an MAI (MUE adjudication indicator) value of 1, 2 or 3 is also assigned.

This rule evaluates date ranges to determine if the MUE has been exceeded.

The history line and the current line quantities are summed for the same date of service and provider. If the total quantity exceeds the recommended value, only the incorrect line is denied (all current lines are not denied). A new line may be added with the allowed MUE and processed accordingly.

Code Edit: Medicare Medically Unlikely Edits (MUE) Practitioner Date of Service

Effective Date: January 1, 2021
Claim Type: Professional claims, CMS 1500

Definition: This rule identifies claim lines where the MUE has been exceeded for a CPT®/HCPCS code with MUE adjudication indicator (MAI) = 1, 2 or 3, reported by the same provider, for the

same member, on the same date of service. This rule evaluates date ranges to determine if the MUE has been met or not.
MAI = 1 claim line edit
MAI = 2 date of service edits (based on policy)
MAI = 3 date of service edits (based on clinical benchmarks)

MUE for a HCPCS/CPT® code is maximum units of service that a provider would report under most circumstances for a single member on a single date of service. The MUE values are based upon anatomic considerations, HCPCS/CPT® code descriptors, HCPCS/CPT® instructions, CMS policies, nature of analyte, nature of service/procedure, nature of equipment, and/or clinical judgment prescribing information and claims data.

This rule evaluates date ranges to determine if the MUE has been exceeded.

The history line and the current line quantities are summed for the same date of service and provider. If the total quantity exceeds the recommended value, only the incorrect line is denied (all current lines are not denied). A new line may be added with the allowed MUE and processed accordingly.

Code Edit: Missing Professional Component Modifier -26

Effective Date: January 1, 2021
Claim Type: Professional Claims, CMS 1500
Source: CMS

Definition: Identifies claim lines where a modifier -26, denoting professional component, should have been reported for the procedure performed at the noted Place of Service (POS).

The CMS guidelines establish that certain procedures, when performed in certain settings, require the billing of the professional component modifier. Procedure codes with a modifier -26 line in the National Physician Fee Schedule Relative Value File are included in this list of procedures.

This rule recommends the denial of claim lines containing a procedure code submitted without a professional component modifier –26 in a facility setting (POS: 02, 19, 21, 22, 23, 24, 26, 31, 34, 51, 52, 53, 56, and 61). The rule replaces the line with a new line with the same procedure code and the professional component modifier –26.

Code Edit: Modifier Policy

Effective Date: January 13, 2023
Claim Type: Professional Claims, CMS 1500, Outpatient Facility Claim Submitted on a UB-04 and Ambulatory Surgical Center (ASC) claims submitted on a CMS-1500 or CMS-1450 formats.
Source: CMS, AMA CPT Manual, AMA Coding with Modifiers, AMA HCPCS Level II

Definition: Identifies claim lines with procedures that were billed with inappropriate modifiers in accordance with the sources listed above.

Code Edit: Modifier to Procedure Validation Payment Modifiers

Effective Date: January 1, 2021
Claim Type: Professional Claims, CMS 1500
Source: AMA/CMS

Definition: Identifies claim lines with invalid modifier to procedure code combinations for those modifiers identified as payment modifiers.

This rule recommends the denial of procedure codes when billed with any payment-affecting modifier that is not likely or appropriate for the procedure code billed. When multiple modifiers are submitted on a line, all are evaluated and if at least one is found invalid with the procedure code, the line is recommended for denial.

Code Edit: Multiple Code Re-Bundling

Effective Date: January 1, 2021
Claim Type: Professional Claims, CMS 1500
Source: AMA

Definition: Identifies claims containing two or more procedure codes used to report a service when a single, more comprehensive procedure code exists that more accurately represents the service performed. This is typically identified by the CPT® code description of each code.

Occasionally, the code that represents the comprehensive procedure is added to the claim resulting in the component procedures being disallowed. To correct this type of coding error, the unbundled procedure code(s) is re-bundled to the comprehensive procedure code.

This rule recommends the denial of claim lines when another more comprehensive procedure is submitted for the same date of service for the same provider identification. The rule may also recommend denial of multiple claims lines with replacement of those claim lines with a single, more comprehensive procedure code.

Code Edit: Multiple Endoscopy

Effective Date: April 1, 2023
Claim Type: Professional Claims, CMS 1500
Source: CMS

Definition: When multiple endoscopies that share the same base endoscopy are performed on the same date of service, they are termed related. This Edit applies multiple endoscopy reduction logic for related endoscopies with payment of the highest RVU priced endoscopy at 100% and subsequent related endoscopies at the difference of their RVU price from the base

endoscopy RVU price. When the base endoscopy has a higher RVU price than the related endoscopy the claim line containing the related endoscopy are denied.

When related endoscopies are performed with non-endoscopy services that are subject to multiple procedure rules, the Multiple Endoscopy logic and Multiple Procedure Reduction will apply accordingly. When multiple non-endoscopy services that are subject to multiple procedure guidelines are billed for the same date of service, then the standard multiple procedure reduction applies to these services. Please see the Multiple Procedure Reduction for details.

Surgical procedures can be billed across multiple claims and/or at different times. When this occurs on endoscopies within the same family, the second endoscopy received will be reduced by the base endoscopy allowance, even if the second endoscopy received had the highest RVU price in the set.

This Edit takes into account other payment-affecting modifiers, such as 50 (Bilateral Procedure) to ensure that the service with the highest value is being appropriately identified.

The Multiple Procedure Reduction concept applies only to specific CMS or AMA designated codes. When a provider appends modifier 51 to a code that is not subject to Multiple Procedure Reduction guidelines, claims editing logic will remove modifier 51 from the line.

Code Edit: Multiple Procedure Reduction (MPR) Endoscopic Procedures

Effective Date: April 1, 2023
Claim Type: Professional Claims, CMS 1500, Outpatient Facility Claim Submitted on a UB-04 and Ambulatory Surgical Centers (ASC) claims
Source: CMS, AMA, OCE Data Files

Definition: MPR applies when a provider performs two or more surgical procedures on the same date of service that are subject to multiple surgery guidelines. This edit will mainly utilize the list of procedures that CMS specifies are subject to multiple procedure reduction. This list also includes the procedures that CMS has indicated are subject to multiple endoscopy guidelines. Procedures that are split billed will also be evaluated within editing logic for multiple procedures.

***Note:** This Edit will follow the American Medical Association (AMA) CPT® Manual regarding procedures that are exempt from multiple surgery guidelines. It will exclude codes from Multiple Procedure Reduction processing that the AMA indicates are modifier 51 exempt.

Appropriate percentages are applied to eligible claim line(s), including adjustments for multiple procedure, as well as bilateral, multiple quantity, and additional payment modifiers. This includes both codes billed on separate claim lines and multiple units on the same claim line. This Edit may add modifier -51 to secondary procedures for the purpose of applying MPR logic.

Providers should continue to bill for multiple procedures, bilateral procedures, multiple quantity, and additional payment modifiers as instructed by the Provider Handbook. Editing contains logic to accommodate current billing instructions.

Code Edit: Multiple Procedure Reduction (MPR) for Cardiovascular Services

Effective Date: April 1, 2023
Claim Type: Professional Claims, CMS 1500, Outpatient Facility Claim Submitted on a UB-04
Source: CMS

Definition: MPR reduction for cardiovascular services applies when two or more diagnostic services are performed on the same date of service by the same Tax ID and Specialty. It applies only to the technical component. It will assign appropriate pay percentage to eligible claim line(s), including adjustments for multiple procedure, as well as bilateral, multiple quantity, and additional payment modifier.

Editing logic will also take into account and allow Distinct Service Modifiers 59, XE or XU to be appended processing the claim accordingly. In addition, this edit also accounts for modifier 76 (Repeat procedure by same physician) and modifier 77 (Repeat procedure by another physician) to be reported as appropriate.

When multiple diagnostic cardiovascular services are billed on separate claims and processed on separate days, the technical component for subsequently received services will be reduced regardless of ranking.

Providers should continue to bill for multiple procedures, bilateral procedures, multiple quantity, and additional payment modifiers as instructed by the Provider Handbook. Editing contains logic to accommodate current billing instructions.

Code Edit: Multiple Procedure Reduction (MPR) for Ophthalmology Services

Effective Date: April 1, 2023
Claim Type: Professional Claims, CMS 1500, Outpatient Facility Claim Submitted on a UB-04
Source: CMS

Definition: Multiple Procedure Reduction for Ophthalmology Services applies when two or more diagnostic services are performed on the same date of service by the same Tax ID and Specialty. It applies only to the technical component. It will assign appropriate pay percentage to eligible claim line(s), including adjustments for multiple procedure, as well as bilateral, multiple quantity, and additional payment modifier.

Editing logic will also take into account and allow Distinct Service modifiers -59, -XE or -XU to be appended processing the claim accordingly.

When multiple diagnostic ophthalmology services are billed on separate claims and processed on separate days, the technical component for subsequently received services will be reduced regardless of ranking.

Providers should continue to bill for multiple procedures, bilateral procedures, multiple quantity, and additional payment modifiers as instructed by the Provider Handbook. Editing contains logic to accommodate current billing instructions.

Code Edit: Multiple Procedure Reduction for Radiology

Effective Date: April 1, 2023
Claim Type: Professional claims, CMS 1500 and Outpatient Facility Claim Submitted on a UB-04.
Source: CMS

Definition: Identifies claims lines where a 50% reduction to the technical component and a 5% reduction to the professional component are applicable when multiple imaging codes from the same CMS defined code family are billed by any provider with the same tax ID for the same date of service.

Note: This Editing is secondary and only occurs when the CXT Rule Pay Percent Multiple Radiology is not applicable to a claim.

Code Edit: National Correct Coding Initiative (NCCI)

Effective Date: January 13, 2023
Claim Type: Professional Claims, CMS 1500 and Outpatient Facility Claim Submitted on a UB-04
Source: CCI Edits, CMS's Correct Coding Initiative (CCI) and Policy Manual

Definition: The CMS National Correct Coding Initiative (NCCI) policies are based on coding conventions defined in the American Medical Association (AMA) CPT® Manual, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice and/or current coding practice. This edit denies claim lines for which the submitted procedure is not recommended for reimbursement as defined by a code pair found in the NCCI.

Code Edit: National Correct Coding Manual

Effective Date: January 13, 2023
Claim Type: Professional Claims, CMS 1500
Source: CCI Policy Manual, CMS's Correct Coding Initiative (CCI) and Policy Manual

Definition: Apply the National Correct Coding Initiative Policy Manual (NCCIPM) and denies procedures considered to be inappropriately coded based on National Correct Coding Initiative

Policies and Guidelines. These supplement the CCI edits and are based on the AMA CPT® Manual.

Code Edit: New Patient Code for Established Patients

Effective Date: January 1, 2021
Claim Type: Professional Claims, CMS 1500
Source: AMA/CMS
Definition: According to the AMA, "A new patient is 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."

When a new patient Evaluation and Management code is found on the claim, but another Evaluation and Management or other Face-to-face professional service was performed within the last three years, the new patient code is denied and replaced with the appropriate established patient code.

When a new patient code inconsistency is identified on a claim, the code(s) in question are denied. Where an appropriate replacement procedure code exists, the inappropriate procedure code is denied and a new claim line with the appropriate procedure code may be added to the claim and processed accordingly.

Code Edit: Outpatient Code Editor CMS CCI Bundling

Effective Date: January 1, 2021
Claim Type: Outpatient Facility Claims submitted on a UB-04
Source: CMS

Definition: Identifies claims containing code pairs found to be unbundled according to CMS Integrated Outpatient Code Editor (I/OCE).

One of the functions of the I/OCE is to edit claims data to identify errors for one of the following reasons:

- Procedure is a mutually exclusive procedure that is not allowed by the Correct Coding Initiative (CCI).
- Procedure is a component of a comprehensive procedure that is not allowed by the CCI.

Critical Access Hospitals (bill type 85x) submitting claims containing both facility services and professional services that are reported with revenue codes (096x, 097x, 098x), do not have NCCI editing applied across facility and professional services appearing on the same day; NCCI editing is applied for the professional services separately from facility services.

This rule recommends the denial of claim lines for which the submitted procedure is not recommended for reimbursement when submitted with another procedure as defined by a

code pair found in the I/OCE. Both codes must have the same provider identification, same member, and same date of service.

Code Edit: Pay Percent Assistant Surgery

Effective Date: January 1, 2021
Claim Type: Professional claims, CMS 1500
Source: AMA/CMS

Definition: Identifies claim lines that are eligible for an Assistant Surgeon Pay Percent reduction. Assigns appropriate pay percentage to the eligible line(s), including adjustments for assistant surgeon status, multiple procedure, *bilateral, *multiple quantity, and *additional payment modifiers.

Code Edit: Pay Percent for Single Lines with Payment Modifiers or Multiple Quantity

Effective Date: January 1, 2021
Claim Type: Professional claims, CMS 1500
Source: AMA/CMS

Definition: Identifies claim lines that are eligible for Pay Percent adjustments for bilateral, multiple quantity, and/or payment modifiers.

Also, identifies claim lines/certain procedures that are subject to payment reduction when the x-rays are taken using film or computed radiography. Such procedures are required to be submitted with modifier -FX or -FY and receive a reduction in payment.

Code Edit: Pay Percent Modifier -51

Effective Date: January 1, 2021
Claim Type: Professional claims, CMS 1500
Source: CMS

Definition: Identifies claim lines that are eligible for a Multiple Procedure Pay Percent- Multiple Surgeries reduction. Assigns appropriate pay percentage to the eligible line(s), including adjustments for multiple procedure, as well as bilateral, multiple quantity, and additional payment modifiers.

Code Edit: Pay Percent Multiple Radiology

Effective Date: January 1, 2021
Claim Type: Professional claims, CMS 1500. This includes CMS 1500 claim submitted with a facility place of service.
Source: CMS

Definition: Identifies claim lines that are eligible for a Multiple Procedure Payment ReductionMultiple Diagnostic Imaging services. Also, identifies claim lines/ certain procedures that are subject to payment reduction when the CT equipment does not meet (NEMA) Standard XR-29-2013. Such procedures are required to be submitted with modifier -CT and receive a reduction in payment.

Assigns appropriate pay percentage to the eligible line(s), including adjustments for multiple procedure, as well as bilateral, multiple quantity, and additional payment modifier.

Editing occurs across claims and follows applicable guidelines based on the date of service. If a claim for a primary procedure is received subsequent to claim(s) already processed for procedures determined to be cut-back, the previously processed claims may be adjusted accordingly.

Code Edit: Pay Percent Therapy Facility

Effective Date: January 1, 2021
Claim Type: Outpatient Facility Clams submitted on a UB-04
Source: CMS

Definition: Identifies claim lines which should receive the reduced reimbursement on certain therapy procedures per CMS for institutional facility (UB-04) claims

Code Edit: Place of Service

Effective Date: April 1, 2023 (except (1) Inpatient Only Services (2) Physician Fee Schedule Non-Facility NA Indicator (3) Laboratory Services Billed by a Physician and (4) Professional Component of Radiology Services in Facility Place of Service were all effective January 13, 2023)
Source: See each edit for specifics

I. **Outpatient ESRD services**
Claim Type: Professional Claims, CMS 1500 and Outpatient Facility Claim Submitted on a UB-04
Source: AMA CPT® Manual

Definition: According to the AMA CPT® Manual, codes 90951-90962 are utilized to report monthly age-specific services related to a patient's end stage renal disease (ESRD) performed in an **outpatient setting**. There are three levels of service based on the number of face-to face visits. The CPT® Manual directs providers to utilize a different set of codes (e.g., 90935-90937 or 90945-90947) for ESRD dialysis services performed in an inpatient setting. Therefore, monthly ESRD services 90951-90962 are denied when billed in an inpatient setting.

II. **Inpatient Only Services**

Claim Type: Professional Claims, CMS 1500 and Outpatient Facility Claim Submitted on a UB-04
Source: CMS
Note: Original effective date January 13, 2023

Definition: Identifies services that may only be performed in an inpatient setting, Place of Service (POS) 21 due to the nature of the service, the need for postoperative care, and the underlying condition of the patient requiring the service.

*Note: This Edit allows for procedures to be billed as outpatient procedures with POS 22 when appropriate.

Inpatient-Only Non-Separate Procedures and Modifier -CA

- An exception for facility claims in a situation where a patient expires in an outpatient setting prior to an inpatient admission. If this occurs, the facility is required to use a modifier -CS (procedure payable only in the inpatient setting when preformed urgently on an outpatient basis prior to admission.) Inpatient-Only Separate Procedures
- Procedures designated as Inpatient Separate procedures are not payable regardless of the modifier CA
- If identified services are billed in the outpatient setting or if billed with a -CA modifier inappropriately the services are denied.

III. E/M Place of Service

Claim Type: Professional Claims, CMS 1500
Source: AMA CPT® Manual, HCPCS Level II Manual and Pub 100-4 Medicare Claims Processing

Definition: Identifies claim lines containing E/Mcodes with a place of service that conflicts with guidelines contained within AMA CPT® Manual, HCPCS Level II Manual and CMS policy for claims processing. E/M codes reported with inappropriate places of service are denied.

Examples include but are not limited to:

- Home visits E/M services billed in a place of service other than patient's home (12), or telehealth provided in patient's home (10)
- Outpatient consultation services billed with a place of service 21 (inpatient hospital)
- Emergency department visits billed in any place of service other than 23 (Emergency Department)
- Critical care services delivered by a physician, face-to-face, during interfacility transport of a critically injured pediatric patient when billed in a place of service other than 41 (Ambulance-land) or 42 (Ambulance-air or water)

IV. Supplies and Equipment Provided in the Facility Setting

Claim Type: Professional Claims, CMS 1500 and Outpatient Facility Claim Submitted on a UB-04

Source: Pub 100-4 Medicare Claims Processing (https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912)

Definition: Medical and surgical supplies (including drugs and vaccines) and durable medical equipment (DME) billed in a facility setting are not reimbursable as professional services (i.e., reported by professional providers).

V. Physical and Occupational Therapy in a SNF

Claim Type: Professional Claims, CMS 1500

Source: Pub 100-4 Medicare Claims Processing

Definition: Identifies claim lines with certain casting and strapping procedures provided by a physical or occupational therapist in a skilled nursing facility (SNF) per CMS policy.

VI. HCPCS 'C' Codes (C1052-C9899)

Claim Type: Professional Claims, CMS 1500 and Outpatient Facility Claim Submitted on a UB-04

Source: OCE Edits (https://www.cms.gov/medicare/coding-billing/outpatient-code-editor)

Definition: Identifies and denies claim lines reporting C Codes (may include device categories, new technology procedures, and drugs, biologicals and radiopharmaceuticals).) billed on claim type P (Professional).

VII. Surgical Dressings in the Provider's Office

Claim Type: Professional Claims, CMS 1500

Source: Regional CMS Policy (LOCAL COVERAGE DETERMINATION [LCD])

Definition: Identifies and denies claim lines reporting surgical dressings billed in the provider's office (POS 11).

VIII. Home Health/Home Infusion Procedures Place of Service

Claim Type: Professional Claims, CMS 1500 and Outpatient Facility Claim Submitted on a UB-04

Source: AMA CPT® MANUAL; CMS HCPCS LEVEL II MANUAL and Pub 100-4 Medicare Claims Processing

Definition: Identifies claim lines where the place of service reported is not appropriate for Home Health/Home Infusion procedures according to CPT® Manual, HCPCS Levell II Manual and CMS guidelines.

Home infusion or home therapy services billed on the same date of service as subsequent inpatient hospital or skilled nursing facility care, when initial inpatient hospital or skilled nursing care is present the day prior and there is not a facility discharge service on the same day by any tax ID, provider ID, or specialty are denied.

Bill Types 0330-033Z are not valid for the reporting of home health services and are denied.

IX. Physician Fee Schedule Non-Facility NA Indicator
Claim Type: Professional Claims, CMS 1500
Source: CMS
Note: Original Effective Date is January 13, 2023

Definition: Procedures that generally require general anesthesia and are billed with a status indicator of "N/A" in the Non-Facility NA indicator column of the CMS Physician Fee Schedule when billed in place of service 11 (Office) are denied.

Examples:

- 29880 – Arthroscopy, knee surgical with meniscectomy (medial and lateral including any meniscal shaving)
- 50949 – Unlisted laparoscopy procedure, ureter

X. Diagnostic Imaging
Claim Type: Professional Claims, CMS 1500 and Outpatient Facility Claim Submitted on a UB-04
Source: Regional CMS Policy (Local Coverage Determination [LCD]), Pub 100-4 Medicare Claims Processing

Definition: Identifies claim lines containing imaging procedures of the head and neck (70370, 70371) and gastrointestinal tract (74230) and follows CMS guidelines for appropriate reporting of place of service for these procedures.

XI. Physical Therapy Services Provided in an Inpatient or Outpatient Hospital
Claim Type: Professional Claims, CMS 1500
Source: CMS National Physician Relative Value File

Definition: Identifies and denies services provided by a physical therapist, occupational therapist, or speech-language pathologist in private practice for services provided in an inpatient or outpatient setting. Services performed by an

independent therapist during an inpatient hospital stay are denied regardless of the place of service reported.

Physical therapy services provided by a physical therapist, an occupational therapist, or a speech-language pathologist when the date of service falls after the admission date and prior to the discharge date for any inpatient admission are denied. Additionally, physical therapy services provided by a physical therapist, an occupational therapist, or a speech-language pathologist and the same code was billed by any outpatient hospital for the same date of service are denied. (CMS-1450)

XII. Mutually Exclusive Places of Service

Claim Type: Professional Claims, CMS 1500
Source: Pub 100-4 Medicare Claims Processing

Definition: Denies any service (other than inpatient care) billed by any professional provider on the same date of service as inpatient care but with a different place of service, when the member also received inpatient care the previous day and was not discharged on the same day, or on the subsequent day. Additionally, deny any service billed in an outpatient hospital - off campus, outpatient hospital - on campus or emergency room – hospital setting by any professional provider on the same date of service as inpatient care, when the member also received inpatient care the previous day and was not discharged.

XIII. Telehealth Services

Claim Type: Professional Claims, CMS 1500
Source: Pub 100-4 Medicare Claims Processing
Definition: Telehealth services when billed with modifier -GQ (Via asynchronous telecommunications system) and the place of service is not 02 (Telehealth Provided Other than in patient's home) or 10 (Telehealth Provided in Patient's Home) is denied.

XIV. Moderate Sedation Service in a Non-Facility Setting by a Second Physician

Claim Type: Professional Claims, CMS 1500
Source: AMA CPT® Manual

Definition: Per AMA CPT® Manual, when moderate sedation services are performed in a non-facility setting by a second physician, or a health care professional other than the health care professional performing the diagnostic or therapeutic service, codes 99155-99157 are not to be reported. Therefore, when 99155-99157 (Moderate sedation services by a second provider) are billed in a non-facility place of service these codes are denied.

XV. Inpatient Clinical Social Worker (CSW) Services

Claim Type: Professional Claims, CMS 1500
Source: Pub 100-2 Medicare Benefit Policy

Definition: Any service billed in an inpatient hospital setting (POS 21) by a social worker (SOC) is denied.

XVI. Outpatient Hospital Services and Clinical Trials
Claim Type: Outpatient Facility Claim Submitted on a UB-04
Source: Pub 100-4 Medicare Claims Processing

Definition: This Edit will require claims billing for clinical trial services provided in an outpatient facility to include the following:

- Modifier Q0 (Investigational clinical service provided in a clinical research study that is in an approved clinical research study) or modifier Q1 (Routine clinical service provided in a clinical research study that is in an approved clinical research study [institutional facility])
- Condition code 30 (Qualifying clinical trial)
- Bill type 013X (Outpatient hospital)

*Note: Providers are still expected to refer to Blue Cross VT's Clinical Trials Corporate Medical Policy for guidelines, definitions, and benefit responsibilities when billing for these services.

XVII. Immunizations
Claim Type: Outpatient Facility Claim Submitted on a UB-04
Source: Pub 100-4 Medicare Claims Processing

Definition: Hepatitis A/B, influenza, or pneumococcal vaccines and their administration codes provided in a place of service designated Outpatient Rehabilitation Facility (ORF) (Bill Type 0740- 074Z) is denied.

XVIII. Condition Code 44
Claim Type: Outpatient Facility Claim Submitted on a UB-04
Source: CMS Pub 100-04

Definition: According to CMS policy, condition code 44 (Inpatient admission changed to outpatient) should be reported with Bill Types 0130-013Z (Outpatient hospital), or 0850-085Z (Critical access hospital). Therefore, any procedure billed with condition code 44 that are not billed with Bill Types 0130-013Z (Outpatient hospital), or 0850-085Z (Critical access hospital) are denied.

Code Edit: Post-Operative Visit

Effective Date: January 1, 2021
Claim Type: Professional claims, CMS 1500
Source: CMS

Definition: Identifies and recommends denial of Evaluation and Management or global procedure codes billed by the same provider within a procedures post-operative period. Claim line denies.

Code Edit: Pre-Operative Visit

Effective Date: January 1, 2021
Claim Type: Professional claims, CMS 1500
Source: CMS

Definition: Identifies procedure codes billed by the same provider within a procedure's preoperative period. Claim line denies.

Code Edit: Procedure Age

Effective Date: January 13, 2023
Claim Type: Professional claims, CMS 1500
Source: ADA Dental Services Manual, AMA CPT® Assistant, AMA CPT® Manual, AMA principles of CPT® coding; CMS, HCPCS Level II Manual.

Definition: Certain procedure codes, by definition or nature of the procedure, are limited to the treatment of a specific age or age group. Claims and/or claim lines reported with procedure codes that are inconsistent with the patient's age are denied.

Code Edit: Procedure Code Definition

Effective Date: January 13, 2023
Claim Type: Professional claims, CMS 1500 and Outpatient Facility Clams submitted on a UB-04
Source: AMA CPT® Manual, CMS, HCPCS Level II Manual.

Definition: This policy is based on our efforts to support correct coding and edits based on the definition or nature of a procedure code or a combination of procedure codes. These rules deny procedures based on the appropriateness of the code selection.

This edit applies:
Out of sequence claims (Mutually Exclusive and Non-Mutually Exclusive Edits):

Out of sequence claims are claims that involve procedures that have been performed on the same date of service and billed on multiple claims at different times. The claim with services that would usually be bundled is billed on a date prior to billing a claim with the more comprehensive procedure. When out of sequence claims are received, the subsequent services are denied.

Modifiers included in this policy: -24, -25, -57, -58, -78, -79, -27, -59, -91, -XE, -XS, -XP, -XU, -E1, -E2, -E3, -E4, - FA, -F1, F2, F3, -F4, -F5, -F6, -F7, F8, -F9, -TA, -T1, -T2, -T3, -T4, -T5, T6, -T7, -T8, -T9, -LT, -RT, -LC, -LD, -RC, - LM, -RI.

Code Edit: Procedure Code Guideline

Effective Date: January 13, 2023
Claim Type: Professional claims, CMS 1500
Source: AMA CPT® Assistant, AMA CPT® Manual, CMS, HCPCS Level II Manual, ADA Dental Services Manual

Definition: Throughout the AMA CPT® Manual and CMS HCPCS Level II Manual, publishers have provided instructions on code usage. This edit applies these guidelines and denies services that are coded inappropriately based on CPT® /HCPCS Procedure Code Guidelines.

Examples of edits applied:

- Modifier -63 when coded inappropriately based on CPT® /HCPCS Procedure Code Guidelines
- Out of Sequence Claims

Out of sequence claims are claims that involve procedures that have been performed on the same date of service and billed on multiple claims at different times. The claim with services that would usually be bundled is billed on a date prior to billing a claim with the more comprehensive procedure. This edit addresses out of sequence claims as they relate to services that would have been recoded into different procedures had they been billed together. When out of sequence claims are received, the subsequent services are denied.

Code Edit: Professional, Technical, and Global Services

Effective Date: January 13, 2023
Claim Type: Professional claims, CMS 1500 and Outpatient including Ambulatory Surgical Centers (ASC)
Source: CMS, AMA Principles of CPT® Coding, CMS National Physician Relative Value File

Definition: 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 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.

This edit applies AMA Principles of CPT® coding to verify if modifiers- 26 and -TC were appropriately reported. Claims and/or claim lines coded incorrectly or missing the appropriate modifiers are denied.

Payment is based on no more than the global service regardless of whether the billing is from the same or different provider, specialty, or Tax Identification. If any provider splits components of the same global service, whether on the same or different claims, then the claim(s) are adjusted to allow only the global service. (CMS guidelines).

Code Edit: Revenue Code

Effective Date: April 1, 2023
Claim Type: Outpatient Facility Claims Submitted on a UB-04
Source: See each edit for specifics

I. **Revenue Code Validity**
Source: OCE Edits
Definition: Identifies and denies claim lines with invalid revenue codes.

II. **Revenue Code Requires HCPCS**
Source: OCE Edits and Pub 100-4 Medicare Claims Processing

Definition: Claim lines containing revenue codes that CMS indicates requires a HCPCS code are denied when billed without the required HCPCS code. Additionally, CMS indicates that if a revenue code is billed with a modifier, a HCPCS code must be present on the same claim line. Revenue codes billed with a modifier and no HCPCS code is associated with the claim line is denied.

III. **Revenue Code-HCPCS Code Links**
Source: Official UB-04 Data Specifications Manual 2015 and UNIFORM BILLING EDITOR (UBE)

Definition: According to the Official UB-04 Data Specifications Manual and the Uniform Billing Editor (UBE), certain revenue codes require an appropriate HCPCS code to be billed on the same line. Furthermore, claim lines billed with HCPCS are required to match the revenue codes reported or the service is denied.

Revenue code included in this edit:

- 0278 (Other implants)

IV. **Professional Fee Revenue Codes**
Source: Pub 100-4 Medicare Claims Processing

Definition: Revenue Codes 0960-0989 represent professional fees that are being billed by the facility on behalf of a physician or other health care professional. It is not appropriate for the facility to use C codes, which are drugs, biologicals, devices, or technical services, with Revenue Codes 0960-0989. Drugs, biologicals, devices, and technical services should be billed under revenue codes other than 0960-0989. Professional components for technical services should be billed using the correct CPT® or HCPCS codes. Therefore, C codes billed with Revenue Codes 0960-0989 are denied.

V. Room and Board
Source: Coding Industry

Definition: Room and Board revenue codes 0100-0219 are intended to be used in the inpatient hospital setting. It is inappropriate for these codes to be billed under outpatient hospital bill types (0120-014Z). Therefore, room and board revenue codes are denied when billed in an outpatient hospital setting.

VI. Blood Products, Storage and Processing
Source: OCE Edits
Definition: The edit will follow Blue Cross VT's guidelines outlined on the Corporate Medical Policy for Blood and Blood Components, Platelet Derived Growth Factors and Prolotherapy. This Edit will identify and deny blood products P9010-P9040, P9043, P9044, P9048, P9051-P9060, P9070-P9071, P9073, P9099 when billed without Revenue Code 0392.

VII. Therapy Services Modifiers -GN, -GO and -GP
Source: Pub 100-4 Medicare Claims Processing

Definition: When a facility bills for a therapy service with Revenue Code 0420-0429 (Physical Therapy), 0430-0439 (Occupational therapy), or 0440-0449 (Speech-language pathology), the procedure or service must include a therapy modifier (-GN, -GO, or -GP) on the same line and the therapy services modifier should be appropriate to the revenue code reported for the service. Claims not following these guidelines are identified and denied.

VIII. Emergency Room Services and EMTALA Screening
Source: Pub 100-4 Medicare Claims Processing

Definition: Additional emergency services performed following an Emergency Treatment and Labor Act (EMTALA) screening must be reported with the EMTALA screening service. Therefore, services reported with Revenue Code 0452 (ER beyond EMTALA screening) is denied, unless services reported with Revenue Code 0451 (EMTALA emergency medical screening services) are also billed.

Additionally, E/M services reported with Revenue Code 0450 (Emergency Room General Classification) may not be reported in conjunction with E/M services reported under Revenue Code 0451 or 0452. In this instance the E/M billed with Revenue Code 0450 is denied.

IX. Laboratory Services
Source: CMS Transmittals, Memos and Publications

Definition: Identifies and denies claim lines with bill Type 0140-014Z (Hospital – laboratory services provided to non-patients) billed without the appropriate laboratory/pathology revenue codes (0300- 0319).

X. Allogeneic Stem Cell Acquisition Services
Source: Pub 100-4 Medicare Claims Processing

Definition: Revenue Code 0815 (Allogeneic stem cell acquisition/donor services) is required to be billed with an appropriate bill type (hospital inpatient, hospital outpatient or special facilities-critical access hospital).

XI. Home Health Services
Source: Pub 100-4 Medicare Claims Processing

Definition: Home Health services are required to have appropriate Revenue Codes and HCPCS codes. When the codes reported on a claim don't match, they are denied.

Code Edit: Same Day Visit

Effective Date: January 1, 2021
Claim Type: Professional claims, CMS 1500
Source: CMS

Definition: This claim editing logic identifies when an Evaluation and Management (E&M) service is billed on the same day as a surgical procedure or substantial diagnostic or therapeutic (such as dialysis, chemotherapy, and osteopathic manipulative treatment) procedure.

An E&M code reported for the same date of service as a procedure rendered by that same provider is considered included within the global reimbursement for that procedure. In such circumstances, CXT editing does not consider the E&M service for reimbursement and line is denied.

Code Edit: Separate Procedures

Effective Date: January 13, 2023

Claim Type: Professional claims, CMS 1500
Source: AMA CPT® Manual

Definition: CPT® codes that represent a "separate procedure" as described within the CPT® Manual is edited and denied when reported in conjunction with, and related to, a major service. However, in instances where the separate procedure is carried out independently from, or is unrelated to, the major procedure, then the service may be reported with a distinct services modifier as appropriate to the circumstance.

Code Edit: Split Surgical Care

Effective Date: January 13, 2023
Claim Type: Professional claims, CMS 1500
Source: AMA Principles of CPT Coding, CMS and Pub 100-4 Medicare Claims Processing

Definition: 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.

This edit will apply CMS guidelines to split surgical care and deny procedures inappropriately billed with modifiers, 54 (Surgical care only), 55 (Post-op management only), and 56 (Pre-op management only only). Additionally, this edit will deny a procedure billed with either modifier 54, 55 or 56 when another provider has billed the same code globally without a modifier.

Code Edit: Team Surgery

Effective Date: January 13, 2023
Claim Type: Professional Claims, CMS 1500
Source: CMS, and Current Procedural Terminology® (CPT®) guidelines

Definition: The Medicare Physician Fee Schedule includes a list of procedures and services where the Team Surgery concept does not apply. These are generally procedures that are minor or services that are non-surgical in nature and denied if billed with modifier -66 (team surgery).

Additional circumstances edited when billed with modifier -66:

Previously Processed Claims with Modifier -66

When a claim is received without modifier -66 and there exists a previously processed claim for the same procedure code with modifier -66 by any provider, the second claim is denied.

Previously Processed Claims Without Modifier -66

If a provider bills a procedure with modifier -66 and a claim has already been processed for any provider without modifier -66 appended to the code, the second claim is denied.

Please refer to the Provider Handbook for additional information on modifiers.

Code Edit: Therapy and Assistant Therapy Modifier

Effective Date: January 13, 2023
Claim Type: Professional claims, CMS 1500 and Outpatient Facility Clams submitted on a UB-04
Source: CMS

Definition: Therapy services are required to be billed with the following modifiers:

Therapy Services Modifiers-

- -GN - Services delivered under an outpatient speech language pathology plan of care
- -GO - Services delivered under an outpatient occupational therapy plan of care
- -GP - Services delivered under an outpatient physical therapy plan of care

Assistant Therapy Services Modifiers-

- -CO - Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant
- -CQ - Outpatient physical therapy services furnished in whole or in part by a physical therapy assistant

Claims for physical, speech, and occupational therapies are required to be billed with the appropriate modifier for the service. Claims without the appropriate modifier for services are denied.

Please refer to the Corporate Medical Policies for Physical Therapy/Medicine, Speech Language Pathology/Therapy Services and Occupational Therapy for additional information on these services.