Code Editing Guidelines on Professional Claims

As announced in our October 12, 2009 letter sent to our Provider Network, CareSource continues to be committed to industry standard claim adjudication practices. We have been actively involved in assessing a better way to evaluate claims that provides consistent reimbursement using Medicare and national coding standards. One of the key requirements in the process has been to provide you improved transparency and more detailed information regarding adjudication of your claims.

CareSource is updating its previously established claim processing edits to make it easier for you to work with us. The update is scheduled for November 2009. Concurrent with this update, we will launch enhanced claims inquiry functionality on our secure Provider Portal located on our website, **www.caresource.com.** The new functionality will provide more detailed claim line edit descriptions.

All of the edits below will be enhanced or implemented effective November 2009. These edits will apply to professional claims submitted on a CMS 1500 form.

ICD-9 codes with 4th and 5th digit specificity

These edits will identify claim lines that contain a diagnosis code, per Medicare standards, that require a 4th or 5th digit for appropriate specificity.

Inappropriate Diagnosis for Gender

CareSource will enhance this edit to include claims submitted with specific diagnosis coding that is only applicable to one gender. For example, a diagnosis of pregnancy would not be payable for a male member.

Inappropriate Modifier Combination

This edit validates the appropriateness of modifier and code combinations. When an inappropriate combination has been submitted, the claim will be denied. A corrected claim may be submitted with appropriate modifiers if within timely filing standards. Modifier relationships are based on publications from the Centers for Medicare & Medicaid (CMS) and the American Medical Association, CPT Professional and Standard Editions.

Global Days

A surgical package is defined as the period one day prior to a procedure, and a certain number of days after the procedure as defined by CMS (either 0, 10, or 90 days). Payment for surgical procedures is inclusive of any follow-up days for that procedure. If an E/M service is billed within the global surgical period, the claim line will be denied. For purposes of this edit, professional services from a physician or another physician of the same specialty who belongs to the same

group practice (by Tax Identification) that renders an E/M within the global period would also be denied.

Maximum Frequency per Day

This edit is based on CPT and HCPCS code descriptions, along with CMS standards, that define maximum billable units per procedure. If a claim line contains units that exceed these limits, CareSource will only allow the appropriate unit values associated with that code.

Unbundle

This edit compares CPT codes reported for the same date of service to find procedures that should not be submitted together. Unbundling is the act of billing CPT codes which are components of other CPT codes. Unbundling can either be incidental (procedures which are not essential to complete the procedure) or mutually exclusive (related procedures). Depending on the particular code combination, CareSource may deny one or more of the related codes.

There are 3 defined unbundling edits used by CareSource:

U = Unbundling

Unbundling is to inappropriately bill more CPT/HCPCS codes than necessary. This edit is applied when certain codes represent procedures that are basic steps necessary to accomplish the primary procedure.

For example: Laboratory should bill CPT code 80048 (basic, metabolic panel) when coding for a calcium, carbon dioxide, chloride, creatinine, glucose, potassium, sodium, and urea nitrogen performed as automated multichannel tests. It would be inappropriate to report CPT codes 82310, 82374, 82435, 82565, 82947, 84132, 84295 and/or 84520.

I = Incidental

Incidental includes procedures that can be performed along with the primary procedure, but are not essential to complete the procedure. They do not typically have a significant impact on the work and time of the primary procedure. Incidental procedures are not separately reimbursable when performed with the primary procedure.

For example: CPT code 58660, Lysis of adhesions, is not to be reported separately when done in conjunction with CPT code 58661, Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy).

E = Exclusive

Mutually exclusive procedures are a coding combination billed in error that follows one or both of the following criteria: Either the two services cannot reasonably be done in the same service, or the coding combination represents two methods of performing the same service.

For example: CPT code 49203, Excision or destruction by any method of intraabdominal or retro-peritoneal tumor or cysts or endometriomas, is recognized as mutually exclusive of code 47380, Ablation, open, of one or more liver tumor(s).

Not a Primary Diagnosis Code

This edit identifies ICD-9 diagnosis codes that are not allowed for reporting alone or as a primary diagnosis. Claims submitted with these ICD-9 codes will be denied and must be resubmitted with a valid Primary Diagnosis Code.

Corrected Claims

Please note that you do not need to appeal a claim denied for clinical editing if you are correcting information to make the claim coding compliant. You can resubmit the claim electronically using the appropriate EDI indicators to designate the claim as corrected or resubmit paper claims clearly marked with the word "Corrected" using the normal claim submission process.

If you have any questions about the information provided above please contact Provider Services at **1-800-488-0134** or call your CareSource Provider Relations Representative.