PROVIDER BULLETIN
#16-2018

TO: Participating hospitals and ambulatory surgical centers that provide covered services to AmeriHealth Pennsylvania members

FROM: Provider Contracting and Reimbursement

DATE: August 17, 2018

SUBJECT: Enhanced claim edits to align with industry standard billing rules

We are sending this bulletin to remind you that claims received by AmeriHealth HMO, Inc. (AmeriHealth) **on or after June 10, 2018,** are subject to a claim editing process during prepayment review. This process ensures compliance with current industry standards and supports the automated application of correct national coding principles.* If you have been submitting claims in accordance with industry standards, you will have no issues with the topics in this bulletin. However, if you have not, please be advised that you may see an increase in claim rejections and/or denials due to the new claim edits. Some examples of what you can expect to see are listed below.

**Self-funded groups have the option to opt out of the enhanced claim edits; therefore, your outcomes may vary by plan.*

Modifiers

While modifiers are only required on outpatient claims reimbursed according to Ambulatory Payment Classifications (APC), should modifiers be billed on non-APC reimbursed claims, it must be in accordance with national billing standards, such as:

- Centers for Medicare & Medicaid Services (CMS)
- American Medical Association (AMA) Current Procedural Terminology (CPT®) coding guidelines
- CMS HCPCS LEVEL II Manual coding guidelines

ICD-10 coding

ICD-10 codes must be billed according to the highest level of specificity. In addition, primary diagnosis codes cannot be billed with the following:

- diagnosis of external causes
- manifestation codes
- secondary diagnosis code

continued on the next page

We encourage you to share this information with appropriate members of your staff.

Bill types and revenue codes

If the bill type is not appropriate for the revenue code billed or the revenue code billed is not appropriate for the corresponding HCPCS code billed, the claim may be denied. Bill types and revenue codes should be billed according to the following industry standards:

- CMS standards
- Official UB-04 Data Specifications Manual

More information

Please review the *Partners in Health Update*[SM] article, *Enhanced claim edits to support correct coding principles*, which was posted on the AmeriHealth Provider News Center on June 11, 2018. For further questions about the enhanced claim editing process, review our *Claim edit enhancements: Frequently asked questions (FAQ)*, which can also be found in the Frequently Asked Questions archive on AmeriHealth NaviNet® Plan Central.

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