



## Network Notification

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**Date:** October 5, 2010

**Number:** OH-P-2010-25

**To:** Ohio Providers

**From:** CareSource

**Subject:** CareSource Code Editing

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### **CareSource Code Editing**

When an edit recommendation is made on codes submitted on a claim, a general explanation of the reason for the edit will be detailed on the Explanation of Payment (EOP).

The following list outlines examples where the code editing software will make a recommendation on submitted codes:

**z58 – Medicare unbundled Scenario:** Based on CMS' Correct Coding Initiative (CCI), a physician should not unbundle services that are integral to a more comprehensive procedure.

- *Example:* Surgical access is integral to a surgical procedure. CPT code 49000 (Exploratory laparotomy) should not be billed when performing an open abdominal procedure such as a total abdominal colectomy, 44150.
- If the bundled code is listed as a modifier allowed per the CCI Column 1/Column 2 logic, modifier 59 can be billed. Please remember to include notes with the claim when billing with modifier 59.

**z60 – Not a Primary Diagnosis Code:** Based on ICD-9-CM guidelines codes listed in the manual, those with a blue dot indicate that the code should not be reported as the first-listed (primary) diagnosis. Or in the case of "V" diagnosis codes, a purple circle with a "1" will appear before a "V" code which indicates that the code is acceptable as a first listed code.

- *Example:* V46.13 Encounter for weaning from respirator – per the ICD-9, it is listed as a primary code
- *Example:* V46.11 Dependence on respirator, status – per the ICD-9, it is listed as a non-primary code

**z88** – LCD Part B Missing or Invalid Diagnosis: Per CMS guidelines, the diagnosis billed with the procedure (CPT/HCPC) to best describe the reason for the service performed.

- *Example*: 87086 billed with Dx code V22.1 is an acceptable procedure code to diagnosis code combination.
- *Example*: 84443 billed with Dx code 780.4 should not be billed together.

**z45** – Typical Daily Frequency Exceeded: CMS/OCE Edits refer to this as an MUE edit. MUE for a HCPCS/CPT code is the maximum number of units of service allowable by the same provider for the same beneficiary on the same date of service. Units of service in excess of an MUE are denied. MUEs do not exist for all HCPCS/CPT codes. At the current time, there is no modifier that will bypass an MUE.

- *Example*: 58956 (bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy, this has a MUE of 1 since the vast majority of women have only one uterus.)

**z28** – Not a Freq Dx Code with Procedure: Typically the diagnosis billed with the procedure (CPT/HCPC) will best describe the reason for the service performed. This edit focuses strictly on surgical procedures.

- *Example*: 44960 (Appendectomy for ruptured appendix with abscess or generalized peritonitis) billed with Dx code 789.36 (abdominal or pelvic swelling, mass or lump, epigastric) is an acceptable procedure code to diagnosis code combination.
- *Example*: 44960 billed with Dx code 535.4 (other specified gastritis) should not be billed together.

**z46** – Global Follow-Up by Provider: Since 2006, CareSource has followed the Global Follow up days defined by CMS. The global days are 0, 10, and 90.

If a procedure has a global period of 000 or 10 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service.

However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. Notes are required to be billed when using modifier 25.

- 17110 (Destruction of benign lesion) has a global follow up period of 10 days.
- 99213 (Office or other outpatient visit for the E&M of an established patient) is submitted within 5 days of the minor procedure. When a minor procedure is performed, the E&M service is considered part of the global period and will be denied.

If a procedure has a global period of 90 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57.

Other E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable.

For more detail, please refer to the E&M and Modifier 57 Payment Policy.

- *Example:* 27447 (Arthroplasty, knee) has a global follow up period of 90 days.
- 99213 (Office or other outpatient visit for the E&M of an established patient) is submitted with a date of service that is within the 90-day global period.
- When a substantial diagnostic or therapeutic procedure is performed, the E&M service is included in the global period and will be denied.

**z32** – Nonspecific Diagnosis Code: Based on ICD-9-CM guidelines, these have a purple square before the code to indicate that although these codes are valid as a principal (first-listed) diagnosis, they are usually too general to be used and further review should continue until a code that is more specific is identified.

- *Example:* 523.40 (Chronic periodontitis, unspecified) would be considered as a nonspecific diagnosis code.
- A better code would be to use either 523.41 (Chronic periodontitis, localized) or 523.42 (Chronic periodontitis, generalized).