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

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bundled Services Not Payable Under Any Circumstances</td>
<td>Deny bundled services for which payment is always routinely bundled into other services and supplies.</td>
</tr>
</tbody>
</table>

### Duplicate Services

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duplicate Claim Logic for Anesthesia Services by Any Provider</td>
<td>Deny duplicate anesthesia service claims when billed by any provider.</td>
</tr>
<tr>
<td>Duplicate Claim Logic for Co-Surgeon Services</td>
<td>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.</td>
</tr>
</tbody>
</table>

### Evaluation and Management (E&M) Services

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>E&amp;M services with Electrocardiogram (ECG)</td>
<td>Deny 93042 when billed with an E&amp;M service in the hospital setting.</td>
</tr>
<tr>
<td>E&amp;M Services with Critical Care</td>
<td>Deny E&amp;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.</td>
</tr>
<tr>
<td>E&amp;M Services with Pulmonary Diagnostic Procedures</td>
<td>Deny an E&amp;M service when billed with 94010-94799 (Pulmonary function testing).</td>
</tr>
<tr>
<td>Multiple E&amp;M Services on the Same Day</td>
<td>Allow the E&amp;M code with the highest Relative Value Unit (RVU) price, when multiple E&amp;M services are billed for the same date of service, provider group and specialty, except when modifier 25 is appended to the additional E&amp;M service.</td>
</tr>
<tr>
<td>New Patient Visits</td>
<td>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.</td>
</tr>
<tr>
<td>Discharge Services</td>
<td>Deny hospital discharge services (99238-99239) when 99238 or 99239 has been billed for the same date of service.</td>
</tr>
<tr>
<td>Multiple Inpatient Admission or Consultation Services</td>
<td>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.</td>
</tr>
<tr>
<td>Inpatient Neonatal and Pediatric Critical Care and Intensive Care Services</td>
<td>Limit any combination of 99468-99476 (Neonatal and pediatric critical care) to one unit per date of service by any provider.</td>
</tr>
<tr>
<td>Observation Services</td>
<td>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).</td>
</tr>
</tbody>
</table>
### National Correct Coding Initiative (NCCI) Edits

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Column One and Column Two Code Edits for Medicare Part B NCCI</td>
<td>Deny Column Two procedure code when billed with associated Column One procedure code. Non-Mutually Exclusive Edits.</td>
</tr>
<tr>
<td>Mutually Exclusive Edits for Medicare Part B NCCI</td>
<td>Deny Column Two procedure code when billed with associated Mutually Exclusive Column One procedure code.</td>
</tr>
</tbody>
</table>

### Place of Service

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory Services Billed By Physicians</td>
<td>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.</td>
</tr>
<tr>
<td>Supplies and Equipment Provided in the Facility Setting</td>
<td>Deny medical and surgical supplies and DME when reported by professional providers with inpatient or facility places of service (CMS-1500)</td>
</tr>
</tbody>
</table>

### Professional, Technical and Global Services

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Laboratory Services</td>
<td>Deny clinical laboratory services with modifier 26 for those codes that do not have a separately payable professional service.</td>
</tr>
<tr>
<td>Diagnostic Tests or Radiology Services Performed Outside the Office Setting</td>
<td>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.</td>
</tr>
<tr>
<td>Global Payment of Diagnostic Tests and Radiology Services</td>
<td>Limit professional reimbursement of diagnostic tests and radiology services to no more than the amount for the global service.</td>
</tr>
<tr>
<td>Technical Component in the Facility Setting</td>
<td>Deny diagnostic tests or radiology services billed with modifier TC in the inpatient or outpatient facility setting.</td>
</tr>
<tr>
<td></td>
<td>Deny technical component only procedures in the inpatient or outpatient facility setting.</td>
</tr>
</tbody>
</table>

*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.*

CPT® is a registered mark of the American Medical Association.