

Significant Edits for Total Claims Solution



The Significant Edit listing is based on a review of historical claims data for claims processed in the prior year and is based on CPT/HCPCS codes in effect during that time. The data reflects the edit logic in place at the time the claims were processed.

Significant Edit

A Significant Edit is an edit that, based on experience with submitted claims, will cause, on initial review of submitted claims, the denial or reduction in payment for a particular CPT® code of HCPCS Level II code more than two-hundred and fifty (250) times per year. At this time Total Claims Solution had no significant edits to post. Because edit evolve over time, updates will be posted as needed.

This information is for the sole use of our contracted providers and contains confidential and proprietary information. Any unauthorized review, use, disclosure or distribution is prohibited by the terms of your provider agreement.

Inclusion of a procedure code or edit in the list below does not imply or guarantee coverage. Furthermore, Reimbursement Policies/Edits evolve over time, and we reserve the right to review and update these Reimbursement Policies/Edits periodically.

Stated edits are not a guarantee of benefits. Payments are made according to the covered person's group health plan and Total Claims Solution (TCS) guidelines and or policies, such as, but not limited to utilization/medical review, reimbursement and medical policies. The amount that a group health plan will pay for Covered Services is generally based on the maximum allowable amount. The maximum allowable amount includes deductibles, discounts, co-payments, coinsurance and ineligible amounts. The maximum allowable amount is the lesser of (a) billed charges or (b) the charge listed in any applicable professional fee schedule for that covered service.

Significant Edit Descriptions

Single Code Edits: Denial of payment for certain CPT or HCPCS Level II codes based on the submitted procedure code, diagnosis code and/or Provider Specialty.

Mutually Exclusive: Mutually exclusive procedures are two or more procedures usually not performed during the same patient encounter on the same date of service. Mutually exclusive rules may also govern different procedure code descriptions for the same type of procedure for which the physician should be submitting only one procedure.

Incidental: An Incidental Procedure is performed at the same time as a more complex primary procedure. The incidental procedure does not require significant, additional physician resources and/or is clinically integral to the performance of the primary procedure.

Procedure Unbundling: Procedure unbundling occurs when two or more procedures are used to describe a service when a single, more comprehensive procedure exists that more accurately describes the complete service performed by a Provider. In this instance the two codes may be replaced with the more appropriate code by our bundling system.

Fee Schedule Allowance: The Plan allows for reimbursement of covered medical services up to the fee schedule allowance as determined by the Self Funded ASO Plans. To assist in the determination of the allowable, Total Claims Solution (TCS) contracts with an independent service. This service provides TCS with their database of fee schedule allowance by medical procedure (CPT code) on a bi-annual basis. They obtain the data from various insurance carriers who submit the fees actually submitted for payment by providers. The fees are grouped together by the geographical area (zip code) in which the provider practices and the service is rendered. The providers whose fees are included in the compiled information include, but are not solely based on, specialists with extensive training.

Multiple Surgery: The multiple surgery processing rule is applied when a physician performs separate procedures on the same patient during the same operative session. These separate procedures are not incidental to the primary procedure and are separately payable. Unless Plan specific, the multiple surgery rule is applied as follows: 100% of the fee schedule amount is allowed for the procedure with the highest unit value and 50% of the fee schedule amount is allowed for the second and all subsequent procedures. Add-on Codes listed in Appendix D and Modifier 51 exempt codes listed in Appendix E of the American Medical Association's Current Procedural Terminology (CPT)® book, are exempt from the Multiple Surgery Processing Rule and are allowed at 100% of the fee schedule allowance.

Anesthesia: Anesthesia reimbursement is based off the modifier that is submitted. When modifier QX is billed, the allowance is 25% of the fee schedule allowance, less any discount. When modifier QZ is billed, the allowance is 100% of the fee schedule allowance, less any discount.

Assistant Surgeon: An M.D. Assistant Surgeon is allowable at 20% of the fee schedule allowance, less any discount. A non-Physician Assistant is allowable at 10% of the fee schedule allowance, less any discount.

Modifier 20: Total Claims Solution (TCS) recognizes and considers separate reimbursement of an additional 20% of the fee schedule allowance.

Modifier 22: Total Claims Solution (TCS) recognizes and considers separate reimbursement of an additional 30% of the fee schedule allowance.

Modifier 54: Total Claims Solution (TCS) recognizes and considers 70% of the fee schedule allowance.

Modifier 55: Total Claims Solution (TCS) recognizes and considers 30% of the fee schedule allowance.

Modifier 62: Total Claims Solution (TCS) recognizes and considers 125% of the fee schedule allowance. When billed separately, each physician will receive 50% of the 125% fee schedule allowance.

Modifier 66: Total Claims Solution (TCS) recognizes and considers fee schedule allowance at point of claim based on supporting medical documentation.

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