# Network Notification

**Date: October 31, 2015**

**To: Kentucky physicians**

**From: Humana – CareSource®**

**Subject: New Facility Code Edits for Claims**

Effective December 1, 2015, Humana – CareSource will implement new facility code edits applied to claims during claims processing. The affected facility codes include:

1. Outpatient service submitted for denial
2. Service submitted for fiscal intermediary (FI)/Medicare administrative contractor (MAC) review
3. Facility diagnosis age conflict
4. Service date not within "from" and "through" date
5. Multiple medical visits on same date of service – same claim/different claim
6. Observation Healthcare Common Procedure Coding System (HCPCS) codes only allowed with bill type 13X
7. Nonreportable for site of service
8. Invalid HCPCS code
9. Outpatient incorrect billing of blood and blood products
10. Outpatient claim lacks required procedure code
11. Duplicate of secondary diagnosis
12. "E" code as principal diagnosis
13. Local coverage determination (LCD) profile

For more information, please refer to the following chart.

| Edit | Title | Description |
|---|---|---|
| 010DNY | Outpatient service submitted for denial | Identifies services billed by the provider for a denial notice. The edit surfaces when condition code 21 is present on the claim, indicating a request for denial notification. |
| 011SFR | Service submitted for FI/MAC review | Identifies noncovered services billed by the provider when a beneficiary requests a Medicare review for coverage. Condition code 20 is present, request for FI review, which places the claim in suspension pending Medicare review to determine coverage. |
| 0021AG | Facility diagnosis age conflict | Age conflict: newborns (0 years); adolescents (0-17); maternity (12-55); adults younger than 14 |

| | | |
|---|---|---|
| 023BDS | Service date not within “from” and “through” date | Identifies a “from,” “through,” or line item service date not within normal calendar range. In addition, this edit flags a claim with a “from” date that is greater than the “through” date or with a missing line item service date with HCPCS code, or with line item service dates that are not within the claims “from/through” date range. |
| 042MMV | Multiple medical visits on same date of service – same claim/different claim | This edit occurs when multiple medical visits cannot be billed for the same revenue center code and date of service. |
| 053OTB | Observation HCPCS codes only allowed with bill type 13X | Effective Jan. 1, 2006, the HCPCS codes G0378, observation care by facility, and G0379, direct admit to observation, are not allowed on claims except those with bill type 13x or 85x. |
| 055NRS | Nonreportable for site of service | If an HCPCS code beginning with a “C” is submitted on a claim when the bill type is not 12X or 14X, the claim is flagged and returned to the provider for correction. |
| 0061PC | Invalid HCPCS code | Each HCPCS level I or level II procedure code is edited for completeness or validity. This edit indicates that the HCPCS code is invalid or was not valid for the patient's dates of service. |
| 073IBP | Outpatient incorrect billing of blood and blood products | Identifies whether an outpatient prospective payment system (OPPS) provider pays for the actual blood or blood product itself, in addition to paying for processing and storage codes when blood or blood products are supplied by either a community blood bank or the OPPS provider's own blood bank. The OPPS provider must separate the charge for the blood product(s) from the charge for processing and storage services. |
| 077DPC | Outpatient claim lacks required procedure code | Identifies claims where a specified device is submitted without a code for an allowed procedure and the bill type is NOT 12x. |
| DDSD | Duplicate of secondary diagnosis | Whenever a secondary diagnosis is coded the same as the principal diagnosis, the secondary diagnosis is identified as a duplicate of the principal diagnosis. |
| DXE2 | E code as principal diagnosis | E codes are ICD-10-CM codes beginning with the letter “E.” They describe the circumstance causing the injury, not the nature of the injury, and therefore should not be used as a principal diagnosis. |
| LCPF | 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 the claim or claim line matches the requirements of a national coverage determination (NCD) or LCD policy. |

If you have questions regarding facility code edits, please call Humana – CareSource at 1-855-852-7005. Hours of operation are Monday through Friday, 8 a.m. to 6 p.m. Eastern time.