MVP Significant Custom Claim Edits

MVP uses FACETS clinical edits and McKesson ClaimsXTen software, National Correct Coding Initiative (NCCI), American Medical Association (AMA), Current Procedural Terminology (CPT), and Healthcare Common Procedure Coding System (HCPCS) code guidelines claim edits to accurately process claims.

MVP has made the following custom claim edits to our FACETS clinical edits software:

- The following CPT® codes will be denied if submitted for reimbursement with a preventive care diagnosis code or a preventive care CPT code: 92015, 92081, 92551, 92552, 92553, 92555, 92556, 92557, 92567, 96110, 99172, 99173, 95930, 99174. This rule applies to both participating and non-participating providers.
- CPT® codes 20985, 0054T, and 0055T as global to orthopedic codes.
- CPT® code 99173 denied as global to all Evaluation and Management (E/M) codes.
- HCPCS Codes Q0091 and G0101 are denied as a subset to sick visits. The denial can be reconsidered with proper medical documentation as to a separate service from the problem visit.

MVP has made the following custom claim edits to our claims editing software:

- CRNA billing with place of service 21/22 and with a hospital TIN is considered global to surgery.
- Venipunctures billed with blood labs without a modifier 90 will be denied.
- Allergy testing/treatment is only allowed when performed by allergists, ENTs and dermatologists.
- Established patient E&M codes, IP physician and ER physician CPT codes must be billed with modifier 25 if billed on the same day as allergy injections/immunotherapy, PUVA, UBA, UVA treatments or Surgery.
- Percutaneous tests will be denied when over 50 units are billed. Percutaneous tests billed with food allergy diagnosis will be denied when over 65 units are billed. Intradermal Tests will be denied when over 50 units are billed.
- IP professional charges (visits, consults, anesthesia, etc.) billed by providers employed/staffed by a hospital will be denied "global" (subject to exceptions).
- Surgical Trays are not covered when billed by anesthesiologists (exception: unless billed in conjunction with pain management).
- Osteopathic manipulation is not a covered benefit.
- Surgical procedures that can only be performed in an office/IP/ER setting are defined on the MVP In-Office Procedure list.
- Heparin and saline will be denied "global" when billed with home infusion.
- Immunization Administration codes billed without a V-code diagnosis to describe the immunization being administered are denied for "insufficient medical documentation."
- B-12 injections billed under injection administration codes will be denied to resubmit with HCPCS code.
- When two IP physician visits are billed for the same date of service by the same provider for the same/related condition, only one visit will be approved.
- When the same lab test is billed multiple times on the same date of service, only one test will be approved.
- Lab services that must be performed in office are documented on the MVP Regional In-Office Lab list.
- Radiology services that cannot be performed in office are documented on the MVMA In-Office Radiology list and the South Central Radiology list.
- For pelvic and abdominal procedures on the same date of service — the major procedure is reimbursed at 100 percent, minor procedure reimbursed at 50 percent (Mid-Hudson Region).

- Pap Smear code Q0091 will be denied "subset" when billed with an E&M code (including preventative care codes).
- If the first prenatal office visit is billed with a TH modifier but not a prenatal form, the claim will be denied.
- If a prenatal form is submitted after 90 days, the first prenatal visit will be denied.
- If $300 is paid on the first prenatal visit, but the allowable amount of the total OB code is less than $300, the claim will be denied "global."
- Antepartum care codes billed without the number of prenatal visits that occurred will be denied.
- Two E&M codes billed on the same date of service will not be allowed even if billed with a 25 modifier and multiple diagnosis codes (preventative vs. medical).
- After Hours visit codes are denied when billed by Emergency Med Physicians.
- Telephone calls from physicians to patients, etc. are not covered and will be denied "incidental to other procedures."
- Therapeutic codes billed with non-chemo J codes must be billed with modifier 59 when billed in addition to chemo admin, chemo J codes, Q codes or E&M codes.
- Specimen handling is not covered and will be denied "incidental to other procedures."
- Testing (including hearing and vision testing) is not allowed when billed during a Well Care visit and will be denied "incidental to other procedures" or "included in global fee."
- Tympanometry billed by a PCP in addition to a Well Child Visit will be denied "incidental to other procedures" or "global" (applies to all regions).
- If 99070 is billed with a description of a supply and a valid HCPCS code exists for the supply, will be denied to resubmit with valid HCPCS code.
- Local anesthesia charges billed by providers other than anesthesiologists with office surgery will be denied.
- Caine Injectables billed with Arthrocentesis are not allowed and will be denied "global."
- If two breast ultrasounds are billed for the same date of service, MVP will approve one and deny the other as "global."
- If a Biophysical Profile is billed on the same date of service as a fetal or obstetrical ultrasound, the ultrasound should be reimbursed at 100 percent of allowable, the Biophysical Profile should be reimbursed at 50 percent of allowable (applies to Central Region).
- OB ultrasounds performed by OB/GYNs in the office will be denied "global" to the OB delivery claim (applies to Midstate Region).
- New York State Physicians Pelvic and Transvaginal Ultrasound Policy — codes 76830 and 76817 will be reimbursed at 100 percent of allowable, other codes will be reimbursed at 50 percent of allowable when billed with 76830, 76817.
- Urgent care claims will be denied "ER criteria not met" when billed with routine diagnoses or routine services.
- Effective 1/1/11 – MVP will not longer pay for Pulse Oximetry codes 94760 and 94761. These codes are bundled in the primary service and not reimbursable as a stand alone.