BlueCross BlueShield of Illinois

Claim Edits for Blue Cross Community Health Plans℠ (BCCHP℠)

The goal of Blue Cross and Blue Shield of Illinois (BCBSIL) is to process claims consistently and in accordance with industry best practice standards. For BCCHP claims, BCBSIL has implemented claim edits in alignment with correct-coding initiatives, the Centers for Medicare & Medicaid Services' (CMS) guidelines, national benchmarks, and industry standards.

The following claim edits were implemented beginning with claims processed as of **May 25, 2021**:

Monitored Anesthesia	According to CMS policy, monitored anesthesia care must be reported with a diagnosis that supports medical necessity for the procedure. Therefore, the anesthesia service appended with modifier QS (Monitored anesthesia care service) will be denied when billed without an approved diagnosis or a physical status modifier P3, P4, P5 or MAC modifier G8 or G9.
Screening for Hepatitis B Virus (HBV)	To align with CMS policy, BCBSIL is implementing the following claim edits for Hepatitis B virus (HBV): **General Limitations** • HBV screening for asymptomatic, non-pregnant adolescents and adults who are at high risk for HBV infection (G0499) must be reported with both a diagnosis of encounter for screening for viral diseases (ICD-10 code Z11.59) and a diagnosis indicating continued high risk for HBV infection (ICD-10 code Z72.89) unless a diagnosis of end stage renal disease (ICD-10 code N18.6) is present on the claim; • HBV screening for asymptomatic, non-pregnant, adolescents and adults who are at high risk for HBV infection (G0499) is not covered when reported with a diagnosis of supervision of normal pregnancy (ICD-10 codes Z34-Z34.93) or supervision of high risk pregnancy, unspecified (ICD-10 codes O09.9-O09.93); and • HBV screening (86704, 86706, 87340, 87341) in pregnant women must be reported with a specific pregnancy diagnosis (ICD-10 codes: Z34-Z34.93, O09.9-O09.93) and a diagnosis of encounter for screening for viral diseases (ICD-10 code Z11.59). **Specialty Limitations** • HBV screening for asymptomatic, non-pregnant, adolescents and adults who are at high risk for HBV infection (G0499) is only covered when performed or ordered by a provider whose specialty is Certified Clinical Nurse Specialist, Family and General Practice, Geriatric Medicine, Internal Medicine, Laboratory, Licensed Midwife, Nurse Practitioner, Miscellaneous, Obstetrics and Gynecology, Pediatrics, Pathology, or Physician's Assistant.

	• HBV screening (86704, 86706, 87340 or 87341) is only covered for pregnant patients when billed with both a diagnosis of encounter for screening for other viral diseases (ICD-10 code Z11.59) and a pregnancy diagnosis (ICD-10 Codes: Z34-Z34.93, O09.9-O09.93), when such screening is performed or ordered by a provider whose specialty is a Certified Clinical Nurse Specialist, Family and General Practice, Geriatric Medicine, Internal Medicine, Laboratory, Licensed Midwife, Nurse Practitioner, Miscellaneous, Obstetrics and Gynecology, Pediatrics, Pathology, or Physician's Assistant. • HBV screening claims for any other specialty will be denied. **Place of Service Limitations** • , Hepatitis B screening (G0499) is only allowed when performed in the physician's office, outpatient hospital (on or off campus), independent clinic, state or local public health clinic, or independent laboratory setting. • HBV screening (86704, 86706, 87340 or 87341) when billed with both a diagnosis of encounter for screening for other viral diseases (ICD-10 code Z11.59) and a pregnancy diagnosis (ICD-10 Codes: Z34-Z34.93, O09.9-O09.93), is covered when performed in the physician's office, outpatient hospital (On or off campus), independent clinic, state or local public health clinic, or independent laboratory setting. • Hepatitis B screening and HBV screening claims for all other settings will be denied. **Bill Type Limitations** • HBV screening for asymptomatic, non-pregnant, adolescents and adults who are at high risk for HBV infection (G0499) is covered for bill types 0130-013Z (hospital outpatient), 0140-014Z (Hospital - laboratory services provided to non-patients), 0720-072Z (Clinic - hospital-based), and 0850-085Z (Critical access center outpatient Part B). • HBV screening for asymptomatic, non-pregnant, adolescents and adults who are at high risk for HBV infection (G0499) when billed with both a diagnosis of encounter for screening for other viral diseases (ICD-10 code Z11.59) and a pregnancy diagnosis (ICD-10 Codes: Z34-Z34.93, O09.9-O09.93) is covered for bill types 0130-013Z (Hospital outpatient), 0140-014Z (hospital - laboratory services provided to non-patients), 0720-072Z (clinic - hospital-based), or 0850-085Z (critical access center outpatient Part B). • HBV screening claims for other bill types will be denied. **Renal Dialysis Center Billing Requirements**

	• HBV screening for asymptomatic, non-pregnant, adolescents and adults who are at high risk for HBV infection (G0499) is only covered in a renal dialysis center (bill type 0720-072Z) when reported with modifier AY (item or service furnished to an ESRD patient that is not for the treatment of ESRD). **Frequency Limitations** • HBV screening for asymptomatic, non-pregnant, adolescents and adults who are at high risk for HBV infection (G0499) is only allowed once per year for patients at continued high risk. Therefore, when HBV screening is billed with both a diagnosis of encounter for screening for other viral diseases (ICD-10 code Z11.59) and a specific high risk diagnosis and G0499 has been paid in the previous year, the HBV screening (G0499) will be denied, unless a diagnosis of ESRD (N18.6) is present on the claim. • **High Risk ICD-10 Diagnosis Codes**: F11-F11.99, F13-F13.99, F14-F14.99, F15-F15.99, Z20.2, Z20.5, Z72.52, Z72.53
Laser Treatment of Psoriasis	According to the American Medical Association (AMA) CPT manual and the American Academy of Dermatology Association, laser treatment of psoriasis (96920-96922) should only be reported with a diagnosis of psoriasis (ICD-10 codes L40.0-L40.4, L40.8-L40.9) or parapsoriasis (ICD-10 codes L41-L41.9). In addition, laser treatment of psoriasis (96920-96922) should not be reported more than once in two days as there should be a minimum of 48 hours between treatments. Therefore, the laser treatment will be <u>denied</u> when the criteria is met.
National Correct Coding Initiative (CCI) Supplemental Edits for Inpatient and Outpatient Consultation Codes	Evaluation and Management Inpatient and Outpatient Consultation codes (99241-99255) are no longer supported in the National CCI because CMS no longer considers these codes valid for Medicare purposes). CMS has provided instructions for the coding of these services utilizing the initial and subsequent care codes for inpatient hospital and nursing facility.
Electroencephalogram (EEG)	An electroencephalogram (EEG) is a diagnostic test that measures the electrical activity of the brain (brainwaves) using highly sensitive recording equipment attached to the scalp by fine electrodes. **EEG In the Evaluation of Headache or Migraine** According to the American Academy of Neurology, no study has consistently demonstrated that an EEG improves diagnostic accuracy for the headache sufferer. An EEG has not been convincingly shown to identify headache subtypes, nor has it been shown to be an effective screening tool for structural causes of headache. Therefore, EEG (95812, 95813, 95816, 95819, 95822) should not be performed when the only diagnosis on the claim is one of the following headache or migraine diagnoses: - Headache (ICD-10 codes G44-G44.89, R51-R51.9) - Headache due to lumbar puncture (ICD-10 code G97.1)

	- Migraine (ICD-10 codes G43.0-G43.719, G43.B-G43.C1, G43.8-G43.919) **Diagnosis Requirement for Electroencephalography (EEG) Testing** According to CMS policy, EEG testing (95700, 95705-95726 or 95957) is appropriate to differentiate between seizures, syncopal attacks, sleep apnea, cardiac arrhythmias or hysterical episodes and is appropriate for various neurological conditions where seizures/epilepsy is suspected by history or confirmed on a patient with the need for additional management. EEG testing claims submitted without an appropriate diagnosis, such as those shown below, **will be denied**. **Examples of Appropriate Diagnoses:** - Conversion disorder with motor symptom/seizures/convulsions or sensory symptoms (ICD-10 codes F44.4-F44.7) - Meningococcal encephalitis (ICD-10 code A39.81) - Nontraumatic intracranial hemorrhage (ICD-10 code I62.9) - Syncope and collapse (ICD-10 code R55) - Unspecified coma (ICD-10 code R40.20) **Frequency Limits** According to CMS policy, it is not expected to see more than three ambulatory outpatient EEG services (95957) billed. Therefore, only one service will be allowed within a three-day period. Additionally, it would not be expected to see more than three EEG services (95957) billed in most circumstances within a one-year period. **Epileptic Spike Analysis** According to the AMA CPT manual, automated spike and seizure detection (95957) is included in long-term continuous recording EEG services (95700-95726), when performed. Therefore, reporting of 95957 on the same date of service with 95700-95726 when performed for spike analysis will be denied since it represents overlapping services.
Nerve Conduction Studies (NCS) and Electromyography (EMG) for Radiculopathy	According to the American Association of Neuromuscular & Electrodiagnostic Medicine and CMS policy, nerve conduction studies (NCS) and a needle electromyography (EMG) must both be performed in order to diagnose radiculopathy (pinched nerve in back or neck). When the NCS or the needle EMG is used on its own, the results can be misleading and important diagnoses may be missed. Therefore, if the NCS (95905) is billed without a needle EMG (95860-95864) and the only diagnosis is radiculopathy (ICD-10 codes M47.21-M47.28, M50.1-M50.23, M51.1-M51.27, M51.9, M53.80, M54.1-M54.18, M54.3-M54.42, M79.2), the NCS claim will be denied. When a diagnosis of radiculopathy is already established and EMG is performed during surgery, for the purpose of intraoperative monitoring, then NCS is not required. Conversely, in this setting, if NCS is performed during surgery, then needle EMG is not required. Therefore, when a needle EMG (95860-95864) is billed without a NCS (95905) or continuous intraoperative neurophysiology monitoring (95940, 95941, G0453) and the only diagnosis is radiculopathy (ICD-10 codes

	M47.21-M47.28, M50.1-M50.23, M51.1-M51.27, M51.9, M53.80, M54.1-M54.18, M54.3-M54.42, M79.2), the needle EMG will be denied. Also, when the NCS (95907-95913) is billed without a needle electromyography (95885, 95886) or continuous intraoperative neurophysiology monitoring (95940, 95941, G0453) and the only diagnosis on the claim is radiculopathy (ICD-10 codes M47.21-M47.28, M50.1-M50.23, M51.1-M51.27, M51.9, M53.80, M54.1-M54.18, M54.3-M54.42, M79.2), the NCS will be denied.
Psychological-Neuropsychological Testing	Psychological testing evaluates personality and general cognitive functioning to diagnose psychiatric conditions. Neuropsychological testing is an assessment of cognitive processes to better understand functioning of the brain. **Covered Indications** According to CMS policy, psychological/neuropsychological testing (96130-96133, 96136-96139, G0451) is considered medically necessary to determine intellectual strengths, psychopathology, psychodynamics, mental health risks, insight, motivation, and other factors influencing treatment and prognosis. **Examples of Approved Diagnoses:** - Alzheimer's disease (ICD-10 codes G30-G30.9) - Mental and behavioral disorders due to psychoactive substance use (ICD-10 codes F10.11-F19) - Mental disorders due to known physiological conditions (ICD-10 codes F01-F09) - Mood (affective) disorders (ICD-10 codes F30-F39) - Schizophrenia, schizotypal, delusional and other non-mood psychotic disorders (ICD-10 codes F20-F29)
Injections Involving Tendons, Ligaments and Ganglion Cysts	Injections into tendon sheaths, ligaments, tendon origins or insertions, or ganglion cysts (20526, 20527, 20550, 20551, 20612) may be indicated to relieve pain or dysfunction resulting from inflammation or other pathological changes. According to CMS policy, there are numerous diagnoses that are appropriate indications for these types of therapeutic injections including, but not limited to bursitis, carpal tunnel syndrome, hallux valgus, Morton's neuroma, and Depuytren's contracture. These injection codes are not considered to be billable services unless an appropriate diagnosis is reported. Therefore, the injections will be denied when the criteria is **not met**. **Examples of Appropriate Diagnoses:** - Bursitis of shoulder (ICD-10 codes M75.51-M75.52) - Carpal tunnel syndrome (ICD-10 codes G56.0-G56.03) - Hallux valgus (ICD-10 code M20.10) - Morton's metatarsalgia, neuralgia, or neuroma (ICD-10 codes G57.6-G57.63) - Palmar fascial cord (Depuytren's contracture) (ICD-10 code M72.0)