Correct Coding/Code-Editing Guidelines

Beginning **October 11, 2019**, Horizon BCBSNJ will begin adjusting certain professional claims processed between **July 1, 2018** and **February 25, 2019** to ensure they are processed in accordance with the following nationally recognized coding and code-editing guidelines.

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.

Assistant at Surgery Services

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

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.

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 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 a previously processed claim exists for the same procedure with modifier 62 by a different provider.
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 for the same service when billed by different providers.

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Duplicate Services *(continued)*

Guideline	Action
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
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.
	Deny hospital discharge services (99238- 99239) when 99238 or 99239 was billed and allowed on the subsequent 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).
	Deny hospital discharge services (99238-99239) when 99238 or 99239 was billed the previous day.

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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.

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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.

National Correct Coding Initiative (NCCI) Edits

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

Procedure Code Rules/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 or 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).

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.