Network Notification

Date: **March 4, 2016**
To: **Ohio Medicaid Health Partners**
From: **CareSource®**
Subject: **Change in LCD Procedure Code Edits**

Attention: This notification has been revised. See the updated notification dated April 14, 2016.

CareSource continually evaluates the use of correct coding edits as part of our payment policies. During a recent review, it was determined that certain edits are currently not appropriate for Medicaid. Effective February 22, 2016, the LCD edits listed on the following page have been removed.

Claims containing affected procedure codes with dates of service from January 1, 2015, to the present will be reviewed and reprocessed as applicable.

All affected claims will be reprocessed within the next sixty (60) days. **At this time, please do not resubmit any impacted claims.**

The following page contains a comprehensive list of edits removed on February 22, 2016. **For additional information, please contact Provider Services at 1-800-488-0134.**

Additional Information on National Correct Coding Initiative Edits

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate claims payments. These policies are based on the following coding conventions:

- American Medical Association's (AMA) Current Procedural Terminology (CPT) manual
- National and Local Coverage Determinations (NCDs and LCDs)
- Coding guidelines developed by national societies
- Analysis of standard medical and surgical practices
- Review of current coding practices

These standards set the coding requirements that all plans and providers must follow in order to secure reimbursement for Medicare and Medicaid services.

Please visit the sites below for additional information:

- **NCCI Edits** - http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
- **AMA** - http://www.ama-assn.org/ama
- **NCD** - http://www.cms.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx
- **LCD** - http://www.cms.gov/medicare-coverage-database/indexes/lcd-state-index.aspx

Below is a listing of the clinical coding edits that were removed, effective February 22, 2016:

Removed Clinical Edits	**HIPAA Compliant HealthCare Claim Adjustment Code**	**Explanation Code**
(BAG) LCD Part B Procedure Not Typical with Patient Age The BAG edit identifies claims containing CPT codes that can only be performed with a specified age per LCD/NCD.	6	LCD/ NCD: Age does not meet policy requirements for procedure or DX
(BCC) LCD Part B Code to Code Missing or Invalid The BCC edit identifies claim lines that do not meet an LCD policies requirement for a code to code relationship.	A1	LCD/ NCD: CMS ID needs additional procedure code
(BFR) LCD Part B Procedure Frequency Exceeded w/ CS Exclusions The BFR edit identifies a claim where a procedure code has been billed that exceeds frequency requirements for the policy.	B5	LCD/ NCD: Frequency does not meet policy requirements for procedure c
(BPO) LCD Part B Invalid Place of Service-w/ CS Exclusions The BPO edit identifies claims containing CPT codes that can only be performed in specified Place(s) of Service per LCD/NCD policy.	58	LCD/ NCD: POS does not meet policy requirements for procedure code
(BSP) LCD Part B Missing or Invalid Provider Specialty The BSP edit identifies claim lines that the provider specialty does not meet an LCD policies requirement.	8	LCD/ NCD: provider specialty does not meet policy for procedure code.
(BSX) LCD Part B Missing or Invalid Patient Gender The BSX edit identifies claims containing CPT codes that can only be performed on a specific gender per LCD/NCD.	7	LCD/ NCD: Patients gender does not meet policy requirements
(LBI) LCD Part B Missing or Invalid Diagnosis-w/ CS Exclusions=many The LBI is issued if a diagnosis code does not meet guidelines for a policy with non- sequenced diagnosis codes.	146	LCD/ NCD: Diagnosis code(s), for procedure code is missing or invalid
(LBM) LCD Part B Missing Required Modifier w/ CS Exclusions=many This edit identifies claims containing CPT codes that require a modifier per LCD/NCD guidelines.	182	LCD/ NCD: A modifier for procedure code is missing or invalid
(LBP) LCD Part B Missing Required Primary Diagnosis w/ CS Exclusions The LBP is issued when a diagnosis code is required to be in a primary position and it is not or if the diagnosis in the primary position is not covered and the policy has sequencing requirements.	16	LCD/ NCD: A primary diagnosis code is missing or invalid

(LBS) LCD Part B Missing Required Secondary Diagnosis w/ CS Exclusions The LBS is issued when the primary sequencing is met, and the diagnosis in the secondary position does not meet the secondary sequencing requirements.	16	LCD/ NCD: A secondary diagnosis code is missing or invalid
(LBT) LCD Part B Missing Required Tertiary Diagnosis The LBT is issued when the primary sequencing is met, and the diagnosis in the tertiary position does not meet the tertiary sequencing requirements.	146	LCD/ NCD: A tertiary diagnosis code which meets medical necessity
(LCAG) LCD Procedure Not typical with Patient Age Some LCD policies place conditions on what can, or cannot, be billed based on the patient's age. The LCAG flag is triggered when the patient age on the claim does not meet the requirement of an LCD/NCD policy.	6	Per LCD or NCD, the patient's age does not meet policy requirements
(LCC) LCD Code to Code Missing or Invalid NCD and LCD policies outline several different requirements. There are policies that state a procedure code cannot be billed without another procedure code, this relationship is referred to as a code to code relationship. This pertains to add-on codes as well as other procedures.	A1	Per LCD or NCD guidelines, an additional procedure code
(LCDY) LCD Deny While most policies state that a claim can be paid if it meets the requirements of the policy, some policies specify that the claim line should be denied, or that documentation should be requested or reviewed. The edit action rule identifies the appropriate action to be taken when a claim or claim line matches the requirements of an NCD or LCD policy.	A1	Per LCD or NCD guidelines, procedure code has a denied relationship.
(LCFR) LCD Procedure Frequency Exceeded Some LCD policies limit the number of times that certain procedure codes can be billed. The LCFR flag is triggered when a procedure code does not meet the frequency requirements of an LCD/NCD policy.	B5	Per LCD or NCD, the frequency does not meet policy requirements
(LCG) LCD Inappropriate Gender Some LCD policies place conditions on what can, or cannot, be billed based on the patient's gender. The LCG flag is triggered when the patient gender on the line does not meet the requirement of an LCD/NCD policy.	7	Per LCD or NCD, the patient's gender does not meet policy requirements
(LCI) LCD Missing or Invalid Diagnosis Code NCD and LCD policies outline the medical necessity requirements for many procedure codes. These requirements may include non-sequenced diagnosis.	146	Per LCD or NCD guidelines, a diagnosis code(s), which meets medical
(LCM) LCD Missing Required Modifier NCD and LCD policies outline the medical necessity requirements for many procedure codes. These requirements may include non-sequenced diagnosis codes; primary, secondary, or tertiary diagnosis codes; or modifiers.	182	Per LCD or NCD guidelines, a modifier, which meets medical necessity

(LCON) LCD Missing or Invalid Condition Code(s) Some LCD policies place conditions on what can, or cannot, be billed based on the condition code(s) found on the claim. The LCON flag is triggered when the condition code(s) on the claim does not meet the requirement of an LCD/NCD policy.	16	Per LCD or NCD, the condition code(s) is missing or does not
(LCP) LCD Missing Primary Diagnosis Code NCD and LCD policies outline the medical necessity requirements for many procedure codes. These requirements may include non-sequenced diagnosis codes; primary, secondary, or tertiary diagnosis codes; or modifiers.	16	Per LCD or NCD guidelines, a primary diagnosis code, which meets
(LCP) LCD Profile While most policies state that a claim can be paid if it meets the requirements of the policy, some policies specify that the claim line should be denied, or that documentation should be requested or reviewed. The edit action rule identifies the appropriate action to be taken when a claim or claim line matches the Profile requirements of an NCD or LCD policy.	A1	Per LCD or NCD guidelines, procedure code has a profiled
(LCRD) LCD Review/Request Documentation While most policies state that a claim can be paid if it meets the requirements of the policy, some policies specify that the claim line should be denied, or that documentation should be requested or reviewed. The edit action rule identifies the appropriate action to be taken when a claim or claim line matches the requirements of an NCD or LCD policy.	A1	Per LCD or NCD guidelines, documentation should be requested
(LCS) LCD Missing Secondary Diagnosis Code NCD and LCD policies outline the medical necessity requirements for many procedure codes. These requirements may include non-sequenced diagnosis codes; primary, secondary, or tertiary diagnosis codes; or modifiers.	16	Per LCD or NCD guidelines, a secondary diagnosis code, which meets
(LCT) LCD Missing Tertiary Diagnosis Code NCD and LCD policies outline the medical necessity requirements for many procedure codes. These requirements may include non-sequenced diagnosis codes; primary, secondary, or tertiary diagnosis codes; or modifiers.	16	Per LCD or NCD guidelines, a tertiary diagnosis code, which
(LDY) LCD Part B Deny w/ CS Exclusions=many The LDY edit is an edit action. If a claim line meets an LCD requirement, but the relationships says to deny it if the requirement is met, this flag is issued.	A1	LCD/ NCD: Procedure code has a denied relationship.
(LPF) LCD Part B Profile The LPF edit is an edit action. If a claim line meets an LCD requirement, but the relationships says profile it if the requirement is met, this flag is issued.	A1	LCD/ NCD: Procedure code is a profiled relationship. Please review

(LRC) LCD Missing or Invalid Revenue Code Some LCD/NCD policies place conditions on what can, or cannot, be billed based on the revenue code submitted on the claim line. The LRC flag is triggered when the revenue code on the line does not meet the requirement of an LCD/NCD policy. The LCD Revenue Code rule will look at the current line on the claim for the revenue code. This rule does not need to consider other lines on the claim or in the patient's history.	5	Per LCD or NCD, the revenue code does not meet
(LRD) LCD Part B Review/Request Documents The LRD edit is an edit action. If a claim line meets an LCD requirement, but the relationship says to request or review documentation if the requirement is met, this flag is issued.	A1	LCD/ NCD: Documentation should be requested or reviewed
(LTOB) Invalid Type of Bill Some LCD policies place conditions on what can, or cannot, be billed based on the type of bill. The LTOB flag is triggered when the type of bill on the claim does not meet the requirement of an LCD/NCD policy.	5	Per LCD or NCD, the type of bill does
(LVC) LCD Missing or Invalid Value Code(s) Some LCD policies place conditions on what can, or cannot, be billed based on the value code(s). The LVC flag is triggered when the value code(s) on the claim does not meet the requirement of an LCD/NCD policy.	16	Per LCD or NCD, the value code(s) is missing or