Network Notification

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Date: September 3, 2015

To: CareSource Health Partners

From: CareSource

Subject: New Facility Code Edits for Claims

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Effective 10/01/15 CareSource will be implementing new Facility Code edits to be applied to claims during claims processing. These edits include:

1. Outpatient Service Submitted for Denial

2. Service Submitted for FI/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 HCPCS Codes Only Allowed with Bill Type 13X

7. Non-Reportable 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 Principle Diagnosis

13. LCD Profile

See the informational chart on the next page. Thank you for your partnership with CareSource.

Edit	Title	Description
010DNY	Outpatient Service Submitted for Denial	Identifies services that are 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 non-covered services that are billed by the provider when a beneficiary requests a Medicare review for coverage. Condition Code 20 is present, Request for FI Review, which will place the claim in suspension pending Medicare review to determine coverage.
0021AG	Facility Diagnosis Age Conflict	Age Conflict: Newborns (0 yrs.); Adolescents (0-17 yrs.); Maternity (12-55 yrs.) Adults >14 yrs.
023BDS	Service Date not Within From and Through Date	Identifies a 'from', 'thru', or line item service date that is not within the normal calendar range. In addition, this edit flags claims with a 'from' date that is greater than the 'thru' 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/thru' 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	1.1.06 and after - the HCPCS codes G0378 Observation Care by Facility, and G0379 Direct Admit to observation, are not allowed on any claim except those with bill type 13x or 85x.
055NRS	Non-Reportable for Site of Service	If a HCPCS code beginning with a 'C' is submitted on a claim where the bill type is not 12X-14X, the claim is flagged and the claim in 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 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 OPS provider's own blood bank. The OPS 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 devise 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 principle diagnosis, the secondary diagnosis is identified as a duplicate of the principle diagnosis.
DXE2	E-Code as Principle Diagnosis	E-Codes are ICD-9-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 principle 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 an NCD or LCD policy.