ADDITIONAL CODING EDITS

(Revision Date: April 26, 2017)

ConnectiCare periodically reviews its claim processing edits to ensure they are up-to-date with current clinical practice. Upon review, we have determined that the following edits* will be made to claims processed on or later than the effective date noted below. These edits apply to both commercial and Medicare lines of business, unless otherwise noted. The "effective date" listed in the table refers to the claim processed date, unless otherwise specified.

1. AAOS Intraoperative Services
2. Add-on Codes
3. Correct Coding Initiative Policies and Guidelines
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12. E & M with Stress Test
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23. Videofluoroscopy and Endoscopic Swallowing Studies

Category	Applies to...	Description of Edit	Effective Date
AAOS Intraoperative Services	Both commercial and Medicare plans	According to the AAOS, there are several services that are considered to be an integral part of the primary Orthopedic or Neurosurgical procedure. These services should not be reported separately.	January 26, 2010
Add-on Codes	Both commercial and Medicare plans	According to the CMS HCPCS Manual, an add-on code describes additional intra-service work associated with the primary procedure and must never be reported as a stand-alone code.	January 26, 2010
Correct Coding Initiative Policies and Guidelines	Both commercial and Medicare plans	The billed endoscopy procedure is considered to be included in the bronchoscopy procedure by the National Correct Coding Initiative Policy Manual.	July 28, 2009
	Both commercial and Medicare plans	The billed umbilical hernia repair was not paid for because it is included in the more extensive hernia repair per the National Correct Coding Initiative Policy Manual.	July 28, 2009
	Both commercial and Medicare plans	According to the National Correct Coding Policy Manual, when a laporoscopic procedure is converted to an open procedure, only the open procedure should be reported.	July 28, 2009

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Category	Applies to...	Description of Edit	Effective Date
	Both commercial and Medicare plans	According to National Correct Coding Initiative Policy Manual, cardiac catheterization procedures may require procurement of EKG tracings during the procedure to assess chest pain during catheterization and angioplasty; when performed in this fashion, these EKG tracings are not separately reported.	July 28, 2009
Diagnosis-Age Consistency	Both commercial and Medicare plans	According to CMS Policy, it is inappropriate to bill procedures using an ICD-9 diagnosis code that is specific to maternity when the patient is not of maternity age.	January 26, 2010
Diagnostic/ Therapeutic Imaging Radiopharmaceutical and Contrast Agent Link	Both commercial and Medicare plans	According to CMS policy, when a radiopharmaceutical is billed, it is to accompany a related imaging procedure.	January 26, 2010
Distinct Service Modifiers	Both commercial and Medicare plans	According to our policy when more than one Evaluation and Management service is billed on the same date of service, with the same provider ID, within the same provider specialty only one will be allowed.	October 1, 2009
Drugs & Biologicals	Both commercial and Medicare plans	J0585 (Injection, onabotulinumtoxinA, [Botox®], 1 unit) J0586 (Injection, abobotulinumtoxinA, [Dysport®], 5 units) J0587 (Injection, rimabotulinumtoxinB, [Myobloc®], 100 units) J0588 (Injection, incobotulinumtoxinA, [Xeomin®], 1 unit) are not payable for facial wrinkles.	September 30, 2014
	Medicare plans only	Lupron Depot®, Eligard® J9150 (Injection, leuprolide acetate [for depot suspension] per 3.75 mg) is payable when billed with quantity and frequency limit, age and/or gender, and diagnosis specific to FDA labeled and off-label indications.	September 30, 2014
	Medicare plans only	Emend® J1453 (Injection, fosaprepitant, 1 mg) is payable when billed within FDA labeled quantity limit.	September 30, 2014
	Both commercial and Medicare plans	Lucentis® (J2778) Ranibizumab is payable when billed with diagnoses codes specific to FDA labeled and off-label indications as well as CMS policy. Dose and frequency limits apply based on the diagnoses. Age restrictions apply.	September 30, 2014

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Category	Applies to...	Description of Edit	Effective Date
	Medicare plans only	Lupron® J9218 (Leuprolide acetate, 1 mg) is payable when billed with diagnoses codes specific to FDA labeled and off-label indications, including gender.	September 30, 2014 (Specific to gender only)
	Both commercial and Medicare plans	Modifier JW (drug wastage) is not appropriate to bill: • with a non-drug code. • with a drug dispensed from a multi-dose vial. • on a single service line where the same drug is not also billed on another claim line without modifier JW • for an excessive amount based on the vial content/size. • outside of Medicare guidelines	July 29, 2014
	Both commercial and Medicare plans	Taxotere® (J9171) (Docetaxel) is payable when billed with diagnoses codes specific to FDA labeled and off-label indications. Dosage is limited based on FDA package insert and varies based on the diagnosis. Frequency is limited to no more than one administration per week by any provider.	July 29, 2014
	Both commercial and Medicare plans	Paclitaxel Protein-Bound Particles (J9264) is payable when billed with diagnoses specific to FDA approved and off-label indications.	July 29, 2014
	Both commercial and Medicare plans	Actemra® (J3262) (Tocilizumab) is payable when billed with a diagnosis of rheumatoid arthritis or systemic juvenile idiopathic arthritis. Frequency and dose limits apply and vary based on diagnoses.	July 29, 2014
	Medicare plans only	Ferumoxytol (Q0138, Q0139) is payable when billed with ESRD and non-ESRD diagnoses codes specific to FDA labeled and off-label indications. Dosage is limited based on FDA package insert and varies based on the diagnosis. Frequency, dose and age limits apply and vary based on diagnoses.	July 29, 2014
	Medicare plans only	Lupron® J9218 (Leuprolide acetate, 1 mg) is payable when billed with diagnoses codes specific to FDA labeled and off-label indications.	July 29, 2014
	Medicare plans only	Lupron Depot®, Eligard® J1950 (Injection, leuprolide acetate [for depot suspension] per 3.75 mg) is payable when billed with diagnoses codes specific to FDA labeled and off-label indications.	July 29, 2014

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Category	Applies to...	Description of Edit	Effective Date
	Medicare plans only	Lupron Depot©, Eligard© (J9217) Leuprolide Acetate Depot, 7.5 mg) is payable when billed with diagnoses codes specific to FDA labeled and off-label indications. Dosage is limited based on FDA package insert and varies based on the diagnosis. Frequency, dose and age limits apply and vary based on diagnoses.	July 29, 2014
	Medicare plans only	J9219 (Leuprolide acetate implant, 65 mg) is payable when billed with diagnoses codes specific to FDA labeled and off-label indications. Dosage is limited based on FDA package insert and varies based on the diagnosis. Frequency, dose and age limits apply and vary based on diagnoses. Must be billed with an appropriate surgical procedure code.	July 29, 2014
	Medicare plans only	Emend® J1453 (Injection, fosaprepitant, 1 mg) is payable when billed with a diagnosis code specific to FDA labeled indication.	July 29, 2014
	Both commercial and Medicare plans	Eylea® (J0178) Aflibercept is payable when billed with diagnoses specific to FDA approved indications including central retinal vein occlusion, with a diagnosis of retinal edema. Dosage is limited based on FDA package insert. Age restrictions apply to less than 18 years old. Unilateral or bilateral modifiers are required. Must be billed with the appropriate intravitreal injection procedure code.	July 29, 2014
	Medicare plans only	Neulasta® (J2505) Pegfilgrastim is payable when billed with diagnoses codes specific to FDA labeled and off-label indications. Dose and frequency limits apply based on the diagnoses. Age restrictions apply.	July 29, 2014
	Both commercial and Medicare plans	Lucentis® (J2778) Ranibizumab allow two (2) unique visits within a 27-day period.	November 26, 2013
	Both commercial and Medicare plans	Bevacizumab is only payable when billed with Leucovorin, Irinotecan, Interferon alfa, Oxaliplatin, Fluorouracil, Carboplatin or Paclitaxel and when the diagnosis is other than malignant neoplasm of kidney, malignant neoplasm of brain, malignant neoplasm of ovary, or ophthalmic indications.	May 24, 2011

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Category	Applies to...	Description of Edit	Effective Date
	Both commercial and Medicare plans	Filgrastim (g-csf) is not payable when billed on the same date of service as either a chemotherapy drug or radiation therapy delivery service, regardless of which provider administers it.	April 26, 2011
	Both commercial and Medicare plans	Infliximab injections are limited to 57 units, unless the diagnosis on the claim is rheumatoid arthritis or Crohn's disease.	April 26, 2011
	Both commercial and Medicare plans	Pegfilgrastim is not payable when provided on the same day that a chemotherapy drug was administered, or when administered 2 weeks or more after the prior administration of pegfilgrastim.	March 29, 2011
	Both commercial and Medicare plans	Palonosetron HCL is payable only when there is a diagnosis of malignant neoplasm, secondary neuroendocrine tumor, or carcinoma in situ neoplasm, and when billed with antineoplastic chemotherapy services.	March 29, 2011
	Both commercial and Medicare plans	Rituximab is not payable when billed for the following diagnoses: non-Hodgkin's lymphoma, Hodgkin's lymphoma, chronic lymphoid leukemia, post-transplant lymphoproliferative disorder, other lymphatic and hematopoietic tissues, Waldenstrom's macroglobulinemia, thrombocytopenic purpura, alpha-1-antitryspin deficiency, chronic graft-versus-host disease, autoimmune hemolytic anemia, acquired blood factor deficiency, multiple sclerosis, Wegener's granulomatosis, thrombotic microangiopathy, pemphigus vulgaris, systemic lupus erythematosus, rheumatoid arthritis, Castleman's disease, malignant ascites, or other/unspecified nonspecific immunological findings.	May 24, 2011
Duplicate Claim Logic for Anesthesia Services by Different Providers	Both commercial and Medicare plans	The anesthesia procedure in question was denied as a duplicate because the same service code has been previously processed.	July 28, 2009
Duplicate Claims from any Provider Under Same Tax ID and Specialty	Both commercial and Medicare plans	The co-surgery procedure was denied as a duplicate claim because it has been previously processed.	July 28, 2009

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Electrocardiographic Monitoring	Both commercial and Medicare plans	CPT codes 93224-93233 and 93235-93237 should not be used for more than 24 or 48 hours of monitoring. Monitoring for more than 24 or 48 hours should be coded using CPT codes 93012, 93014, 93268-93272, 93228 and/or 93229.	November 24, 2009
	Both commercial and Medicare plans	All CPT codes billed should include the appropriate associated ICD-9 diagnosis code.	November 24, 2009
Evaluation and Management Services	Both commercial and Medicare plans	It is inappropriate to bill multiple units of initial or new patient care on the same date of service, per the AMA CPT manual. For care following the initial visit, providers should use subsequent visits or established patient care codes.	October 1, 2009
	Both commercial and Medicare plans	According to our Policy, it is inappropriate to bill E&M service office visits 99201-99205 or 99211-99215 without the appropriate place of service code.	January 26, 2010
	Both commercial and Medicare plans	According to the AMA-CPT certain Evaluation and Management codes (99221-99223, 99231-99233 and 99238-99239) are limited to being rendered in an inpatient setting.	January 26, 2010
	Both commercial and Medicare plans	According to the AMA CPT Manual, it is inappropriate to bill office/outpatient consultations (99241-99245) for a consultation performed in the inpatient hospital location.	January 26, 2010
E & M Service with Stress Test	Both commercial and Medicare plans	According to the National Correct Coding Initiative Policy Manual, in order to bill and E & M service with a cardiac procedure, it must be a significant and separately identifiable service.	February 23, 2010
Home INR Monitoring	Both commercial and Medicare plans	According to CMS Policy, G0249 and G0250 should only be billed once (which includes 4 tests) per 28 days.	February 23, 2010
Multiple Inpatient Admission or Consultation Services within 7 Days	Both commercial and Medicare plans	According to our Policy, an initial inpatient admission will be allowed once every 7 days.	January 26, 2010
	Both commercial and Medicare plans	According to our Policy, it is considered inappropriate for a provider to bill an inpatient consultation or subsequent hospital care code and then bill an initial inpatient admission for the same patient within a 7-day period.	January 26, 2010

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Category	Applies to...	Description of Edit	Effective Date
New Patient Visits	Both commercial and Medicare plans	According to the AMA CPT Manual, a new patient is "one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group within the past 3 years." A provider cannot bill a new patient.	January 26, 2010
Observation Services	Both commercial and Medicare plans	99217 (Observation care discharge service) is not paid if the qualifying 99218-99220 (Initial observation care admission service) has not been billed within the previous three days.	July 28, 2009
Procedure Code Definition Rules	Both commercial and Medicare plans	According to the AMA CPT Manual's definition of continuing medical radiation physics consultation is to be reported per week of therapy.	January 26, 2010
	Both commercial and Medicare plans	According to the AMA CPT Manual if a global service is billed with a 26 modifier and there is a CPT code that indicates the Professional component only, the CPT code will be changed to the appropriate Professional only CPT code.	January 26, 2010
	Both commercial and Medicare plans	According to the AMA CPT Manual, if a global service is billed with a TC modifier and there is a CPT code that indicates the Technical component only, the CPT code will be changed to the appropriate Technical only CPT code.	January 26, 2010
	Both commercial and Medicare plans	According to the AMA CPT Manual, 99463 includes discharge services. Therefore, 99238 or 99239 should not be reported separately.	January 26, 2010
	Both commercial and Medicare plans	According to the AMA CPT Manual, the procedures reported as 70551 and 70552 are more appropriately reported as the single comprehensive code 70553.	January 26, 2010
	Both commercial and Medicare plans	The measurement of a post-voiding residual urine is often performed at the same session as urodynamic studies (51725-51741) using ultrasound. According to our policy, a limited ultrasound to determine the post-voiding residual urine should be billed using 51798.	January 26, 2010
	Both commercial and Medicare plans	According to the AMA CPT Manual if 33216 or 33217 are billed with 33240 the code should be billed as 33249.	January 26, 2010

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Category	Applies to...	Description of Edit	Effective Date
	Both commercial and Medicare plans	According to the AMA CPT Manual, the procedures reported as 57240 and 57250 are more appropriately reported as the single comprehensive code 57260.	January 26, 2010
Procedure Code Guidelines	Both commercial and Medicare plans	According to the AMA CPT Manual, subcutaneous or intramuscular injection (90772 or 96372) is inappropriate to use for the administration of vaccines and toxoids (90476-90749).	July 28, 2009
Procedures Payable at 150% when Billed Bilaterally (Indicator 1) – Set A	Both commercial and Medicare plans	Apply policy set for Bilateral Indicator 1 (CMS).	January 26, 2010
Quality of Care	Both commercial and Medicare plans	There are numerous services that are considered within the scope of practice for podiatrists. All others are not considered billable services.	January 26, 2010
Supplies and Equipment Provided in the Facility Setting	Both commercial and Medicare plans	According to CMS Policy, medical supplies, surgical supplies and durable medical equipment can be billed by the physician in the office setting. These services should not be billed by the physician for the outpatient or inpatient setting.	January 26, 2010
Therapeutic Services	Both commercial and Medicare plans	The typical encounter with the physical medicine patient should last no more than 8, 15-minute units.	January 26, 2010
Videofluoroscopy and Endoscopic Swallowing Studies	Both commercial and Medicare plans	According to CMS Policy, procedures 92611 and 92612 are only appropriate when billed in place of service 11, 21, 22, 23, 31, 32, 61 and 62.	January 26, 2010

*Note: This is not a complete listing of all edits that may be made.

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