Cotiviti Edit Descriptions

<table>
<tr><th>EDIT NAME</th><th>EDIT DESCRIPTION</th></tr>
<tr><td>Coding for Services within the Global Surgical Period

Effective: 01/10/2022</td><td>Centers for Medicare and Medicaid Services (CMS) defines specific time periods during which certain services related to a surgical procedure, performed by the provider who performed the surgery, are to be included in the payment of the surgical procedure.

The Global Surgery Package includes review of preoperative evaluation and management visits after the decision is made to operate, where the visits occur one day prior to major surgery and on the same day a major or minor surgical procedure is performed. When a physician sees a patient within the global follow-up period of a surgical procedure that has a 10-, or a 90-day post-operative period, the physician should report the appropriate modifier(s), relevant to the circumstance, for the procedure performed. The physician should report the appropriate modifier for any surgical procedure performed within the follow-up period of the original surgical procedure, if applicable. The appropriate, applicable modifiers are as follows:
• 58 - Staged or Related Procedure or Service by the Same Physician
• during the Postoperative Period
• 78 - Unplanned Return to the Operating/Procedure Room by the Same
• Physician or Other Qualified Health Care Professional Following Initial
• Procedure for a Related Procedure During the Postoperative Period
• 79 - Unrelated Procedure or Service by the Same Physician during the
• Postoperative Period</td></tr>
<tr><td>Anatomical Modifier

Effective: 04/1/2022</td><td>This edit will validate the claim lines procedure and modifier against a set of required modifiers by procedure. If a procedure with a required modifier does not have the modifier appended, the claim line will deny.

If an anatomical modifier is necessary to differentiate right or left and is not appended, the claim will be denied. Likewise, if a modifier is appended to a procedure code that does not match the appropriate anatomical site, the claim will be denied. CMS has identified a set of anatomical modifiers to facilitate correct coding for claims processing. Please append the modifier in box 24D of the CMS 1500 claim form, or electronically report the first modifier in SV101-3; use the additional fields SV101-4, SV101-5 or SV101-6 if needed for additional modifiers relevant to the procedure code on the service line. The anatomical modifiers are:

<table>
<tr><td>E1 – E4</td><td>Eyelids</td></tr>
<tr><td></td><td></td></tr>
<tr><td>FA, F1 – F9</td><td>Fingers</td></tr>
<tr><td>TA, T1 – T9</td><td>Toes</td></tr>
<tr><td>LC</td><td>Left circumflex, coronary artery</td></tr>
<tr><td>LD</td><td>Left anterior descending coronary artery</td></tr>
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LM	Left main coronary artery
LT	Left
RI	Ramus intermedius
RC	Right coronary artery
RT	Right
50	Bilateral procedure

Diagnosis Code Guideline Policy (Professional and Facility)

Effective: 04/1/2022

This edit will identify when diagnosis codes were not submitted in accordance with the International Classification of Diseases (IDC) ICD-10 coding guidelines and CMS policies.

Diagnosis Code Guideline Policy (Professional and Facility)

The Diagnosis Code Guideline Policy identifies multiple scenarios where a diagnosis submitted for a procedure or service is reported in an inappropriate position on a Professional and/or Facility claim line(s). ICD-10 guidelines and CMS policies have indicated specific groups of diagnoses that are not acceptable or required to be reported as the primary or principal diagnosis on the claim or claim line, as well as clinical scenarios where a diagnosis code cannot be submitted as the only reported diagnosis for the procedure. In addition, this policy edits when inappropriate diagnosis code pairs are reported based on ICD-10 Excludes One notation for Professional claims only.

Primary or Principal Diagnosis or the ONLY Diagnosis: The following groups of diagnosis codes are not allowed to be reported as the ONLY diagnosis on the claim or claim line, the Primary diagnosis on a Professional claim, or as the Principal diagnosis on a Facility claim.

- **External Causes Diagnosis**: According to the ICD Manual guidelines, ICD-10 "V-Y" codes (External causes of morbidity) are used to classify environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects. These codes are intended to be used as a supplement to the principal or primary diagnosis code indicating the nature of the condition. In addition, based on this guideline, a diagnosis code of external causes cannot be the only diagnosis on the claim. Therefore, services claims received with a diagnosis of ICD-10 "V-Y" codes as the ONLY diagnosis will be denied.
- **Manifestation Diagnosis**: Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD Manual coding guidelines have established a coding convention that requires the underlying condition to be sequenced first followed by the manifestation. According to the ICD Manual coding guidelines, the primary, first listed or principal diagnosis cannot be a manifestation code. Therefore, manifestation codes billed in the primary, first listed or principal diagnosis position will result in the associated services being denied. In addition, based on this guideline, a manifestation code cannot be the only diagnosis on the claim. Therefore, services reported with a manifestation code as the only diagnosis on the claim will also be denied.
- **Secondary Diagnosis**: According to ICD guidelines, a secondary diagnosis code can only be used as a secondary diagnosis. Since these codes are only for use as additional codes, any procedure or service received with a secondary diagnosis code as the principal or primary diagnosis will be denied

as incorrectly coded. In addition, based on this guideline, a secondary diagnosis code cannot be the only diagnosis on the claim. Therefore, services reported with a secondary diagnosis code as the only diagnosis on the claim will also be denied.

- **Sequela Diagnosis**: According to the ICD-10-CM Manual guidelines, a sequela (7th character "S") code cannot be listed as the primary, first listed or principal diagnosis on a claim. Coding of a sequela requires reporting of the condition or nature of the sequela sequenced first, followed by the sequela (7th character "S") code. In addition, based on this guideline, a sequela (7th character "S") code cannot be the only diagnosis on a claim.

Required Diagnosis for Chemotherapy Administration Procedure Codes: Specified Chemotherapy Administration procedure codes are required to have Z51.11 and Z51.12 as the primary or principal diagnosis. In addition, ICD-10 guidelines state when a patient's encounter is solely to receive chemotherapy for the treatment of neoplasm, two diagnosis codes are required.

Evaluation and Management Procedure Codes Reported with ONLY a Diagnosis Code from Range Z00-Z99: "Z" diagnosis codes (Factors Influencing Health Status and Contact with Health Services) allow for the description of encounters for routine examinations (e.g. a general check-up, examinations for administrative purposes or pre-employment physicals). These codes are not to be used if the examination is for diagnosis of a suspected condition or for treatment purposes; in such cases, the specific diagnosis code (from other chapters) is used. During a routine exam, should a diagnosis or condition be discovered, it should be reported as an additional code. Therefore, when an Evaluation and Management (E/M) service code (99201-99380, 99441-99496, 99499) is reported with an ICD-10 "Z" code as the only diagnosis on the claim, and a preventive medicine service (99381-99429) was also performed on the same date, then the E/M service will be denied.

Excludes 1 Code Pair: One of the unique attributes of the ICD-10-CM code set is the new concept of Excludes 1 Notes. An Excludes 1 Note indicates that the excluded code identified in the note should never be used at the same time as the code or code range listed above the Excludes 1 Note. An Excludes 1 Note is used to indicate when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition. These conditions are mutually exclusive code combinations. These notes are located under the applicable section heading or specific ICD-10-CM code to which the note is applicable. When the note is located following a section heading, then the note is applicable to all codes in the section.

Laterality Policy: One of the unique attributes to the ICD-10-CM code set is that laterality has been built into some diagnosis code descriptions identifying when the ICD-10-CM codes condition occurs on the left or right or is bilateral. If no bilateral code is provided and the condition is bilateral, then codes for both left and right should be assigned. If the side is not identified in the medical record, then the unspecified code should be assigned. This module is divided into two different edits to validate the laterality of the procedure performed is accurately coded with the appropriate modifier or diagnosis code.

- **Laterality Modifier to Diagnosis Mismatch:** The Laterality Modifier to Diagnosis edit assesses the lateral diagnosis associated to the claim line or header to determine if the procedure modifier matches the lateral

	diagnosis. The Laterality Modifier edit identifies when modifiers RT, LT or 50 do not correlate with the submitted diagnosis on the line. **Laterality Diagnosis to Diagnosis Mismatch**: This edit will deny procedures when there are 2 diagnoses on the line that conflict. For example, it will edit if C34.01 (Malignant neoplasm of left main bronchus) and C34.00 (Malignant neoplasm of unspecified main bronchus) are billed on the same line as the procedure.

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