



April 2, 2013

Dear Provider:

As a requirement of the Affordable Care Act (Title VI, Subtitle F, Section 6507) VPHP is reviewing claims for correct coding as defined by the National Correct Coding Initiative (NCCI). We have partnered with HealthCare Insight (HCI) in order evaluate claims on a post adjudication/pre-payment basis. A list of edits being applied to claims and their general description has been provided in an attachment to this letter.

Effective April 1, 2013 these edits will be evaluated and implemented. This may mean that services that historically were reimbursed will not be in the future. All edits comply with NCCI standards and should be part of your normal billing practices.

If you have any questions or would like any additional information about this program, feel free to reach out to us at (804) 819-5151.

Sincerely,

Dana Rodwell
Director, Cost Containment and Encounters

Virginia Premier Health Plan, Inc.

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EDIT	EOB Short Description	EOB Long Description
ACW	Incorrect anesthesia code	Procedure <code> (<short description>) on line <number> appears to be anesthesia service that has been billed using a surgical procedure code. This service should be billed using an anesthesia code. Procedure <code> (<short description>) is a possible replacement code.
ADD	Add-on code denied as primary code was denied	Procedure <code> (<short description>) on line <number> is an add-on procedure code. Because the primary procedure has been disallowed, the add-on code is also disallowed. (see ClaSeq: <claim number>)
AGE	Inappropriate for age	Procedure <code> (<short description>) on line <number> is inappropriate for the patient's age.
AGM	Routine ante partum services	This Service <code> (<short description>) is denied as routine ante partum care and is not separately reimbursable.
ASM	Does not match surgeon	Procedure <code> (<short description>) on line <number> billed as an assistant surgeon service does not match the procedure code billed on the same date by the provider identified as the primary surgeon. The assistant surgeon should be billing the same procedure codes as the primary surgeon. (see ClaSeq: <claim number>)
ASP	Assistant bill w/o surgeons bill	There is no history of the primary surgeon's bill for the assistant surgeon service on line <number> procedure <code> (<short description>). Reimbursement should be based on the procedure codes billed by the primary surgeon. (See <claim number>. Line <number>)
ASR	Reduction for assistant	The Suggested Paid amount on line <number> for Procedure <code> (<short description>) has been adjusted to reflect reductions for assistant surgeons.
AWP	Anesthesia no surgeon	There is no history of the primary surgeon's bill for the anesthesia services on line <number> procedure <code> (<short description>). Reimbursement should be based on the procedure codes billed by the primary surgeon.
BIL	Bilateral disallowed	Procedure <code> (<short description>) on line <number> is not appropriately billed more than once per day. (see ClaSeq: <claim number>)
COS	Cosmetic procedure	Procedure <code> (<short description>) on line <number> is typically a cosmetic procedure and may not be covered.
CPD	Duplicate services	Procedure <code> (<short description>) typically requires only one provider. Another provider has billed for this service on <claim number>.
CSA	No co-surgeon allowed	Procedure <code> (<short description>) on line <number> typically does not require co-surgeons.
CSR	Reduce, surgical team	The Suggested Paid amount on line <number> for Procedure <code> (<short description>) has been adjusted to reflect reductions for co-surgeons or teams of surgeons.

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DEL	Deleted Code	Procedure <code> <short description> on line <number> is not effective for the date of service billed. Procedure <code> was deleted <deletion date>.
DUP	Duplicate billing	This line is a duplicate of <claim number>.
EFR	Endoscopic Family Reduction	An Endoscopic Family Reduction was applied to line <number>. A reduction of <percentage>% was applied to procedure code <code> (code short description) which represents the value of base procedure code <code> (code short description).
ELG	Patient not eligible	Services on line <number> were provided on a date that is not within the eligibility period on record for the patient.
FOT	Frequency Over Time	Procedure code <code>, <short desc>, on (claseq, line) exceeds the number of services allowed over a given period of time. <number> units are recommended <time period>. The suggested paid amount has been reduced to reflect this recommendation.
FRE	Reimbursable once per day	The occurrence of procedure <code> (<short description>) on line <number> exceeds the number of times the procedure can typically be performed on the same day based on the description of the code or due to physiological or anatomical limitations. <number> units are recommended. The suggested paid amount has been reduced to reflect the recommended number of units.
FUD	Part of global service	Procedure <code> (<short description>) is within days of procedure (<code> (<short description>) on line <number>. This is within the normal global follow-up period for that service. (See <claim number>. Line <number>)
GDR	Antepartum care included in global code	This service <code> (<short description>) was reduced for antepartum services previously reimbursed that are included in the global maternity package. (See <claim number>. Line <number> code <code> (<short description>.)
GEN	Incorrect patient gender	Procedure <code> (<short description>) on line <number> is inappropriate for the patient's gender.
GPA	Part of global service	Procedure <code> (<short description>) listed in <claim number> is within days of procedure <code> (<short description>). The Paid amount for the previously paid line has been subtracted from the Paid for this line. (See <claim number>. Line <number>)
IFR	Multiple radiological procedure reduction	An Imaging Family Reduction was applied to line <number>. A reduction of <percentage>% was applied to procedure code <code> (code short description) which represents the reduced value of the technical component.
INVC	Invalid CPT/HCPCS Code	Procedure <code> <short description> on line <number> is not a valid CPT or HCPCS code.
INVR	Invalid Revenue Code	Revenue <code><short description> on line <number> is not a valid revenue code.

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LIF	Service reported more than typical	Procedure <code> (<short description>) on line <number> has exceeded the number of times the procedure can typically be performed during a patient's lifetime for physiological or anatomical reasons. (See <claim number>. Line <number>)
M52	Modifier 52 reduction	The suggested paid amount on line <number> for procedure <code> (<short description>) has been adjusted to reflect reductions for reduced services as indicated by the presence of modifier 52.
M53	Modifier 53 reduction	The suggested paid amount on line <number> for procedure <code> (<short description>) has been adjusted to reflect reductions for discontinued services as indicated by the presence of modifier 53.
M73	Modifier 73 reduction	The suggested paid amount on line <number> for procedure <code> (<short description>) has been adjusted to reflect reductions for discontinued outpatient services prior to the administration of anesthesia as indicated by the presence of modifier
M74	Modifier 74 reduction	The suggested paid amount on line <number> for procedure <code> (<short description>) has been adjusted to reflect reductions for discontinued outpatient services after the administration of anesthesia as indicated by the presence of modifier
MAT	Part of global service	Procedure <code> (<short description>) for maternity care was reimbursed with global maternity procedure code <code> (<short description>) on claim <claim number> on line <number>. (See <claim number>. Line <number>)
MAX	Exceeds daily limits	Procedure <code> (<short description>) on line <number> is not typically billed more than twice per day.
MEX	Unbundled to <code>	Procedure <code> (<short description>) on line <number> is mutually exclusive to procedure code on line <number>. (See <claim number>. Line <number>)
MNR	Review for Medical Necessity	HCI's Clinical Director has determined procedure <code> (<short description>) on line <number> requires additional clinical review for medical necessity.
MOD	Inappropriate use of modifier 26	The modifier assigned to line <number> is inappropriate for procedure <code> (<short description>).
MPR	Multiple procedure reduction	Procedure <code> (<short description>) on line <number> is a secondary procedure to <code> (<short description>) on line <number> and should have been reduced as multiple procedures were rendered at the same time. The Suggested Allowance reflects this reduction. (See <claim number>. Line <number>)
MTC	Inappropriate use of TC modifier	The technical component modifier assigned to line <number> is inappropriate for Procedure <code> (<short description>).
NCS	Not covered by plan	Services provided on line <number> are not covered by the benefit plan.

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NEV	Never paid event	Procedure <code> (<short description>) has been denied as a never payable event.
NPR	New E&M not allowed	This patient previously received care by this provider. The new patient E&M code on line <number> should be changed to an established patient E&M code. Procedure <code> (<short description>) could be considered as a possible replacement code. (See <claim number>. Line <number>)
NPT	New E&M not allowed	This patient previously received care by this provider. The new patient E&M code on line <number> should be changed to an established patient E&M code. (See <claim number>. Line <number>)
PAY	Payment exceeds billed amount	Procedure<code> (<short description>) on line <number> has an adjusted paid amount that is greater than the amount billed.
PEDM	Procedure to Excluded Diagnosis Mismatch	Procedure <code> (<short description>) on line <number> was billed with diagnosis <code> (<short description>) that does not support reimbursement.
PRDM	Procedure to Required Diagnosis Mismatch	Procedure <code> (<short description>) on line <number> was billed without a diagnosis code(s) that supports reimbursement.
PS	Postpartum services included in the global code	Procedure <code> (<short description>) for postpartum care was reimbursed with global maternity procedure code <code> (<short description>) on claim <claim number> on line <number>. (See <claim number>. Line <number>)
PSU	Documentation needed for processing	Procedure <code> (<short description>) Physician Claim Suspect Provider
RASM	Surgeon and Assistant do not match	Procedure <code> (<short description>) on line <number>. The primary surgeon and the assistant surgeon have not billed using the same procedure code(s) and the surgeons claim is received after the assistant surgeons claim.
RBP	Rebundled to a suggested code	Procedure <code> (<short description>) should be rebundled to procedure code <code> (<short description>), which more accurately represents correct billing for the services provided. Payment amounts allowed for this corrected code represents appropriate reimbursement for the rebundled services.
RD	Duplicate services in same range of codes	Procedure <code> (<short description>) typically requires only one provider. Another provider has billed for this service on line <number>.
REB	Rebundling	Procedure <code> (<short description>) and the procedure(s) on line(s) <number> are rebundled to the correct code <code> (<short description>).
RMEA	Unbundled to <code>	Procedure <code> (<short description>) on line <number> includes the mutually exclusive services of Procedure <code> (<short description>) that were previously submitted and paid. Payment for this service has been reduced by the amount previously paid for the unbundled service.

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RPR	Review Prior to Reimbursement	Recommend review of <code> or <Rev Code> (<short description>) on line <number> to determine if reimbursement is appropriate.
RUPA	Adjustment for reverse unbundled code	Procedure <code> (<short description>) on line <number> includes the unbundled services of Procedure <code> (<short description>) that were previously submitted and paid. Payment for this service has been reduced by the amount previously paid for the unbundled service. (See <claim number>. Line <number>)
SAS	Assistant not allowed	Procedure <code> (<short description>) on line <number> typically does not require a surgical assistant.
TSA	Team surgery not allowed	Procedure <code> (<short description>) on line <number> typically does not require a team of surgeons.
UNB	Unbundled to <code>	Procedure <code> (<short description>) on line <number> is unbundled to procedure <code> (<short description>) on line <number>.
UNL	Unlisted code	Procedure <code> (<short description>) on line <number> is an unlisted procedure code. Medical documentation is required before reimbursement can be made.
UPA	Unreasonable Paid Amount	Procedure <code> <short description> on line <number> has been submitted with a billed charge that exceeds the expected value for this procedure or code and is considered an outlier. Review of billed charge and verification of pricing methodology is required before reimbursement can be considered.

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