Correct Coding/Code Editing Guidelines

Beginning **January 5, 2018**, Horizon Blue Cross Blue Shield of New Jersey will begin adjusting certain professional claims processed between **July 2016** and **March 2017** to ensure that they are processed in accordance with the following nationally-recognized coding and code-editing guidelines.

Assistant at Surgery Services

Guideline	Action
Assistant Surgeons Not Allowed	Deny codes when billed as assistant surgeon when the codes are designated as *assistant surgeon not allowed*.

Co-Surgeon Services

Guideline	Action
Co-Surgeons Allowed and Specialty Requirements Are Met	Deny co-surgeon claims when both surgeons have the same specialty for procedures designated as *co-surgeons are allowed*.
Co-Surgeon Services Not Billed with Modifier 62	Deny procedures designated as *co-surgeons allowed* when billed without modifier 62 and there exists a previously processed claim for the same procedure code with modifier 62 by a different provider.
Co-Surgeon Services Billed with Modifier 62	Deny procedures designated as *co-surgeons allowed* when billed with modifier 62 when there exists a previously processed claim for the same procedure code by a different provider without modifier 62.

Duplicate Services

Guideline	Action
Duplicate Claim Logic for Global Surgery Procedures	Deny 0-, 10- or 90-day procedures when the same code has been billed for the same date of service with the same number of submitted units by a different Tax ID, different Provider ID and any specialty.
Duplicate Claim Logic for Independent Laboratory Services	Deny claim lines reported by an independent laboratory when billed by a different Tax ID Number, any Provider ID or any specialty.
Duplicate Laboratory Services for Office and Independent Laboratory	Deny claim lines as duplicates when the duplicate criteria have been met.
Duplicate/Multiple Professional Components for the Same Service	Reimburse only one professional component for the same service when billed by different providers.
	Reimburse only one professional component code for the same service when billed by different providers.
Duplicate/Multiple Technical Components for the Same Service	Reimburse only one technical component for the same service when billed by different providers.
	Reimburse only one technical component code for the same service when billed by different providers.

Evaluation and Management (E&M) Services

Guideline	Action
Discharge Services	Deny hospital discharge services (99238- 99239) when 99238 or 99239 was billed and allowed on the subsequent date of service.
Observation Services	Deny hospital discharge services (99238-99239) when 99238 or 99239 was billed the previous day.

Global Surgery Services

Guideline	Action
Major Surgery: 90-Day Procedures	Deny E&M services when performed the day prior to a 90-day medical or surgical service.
	Deny E&M services when performed the same day as a 90-day medical or surgical service.
	Deny E&M services performed within 90 postoperative days of a 90-day medical or surgical service.
	Deny E&M services performed within 90 postoperative days of a 90-day medical or surgical service when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of Provider ID and specialty, and the E&M service has a primary diagnosis associated to the 90-day medical or surgical service.
	Deny E&M services performed within 90 postoperative days of a 90-day medical or surgical service when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of Provider ID and specialty, and the diagnosis is a complication of surgical and medical care or an aftercare diagnosis.
Minor Surgery: 0-Day Procedures	Deny E&M services when billed on the same day as a 0-day medical or surgical service.
	Deny E&M services when performed the same day as a 10-day medical or surgical service.
	Deny E&M services performed within 10 postoperative days of a 10-day medical or surgical service.
Modifier 24 with E&M Services During the Postoperative Period of Major Procedures	Deny E&M services when billed with modifier 24 and a major surgical procedure with a 90-day postoperative period has been billed in the previous 90 days and the E&M service has a primary diagnosis associated with the 90-day medical or surgical service.
	Deny E&M services when billed with modifier 24 and a major surgical procedure with a 90-day postoperative period has been billed in the previous 90 days and the E&M diagnosis is a complication of surgical and medical care or an aftercare diagnosis.
Modifier 24 with E&M Services During the Postoperative Period of Minor Procedures	Deny E&M services when billed with modifier 24 and a minor surgical procedure with a 10-day postoperative period has been billed in the previous 10 days and the E&M service has a primary diagnosis associated to the 10-day medical or surgical service.
	Deny E&M services when billed with modifier 24 and a minor surgical procedure with a 10-day postoperative period has been billed in the previous 10 days and the E&M diagnosis is a complication of surgical and medical care or an aftercare diagnosis.
Other Medical and Surgical Service during the Postoperative Period	Deny 0, 10 or 90-day surgical procedures performed within 90 days of a 90-day surgical procedure.
	Deny separate reimbursement for services typically considered part of a minor 10-day surgical procedure.
	Deny 0-day and 10-day surgical procedures performed within 10 postoperative days of a 10-day procedure.
	Deny separate reimbursement for services typically considered part of a major 90-day surgical procedure.
	Deny 0-day and 10-day surgical procedures performed within 10 postoperative days of a 10-day surgical procedure when submitted by the same Provider ID, regardless of Tax ID and specialty.
	Deny 0, 10 or 90-day surgical procedures billed by the same Provider ID, regardless of Tax ID and specialty within 90 days of a 90-day surgical procedure.

Incident To Services

Guideline	Action
Incident To Services	Deny *incident to services* when billed with a place of service code 19, 21, 22, 23, 24, 26, 31, 34, 41, 42, 51, 52, 53, 56, or 61.

Place of Service

Guideline	Action
Professional Component of Radiology Services in Facility Places of Service	Deny professional radiology services when billed by an anesthesiologist in the inpatient or outpatient hospital setting.
	Deny professional radiology services when billed by a radiation oncologist in the inpatient or outpatient hospital setting.
	Deny professional radiology services when billed by a cardiologist in the inpatient or outpatient hospital setting.

Procedure Code Definitions/Guidelines

Guideline	Action
Procedure Code Definition Rules	Deny procedures based on CPT® and HCPCS procedure code definition (e.g., denial based on a code's stated inclusion of another code, denial of a code based on its defined frequency).
Procedure Code Guidelines	Deny services that are coded inappropriately based on CPT/HCPCS procedure code guidelines (e.g., denial of a particular code when billed in combination with other codes if the use of another code is more appropriate).

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 on ***HorizonBlue.com/providernews*** *in the future to advise of additional claim adjustment efforts to be conducted.*