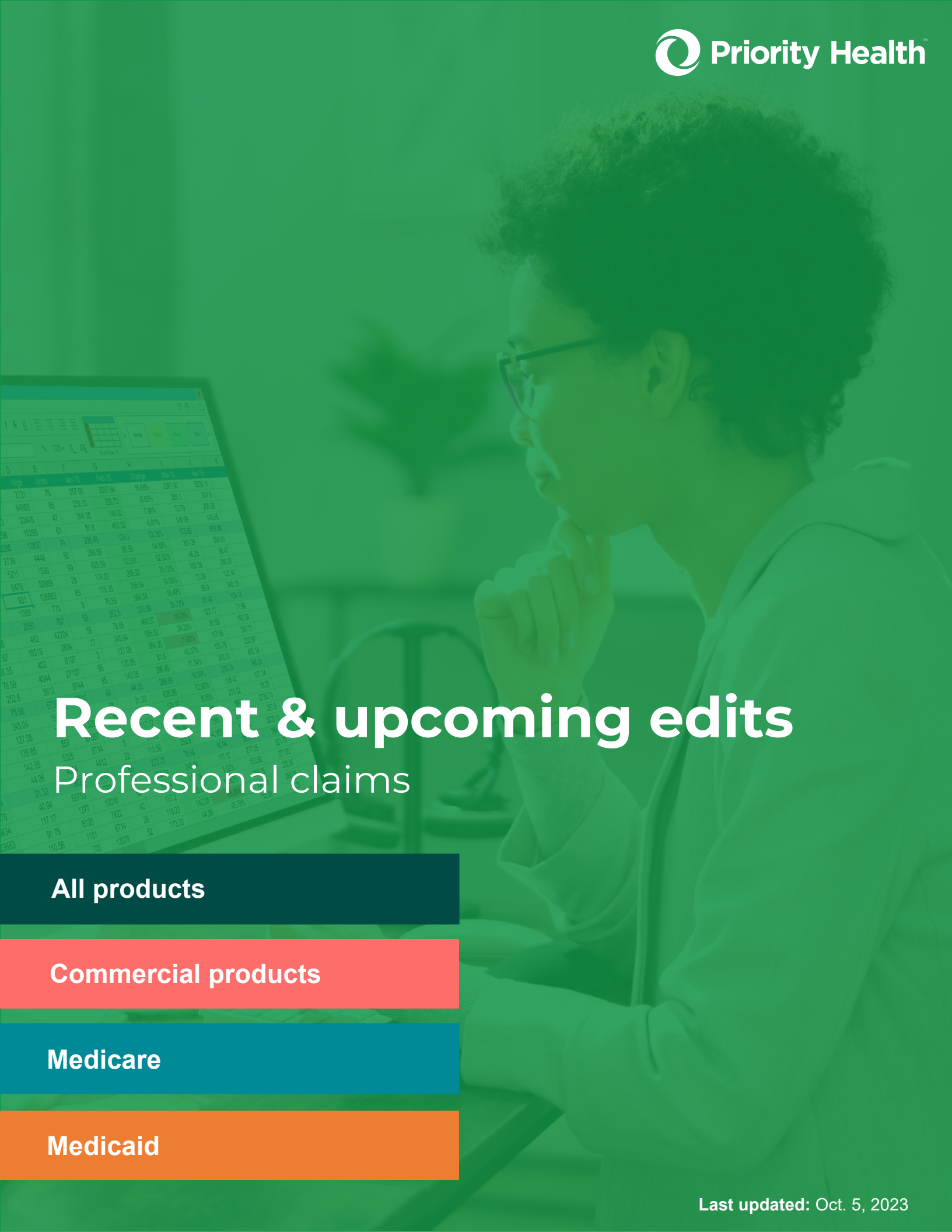
Priority Health



Recent & upcoming edits

Professional claims

All products

Commercial products

Medicare

Medicaid

Last updated: Oct. 5, 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 During Inpatient Stay

Effective: May 19, 2022

Ambulance services are not separately payable when reported with a date of service within an admission and discharge date of an inpatient claim per PH payment policy. The service is considered bundled to the inpatient stay and will be denied. The edit will not apply if the service was provided on the day of admission or day of discharge of the inpatient stay. Ambulance services provided during an inpatient leave of absence (LOA) that have been denied with the edit may be reconsidered via the Reviews & Appeals process.

Ambulance Required Modifiers for Ambulance Service HCPCS Code Rule

Effective: Q3 2022

Ambulance origin and destination modifiers should be appended to ambulance services. Ambulance codes that are missing origin and destination modifiers will be denied. Exception – an ambulance service will not be denied for missing origin and destination modifiers if modifier QL is appended to indicate the patient was pronounced dead after the ambulance was called.

Antepartum Care Codes Submitted in History Prior to OB Package Code

Effective: May 19, 2022

The maternity global package codes include routine antepartum care, delivery and postpartum care per CPT guidelines. Antepartum care only codes will be denied when reported by the same provider within 280 days prior to a global delivery code.

Anatomical Modifier Not Appropriate

Effective: June 29, 2022

Anatomical modifiers are used to designate the area or part of the body on which the procedure is performed. When an anatomical modifier is appended to a procedure code that doesn't match the anatomical site indicated by the modifier, the service will be denied.

Anatomical Modifiers Use Max Frequency

Effective: May 19, 2022

Claims will deny excess units when any provider bills more than one unit of service with an anatomical modifier E1-E4 (Eyes), FA-F9 (Fingers), and TA-T9 (Toes). Anatomical modifiers of E1-E4, FA-F9, TA-T9 have a maximum allowable of one unit per anatomical site for a given date of service. Any service billed with an anatomical modifier for more than one unit of service will be adjusted accordingly.

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. Please 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.

E/M service bundling

Effective: Nov. 26, 2023

E/M services are inherently included in procedures and services performed on the same date. These services are considered bundled into the more comprehensive procedure or service performed on this date. Services performed on the same date will be considered inclusive unless the E/M service is considered significant, separately identifiable and supported within the medical record. These guidelines are detailed within the National Correct Coding Initiative (NCCI) guidelines. We use NCCI guidelines as a component of our clinical edit criteria. Claims reported with E/M codes on the same date as another procedure or service may deny per our clinical editing guidelines. The appropriate modifier should be appended if appropriate. See our Provider Manual for clinical edit information.

ESRD Services Billed More Than Once Per Month

Effective: Aug. 15, 2023

CPT Professional Edition guidelines provide specific guidance for reporting ESRD services. Pay close attention to the timing defined in the codes below for accurate reporting. Services will deny if the frequency doesn't align with the code definition:

- **90951 –** 4 or more face-to-face visits by a physician or other qualified health care professional per month and the patient is younger than 2 years of age
- **90954 –** 4 or more face-to-face visits by a physician or other qualified health care professional per month and the patient is 2-11 years of age.
- **90957 –** 4 or more face-to-face visits by a physician or other qualified health care professional per month and the patient is 12-19 years of age.
- **90960 –** 4 or more face-to-face visits by a physician or other qualified health care professional per month and the patient is 20 years of age or older.
- **90952 –** 2-3 face-to-face visits by a physician or other qualified health care professional per month and the patient is younger than 2 years of age.
- **90955 –** 2-3 face-to-face visits by a physician or other qualified health care professional per month and the patient is 2-11 years of age.
- **90958 –** 2-3 face-to-face visits by a physician or other qualified health care professional per month and the patient is 12-19 years of age.
- **90961 –** 2-3 face-to-face visits by a physician or other qualified health care professional per month and the patient is 20 years of age or older.
- **90953 –** 1 face-to-face visit by a physician or other qualified health care professional per month and the patient is younger than 2 years of age.
- **90956 –** 1 face-to-face visit by a physician or other qualified health care professional per month and the patient is 2-11 years of age.
- **90959 –** 1 face-to-face visit by a physician or other qualified health care professional per month and the patient is 12-19 years of age.
- **90962 –** 1 face-to-face visit by a physician or other qualified health care professional per month and the patient is 20 years of age or older.

Global Surgical Packages

Effective: Oct. 29, 2023

As an industry standard, our correct coding policy adopted the CMS global surgical package guidelines. As defined by CMS Medicare Fee Schedule Database (MFSDB), services are defined for global surgical package with a 0-, 10-, or 90-day global period (10-day is minor; 90-day is major). Refer to our provider manual for more information.

Inappropriate Use of Modifier 25

Effective: June 29, 2022

Refer to the Modifier 25, separate E&M service, same physician, same day page in the Provider Manual for information on appropriate use of modifier 25. E&M services billed with Modifier 25 will be denied if the only other service reported for the member for the same date of service is a major surgery.

Inappropriate Use of Modifier 57

Effective: June 29, 2022

Modifier 57 is appropriate for use when the E&M service has resulted in a decision to perform a major procedure. E&M services billed with modifier 57 will be denied if a major surgery isn't reported on the same date of service or one day after the E&M service.

Missing Injection Code on Claim for Xiaflex® for Peyronie's Disease

Effective: Apr. 23, 2023

We're adopting CMS policy that requires injections associated with HCPCS J0775 for diagnosis of Peyronie's disease (N48.6) to be reported on the same date with CPT 54200 (Injection procedure for Peyronie disease). Edits will apply to claims with J0775 when billed with a diagnosis of Peyronie's disease and injection code 54200 has not been billed for the same date of service by any provider.

Misuse of JW Modifier

Effective: Apr. 23, 2023

We've defined billing guidelines associated with the use of the JW modifier. The JW modifier is used to identify waste or discarded amounts not administered to the member. See our JW modifier page for guidelines on reporting the JW. An edit will apply to a drug when billed with modifier JW (drug amount discharged / not administered to any patient) and another claim line does not exist for the same drug on the same date of service.

Obstetric Services, Global Care

Effective: May 19, 2022

Claims will deny Evaluation and Management services (99202-99215) when billed with a diagnosis of post-partum care uncomplicated postpartum care (ICD-10 codes Z39-Z39.2), contraceptive management (ICD-10 codes Z30.011, Z30.013-Z30.09), or family planning advice when a delivery care only service (59409, 59514, 59612, 59620) has been billed in the past 42 days (6 weeks) by any provider.

AMA CPT manual instructs postpartum care cannot be reported as a separate E/M service during the postpartum period, whether performed by the same provider who

performed the delivery or by a different provider. Postpartum care is correctly reported.

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.

Online Digital E/M or Assessment Group Frequency

Effective: Q3 2022

Online digital evaluation and management (E/M) services may be reported only once in a 7-day period by the same provider per CPT coding guidelines. Online digital evaluation and management (E/M) services reported more than once in a 7-day period by the same provider will be denied.

Oxygen, supplies and accessories rentals

Effective: Nov. 26, 2023

As a reminder, oxygen, oxygen supplies and accessories related to a rental device should only be reported once per month. Rental items reported more than once per month may be denied. See our Provider Manual for more information.

Pelvic & transvaginal ultrasounds performed concurrently

Effective: Nov. 26, 2023

Pelvic and transvaginal ultrasounds are commonly performed in conjunction with one another. Typically, one method leads to another for a more accurate view of the anatomy. In these cases, the pelvic ultrasound service (76856-76857) would be considered inclusive to transvaginal ultrasound (76830) since the same anatomical elements are assessed when performed on the same date. Services performed during separate encounters should be reported with the appropriate modifier(s).

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.

Surgical Supplies

Effective: May 19, 2022

Claims will deny when surgical dressings A6010-A6011, A6021-A6025, A6196-A6224, A6228-A6248, A6250-A6262, A6266, A6402-A6404, A6407, A6413, A6441-A6456 are billed in the provider's office (POS 11). According to CMS policy, when a physician applies surgical dressings as part of a professional service, the surgical dressings are considered incident to the professional services of the health care practitioner and are not separately payable.

Trastuzumab Biologics, Multiple Vials

Effective: Apr. 23, 2023

We're aligning with Centers for Medicare & Medicaid Services (CMS) policy on multi-vial drugs to deny units that align with an entire multi-use vial. Discarded amounts of multi-use vials are not payable. Edits will apply to claims reported with Q5112-Q5117 when billed with units representing a multiple of an entire vial (42, 84 or 126 units) and another claim line for the same drug does not exist on the same claim for the same date of service.

Vaccines and Administration

Effective: May 19, 2022

Claims will deny immunization administration (90460-90461, 90471-90474) when billed without a vaccine/toxoid code (90476-90750, 90756, 90758, 90759, J3530, Q2034-Q2039) by any provider on the same date of service. AMA CPT Manual and the HCPCS Level II Manual, immunization administration for vaccines and toxoids (90460-90461, 90471-90474) must be reported in addition to the vaccine and toxoid codes (90476-90750, 90756, 90758, 90759, J3530, Q2034-Q2039).

For Priority Health Medicaid, vaccines should be reported with a zero allowed amount for vaccines supplied though the State as part of the Vaccine for Children (VFC) program. See page 20 of Michigan VFC Provider Manual for additional detail.

Commercial products

Anterior Cervical Procedures Performed on the Same Day

Effective: Aug. 15, 2023

Pay close attention to coding guidelines for statements that direct specific coding guidance. Failure to follow the CPT defined coding guidelines can result in claim denials.

For example: An anterior cervical interbody fusion and an anterior cervical discectomy performed on the same date (same or different providers). The CPT Professional Edition coding guidelines states, "Do not report 22554 in conjunction with 63075, even if performed by a separate individual." CPT redirects to use CPT 22551: "To report anterior cervical discectomy and interbody fusion at the same level during the same session, use code 22551."

Bevacizumab and Biosimilars Billed without Approved Indication

Effective: May 28, 2023

The FDA provides guidance around approved indications or approved off-label indications for use of defined drugs and biologicals. These approved indications or off-label indications identify conditions or diagnoses appropriate for use with this drug. A denial will be applied to claims reported for the following codes when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim:

- J9035 – Injection, bevacizumab, 10 mg
- Q5107 – Injection bevacizumab-AWWB, biosimilar, (MVASI), 10 mg
- Q5118 – Injection, bevacizumab-BVZR, biosimilar, (ZIRABEV), 10 mg
- Q5126 – Injection, bevacizumab-MALY, biosimilar, (ALYMSYS), 10 mg

Daratumumab Injection Code on Claim without Approved Indication

Effective: May 28, 2023

The FDA provides guidance around approved indications or approved off-label indications for use of defined drugs and biologicals. These approved indications or off-label indications identify conditions or diagnoses appropriate for use with this drug. A denial will be applied to claims reported for J9144 (Injection, daratumumab, 10 mg and hyaluronidase-fihj) when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim. FDA approved codes: C90.00-C90.32 and E85.81.

FS Modifier Reported with Office Visits by POS Code

Effective: July 25, 2023 or after

We're aligning with Centers for Medicare & Medicaid Services (CMS) policy and the American Medical Association (AMA) to deny claims coded with the FS modifier (split or shared evaluation and management (E&M) visit) when reported with office visit codes with the following place of service (POS) codes: 03, 04, 05, 07, 09, 11, 15, 17, 20, 26, 49, 50, 57, 65, 71, 72

Multiple Gestation Delivery

Effective: May 19, 2022

Diagnosis codes for multiple gestation and outcome of delivery should be reported when billing multiple vaginal or cesarean procedure codes for the delivery of multiple gestations. Multiple vaginal or cesarean procedure codes reported without a multiple gestation diagnosis code and an outcome of delivery code will be denied.

Spravato Reported with Inappropriate NDC Code

Effective: July 23, 2023

We're aligning with Centers for Medicare & Medicaid Services (CMS) HCPCS Level II Manual and the National Drug Code (NDC) directory to deny Spravato (exketamine hydrochloride) when billed with an inappropriate NDC code.

According to the NDC directory, Spravato is dispensed with a strength of 28mg/0.2ml. NDC package code* 50458-028-03 describes an 84mg kit with three blister packs at 28mg each.

Edits will apply when HCPCS code S0013, "Esketamine nasal spray, 1mg" is reported with an NDC number that doesn't match the units ordered to be reimbursed.

Clinical examples*:

- Will pay: A provider bills S0013 with 84 units and NDC code 50458-028-03
- Will deny: A provider bills S0013 with 56 units and NDC code 50458-028-03

**Note: NDC package codes can change. The current NDC code should be used.*

Telehealth Services: New vs. Existing Patients

Effective: Dec. 5, 2023

pay close attention to coding guidelines as defined in the CPT Manual. Coding guidelines are aligned with edit logic in our system and failure to follow these guidelines may result in claim denials. For example, telehealth services shouldn't be coded for new patients when the code description is specific to established patients. These services will be denied in our system. Refer to the Provider Manual for additional details on correct coding and clinical edit sources.

Unattended Home Sleep Studies & Modifier TC

Effective: Aug. 29, 2023

Pay close attention to CPT descriptions to accurately align place of service (POS) and applicable modifiers. When CPT codes specifically define where a service is being performed, such as unattended home sleep studies (codes below), the POS reported must align with the code description:

- 95800
- 95801
- 95806
- G0398
- G0399
- G0400

Services rendered in the home setting should align with place of service 12 – Home.

Medicare

Bevacizumab and Biosimilars Billed without Approved Indication

Effective: May 28, 2023

The FDA provides guidance around approved indications or approved off-label indications for use of defined drugs and biologicals. These approved indications or off-label indications identify conditions or diagnoses appropriate for use with this drug. A denial will be applied to claims reported for the following codes when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim:

- J9035 – Injection, bevacizumab, 10 mg
- Q5107 – Injection bevacizumab-AWWB, biosimilar, (MVASI), 10 mg
- Q5118 – Injection, bevacizumab-BVZR, biosimilar, (ZIRABEV), 10 mg
- Q5126 – Injection, bevacizumab-MALY, biosimilar, (ALYMSYS), 10 mg

Daratumumab Injection Code on Claim without Approved Indication

Effective: May 28, 2023

The FDA provides guidance around approved indications or approved off-label indications for use of defined drugs and biologicals. These approved indications or off-label indications identify conditions or diagnoses appropriate for use with this drug. A denial will be applied to claims reported for J9144 (Injection, daratumumab, 10 mg and hyaluronidase-fihj) when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim. FDA approved codes: C90.00-C90.32 and E85.81.

DME rentals reported monthly

Effective: Nov. 26, 2023

As a reminder, rental durable medical equipment (DME) items should only be reported once per month. Rental items reported more than once per month may be denied. See our Provider Manual for more information.

IgE allergy testing

Effective: June 24, 2023

Based on CMS policy, CPT code 86003 (Allergen specific IgE; quantitative or semiquantitative, crude allergen extract, each) shouldn’t exceed more than 30 units one year. This code will be denied when billed beyond 30 units in one year (a rolling 12-month period based on DOS).

Modifier 57 and planned major surgeries

Effective: June 29, 2022

Claim will deny the Evaluation and management (E/M) services with modifier 57 when billed with planned major surgical services. You shouldn't bill modifier 57 which allows the Evaluation and Management (E/M) services to be paid with a surgery that has been planned in advance.

The intended use of modifier 57 (Decision for surgery) is to represent that the decision to perform major surgery has occurred on the date of, or the date prior to the surgery. (See next page for an exception.)

Exception: This edit will exclude office consultation codes, CPT codes 99241-99245 with place of service (POS) 11; office consultations, CPT codes 99221-99223 (Initial hospital care) and 99251-99255 (Inpatient consultation) with POS 21 and E/M codes billed within the emergency room setting with POS 23.

Screening studies

Effective: Nov. 26, 2023

CPT 76706 should be reported for screening studies only. CPT has designated another code set (76770-76775) for diagnostic purposes. As outlined in our Provider Manual, there are specific guidelines associated with reimbursement of CPT 76706. Services reported outside of defined guidelines may result in a denial. See our Provider Manual for more information on preventive care service codes.

Spravato Reported with Inappropriate NDC Code

Effective: July 23, 2023

We're aligning with Centers for Medicare & Medicaid Services (CMS) HCPCS Level II Manual and the National Drug Code (NDC) directory to deny Spravato (exketamine hydrochloride) when billed with an inappropriate NDC code.

According to the NDC directory, Spravato is dispensed with a strength of 28mg/0.2ml. NDC package code* 50458-028-03 describes an 84mg kit with three blister packs at 28mg each.

Edits will apply when HCPCS code S0013, "Esketamine nasal spray, 1mg" is reported with an NDC number that doesn't match the units ordered to be reimbursed.

Clinical examples*:

- Will pay: A provider bills S0013 with 84 units and NDC code 50458-028-03
- Will deny: A provider bills S0013 with 56 units and NDC code 50458-028-03

**Note: NDC package codes can change. The current NDC code should be used.*

Medicaid

Blood Pressure Monitor Limits

Effective: June 13, 2023

The Michigan Department of Health and Human Services (MDHHS) issued changes to its blood pressure monitoring policy in June 2022 (see HASA 22-16). In accordance with these changes, the following denials will be applied:

- CPT A4663 when reported more than once in a two-year period
- CPT A4660 and A4670 reported with modifier NU, when reported more than a total of once in a 5-year period

Discontinued Coverage for 58565 & A4264

Effective: July 11, 2023

The Michigan Department of Health and Human Services (MDHHS) issued Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) code updates in January 2020 (see MSA 20-01). These updates included discontinued coverage for the following codes, effective Dec. 31, 2019:

- **CPT 58565**: Under Laparoscopic/Hysteroscopic Procedures on the Corpus Uteri
- **HCPCS A4264**: Permanent implantable contraceptive intratubal occlusion device(s) and delivery system

As these codes are not covered, they will be denied.