Zelis Claim Cost Solutions

EDIT OVERVIEW

December 2022

Zelis Confidentiality Statement

Table of Contents

Edit 001-01: Ineffective or Deleted CPT/HCPCS Code (Professional and Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Ineffective or Deleted CPT/HCPCS Code	Per the Centers for Medicare and Medicaid Services (CMS), the Healthcare Common Procedure Coding System (HCPCS) codes are adopted as the code set for use in Health Insurance Portability and Accountability Act (HIPAA) transactions for reporting outpatient procedures, items, and services. CMS further states procedures for the HIPAA medical code sets are required to be date of service (DOS) compliant therefore all service/procedure codes are issued an effective and termination date. The American Medical Association (AMA) updates and republishes CPT®-4 codes annually and provides CMS with the updated data. The CMS updates the alpha-numeric (Level II) portion of HCPCS and incorporates the updated AMA material to create the HCPCS code file. Both entities release code changes via updated files that consist of new, deleted, and revised codes. The AMA also publishes an errata or release notes with correction or updates to CPT® codes and guidelines which are published on their website until it is published in the AMA CPT® manual the following year.	Deny procedure [OR service] codes deemed invalid for the submitted date of service.

Edit 001-02: Invalid CPT/HCPCS Code (Professional and Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Invalid CPT/HCPCS code	Per the Center for Medicare and Medicaid Services (CMS), Healthcare Common Procedure Coding System (HCPCS) codes are adopted as the code set for uses in Health Insurance Portability and Accountability Act (HIPAA) transactions for reporting outpatient procedures, items, and services. The American Medical Association (AMA) updates and republishes CPT®-4 codes annually and provides CMS with the updated data. The CMS updates the alpha-numeric (Level II) portion of HCPCS and incorporates the updated AMA material to create the HCPCS code file. Both entities release code changes via updated files that consist of new, deleted, and revised codes. The AMA also publishes an errata or release notes with correction or updates to CPT® codes and guidelines which are published on their website until it is published in the AMA CPT® manual the following year. **NOTE:** Invalid procedure or service codes are defined as codes submitted by a provider that cannot be correlated to a procedure or service code that was valid at any point in time.	Deny procedure [OR service] codes that cannot be correlated to a procedure or service code that was valid at any point in time.

Edit 002-02: Experimental/Investigational Procedures (Professional and Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Procedure considered experimental	Per the Center for Medicare and Medicaid Services (CMS), if a procedure or service is not reasonable and necessary to treat an illness or injury for any reason (including lack of safety and efficacy because it is experimental etc.) the service will be considered non-covered. The three (3) scenarios within the logic for this edit in which a procedure is considered Experimental/ Investigational (E/I) are: • regardless of the diagnosis codes billed. • unless it is billed with a specific qualifying diagnosis code. • when billed with a specific combination of other procedures or diagnosis codes.	Deny procedures or services that are considered experimental or investigational.

Edit 003-02: Cosmetic/Discretionary Procedures (Professional and Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Procedure considered cosmetic or discretionary	Per the Centers for Medicare & Medicaid Services (CMS) cosmetic surgery is performed to reshape normal structures of the body to improve the patient's appearance and self-esteem. Cosmetic surgery performed purely for the purpose of enhancing one's appearance is not eligible for coverage. The four (4) scenarios included in this logic in which a procedure is considered Cosmetic/Discretionary are: • regardless of the diagnosis codes billed. • unless it is billed with a specific qualifying diagnosis code. • unless it is billed after another procedure has been performed. • when billed with a specific diagnosis code	Deny procedures or services that are categorized as cosmetic or discretionary.

Edit 004: Co-Surgeon/Team Surgery Inappropriate (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Co-Surgeon /Team Surgery Inappropriate	Per the Centers for Medicare and Medicaid Services (CMS), there are some circumstances in which the individual skills of two or more surgeons are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedure(s) and/or the patient's condition. In these cases, the additional physicians are not acting as assistants-at- surgery. Co-surgeon: If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with a modifier "-62." Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously (i.e., heart transplant or bilateral knee replacements). Team Surgery: If a team of surgeons (more than 2 surgeons of different specialties) is required to perform a specific procedure, each surgeon bills for the procedure with a modifier "-66."	Deny procedures or services deemed inappropriate for co-surgery and team surgeon modifiers -62 or -66.

Edit 004-02: Inappropriate use of Modifier (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Inappropriate Use of Modifier	Per the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA), a modifier is a two-position alpha or numeric code that is appended to a procedure [OR service] code to clarify the service being billed. Modifiers provide a means by which a service can be altered without changing the procedure code and they add more information such as anatomical site etc. Modifiers are also used to increase the accuracy in reimbursement and coding consistency, ease editing, capture payment data and help eliminate the appearance of duplicate billing and unbundling. CMS provides further guidance within the National Physician Fee Schedule Relative Value File (NPFSRVF) regarding Payment Indicator categories which designate the appropriateness of submitting a procedure code with Bilateral (50) modifier.	Deny procedures or services when submitted with an inappropriate modifier.

Edit 005-01: Separate Procedures (Add-on Code) (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Add on code, primary procedure not found	Per the American Medical Association (AMA), certain procedure codes are commonly carried out in addition to the performance of a primary procedure. These additional or supplemental procedures are referred to as add-on procedures and describe additional intra-service work associated with the primary procedure. Add-on codes should never be reported as a stand-alone service. Certain add-on codes represent additional units of service that are the same as the primary procedure; these codes are usually identified by the language “each additional” in their descriptions. CMS provides additional guidance that some codes in the AMA CPT® Manual are identified as Add-on Codes (AOCs) which describe a service that can only be reported in addition to a primary procedure. The AMA CPT® Manual instructions specify the primary procedure code(s) for most AOCs. For other AOCs, the primary procedure code(s) are not specified. When the AMA CPT ® Manual identifies specific primary codes, the AOCs shall not be reported as a supplemental service for other HCPCS/CPT® codes not listed as a primary code. An add-on code is rarely eligible for payment if it is the only procedure reported by a practitioner.	Deny add-on codes when an applicable primary code is not billed and paid.

Edit 005-02: Separate Procedures (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Not allowed separate payment with procedure {0}	Per the American Medical Association, some of the procedures or services listed in the CPT® codebook that are commonly carried out as an integral component of a total service or procedure have been identified by the inclusion of the term "separate procedure." The code designation as "separate procedure" should not be reported in addition to be code for the total procedure or service of which it is considered an integral component. The Centers for Medicare and Medicaid Services (CMS) also states if a CPT® code descriptor includes the term "separate procedure", the CPT® code may not be reported separately with a related procedure. The CMS interprets this designation to prohibit the separate reporting of a "separate procedure" when performed with another procedure in an anatomically related region often through the same skin incision, orifice, or surgical approach. CMS further states, a CPT® code with the "separate procedure" designation may be reported with another procedure if it is performed at a separate patient encounter on the same date of service or at the same patient encounter in an anatomically unrelated area often through a separate skin incision, orifice, or surgical approach. Modifiers 59 or -X{ES} (or a more specific modifier, e.g., anatomic modifier) may be appended to the "separate procedure" CPT® code to indicate that it qualifies as a separately reportable service.	Deny separate procedures when submitted with a related major procedure. {**EXCLUSION**: Modifier -59 or -X{EPSU} when applicable]

Edit 005-04: Separate Procedures (Bundled) – (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Incidental to proc/svs and is bundled no separate payment warranted	Per the Centers for Medicare and Medicaid Services (CMS), there are a number of services and/or supplies that bundle into the payment for other related services. These services are grouped into a few categories per the Status Indicators (S/I) within the CMS Medicare National Physician Fee Schedule Relative Value File (NPFSRVF): 1. B: Payment for covered services are always bundled into payment for other services not specified. 2. T: only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider Also, included in this Separate Procedures (Bundled) edit are codes that are deemed incidental or packaged procedure and services per the Ambulatory Surgery Center (ASC) Payment Indicator N1.	Deny procedures or services that are deemed bundled or incidental.

Edit 005-07: ASC Packaged Item/Service (Ambulatory Surgical Centers [ASC])

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Packaged Item/Service; Separate Payment Not Allowed	Per the Centers for Medicare and Medicaid Services (CMS), covered Ambulatory Surgical Center (ASC) services include items and services that are designated as "packaged service/item; no separate payment made" per Payment Indicators (PI) within the ASC Payment Rate files. CMS provides further guidance which states Ambulatory Surgical Center (ASC) services for which payment is included in the ASC payment for a covered surgical procedure include but is not limited to: 1. Nursing, technician and related services. 2. Use of the facility where the surgical procedures are performed. 3. Any laboratory testing performed under a Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate of waiver. 4. Drugs and biologicals for which separate payment is not allowed under the hospital outpatient prospective payment system (OPPS). 5. Medical and surgical supplies not on pass-through status under Subpart G of Part 419 of 42 CFR. 6. Equipment 7. Surgical dressings 8. Implanted prosthetic devices, including intraocular lenses (IOLs), and related accessories and supplies not on pass-through status under Subpart G of Part 419 of 42 CFR. 9. Implanted DME and related accessories and supplies not on pass-through status Subpart G of Part 419 of 42 CFR. 10. Splints and casts and related devices 11. Radiology services for which payment is not allowed under the OPPS, and other diagnostic tests or interpretive services that are integral to a surgical procedure 12. Administrative, recordkeeping and housekeeping items and services 13. Materials, including supplies and equipment for the administration and monitoring of anesthesia 14. Supervision of the services of an anesthesia by the operation surgeon Under the revised ASC payment system, the above items and services fall within the scope of ASC facility services, and payment for them is packaged into the ASC payment for the covered surgical procedure. ASCs must incorporate charges for packaged services into the changes reported for the separately payable services with which they are provided.	Deny claims/claim lines considered part of a surgical package and now paid separately.

Edit 006: Assistant Surgery Inappropriate (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Assistant surgery not appropriate	Per the Centers for Medicare & Medicaid Services (CMS) an “assistant at surgery” is a physician who actively assists the physician in charge of a case in performing a surgical procedure. The “assistant at surgery” provides more than just ancillary services. The operative note should clearly document the assistant surgeon’s role during the operative session. CMS provides further guidance regarding procedures that are not allowed, or payment restrictions apply unless supporting documentation is submitted to establish necessity as it pertains to Assistant Surgery. These procedures are generally minor in nature and are identified within the CMS National Physician Fee Schedule by Assistant Surgeon Payment Indicators designations for modifiers (80, 81, 82 or AS).	Deny procedures or services appended with modifier -80, -81, -82 or -AS that are deemed not permitted, supporting documentation is necessary or concept does not apply.

Global Surgery Suite (Edits 00801-00808) - (Professional)

Global Surgery Package

Per the Centers for Medicare & Medicaid Services (CMS), the national definition of the Global Surgery Package (also called "global surgery") was instituted to provide consistency in coverage and to prevent payment for services that are more or less comprehensive than intended. The Global Surgery Package includes all necessary services normally furnished by the physician who performs the surgery ("surgeon") before, during and after a surgical procedure.

Payment for a surgical procedure includes the preoperative, intra-operative, and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty. Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.

Global surgery applies in any setting, including an inpatient hospital, outpatient hospital, Ambulatory Surgical Center (ASC) and physician's office. When a surgeon visits a patient in an intensive care or critical care unit, the visits are included in the global surgery package.

There are three types of global surgical packages based on the number of post-operative days:

- 0-Day Post-operative Period (endoscopies and some minor procedures)
  - No pre-operative period
  - No post-operative days
  - Visit on day of procedure is generally not payable as a separate service

- 10-Day Post-operative Period (other minor procedures)
  - No pre-operative period
  - Visit on day of procedure is generally not payable as a separate service
  - Toral global period is 11 days; count the day of the surgery and the 10 days immediately following the day of the surgery

- 90-Day Post-operative Period (major procedures)
  - One day pre-operative included
  - Day of the procedure is generally not payable as a separate service
  - Total global period is 92 day; count 1 day before the day of the surgery, the day of the surgery and the 90 days immediately following the day of surgery.

Global Surgery Suite (Edits 00801-00808 (Professional)

Global Surgery Package (con't)

The Centers of Medicare and Medicaid Services (CMS), provides additional guidance regarding the services **included** in the global surgery payment when provided in addition to the surgery:

- Pre-operative visits after the decision is made to operate; for major procedures, this included pre-operative visits the day before the day of surgery. For minor procedures, this includes pre-operative visits the day of surgery.
- All intraoperative services that are normally a usual and necessary part of a surgical procedure.
- All additional medical or surgical services require of the surgeon during the post-operative period of the surgery because of complications, which do not require additional trips to the operating room.
- Follow-up visits during the post-operative period of the surgery that are related to the recovery from the surgery.
- Post-surgical pain management by the surgeon
- Supplies, except for those identified as exclusions
- Miscellaneous services, such as dressing changes, local incision care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

The below services are **not included** in the global surgical package payment; these services may be billed and paid separately for:

- Initial consultation or evaluation of the problem by the surgeon to determine the need for major surgeries. This is billed separately using modifier -57 (Decision for surgery). The visit may be billed separately only for major surgical procedures.
  - **NOTE:** the initial evaluation for minor surgical procedures and endoscopies are always included in the global surgery package. Visits by the same physician on the same day as a minor surgery or endoscopy are included in the global package, unless a significant, separately identifiable service is also performed. Modifier -25 is used to bill a separately identifiable evaluation and management (E/M) service by the same physician on the same day of the procedures.
- Services of other physicians related to the surgery, except when the surgeon and the other physician(s) agree on the transfer of care. This agreement may be in the form of a letter or an annotation in the discharge summary, hospital or ASC record.
- Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complication of the surgery.
- Treatment of the underlying condition or an added course of treatment which is not part of normal recovery from surgery.
- Diagnostic tests and procedures, including diagnostic radiological procedures
- Clear distinct surgical procedures that occur during the post-operative period which are not re-operations or treatment for complications.
- Diagnostic tests and procedures, including diagnostic radiological procedures
- Clear distinct surgical procedures that occur during the post-operative period which are not re-operations or treatment for complications.
- Treatment for post-operative complications requiring a return trip to the operating room (OR). An OR for the purpose, is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite and an endoscopic suite. It does not include a patient's room, a minor treatment room, a recovery room or an intensive care unit (unless the patient's condition was so critical there would insufficient time for transportation to an OR).
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately.
- Immunosuppressive therapy for organ transplants.
- Critical care services (CPT codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician.

CMS provides further guidance, that states when treatment for complications requires a return trip to the operating room, physicians must bill the CPT code that describes the procedure(s) performed during the return trip. If no such code exists, use the unspecified procedure code in the correct series, i.e., 47999 or 64999. The procedure code for the original surgery is not used except when the identical procedure is repeated.
In addition to the CPT code, physicians use CPT modifier "-78" for these return trips (return to the operating room for a related procedure during a postoperative period).

NOTE: The CPT definition for this modifier does not limit its use to treatment for complications.

- Staged or Related Procedures

  Modifier "-58" was established to facilitate billing of staged or related surgical procedures done during the postoperative period of the first procedure. This modifier is not used to report the treatment of a problem that requires a return to the operating room.

  The physician may need to indicate that the performance of a procedure or service during the postoperative period was:
  a. Planned prospectively or at the time of the original procedure.
  b. More extensive than the original procedure; or
  c. For therapy following a diagnostic surgical procedure.

  These circumstances may be reported by adding modifier "-58" to the staged procedure. A new postoperative period begins when the next procedure in the series is billed.

- Unrelated Procedures or Visits During the Postoperative Period

  Modifiers were established to simplify billing for visits and other procedures which are furnished during the postoperative period of a surgical procedure, but which are not included in the payment for the surgical procedure.

  Modifier "-79": Reports an unrelated procedure by the same physician during a postoperative period. The physician may need to indicate that the performance of a procedure or service during a postoperative period was unrelated to the original procedure. A new postoperative period begins when the unrelated procedure is billed.

  Modifier "-24": Reports an unrelated evaluation and management service by same physician during a postoperative period. The physician may need to indicate that an evaluation and management service was performed during the postoperative period of an unrelated procedure. This circumstance is reported by adding the modifier "-24" to the appropriate level of evaluation and management service. Services submitted with the "-24" modifier must be sufficiently documented to establish that the visit was unrelated to the surgery. A diagnosis code that clearly indicates that the reason for the encounter was unrelated to the surgery is acceptable documentation.

  A physician who is responsible for postoperative care and has reported and been paid using modifier "-55" also uses modifier "-24" to report any unrelated visits.

Major Surgery: 90-Day Procedures

i. Edit 008-01: E/M Visit One Day Prior

Edit 008-01: 90 Day Global Surgery with Evaluation and Management Visit One Day Prior (In Sequence)	
REMARK CODE	EDIT OUTCOME
E/M Service Billed One Day Prior is Included in 90 Day Global Service	Deny Evaluation and Management services submitted one day prior to a 90-day procedure (EXCEPTION: Modifier -57)

ii. Edit R08-01: E/M Visit One Day Prior [OOS])

Edit R08-01: 90 Day Global Surgery with Evaluation and Management Visit One Day Prior (Out of Sequence)	
REMARK CODE	EDIT OUTCOME
E/M Service Billed One Day Prior is Included in 90 Day Global Service	Reduce [OR Deny] the 90-day procedure when E/M service(s) are previously billed and paid one day prior to the 90-day procedure. (EXCEPTION: Modifier 57)

iii. Edit 008-02: E/M Visit on the Same Day

Edit 008-02: 90 Day Global Surgery with Evaluation and Management Visit on the Same Day (In Sequence)	
REMARK CODE	EDIT OUTCOME
E/M Service Billed on the Same Day is Included in the 90 Day Global Service	Deny Evaluation and Management services submitted on the same day as a 90-day procedure (EXCEPTION: Modifier -57 or -25)

iv. Edit R08-02: E/M on the Same Day [OOS])

Edit R08-02: 90 Day Global Surgery with Evaluation and Management Visit on the Same Day (Out of Sequence)	
REMARK CODE	EDIT OUTCOME
E/M Service Billed on the Same Day is Included in the 90 Day Global Service	Reduce [or Deny] 90-day procedure when Evaluation and Management service(s) is previously billed and paid for the same date of service as the 90-day procedure. (EXCEPTION: Modifier 25 or 57)

v. Edit 008-05: Related Post Operative E/M Visit

Edit 008-05: 90 Day Global Surgery and Related Postoperative Evaluation and Management Visit (In Sequence)	
REMARK CODE	EDIT OUTCOME
E/M Service Billed During Postop Included in 90 Day Global Service	Deny related Evaluation and Management services submitted within the post-operative period of a major [90 day] procedure. [EXCEPTION: Modifiers -24]

Major Surgery: 90-Day Procedures

vi. Edit R08-05: Related Post Operative E/M Visit (OOS)

Edit R08-05: 90 Day Global Surgery and Related Postoperative Evaluation and Management Visit (Out of Sequence)	
REMARK CODE	**EDIT OUTCOME**
E/M Service Billed During Postop Included in 90 Day Global Service	Reduce [or Deny] 90-Day procedure when related postoperative Evaluation and Management service(s) has been previously billed and paid. [EXCEPTION: Modifiers -24]

Minor Surgery: 10-and 0-Day Procedures

i. Edit 008-03: E/M Visit on the Same Day

Edit 008-03: 10 Day Global Surgery with Evaluation and Management Visit on the Same Day (In Sequence)	
REMARK CODE	**EDIT OUTCOME**
E/M Service Billed on the Same Day is Included in 10 Day Global Service	Deny Evaluation and Management services submitted on the same day as a 10-day procedure (EXCEPTION: Modifier -25)

ii. Edit R08-03: E/M Visit on the Same Day (OOS)

Edit R08-03: 10 Day Global Surgery with Evaluation and Management Visit on the Same Day (OOS)	
REMARK CODE	**EDIT OUTCOME**
E/M Service Billed on the Same Day is Included in 10 Day Global Service	Reduce [or Deny] 10-day procedure when Evaluation and Management service(s) have been billed and paid for the same date of service as the 10-day procedure. (EXCEPTION: Modifier 25)

iii. Edit 008-06: Related Postoperative E/M Visit

Edit 008-06: 10 Day Global Surgery and Related Postoperative Evaluation and Management Visit (In Sequence)	
REMARK CODE	**EDIT OUTCOME**
E/M Service Billed During Postop Included in 10 Day Global Service	Deny related Evaluation and Management services submitted within the post-operative period of a minor [10 day] procedure. [EXCEPTION: Modifier 24]

iv. Edit R08-06: Related Postoperative E/M Visit (OOS)

Edit R08-06: 10 Day Global Surgery and Related Postoperative Evaluation and Management Visit (Out of Sequence)	
REMARK CODE	**EDIT OUTCOME**
E/M Service Billed During Postop Included in 10 Day Global Service	Reduce [or Deny] 10-Day procedure when Evaluation and Management service(s) has been previously billed and paid during the post-operative period.[EXCEPTION: Modifiers -24]

v. Edit 008-04: E/M Visit on the Same Day

Edit 008-04: 0 Day Global Surgery with Evaluation and Management Visit on the Same Day (In Sequence)	
REMARK CODE	EDIT OUTCOME
E/M Service Billed on the Same Day is Included in 0 Day Global Service	Deny Evaluation and Management services submitted on the same day as a 0-day procedure (EXCEPTION: Modifier -- 25)

vi. Edit R08-04: E/M Visit on the Same Day (OOS)

Edit R08-04: 0 Day Global Surgery with Evaluation and Management Visit on the Same Day (Out of Sequence)	
REMARK CODE	EDIT OUTCOME
E/M Service Billed on the Same Day is Included in 0 Day Global Service	Reduce or Deny 0-day procedure when Evaluation and Management service(s) billed for the same date of service as the 0-day procedure has already been paid. (EXCEPTION: Modifier 25)

Secondary Procedures: 90-and 10-Day Procedures

i. Edit 008-07: Secondary Procedure During 90 Day Global Surgery Period

Edit 008-07: Secondary Procedure(s) Billed During Primary 90 Day Global Surgery Period (In Sequence)	
REMARK CODE	EDIT OUTCOME
Secondary Procedure Included in 90 Day Primary Procedure Global Service	Deny the “0”, “10”, “90” day (“secondary procedures”) when submitted within the post-operative period of a 90-day primary procedure. (EXCEPTION: Modifier 58, 78, or 79)

ii. Edit R08-07: Secondary Procedure During 90 Day Global Surgery Period (OOS)

Edit R08-07: Secondary Procedure(s) Billed During Primary 90 Day Global Surgery Period (Out of Sequence)	
REMARK CODE	EDIT OUTCOME
Secondary Procedure Included in 90 Day Primary Procedure Global Service	Reduce [or Deny] the 90-day primary procedure when a “0”, “10” and/or “90” day secondary procedure was previously billed and paid by the same provider within the 90-day post-operative period.

Secondary Procedures: 90- and 10-Day Procedures

Edit 008-08: Secondary Procedure(s) Billed During Primary 10 Day Global Surgery Period	
REMARK CODE	EDIT OUTCOME
Secondary Procedure Included in 10-Day Primary Procedure Global Service	Deny the “0”, “10”, “90” day (“secondary procedures”) when submitted within the post-operative period of a10-day primary procedure. (EXCEPTION: Modifier 58 78, or 79)

Secondary Procedures: 90- and 10-Day Procedures (OOS)

Edit R08-08: Secondary Procedure(s) Billed During Primary 10 Day Global Surgery Period	
REMARK CODE	EDIT OUTCOME
Secondary Procedure Included in 10-Day Primary Procedure Global Service	Reduce [OR Deny] 10-day primary procedure when a “0”, “10” and/or “90” day secondary procedure billed by the same provider within the 10-day post-operative period has already been submitted and paid on a separate claim.

Edit 009X: New Patient Frequency (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Too many new patient codes. Replace with code {0}	Per the Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA), a new patient is one who has not received any professional services from the same provider in the past three (3) years.	Deny new patient visits when a new patient visit was billed/paid in the previous three (3) years.

Edit 013: Physician Visit Frequency (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Other office visit {0} on same service date	Per the Centers for Medicare and Medicaid Services (CMS), two Evaluation and Management (E/M) office visits billed by a provider may not be paid for the same beneficiary on the same day unless the physician documents that the visits were for unrelated problems which could not be provided during the same encounter.	Deny multiple office visits when submitted for the same DOS with the same or related diagnosis.

Edit 016: Invalid HCPCS Code (HCFA)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Inappropriate use of HCPCS code; CPT code exists	Per the Centers for Medicare and Medicaid Services (CMS), the Healthcare Common Procedure Coding System (HCPCS) Level II is a standardized coding system that is primarily used to identify products, supplies and services not included in the CPT-4® codes, such as ambulance services, durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. **NOTE:** CMS provides guidance within the HCPCS Manual to apply the CPT® code when both a CPT® and HCPCS Level II code share nearly identical narratives.	Deny procedure or services submitted with a HCPCS code when a more specific CPT® code exists.

Edit 020 Medical Protocol (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Not within medical protocol. Dx does not qualify proc or freq of proc.)	There is guidance within evidence-based literature regarding medical standards and guidelines. This Medical Protocol edit identifies if there is a deviation from "medical protocol" by reviewing the current diagnosis, as well as past diagnoses and procedures to determine if the current procedure is justified/ The published evidence-based coding literature is acquired from various medical academies, societies, associations, and colleges including and not limited to: • Centers for Disease Control (CDC) • United States Preventive Services Task Force (USPSTF) • American College of Obstetricians and Gynecologist (ACOG) • Centers for Medicare and Medicaid Services (CMS) **NOTE**: The logic within the Medical Protocol Edit 020 is customizable to align with individual client policies and guidelines.	Deny procedures or services that exceed the allowable age or frequency without a "reasonable and necessary" diagnosis (when applicable).

Edit 020AM: Medical Protocol - Ambulance (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Ambulance charge denied due to lack of medical necessity	Per the Centers for Medicare and Medicaid Services (CMS), to be covered, ambulance services must be reasonable and necessary. Necessity is established when the patient's condition is such that any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used with used without endangering the individual's health, whether such other transportation is available, no payment may be made for ambulance services. CMS provides further guidance that equipment and supplies are considered part of the general ambulance service and payment is included in the payment rate for the transport.	Deny ambulance services without a reasonable and necessary diagnosis AND separately submitted equipment or supplies.

Edit 020-04: Procedure Frequency (Professional and Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Exceeds clinical guidelines	If a qualitative (presumptive) or quantitative (definitive) Urine Drug Testing (UDT) is submitted with an occurrence (DOS) that exceeds the annual frequency [as defined by the client], this Procedure Frequency Edit 020-04 will apply a recommendation to deny. **NOTE:** The Zelis default frequency is 24 qualitative (presumptive) and 16 quantitative (definitive) annually (calendar year).	Deny urine drug testing (UDT) that exceeds an annual frequency.

Edit 021X: Fragmented Procedures (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Rebundle with other procedure(s) into procedure {0}	Per the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA), in a family of codes, there are two or more component codes that are not billed separately because they are included in a more comprehensive code as members of the code family. Comprehensive codes include certain services that are separately identifiable by other component codes. The component codes as members of the comprehensive code family represent parts of the procedure that should not be listed separately when the complete procedure is done. However, the component codes are considered individually if performed independently of the complete procedure and if not all of the services listed in the comprehensive codes were rendered to make up the total service. CMS further states, procedures shall be reported with the most comprehensive CPT® code that describes the services performed. A physician shall not report multiple HCPCS or CPT® codes when a single comprehensive HCPCS or CPT® code describes these services. A physician shall not fragment a procedure into component parts.	Deny component codes of a code family when submitted on the same DOS by the same provider.

Edit 022: Secondary Procedures (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Payment reduced as secondary procedure to {0}	Per the Centers for Medicare and Medicaid Services (CMS), multiple surgeries are performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment is allowed. Co-surgeons, surgical teams or assistants-at- surgery may participate in performing multiple surgeries on the same patient on the same day. Multiple surgeries are distinguished from procedures that are components of or incidental to the primary procedure. These intra-operative services, incidental surgeries, or components of more major surgeries are not separately billable. The CMS National Physician Fee Schedule indicates the codes in which the standard payment policy rules apply to multiple surgeries with reimbursement based on a 100%/50%/50%/50%/50% methodology. The procedure with the highest allowed amount is reimbursed at 100% and all secondary procedures are reimbursed at 50% of the allowed amount. This payment methodology is only applicable to procedures that have been identified by CMS as being subject to multiple procedure guidelines per the CMS Medicare NPFSRVF.	Allow a surgical procedure with the highest allowed amount at 100% with a 50% MPR reduction for all subsequent procedures.

Edit 022: Secondary Procedures - IMAGING (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Payment reduced as secondary procedure to {0}	Per the Centers for Medicare and Medicaid Services (CMS), a multiple procedure payment reduction (MPPR) on certain diagnostic imaging services applies to professional component (PC) and technical component (TC) services. It applies to both PC-only services, TC-only services, and to the PC and TC of global services. The MPPR on diagnostic imaging applies when multiple services are furnished by the same physician, to the same patient, in the same session, on the same day. Full payment is made for each PC and TC service with the highest payment under the Medicare Physician Fee Schedule (MPFS). Payment is made at 95 percent for subsequent PC services furnished by the same physician, to the same patient in the same session on the same day. Payment is made at 50 percent for subsequent TC services furnished by the same physician, to the same patient, in the same session on the same day. The individual PC and TC services with the highest payments under the MPFS of globally billed services must be determined in order to calculate the reduction.	Allow the professional component (PC) and technical component (TC) of an imaging procedure with the highest allowed amount at 100% with a 5% reduction of the subsequent PC service and a 50% reduction of the subsequent TC service.

Edit 022: Secondary Procedures - CARDIO (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Payment reduced as secondary procedure to {0}	Per the Center for Medicare and Medicaid Services (CMS), the Multiple Procedure Payment Reduction (MPPR) policy has been extended to applying MPPRs to the Technical Component (TC) of diagnostic cardiovascular and ophthalmology procedures when multiple services are furnished to the same patient on the same day, effective January 1,2013. The MPPRs apply independently to cardiovascular and ophthalmology services. The MPPRs apply to TC-only services, and to the TC of global services. For cardiovascular services, full payment is made for the TC service with the highest payment under the Medicare Physician Fee Schedule (MPFS). Payment is made at 75 percent for subsequent TC services furnished by the same physician (or by multiple physicians in same group practice, i.e., same Group National Provider Identifier (NPI) to the same patient on the same day. **NOTE:** The cardiovascular MPPR does not apply to professional component (PC) services.	Allow the technical component (TC) of a cardiovascular procedure with the highest allowed amount at 100% with a 25% reduction of the subsequent TC service.

Edit 022: Secondary Procedures - OPHTHALMOLOGY (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Payment reduced as secondary procedure to {0}	Per the Centers for Medicare and Medicaid Services (CMS), the Multiple Procedure Payment Reduction (MPPR) policy has been expanded to applying MPPRs to the Technical Component (TC) of diagnostic cardiovascular and ophthalmology procedures when multiple services are furnished to the same patient on the same day, effective January 1, 2013. The MPPRs apply independently to cardiovascular and ophthalmology services. The MPPRs apply to TC-only services, and to the TC of global services. For ophthalmology services, full payment is made for the TC service with the highest payment under the Medicare Physician Fee Schedule (MPFS). Payment is made at 80 percent for subsequent TC services furnished by the same physician (or by multiple physicians in same group practice, i.e., same Group National Provider Identifier (NPI) to the same patient on the same day. **NOTE:** The ophthalmology MPPR does not apply to professional component (PC) services.	Allow the technical component (TC) of a ophthalmology procedure with the highest allowed amount at 100% with a 20% reduction of the subsequent TC service.

Edit 022: Secondary Procedures - THERAPY (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Payment reduced as secondary procedure to {0}	Per the Centers for Medicare and Medicaid Services (CMS), a multiple procedure payment reduction (MPPR) is applied to the practice expense (PE) payment of select therapy services. The reduction applies to the HCPCS codes contained on the list of "always therapy" services excluding A/B MAC (B)-priced, bundled and add-on codes, regardless of the type of provider or supplier that furnishes the services. The MPPR is applied to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well multiple procedures. Many therapy services are time-based codes, i.e. multiple units may be billed for a single procedure. The MPPR applies to all therapy services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines such as physical therapy, occupational therapy, or speech-language pathology. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures with dates of service on or after April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice and 50 percent payment is made for the PE for services submitted on either professional or institutional claims. To determine which service will receive the MPPR, contractors shall rank services according to the applicable PE relative value units (RVU) and price the services with the highest PE RVU at 100% and apply the appropriate MPPR to the remaining services.	Allow the first unit [or therapy service] with the highest allowed amount at 100% with a 50% reduction of the practice expense of all subsequent therapy services.

Edit 027X: Chemistry Lab Unbundled (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Rebundle with other procedure(s) into procedure {0}	Per the American Medical Association (AMA), when components of a specific organ or disease-oriented laboratory panel (e.g., codes 80061 and 80059) or automated multi-channel tests (e.g., codes 80002 - 80019) are billed separately, they must be bundled into the comprehensive panel or automated multichannel test code as appropriate that includes the multiple component tests. The Centers for Medicare and Medicaid Services further states "the CPT® Manual" defines organ and disease panels of laboratory tests. If a laboratory performs all test included in one of these panels, the laboratory shall report the CPT® code for the panel. The individual tests that make up a panel or can be performed on an automated multi- channel test analyzer are not to be separately billed.	Deny individual components of a disease-oriented or chemistry panel when submitted for the same DOS by the same provider.

Edit 030: NCCI Comprehensive Component (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
As per Medicare National Correct Coding Initiative (NCCI), not allowed separate payment with procedure {0}	Per the Centers for Medicare and Medicaid Services (CMS), the National Correct Coding Initiative (NCCI) program was developed to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of claims. The coding policies are based on coding conventions defined in the American Medical Association (AMA) "Current Procedural Terminology (CPT®) Manual", national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical surgical practice and/or current coding practice. The NCCI program includes 3 types of edits: NCCI Procedure-to-procedure (PTP) edits, Medically Unlikely Edits (MUEs) and Add-on Code (AOC) edits. NCCI PTP edits prevent inappropriate payment of services that should not be reported together. Each edit has a Column I and Column II HCPCS/CPT® code. CMS further states, if a provider or supplier reports the 2 codes of an edit pair for the same beneficiary on the same date of service, the Column I code is eligible for payment and the Column II code is denied unless a clinically appropriate NCCI PTP-associated modifier is also reported. **NOTE**: Zelis also offers an Out of Sequence version of all NCCI logic that will deny the Column I code if the Column II code was already billed and paid by the same provider in the member's history to prevent overpayment.	Deny Column II service or procedure codes submitted by the same provider for same DOS as an associated Column I code.

Edit 031: NCCI Mutually Exclusive (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
As per Medicare National Correct Coding Initiative (NCCI), mutually exclusive to procedure {0}	Per the Centers for Medicare and Medicaid Services (CMS), the National Correct Coding Initiative (NCCI) program was developed to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of claims. The coding policies are based on coding conventions defined in the American Medical Association's "Current Procedural Terminology (CPT®) Manual", national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical surgical practice and/or current coding practice. The NCCI program includes 3 types of edits: NCCI Procedure-to-procedure (PTP) edits, Medically Unlikely Edits (MUEs) and Add-on Code (AOC) edits. NCCI PTP edits prevent inappropriate payment of services that should not be reported together. Each edit has a Column I and Column II HCPCS/CPT® code. CMS further states, if a provider or supplier reports the 2 codes of an edit pair for the same beneficiary on the same date of service, the Column I code is eligible for payment and the Column II code is denied unless a clinically appropriate NCCI PTP-associated modifier is also reported. **NOTE**: Mutually exclusive procedures are procedures that cannot be done at the same session by same provider on the same patient. These codes are considered mutually exclusive of one another based on the CPT® definition or medical impossibility or improbability that the procedures could be perform ed at the same session. **EDIT EXAMPLE(S):** (1) repair of an organ can be performed by two different methods. One repair method must be chosen to repair the organ and must be billed. (2) billing an "initial" service and a "subsequent" service. It is contradictory for a service to be classified as an initial and a subsequent service at the same time	Deny Column II service or procedure codes submitted by the same provider for same DOS as an associated mutually exclusive Column I code.

Edit U0101: NCCI PTP (Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
As per NCCI, not allowed separate payment with procedure {0}	Per the Centers for Medicare and Medicaid Services (CMS), the National Correct Coding Initiative (NCCI) program was developed to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of claims. The coding policies are based on coding conventions defined in the American Medical Association's "Current Procedural Terminology (CPT®) Manual", national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical surgical practice and/or current coding practice. The NCCI program includes 3 types of edits: NCCI Procedure-to-procedure (PTP) edits, Medically Unlikely Edits (MUEs) and Add-on Code (AOC) edits. NCCI PTP edits prevent inappropriate payment of services that should not be reported together. Each edit has a Column I and Column II HCPCS/CPT® code. CMS further states, if a provider or supplier reports the 2 codes of an edit pair for the same beneficiary on the same date of service, the Column I code is eligible for payment and the Column II code is denied unless a clinically appropriate NCCI PTP-associated modifier is also reported. **NOTE:** Mutually exclusive procedures are procedures that cannot be done at the same session by same provider on the same patient. These codes are considered mutually exclusive of one another based on the CPT® definition or medical impossibility or improbability that the procedures could be perform ed at the same session. **EXAMPLE:** (1) repair of an organ can be performed by two different methods. One repair method must be chosen to repair the organ and must be billed. (2) billing an "initial" service and a "subsequent" service. It is contradictory for a service to be classified as an initial and a subsequent service at the same time.	Deny Column II service or procedure codes submitted by the same provider for same DOS as an associated mutually exclusive Column I code.

Edit 033: Disallowed Multiple Procedures (Professional, ASC and Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Too many procedures of this type billed	Per the Centers for Medicare and Medicaid Services (CMS), the National Correct Coding Initiative (NCCI) program was developed to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of claims. The coding policies are based on coding conventions defined in the American Medical Association (AMA) "Current Procedural Terminology (CPT®) Manual", national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical surgical practice and/or current coding practice. The NCCI program includes 3 types of edits: NCCI Procedure-to-procedure (PTP) edits, Medically Unlikely Edits (MUEs) and Add-on Code (AOC) edits. Each edit has a Column I and Column II HCPCS/CPT® code. CMS further states, the purpose of the NCCI MUE program is to prevent improper payments when services are reported with incorrect units of service (UOS). The CMS developed MUEs to reduce the paid claims error rate. An MUE for a Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT®) code is the maximum UOS that a provider or supplier would report under most circumstances for a single beneficiary on a single date of service This Disallowed Multiple Procedures edit will apply a recommendation to deny claims lines with units for procedures or services that exceed the maximum number of units of service (UOS) values for the below indicated scenarios: ➢ Maximum units per day ➢ Medically Unlikely and/or Improbable based on: • Units allowed per the member's lifetime ○ Two (2) units for an appendectomy ○ Three (3) units for an amputation of an extremity • A subsequent procedure provided after another procedure was performed ○ Pregnancy after hysterectomy This edit will review the data elements submitted on the current claim and/or the member's history to determine if the units of service (UOS) for the submitted procedure or service is allowable per the AMA guidelines and/or CMS policy.	Deny procedures or services submitted with units that exceed the maximum units allowed per DOS, per lifetime or after subsequent to another procedure.

Edit 038-06: Inappropriate Age Code Use (Professional and Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Procedure is inconsistent with the patient's age	Per the American Medical Association (AMA), many procedures have a specific age designation included in the code description that provides guidance regarding the allowable age(s) for the procedure or service.	Deny procedure or services when the age/age range designation does not correspond with the member's age

Edit 038-07: Inappropriate Gender Code Use (Professional and Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Procedure is inconsistent with the patient's gender	Per the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA) many procedure codes have a sex designation within their narrative.	Deny procedure or services that do not correspond with the member's gender

Edit 038-09: Inappropriate Age Code Use (Professional and Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Diagnosis is inconsistent with the patient's age	Within the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Manual, there are symbols that provide guidance regarding age designations for various code specific to newborn, pediatric, maternity and adult. Additionally, the Centers for Medicare & Medicaid Services (CMS) - Medicare Code Editor (MCE) provides guidance for codes that are designated for the newborn, pediatric, maternity, and adult age group	Deny procedures or services submitted with a diagnosis code that does not correspond with the member's age.

Edit 038-10: Inappropriate Gender Code Use (Professional and Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Diagnosis is inconsistent with the patient's gender	Within the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Manual, there are codes that are listed with a male or female symbol to designate the appropriate gender for each code. Additionally, the Centers for Medicare & Medicaid (CMS) - CMS Medicare Coder Editor (MCE) provides guidance regarding codes with a gender designation as male or female.	Deny procedures or services submitted with a diagnosis code that does not correspond with the member's gender.

Edit 041: Procedure-Diagnosis Incompatible (Professional and Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Procedure not compatible with diagnosis	This Procedure-Diagnosis Incompatibility edit will apply a recommendation to deny claims submitted with procedures and/or services without a reasonable or compatible diagnosis code based on the following scenarios: • Correct procedure code, incorrect diagnosis code • Correct diagnosis code, incorrect procedure The specific code combinations included within this Procedure-Diagnosis Incompatibility edit is based on the published guidelines from the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), American Medical Association (AMA) Current Procedural Terminology (CPT®) and/or the Centers for Medicare & Medicaid Services (CMS) policy. The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all healthcare settings. Adherence to the Guidelines for Coding and Reporting when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA) and has been adopted for all healthcare settings. These guidelines are maintained to assist the provider and coder in identifying the most appropriate diagnosis that describe the services provided. The Current Procedural Terminology (CPT®) was developed by the American Medical Association (AMA) to provide a standard language and numerical coding methodology to accurately communicate the medical, surgical, diagnostic, and therapeutic services provided by physicians and qualified healthcare professionals (QHPs). For Medicare members, the Centers for Medicare & Medicaid Services (CMS) provides guidance which states for any item to be covered by Medicare, it must (1) be eligible for a defined Medicare benefit category, (2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and (3) meet all other applicable Medicare statutory and regulatory requirements. The "reasonable and necessary" criteria are based on Social Security Act §1862(a)(1)(A) provisions Zelis also utilizes published evidence-based coding literature acquired from various medical academies, societies, associations, and colleges including and not limited to: • Centers for Disease Control (CDC) • United States Preventive Services Task Force (USPSTF) • American College of Radiology (ACR).	Deny procedures or services submitted an incompatible diagnosis code.

Edit 045-01: Diagnosis Laterality (Professional and Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Unspecified laterality diagnosis code	Per the Centers for Medicare & Medicaid Services (CMS) and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Official Guidelines for Coding and Reporting some ICD-10 codes indicate laterality specifying whether the condition occurs on the left, right or is bilateral. If the side is not identified in the medical record, assign the code for the unspecified side. The ICD-10-CM Official Guidelines for Coding and Reporting also states, adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Tabular List and Alphabetic Index) have been adopted under HIPAA for all healthcare settings. A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated. The ICD-10-CM guidelines provides further guidance regarding the following: ○ it is essential to use both the Alphabetic and the Tabular List when locating and assigning a code. The Alphabetic Index does not always provide the full code. Selection of the full code, including laterality and any applicable 7th character can only be done in the Tabular list. ○ Each unique ICD-10-CM diagnosis code may be reported only once for an encounter. This applies to bilateral conditions when there are no distinct codes identifying laterality or two different conditions classified to the same ICD-10-CM diagnosis code. ○ If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side. ○ When a patient has a bilateral condition and each side is treated during separate encounters, assign the “bilateral” code (as the condition still exists on both sides), including for the encounter to treat the first side. For the second encounter for treatment after one side has previously been treated and the condition no longer exists on that side, assign the appropriate unilateral code for the side where the condition still exists (e.g., cataract surgery performed on each eye in separate encounters). The bilateral code would not be assigned for the subsequent encounter, as the patient no longer has the condition in the previously treated site. If the treatment on the first side did not completely resolve the condition, then the bilateral code would still be appropriate.	Deny procedures or services submitted with a diagnosis code without the associated laterality.

Edit 045-02: Diagnosis Specificity (Professional and Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Incomplete diagnosis code	Per the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) manual, a code reported must be the full ICD-10 code, including all applicable digits, up to seven digits. Additionally, ICD-10 Official Guidelines for Coding and Reporting provides specific instructions regarding the format and structure of an ICD-10 code. These instructions provide regarding use of codes for reporting purposes, placeholder character and 7th characters. Per the ICD-10 Manual: • Format and Structure: The ICD-10-CM Tabular List contains categories, subcategories, and codes. Characters for categories, subcategories and codes may either be a latter or a number. All categories are 3 characters. A three-character category that has no further subdivision is equivalent to codes. Subcategories are either 4 or 5 characters. Codes may be 3, 4, 5, 6 or 7 characters. That is, each level of subdivision after a category is a subcategory. The final level of subdivision is a code. Codes that have applicable 7th characters are still referred to as codes, not subcategories. A code that has an applicable 7th character is considered invalid without the 7th character. The ICD-10-CM uses an indented format for ease in reference. • Use of Codes for Reporting Purposes: For reporting purposes only codes are permissible, not categories or subcategories, and any applicable 7th character is required. • Placeholder Characters: The ICD-10-CM utilizes a placeholder character “X”. The “X” is used as a placeholder at certain codes to allow for future expansion. • 7th Characters: Certain ICD-10-CM categories have applicable 7th characters. The applicable 7th character is required for all codes within the category, or as the notes in the Tabular list instruct. The 7th character must always be the 7th character in the data field. If a code that requires a 7th character is not 6 characters, a placeholder “X” must be used to fill the empty characters.	Deny procedures or services submitted without the full diagnosis code with all applicable digits.

Edit 045-03: Manifestation Dx Code Billed as Primary Code (Professional and Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Manifestation code billed as primary diagnosis	Per the Centers for Medicare and Medicaid Services (CMS) and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Official Guidelines for Coding and Reporting, certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first, if applicable, followed by the manifestation. Wherever such a combination exists, there is a "use additional code" note at the etiology code, and a "code first" note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation. In most cases the manifestation codes will have in the code title, "in diseases classified elsewhere." Codes with this title are a component of the etiology/ manifestation convention. The code title indicates that it is a manifestation code. "In diseases classified elsewhere" codes are never permitted to be used as first listed or principal diagnosis codes. They must be used in conjunction with an underlying condition code, and they must be listed following the underlying condition. There are manifestation codes that do not have "in diseases classified elsewhere" in the title. For such codes, there is a "use additional code" note at the etiology code and a "code first" note at the manifestation code, and the rules for sequencing apply.	Deny procedures or services submitted with a manifestation diagnosis code as the first listed or primary diagnosis.

Edit 045-04: Ineffective or Deleted Diagnosis Code (Professional and Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Ineffective or deleted diagnosis code	Per the Centers for Medicare and Medicaid Services (CMS), the Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets be date of service compliant. Since ICD-10 diagnosis codes are a medical code set, a grace period is not allowed for providers to use in billing discontinued diagnosis codes. Proper coding is necessary because code are generally used in determining coverage and payment amounts. CMS accepts only HIPAA approved ICD-10 codes which are updated annually through October each year and published in the Federal Register. The updated files are normally released in June and contain new, revised, and discontinued codes which are effective for dates of service on and after October 1. Physicians, practitioners, and suppliers must use the current a valid diagnosis code that is in effect for the date of service.	Deny procedures or services submitted with a diagnosis deemed ineffective or deleted for the associated date of service.

Edit 045-05: Invalid Diagnosis Code (Professional and Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Invalid diagnosis code	Per the Centers for Medicare and Medicaid Services (CMS), the Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets be date of service compliant. Since ICD-10 diagnosis codes are a medical code set, a grace period is not allowed for providers to use in billing discontinued diagnosis codes. CMS providers further guidance that proper coding is necessary because code are generally used in determining coverage and payment amounts. CMS accepts only HIPAA approved ICD-10 codes which are updated annually through October each year and published in the Federal Register. The updated files are normally released in June and contain new, revised, and discontinued codes which are effective for dates of service on and after October 1. Physicians, practitioners, and suppliers must use the current valid diagnosis code that is in effect for the date of service.	Deny procedures or services submitted with a diagnosis that cannot be correlated to a diagnosis that was valid at any point in time.

Edit 045-06: External Cause of Morbidity as Primary Dx (Professional and Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
External cause of morbidity dx billed as primary dx	Per the Centers for Medicare & Medicaid Services (CMS) and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), the external cause of morbidity codes should never be sequenced as the first listed or principal diagnosis. External cause codes are intended to provide data for injury research and evaluation of injury prevention strategies. External cause of morbidity codes also captures how the injury or health condition happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), the place where the event occurred, the activity of the patient at the time of the event and the person's status (e.g., civilian, military).	Deny procedure [OR service] code when an external cause of morbidity dx is submitted as primary dx.

Edit 046-01: DME Procedure-Diagnosis Mismatch (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Procedure not compatible with diagnosis	Per the Centers for Medicare and Medicaid Services (CMS), for any item to be covered by Medicare, it must (1) be eligible for a defined Medicare benefit category, (2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and (3) meet all other applicable Medicare statutory and regulatory requirements. The "reasonable and necessary" criteria is based on Social Security Act §1862(a)(1)(A) provisions CMS further states you are required to correctly code for the items billed. An item/service is correctly coded when it meets all the coding guidelines listed in the CMS Healthcare Common Procedure Coding System (HCPCS) guidelines, Local Coverage Determinations (LCDs) or Medicare Administrative Contractor (MAC) articles. LCDs are developed jointly by the Durable Medical Equipment (DME) MACs. The DME MACs have the authority and responsibility to establish LCDs when there is no national policy on a subject or when there is a need to further define a National Coverage Determination (NCD). The LCDs are identical for all DME MACs For LCDs and LCD-related Policy Articles that use ICD-10 diagnosis codes, correct coding of the ICD-10 code is required. A diagnosis is correctly coded when it meets all the coding guidelines listed in International Classification of Diseases (ICD) guidelines, CMS policy or guideline requirements within the LCDs, or MAC articles	Deny DME codes submitted with an incompatible diagnosis code.

Edit 046-02: DME Non-Covered Procedure (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Non-covered procedure or service	Per the Centers for Medicare and Medicaid Services (CMS), for any item to be covered by Medicare, it must (1) be eligible for a defined Medicare benefit category, (2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and (3) meet all other applicable Medicare statutory and regulatory requirements. The "reasonable and necessary" criteria is based on Social Security Act §1862(a)(1)(A) provisions. CMS further states, you are required to correctly code for the items billed. An item/service is correctly coded when it meets all the coding guidelines listed in the CMS Healthcare Common Procedure Coding System (HCPCS) guidelines, Local Coverage Determinations (LCDs) or Medicare Administrative Contractor (MAC) articles. The Non-Medical Necessity Coverage and Payment Rules section of an LCD or Local Coverage Article (LCA) identifies situations in which an item does not meet the statutory definition of a benefit category (e.g., durable medical equipment, prosthetic devices, etc.) or when it does not meet other requirements specified in the regulations. It also identifies situations in which an item is statutorily excluded from coverage for reasons other than medical necessity. In situations in which an item is statutorily excluded from coverage for reasons other than medical necessity, the term used to describe the denial is "noncovered". Additionally, the LCDs and LCAs also include statements defining when an item will be denied as "not separately payable" or situations in which claim processing for the item is not within the DME MAC's jurisdiction	Deny non-covered DME codes.

Edit 046-03: DME Place of Service (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Procedure inconsistent with the place of service	Per the Centers for Medicare and Medicaid Services (CMS), for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) claims, the place of service is considered to be the place where the beneficiary will primarily use the DMEPOS item. Coverage for any DMEPOS item will be considered if the place of service is 01 (Pharmacy), 04 (Homeless Shelter), 12 (Home), 13 (Assistant Living Facility), 14 (Group Home), 16 (Temporary Lodging), 33 (Custodial Care Facility), 54 (Intermediate Care Facility/ Mentally Retarded), 55 (Residential Substance Abuse Treatment Facility) 56 (Psychiatric Residential Treatment Center) and 65 (End Stage Renal Disease Treatment Facility (valid POS for Parental Nutrition Therapy)) Coverage consideration for DMEPOS items in a Skilled Nursing Facility (31) unless the beneficiary is in a covered Part A stay**, or a Nursing Facility (32) is limited to the following: • Prosthetics, orthotics, and related supplies • Urinary incontinence supplies • Ostomy supplies • Surgical dressings • Oral anticancer drugs • Oral antiemetic drugs • Therapeutic shoes for Diabetics • Parenteral/enteral nutrition (including E0776BA, the IV pole uses to administer parenteral/enteral nutrition and supplies) • Immunosuppressive drugs NOTE: This list does not apply to situations in which the beneficiary is in a Part A covered Skilled Nursing Facility (SNF) stay.	Deny DME codes submitted by a DME Provider with a POS other than 01, 04, 12, 13, 14, 16, 33, 54, 55, 56 or 65.

Edit 046-04: DME Required Modifier (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Procedure inconsistent with the modifier used or a require modifier is missing	Per the Centers for Medicare and Medicaid Services (CMS), for any item to be covered by Medicare, it must (1) be eligible for a defined Medicare benefit category, (2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and (3) meet all other applicable Medicare statutory and regulatory requirements. The reasonable and necessary criteria is based on Social Security Act §1862(a)(1)(A) provisions. CMS further states, you are required to correctly code for the items billed. An item/service is correctly coded when it meets all the coding guidelines listed in the CMS Healthcare Common Procedure Coding System (HCPCS) guidelines, Local Coverage Determinations (LCDs) or Medicare Administrative Contractor (MAC) articles. Local Coverage Determinations (LCDs) are developed jointly by the DME MACs. The DME MACs have the authority and responsibility to establish LCDs when there is no national policy on a subject or when there is a need to further define an NCD. The LCDs are identical for all DME MACs. Within each LCD and/or LCA there is guidance regarding General Documentation Requirements that are applicable to all DMEPOS policies. Included in these sections are modifiers that "must be added" to the code and/or modifier that are designated as "required."	Deny DMEPOS codes submitted without required modifier.

Edit 046-05: DME Capped Rental (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Billing exceeds the rental period	Per the Centers for Medicare and Medicaid Services (CMS), for any item to be covered by Medicare, it must (1) be eligible for a defined Medicare benefit category, (2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and (3) meet all other applicable Medicare statutory and regulatory requirements. The "reasonable and necessary" criteria is based on Social Security Act §1862(a)(1)(A) provisions. CMS further states, reimbursement for most Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) is established by fee schedules. The DMEPOS Fee Schedule classifies items that are categorized into one of six categories which includes capped rental items. The items designated to be "capped rental" are identified with a "CR" within the Category column within the DMEPOS Fee Schedule. Items in this category are paid on a monthly rental basis not to exceed a period of continuous use of 13 months.	Deny "capped rental" DME codes that exceed rental period.

Edit 046-06: DME Frequency Over Time (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Exceeds number/Frequency allowed within timeframe	Per the Centers for Medicare and Medicaid Services (CMS), for any item to be covered by Medicare, it must (1) be eligible for a defined Medicare benefit category, (2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and (3) meet all other applicable Medicare statutory and regulatory requirements. The reasonable and necessary criteria is based on Social Security Act §1862(a)(1)(A) provisions. CMS further states, you are required to correctly code for the items billed. An item/service is correctly coded when it meets all the coding guidelines listed in the CMS Healthcare Common Procedure Coding System (HCPCS) guidelines, Local Coverage Determinations (LCDs) or Medicare Administrative Contractor (MAC) articles. Local Coverage Determinations (LCDs) are developed jointly by the DME MACs. The DME MACs have the authority and responsibility to establish LCDs when there is no national policy on a subject or when there is a need to further define an NCD. The LCDs are identical for all DME MACs. Within the Coverage Indications, Limitations, and/or Medical Necessity section of various LCD and/or LCD is specific guidance regarding the usual maximum quantity of supplies for specific Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) over a specified timeframe for a member regardless of provider.	Deny DMEPOS codes that exceed allowed frequency.

Edit 046-07: DME NCCI (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
As per NCCI, not allowed separate payment with procedure {0}	Per the Centers for Medicare and Medicaid Services (CMS), the National Correct Coding Initiative (NCCI) program was developed to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of claims. The coding policies are based on coding conventions defined in the American Medical Association's "Current Procedural Terminology (CPT®) Manual", national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical surgical practice and/or current coding practice. The NCCI program includes 3 types of edits: NCCI Procedure-to-procedure (PTP) edits, Medically Unlikely Edits (MUEs) and Add-on Code (AOC) edits. NCCI PTP edits prevent inappropriate payment of services that should not be reported together. Each edit has a Column I and Column II HCPCS/CPT® code. CMS further states, if a provider or supplier reports the 2 codes of an edit pair for the same beneficiary on the same date of service, the Column I code is eligible for payment and the Column II code is denied unless a clinically appropriate NCCI PTP-associated modifier is also reported. **NOTE**: This edit is specific to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items and is based on the Medicaid National Correct Coding Initiative (NCCI) Edit Files which promotes national correct coding methodologies and reduces improper coding which may result in inappropriate payments of Medicare Part B and Medicaid claims. This NCCI DME edit refers to provider claims for durable medical and defines pairs of Healthcare Common Procedure Coding System (HCPCS) codes that should not be reported together for a variety of reasons which include but are not limited to: • CPT® "Separate procedure" definition • Gender specific (formerly designation of sex) procedures • HCPCS/CPT® procedure code definition • Misuse of Column II code with Column I code • More extensive procedure • Mutually exclusive procedures	Deny Column II DMEPOS code when submitted with an associated Column I DME POS code.

Edit 046-08: DME Dual Modifier (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
DME requires additional modifier	Per the Centers for Medicare and Medicaid Services (CMS), for any item to be covered by Medicare, it must (1) be eligible for a defined Medicare benefit category, (2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and (3) meet all other applicable Medicare statutory and regulatory requirements. The reasonable and necessary criteria is based on Social Security Act §1862(a)(1)(A) provisions. CMS further states, you are required to correctly code for the items billed. An item/service is correctly coded when it meets all the coding guidelines listed in the CMS Healthcare Common Procedure Coding System (HCPCS) guidelines, Local Coverage Determinations (LCDs) or Medicare Administrative Contractor (MAC) articles. Local Coverage Determinations (LCDs) are developed jointly by the DME MACs. The DME MAC have the authority and responsibility to establish LCDs when there is no national policy on a subject or when there is a need to further define an NCD. The LCDs are identical for all DME MACs.	Deny DMEPOS codes submitted without all required modifiers

Edit 047-01: Telehealth/Telemedicine Service: Inappropriate Use of Modifier (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Inappropriate Use of Modifier	Per the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA), a modifier is a two-position alpha or numeric code that is appended to a CPT® or HCPCS code to clarify the service being billed. The below listed modifiers are indicative of a telehealth/telemedicine service and specifies the type of technology used: • 95: Synchronous Telemedicine Service Rendered Via a Realtime Interactive Audio and Video Telecommunications System • G0 (zero): Telehealth services for diagnosis, evaluation, or treatment of symptoms of an acute stroke • GT: Via interactive audio and video telecommunication systems • GQ: Via asynchronous telecommunications system Additionally, CMS publishes a list of services that are ordinarily furnished in-person; however, they are eligible for payment may be made when furnished using interactive, real-time telecommunication technology.	Deny procedure [OR service] codes determined to be ineligible for telehealth or telemedicine modifiers.

Edit 047-02: Telehealth/Telemedicine Service: Place of Service (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Procedure inconsistent with the place of service	Per the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA), Place of Service, (POS) codes are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. The Place of Service code set is required for use in the implementation guide adopted as the national standard for electronic transmission of professional health care claims under the provisions of the Health Insurance Potability and Accountability Act of 1996 (HIPAA). **NOTE**: POS 02 – Telehealth is the location where health services and health related services are provided or received through a telecommunication system.	Deny procedure [OR service] codes determined to be ineligible for a telehealth place of service.

Edit 047-03: Telehealth/Telemedicine Service: Required Modifier (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Missing required modifier	Per the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA), when a service is performed via Telehealth (or Telemedicine) one of the below listed modifiers must be appended to indicate the type of technology used and to identify the service as Telehealth: • GT: Via interactive audio and video telecommunication systems • GQ: Via asynchronous telecommunications system • 95: Synchronous Telemedicine Service Rendered Via a Realtime Interactive Audio and Video Telecommunications System • G0 (zero): Telehealth services for diagnosis, evaluation, or treatment of symptoms of an acute stroke	Deny codes submitted as a telehealth service without required telehealth modifier.

Edit 047-04: Telehealth/Telemedicine Service: Place of Service (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Inappropriate or Invalid Place of Service	Per the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA), when a physician or practitioner submits a claim for their services, including claims for telehealth services, they include a place of service (POS) code that is used to determine whether a service is paid using the facility or non-facility rate. Prior to March 1, 2020, CMS required claims for telehealth services include the POS code 02, which is specific to telehealth services. Effective March 1, 2020, under the waiver authority exercised by the Secretary of Health and Human Services, in response to the Public Health Emergency (PHE) for the COVID-19 pandemic, Medicare telehealth services can be furnished to patients wherever they are located, including in the patient's home. As provided by the amendments to section 1135(b)(8) of the Social Security Act, when telehealth services are furnished under the waiver to beneficiaries located in places that are not identified as permissible originating sites in section 1834(m)(4)(C)(ii)(I) through (IX) of the Act, no originating site facility fee is paid. CMS further states, on an interim basis, physicians and practitioners who bill for Medicare telehealth services are instructed to report the POS code that would have been reported had the service been furnished in person. This will allow appropriate payment for services furnished via Medicare telehealth which, if not for the PHE for the COVID-19 pandemic, would have been furnished in person, at the same rate they would have been paid if the services were furnished in person. Additionally, the POS code on the claim to identifies Medicare telehealth services, and on an interim basis the use of the CPT telehealth modifier 95, should be appended to claim lines that describe services furnished via telehealth. CMS maintained the facility payment rate for services billed using the general telehealth POS code 02, should practitioners choose, for whatever reason, to maintain their current billing practices for Medicare telehealth during the PHE for the COVID-19 pandemic	Deny telehealth or telemedicine services when submitted with a telehealth or telemedicine modifier without a telehealth place of service (POS) or an appropriate distant site POS.

Edit 047-05: Non-face-to-face Telephone Services Post Digital E/M (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Services denied as same/similar svc/proc. already paid within a set timeframe	Per the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA), telephone services are non-face-to-face evaluation and management (E/M) services provided to a patient using the telephone by a physician or other qualified health care professional, who may report evaluation and management services. Non-face-to-face telephone services (99441-99443) are used to report episodes of patient care initiated by an established patient or guardian of an established patient. If the telephone service ends with a decision to see the patient within 24 hours or next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the preservice work of the subsequent E/M service, procedure, and visit. Likewise, if the telephone call refers to an E/M service performed and reported by that individual within the previous seven days (either requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) is considered part of that previous E/M service or procedure. (Do not report 99441-99443, if 99421, 99422, 99423 have been reported by the same provider in the previous seven days for the same problem).	Deny non-face-to-face E/M services when an online digital E/M was billed and paid within the previous seven (7) days for the same problem.

Edit 047-06: Non-face-to-face Telephone Services Prior to E/M (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Services denied as same/similar svc/proc. already paid within a set timeframe	Per the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA), telephone services are non-face-to-face evaluation and management (E/M) services provided to a patient using the telephone by a physician or other qualified health care professional, who may report evaluation and management services. Non-face-to-face telephone services (99441-99443) are used to report episodes of patient care initiated by an established patient or guardian of an established patient. If the telephone service ends with a decision to see the patient within 24 hours or next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the preservice work of the subsequent E/M service, procedure, and visit. Likewise, if the telephone call refers to an E/M service performed and reported by that individual within the previous seven days (either requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) is considered part of that previous E/M service or procedure. (Do not report 99441-99443, if 99421, 99422, 99423 have been reported by the same provider in the previous seven days for the same problem).	Deny non-face-to-face E/M services when submitted within 24 hours of a face-to-face E/M visit.

Edit 047-07: Telehealth – Originating Site Facility Fee (Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Q3014 was submitted with an inappropriate type of bill	Per the Centers for Medicare and Medicaid Services (CMS), to receive the originating facility site fee, the provider submits claims with HCPCS code “Q3014; telehealth originating site facility fee” [short description “telehealth facility fee”]. By submitting Q3014 HCPCS code, the originating site authenticates they are located in either a rural HPSA or non-MSA county. CMS provides further guidance that this benefit may be billed on Bill Types: 12X, 13X, 22X, 23X, 71X, 72X, 73X, 76X AND Revenue Code: 078X.	Deny Q3014 when submitted without Bill Type 12X, 13X, 22X, 23X, 71X, 72X, 73X, 76X.

Edit 047-08: Telehealth Originating Site Facility Fee (Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Q3014 was submitted with an inappropriate revenue code	Per the Centers for Medicare and Medicaid Services (CMS), to receive the originating facility site fee, the provider submits claims with HCPCS code “Q3014; telehealth originating site facility fee” [short description “telehealth facility fee”]. By submitting Q3014 HCPCS code, the originating site authenticates they are located in either a rural HPSA or non-MSA county. CMS provides further guidance that this benefit may be billed on Bill Types: 12X, 13X, 22X, 23X, 71X, 72X, 73X, 76X AND Revenue Code: 078X.	Deny Q3014 when submitted without Revenue Code 078X

Edit 049-01: Therapy Services: Combination Modifiers (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Therapy code was received with more than one therapy modifier	Per the Centers for Medicare and Medicaid Services (CMS), therapy claims must include a therapy modifier to distinguish the discipline of the plan of care under which the service is delivered. **Therapy Modifiers**: GN - Services delivered under an outpatient speech language pathology plan of care GO - Services delivered under an outpatient occupational therapy plan of care GP - Services delivered under an outpatient physical therapy plan of care Modifiers GN, GO and GP refer only to services provided under plans of care for physical therapy, occupational therapy and speech-language pathology services CMS further states, no more than one GN, GO or GP modifier may be reported on the same service line. A specific service can only be reported by the rendering provider and can only be part of one discipline of care for that specific instance.	Deny therapy service codes if a combination of modifiers GN, GO or GP is submitted on the same claim line.

Edit 049-02: Therapy Services -Physical Therapy Assistant (PTA) (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Assistant therapy code requires additional modifier	Per the Centers of Medicare and Medicaid Services (CMS), two modifiers CO and CQ have been established for services furnished in whole or in part by occupational therapy assistants (OTAs) and physical therapist assistants (PTAs). Effective for claims with dates of service on and after January 1, 2020, the CO and CQ modifiers are required to be used when applicable for service furnished in whole or in part by OTAs and PTAs on the claim line of the service alongside the respective GO or GP therapy modifier to identify those OTA and PTA services furnished under a OT or PT plan of care.	Deny physical therapy service codes submitted with physical therapist assistant modifier (CQ) without the required therapy modifier to distinguish the discipline of the plan of care

Edit 049-03: Therapy Services-Occupational Therapy Assistant (OTA) (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Assistant therapy code requires additional modifier	Per the Centers of Medicare and Medicaid Services (CMS), two modifiers CO and CQ have been established for services furnished in whole or in part by occupational therapy assistants (OTAs) and physical therapist assistants (PTAs). Effective for claims with dates of service on and after January 1, 2020, the CO and CQ modifiers are required to be used when applicable for service furnished in whole or in part by OTAs and PTAs on the claim line of the service alongside the respective GO or GP therapy modifier to identify those OTA and PTA services furnished under a OT or PT plan of care.	Deny occupational therapy service codes submitted with physical therapist assistant modifier (CO) without the required therapy modifier to distinguish the discipline of the plan of care

Edit 049-04: Therapy Services-Required Therapy Modifier (Professional and Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Always therapy code missing required modifier	Per the Centers for Medicare and Medicaid Services (CMS), therapy plans of care must be certified by a physician or non-physician practitioner (NPP). The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered. **Therapy Modifiers**: • GN - Services delivered under an outpatient speech language pathology plan of care • GO - Services delivered under an outpatient occupational therapy plan of care • GP - Services delivered under an outpatient physical therapy plan of care CMS further states certain codes are "always therapy" services, regardless of who performs them. These codes always require a therapy modifier (GN, GO, GP) to indicate that they're furnished under a physical therapy, occupational therapy or speech-language pathology plan of care, respectively. Claims containing any of the "always therapy" codes must have one of the therapy modifiers appended (GN, GO or GP).	Deny always therapy code submitted without a required therapy modifier.

Edit 049-05: Therapy Services: Always Speech Language Pathology (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Always ST code missing required modifier	Per the Centers for Medicare and Medicaid Services (CMS), therapy plans of care must be certified by a physician or non-physician practitioner (NPP). CMS further states some codes require a specific therapy modifier (GN, GO or GP) to indicate when an evaluation service is furnished under a physical therapy, occupational therapy or speech language pathology plan of care, respectively. The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered. **Therapy Modifiers**: • GN - Services delivered under an outpatient speech language pathology plan of care • GO - Services delivered under an outpatient occupational therapy plan of care • GP - Services delivered under an outpatient physical therapy plan of care	Deny always speech language pathology codes submitted without required modifier indicating services delivered under a speech language pathology plan of care.

Edit 049-06: Therapy Services – Always Occupational Therapy (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Always OT code missing required modifier	Per the Centers for Medicare and Medicaid Services (CMS), therapy plans of care must be certified by a physician or non-physician practitioner (NPP). CMS further states some codes require a specific therapy modifier (GN, GO or GP) to indicate when an evaluation service is furnished under a physical therapy, occupational therapy or speech language pathology plan of care, respectively. The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered. **Therapy Modifiers**: • GN - Services delivered under an outpatient speech language pathology plan of care • GO - Services delivered under an outpatient occupational therapy plan of care • GP - Services delivered under an outpatient physical therapy plan of care	Deny always occupational therapy codes submitted without required modifier indicating services delivered under a speech language pathology plan of care.

Edit 049-07 Therapy Services Always Physical Therapy (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Always PT code missing required modifier	Per the Centers for Medicare and Medicaid Services (CMS), therapy plans of care must be certified by a physician or non-physician practitioner (NPP). CMS further states some codes require a specific therapy modifier (GN, GO or GP) to indicate when an evaluation service is furnished under a physical therapy, occupational therapy or speech language pathology plan of care, respectively. The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered. **Therapy Modifiers**: • GN - Services delivered under an outpatient speech language pathology plan of care • GO - Services delivered under an outpatient occupational therapy plan of care • GP - Services delivered under an outpatient physical therapy plan of care	Deny always physical therapy codes submitted without required modifier indicating services delivered under a speech language pathology plan of care.

Edit 049-08: Therapy Services – Always Therapy Revenue Code (Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Always therapy REV code with inappropriate modifier pairing	Per the Centers for Medicare and Medicaid Services (CMS), therapy plans of care must be certified by a physician or non-physician practitioner (NPP). CMS further states some codes require a specific therapy modifier (GN, GO or GP) to indicate when an evaluation service is furnished under a physical therapy, occupational therapy or speech language pathology plan of care, respectively. The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered. **Therapy Modifiers**: • GN - Services delivered under an outpatient speech language pathology plan of care • GO - Services delivered under an outpatient occupational therapy plan of care • GP - Services delivered under an outpatient physical therapy plan of care CMS further states, on institutional claims, therapy modifiers and revenue codes must be reported only in the following combinations: • Revenue Code 042X (Physical Therapy) lines may only contain modifier GP • Revenue Code 043X (Occupational Therapy) lines may only contain modifier GO • Revenue Code 044X (Speech-Language Pathology) may only contain modifier GN	Deny always therapy codes submitted with revenue code 042X, 043X or 044X with an inappropriate modifier OR without the associated modifier to distinguish the discipline of care in which the service was delivered.

Edit 049-09: Therapy Services – Always Speech Language Pathology (Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Always ST code with inappropriate modifier/REV code pairing	Per the Centers for Medicare and Medicaid Services (CMS), therapy plans of care must be certified by a physician or non-physician practitioner (NPP). CMS further states some codes require a specific therapy modifier (GN, GO or GP) to indicate when an evaluation service is furnished under a physical therapy, occupational therapy or speech language pathology plan of care, respectively. The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered. **Therapy Modifier:** • GN - Services delivered under an outpatient speech language pathology plan of care CMS further states, on institutional claims, therapy modifiers and revenue codes must be reported only in the following combination: • Revenue Code 044X (Speech-Language Pathology) may only contain modifier GN	Deny always speech language pathology therapy code submitted without the required associated therapy revenue code and modifier to distinguish the discipline of the plan of care.

Edit 049-10: Therapy Services – Always Occupational Therapy (Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Always OT code with inappropriate modifier/REV code pairing	Per the Centers for Medicare and Medicaid Services (CMS), therapy plans of care must be certified by a physician or non-physician practitioner (NPP). CMS further states some codes require a specific therapy modifier (GN, GO or GP) to indicate when an evaluation service is furnished under a physical therapy, occupational therapy or speech language pathology plan of care, respectively. The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered. **Therapy Modifier:** • GO - Services delivered under an outpatient occupational therapy plan of care CMS further states, on institutional claims, therapy modifiers and revenue codes must be reported only in the following combination: • Revenue Code 043X (Occupational Therapy) lines may only contain modifier GO	Deny always occupational therapy code submitted without the required associated therapy revenue code and modifier to distinguish the discipline of the plan of care.

Edit 049-11: Therapy Services – Always Physical Therapy (Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Always PT code with inappropriate modifier/REV code pairing	Per the Centers for Medicare and Medicaid Services (CMS), therapy plans of care must be certified by a physician or non-physician practitioner (NPP). CMS further states some codes require a specific therapy modifier (GN, GO or GP) to indicate when an evaluation service is furnished under a physical therapy, occupational therapy or speech language pathology plan of care, respectively. The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered. **Therapy Modifier:** • GP - Services delivered under an outpatient physical therapy plan of care CMS further states, on institutional claims, therapy modifiers and revenue codes must be reported only in the following combination: • Revenue Code 042X (Physical Therapy) lines may only contain modifier GP	Deny always physical therapy code submitted without the required associated therapy revenue code and modifier to distinguish the discipline of the plan of care.

Edit 049-12: Therapy Services – Sometimes Therapy Code (Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Sometime therapy modifier and REV code pairing is missing or inappropriate	Per the Centers for Medicare and Medicaid Services (CMS), therapy plans of care must be certified by a physician or non-physician practitioner (NPP). CMS provides additional guidance that some codes are designated to be “sometimes therapy” codes which when furnished by a therapist require the use of a therapy modifier – GP, GO or GN – in order to indicate the service is furnished under a physical therapy, occupational or speech-language pathology plan of care, respectively. While this disposition designates that a particular HCPCS/CPT code will not of itself always indicate that a therapy service was rendered, these codes always represent therapy services when rendered by therapists or by practitioners who are not therapists in situations where the service provided is integral to an outpatient rehabilitation therapy plan of care. For these situations, these codes must always have a therapy modifier. For example, when the service is rendered by either a Doctor of Medicine or a nurse practitioner (acting within the scope of his or her license when performing such service), with the goal of rehabilitation, a therapy modifier is required. When there is doubt about whether a service should be part of a therapy plan of care, the contractor shall make that determination. . **Therapy Modifiers:** • GN - Services delivered under an outpatient speech language pathology plan of care • GO - Services delivered under an outpatient occupational therapy plan of care • GP - Services delivered under an outpatient physical therapy plan of care CMS further states, on institutional claims, therapy modifiers and revenue codes must be reported only in the following combinations: • Revenue Code 042X (Physical Therapy) lines may only contain modifier GP • Revenue Code 043X (Occupational Therapy) lines may only contain modifier GO • Revenue Code 044X (Speech-Language Pathology) may only contain modifier GN	Deny sometimes therapy codes submitted with revenue codes 042X, 043X or 044X without the required associated therapy modifier to distinguish the discipline of the plan of care.

Edit 050-02: Modifier Validation – Inappropriate Use of Modifier -59

EDIT OVERVIEW
This Inappropriate Use of Modifier -59 edit will ensure claims/claim lines are not reimbursed for NCCI code pairs submitted with modifier -59 when a desktop review of the claim details and member history determines the submitted procedure is deemed ineligible. According to the Centers for Medicare and Medicaid Services (CMS), some National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) associated edits have a Correct Coding Modifier Indicator (CCMI) of "1" which indicates you may report the codes together only in defined circumstances by using specific NCCI PTP-associated modifiers. One purpose of NCCI PTP-associated edits is to prevent payment for codes that report overlapping services except where the services are "separate and distinct". CMS provides further guidance that states Modifier -59 is an important NCCI PTP-associated modifier the providers often use incorrectly. **NOTE:** CMS further states do not use modifier -59, -X{EPSU} and other NCCI PTP-associated modifiers to bypass an NCCI PTP edit unless the proper criteria for use of the modifiers are met.

Edit 051-01: Waiver of Liability - Modifier GA

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
CPT/HCPCS submitted with waiver of liability modifier GA	Per the Centers of Medicare and Medicaid Services (CMS), providers and suppliers are required to use the GA modifier for claims they expect to be denied as "not reasonable and necessary" for which they have an Advance Beneficiary Notice of Noncoverage (ABN) signed by the beneficiary on file. Modifier -GA has been redefined to mean "Waiver of Liability Statement Issued as Required by Payer Policy" and should be used to report when a required ABN was issued for a service. One of the purposes of the ABN is to inform the beneficiary that the service or items certainly or probably will not be paid for that occasion. The GA modifier may be used only if a beneficiary signed an ABN indicating that he or she accepts liability for the cost of the service or item if it is not paid. CMS provider further guidance that claims submitted with modifier –GA will be denied (rather than subjecting them to possible medical review).	Deny procedures and services submitted with modifier -GA.

Edit 051-02: Waiver of Liability - Modifier GZ

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
CPT/HCPCS submitted with Not Reasonable and Necessary Modifier GZ	Per the Centers of Medicare and Medicaid Services (CMS), providers and suppliers are required to use the GZ modifier for claims they expect to be denied as not reasonable and necessary when an Advance Beneficiary Notice of Noncoverage (ABN) signed by the beneficiary is not on file. The GZ modifier indicates that an Advance Beneficiary Notice of Noncoverage (ABN) was not issued to the beneficiary and signifies that the provider expects denial due to a lack of medical necessity based on an informed knowledge of payment policies. In this instance, if the claim is denied as not reasonable or necessary, the beneficiary cannot be held liable for the cost of the service or item CMS provides further guidance that claim lines with items or services submitted with a GZ modifier should be automatically denied and a complex medical review is not performed.	Deny procedures and services submitted with modifier -GZ.

Edit 051-03: Notice of Liability - Modifier GX

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
CPT/HCPCS submitted with Notice of Liability Modifier GX	Per the Centers of Medicare and Medicaid Services (CMS), Modifier –GX has been created with the definition "Notice of Liability Issue, Voluntary Under Payor Policy" and is to be used to report when a voluntary Advance Beneficiary Notice of Noncoverage (ABN) was issued for a service. The –GX modifier is used to provide beneficiaries with voluntary notice of liability regarding services excluded from Medicare coverage by statute, resulting in beneficiary liability. CMS provides further guidance that claim lines with modifier GX should be automatically	Deny procedures and services submitted with modifier -GX.

Edit 051-04: Statutorily Excluded Item or Services - Modifier GY

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
CPT/HCPCS submitted with Statutorily Excluded Modifier GY	Per the Centers of Medicare and Medicaid Services (CMS), the GY modifier is used to indicate that a service or item is not covered either because it is statutorily excluded, or it does not meet the definition of any Medicare benefit. CMS further states, claim lines for services that are statutorily excluded will deny whether or not the modifier is present on the claim. An Advance Beneficiary Notice of Noncoverage (ABN) is not required with the GY modifier. Since these services or items are non-covered, the beneficiary is liable for payment.	Deny procedures and services submitted with modifier -GY.

Edit 052-01: Missing Place of Service

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Missing Place of Service Required on Claim	Per the Centers of Medicare and Medicaid Services (CMS), the final rule "Health Insurance Reform: Standards for Electronic Transactions " published in the Federal Register August 17,2000, adopts the standards to be used under Health Insurance Portability and Accountability Acct (HIPAA) and names the implementation guides to be used for these standards. The ASC X12N 837 professional is the standard to be used for transmitting healthcare claims electronically, and its implementation guide requires the use of POS (place of service) codes from the National POS code set, currently maintained by CMS. Covered entities under the HIPAA must use the POS codes from the National POS code set for processing its electronically submitted claims.	Deny claims submitted without required POS.

Edit 052-02: Ineffective or Deleted Place of Service

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Ineffective or Deleted Place of Service.	Per the Centers of Medicare and Medicaid Services (CMS), the final rule "Health Insurance Reform: Standards for Electronic Transactions " published in the Federal Register August 17,2000, adopts the standards to be used under Health Insurance Portability and Accountability Acct (HIPAA) and names the implementation guides to be used for these standards. The ASC X12N 837 professional is the standard to be used for transmitting healthcare claims electronically, and its implementation guide requires the use of POS (place of service) codes from the National POS code set, currently maintained by CMS. Covered entities under the HIPAA must use the POS codes from the National POS code set for processing its electronically submitted claims. CMS provides further guidance regarding the National POS Code Set and instructions for using it. The instructions include the current national POS code set, with facility and non-facility designation noted for payment on the Physician Fee Schedule. As a new POS code is established, the health care industry is permitted to use this code from the date that it is published in posted in the CMS Medicare Place of Service Code Set Web page which is typically expected to be some months ahead of the final effective date for use. The code set is annotated with the effective dates for all codes added after 2003. Codes without effective dates annotated are long standing and in effect on and before January 1, 2003.	Deny procedures and services when the POS is determined to be ineffective or deleted.

Edit 052-03: Invalid Place of Service

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Invalid Place of Service	Per the Centers of Medicare and Medicaid Services (CMS), the final rule "Health Insurance Reform: Standards for Electronic Transactions " published in the Federal Register August 17,2000, adopts the standards to be used under Health Insurance Portability and Accountability Acct (HIPAA) and names the implementation guides to be used for these standards. The ASC X12N 837 professional is the standard to be used for transmitting healthcare claims electronically, and its implementation guide requires the use of POS (place of service) codes from the National POS code set, currently maintained by CMS. Covered entities under the HIPAA must use the POS codes from the National POS code set for processing its electronically submitted claims. CMS provides guidance regarding the National POS Code Set and instructions for using it. The instructions include the current national POS code set, with facility and non-facility designation noted for payment on the Physician Fee Schedule. As a new POS code is established, the health care industry is permitted to use this code from the date that it is published in posted in the CMS Medicare Place of Service Code Set Web page which is typically expected to be some months ahead of the final effective date for use. The code set is annotated with the effective dates for all codes added after 2003. Codes without effective dates annotated are long standing and in effect on and before January 1, 2003.	Deny procedures and services when the POS is determined to be invalid.

Edit 052-04: Missing Type of Bill

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Missing Type of Bill Required on Claim	Per the Centers of Medicare and Medicaid Services (CMS), the Uniform Billing with Form CMS-1450 (also known as the UB-04) is a uniform institutional provider bill suitable for use in billing multiple third-party payers. The National Uniform Billing Committee (NUBC) maintains lists of approved coding for the form. CMS provide guidance regarding the requirements for use of codes maintained by the NUBC that are needed in completion of the Form CMS-1450 and compliant Accredited Standards Committee (ASC) X12 837 institutional claims. Instructions for completion are the same for inpatient and outpatient claims unless otherwise noted. The A/B MAC (A) or (HHH) does not need to search paper files to annotate missing data unless it does not have an electronic history record. It does not need to obtain data that is not needed to process the claim. CMS provides further guidance stating the Form Layout (FL 4) Type of Bill which is a required four-digit alphanumeric code which provide three specific pieces of information after a leading zero: • Type of facility • Type of care • Sequence of bill in the episode of care (frequency code)	Deny procedures and services submitted without required Type of Bill.

Edit 052-05: Ineffective or Deleted Type of Bill

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Ineffective or Deleted Type of Bill	Per the Centers of Medicare and Medicaid Services (CMS), the Uniform Billing with Form CMS-1450 (also known as the UB-04) is a uniform institutional provider bill suitable for use in billing multiple third-party payers. The National Uniform Billing Committee (NUBC) maintains lists of approved coding for the form. CMS provide guidance regarding the requirements for use of codes maintained by the NUBC that are needed in completion of the Form CMS-1450 and compliant Accredited Standards Committee (ASC) X12 837 institutional claims. Instructions for completion are the same for inpatient and outpatient claims unless otherwise noted. The A/B MAC (A) or (HHH) does not need to search paper files to annotate missing data unless it does not have an electronic history record. It does not need to obtain data that is not needed to process the claim. CMS provides further guidance stating the Form Layout (FL 4) Type of Bill which is a required four-digit alphanumeric code which provide three specific pieces of information after a leading zero: • Type of facility • Type of care • Sequence of bill in the episode of care (frequency code) The National Uniform Billing Committee (NUBC) maintains lists of approved coding for the form.	Deny procedures and services when the type of bill is determined to be ineffective or deleted.

Edit 052-06: Invalid Type of Bill

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Invalid Type of Bill	Per the Centers of Medicare and Medicaid Services (CMS), the Uniform Billing with Form CMS-1450 (also known as the UB-04) is a uniform institutional provider bill suitable for use in billing multiple third-party payers. The National Uniform Billing Committee (NUBC) maintains lists of approved coding for the form. CMS provide guidance regarding the requirements for use of codes maintained by the NUBC that are needed in completion of the Form CMS-1450 and compliant Accredited Standards Committee (ASC) X12 837 institutional claims. Instructions for completion are the same for inpatient and outpatient claims unless otherwise noted. The A/B MAC (A) or (HHH) does not need to search paper files to annotate missing data unless it does not have an electronic history record. It does not need to obtain data that is not needed to process the claim. CMS provides further guidance stating the Form Layout (FL 4) Type of Bill which is a required four-digit alphanumeric code which provide three specific pieces of information after a leading zero: • Type of facility • Type of care • Sequence of bill in the episode of care (frequency code) The National Uniform Billing Committee (NUBC) maintains lists of approved coding for the form.	Deny procedures and services when the type of bill is determined to be invalid.

Edit 057-01: In appropriate Use of Modifier 26

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Inappropriate CPT/HCPCS Code Billed with Modifier 26	Per the Centers for Medicare and Medicaid Services (CMS), the professional component (PC) of radiology services furnished by a physician to an individual patient in all settings under the fee schedule for physician services must be paid regardless of the of the specialty of the physician who performs the service. For services furnished to hospital patient, services are only paid if the services meet the conditions for fee schedule payment and are identifiable, direct, and discrete diagnostic or therapeutic services to an individual patient, such as an interpretation of diagnostic procedures and the professional component of therapeutic procedures. The interpretation of a diagnostic procedures includes a written report. Modifier -26 is used when only the professional component (PC) is being billed with certain services combine both the professional and technical portions in one procedure code. The professional component (PC) is the supervision and interpretation portion of the procedure and includes indirect practice and malpractice expenses related to that work. The total RVUs (Relative Value Units) for codes reported with a 26 modifier include values for physician work, practice expense and malpractice expense. Modifier -26 is to be used when a physician interprets but does not perform the test Most radiology codes including ultrasounds, x-rays, CT scans, magnetic resonance angiography, and MRIs may be billed with modifier 26 or TC, or with no modifier at all, indicating that the provider performed both the professional and technical services.	Deny procedure or services determined to be inappropriate for modifier -26.

Edit 057-02: Inappropriate Use of Modifier TC

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Inappropriate CPT/HCPCS Code Billed with Modifier TC	Per the Centers for Medicare and Medicaid Services (CMS), modifier TC is used when only the technical component of a procedure is being billed when certain services combine both the professional and technical portions in one procedure code. The technical component (TC) modifier is to be used when the physician performs the test but does not do the interpretation. Payment for the technical component portion of a test includes the practice expense and the malpractice expense. The technical component (TC) of the imaging service are paid for services furnished to beneficiaries who are not patients of any hospital, and who receive services in physician's office, a freestanding imaging or radiation oncology center, ambulatory surgical center (ASC) or other setting that is not part of a hospital.	Deny procedure or services determined to be inappropriate for modifier -TC

Edit 057-03: PC/TC Indicator 8 – Inappropriate Place of Service

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Inappropriate Place of Service for PC/TC Indicator 8 CPT/HCPCS	Per the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule Relative Value File (NPFSRVF), PC/TC Payment Indicator 8 (Physician Interpretation Codes) identifies the PC (Professional Component) of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. CMS provides further guidance that this applies only to applies only to CPT code 85060 (blood smear, peripheral, interpretation by physician with written report).	Deny Physician Interpretation codes submitted with a POS other than 21.

Edit 057-04: PC/TC Modifiers Submitted with Global Service

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
CPT/HCPCS Billed with Modifier 26 or TC with a Global Service in Same Place of Service	Per the Centers for Medicare & Medicaid Services (CMS), a global service includes both the professional and technical components of a single service. If is identified by reporting the eligible code without modifier 26 or TC. When the global service is submitted, reimbursement includes equipment, supplies, technical support as well as the interpretation of the report. CMS provides further guidance that claims for CPT/HCPCS codes that are billed with a TC and/or PC modifier in addition to the global procedure by the same provider will be denied.	Deny procedures and services submitted with professional or technical component modifier(s) when the same global service has been billed/paid for the same DOS in the same POS.

Edit 057-05: PC/TC Component Codes Requiring Global Service

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
CPT/HCPCS Billed with Modifier 26 or TC on Separate Claim Lines Requiring a Global Service to be Billed in Same Place of Service.	Per the Centers for Medicare & Medicaid Services (CMS), most radiology codes including ultrasounds, x-rays, CT scans, magnetic resonance angiography, and MRIs may be billed with modifier 26 or TC, or with no modifier at all, indicating that the provider performed both the professional and technical services. It is inappropriate to bill modifier 26 (Professional Component) and TC (Technical Component) when billing for a complete service. These modifiers should only be used to indicate less than a complete service was rendered.	Deny procedure or service submitted with both PC/TC modifiers for the same DOS by the same provider for the same POS.

Edit 057-06: Inappropriate Submission of Global Service in Hospital Setting

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Inappropriate Global Service Billed in a Hospital Setting	Per the Centers for Medicare & Medicaid Services (CMS), some imaging services are split into professional components (PC) and technical components (TC), each separately payable. CMS provide further guidance that the technical component (TC) modifier is to be used when the physician performs the test but does not do the interpretation. The technical component (TC) of the imaging service are paid for services furnished to beneficiaries who are not patients of any hospital, and who receive services in physician's office, a freestanding imaging or radiation oncology center, ambulatory surgical center (ASC) or other setting that is not part of a hospital.	Deny procedure or service submitted as a global service or with both PC/TC modifiers on the same claim line (indicating "global service") in a hospital setting.

Edit 057-07: Inappropriate TC Modifier in Hospital Setting

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Inappropriate Technical Component Billed in a Hospital Setting	Per the Centers for Medicare & Medicaid Services (CMS), some imaging services are split into professional components (PC) and technical components (TC), each separately payable. CMS provide further guidance that the technical component (TC) modifier is to be used when the physician performs the test but does not do the interpretation. The technical component (TC) of the imaging service are paid for services furnished to beneficiaries who are not patients of any hospital, and who receive services in physician's office, a freestanding imaging or radiation oncology center, ambulatory surgical center (ASC) or other setting that is not part of a hospital.	Deny procedure or service submitted with a TC modifier in a hospital setting.

Edit 058-01: Drug Waste with No Separate Line for Same HCPCS (Professional and Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Drug waste billed without identical HCPCS code	Per the Centers for Medicare & Medicaid Services (CMS), physicians, hospitals and other provides/suppliers are encouraged to care for and administer drugs and biologicals to patients in such a way that they can use drugs and biologicals most efficiently, in a clinically appropriate manner. When a physician, hospital or other provider/supplier must discard the remainder of a single use vial or other single use package after administering a dose/quantity of the drug or biological, payment is provided for the amount of drug or biologic discarded, as well as the does administered, up to the amount of the drug or biological as indicated on the vial or package label. CMS further states, the use of the modifier JW (Drug amount discarded/not administered to any patient) is required to identify unused drugs and biologicals from single use vials or single use packages that are appropriately discarded. This modifier must be billed on a separate line to provide payment for the amount of the discarded drug or biological. **NOTE:** Multi-use vials are not subject to payment for discarded amounts of drugs or biologicals.	Deny drugs or biologicals submitted with modifier JW without a corresponding claim line for the same HCPCS code.

Edit 058-02: Drug Waste When Same HCPCS is Not Paid/Denied (Professional and Outpatient Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
JW modifier billed and HCPCS code for amount administered not payable	Per the Centers for Medicare & Medicaid Services (CMS), physicians, hospitals and other provides/suppliers are encouraged to care for and administer drugs and biologicals to patients in such a way that they can use drugs and biologicals most efficiently, in a clinically appropriate manner. When a physician, hospital or other provider/supplier must discard the remainder of a single use vial or other single use package after administering a dose/quantity of the drug or biological, payment is provided for the amount of drug or biologic discarded, as well as the does administered, up to the amount of the drug or biological as indicated on the vial or package label. CMS further states, the use of the modifier JW (Drug amount discarded/not administered to any patient) is required to identify unused drugs and biologicals from single use vials or single use packages that are appropriately discarded. This modifier must be billed on a separate line to provide payment for the amount of the discarded drug or biological. **NOTE:** Multi-use vials are not subject to payment for discarded amounts of drugs or biologicals.	Deny drugs or biologicals submitted with modifier JW without a corresponding claim line with the same HCPCS code was billed but not paid.

Edit 064-19: Medically Unlikely Edits- Medicaid Practitioner, Claim Line Edit (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Units of Service Exceed Medicaid Practitioner MUE Value.	Per the Centers for Medicare and Medicaid Services (CMS), the National Correct Coding Initiative (NCCI) program was developed to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of claims. The coding policies are based on coding conventions defined in the American Medical Association (AMA) "Current Procedural Terminology (CPT®) Manual", national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical surgical practice and/or current coding practice. The NCCI program includes 3 types of edits: NCCI Procedure-to-procedure (PTP) edits, Medically Unlikely Edits (MUEs) and Add-on Code (AOC) edits. Each edit has a Column I and Column II HCPCS/CPT® code. CMS further states, the purpose of the NCCI MUE program is to prevent improper payments when services are reported with incorrect units of service (UOS). The CMS developed MUEs to reduce the paid claims error rate. An MUE for a Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT®) code is the maximum UOS that a provider or supplier would report under most circumstances for a single beneficiary on a single date of service The purpose of the NCCI MUE program is to prevent improper payments when services are reported with incorrect units of service (UOS). The CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. An MUE for a Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) code is the maximum units of service that a provider or supplier would report under most circumstances for a single beneficiary on a single date of service. This Disallowed Multiple Procedures edit will apply a recommendation to deny claims lines with units for procedures or services that exceed the maximum number of units of service (UOS) values for the below indicated scenarios: • Maximum units per day for Medicaid line of business This edit will review the data elements submitted on the current claim and/or the member's history to determine if the units of service (UOS) for the submitted procedure or service is allowable per the CMS Medicaid policy.	Deny procedures or services submitted with units that exceed the maximum units allowed per DOS.

Edit 064-20: Medically Unlikely Edits- Medicaid Facility Outpatient Hospital, Claim Line Edit (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Units of Service Exceed Medicaid Outpatient Hospital MUE Value.	Per the Centers for Medicare and Medicaid Services (CMS), the National Correct Coding Initiative (NCCI) program was developed to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of claims. The coding policies are based on coding conventions defined in the American Medical Association (AMA) "Current Procedural Terminology (CPT®) Manual", national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical surgical practice and/or current coding practice. The NCCI program includes 3 types of edits: NCCI Procedure-to-procedure (PTP) edits, Medically Unlikely Edits (MUEs) and Add-on Code (AOC) edits. Each edit has a Column I and Column II HCPCS/CPT® code. CMS further states, the purpose of the NCCI MUE program is to prevent improper payments when services are reported with incorrect units of service (UOS). The CMS developed MUEs to reduce the paid claims error rate. An MUE for a Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT®) code is the maximum UOS that a provider or supplier would report under most circumstances for a single beneficiary on a single date of service The purpose of the NCCI MUE program is to prevent improper payments when services are reported with incorrect units of service (UOS). The CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. An MUE for a Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) code is the maximum units of service that a provider or supplier would report under most circumstances for a single beneficiary on a single date of service. This Disallowed Multiple Procedures edit will apply a recommendation to deny claims lines with units for procedures or services that exceed the maximum number of units of service (UOS) values for the below indicated scenarios: - Maximum units per day for Medicaid line of business This edit will review the data elements submitted on the current claim and/or the member's history to determine if the units of service (UOS) for the submitted procedure or service is allowable per the CMS Medicaid policy.	Deny procedures or services submitted with units that exceed the maximum units allowed per DOS.

Edit 064-21: Medically Unlikely Edits- Medicaid Durable Medical Equipment, Claim Line Edit (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Units of Service Exceed Medicaid DME MUE Value.	Per the Centers for Medicare and Medicaid Services (CMS), the National Correct Coding Initiative (NCCI) program was developed to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of claims. The coding policies are based on coding conventions defined in the American Medical Association (AMA) "Current Procedural Terminology (CPT®) Manual", national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical surgical practice and/or current coding practice. The NCCI program includes 3 types of edits: NCCI Procedure-to-procedure (PTP) edits, Medically Unlikely Edits (MUEs) and Add-on Code (AOC) edits. Each edit has a Column I and Column II HCPCS/CPT® code. CMS further states, the purpose of the NCCI MUE program is to prevent improper payments when services are reported with incorrect units of service (UOS). The CMS developed MUEs to reduce the paid claims error rate. An MUE for a Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT®) code is the maximum UOS that a provider or supplier would report under most circumstances for a single beneficiary on a single date of service The purpose of the NCCI MUE program is to prevent improper payments when services are reported with incorrect units of service (UOS). The CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. An MUE for a Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) code is the maximum units of service that a provider or supplier would report under most circumstances for a single beneficiary on a single date of service. This Disallowed Multiple Procedures edit will apply a recommendation to deny claims lines with units for procedures or services that exceed the maximum number of units of service (UOS) values for the below indicated scenarios: - Maximum units per day for Medicaid line of business This edit will review the data elements submitted on the current claim and/or the member's history to determine if the units of service (UOS) for the submitted procedure or service is allowable per the CMS Medicaid policy.	Deny procedures or services submitted with units that exceed the maximum units allowed per DOS.

Edit 067-01: NCCI PTP Edits - Medicaid Practitioner Services (Except ASC Facility Charges) (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Service Is Not Payable With Another Service On The Same DOS.	Per the Centers for Medicare and Medicaid Services (CMS), the National Correct Coding Initiative (NCCI) program was developed to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of claims. The coding policies are based on coding conventions defined in the American Medical Association (AMA) "Current Procedural Terminology (CPT®) Manual", national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical surgical practice and/or current coding practice. The NCCI program includes 3 types of edits: NCCI Procedure-to-procedure (PTP) edits, Medically Unlikely Edits (MUEs) and Add-on Code (AOC) edits. NCCI PTP edits prevent inappropriate payment of services that should not be reported together. Each edit has a Column I and Column II HCPCS/CPT® code. CMS further states, if a provider or supplier reports the 2 codes of an edit pair for the same beneficiary on the same date of service, the Column I code is eligible for payment and the Column II code is denied unless a clinically appropriate NCCI PTP-associated modifier is also reported. NOTE: Zelis also offers an Out of Sequence version of all NCCI logic that will deny the Column I code if the Column II code was already billed and paid by the same provider in the member's history to prevent overpayment.	Deny Column II service or procedure codes submitted by the same provider for same DOS as an associated Column I code.

Edit 067-02: NCCI PTP Edits - Medicaid Practitioner Services for ASC Facility Charge (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Service Is Not Payable With Another Service On The Same DOS.	Per the Centers for Medicare and Medicaid Services (CMS), the National Correct Coding Initiative (NCCI) program was developed to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of claims. The coding policies are based on coding conventions defined in the American Medical Association (AMA) "Current Procedural Terminology (CPT®) Manual", national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical surgical practice and/or current coding practice. The NCCI program includes 3 types of edits: NCCI Procedure-to-procedure (PTP) edits, Medically Unlikely Edits (MUEs) and Add-on Code (AOC) edits. NCCI PTP edits prevent inappropriate payment of services that should not be reported together. Each edit has a Column I and Column II HCPCS/CPT® code. CMS further states, if a provider or supplier reports the 2 codes of an edit pair for the same beneficiary on the same date of service, the Column I code is eligible for payment and the Column II code is denied unless a clinically appropriate NCCI PTP-associated modifier is also reported. NOTE: Zelis also offers an Out of Sequence version of all NCCI logic that will deny the Column I code if the Column II code was already billed and paid by the same provider in the member's history to prevent overpayment.	Deny Column II service or procedure codes submitted by the same provider for same DOS as an associated Column I code.

Edit 067-03: NCCI PTP Edits - Medicaid Facility Outpatient Hospital Services (Except ASCs) (Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Outpatient Service Is Not Payable With Another Service On The Same DOS.	Per the Centers for Medicare and Medicaid Services (CMS), the National Correct Coding Initiative (NCCI) program was developed to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of claims. The coding policies are based on coding conventions defined in the American Medical Association (AMA) "Current Procedural Terminology (CPT®) Manual", national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical surgical practice and/or current coding practice. The NCCI program includes 3 types of edits: NCCI Procedure-to-procedure (PTP) edits, Medically Unlikely Edits (MUEs) and Add-on Code (AOC) edits. NCCI PTP edits prevent inappropriate payment of services that should not be reported together. Each edit has a Column I and Column II HCPCS/CPT® code. CMS further states, if a provider or supplier reports the 2 codes of an edit pair for the same beneficiary on the same date of service, the Column I code is eligible for payment and the Column II code is denied unless a clinically appropriate NCCI PTP-associated modifier is also reported. NOTE: Zelis also offers an Out of Sequence version of all NCCI logic that will deny the Column I code if the Column II code was already billed and paid by the same provider in the member's history to prevent overpayment.	Deny Column II service or procedure codes submitted by the same provider for same DOS as an associated Column I code.

Edit 067-04: NCCI PTP Edits - Medicaid Facility Services for ASCs (Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
ASC Service Is Not Payable With Another Service On The Same DOS.	Per the Centers for Medicare and Medicaid Services (CMS), the National Correct Coding Initiative (NCCI) program was developed to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of claims. The coding policies are based on coding conventions defined in the American Medical Association (AMA) "Current Procedural Terminology (CPT®) Manual", national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical surgical practice and/or current coding practice. The NCCI program includes 3 types of edits: NCCI Procedure-to-procedure (PTP) edits, Medically Unlikely Edits (MUEs) and Add-on Code (AOC) edits. NCCI PTP edits prevent inappropriate payment of services that should not be reported together. Each edit has a Column I and Column II HCPCS/CPT® code. CMS further states, if a provider or supplier reports the 2 codes of an edit pair for the same beneficiary on the same date of service, the Column I code is eligible for payment and the Column II code is denied unless a clinically appropriate NCCI PTP-associated modifier is also reported. NOTE: Zelis also offers an Out of Sequence version of all NCCI logic that will deny the Column I code if the Column II code was already billed and paid by the same provider in the member's history to prevent overpayment.	Deny Column II service or procedure codes submitted by the same provider for same DOS as an associated Column I code.

Edit R67-01: NCCI PTP Edits - Medicaid Practitioner Services (Except ASC Facility Charges) (Out of Sequence) (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Service Is Not Payable With Another Service On The Same DOS.	Per the Centers for Medicare and Medicaid Services (CMS), the National Correct Coding Initiative (NCCI) program was developed to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of claims. The coding policies are based on coding conventions defined in the American Medical Association (AMA) "Current Procedural Terminology (CPT®) Manual", national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical surgical practice and/or current coding practice. The NCCI program includes 3 types of edits: NCCI Procedure-to-procedure (PTP) edits, Medically Unlikely Edits (MUEs) and Add-on Code (AOC) edits. NCCI PTP edits prevent inappropriate payment of services that should not be reported together. Each edit has a Column I and Column II HCPCS/CPT® code. CMS further states, if a provider or supplier reports the 2 codes of an edit pair for the same beneficiary on the same date of service, the Column I code is eligible for payment and the Column II code is denied unless a clinically appropriate NCCI PTP-associated modifier is also reported. NOTE: Zelis also offers an Out of Sequence version of all NCCI logic that will deny the Column I code if the Column II code was already billed and paid by the same provider in the member's history to prevent overpayment.	Reduce the allowed amount for the Column I service/procedure codes submitted by the same provider for same DOS as an associated Column II code.

Edit R67-02: NCCI PTP Edits - Medicaid Practitioner Services for ASC Facility Charge (Out of Sequence) (Professional)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
Service Is Not Payable With Another Service On The Same DOS.	Per the Centers for Medicare and Medicaid Services (CMS), the National Correct Coding Initiative (NCCI) program was developed to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of claims. The coding policies are based on coding conventions defined in the American Medical Association (AMA) "Current Procedural Terminology (CPT®) Manual", national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical surgical practice and/or current coding practice. The NCCI program includes 3 types of edits: NCCI Procedure-to-procedure (PTP) edits, Medically Unlikely Edits (MUEs) and Add-on Code (AOC) edits. NCCI PTP edits prevent inappropriate payment of services that should not be reported together. Each edit has a Column I and Column II HCPCS/CPT® code. CMS further states, if a provider or supplier reports the 2 codes of an edit pair for the same beneficiary on the same date of service, the Column I code is eligible for payment and the Column II code is denied unless a clinically appropriate NCCI PTP-associated modifier is also reported.	Reduce the allowed amount for the Column I service/procedure codes submitted by the same provider for same DOS as an associated Column II code.

Edit R67-03: NCCI PTP Edits - Medicaid Facility Outpatient Hospital Services (Except ASCs) (Out of Sequence) (Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME

Outpatient Service Is Not Payable With Another Service On The Same DOS.	Per the Centers for Medicare and Medicaid Services (CMS), the National Correct Coding Initiative (NCCI) program was developed to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of claims. The coding policies are based on coding conventions defined in the American Medical Association (AMA) "Current Procedural Terminology (CPT®) Manual", national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical surgical practice and/or current coding practice. The NCCI program includes 3 types of edits: NCCI Procedure-to-procedure (PTP) edits, Medically Unlikely Edits (MUEs) and Add-on Code (AOC) edits. NCCI PTP edits prevent inappropriate payment of services that should not be reported together. Each edit has a Column I and Column II HCPCS/CPT® code. CMS further states, if a provider or supplier reports the 2 codes of an edit pair for the same beneficiary on the same date of service, the Column I code is eligible for payment and the Column II code is denied unless a clinically appropriate NCCI PTP-associated modifier is also reported.	Reduce the allowed amount for the Column I service/procedure codes submitted by the same provider for same DOS as an associated Column II code.

Edit R67-04: NCCI PTP Edits - Medicaid Facility Services for ASCs (Out of Sequence) (Facility)

REMARK CODE	EDIT OVERVIEW	EDIT OUTCOME
ASC Service Is Not Payable With Another Service On The Same DOS.	Per the Centers for Medicare and Medicaid Services (CMS), the National Correct Coding Initiative (NCCI) program was developed to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of claims. The coding policies are based on coding conventions defined in the American Medical Association (AMA) "Current Procedural Terminology (CPT®) Manual", national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical surgical practice and/or current coding practice. The NCCI program includes 3 types of edits: NCCI Procedure-to-procedure (PTP) edits, Medically Unlikely Edits (MUEs) and Add-on Code (AOC) edits. NCCI PTP edits prevent inappropriate payment of services that should not be reported together. Each edit has a Column I and Column II HCPCS/CPT® code. CMS further states, if a provider or supplier reports the 2 codes of an edit pair for the same beneficiary on the same date of service, the Column I code is eligible for payment and the Column II code is denied unless a clinically appropriate NCCI PTP-associated modifier is also reported.	Reduce the allowed amount for the Column I service/procedure codes submitted by the same provider for same DOS as an associated Column II code.