Zebu ClaimScrub™ Edit Summary

(888) 395-9029 or Fax: (888) 565-1170
609 2nd Street, Suite 2, Portsmouth, OH 45662

Zebu ClaimScrub™ Edit Summary

Overview

ClaimScrub from Zebu Compliance Solutions is a full-service scrubbing solution designed for both pre- and post- service claims validation.

Out of the box, ClaimScrub supports a vast library of edit modules. These modules are organized around specific claim concepts: medical necessity, procedure validation, bundling logic just to name a few. A summary of each edit module, along with the requisite claim fields can be found in this document.

Zebu ClaimScrub™ Edit Summary

Module: *Diagnosis code validation*

Required input elements:

- Date(s) of Service
- Diagnosis or Diagnoses
- ICD Version (ICD-9, ICD-10)

Description:

The diagnosis validation module scrubs for invalid diagnosis codes, taking into account the underlying codeset (e.g. ICD-9/ICD-10) and the date of service.

Scrub edits:

- Diagnosis has never been a valid ICD code
- Diagnosis is truncated and does not adequately identify the condition
- Diagnosis is invalid for the claim date(s) of service
- Diagnosis is missing a required POA indicator (institutional claims)

Zebu ClaimScrub™ Edit Summary

Module: *Procedure code validation*

Required input elements:

- Date(s) of Service
- Procedure(s)

Description:

The procedure validation module scrubs for invalid CPT/HCPCS codes on the date of service.

Scrub edits:

- Procedure code has never been a valid CPT/HCPCS code
- Procedure code is invalid for the claim date(s) of service

Module: *Medical necessity validation*

Required input elements:

- ZIP Code (Medicare) --OR--
- Payer identifier
- Date(s) of service
- Procedure(s)
- Diagnosis or diagnoses
- ICD Version (ICD-9, ICD-10)

Description:

The medical necessity validation module scrubs for any medical necessity issues that may cause the claim to be denied according to the payer's coverage decision. Included are non-covered diagnoses (primary and secondary), frequency restrictions, and contextual coverage. In all cases, the policy name, number, and URL can be included for the user's information.

Scrub edits:

- Procedure not covered for diagnosis according to coverage decision
- Procedure is never covered according to coverage decision
- The associated diagnosis is never covered
- The procedure has an associated textual warning giving more information about the coverage decision
- Procedure has a coverage restriction defined in a permissive edit. Permissive edits define coverage that only applies in certain situations. For example, a physical therapy code may have a coverage decision that only applies to the rendering of the service in the context of vision services.
- Procedure has a frequency restrictions in a coverage decision. Any information about the frequency requirements are also provided.
- Procedure is not covered without secondary diagnosis according to coverage decision. This edit will report when a valid procedure/primary diagnosis relationship is encountered but a secondary diagnosis requirement is not fulfilled.

Module: *Medical necessity validation, continued*

- Override medical necessity, an ABN is on file (-GA modifier). This edit will report when a medical necessity issue as described above has been detected but the claim includes the GA modifier to indicate an ABN has been signed by the patient
- Override medical necessity, an ABN is NOT on file and a denial is expected (-GZ modifier). This edit will report when a medical necessity issue as described above has been detected but the claim includes the GZ modifier to indicate a denial is expected from the payer.
- Override medical necessity based on statutory exclusion (-GX or -GY modifiers).
- Procedure requires at least one associated diagnosis. This edit will report when a procedure has no diagnoses present.

(888) 395-9029 or Fax: (888) 565-1170
609 2nd Street, Suite 2, Portsmouth, OH 45662

Zebu ClaimScrub™ Edit Summary

Module: *Diagnosis usage validation*

Required input elements:

- Diagnosis or diagnoses
- Patient sex
- Patient DOB
- Date(s) of service

Description:

The diagnosis usage validation module scrubs for any potential issues arising from improper coding of the diagnosis code(s). Age and gender guidelines are applied as well as rules such as secondary only diagnoses.

Scrub edits:

- Diagnosis is not typically reported for males/females
- Diagnosis is not typically report for children/non-newborns/adults/maternity
- Diagnosis is secondary only
- Diagnosis is mutually exclusive of another diagnosis
- Diagnosis should be billed with an additional diagnosis code
- Diagnosis is on the POA Exempt list

Module: *Procedure usage validation*

Required input elements:

- CPT/HCPCS code
- Patient sex
- Patient DOB
- Date(s) of service

Description:

The procedure usage validation module scrubs for any potential issues arising from improper coding of the procedure code(s). Age and gender guidelines are applied as well as rules for concepts such as add-on codes, immunization, panels, and more.

Scrub edits:

- Procedure is not typically reported for males/females
- Procedure is not typically report for children/non-newborns/adults/maternity/custom age range
- Procedure is always an add-on code and no appropriate base procedure is present on the claim
- Procedure should not be billed with moderate sedation
- Vaccine product codes must be billed with the appropriate immunization administration code
- Procedure is always bundled and will not be separately reimbursed
- Procedure appears multiple times for the same date of service and no appropriate modifier was found
- Procedure appears multiple times with the same modifier
- Procedure is not valid for Medicare use
- All components of a panel code are present on a claim, indicating the panel code may be more appropriate
- The procedure is a cast application procedure and should be billed with the appropriate supply code (Q4XXX)
- Procedure is conditionally bundled and will not be separately reimbursed when billed with other codes

Module: *Procedure usage validation, continued*

- Procedure is identified as “Incident To Code”and will not be paid with POS indicators 21-23 on professional claims
- Procedure is an immunization administration code and must be billed with an appropriate vaccine product code

Module: *Modifier validation*

Required input elements:

- Date(s) of Service
- Modifier(s)

Description:

The procedure validation module scrubs for invalid CPT/HCPCS modifiers on the date of service.

Scrub edits:

- Modifier has never been a valid CPT/HCPCS modifier
- Modifier is invalid for the claim date(s) of service

ClaimScrub™

Zebu ClaimScrub™ Edit Summary

Module: *Modifier-procedure validation*

Required input elements:

- Insurance Type
- CPT/HCPCS code
- Diagnosis or diagnoses
- Modifier(s)
- Type of bill
- Place of service

Description:

The modifier-procedure validation module scrubs for coding issues associated with incorrect procedure/modifier usage.

Scrub edits:

- Procedure inappropriate for multiple procedure payment (-51)
- Procedure inappropriate for bilateral surgery payment (-50, -RT, -LT)
- Procedure inappropriate for co-surgery (-62)
- Procedure inappropriate for team surgery (-66)
- Procedure inappropriate for assistant-at-surgery
- Procedure inappropriate for surgical care only (-54)
- Procedure inappropriate for postoperative management only (-55)
- Procedure inappropriate for preoperative management only (-56)
- Procedure inappropriate for increased procedural services (-22)
- Procedure inappropriate for professional component (-26)
- Procedure inappropriate for technical component (-TC)
- Procedure inappropriate for E/M modifier
- E/M procedure inappropriate for modifier
- E/M procedure should not be billed with maternity diagnosis
- Chiropractic procedure requires acute therapy modifier (-AT)
- Procedure inappropriate for acute modifier (-AT)
- Procedure inappropriate for Category II modifier
- Therapy procedure missing therapy modifier
- Ambulance procedure missing origin/destination modifier

Module: *Modifier-procedure validation, continued*

- Procedure not on list of CLIA waived tests (-QW)
- Procedure inappropriate for anesthesia modifier
- Anesthesia procedure inappropriate for modifier (-47)
- Procedure not on list of covered abortions (-G7)
- Procedure not on list of diagnostic mammograms (-GG, -GH)
- Procedure not on intensive procedure/device list (-FB, -FC)
- Procedure inappropriate for oxygen modifier
- Procedure inappropriate for modifier -63
- Procedure inappropriate for surgery modifier
- Procedure inappropriate for laboratory modifier
- Procedure inappropriate for medical nutrition modifier (-AE)
- Procedure inappropriate for psychology modifier (-AH)
- Procedure inappropriate for social work modifier (-AJ)
- Procedure inappropriate for blood product modifier (-BL)
- Procedure inappropriate for Automated Multi-Channel Chemistry modifier
- Procedure inappropriate for ESA modifier
- Procedure inappropriate for ESRD ESA modifier
- Procedure inappropriate for telehealth modifier (-GQ, -GT)
- Skin substitute missing required modifier (-JC, -JD)
- Procedure inappropriate for skin substitute modifier (-JC, -JD)
- Procedure inappropriate for modifier -KZ
- Procedure inappropriate for Left Circumflex Coronary Artery modifier (-LC)
- Procedure inappropriate for Left Anterior Descending Coronary Artery modifier (-LD)
- Procedure inappropriate for Right Coronary Artery modifier (-RC)
- Procedure inappropriate for Second Opinion modifier (-SF)
- Procedure inappropriate for Laboratory Round Trip modifier (-LR)
- Procedure inappropriate for modifier -51
- Procedure inappropriate for modifier -AI
- Procedure inappropriate for Enteral Nutrition modifier (-BO)

(888) 395-9029 or Fax: (888) 565-1170
609 2nd Street, Suite 2, Portsmouth, OH 45662

Module: *Modifier-procedure validation, continued*

- Procedure inappropriate for Parenteral/Enteral Nutrition modifier (-BA)
- Procedure inappropriate for Diagnostic ESRD modifier (-CB)
- Procedure inappropriate for DME Competitive Bidding modifier (-J4)
- CLIA Waived test missing required modifier (-QW)
- E/M procedure must be billed with modifier -25 when billed on same date as significant procedure
- Procedure inappropriate for modifier -92
- Procedure inappropriate for modifier -SW
- Procedure inappropriate for modifier -KX
- Procedure inappropriate for laterality modifiers (-LT, -RT)
- Procedure inappropriate for modifier -59 used as CCI override (note that -59 may still be used to indicate multiple instances of the same service performed on the same day)
- E/M Procedure must be billed with modifier -57 when billed on same date as major procedure
- Modifier inappropriate in ASC setting

 (888) 395-9029 or Fax: (888) 565-1170
609 2nd Street, Suite 2, Portsmouth, OH 45662

Module: *CCI validation*

Required input elements:

- CPT/HCPCS code
- Modifier(s)
- Date(s) of service
- Insurance type

Description:

The CCI validation module scrubs for compliance with Correct Coding Initiative component and mutually exclusive rules. In all cases, both the Column 1 (master) and Column 2 (component) codes are returned

Scrub edits:

- CCI component found; override modifier not allowed
- CCI component found, override modifier allowed but not found
- CCI component found, but override modifier allowed and present on claim
- CCI mutually exclusive code found, override modifier not allowed
- CCI mutually exclusive code found, override modifier allowed but not found
- CCI mutually exclusive code found, but modifier allowed and present on claim

Module: *Place of service validation*

Required input elements:

- Place of service
- Date(s) of service

Description:

The place of service validation module scrubs for invalid place of service codes on the date of service.

Scrub edits:

- Place of service has never been a valid place of service code
- Place of service invalid for the claim date(s) of service

Module: *Place of service-procedure validation*

Requires input elements:

- CPT/HCPCS code
- Modifier(s)
- Place of service
- Insurance type
- Type of bill

Description:

The place of service-procedure validation module scrubs for coding issues associated with inappropriate combinations of a CPT/HCPCS code and the place of service code.

Scrub edits:

- Procedure only performed in an outpatient setting
- Procedure is on ASC excluded list (Addendum EE)
- Procedure not typically performed in the facility setting (note: if MPFS indicates the procedure is allowable in the facility setting with modifier -26, this response will reflect that)
- Procedure is not typically performed in a non-facility setting
- Procedure should not be billed in Ambulatory Surgical Center setting (POS 24)
- Procedure should not be billed in Pharmacy setting (POS 01)
- Procedure should not be billed in School setting (POS 03)
- Procedure should not be billed in Homeless Shelter setting (POS 04)
- Procedure should not be billed in Office setting (POS 11)
- Procedure should not be billed in Home setting (POS 12)
- Procedure should not be billed in Assisted Living setting (POS 13)
- Procedure should not be billed in Group Home setting (POS 14)
- Procedure should not be billed in Mobile Unit setting (POS 15)
- Procedure should not be billed in Temporary Lodging setting (POS 16)
- Procedure should not be billed in Retail Health Clinic setting (POS 17)
- Procedure should not be billed in Urgent Care setting (POS 20)

(888) 395-9029 or Fax: (888) 565-1170
609 2nd Street, Suite 2, Portsmouth, OH 45662

Module: *Place of service-procedure validation, continued*

- Procedure should not be billed in Inpatient Hospital setting (POS 21)
- Procedure should not be billed in Outpatient Hospital setting (POS 22)
- Procedure should not be billed in Emergency Room setting (POS 23)
- Procedure should not be billed in Birthing Center setting (POS 25)
- Procedure should not be billed in Miltary setting (POS 26)
- Procedure should not be billed in Skilled Nursing setting (POS 31)
- Procedure should not be billed in Nursing setting (POS 32)
- Procedure should not be billed in Custodial Care setting (POS 33)
- Procedure should not be billed in Hospice setting (POS 34)
- Procedure should not be billed in Land Ambulance setting (POS 41)
- Procedure should not be billed in Air or Water Ambulance setting (POS 42)
- Procedure should not be billed in Independent Clinic setting (POS 49)
- Procedure should not be billed in FQHC setting (POS 50)
- Procedure should not be billed in Inpatient Psychiatric setting (POS 51)
- Procedure should not be billed in Psychiatric Partial Hospitalization setting (POS 52)
- Procedure should not be billed in CMHC setting (POS 53)
- Procedure should not be billed in ICF/MR setting (POS 54)
- Procedure should not be billed in Residential Substance Abuse setting (POS 55)
- Procedure should not be billed in PRTF setting (POS 56)
- Procedure should not be billed in Non-residential Substance abuse setting (POS 57)
- Procedure should not be billed in Mass Immunization setting (POS 60)
- Procedure should not be billed in CIRF setting (POS 61)
- Procedure should not be billed in CORF setting (POS 62)
- Procedure should not be billed in ESRD Treatment setting (POS 65)
- Procedure should not be billed in Public Health Clinic setting (POS 71)
- Procedure should not be billed in Rural Health Clinic setting (POS 72)
- Procedure should not be billed in Independent Laboratory setting (POS 81)
- Procedure should not be billed in Other setting (POS 99)

(888) 395-9029 or Fax: (888) 565-1170
609 2nd Street, Suite 2, Portsmouth, OH 45662

Module: *MUE validation*

Required input elements:

- CPT/HCPCS code(s)
- Modifier(s)
- Date(s) of service
- Insurance type

Description:

The MUE validation module scrubs for compliance with Medically Unlikely Edits ruleset(s). In all cases, the offending CPT/HCPCS and number of service units on the claim are returned.

Scrub edits:

- Service units exceed the maximum allowable - line edit (MAI 1)
- Service units exceed the maximum allowable - absolute date of service edit (MAI 2)
- Service units exceed the maximum allowable - date of service edit (MAI 3)

Module: *National Provider Identifier validation*

Required input elements:

- National Provider Identifier

Description:

The National Provider Identifier module scrubs for invalid or malformed NPI numbers on claims.

Scrub edits:

- NPI is in invalid format
- NPI does not exist

Module: *ZIP Code validation*

Required input elements:

- ZIP Code
- State

Description:

The ZIP code validation module scrubs for invalid ZIP codes or ZIP codes attached to incorrect states.

Scrub edits:

- ZIP code is invalid
- ZIP code is incorrect for provided state

Module: *Modifier combination validation*

Required input elements:

- Modifier(s)

Description:

The modifier combination validation module scrubs for modifiers that should not be present with other modifiers for a given service line.

Scrub edits:

- Invalid modifier combination. Both offending modifiers are returned

Module: *Revenue code validation*

Required input elements:

- Revenue code(s)
- Date(s) of service

Description:

The revenue code validation module scrubs for valid revenue codes.

Scrub edits:

- Invalid revenue code. Offending code is returned

Module: *DRG validation*

Required input elements:

- DRG code
- Date(s) of service

Description:

The revenue code validation module scrubs for valid DRG codes.

Scrub edits:

- Invalid DRG code. Offending code is returned

Module: *National Drug Code validation*

Required input elements:

- National Drug Code
- Date(s) of service
- CPT/HCPCS code(s)

Description:

The National Drug Code validation module scrubs for valid NDC codes and for valid NDC/HCPCS crosswalking.

Scrub edits:

- Invalid NDC. The offending code is returned
- Invalid NDC/HCPCS crosswalk. The offending NDC and HCPCS code are returned

ClaimScrub™

Zebu ClaimScrub™ Edit Summary

Module: *Revenue code/procedure validation*

Required input elements:

- Revenue code
- Date(s) of service
- CPT/HCPCS code(s)

Description:

The revenue code/procedure validation module scrubs for incorrect CPT/HCPCS - revenue code pairings.

Scrub edits:

- Procedure inappropriate for revenue code. The offending revenue code and CPT/HCPCS are returned

Module: *Medicare Code Editor validation*

Required input elements:

- ICD Version (ICD-9, ICD-10)
- CPT/HCPCS code
- Diagnosis or diagnoses
- Date(s) of service
- Patient gender
- Patient DOB

Description:

The Medicare Code Editor validation module scrubs for compliance with guidelines set forth in the Medicare Code Editor manual.

Scrub edits:

- Invalid diagnosis or procedure code
- Diagnosis cannot be billed as principal
- Principal diagnosis is listed multiple times on the claim
- Conflict exists between procedure or diagnosis and patient's age
- Conflict exists between procedure or diagnosis and patient's gender
- Manifestation diagnosis code listed as principal diagnosis
- Diagnosis does not justify admission to acute care hospital
- ICD procedure code is not valid for Medicare
- Bilateral procedures billed must be performed on different joints
- Patient age is greater than 123 or less than 0
- Patient gender is not male or female
- Discharge Status code is not valid
- Procedure has limited coverage under Medicare
- Procedure inconsistent with length of stay

Zebu ClaimScrub™ Edit Summary

Module: *TAR validation*

Required input elements:

- CPT/HCPCS code(s)
- Date(s) of service
- Patient DOB
- Diagnosis or diagnoses

Description:

The TAR validation module scrubs for compliance with California Medicaid (Medi-Cal) requirements for Treatment Authorization Requests (TARs) and Service Authorization Requests (SARs).

Scrub edits:

- Procedure is not a covered benefit
- Procedure requires submission of a Treatment Authorization Request. Notes are returned denoting any additional information that should be submitted on TAR
- Assistant surgeons will not be reimbursed for this service
- Diagnoses should be included on TAR
- TAR required if frequency is exceeded
- TAR is valid for the specified periods (Period value is returned)
- Procedure is covered by Service Authorization Request for the returned Service Code Groupings (SCGs)
- Procedure always requires Service Authorization Request, even if SAR for SCG 51 has been obtained
- Procedure not found under any SCG, SAR is required

ClaimScrub™

Zebu ClaimScrub™ Edit Summary

Module: *Patient history validation*

Required input elements:

- Patient identifier/reference
- Date(s) of service
- Patient DOB
- Insurance information

Description:

The patient history validation module extends the scrub capabilities found in the usage and medical necessity modules by building and maintaining a repository of historical data comprising the medical history of the patient.

Scrub edits:

- Procedure was performed in the global period of a previous procedure. The previous CPT/HCPCS code, the previous date of service, and the global period are returned
- New patient code may be inappropriate, as patient as been seen within three years of service date. The previous CPT/HCPCS and date of service are returned
- Established patient code may be inappropriate, as patient has not been seen within three years of service date.
- Procedure violates frequency restrictions in coverage decision. The frequency requirement, any policy information (names, numbers, URLs) pertinent to the frequency restriction are returned, along with a textual warning that may contain qualifying information pertaining to the frequency requirement
- Procedure must be billed in global period of a previous procedure, but no global period found

Module: *DRG grouper*

Required input elements:

- Diagnosis or Diagnoses
- Present on Admission Indicator
- Discharge status
- Patient gender
- Procedure codes

Description:

The DRG grouper module is a complete MS-DRG grouper.

Scrub edits:

- The resultant DRG assignment will be returned, along with the associated description and relative weight

Module: *APC grouper*

Required input elements:

- CPT/HCPCS code(s)
- Type of bill
- Condition code(s)
- Wage Index
- Unmet deductible
- Sole Community Hospital indicator

Description:

The APC grouper module is a complete APC grouper.

Scrub edits:

- The resultant APC assignment will be returned, along with the relative weight, status indicator, and payment rate.