Claim edit enhancements: Automated claim edits

This document shows examples of the higher volume enhanced claim edits we continue to see:

ICD-10 coding

- **Excludes 1 Notes:** Claim lines reported with mutually exclusive code combinations according to the ICD-10-CM Excludes 1 Notes will be denied.
  - When a code from range H73.0 – H73.099 (Acute myringitis) is associated to the same claim line as a code in either the range H65 – H65.93 (Nonsuppurative otitis media) or the range H66 – H66.93 (Suppurative and unspecified otitis media), then the claim line will be denied.
- **Laterality:** The Diagnosis-to-Modifier comparison assesses the lateral diagnosis associated to the claim line to determine if the procedure modifier matches the lateral diagnosis. If it does not match, the claim line will be denied.
  - **DIAG1:** H60.332 (Swimmer's ear, left ear)
  - **CPT:** 69000 (Drainage external ear, abscess, or hematoma; simple)
  - **MOD:** RT
- **Primary diagnosis code reporting:** Certain diagnosis codes cannot be reported as the only or primary diagnosis code on a claim. If one of the following codes is reported as the only or primary diagnosis, then the claim line will be denied:
  - Manifestation codes
  - External causes (i.e., "V – Y" codes)
  - Secondary codes (e.g., Z33.1)

Evaluation and Management services

- Only one new patient visit will be allowed to the same group practice and specialty within three years.
- Only one initial inpatient hospital visit and inpatient hospital discharge will be allowed per hospital stay.
- Only one observation care code (99218 – 99220, 99224 – 99226) may be reported per patient per day by any provider.

Surgical services

- Accurate reporting of modifiers for the billing of surgical services rendered by one or more providers.
- Primary surgeon should not also report as the assistant surgeon.

Code combinations

- Vaccine toxoid must be reported on the same day as a vaccine administration.
- Ambulance mileage must be reported on the same day as an ambulance transport.

Procedure/Diagnosis vs. Age consistency

Certain procedure and diagnosis codes are limited to a specific age group. The age groups recognized within our edits are as follows:

- **Newborn/Neonatal:** < 29 days
- **Infant:** < 1 year (includes newborn/neonatal)
- **Child:** 1 – 11 years
- **Adolescent:** 12 – 17 years
- **Pediatric:** 0 – 17 years (includes newborn/neonatal, infant, child, and adolescent)
- **Adult:** 15 years and older
- **Maternity:** 12 – 55 years
- **Geriatric:** 70 years and older

Learn more

For questions about the claim editing process, please review our *Claim edit enhancements: Frequently asked questions (FAQ)*.

If you still have questions after reviewing the FAQ, please send an email to ahclaimeditquestions@amerihealth.com.