Network Notification

Notice Date: **9/10/2018**
To: **Kentucky Medicaid Providers**
From: **Humana – CareSource®**
Subject: **Claim Coding Edits**
Effective Date: **12/10/2018**

Humana – CareSource performs ongoing reviews of claim data to ensure claims are processed accurately and efficiently and to be consistent with Kentucky Department for Medicaid Services (KDMS), Centers for Medicare & Medicaid Services (CMS) and national commercial standards regarding the acceptance, adjudication and payment of claims.

The additional claim coding edits below have been identified as necessary to comply with correct coding and industry standard guidelines. Please ensure your claim submissions are in compliance with these edits to avoid delays in claim processing.

Edit	Description	Source/Reference
Patient Reason for Visit Required	The patient's reason for visit code is required on facility claims according to the National Uniform Billing Committee (NUBC). The reason for visit code is commonly the diagnosis for the patient's chief complaint.	National Uniform Billing Committee (NUBC), Official UB-04 Data Specifications Manual
Only One Initial Infusion Service Allowed Per Encounter	This edit applies to an outpatient claim when there is more than one initial drug administration service submitted on the same claim. Only one initial drug administration service is to be reported per vascular access site per encounter, including during an encounter where services span more than one calendar day.	National Correct Coding Initiative (NCCI)
Interim Claims with Frequency Code 2 or 3 Require Patient Discharge Status Code 30 – Outpatient	This rule applies when claims contain a type of bill (TOB) with a frequency digit of 2 or 3 and the patient discharge status code does not equal 30. Patient discharge status code 30 (Still Patient) is used when the patient is still within the same facility and typically is used when billing for leave of absence days or interim bills.	National Uniform Billing Committee (NUBC), Official UB-04 Data Specifications Manual , CMS
Repeat Radiology Requires Repeat Modifier	This rule identifies a repeat radiology procedure that does not have the appropriate modifier submitted. Modifier 76 should be submitted if the same provider is performing the procedure, and modifier 77 should be submitted for a different provider.	Current Procedural Terminology® (CPT)

Edit	Description	Source/Reference
Dates of Service to Units Discrepancy	This edit checks for consistency between the number of units on a claim line and the number of dates of service when there is a date span between the beginning and ending dates of service. If units are not equal to the number of dates of service, the Dates of Service to Unit Discrepancy flag is issued. For example, if a claim line contains a date span of five days (e.g., July 1 – July 5) and the number of units reported is three, this flag is issued. Anesthesia claims and other CPT codes that include multiple dates of service in their code descriptors are excluded from this flag.	Billing validation rule
Missing or Invalid Type of Bill – Outpatient	This edit identifies a claim that is submitted with a type of bill that is invalid or missing. The type of bill indicates the specific type of bill (e.g., hospital inpatient, outpatient, replacements, voids, etc.).	Official UB-04 Data Specifications Manual , CMS Claims Processing Manual
Facility Principal Diagnosis Age Conflict	This edit identifies when an ICD diagnosis code is inconsistent with the patient's age.	CMS Outpatient Code Editor (OCE)
Patient Discharge Status Invalid	This edit applies when a claim is submitted with a missing or invalid patient status code. When an invalid discharge status is reported, the patient is presumed to have been discharged alive for the purpose of performing the non-specific principal diagnosis check. This is based on requirements from the National Uniform Billing Committee (NUBC) and the Centers for Medicare and Medicaid Services (CMS).	National Uniform Billing Committee (NUBC), Official UB-04 Data Specifications Manual
Medicaid Add-On Procedure – Primary Procedure Flagged	This rule enforces add-on code coding policy. It will review if a primary procedure code is submitted for the same provider, billing department and date of service as its associated add-on code. If the primary code has received a denial, this rule will apply a denial to the associated add-on code, as an add-on code can only be paid when the primary code is eligible for payment.	CMS Policy/Add-on Code Edits/Transmittal 2636
New Patient Code for Established Patient Rule	This edit identifies when the patient history indicates the patient has been seen by the same provider within three years of the current claim line's beginning date of service. The edit identifies new patient Evaluation and Management (E/M) services reported in error.	CPT, CMS Hospital Outpatient Prospective Payment System (OPPS)

Edit	Description	Source/Reference
Repeat Laboratory Procedure Requires Modifier – -Global	This edit applies to a claim line when a repeat test or procedure is performed on the same date of service and the claim is submitted inappropriately without a 59 or 91 modifier. This is based on guidelines from the AMA, the current CPT® Professional Edition and CMS.	CPT, CMS
Medicaid Add-On Procedure – Critical Care	This rule enforces add-on code coding policy. It will review critical care add-on codes to determine if the primary critical care code was billed either on the same claim or on a claim in history. If the primary critical care code is not found, the add-on code will be denied.	CMS Policy/Add-on Code Edits/Transmittal 2636
Missing or Invalid Admission Date	This edit identifies claims that are missing a required admission date or an admission date that is after the through date.	National Uniform Billing Committee (NUBC), Official UB-04 Data Specifications Manual
Invalid Procedure Code	The system will analyze each Healthcare Common Procedure Coding System (HCPCS) code on a claim and determine if the code is valid for the date of service on the claim.	CPT