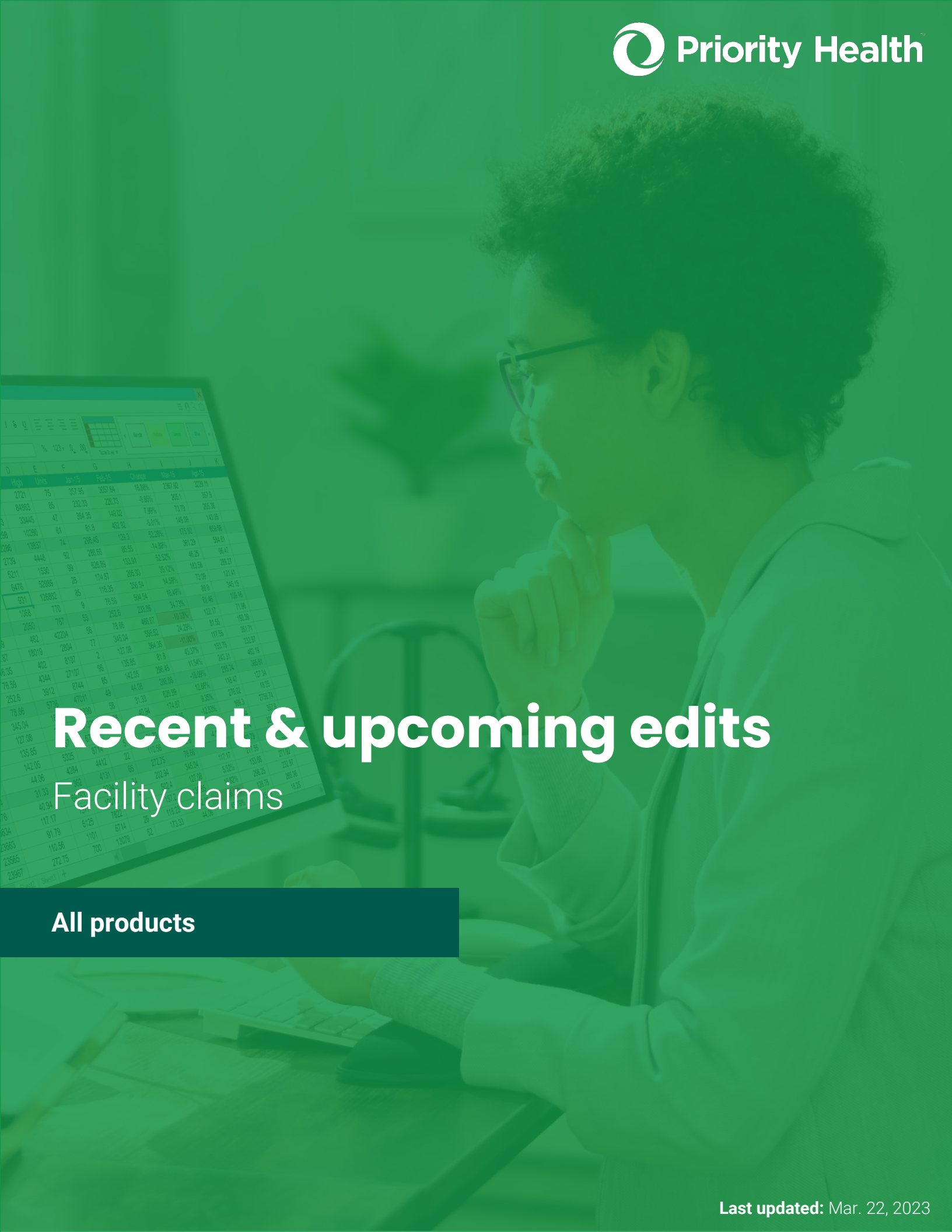
Priority Health



Recent & upcoming edits

Facility claims

All products

Last updated: Mar. 22, 2023

We value the care you provide our members and strive to reimburse you accurately and fairly for that care. Thoughtful implementation of clinical edits supports this goal, while allowing us to process your claims more efficiently.

This guide includes descriptions of our upcoming or newly implemented clinical edits, organized by claim and product type.

Starting in 2023, we'll update this document monthly. Bookmark the document URL in your internet browser to make sure you always have access to the most up-to-date version.

Use our **Edits Checker tool** to enter your claims data and view any clinical edits that will apply, with the associated rationale.

Access Edits Checker
(login required)

Learn more about clinical edits, including our clinical edits policy, unbundling payment policy, appeals and more.

See Clinical Edits info online

All products

Ambulance Required Modifiers for Ambulance Service HCPCS Code Rule

Effective: Q3 2022

Ambulance origin and destination modifiers should be appended to ambulance services. A modifier indicating whether the service was provided under arrangement or directly should also be appended. Ambulance codes that are missing origin and destination modifiers and/or a modifier to indicate whether the service was provided under arrangement or directly will be denied. Refer to the Ambulance services page in the Provider Manual for exceptions and further information.

Covid-19 Lab Add-On Code Reported Without Required Primary Procedure

Effective: May 19, 2022

Procedure code U0005 is reported in addition to either HCPCS code U0003 or U0004 per HCPCS guidelines. Procedure code U0005 reported without U0003 or U0004 for the same date of service will be denied.

Critical Access Hospital (CAH) Bilateral Procedures Rule

Effective: May 19, 2022

Modifiers LT (left side) and RT (right side) shouldn't be reported when Modifier 50 (bilateral procedure) is applicable. A CAH bilateral service will be denied when it's reported with the same service date on two separate claim lines, once with modifier LT and again with modifier RT. A CAH bilateral service will also be denied when it's reported on a single claim line with both modifier LT and RT.

Device-Intensive Procedures Requiring Device HCPCS Code

Effective: Sept. 15, 2022

Claims submitted for device-intensive procedures require the reporting of the device HCPCS code on the same date of service. Claims submitted without the device HCPCS code will be denied. Discontinued procedures would be excluded from editing (identified by modifiers 73,74) as well as revision procedures (identified by CG modifier).

Diagnosis Coding - Excludes1

Effective: Oct. 15, 2022

ICD-10's Excludes1 criteria details diagnosis codes that shouldn't be reported together because the two codes can't occur at the same time. Reference the ICD-10 coding manual's Excludes Notes section for more detail and examples.

Durable Medical Equipment Required Modifiers

Effective: Aug. 30, 2022

Several DME, PO and supplies HCPCS codes require the use of modifiers to identify that anatomical, laterality, functional or support policy criteria is met. Claims reported without required modifiers will be denied. Those reported with modifiers that do not support medical necessity may be member liability. Note that this does not replace the need for NU, RR, UE, etc. associated with DME items. For more detail, see DME authorizations and billing.

Duplicative Laboratory Professional and Facility Procedures

Effective: May 19, 2022

The professional component of a laboratory service should only be reported by either the practitioner or facility; likewise, the technical component of a laboratory service should only be reported by either the practitioner or facility. The laboratory service will be denied when the same laboratory service component has been reported for the same date of service on a professional claim.

Multiple Facility E/M Services on the Same Date

Effective: Sept. 15, 2022

When multiple E/M services (including clinic visits) are performed by the same facility on the same date of service, modifier 27 and condition code G0 should be appended to the facility claim to indicate visits were considered distinct and independent from one another. These modifiers and condition codes should be reported on the second claim (and additional) submitted for the date of service. Claims submitted without the appropriate modifier and condition code will be denied.

Ocrelizumab Injection Code Billed More Than Twice Per Month

Effective: May 28, 2023

The FDA provides guidance around approved indications for use of defined drugs and biologicals. These approved indications identify timing or dosing requirements appropriate for use with this drug for defined treatments or diagnoses. In alignment with the dosing instructions for J2350 (Injection, ocrelizumab, 1 mg), two 300-mg infusions should occur two weeks apart. To apply accurate dosing criteria, a denial will apply to J2350 when billed by any provider more than two visits per month and the diagnosis is relapsing or primary progressive multiple sclerosis.

Principal or First-Listed Diagnosis Codes

Effective: Oct. 1, 2022

ICD-10 coding guidelines require coding to the highest level of specificity. They've designated certain diagnosis codes to be principal or first-listed. As the description indicates, these diagnosis codes should be listed first on the claim. Details are available in the ICD-10-CM Guidelines – April 2022 update.

Revenue Code Requires HCPCS

Effective: Sept. 15, 2022

There are certain revenue codes that require the reporting of a HCPCS code. Claims submitted with revenue codes that are missing the required HCPCS will be denied. This edit will impact claim lines with charges, a revenue code that requires an HCPCS code (not packaged), with no HCPCS codes. The logic Medicare Claims Manual, Section 20.1 General states: “The HCPCS codes are required for all outpatient hospital services unless specifically defined as an exception in manual instructions. This means that codes are required on surgery, radiology, other diagnostic procedures, clinical diagnostic laboratory, durable medical equipment, orthotic-prosthetic devices, take-home surgical dressings, therapies, preventative services, immunosuppressive drugs, other covered drugs, and most other services."

Resubmissions for Adjusted Claim Type of Bills and Change Reason Codes

Effective: Sept. 15, 2022

For accurate identification of facility claim corrections, facilities should report the appropriate adjustment indicator for a corrected or voided/canceled claim along with the claim change reason code. To accurately identify these, report with one of the following bill types:

- **Bill type xx7** should be reported to request an adjustment based on the corrected claim submission along with the appropriate claim change reason code (equal to condition codes D0-D4, D7, D8, D9*, or E0)
- **Bill type xx8** should be reported to request the claim be voided or cancelled along with the appropriate claim change reason code (equal to condition codes D5 and D6)

Claims reported without this bill type and correct claim change reason code (see below) will be denied.

Claim change reason codes

- **D0** - Changes to service dates
- **D1** - Changes in charges
- **D2** - Changes in revenue code/HCPC
- **D3** - Second or subsequent interim PPS bill
- **D4** - Change in Grouper input (DRG)
- **D5** - Cancel only to correct a patient's Medicare ID number or provider number
- **D6** - Cancel only - duplicate payment, outpatient to inpatient overlap, OIG overpayment
- **D7** - Change to make Medicare secondary payer
- **D8** - Change to make Medicare primary payer
- **D9** - Any other changes (should be used only when no other change reason is applicable)

Use of condition code D9 should also include a remark to mirror bold criteria below on the second line of remarks:

- **Patient control nbr** - changing or adding a patient control number

- **Admission hour** - changing or adding the admission hour
- **Admission type** - changing or adding the admission type
- **Admission source** - changing or adding the admission source
- **Medical record number** - changing or adding the medical record number
- **Condition code** - changing or adding a condition code
- **Occ codes** - changing or adding an occurrence code
- **Occ span codes** - changing or adding an occurrence span code
- **Value codes** - changing or adding a value code
- **Modifier** - changing or adding a modifier
- **Date of service** - changing a date of service on a line or changing the statement from and to dates, use a D0
- **Units** - changing units
- **Recalculation** - claim recalculated for a different payment
- **Multiple changes** - Please enter your changes
- **DX code** - changing a diagnosis code on an outpatient claim, inpatient claims would use a D4
- **POA** - changing, adding, or removing a Present on Admission (POA) indicator, unless you are changing an N to a Y and/or if it affects reimbursement then you would use a D4
- **Removed non** - removing non-covered charges
- **Other** - Place this information on the second line of the claim only. On the third line of claim include a brief description of why the claim is being adjusted

Unspecified Code

Effective: Oct. 11, 2022

Diagnosis codes should be reported to the highest level of specificity. Certain unspecified diagnoses codes designated as either a Complication or Comorbidity (CC) or Major Complication or Comorbidity (MCC) will be denied when reported on an inpatient claim.