Provider Update

Virginia Premier: Correct Coding Review

Date: February 21, 2020

In order to improve payment integrity, Virginia Premier has implemented an Optum tool to evaluate claims for correct coding on a post adjudication/pre-payment basis. Optum's Claims Edit System (CES) will automatically review and edit claims submitted by physicians and facilities. A list of edits being applied to claims and their general description is attached to this notification.

Effective **March 23, 2020**, these edits will be evaluated and implemented. This may mean that services that historically were reimbursed will not be in the future. All edits comply with national coding standards and should be part of your normal billing practices.

If you have any questions, please contact Provider Services. We are available Monday through Friday from 8:00 am to 6:00 pm at 804-819-5151 or toll-free 800-727-7536, then select option 2 followed by option 6.

Thank you!

Provider Services

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CES Edit Mnemonic	CES Edit Description
sAP	The sAP edit will review if a primary procedure code is submitted for the same provider on the same date of service as its associated add-on code. When the primary code does not receive an edit it is considered a clean claim line and the associated add-on code will also process without receiving any edits. Alternatively when the primary procedure receives a flag, the associated add-on procedure will receive the sAP edit with a message indicating the add-on procedure code should be reviewed as the associated primary procedure code has received an edit.
sDP	The sDP edit identifies Medicaid claim lines that contain E/M code(s) submitted without proper modification when billed with a different diagnosis code during the global period of a previously submitted procedure code by the same provider. Modifier 24 bypasses the edit
sEM	This edit identifies claim lines that contain an evaluation and management code that was submitted without modifier 25 on the same date of service as a minor surgical procedure (000 or 010 day global period), or billed without modifier 57 on the same date of service or one day before a major surgical procedure (090 day global period).
26TC	A global procedure code includes both a professional component (PC) and a technical component (TC). The modifier 26 is used when reporting the professional component and the modifier TC is used when reporting the technical component. When a global procedure is reported neither of the above modifiers should be reported on the same date of service.

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sDT	The sDT will fire on Medicaid claim lines that contain codes that do not have the modifier 26 appended appropriately when submitted with a place of service of inpatient hospital, outpatient hospital, or skilled nursing facility per Medicaid policies and guidelines.
sGT	The sGT edit identifies Medicaid claim lines that contain codes that have the modifier 26 or TC appended inappropriately. The concept of professional and technical components splits (PC/TC) does not apply since global test only codes identified by the indicator of "4" in the PC/TC column of the NPFS cannot be split into professional and technical components under CMS rules. Modifier 26 and TC cannot be used with these codes.
sPC	The sPC edit identifies Medicaid claim lines that contain codes that have the modifier 26 or TC appended inappropriately per Medicaid policies and guidelines.
PDO	The PDO edit identifies claim lines that contain diagnosis codes that may only be used as first-listed or primary.
sEV	The sEV edit will fire when more than one Evaluation and Management (E/M) code is billed with the same diagnosis, by the same provider, and for the same patient.
sMGZ	The sMGZ edit will fire on all claim lines with modifier GZ appended indicating an item or service is expected to be denied as not reasonable and necessary per CMS and Medicaid guidelines.

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CES Edit Mnemonic	CES Edit Description
084LPC	FQHC Claim Lacks Required Primary Code - Mental Health
26TCh	A global procedure code includes both a professional component (PC) and a technical component (TC). The modifier 26 is used when reporting the professional component and the modifier TC is used when reporting the technical component. When a global procedure is reported neither of the above modifiers should be reported on the same date of service.
aVPAmbSup	This rule identifies claim lines where ambulance supplies have been unbundled from the transportation payment. AmbSup will fire if an ambulance supply HCPCS code is paid to the same provider on the same service date as ambulance transportation codes.
aVPDupAne	The DupAne edit evaluates for claims where two Anesthesiologists or two Certified Registered Nurse Anesthetists (CRNA) bill for the same anesthesia procedure on the same date of service. The edit will fire on the second claim received when claim history shows that for the same member, on the same date of service, the same anesthesia CPT code had been paid to a different physician from the same group practice, billing with physician anesthesia modifiers AA, AD, QK or QY.
aVPSPAM	Anatomical modifiers should be appended to procedures to indicate the side of the body or other specified location where the procedure was performed.
aVPSPAMf	Anatomical modifiers should be appended to procedures to indicate the side of the body or other specified location where the procedure was performed.

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aVPDupDC	Discharge day management codes should only be reported by the attending physician. Other physicians providing services on the day of discharge should use subsequent hospital care codes. Also, only one hospital discharge day management service is payable per patient per hospital stay. This rule will deny codes 99238 or 99239 when billed more than once on the same day, or within one day, for the same member by providers in the same group practice.
BHCMh	The CPT® Professional Edition guidelines state "Behavioral health integration care management and psychiatric collaborative care management may not be reported by the same professional in the same month."
CAGVAC	The CAGVAC edit identifies line items where the listed procedure code is not typically performed for a person of the patient's age excluding the vaccine codes (90476-90756) which are sourced to the Food and Drug Administration (FDA). Although the FDA provides age information for approved use, some physicians may find a vaccine is warranted even if the patients age is not within the recommended FDA approved use age range.
CCM2h	Chronic care management services are included in end stage renal disease (ESRD) service codes and in physician supervision service codes G0181 in the same calendar month. This is based on guidelines from the CPT Professional Edition codebook and the Centers for Medicare and Medicaid Services (CMS).

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IMD	The IMD edit identifies modifier to diagnosis (ICD-10-CM) relationships which indicate a discrepancy with the laterality and/or anatomical site between the diagnosis code and modifier when submitted together on the same claim line.
LNM	The LNM edit fires when a lab procedure is submitted with modifier 91 signifying the procedure to be a repeat of the same procedure done previously during the day, yet review of claim history shows that there was no original same procedure submitted for that date of service.
LPR	The LPR edit fires on a claim line when a repeat test or procedure is performed on the same date of service, which requires a repeat lab modifier 59 or 91, but is inappropriately submitted without a 59 or 91 modifier.
PCCMh	Based on CPT guidelines, subsequent psychiatric collablorative care code 99493 may not be reported in the same calendar month as initial psychiatric collablorative care code 99492 . 99493 is reported in a subsequent month from 99492.
PCCMh	Based on CPT guidelines, subsequent psychiatric collablorative care code 99493 may not be reported in the same calendar month as initial psychiatric collablorative care code 99492 . 99493 is reported in a subsequent month from 99492.
PCME	Initial psychiatric collaborative care management service code 99492 may not be reported within six calendar months of another psychiatric collaborative care management service code, 99492 or 99493. The CPT® codebook guidelines state "A new episode of care starts after a break in episode of six calendar months or more."
PSX	Missing patient gender

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RDL	The RDL edit fires on a claim line when a repeat radiology procedure does not have the appropriate repeat modifier appended. Modifier 76 is used if the same provider is performing the repeat procedure or service and modifier 77 is used if a different provider is performing the repeat procedure or service.
REF	Referring Physician is Missing
sAM	The sAM edit identifies Medicaid claim lines that contain an ambulance HCPCS code without a required ambulance modifier appended. If the Medicaid claim line contains an ambulance code identified in the CMS Ambulance HCPCS Codes system list and there is not an ambulance modifier appended that has a first character of D, E, G, H, I, J, N, P, R, or S and a second character of D, E, G, H, I, J, N, P, R, S or X, then apply the sAM flag per CMS and Medicaid guidelines.
sANE	The sANE edit identifies claim lines that contain an anesthesia code with an anesthesia modifier that affects payment for the anesthesia services.
sAR	The sAR edit will fire on all Medicaid claim lines with HCPCS codes A0425 or A0428 when billed with modifiers ''G'' or ''J'' in either the first position (origin code) or second position (destination code) within the two-digit ambulance modifier code. The edit is to assure an ambulance payment reduction of 10% is taken for non-emergency basic life support transports to and from Renal Dialysis Facilities for individuals with end-stage renal disease (ESRD).
sCO	The sCO edit identifies claim lines that contain codes that co-surgeons are not permitted to perform, but the code was billed with modifier 62 to indicate a co-surgeon
sPA	The sPA edit utilizes Medicaid policies and guidelines to identify claim lines that include a procedure code that requires prior authorization.

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sD1	The sD1 edit identifies Medicaid claim lines that contain procedure codes that have modifiers 80, 81, 82, or AS appended for which separate payment may not be made unless supporting documentation is submitted to establish medical necessity per Medicaid policies and guidelines.
sD2	The sD2 edit identifies Medicaid claim lines that contain procedure codes that have modifier 62 appended for which separate payment may not be made unless supporting documentation is submitted to establish medical necessity per Medicaid policies and guidelines.
sD3	The sD3 edit identifies Medicaid claim lines that contain procedure codes that have modifier 66 appended for which separate payment may not be made unless supporting documentation is submitted to establish medical necessity under CMS guidelines. CMS has designated codes that are identified by the indicator of "1" in the assistant surgeon column of the NPFS as eligible for modifier 66 pending review of documentation.
sDEY	The sDEY edit identifies Medicaid claims that contain an EY modifier on all lines indicating "no physician or other licensed health care provider order for this item or service." Per CMS guidelines, claim lines that do not have a physician order or prescription for the service or item provided, will cause return of the claim as unprocessable. The sDEY edit will fire on all Medicaid claim lines with modifier EY.
sDPh	The sDPh edit identifies Medicaid claim lines that contain a procedure code which has global follow-up days when an E/M procedure code in history has been submitted without the appropriate modifier and billed with a different diagnosis code during the global period by the same provider.

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sEH (Pattern 374)	The sEH edit identifies Medicaid claim lines in history that contain an E/M code without the appropriate modifier when billed on the same day of a minor procedure or the same day or day before a major procedure as determined by the CMS global surgical package guidelines.
sEH (Pattern 396)	The sEH edit identifies Medicaid claim lines in history that contain an E/M code without the appropriate modifier when billed on the same day of a minor procedure or the same day or day before a major procedure as determined by the CMS global surgical package guidelines.
sFP24	The sFP edit identifies claim lines that contain E/M code(s) submitted with the same diagnosis code during the global period of a previously submitted procedure code by the same provider. Documentation is required to support that the service is unrelated to the surgery.
sFP24h	The sFPh edit identifies claim lines that contain a procedure code which has global surgical follow up days when an E/M procedure code in history has been submitted with the same diagnosis code during the global period by the same provider.
sFPh	The sFPh edit identifies claim lines that contain a procedure code which has global surgical follow up days when an E/M procedure code in history has been submitted with the same diagnosis code during the global period by the same provider.
sFR	The sFR edit utilizes Medicaid policies and guidelines to identify claim lines in which the total units of a procedure code exceed the maximum number of units allowed within a specified time frame.
sIC	The sIC edit identifies Medicaid claim lines that contain codes that have the modifier 26 or TC appended inappropriately per Medicaid polices and guidelines.
sIM (pattern 131)	The sIM edit identifies claims lines submitted with modifier 22 with NPFS follow up days of MMM, XXX, or ZZZ.

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sIM (pattern 171)	This edit identifies claim lines submitted with modifier 62 with an NPFS Co-Surgeon indicator of "9".
sIM (pattern 172)	This edit utilizes the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine whether a procedure code billed on a Medicaid claim is submitted with an inappropriate modifier. This edit identifies claims submitted with modifier 66 with an NPFS Team Surgeon Indicator of "9".
sIM (pattern 173)	This edit utilizes the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) to determine whether a procedure code billed on a Medicaid claim is submitted with an inappropriate modifier. This edit identifies claims submitted with modifiers 80, 81, 82 or AS with an NPFS Assistant Surgeon Indicator of "9".
sINh	The sINh edit will review procedure codes to determine if a procedure in history is submitted for the same provider and date of service as another procedure code with a Status Code indicator of ''A'' (active) is eligible for separate reimbursement under the National Physician Fee Schedule (NPFS).
SIP	The SIP edit identifies the sequential intravenous push of the same substance/drug, Current Procedural Terminology (CPT®) code 96376, reported on a professional claim. This code is to be reported by a facility only. The CPT codebook states, "96376 may be reported by facilities only."
sLIH	The sLIH edit utilizes the Centers for Medicare and Medicaid Services' (CMS) Medicare Physician Fee Schedule (MPFS) to determine eligibility of a CPT® code to be split into professional and technical components. This edit will fire on all claim lines containing codes that have an indicator of ''6'', when submitted with a modifier 26, in the PC/TC column of the MPFS that are submitted with a location of inpatient or outpatient hospital.

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sM54	The sM54 edit will fire on Medicaid claim lines when the modifier 54 is present and a number, other than zero, is listed in the Intra Op column in the NPFS. The sM54 edit will review a primary surgical procedure code to determine if it is eligible for a reduction. When the modifier 54 is present and a zero is listed in the Intra Op column in the NPFS the line will not receive the edit. Also when modifier 54 is not present and a number, other than zero, is listed in the Intra Op column in the NPFS the line will not receive the edit
sM55	The sM55 edit will fire on Medicaid claim lines when the modifier 55 is present and a number, other than zero, is listed in the Post Op column in the NPFS. The sM55 edit will review a primary surgical procedure code to determine if it is eligible for a reduction. When the modifier 55 is present and a zero is listed in the Post Op column in the NPFS the line will not receive the edit. Also when modifier 55 is not present and a number, other than zero, is listed in the Post Op column in the NPFS the line will not receive the edit.
sM56	The sM56 edit will fire on Medicaid claim lines when the modifier 56 is present and a number, other than zero, is listed in the Intra Op column in the NPFS. The sM56 edit will review a primary surgical procedure code to determine if it is eligible for a reduction. When the modifier 56 is present and a zero is listed in the Intra Op column in the NPFS the line will not receive the edit. Also, when modifier 56 is not present and a number, other than zero, is listed in the Intra Op column in the NPFS the line will not receive the edit.
sM62	The sM62 edit identify claim lines where a modifier 62 is appended to a procedure code(s) and there is another claim for the same procedure and same date of service for a different provider, without modifier 62 appended.
sM62h	The sM62h edit identify claim lines where a modifier 62 is appended to a procedure code(s) and there is another claim for the same procedure and same date of service for a different provider, without modifier 62 appended.

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sM66	The sM66 edit identifies Medicaid claim lines where a modifier 66 is appended to a procedure code with an indicator of 1 or 2 in the team surgery column of the NPFS and there is another claim in history for the same procedure and same date of service for a different provider, without modifier 66 appended.
sM66h	The sM66h edit identifies Medicaid claim lines where a modifier 66 is appended to a procedure code with an indicator of 1 or 2 in the team surgery column of the NPFS and there is another claim in history for the same procedure and same date of service for a different provider, without modifier 66 appended.
sM78	The sM78 edit will fire on all Medicaid claim lines when modifier 78 is present and a number, other than zero, is listed in the Intra Op column of the NPFS. The sM78 edit will review a surgical procedure code to determine if it is eligible for a reduction.
sMEY	The sMEY edit identifies Medicaid claims that contain an EY modifier on any line of a Medicaid claim. Per CMS guidelines, claim lines for which there is ''no physician or other licensed health care provider order for this item or service'' must be submitted on a Medicaid claim separate from claim lines for which there is 'a physician or other licensed health care provider order'.
sMGK	The sMGK edit will fire on all Medicaid claim lines with modifier GK appended and an additional Medicaid claim line does not contain modifier GA or GZ per Medicaid policies and guidelines.
sMOD	The sMOD edit fires on a claim line when a procedure or service code does not have the appropriate modifier appended. This is based on guidelines from CPT, the AMA, and the CMS.
sNS	The sNS edit utilizes Medicaid policies and guidelines to identify claim lines that contain codes specified as ''non-covered services''.

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sNP	The sNP edit identifies Medicaid claim lines that contain codes that represent services submitted under incident to guidelines with an inappropriate place of service. Following NPFS and Centers for Medicare and Medicaid Services' guidelines, codes that have a PC/TC indicator of ''5'' will not be eligible for payment if the service was provided by auxiliary personnel under physician supervision and done in a skilled nursing facility, hospital inpatient, or hospital outpatient.
sPI	The sPI edit identifies claim lines that contain codes that are billed with a place of service other than inpatient. This edit will fire on all Medicaid claim lines containing codes that have an indicator of ''8'' in the PC/TC column of the NPFS that are submitted with a TC modifier
sPT	The sPT edit identifies Medicaid claim lines that contain codes that represent therapy services submitted with an inappropriate place of service. Following the CMS NPFS and the Code of Federal Regulations, independent practicing therapists can only submit to CMS services performed in their private practice office or in the patient's private home.
sSAM	The sSAM edit identifies Medicaid claim lines that include an assistant surgeon modifier 80, 81, 82 or AS appended to a procedure code, and there is another claim line in history for the same procedure code with an assistant surgeon modifier appended for the same patient on the same date of service by a different provider.
sSB	The sSB edit will look on the current claim line and claim lines in history to determine that a primary code is submitted for a given add-on code for the same provider and date of service as its associated add-on code. When the primary procedure code is not found in the current claim line or claim lines in history for the same date of service as the add-on procedure, the associated add-on procedure will deny. The edit message will indicate the procedure is an add-on code and should be billed in conjunction with or completely replaced by a primary procedure code.

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sSED	The sSED edit utilizes the Centers for Medicare and Medicaid Services' (CMS) Claims Processing Manual Chapter 18, Section 60.1.1 to identify claim lines where a screening colonoscopy service (G0105 or G0121) is billed with Moderate Sedation code (G0500 or 99153) on the same date of service and Modifier 33 is not appended to Sedation code.
sSPh	The sSPh edit identifies Medicaid claim lines in history that contain a procedure code submitted for the same provider without an appropriate modifier and billed within the global period of another surgical procedure.
sSX	The sSX edit utilizes Medicaid policies and guidelines to identify claims that include a patient's gender that does not meet policy requirements for a procedure or diagnosis code.
sTCH	The sTCH edit identifies claim lines that contain codes submitted with a place of service of inpatient hospital or hospital under CMS guidelines. The concept of professional and technical component splits (PC/TC) does not apply to these codes that are identified by the indicator of "3" in the PC/TC column of the MPFS. Billing of the technical component is inappropriate by the physician in an inpatient or outpatient hospital, as the facility should be responsible for submitting it. Modifiers 26 and TC cannot be used with these codes.
sTF	The sTF edit utilizes Medicaid policies and guidelines to identify claims that are received past a specified timely filing deadline.
sTS	The sTS edit identifies Medicaid claim lines that contain procedure codes with modifier 66 appended inappropriately per Medicaid policies and guidelines.
UNL	The UNL flag identifies the procedure code on the claim line as an unlisted code.

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CES Edit Mnemonic	CES Edit Description
UNLf	The UNL flag identifies the procedure code on the claim line as an unlisted code.

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