Horizon Blue Cross Blue Shield of New Jersey

Correct Coding/Code Editing Guidelines

Beginning **September 14, 2017**, Horizon Blue Cross Blue Shield of New Jersey will begin adjusting certain professional claims processed between **April 1, 2016** and **March 31, 2017** to ensure that they are processed in accordance with the following nationally-recognized coding and code editing guidelines.

The initial population of claims to be adjusted beginning **September 14, 2017** are those for services rendered by nonparticipating practices. The adjustment of claims for services rendered by participating practices will be adjusted following a period of no less than 30 days from this announcement.

Bundled Services

Guideline	Action
Bundled Services Not Payable Under Any Circumstances	Deny bundled services for which payment is always routinely bundled into other services and supplies.

Duplicate Services

Guideline	Action
Duplicate Claim Logic for Anesthesia Services by Any Provider	Deny duplicate anesthesia service claims when billed by any provider.
Duplicate Claim Logic for Co-Surgeon Services	Deny co-surgeon procedures billed without modifier 62 when there exists a previously processed claim for the same procedure with modifier 62 by a different provider.

Evaluation and Management (E&M) Services

Guideline	Action
E&M services with Electrocardiogram (ECG)	Deny 93042 when billed with an E&M service in the hospital setting.
E&M Services with Critical Care	Deny E&M services (99201-99215, 99221-99223, 99231-99233, 99431, 99460, G0175) when billed with critical care service (99291) and the place of service is the same.
E&M Services with Pulmonary Diagnostic Procedures	Deny an E&M service when billed with 94010-94799 (Pulmonary function testing).
Multiple E&M Services on the Same Day	Allow the E&M code with the highest Relative Value Unit (RVU) price, when multiple E&M services are billed for the same date of service, provider group and specialty, except when modifier 25 is appended to the additional E&M service.
New Patient Visits	Deny a new patient visit when face-to-face service has previously been billed by the same physician or a physician from the same group practice (with the same specialty and subspecialty) within the last three years.
Discharge Services	Deny hospital discharge services (99238-99239) when 99238 or 99239 has been billed for the same date of service.
Multiple Inpatient Admission or Consultation Services	Deny an initial hospital care (99221-99223) to a subsequent hospital care (99231-99233), if an initial hospital care has been billed in the previous three days with the same diagnosis by the same Tax ID and subspecialty.
Inpatient Neonatal and Pediatric Critical Care and Intensive Care Services	Limit any combination of 99468-99476 (Neonatal and pediatric critical care) to one unit per date of service by any provider.
Observation Services	Deny initial observation care codes (99218-99220) or codes that include the initial observation care (99234-99236) when an initial observation care code has been billed for the previous day by any provider.
	Deny 99218-99220, 99224-99226 (Observation services) when billed for more than one unit per date of service in any combination by any provider and the place of service is 19 (Outpatient hospital - off campus), 21 (Inpatient hospital), 22 (Outpatient hospital - on campus), 23 (Emergency department) or 24 (Ambulatory Surgical Center).

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National Correct Coding Initiative (NCCI) Edits

Guideline	Action
Column One and Column Two Code Edits for Medicare Part B NCCI	Deny Column Two procedure code when billed with associated Column One procedure code. Non-Mutually Exclusive Edits.
Mutually Exclusive Edits for Medicare Part B NCCI	Deny Column Two procedure code when billed with associated Mutually Exclusive Column One procedure code.

Place of Service

Guideline	Action
Laboratory Services Billed By Physicians	Deny laboratory services (80000-89999) when billed in Place of Service 19 (Outpatient hospital-off campus), 21 (Inpatient hospital), 22 (Outpatient hospital-on campus), 23 (Emergency department), or 24 (ASC) by a provider with a specialty other than Dermatology, Genetics, Hematology, Laboratory, or Pathology.
Supplies and Equipment Provided in the Facility Setting	Deny medical and surgical supplies and DME when reported by professional providers with inpatient or facility places of service (CMS-1500)

Professional, Technical and Global Services

Guideline	Action
Clinical Laboratory Services	Deny clinical laboratory services with modifier 26 for those codes that do not have a separately payable professional service.
Diagnostic Tests or Radiology Services Performed Outside the Office Setting	Deny claim lines for diagnostic tests or radiology services when submitted by a provider in a facility place of service that are not appropriately appended with modifier 26.
Global Payment of Diagnostic Tests and Radiology Services	Limit professional reimbursement of diagnostic tests and radiology services to no more than the amount for the global service.
Technical Component in the Facility Setting	Deny diagnostic tests or radiology services billed with modifier TC in the inpatient or outpatient facility setting.
	Deny technical component only procedures in the inpatient or outpatient facility setting.

Please note that the correct coding guidelines listed here are part of a larger Horizon BCBSNJ effort to address/correct claims not processed in accordance with nationally-recognized coding and code editing guidelines. Additional notices will be posted in the future to advise of additional claim adjustment efforts to be conducted.

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