

Upcoming Code Edits (Effective Oct. 1, 2019)

Over the past several years, BlueCross has been implementing payment policies to process claims efficiently and deliver payments to providers with more accuracy. We're aligning our payment policies with correct-coding initiatives (CCI), Centers for Medicare & Medicaid Services (CMS) guidelines and national benchmarks and industry standards.

Beginning Oct. 1, 2019, we'll implement code edits for:

- **Inappropriate Age for Procedure**
- **Pneumococcal Vaccine Frequency**
- **Diagnosis Code Guideline Policies**

The following table outlines the new coding guidelines.

Coding Policy	Description
Inappropriate Age for Procedure	This edit identifies line items where the listed procedure code is not typically performed for a person of the patient's age.
Pneumococcal Vaccine Frequency	This edit identifies when the same or a different, second pneumococcal vaccine is administered within 1 year after the first vaccine was administered (i.e., 11 full months have passed following the month in which the last pneumococcal vaccine was administered) and that each vaccine is not reported more than once per lifetime.
Diagnosis Code Guideline Policies	<p>ICD-10 Excludes 1 Note Policy The ICD-10-CM has new and unique features, which are specific to the Excludes 1 Note and the inclusion of laterality in the code descriptions. An Excludes 1 Note indicates the excluded code should never be used at the same time as the code or code range listed above the Excludes 1 Note.</p> <p>ICD-10-CM Laterality Policy Most modifiers descriptions indicate the procedure applies to a specific area of the body where services were performed distinctly from other services or the special circumstances of the services. Anatomic-specific modifiers (e.g., FA, TA, and LC) show the area or part of the body where the procedure was performed. When an anatomical modifier is added to a procedure code but the anatomical site of the modifier and the documentation doesn't match the services rendered, the service will not be paid.</p> <p>According to the ICD-10-CM Official Guidelines for Coding and Reporting, some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on left, right, or is bilateral.</p>



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One of the unique features of the ICD-10-CM code set is laterality has been built into code descriptions. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side. If the side is not identified in the medical record, assign the code for the unspecified side. It's not appropriate to report unspecified or left and right diagnosis codes when a more specific (e.g., bilateral) code is available.

1. **Diagnosis-to-Modifier** – The Diagnosis-to-Modifier comparison checks the lateral diagnosis to determine if the procedure modifier matches the lateral diagnosis. If it doesn't match, the claim line will be denied.
2. **Diagnosis-to-Diagnosis** – The Diagnosis-to-Diagnosis comparison checks the lateral diagnosis to determine if the combination is inappropriate.

For claims to be processed accurately, there needs to be consistency in how the affected side or sides are reported via ICD-10-CM diagnosis codes and related modifiers. Failure to follow the ICD-10 correct coding guidelines will result in a claim denial.