Payment Policy:
Coding Edit Rules

(Commercial & Medicare)

POLICY NUMBER	REVIEW DATE	APPROVED BY
R20200023	3/8/2024	RPC (Reimbursement Policy Committee)

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY:

ConnectiCare has policies in place that reflect billing or claims payment processes unique to our health plans. Current billing and claims payment policies apply to all our products, unless otherwise noted. ConnectiCare will inform you of new policies or changes in policies through updates to the Provider Manual and/or provider news. The information presented in this policy is accurate and current as of the date of this publication.

The information provided in ConnectiCare's policies is intended to serve only as a general reference resource for services described and is not intended to address every aspect of a reimbursement situation. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to; legislative mandates, physician or other provider contracts, the member's benefit coverage documents and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by ConnectiCare due to programming or other constraints; however, ConnectiCare strives to minimize these variations.

ConnectiCare follows coding edits that are based on industry sources, including, but not limited to; CPT guidelines from the American Medical Association, specialty organizations, and CMS including NCCI and MUE. In coding scenarios where there appears to be conflicts between sources, we will apply the edits we determine are appropriate. ConnectiCare uses industry-standard claims editing software products when making decisions about appropriate claim editing practices. Upon request, we will provide an explanation of how ConnectiCare handles specific coding issues. If appropriate coding/billing guidelines or current reimbursement policies are not followed, ConnectiCare may deny the claim and/or recoup claim payment.

Overview

ConnectiCare utilizes internal and third-party code editing vendors to apply procedure and diagnosis code editing to professional and outpatient facility claims, including ambulance, DMEPOS providers and drugs.

The edits may be sourced to the Centers for Medicare and Medicaid Services (CMS), regional carrier LCDs and Articles, the American Medical Association (AMA) Current Procedural Terminology (CPT®), CPT® Assistant, HCPCS, and ICD-10 publications, the Food and Drug Administration (FDA), National Comprehensive Cancer Network (NCCN), the American Society of Anesthesiology (ASA) manual, and specialty organizations i.e. ACOG, ACR, as well as ConnectiCare Reimbursement Policies.

Health Plan Policies are applied based on ConnectiCare's interpretation of the intent of the use of the procedure code(s). The edits are to ensure accuracy of claims data, to be HIPAA compliant, to address potential Fraud, Waste and Abuse, and to ensure accurate and fair reimbursement for members and providers.

Code editing applies across claims for a member. This includes claims submitted by the same provider in the same provider Tax ID group, or different provider in another group for the same or different date of service depending on the edit.

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Coding Edit Rules
(Commercial & Medicare)

Code Edits:

Claim Type: Facility (F), Professional (P)

Claim Type	Medical Policy	Rule Description	Effective Date
P	Add-on Code Policy	Codes designated as "Add-on" codes are not payable with modifier -51.	2015
F, P	Add-on Code Policy	An add-on code is not payable when the primary code is absent or has been denied for other reasons.	2015
P	Add-on Codes	Identifies claim lines containing an add-on code billed without the presence of the related primary service/procedure.	2015
F, P	Allergy Testing	Limit allergy studies (95004, 95017, 95018, 95024, 95027) to 137 units within one year.	3/1/2023
F, P	Allergy Testing	Limit 95165 (Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens) to 137 units per year when billed by any provider.	3/1/2023
F, P	Ambulance Frequency	This rule recommends the denial of an ambulance claim line when the frequency exceeds than allowed limits for a valid ambulance HCPCS service code reported for the same member on the same date of service from. This rule will evaluate unique ambulance trip frequency, based on an Ambulance Transport code submitted on the same DOS, Same Member, Same PROVIDER ID, same Origin/Destination MODIFIER and on the same claim ID ONLY.	11/1/2020
F, P	Ambulance Modifier Requirements	This rule recommends the denial of ambulance services for the following reasons: - Claim lacks an appropriate origin- destination modifier or modifier QL. - Institutional (facility-based) claim lacks an appropriate arrangement modifier (QM or QN). - Two claim lines for the same date of service lack identical origin-destination and arrangement modifiers. For unique Ambulance trip auditing, this will evaluate Ambulance Transport and mileage codes submitted on the Same Claim ID Only and by the same Provider ID, for same member and on same Date of Service.	11/1/2020
P	Anesthesia Crosswalk - Without Anesthesia procedure code	Identifies claim lines submitted by anesthesiologists for non-anesthesia Procedure Codes that are not eligible to be cross walked to an anesthesia Procedure Code.	2015
P	Anesthesia Crosswalk- To Anesthesia procedure code	Identifies claim lines submitted by anesthesiologists for non-anesthesia services that have a one-to-many relationship with anesthesia services. These services need to be reviewed to determine the appropriate anesthesia Procedure Code.	2015

Payment Policy:
Coding Edit Rules

(Commercial & Medicare)

Claim Type	Medical Policy	Rule Description	Effective Date
P	Anesthesia Policy	Reimbursement and frequency for multiple general anesthesia service codes (00100-01999) billed for the same day is limited to the code with the highest submitted charge amount.	2015
P	Anesthesia Policy	CRNA services billed with modifier QX or QZ are not payable when an anesthesia service performed personally by an anesthesiologist (Modifier AA) has been billed for the same date of service.	2015
P	Anesthesia Policy	An anesthesiologist's claim billed with modifier AA is not payable when a CRNA service billed with modifier QX or QZ has been previously paid for the same date of service.	2015
F, P	Anesthesia Policy	Anesthesia and moderate sedation services (00300, 00400, 00600, 01935-01936, 01991-01992, 99152-99153, 99156-99157) when billed with pain management services, are payable only when billed and a surgical procedure (CPT 10021-69990) has been billed by any provider for a patient age 18 or older.	2015
P	Anesthesia Policy	Anesthesia services (00100-01999) billed by a CRNA without the appropriate CRNA modifier (QX, or QZ) are not payable.	2015
P	Anesthesia Policy	Anesthesiologist's claims billed without medical supervision/direction modifiers are not payable if a CRNA claim with medical direction exists.	2015
P	Anesthesia Policy	Surgical codes billed by anesthesiologists or CRNAs are not payable unless crosswalk the surgical procedure code to the anesthesia service code. Exception: Surgery codes listed in the ASA Manual.	2015
P	Anesthesia Policy	CPT 00100-01999 (Anesthesia services) are not payable if billed without an appropriate modifier.	2015
F, P	Anesthesia Policy	Daily hospital management of epidural or subarachnoid continuous drug administration (01996) is not payable when billed with anesthesia qualifying circumstance codes (99100-99140) and billed without an anesthesia procedure code (00100-01992, 01999).	2015
F, P	Anesthesia Policy	Daily hospital management of epidural or subarachnoid continuous drug administration (01996) is not payable when billed with physical status modifiers P1-P6.	2015
F, P	Assistant Surgeon-Modifiers 80 81, 82, AS	Identifies claim lines containing procedure codes billed with an assistant surgeon modifier that typically do not require an assistant surgeon according to the Centers for Medicare and Medicaid Services (CMS). Assistant surgeon modifiers may be appropriately appended to a variety of surgical procedures that require aid in prepping and draping the patient, maintaining visualization, keeping the wound clear of blood, holding and positioning the patient or the body parts, assisting with wound closure, and dressing and/or casting, as required. In some surgical settings, the additional assistance does not require the surgical expertise of a surgeon; a surgical assistant such as a qualified nurse, orthopedic technician, or resident physician may be the service provider. This rule provides the CMS values for the payment	2018

Claim Type	Medical Policy	Rule Description	Effective Date
		allowances of an Assistant at Surgery according to the Medicare Physician Fee Schedule.	
P	Assistant Surgeon Policy	CPT 59510 (Global obstetrical care, Cesarean delivery) is not payable when billed with an assistant surgeon modifier.	2015
P	Assistant Surgeon Policy	CPT 59618 (Global obstetrical care, Cesarean delivery, following failed VBAC) is not payable when billed with an assistant surgeon modifier.	2015
P	Assistant Surgeon Policy	CPT 59622 (Cesarean delivery only, following failed VBAC, including postpartum care) is not payable when billed with an assistant surgeon modifier.	2015
P	Assistant Surgeon Policy	CPT 59515 (Cesarean delivery only, including postpartum care) is not payable when billed with an assistant surgeon modifier.	2015
F, P	Assistant Surgeon Policy	Only one assistant surgeon is allowed for a surgical procedure.	2015
P	Assistant Surgeon Policy	Midlevel providers billing with modifier -AS as assistants at surgery may be allowed based on whether the procedure allows an assistant. Midlevel providers billing with modifiers 80,81 or 82 are not payable.	2015
P	Assistant Surgeon Policy	Primary surgeons that also bill for assistant surgeon under the same provider ID are not payable.	2015
P	Assistant Surgeon Policy	Assistant surgeon services are payable only when the code allows an assistant in accordance with CMS.	2015
P	Assistant Surgeon Policy	Clinical documentation is required for Assistant surgeon services in accordance with CMS.	2015
P	Assistant Surgeon Policy	Procedure codes billed as assistant surgeon are not payable when the codes are designated as codes to which the concept of Assistant Surgeon Does Not Apply. (CMS)	2015
P	Assistant Surgeon Policy	In accordance with AMA, a procedure code is not payable when billed with modifier 80, 81, 82, or AS (Assistant Surgeon) when the same procedure code has not been billed without modifier 80, 81, 82, or AS (Primary Surgeon) by a different Provider ID.	4/15/2024
P	Bariatric Surgery Policy	Hiatal hernia repair CPT codes 43280, 43281, 43282, 43289, 43499 or 43659, when reported with bariatric surgery code ranges 43770–43775 and 43842–43848, 43644, 43645, 43886, 43887 or 43888, will deny as incidental/inclusive procedures. Modifier 59 will not override these codes as hiatal hernia repair is considered an integral part of bariatric surgery, in accordance with CMS guidelines.	4/15/2024

Claim Type	Medical Policy	Rule Description	Effective Date
P	Base Code Quantity Limit	Identifies claim lines where a provider is billing a primary service/procedure with a quantity greater than one, rather than billing the appropriate add-on ("each additional") code(s).	2015
P	Bilateral Procedures-Modifiers 50, RT, LT	Identifies claim lines where the procedure code is submitted with modifier 50 and the line quantity is greater than 1. Procedures billed with modifier 50 indicate a bilateral procedure and a line quantity greater than one is not allowed. This rule identifies specific bilateral procedures (conditionally bilateral and independently bilateral) that should not be billed with a quantity greater than 1 and modifies the line quantity to equal 1. This rule identifies only specific bilateral procedures from the CMS Conditional or Independent bilateral procedure code lists that are submitted with modifier 50 with a line quantity (units of service) greater than 1. CMS Bilateral Indicators: • Codes with Bilateral Indicator **0**: Bilateral surgery rules do not apply to codes with a status indicator 0. These codes should not be billed with modifiers 50, LT or RT. • Codes with Bilateral Indicator **1**: If the same code is reported once with modifier RT and once with modifier LT this is not allowed. Instead, the code should be reported with modifier 50 for 1 unit. The 150% payment adjustment will apply. • Codes with Bilateral indicator **2:** These codes should not be billed with modifier 50 as these codes are already established as being performed bilaterally. These codes should be billed with no more than 1 unit of service. • Codes with Bilateral Indicator **3**: These codes should be reported with the appropriate anatomical LT or RT modifier, with one unit of service for each. • Codes with Bilateral Indicator **9**: Bilateral surgery concept does not apply. These procedure codes should not be billed with modifiers 50, LT or RT (e.g., xxxxx, billed with 1 unit). The rule modifies the line quantity to equal 1. Modifying the line quantity to the correct quantity of 1 provides a timely and accurate claim resolution. The CMS edit returns the claim to the provider without modifying the line quantity. The source for this edit is the CMS Integrated Outpatient Code Editor(I/OCE).	2015
F, P	Bilateral Procedures Policy	Bilateral procedures are payable when billed in accordance with the CMS Physician RVU file Bilateral designation.	2015

Payment Policy:
Coding Edit Rules

(Commercial & Medicare)

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F, P	Bundled Ambulance Services	This rule recommends the denial of any claim lines with a procedure code other than a valid ambulance HCPCS service or mileage code reported along with a valid ambulance HCPCS procedure code for the same beneficiary, same date of service, by the same provider and on Same Claim Only.	11/1/2020
P	Bundled Services	Identifies claim lines containing Procedure Codes indicated by Centers for Medicare and Medicaid Services (CMS), Medicare Regional Carriers, and ConnectiCare as always bundled when billed with any other procedure. *Separate reimbursement is not allowed.*	2015
P	Bundled Services Policy	Codes with a status indicator T are not payable when other payable services (CMS) are billed on the same day.	2015
P	Bundled Services Policy	Bundled services (Status indicator P) are not payable when billed with other payable services on the same day.	2015
P	Bundled Services Policy	Bundled services for which payment is always routinely bundled into other services and supplies are not payable.	2015
P	Bundles Services Policy	As per the April 2021 AMA CPT Assistant for breast reconstruction revision, if CPT code 19380 is reported, no other codes should be reported for work related to the breast envelope (ie, scar revision, mastopexy, liposuction, capsule modification, etc.). Exchanging an implant (CPT code 19342) or autologous fat-grafting for increased volume or contouring (CPT codes 15571, 15772) may be reported separately.	4/01/2021
P	Cardiology Policy	CPT 93042 (Rhythm ECG, 1-3 leads; interpretation and report only) should be reported only when performed as a separate, distinct test for the evaluation of symptoms or signs suggesting an arrhythmia, not when the service represents as a review of telemetry rhythm strips as part of the overall evaluation and management of the patient. A complete separate written and signed report must be included in the patient's medical records documenting the results and medical necessity of the testing.	2015
P	Cardiology Policy	A complete transthoracic echocardiography is not payable when the same complete echocardiography has been billed within six months with the same diagnosis.	2015
P	Cardiology Policy	CPT 93224-93227 or 0295T-0298T (Ambulatory [ECG]) are not payable when billed more than twice in a six-month period.	Terminated 2/25/2021
P	Cardiology Policy	CPT 93260-93261, 93282-93284, 93289 or 93292 (Programming/interrogation device evaluation [in person] defibrillator system) are not payable when billed greater than once in a three-month period for a diagnosis indicating the presence of an automatic (implantable) cardiac defibrillator.	2015
P	Cardiology Policy	CPT 93922-93931 (Arterial studies) are not payable when billed with 93970-93971 (Venous studies) and a supporting diagnosis for the arterial study is not present.	2015

Claim Type	Medical Policy	Rule Description	Effective Date
P	Cardiology Policy	CPT 93970-93971 (Venous studies) are not payable when billed with 93922-93931 (Arterial studies) and a supporting diagnosis for the venous study is not present.	2015
F, P	Cardiology Policy	External mobile cardiovascular telemetry [MCT](CPT codes 93228-93229) or external patient activated ECG event recording (CPT codes 93268-93272) are not payable when billed more than once in a six month period by any provider.	1/01/2018 *Terminated effective 3/26/2023*
P	Chemistry Lab Unbundled Policy	Unbundled individual components of a disease-oriented or chemistry panel are not payable when submitted for the same date of service by the same provider. Provider must bill the appropriate comprehensive panel or automated multichannel test code that includes the multiple test components.	1/01/2022
P	CMS Coverage Policies	Physician voluntary reporting program codes are not reimbursable with greater than $0.00.	2015
P	CMS Coverage Policies	HCPCS V2787 or V2788 are not payable.	2015
P	CMS Coverage Policies	HCPCS R0070 or R0075 (Transportation of portable x-ray equipment) is not payable when the accompanying radiological service has not been billed or paid for the same date of service by the same or different provider.	2015
P	CMS Coverage Policies	Performance measurement code with status indicator M are not payable >0.00 based on CMS designation.	2015
P	CMS Coverage Policies	Chiropractic manipulation (98940-98942) is not payable when billed without a primary diagnosis of subluxation and a secondary diagnosis for the symptoms associated with the diagnosis of subluxation is not present.	2015
P	CMS Coverage Policies	Chiropractic manipulation (98940-98942) is not payable when billed without modifier AT.	2015
F, P	CMS Coverage Policies	HCPCS G0372 (Physician service required to establish and document the need for a power mobility device) is not payable when billed and a face-to-face Evaluation and Management service has not been billed and paid on the same claim for the same date of service.	2015
P	CMS Coverage Policies	G0438 (Annual wellness visit; initial visit) is not payable when billed more than once in a patient's lifetime.	2015
F, P	CMS Coverage Policies	Injection, heparin sodium, [heparin lock flush], per 10 units (HCPCS code J1642) is not payable.	3/15/2023
P	CMS Coverage Policies	Injection, heparin sodium, [heparin lock flush], per 10 units (HCPCS code J1642) is not payable.	3/15/2023
P	CMS Coverage Policies	Major surgical procedures are not payable when billed by a non-physician practitioner (NPP) and modifier 80, 81, 82 or AS is not appended to the claim line.	2015
P	CMS National Coverage Determinations (NCD) Policy	CPT 82270 or G0328 (Colorectal cancer screening by fecal occult blood test) are not payable when billed by any provider more than once per year.	2015

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	CMS National Coverage Determinations (NCD) Policy	CPT 93784 (Ambulatory blood pressure monitoring) when billed with a diagnosis of elevated blood pressure reading, without diagnosis of hypertension is not payable.	2015
P	CMS National Coverage Determinations (NCD) Policy	HCPCS G0105 (Screening colonoscopy for high risk), or G0120 (Barium enema high-risk alternative to G0105 screening colonoscopy) is not payable when billed by any provider more than once every two years.	2015
P	CMS National Coverage Determinations (NCD) Policy	HCPCS G0121 (Screening colonoscopy for non-high risk) is not payable when billed by any provider more than once every 10 years, unless G0104 (Colorectal cancer screening; sigmoidoscopy) has been billed and paid in the previous four years.	2015
P	CMS National Coverage Determinations (NCD) Policy	HCPCS G0104 (Screening sigmoidoscopy), or G0106 (Colorectal cancer screening; barium enema) are not payable when billed by any provider more than once every four years.	2015
F, P	CMS National Coverage Determinations (NCD) Policy	Bone density services are not payable when billed more than once every two years by any provider.	2015
P	CMS National Coverage Determinations (NCD) Policy	CPT 83036 is not payable when billed by any provider more than once per month and the diagnosis is diabetes mellitus in pregnant women.	2015
P	CMS National Coverage Determinations (NCD) Policy	CPT 82728 (Ferritin) is not payable when the diagnosis is end-stage renal disease and 82728 has been billed more than once in a 90-day period by any provider for the same diagnosis.	2015
F, P	CMS National Coverage Determinations (NCD) Policy	HCPCS G0249 or G0250 (Home prothrombin time [INR] monitoring) are not payable when billed by any provider more than once every 25 days.	2015
P	CMS National Coverage Determinations (NCD) Policy	As per CMS, CPT 99183 (Hyperbaric oxygen therapy) or G0277 (Hyperbaric oxygen under pressure, full body chamber, per 30-minute interval) are not payable when submitted without a requisite diagnosis.	2015
P	CMS National Coverage Determinations (NCD) Policy	HCPCS G0166 is not payable when greater than 35 units have been billed within a two-month period.	2015
P	CMS National Coverage Determinations (NCD) Policy	HCPCS G0102 or G0103 are not payable when billed more than once every 11 months.	2015
P	CMS National Coverage Determinations (NCD) Policy	HCPCS E0650-E0651, or E0655-E0673 (Pneumatic compressor/appliance device) are not payable when billed without a required diagnosis.	2015

Payment Policy:
Coding Edit Rules

(Commercial & Medicare)

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F, P	CMS National Coverage Determinations (NCD) Policy	Knee arthroscopy (surgical) is not payable when billed with a primary diagnosis of osteoarthritis of the knee.	2015
F, P	CMS National Coverage Determinations (NCD) Policy	Ambulatory EEG (95950 or 95953) are not payable when billed and a resting EEG (95812-95824) has not been billed by any provider on the same date of service or in the previous year.	2015
P	CMS National Coverage Determinations (NCD) Policy	HCPCS J0881, J0885 or Q5106 are not payable when billed with modifier EB.	2015
F, P	CMS National Coverage Determinations (NCD) Policy	J0881, J0885 or J0888 are not payable when billed with modifier EC and the diagnosis associated to the claim line is not approved for ESA treatment.	2015
F, P	CMS National Coverage Determinations (NCD) Policy	J0881, J0885 or J0888 are required to be billed with modifier EA, EB or EC as applicable.	2015
F, P	CMS National Coverage Determinations (NCD) Policy	CPT 93025 (Microvolt T-wave alternans for assessment of ventricular arrhythmias) is not payable when billed without a covered diagnosis.	2015
P	CMS National Coverage Determinations (NCD) Policy	G0297 (Low dose CT scan (LDCT) for lung cancer screening) is not payable when billed by any provider more frequently than once per year.	Terminated 12/31/2020
P	CMS National Coverage Determinations (NCD) Policy	CPT 88230-88291 (Cytogenetic studies) are not payable when billed without an approved diagnosis on the claim.	2015
P	CMS Status Indicators	Identifies claim lines containing procedure codes with a status indicator of C, I, M, N, P, R as defined by CMS on the Medicare Physician Fee Schedule. According to the Medicare Physician Fee Schedule, status codes indicate whether the code is in the fee schedule and if it is separately payable when the service is covered. This rule identifies codes subject to a payment review or denial according to their assigned status code defined by CMS.	2016
P	CMS Status Indicators	According to the Medicare Physician Fee Schedule, codes with a status indicator of I are defined as "not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services." These codes are not covered and are non-reimbursable.	2016

Claim Type	Medical Policy	Rule Description	Effective Date
P	CMS Unbundled Pair	Identifies claim lines containing Procedure Codes that are typically not recommended for reimbursement when submitted with certain other Procedure Codes on the same date of service. Provider matching will be based on TIN and Specialty. Modifier override will include both the deny line and support line. This includes Incidental, Mutually Exclusive, Ultimate Parent Rebundling, and Visit codes that are not separately payable. The sources of this edit are the AMA CPT code guidelines, and/or CMS NCCI Policy Manual, and/or CMS Claims Processing Manual. Examples of incidental services are: • CPT 36415 Venipuncture when also billing for laboratory procedure codes. • CPT 81002 Urinalysis dipstick with an Evaluation and Management code unless appended with modifier 25	10/01/2021 *Replaces Unbundled Services-Professional*
P	Co-Surgeon Modifier 62	Identifies claim lines containing procedure codes billed with the co-surgery modifier that typically do not require co-surgeons according to the Centers for Medicare and Medicaid Services (CMS). The co-surgery modifier might be appropriately appended to a variety of surgical procedures that might require co-surgeons for the successful performance of the procedure. This rule provides the CMS values and criteria for the payment allowances of co-surgeons according to the Medicare Physician Fee Schedule (MPFSDB).	2015
P	Co-Surgeon Policy	Procedures designated as co-surgeons allowed and billed with modifier 62 will not be allowed when there exists a previously processed claim for the same procedure code by a different provider without modifier 62 (CMS).	2015
P	Co-Surgeon Policy	Procedures billed with modifier 62 are not payable when designated as co-surgeons not allowed. (CMS)	2015
P	Co-Surgeon Policy	Procedures billed with modifier 62 are not payable without clinical documentation supporting the need for co-surgeons, when designated as co-surgeons payment restriction may apply. (CMS)	2015
P	Co-Surgeon Policy	Procedures designated as co-surgeons allowed are not payable when billed without modifier 62 and there exists a previously processed claim for the same procedure code with modifier 62 by a different provider (CMS).	2015
P	Co-Surgeon Policy	Co-surgeon procedures are not payable when both surgeons have the same subspecialty for procedures designated as co-surgeons are allowed. (CMS)	2015

Payment Policy:
Coding Edit Rules

(Commercial & Medicare)

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P	Continuous Intraoperative Neurophysiology Monitoring (IONM)	Continuous intraoperative neurophysiology monitoring in the operating room (CPT code 95940) is not payable when continuous intraoperative neurophysiology monitoring from outside the operating room (HCPCS code G0453 or CPT code 95940) is reported on the same day by the same provider.	3/01/2022
P	CPAP and BIPAP Services	Identifies supply codes associated with the Continuous Positive Airway Pressure or Bi- level Positive Airway Pressure (CPAP/BIPAP) therapy that are being submitted at a rate that exceeds the usual or customary rate. This rule will also identify those supply codes submitted without modifier –KX (Requirements specified in the medical policy have been met).	2016
F	CPT Not Covered-Facility Claims	Identifies claim lines containing Integrated Outpatient Code Editor (I/OCE) Outpatient Prospective Payment System (OPPS) E Status procedure codes that are not a covered item, code or service. The Centers for Medicare and Medicaid Services (CMS) OPPS has established guidelines for items, codes, and services not paid under OPPS or any other Medicare payment system. The procedure codes classified as not covered are identified with a payment status indicator of E. This rule recommends the denial of claim lines containing procedure codes with an OPPS status indicator of E. This rule audits facility claims.	2016
F, P	Deleted HCPCS Codes Policy	Deleted HCPCS codes will be denied as obsolete.	2015
P	Device and Supply Policy	Imaging agents are not payable when billed without the requisite imaging procedures as defined by Regional CMS guidelines.	2015
P	Device and Supply Policy	Imaging agents are not payable when billed without the requisite imaging procedures as defined by National CMS guidelines.	2015
F, P	Diagnosis Code Guideline Policy	ICD-10 Diagnosis codes are required to be reported in accordance with ICD-10 coding guidelines in the ICD-10 manual and CMS and NGS Medicare. • Code must be valid for the date of service • Code to the highest specificity • Manifestation or secondary diagnoses codes cannot be the only code on the claim. • Encounter diagnoses codes for chemo or immunotherapy administration procedures must be reported with a primary diagnosis for which the treatment is needed.	2015
P	Diagnosis Code Guideline Policy	Claim lines reported with mutually exclusive code combinations according to the ICD-10-CM Excludes 1 Notes guideline policy are not payable.	5/25/2021 *Will apply to preventative services effective 9/15/2023*
P	Diagnosis Code Guideline Policy	When a diagnosis code is billed and it indicates laterality (Right/Left), and the procedure/modifier code is conflicting, the service is not payable.	5/25/2021

Payment Policy:
Coding Edit Rules

(Commercial & Medicare)

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P	Diagnosis Code Guideline Policy	Any procedure or service received with a ICD-10-CM sequela (7th character "S") code billed in the primary, first listed or principal diagnosis position is not payable.	5/25/2021
P	Diagnosis Code Guideline Policy	Any procedure or service received with a ICD-10-CM sequela (7th character "S") code billed as the only diagnosis on the claim is not payable.	5/25/2021
F, P	Diagnosis Code Guideline Policy	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.	8/31/2021
F, P	Diagnosis Code Guideline Policy	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.	8/31/2021
P	Diagnosis Code Guideline Policy	When a diagnosis code is available to specify whether the condition occurs on the Right, Left or Bilateral, it is not appropriate to report an unspecified code for the same condition.	1/01/2018
F, P	Diagnosis Procedure Policy	When a diagnosis code indicates laterality, specifying that the condition occurs on both the left and right and the more specific bilateral code is available, it is not appropriate to report both the left and right code.	1/01/2018
F, P	Diagnosis Procedure Policy	Other peripheral nerve injection (CPT code 64450) is not payable when used for the treatment of multiple neuropathies or peripheral neuropathies caused by underlying systemic diseases.	1/01/2018 *Terminated for Medicare 9/24/2023*
F, P	Diagnosis-Age Policy	Procedures are not payable when the diagnosis and age do not match (except maternity diagnoses).	2015
F, P	Diagnosis-Age Policy	Services reported with a maternity diagnosis are not payable when the member is less than nine years of age or 65 years of age or older.	2015
F, P	Diagnosis Specificity Policy	Claims submitted with diagnosis codes that are not in the full ICD-10 code format are not payable.	1/01/2022
P	DME Rental Maximum	Denies claim lines submitted for the rental of a DME item in which the rental payment for the DME item exceeds the maximum number of rental payments as defined by CMS. Each DME item has a number of rental payments permitted as defined by the DME fee schedule payment guidelines. The rule looks for the presence of rental modifier -RR on both the current and support claim lines.	11/1/2020

Claim Type	Medical Policy	Rule Description	Effective Date
P	DME-Owned	Denies a current claim line for a DME item that has been submitted with an ownership modifier, when the same DME item has been previously paid in history with another or the same ownership modifier. Ownership modifiers are -NU (New), -NR (New when rented), and -UE (Used). They indicate that the DME is paid for in one lump sum (paid for in total, in one payment). The rule looks for the DME item and the presence of ownership modifiers -NU, -NR, or -UE on the current claim and the support claim line.	11/1/2020
P	DME-Owned, Rental not allowed	Denies claim lines submitted for the rental of a DME item when the same DME item is beneficiary owned in history. It is unexpected that a previously owned DME would be rented. A previously submitted paid claim for the same DME indicates that it was beneficiary owned and it is likely that one lump-sum payment or a rental with subsequent purchase has already been made for the DME. The current claim line looks for the presence of rental modifier - RR. The support claim lines look for the presence of ownership modifiers -NU, -UE, and -NR. Modifier Descriptions: -RR – Rental -NU – New Equipment (Indicates Ownership) -NR – New when Rented, subsequently purchased (Indicates Ownership) -UE – Used (Indicates Ownership)	11/1/2020
P	DME Rentals	Capped rentals are not payable when billed without modifier KH, KI, or KJ.	11/16/2021
F, P	Drug and Biological Policy	Consistent with Centers for Medicare & Medicaid Services' (CMS) Internet Only Manual 100-04, Chapter 17, Section 40–Drug Label Guidelines; drug and biological codes dispensed in single use vials/packaging when billed with modifier JW (Drug amount discarded/not administered to any patient) and the billed units equal or exceed the package insert/prescribing information units will be denied. Example: (Based on CMS Policy and the FDA-approved package insert/prescribing information) • Adenosine (J0153) is supplied in 60 mg and 90 mg single-dose vials. It is expected that a provider will use a combination of vial sizes that eliminates or minimizes drug wastage. The billed drug code will be denied when submitted with a modifier indicating the drug was discarded (JW) and the units equaled or exceeded 60.	1/01/2023
F, P	Drug and Biological Policy	J2505, Q5108, Q5111, or Q5120 are not payable when billed by any provider less than 10 days prior to the administration of a cytotoxic chemotherapy drug.	2015

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Drug and Biological Policy	J1442, Q5101, or Q5110 are not payable when billed by any provider on the same date of service as a cytotoxic chemotherapy drug.	2015
P	Drug and Biological Policy	Q0138 and Q0139 are not payable when billed with a diagnosis of anemia in chronic kidney disease and a diagnosis of end stage renal disease is not present.	2015
P	Drug and Biological Policy	HCPCS J9217 (Leuprolide acetate (for depot suspension)) is not payable when billed by any provider more than one visit per month by any provider and the diagnosis on the claim is amenorrhea induction prior to bone marrow transplant, breast cancer, central precocious puberty, ovarian cancer/fallopian tube cancer/primary peritoneal cancer, prostate cancer, salivary gland tumor, or stuttering priapism.	2015
F, P	Drug and Biological Policy	HCPCS J0585 is not payable when billed and the diagnosis is facial wrinkles.	2015
P	Drug and Biological Policy	CPT 20610 or 20611 (Arthrocentesis, aspiration and/or injection; major joint) are not payable when billed with J7318, J7320-J7329, J7331, J7332, or J7333 and the diagnosis on the claim is not osteoarthritis of the knee or shoulder.	2015
F, P	Drug and Biological Policy	HPCPS J1756 is not payable when an FDA-approved indication or an approved off-labeled indication is not present on the claim.	2015
F, P	Drug and Biological Policy	Rituximab J9312, Q5115, or Q5119 is not payable when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.	2015
F, P	Drug and Biological Policy	HCPCS J0881 (darbepoetin alfa) is not payable when billed and a diagnosis for anemia in chronic kidney disease is present and a diagnosis for chronic kidney disease is not also present.	2015
F, P	Drug and Biological Policy	HCPCS J1442, Q5101, or Q5110 (filgrastim) is not payable when billed with a neoplasm diagnosis and a claim for either a chemotherapy administration (96401-96450, 96542, 96549 or G0498) or a chemotherapy drug has not been billed in the previous 18 days by any provider.	Terminated 3/30/2021
F, P	Drug and Biological Policy	HCPCS J7318, J7320-J7329, J7331, J7332, or J7333 are not payable when billed without 20610 or 20611 (Arthrocentesis, aspiration and/or injection, major joint or bursa) for the same date of service.	2015
P	Drug and Biological Policy	HCPCS J2357 is limited to 75 combined units per date of service by any provider when the diagnosis on the claim is moderate to severe persistent asthma.	2015
P	Drug and Biological Policy	HCPCS J9219 is not payable when billed more than once within a 12-month period by any provider.	2015

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Drug and Biological Policy	HCPCS J9171 (docetaxel) is not payable when billed by any provider more than one visit every three weeks and the diagnosis on the claim is angiosarcoma, breast cancer, Ewing's sarcoma, head and neck cancer, melanoma, non-small cell lung cancer, occult primary, osteosarcoma, ovarian cancer/fallopian tube cancer/primary peritoneal cancer, rhabdomyosarcoma, small cell lung cancer, soft tissue sarcoma (extremity/superficial trunk, head/neck) (retroperitoneal/intra-abdominal), or uterine sarcoma.	2015
F, P	Drug and Biological Policy	Intravenous infusion (96365-96372, 96377, or 96379) are not payable when billed with J2469 and no other drug administered by non-chemotherapy administration services has been billed for the same date of service by any provider.	2015
F, P	Drug and Biological Policy	HCPCS J2469 (palonosetron) is limited to 60 combined units per date of service by any provider and the patient is less than 17 years of age and the diagnosis on the claim is chemotherapy-induced nausea and vomiting.	Terminated 3/30/2021
F, P	Drug and Biological Policy	HCPCS J2469 (palonosetron) is not payable when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.	Terminated 3/30/2021
F, P	Drug and Biological Policy	HCPCS J9171 (docetaxel) is not payable when billed without an FDA approved indication or an approved off-labeled indication.	2015
P	Drug and Biological Policy	HCPCS J9219 (Leuprolide acetate implant) is not payable when an FDA approved indication or an approved off-labeled indication is not present on the claim.	2015
P	Drug and Biological Policy	HCPCS J9219 (Leuprolide acetate implant) is not payable when billed and the patient is less than 18 years of age.	2015
P	Drug and Biological Policy	HCPCS J9219 (Leuprolide acetate implant) is not payable when billed and the patient's gender is not male.	2015 *Terminated 8/01/2021*
P	Drug and Biological Policy	HCPCS J9219 (Leuprolide acetate implant) is not payable when billed and 11981 (Insertion, non-biodegradable drug delivery implant) or 11983 (Removal and reinsertion of non-biodegradable drug delivery implant) has not been billed for the same date of service or in the previous two weeks by any provider.	2015
F, P	Drug and Biological Policy	HCPCS J9264 (paclitaxel) is not payable when billed and an FDA-approved indication or an approved off-labeled indication is not present on the claim.	2015
P	Drug and Biological Policy	HCPCS J9217 (Leuprolide acetate (for depot suspension)) is not payable when billed and the patient's gender is female and the diagnosis on the claim is other than amenorrhea induction prior to bone marrow transplant, breast cancer, central precocious puberty, ovarian/cancer/fallopian tube cancer/primary peritoneal cancer, or salivary gland tumor.	2015 *Terminated 8/01/2021*
P	Drug and Biological Policy	HCPCS J9218 is not payable when an FDA-approved indication or an approved off-labeled indication is not present on the claim.	2015

Claim Type	Medical Policy	Rule Description	Effective Date
P	Drug and Biological Policy	HCPCS J1950 is not payable when billed and the patient's gender is male and the diagnosis is on the claim is other than benign prostatic hyperplasia, breast cancer, central precocious puberty, prostate cancer, or stuttering priapism.	2015 *Terminated 8/01/2021*
P	Drug and Biological Policy	HCPCS J1950 is not payable when billed and the patient is greater than 12 years of age, and the patient's gender is male, and the diagnosis on the claim is central precocious puberty.	2015 *Terminated 8/01/2021*
P	Drug and Biological Policy	HCPCS J1950 is not payable when the patient is greater than 11 years of age, and the patient's gender is female, and the diagnosis on the claim is central precocious puberty.	2015 *Terminated 8/01/2021*
P	Drug and Biological Policy	HCPCS J1950 (leuprolide acetate (for depot suspension)) is not payable when billed by any provider for more than one visit per month by any provider and the diagnosis on the claim is amenorrhea induction prior to bone marrow transplant, benign prostatic hyperplasia, breast cancer, central precocious puberty, endometriosis, ovarian cancer/fallopian tube cancer/primary peritoneal cancer, premenstrual syndrome, prostate cancer, stuttering priapism, or uterine leiomyomata.	2015
P	Drug and Biological Policy	HCPCS J1950 (leuprolide acetate (for depot suspension)) is not payable when billed without an FDA approved indication or an approved off-labeled indication.	2015
F, P	Drug and Biological Policy	HCPCS J9267 (Paclitaxel) is not payable when billed and the patient is less than 18 years of age and an FDA approved or an approved off-labeled indication is present.	2015
F, P	Drug and Biological Policy	HCPCS J9267 (Paclitaxel) is not payable when billed and an FDA-approved indication or an approved off-labeled indication is not present on the claim.	2015
P	Drug and Biological Policy	HCPCS J9217 (leuprolide acetate) is not payable when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.	2015
F, P	Drug and Biological Policy	HCPCS J9304 or J9305 are limited to 156 combined units per date of service by any provider when the diagnosis on the claim is bladder cancer, breast cancer, or urothelial carcinoma of the prostate.	2015
F, P	Drug and Biological Policy	HCPCS J2469 is not payable when billed for more than 10 combined units per date of service by any provider and the patient is greater than 17 years of age and the diagnosis on the claim is chemotherapy-induced nausea and vomiting.	Terminated 3/30/2021
F, P	Drug and Biological Policy	HCPCS J9171 is limited to 195 combined units per date of service by any provider and the diagnosis on the claim is personal history of prostate cancer.	2015

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Drug and Biological Policy	HCPCS J9171 is limited to 260 combined units per date of service by any provider and the diagnosis on the claim is angiosarcoma, bladder cancer, breast cancer, endometrial carcinoma, esophageal cancer, esophagogastric junction cancer, gastric cancer, head and neck cancer, melanoma, non-small cell lung cancer, occult primary, ovarian cancer/fallopian tube cancer/primary peritoneal cancer, prostate cancer, rhabdomyosarcoma, small cell lung cancer, soft tissue sarcoma (extremity/superficial trunk, head/neck) (retroperitoneal/intra-abdominal), urothelial carcinoma, or uterine sarcoma.	2015
F, P	Drug and Biological Policy	Modifier JW is not payable with any code that is not a drug code. Modifier JW = Drug amount discarded/not administered to any patient.	2015
F, P	Drug and Biological Policy	A drug billed with modifier JW (Drug amount discarded/not administered to any patient) Is not payable when another claim line does not exist for the same drug on the same date of service.	2015
F, P	Drug and Biological Policy	HCPCS J2778 is not payable when billed by any provider more than two unique visits per month and an FDA approved or an approved off-labeled indication is present.	2015
F, P	Drug and Biological Policy	HCPCS J9035, Q5107, or Q5118 are not payable when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 10.	2015
F, P	Drug and Biological Policy	HCPCS J9041 or J9044 are not payable when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 35.	2015
F, P	Drug and Biological Policy	HCPCS J9055 is not payable when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 10.	2015
F, P	Drug and Biological Policy	HCPCS J0585 is not payable when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 100.	2015
F, P	Drug and Biological Policy	HCPCS J1745, Q5103, Q5104, Q5109, or Q5121 are not payable when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 10.	2015
F	Drug and Biological Policy	HCPCS J3262 is not payable when billed by any provider more than one unique visit within a month and the diagnosis is Castleman's disease or polyarticular juvenile idiopathic arthritis.	Terminated 3/30/2021
F, P	Drug and Biological Policy	HCPCS J3262 is not payable when billed and an FDA-approved indication or an approved off-labeled indication is not present on the claim.	Terminated 3/30/2021
F, P	Drug and Biological Policy	HCPCS J3262 is limited to 800 units when the diagnosis on the claim is rheumatoid arthritis.	Terminated 3/30/2021
F, P	Drug and Biological Policy	HCPCS J2778 is limited to 10 units per date of service when billed by any provider and an FDA approved or an approved off-labeled indication is present.	2015
F, P	Drug and Biological Policy	HCPCS J2778 is not payable when billed and an FDA-approved indication or an approved off-labeled indication is not present on the claim.	2015

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Drug and Biological Policy	HCPCS J2778 is not payable when billed and the patient is less than 18 years of age and an FDA approved or an approved off-labeled indication is present.	2015
F, P	Drug and Biological Policy	HCPCS J9171 is not payable when billed by any provider more than one visit per week and the diagnosis on the claim is bladder cancer, endometrial carcinoma, esophageal cancer, esophagogastric junction cancer, prostate cancer, thyroid carcinoma-anaplastic carcinoma, or urothelial carcinoma.	2015
F, P	Drug and Biological Policy	HCPCS J9171 is limited to 156 combined units per date of service when billed by any provider and the diagnosis on the claim is thyroid carcinoma-anaplastic carcinoma	2015
P	Drug and Biological Policy	HCPCS J9217 is not payable when billed and the patient is greater than 12 years of age and the patient gender is male and the diagnosis on the claim is central precocious puberty.	2015 *Terminated 8/1/2021*
P	Drug and Biological Policy	HCPCS J9217 is not payable when billed and the patient is greater than 11 years of age and the patient gender is female and the diagnosis on the claim is central precocious puberty.	2015 *Terminated 8/1/2021*
F, P	Drug and Biological Policy	HCPCS J9304 or J9305 are limited to 234 combined units per date of service by any provider and the diagnosis is ovarian cancer or primary central nervous system lymphoma.	2015
F, P	Drug and Biological Policy	HCPCS J3262 is not payable when billed by any provider more than one unique visit every two weeks and the diagnosis on the claim is acute graft-versus-host disease following stem cell transplantation, Castleman's disease, or polyarticular juvenile idiopathic arthritis.	2015
F, P	Drug and Biological Policy	HCPCS J0897 is not payable when billed and an FDA-approved indication or an approved off-labeled indication is not present on the claim.	Terminated 3/30/2021
F, P	Drug and Biological Policy	HCPCS J0897 is limited to 60 combined units per date of service by any provider when the diagnosis on the claim is glucocorticoid-induced osteoporosis, intolerance to other available osteoporosis therapy, osteoporosis in men, postmenopausal osteoporosis prophylaxis, postmenopausal osteoporosis treatment, postmenopausal women receiving aromatase inhibitors for early breast cancer, prostate cancer patients receiving androgen deprivation therapy, or systemic mastocytosis	Terminated 3/30/2021
P	Drug and Biological Policy	HCPCS J1950 is limited to 12 combined units per date of service by any provider and the diagnosis on the claim is prostate cancer.	2015
P	Drug and Biological Policy	HCPCS J1950 is not payable when billed more than two units per month by any provider and the diagnosis on the claim is amenorrhea induction prior to bone marrow transplant, or ovarian cancer/fallopian tube cancer/primary peritoneal cancer, or stuttering priapism.	2015
P	Drug and Biological Policy	HCPCS J1950 is limited to 24 combined units every 48 weeks and the diagnosis on the claim is prostate cancer.	2015

Claim Type	Medical Policy	Rule Description	Effective Date
P	Drug and Biological Policy	HCPCS Q0139 is not payable when billed and an FDA-approved indication or an approved off-labeled indication is not present on the claim.	2015
P	Drug and Biological Policy	HCPCS Q0138 is limited to 1020 combined units per date of service by any provider and the diagnosis on the claim is iron deficiency in chronic kidney disease.	2015
P	Drug and Biological Policy	HCPCS Q0138 is not payable when billed and an FDA-approved indication or an approved off-labeled indication is not present on the claim.	2015
P	Drug and Biological Policy	HCPCS J7318, J7320-J7329, or J7331-J7333 are not payable when billed and an FDA-approved indication or an approved off-labeled indication is not present on the claim.	2015
F, P	Drug and Biological Policy	HCPCS J1750 is not payable when billed and an FDA-approved indication or an approved off-labeled indication is not present on the claim.	2015
F, P	Drug and Biological Policy	HCPCS J1756 is limited to 200 combined units per date of service by any provider when the diagnosis on the claim is iron deficiency anemia associated with chronic heart failure, or iron deficiency anemia of pregnancy.	2015
F, P	Drug and Biological Policy	HCPCS J1756 is not payable when billed with a diagnosis of chronic kidney disease, and a diagnosis of anemia in chronic kidney disease is not also present.	2015
F, P	Drug and Biological Policy	HCPCS J9228 is limited to 1360 combined units per date of service by any provider and the diagnosis on the claim is melanoma.	2015
F, P	Drug and Biological Policy	HCPCS J0587 is not payable when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 25.	2015
F, P	Drug and Biological Policy	HCPCS J0588 is not payable when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 50.	2015
P	Drug and Biological Policy	HCPCS J9218 is not payable when billed and the patient's gender is male and the diagnosis is other than benign prostatic hyperplasia, breast cancer, central precocious puberty, or prostate cancer.	2015 *Terminated 8/1/2021*
P	Drug and Biological Policy	HCPCS J9218 is not payable when billed and the patient's gender is female and the diagnosis is other than breast cancer, central precocious puberty, infertility, ovarian cancer, or premenstrual syndrome.	2015 *Terminated 8/1/2021*
P	Drug and Biological Policy	HCPCS J9217 is not payable when billed and the patient's gender is male and the diagnosis on the claim is other than breast cancer, central precocious puberty, prostate cancer, salivary gland tumor, or stuttering priapism.	2015 *Terminated 8/1/2021*
P	Drug and Biological Policy	HCPCS J1950 is not payable when billed and the patient is less than two years of age and the diagnosis on the claim is central precocious puberty.	2015

Claim Type	Medical Policy	Rule Description	Effective Date
P	Drug and Biological Policy	HCPCS J1950 is not payable when billed and the patient's gender is female and the diagnosis on the claim is other than amenorrhea induction prior to bone marrow transplant, breast cancer, central precocious puberty, endometriosis, ovarian cancer/fallopian tube cancer/primary peritoneal cancer, premenstrual syndrome, or uterine leiomyomata.	2015 *Terminated 8/1/2021*
P	Drug and Biological Policy	HCPCS J1950 is not payable when billed and the patient is less than 18 years of age and the diagnosis on the claim is amenorrhea induction prior to bone marrow transplant, benign prostatic hyperplasia, breast cancer, endometriosis, ovarian cancer/fallopian tube cancer/primary peritoneal cancer, premenstrual syndrome, prostate cancer, stuttering priapism, or uterine leiomyomata.	2015
P	Drug and Biological Policy	HCPCS J9217 is not payable when billed and the patient is less than two years of age and the diagnosis on the claim is central precocious puberty.	2015
P	Drug and Biological Policy	HCPCS J9217 is limited to 12 combined units every 48 weeks and the diagnosis on the claim is breast cancer or prostate cancer.	2015
P	Drug and Biological Policy	HCPCS J9217 is not payable when billed and the patient is less than 18 years of age and the diagnosis on the claim is amenorrhea induction prior to bone marrow transplant, breast cancer, ovarian cancer/fallopian tube cancer/primary peritoneal cancer, prostate cancer, salivary gland tumor, or stuttering priapism.	2015
P	Drug and Biological Policy	HCPCS J1453 is limited to 150 combined units per date of service by any provider and the diagnosis on the claim is prevention of nausea and vomiting associated with highly and moderately emetogenic chemotherapy or prevention of nausea and vomiting associated with cisplatin-based chemotherapy with concurrent radiotherapy.	2015
F, P	Drug and Biological Policy	Drugs that are only packaged for multiple doses are not payable when billed with modifier JW (Drug amount discarded/not administered to any patient).	2015
F, P	Drug and Biological Policy	J0178 is limited to four units per date of service when billed by any provider and the diagnosis on the claim is branch retinal vein occlusion with macular edema, central retinal vein occlusion with macular edema, choroidal neovascularization due to ocular histoplasmosis syndrome, diabetic macular edema, diabetic retinopathy, or neovascular (wet) age-related macular degeneration.	2015
F, P	Drug and Biological Policy	J0178 is not payable when the patient is less than 18 years of age and the diagnosis on the claim is branch retinal vein occlusion with macular edema, central retinal vein occlusion with macular edema, choroidal neovascularization due to ocular histoplasmosis syndrome, diabetic macular edema, diabetic retinopathy, or neovascular (wet) age-related macular degeneration.	2015
F, P	Drug and Biological Policy	J0178 is not payable when billed and an FDA-approved indication or an approved off-labeled indication is not present on the claim.	2015

Payment Policy:
Coding Edit Rules

(Commercial & Medicare)

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Drug and Biological Policy	J0178 is not payable when billed without intravitreal injection of a pharmacologic agent (67028).	2015
F, P	Drug and Biological Policy	J0178 is not payable when billed by any provider more than two visits per month and the diagnosis on the claim is branch retinal vein occlusion with macular edema, central retinal vein occlusion with macular edema, choroidal neovascularization due to ocular histoplasmosis syndrome, diabetic macular edema, diabetic retinopathy, or neovascular (wet) age-related macular degeneration.	2015
F, P	Drug and Biological Policy	67028 (Intravitreal injection of a pharmacologic agent) is not payable when billed with J0178 and modifier LT (Left side), RT (Right side), or 50 (Bilateral procedure) is not appended to code 67028.	2015
F, P	Drug and Biological Policy	J0834 is not payable when billed and an FDA-approved indication or an approved off-labeled indication is not present on the claim.	2015
F, P	Drug and Biological Policy	HCPCS J9357 is not payable when billed and 51720 (Bladder instillation therapy) has not been billed by any provider for the same date of service.	2015
F, P	Drug and Biological Policy	HCPCS J7313 is not payable when billed without intravitreal injection of a pharmacologic agent (67028).	2015
F	Drug and Biological Policy	HCPCS J9171 is not payable when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 20	2015
F, P	Drug and Biological Policy	HCPCS J9171 is limited to 325 combined units per date of service by any provider and the diagnosis on the claim is Ewing's sarcoma or osteosarcoma.	2015
F	Duplicate Services Policy	Claims with modifier SG or SU as a duplicate claim are not separately payable when the other duplicate criteria are met.	2015
F, P	Duplicate Services Policy	Duplicate services are not payable. when the duplicate criteria have been met.	2015
P	Duplicate Services Policy	Duplicate drug codes are not payable when the same code with the same units has been billed on a different claim by any provider for the same date of service.	2015
F, P	Duplicate Services Policy	Only one technical-component-only code for the same service will be reimbursed when billed by different providers.	5/25/2021

Claim Type	Medical Policy	Rule Description	Effective Date
F	Duplicate Services Policy	Duplicate claims with the same 11 elements are not payable: ·Different Claim IDs ·Same Date of Service ·Same Subscriber ID ·Same Dependent ID ·Same Tax ID ·Same Procedure Code ·Modifier Combinations (ICMS utilizes proprietary logic to determine if combinations of modifiers indicate that a claim is a duplicate submission from a provider.) ·Same Units ·Same Revenue Code (only when a HCPCS code is absent on the line) ·Same Charge Amount (only when a HCPCS code is absent on the line) ·Same Bill Type Key Point: ·When a HCPCS code is not present, matching will occur based on same revenue code and same charge amount for the same date of service regardless of whether the matching line contains a HCPCS code.	11/30/2021
P	Duplicate-Different Claim	Identifies duplicate claim lines that have been submitted on a previous claim.	2018
F, P	Evaluation and Management Services Policy	Telephone evaluation and management service provided to an established patient (CPT/HCPCS 99441-99443) or (HCPCS G2010, G2012 or G2252) are not payable when an E/M service has been billed on the same day, previous seven days, or following day with the same primary diagnosis to the 3rd digit by the same group practice (same Tax ID, any specialty).	3/01/2022
P	Evaluation and Management Services Policy	Initial observation care codes (99218-99220) or codes that include the initial observation care (99234-99236) are not payable when an initial observation care code has been billed for the previous day by any provider.	2015
P	Evaluation and Management Services Policy	Hospital discharge services (99238-99239) are not payable when 99238 or 99239 has been billed the previous day.	2015
P	Evaluation and Management Services Policy	Second initial hospital care service (99221-99223) are not payable when subsequent hospital care (99231-99233), or another initial hospital care service has been billed in the previous week for the same place of service, and a discharge service (99238-99239) has not also been reported in the previous week.	2015
P	Evaluation and Management Services Policy	New patient visits are not payable when any face-to-face service has previously been billed by the same physician or a physician from the same group practice (with the same specialty and subspecialty) within the last three years.	2015

Claim Type	Medical Policy	Rule Description	Effective Date
p	Evaluation and Management Services Policy	HCPCS G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) or Q0091 (Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) are not payable when billed with 99384-99387 or 99394-99397 (Preventive medicine visits) by the same physician.	2015
P	Evaluation and Management Services Policy	Preventive medicine E/M service with the lower RVU price is not payable when multiple preventive medicine E/M services are billed for the same date of service.	2015
P	Evaluation and Management Services Policy	E/M code with the lower RVU price is not payable, when multiple E/M services are billed for the same date of service, provider group and specialty, except when modifier 25 is appended to the additional E/M service.	2015
F, P	Evaluation and Management Services Policy	Problem-oriented E/M services are not payable when billed with preventive medicine services, unless the E/M service is billed with modifier 25.	2015
P	Evaluation and Management Services Policy	CPT 93042 (EKG report) is not separately payable when billed with an E/M service in the hospital setting.	2015
F, P	Evaluation and Management Services Policy	HCPCS S0610-S0613 are not payable when billed with 99384-99387 or 99394-99397.	2015
F, P	Evaluation and Management Services Policy	E/M services are not payable when billed the same date of service as cardiovascular services (93260-93261, 93282-93284, 93287, 93289, 93292).	2015
P	Evaluation and Management Services Policy	E/M services (99201-99215, 99221-99223, 99231-99233, 99460) are not separately payable when billed with critical care service (99291) and the place of service is the same, except when evaluation and management services (including critical care services) are appended with modifier 25. Note: Consultation codes are not payable after 5/1/2020.	2015
F, P	Evaluation and Management Services Policy	New patient visit or an initial care visit are not payable when billed in excess of one unit.	2015
F, P	Evaluation and Management Services Policy	CPT 99217 (Observation care discharge service) is not payable when billed and 99218-99220 (Initial observation care admission service), 99224-99226 (Subsequent observation care) or a 0, 10 or 90-day global service has not been billed by any provider within the previous three days (CMS + Cotiviti Supplement).	2015
P	Evaluation and Management Services Policy	Inpatient hospital consult (99251-99255) is not payable if any type of inpatient visit (initial inpatient admission, inpatient hospital consult, subsequent hospital care) has been billed in the previous week for the same place of service, and an inpatient discharge visit (99238-99239) has not also been billed. Refer to a subsequent inpatient visit (99231-99233) Note: Consultations are not payable effective 5/1/2020.	2015
P	Evaluation and Management Services Policy	Any combination of 99477-99480 (Neonatal intensive care) is limited to one unit per date of service by any provider.	2015

Claim Type	Medical Policy	Rule Description	Effective Date
P	Evaluation and Management Services Policy	Initial neonatal and pediatric critical care codes 99468, 99471, and 99475 are not payable when the patient has had inpatient critical care services the previous day. Refer to subsequent neonatal and pediatric critical care codes 99475 to 99469, 99472, and 99476.	2015
P	Evaluation and Management Services Policy	Initial neonatal intensive care service 99477 is not payable when reported subsequent to the date of admission.	2015
P	Evaluation and Management Services Policy	Any combination of 99468-99476 (Neonatal and pediatric critical care) is limited to one unit per date of service by any provider.	2015
P	Evaluation and Management Services Policy	G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) or Q0091 (Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) are not payable when billed with S0610-S0612 (Annual GYN exam) by the same physician.	2015
P	Evaluation and Management Services Policy	Evaluation and management services reported with modifier 25 (same code) are limited to one unit when reported by the same provider ID.	2015
P	Evaluation and Management Services Policy	Observation services 99218-99220, 99224-99226, 99234-99236 are not payable when billed for more than one unit per date of service in any combination by any provider and the place of service is 19 (Outpatient hospital - off campus), 21 (Inpatient hospital), 22 (Outpatient hospital - on campus), 23 (Emergency department), 24 (Ambulatory Surgical Center).	2015
P	Evaluation and Management Services Policy	Hospital discharge services (99238-99239) are not payable when 99238 or 99239 has been billed for the same date of service.	2015
P	Evaluation and Management Services Policy	Transitional Care Management (TCM) services (99495-99496) are not payable when another TCM Service (99495-99496) has been billed on the same date of service by any provider.	2015
P	Evaluation and Management Services Policy	A new patient visit is not payable when billed by a non-physician practitioner and any face-to-face service has previously been billed by the same group practice (same Tax ID, any specialty) within the last three years and the primary diagnosis on the new patient visit matches any diagnosis on the previous face-to-face service.	2015
P	Evaluation and Management Services Policy	In accordance with CMS, complexity add-on code G2211 is not payable when reported with the outpatient/office Evaluation and Management visit (Codes 99202, 99205, 99211-99215) with modifier 25.	1/1/2024
F, P	Evaluation and Management Services Policy	CPT 99487, 99489-99491, G2058 (Care management services) are not payable when billed without a secondary diagnosis.	2015
F	External Causes of Injury and Poisoning ICD-10 Diagnosis Codes	Identifies claims using the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) External Causes of Injuries, Poisonings and Adverse Effects of Drugs (E Code) as the principal diagnosis. An E Code may be used with any code in the range of 001-V82.9 which indicates an injury, poisoning, or adverse	2018

Claim Type	Medical Policy	Rule Description	Effective Date
		effect due to an external cause. An E Code can never be a principal diagnosis. External causes of injury and poisoning codes (E codes) are intended to provide data for injury research and evaluation of injury prevention strategies. This rule applies to facility claims only. According to CMS Outpatient Code Editor, an external cause diagnosis (E code) cannot be used as a principal diagnosis. This rule recommends the denial of E Codes that are billed as the principal diagnosis. This edit is generated when the principal diagnosis is one of the diagnosis codes from the External Causes of Injury and Poisoning supplemental section of the ICD-9-CM manual. This edit is not applicable to the admitting diagnosis but only to the principal diagnosis. If a provider submits a claim with an E Code in the claim field for principal diagnosis, the claim will deny.	
F, P	Female Only Diagnosis Codes	Identifies claims containing diagnoses that are inconsistent with the member's gender	2018
P	Fragmented Procedures Policy	Procedures identified as a separate component of a more comprehensive procedure or service are not payable when submitted and review of the current claim or history claim determines another component code within the same family of codes was also billed and paid for the same date of service by the provider.	1/01/2022
P	Frequency Limits	Identifies claim lines containing procedure codes with "single" or "unilateral" in the description that have been submitted more than once per date of service and recommends replacement for all occurrences of the "single/unilateral" with the corresponding "multiple" or "bilateral" code. This rule contains a rule filter that excludes certain lines from being evaluated by this rule. Claim lines with procedures audited in either the MUE_SINGLE_LINE_MADV or MUE_MULT_LINES_MADV rule (content sourced only to CMS) should not be audited in this rule (whose content is not solely sourced to CMS) to avoid overlapping or different auditing results. This rule recommends the denial of procedure codes not audited in the MUE_SINGLE_LINE_MADV or MUE_MULT_LINES_MADV rule when the description of one procedure specifies "single" or "unilateral" and there is another procedure description that specifies "multiple" or "bilateral" performance of the same procedure. Single or unilateral procedures cannot be submitted more than once with the same date of service. In these instances, an alternate code recommendation occurs identifying an "alternate" procedure code recommended for addition to the claim. This rule audits procedure codes reported by the same provider.	2018
P	Frequency Policy	HCPCS G0179 Physician recertification for home health services is not payable if billed more than once every two months.	2015

Payment Policy:
Coding Edit Rules

(Commercial & Medicare)

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Frequency Policy	Care plan oversight and care coordination services are not payable when billed within the same calendar month of a monthly ESRD services code.	2015
F, P	Frequency Policy	Non-Pre-Diabetic Screening Services: Diabetes screening tests are not payable with a diagnosis of screening for diabetes mellitus when billed more than once every year.	2015
F, P	Frequency Policy	CPT 80305-80307 (Presumptive drug testing) is not payable when billed more than one combined unit per day.	2015
F, P	Frequency Policy	HCPCS G0480-G0483, G0659 (Definitive drug testing) are not payable when billed more than one combined unit per day.	2015
P	Gastroenterology Policy	Colonoscopy (45378) is no payable when billed more than once within one year.	2015
P	Gastroenterology Policy	CPT 43264 (Endoscopic retrograde removal of calculus/calculi from biliary and/or pancreatic duct[s]) is not payable when billed with 43274-43276 (Endoscopic retrograde cholangiopancreatography [ERCP] with placement of stent; removal of stent or foreign body; stent exchange; balloon dilation).	2015
P	Gastroenterology Policy	Deny 45335 (Sigmoidoscopy, flexible; with directed submucosal injection(s)) when billed with 45333, 45338, or 45346 (Sigmoidoscopy, flexible).	2015
P	Gastroenterology Policy	CPT 45381 (Colonoscopy, flexible; with injection(s)) is not payable when billed with 45383-45385, 45388, or G6024 (Colonoscopy).	2015
F, P	Gender-Procedure Codes	Identifies claim lines containing Procedure Codes that are inconsistent with the member's gender.	2018
F, P	General Surgery Policy	CPT 15850 or 15851 (Removal of sutures under anesthesia [other than local]) is not payable when the patient's age is greater than 12 years.	2015
F, P	General Surgery Policy	CPT 10080-10081 (Incision and drainage of pilonidal cyst) or 11770-11772 (Excision of pilonidal cyst or sinus) are not payable when billed without a diagnosis of pilonidal cyst or pilonidal sinus on the claim.	2015
F, P	Global Component	Identifies claim lines for which the sum of all payments (total, professional, technical) exceeds the payment expected for the total procedure. This rule will also detect when duplicate submissions have occurred for the total procedure or its components, across providers. The following scenarios are audited: • Global vs. Global • Global vs. Professional • Global vs. Technical • Professional vs. Global • Technical vs. Global • Professional vs. Professional • Technical vs. Technical Auditing could vary based upon a Facility or Non-facility claim.	2018
P	Global Obstetrical Policy	Global delivery codes are not payable when a different provider group has billed for antepartum care only services in the last eight months.	2015

Claim Type	Medical Policy	Rule Description	Effective Date
P	Global Obstetrical Policy	Cerclage removal (59871) is not separately payable when billed on the same date of service as the delivery code.	2015
P	Global Obstetrical Policy	Services which are included in the global obstetrical package for uncomplicated maternity cases are not separately payable when billed on the same day as the delivery.	2015
P	Global Obstetrical Policy	Subsequent delivery codes are not payable if more than one delivery code is billed for the same date of service or within the previous six months by any provider or specialty.	2015
P	Global Obstetrical Policy	Global delivery codes including antepartum care is not payable if the provider has billed antepartum care in the last eight months.	2015
P	Global Obstetrical Policy	Subsequent billings of antepartum care only codes (59425 or 59426) are not payable when either code has been previously billed.	2015
P	Global Obstetrical Policy	E/M services or postpartum care are not payable when billed within 42 days (6 weeks) by the same Tax ID and specialty that performed a delivery that includes postpartum care.	2015
P	Global Obstetrical Policy	Antepartum care services for a normal pregnancy are not payable when billed for the same date of service or within 240 days (8 months) prior to the date of a delivery that includes antepartum care.	2015
P	Global Surgery Policy	Procedure codes with 0, 10 or 90-day global surgery periods are not payable when performed within 90 days of a 90-day surgical procedure (CMS).	2015
P	Global Surgery Policy	Procedure codes with 0, 10 or 90-day global surgery periods billed with modifier 47 or P1-P6 are not payable when the same procedure has also been billed without modifier 47 or P1-P6 (CMS).	2015
P	Global Surgery Policy	CPT 01996 (Daily management of epidural or subarachnoid drug administration) is not payable when billed with a 0-day, 10-day or 90-day surgical procedure (CMS).	2015
P	Global Surgery Policy	Evaluation and management services are not payable when billed on the same day as a 0-day medical or surgical service (CMS). Note: Consultation codes are not payable after 5/1/2020.	2015
P	Global Surgery Policy	Evaluation and management services are not payable when performed the day prior to a 90-day medical or surgical service (CMS).	2015
P	Global Surgery Policy	Evaluation and management services are not payable when performed the same day as a 90-day medical or surgical service (CMS).	2015
P	Global Surgery Policy	Evaluation and management services are not payable when performed within 90 postoperative days of a 90-day medical or surgical service (CMS).	2015
P	Global Surgery Policy	Evaluation and management services are not payable when performed the same day as a 10-day medical or surgical service (CMS).	2015

Claim Type	Medical Policy	Rule Description	Effective Date
P	Global Surgery Policy	Evaluation and management services are not payable when performed within 10 postoperative days of a 10-day medical or surgical service (CMS).	2015
P	Global Surgery Policy	Procedure codes with 0-day and 10-day global period are not payable when performed within 10 postoperative days of a 10-day procedure (CMS).	2015
P	Global Surgery Policy	Evaluation and management services are not payable when performed the same day as a 90-day medical or surgical service when billed by the same Provider ID, regardless of Tax ID and Specialty (CMS).	2015
P	Global Surgery Policy	Evaluation and management services are not payable when performed within 90 postoperative days of a 90-day medical or surgical service when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of Provider ID and Specialty, and the E/M service has a primary diagnosis associated to the 90-day medical or surgical service (CMS).	2015
P	Global Surgery Policy	Evaluation and management services are not payable when performed within 90 postoperative days of a 90-day medical or surgical service when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of Provider ID and Specialty, and the diagnosis is a complication of surgical and medical care or an aftercare diagnosis (CMS).	2015
P	Global Surgery Policy	Evaluation and management services are not payable when performed within 10 postoperative days of a 10-day medical or surgical service when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of Provider ID and Specialty, and the E/M service has a primary diagnosis associated to the 10-day medical or surgical service (CMS).	2015
P	Global Surgery Policy	Evaluation and management services are not payable when performed within 10 postoperative days of a 10-day medical or surgical service when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of Provider ID and Specialty, and the diagnosis is a complication of surgical and medical care or an aftercare diagnosis (CMS).	2015
P	Global Surgery Policy	Evaluation and management services are not payable when performed within 10 postoperative days of a 10-day medical or surgical service billed by the same Provider ID regardless of Tax ID and Specialty (CMS + Cotiviti Supplement).	2015
P	Global Surgery Policy	Evaluation and management services are not payable when billed with modifier 24 and a major surgical procedure with a 90-day postoperative period has been billed in the previous 90 days and the E/M service has a primary diagnosis associated to the 90-day medical or surgical service. (CMS + Cotiviti Supplement)	2015
P	Global Surgery Policy	Evaluation and management services are not payable when billed with modifier 24 and a major surgical procedure with a 90-day postoperative period has been billed in the previous 90 days and the E/M diagnosis is a	2015

Claim Type	Medical Policy	Rule Description	Effective Date
		complication of surgical and medical care or an aftercare diagnosis. (CMS + Cotiviti Supplement)	
P	Global Surgery Policy	Evaluation and management services are not payable when billed with modifier 24 and a minor surgical procedure with a 10-day postoperative period has been billed in the previous 10 days and the E/M service has a primary diagnosis associated to the 10-day medical or surgical service. (CMS + Cotiviti Supplement)	2015
P	Global Surgery Policy	Evaluation and management services are not payable when billed with modifier 24 and a minor surgical procedure with a 10-day postoperative period has been billed in the previous 10 days and the E/M diagnosis is a complication of surgical and medical care or an aftercare diagnosis. (CMS + Cotiviti Supplement)	2015
P	Healthplan Policy	COVID-19 specimen collection services (HCPCS codes G2023 and G2024) are considered integral to the performance of COVID testing. As such, the separate reimbursement is not warranted when a COVID test is rendered.	3/1/2020
P	Healthplan Policy	CPT 99174 1 unit in 12-month period. Exception: Hospital, Ophthalmologist, Optometrist, Neurology, and Pediatric Neurology.	2015
P	Healthplan Policy	CPT 95925, 95926, 95927, or 95938 is payable when billed and an approved diagnosis is not on the claim header based on NGS LCD https://www.cms.gov/medicare- coverage-database/details/article- details.aspx?articleId=57597 that does not apply to CT or NY Part B. It only applies to Part A.	Terminated 2/25/2021
P	Healthplan Policy	Face to face services rendered during the 90-day global period are not separately reimbursable. Example: If 76942 Echo-guide for biopsy or S2083 Adjustment gastric band, is billed and 43770-43774 (Bariatric surgery) has been billed in the past 90 days, then 76942 or S2083 are not reimbursable and considered to be included in the global fee.	2015
F, P	Healthplan Policy	G0471 (Collection of venous blood by venipuncture or urine sample by catheterization from an individual in a skilled nursing facility (SNF) or by a laboratory on behalf of a home health agency (HHA)) is not payable when billed in Place of Service 11, 19, 21, 22, 23, or 24	2015
P	Healthplan Policy	If patient is 3 years or younger, CPT 99174 is not separately payable with another procedure. Exception modifier 52 (Reduced Services). Excludes hospital, ophthalmology, optometry, neurology, pediatric neurology.	2015
P	Healthplan Policy	Services considered to be included in global obstetrical procedures are not separately payable.	2015
P	Healthplan Policy	Change 36410 (Venipuncture, age 3 years or older, necessitating physician's skill [separate procedure], for diagnostic or therapeutic purposes [not to be used for	2015 *Terminated for Medicare*

Claim Type	Medical Policy	Rule Description	Effective Date
		routine venipuncture]) to 36415 (routine venipuncture) when billed without a covered diagnosis.	*effective 9/24/2023*
F, P	ICD-10 Diagnosis Codes-Age Specific	Identifies claim lines containing diagnosis codes that are inconsistent with the patient's age and recommends their denial. Age is calculated using the patient's date of birth and the line date of service. This edit is based on designations defined in the Centers for Medicare and Medicaid Services (CMS) Integrated Outpatient Code Editor (I/OCE).	2018
P	Inappropriate Age Code Use Policy	Procedures with an age/age range designation are not payable when submitted and the member's age does not correspond with the age/age range of the procedure.	1/01/2022
P	Inappropriate Age Code Use Policy	Diagnosis codes with an age/age range designation are not payable when submitted and the member's age does not correspond with the age/age range of the diagnosis code.	1/01/2022
P	Inappropriate Use of Modifier Policy	Procedures that are submitted with modifier 26, 50 or TC and are designated as professional, bilateral or technical component as "not permitted for this procedure" or "concept does not apply" are not payable per the Payment Indicators within the CMS Medicare National Physician Fee Schedule Relative Value File (NPFSRVF).	1/01/2022
P	Inappropriate Use of Modifier Policy	Procedures that are not designated for telehealth/telemedicine are not payable when submitted with modifiers G0, GQ, GT, or 95.	1/01/2022
P	Incident To Services Policy	Procedures designated as an "incident to" service are not payable when billed with a place of service code 02, 19, 21, 22, 23, 24, 26, 31, 34, 41, 42, 51, 52, 53, 56, or 61.	2015
F, P	Incomplete ICD-10 Diagnosis Code	Identifies claims containing incomplete ICD- 10 diagnosis codes	2018
F, P	Invalid ICD-10 Diagnosis Code	Identifies claims containing invalid diagnosis codes.	2018
F, P	Laboratory- Pathology Policy	Modifier QW (CLIA waived test) is not payable when billed with a procedure code that is not designated as a CLIA waived test on the clinical laboratory fee schedule.	2015
P	Laboratory-Pathology Policy	Supplies (e.g. urine dipsticks for glucose or ketones, syringes, alcohol wipes, betadine or iodine swabs etc) are inherent to a laboratory service when the supply must be routinely available for performance of the reported service.	1/1/2018
F, P	Laboratory-Pathology Policy	CPT code 86769 (Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)) is not payable when billed with 0224U (Antibody; severe acute respiratory syndrome coronavirus 2, includes titer(s), when performed) by any provider.	2/01/2022
F, P	Laboratory-Pathology Policy	Nucleic-acid based SARS-CoV-2 viral tests (CPT codes 87631, 87635-87637, 87811, 0240U, 0241U, U0001, and U0003) will be limited to one unit per day, unless reported with modifier 59, by any provider.	2/01/2022
F, P	Laboratory-Pathology Policy	CPT code U0004 (COVID-19 lab test non-CDC high throughput) is not payable when billed with U0002 (COVID-19 lab test non-CDC) by any provider.	2/01/2022

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Laboratory-Pathology Policy	CPT code U0003 (COVID-19 infectious agent detection by nucleic acid, high throughput) is not payable when billed with 87635 (COVID-19 Infectious agent detection by nucleic acid) by any provider.	2/01/2022
F, P	Laboratory-Pathology Policy	CPT code 0224U (Antibody; severe acute respiratory syndrome coronavirus 2, includes titer(s)) is not payable when billed and 86769 (Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) has been previously billed and paid on the same date of service by any provider.	2/01/2022
F, P	Laboratory-Pathology Policy	CPT code U0002 (Covid-19 lab test non-CDC) is not payable when billed and U0004 (Covid-19 lab test non-CDC high throughput) has been previously billed and paid on the same date of service by any provider.	2/01/2022
F, P	Laboratory-Pathology Policy	CPT code 87635 (COVID-19 Infectious agent detection by nucleic acid) is not payable when billed and U0003 (COVID-19 infectious agent detection by nucleic acid, high throughput) has been previously billed and paid on the same date of service by any provider.	2/01/2022
F, P	Laboratory-Pathology Policy	Surgical pathology gross & microscopic exam (88305, 88307, or 88309) are not payable when the only diagnosis on a claim line is a cornea diagnosis code.	3/15/2023
P	Laboratory-Pathology Policy	Surgical pathology gross & microscopic exam (88305, 88307, or 88309) are not payable when the only diagnosis on a claim line is a cornea diagnosis code.	3/15/2023
F, P	Laboratory-Pathology Policy	Surgical pathology gross & microscopic exam (88304, 88305, 88307 or 88309) are not payable when the only diagnosis on the claim line is an encounter for sterilization (Z30.2).	3/15/2023
P	Laboratory-Pathology Policy	Surgical pathology gross & microscopic exam (88304, 88305, 88307 or 88309) are not payable when the only diagnosis on the claim line is an encounter for sterilization (Z30.2).	3/15/2023
F, P	LCD- Procedure Diagnosis Frequency Multiple IDX	Identifies Professional, Inpatient, and Outpatient Facility claim lines for certain procedure codes associated with a single diagnosis code/multiple diagnosis codes or no diagnosis code, modifier, age and frequency requirement where the procedure is not considered medically necessary, payable, or has payment constraints according to Local Coverage Determinations (LCDs). LCD's applicable to Connecticut, Massachusetts and New York are posted and maintained by NGS Medicare at the Medical Policy Center. https://www.ngsmedicare.com/	10/01/2021
F, P	LCD Medical Necessity ICD-10	Identifies Professional, Inpatient, and Outpatient Facility claim lines for certain procedure codes associated with diagnoses where the procedure is not considered medically necessary, payable, or has payment constraints	10/01/2021

Claim Type	Medical Policy	Rule Description	Effective Date
		according to Part A and Part B Local Coverage Determinations (LCDs). LCD's applicable to Connecticut, Massachusetts and New York are posted and maintained by NGS Medicare at the Medical Policy Center. https://www.ngsmedicare.com/	
F, P	Male Only Diagnosis Codes	Identifies claims containing diagnoses that are inconsistent with the member's gender.	2018
F, P	Manifestation Diagnosis Code Policy	Diagnoses designated as manifestation codes are not payable when submitted as the primary diagnosis.	1/01/2022
F, P	Maximum Units Policy	Codes billed for a number of units that exceeds the allowed number of units are not payable.	2015
F	Maximum Units Policy	Excess units are not payable when any provider bills a number of units that exceed the daily assigned allowable unit(s) for that procedure for the same member.	2015
F, P	Maximum Units Policy	As per the ICD-10 Manual; Maternal Fetal Medicine services 59000, 59020, 74713,76802, 76810, 76812, 76814, 76816, 76818-78621, or 76825-76828 are not payable when billed without the requisite diagnosis.	2015
F, P	Maximum Units Policy	Surgeries that allow multiple assistant surgeons as indicated are not payable when billed by same or different provider.	2015
F, P	Maximum Units Policy	Units of service greater than 1 are not payable when billed by any provider for a code with an anatomical modifier (E1-E4, FA-F9, TA-T9).	2015
P	Maximum Units Policy	Procedures are not payable when the same provider bills a certain number of units of team surgery or co-surgery that exceed the daily assigned allowable unit(s) for that procedure for the same member.	2015
F, P	Maximum Units Policy	As per the ICD-10 Manual, Obstetrical procedure codes 74713, 76802, 76810, 76812, 76814 are not payable when billed without the requisite diagnosis.	2015
F, P	Maximum Units Policy	Certain procedures based on the code description or code guidelines, regardless of appended modifier, are limited to one unit per day. (CMS-1500)	2015
F	Maximum Units Policy	Certain procedures based on the code description or code guidelines, regardless of appended modifier, are limited to one unit per day when billed with the same revenue code. (CMS-1500)	2015
P	Medicaid - New York State Policy	CPT 91110 (Gastrointestinal tract imaging, intraluminal [e.g. capsule endoscopy], esophagus through ileum) is not payable when billed and the only diagnosis on the claim is hematemesis.	2015
P	Medical Procedure to Place of Service	Identifies claim lines with procedure code to place of service incompatibility based on procedure code description and guidelines. CCIM only: Identifies claim lines with procedure codes to place of service restrictions based on CMS.	2018

Claim Type	Medical Policy	Rule Description	Effective Date
F	Medically Unlikely Edits (MUE) - Facility	This rule identifies claim lines where the Medically Unlikely Edits (MUE) have been exceeded for a CPT/HCPCS code, reported by the same provider on the same date of service, for the same member. The Multiple Lines FACILITY rule audits across claims and also processes override modifiers (–59, –76, and –91).	2018 *Terminated 10/01/2021 See Medically Unlikely Edits (MUE)- Outpatient*
P	Medically Unlikely Edits (MUE) - Professional	This rule identifies claim lines where the Medically Unlikely Edits (MUE) have been exceeded for a CPT/HCPCS code, reported by the same provider on the same date of service, for the same member. The Multiple Lines MADV rule audits across claims and also processes override modifiers (–59, –76, and – 91).	2018 *Terminated 10/01/2021 See Medically Unlikely Edits (MUE)- Practitioner*
F	Medically Unlikely Edits (MUE)- Outpatient	Identifies claim lines where the CMS Facility MUE has been exceeded for a CPT/HCPCS code with MUE adjudication indicator (MAI) = 1, 2 or 3, reported by the same provider, for the same member, on the same date of service. This rule will evaluate date ranges to determine if the MUE has been met or not. • MAI = 1 claim line edit. If a claim line quantity exceeds the MUE allowed value, that single claim line will be denied. • MAI = 2 date of service edits (based on policy). No Modifier override is allowed and will not be considered if appealed. • MAI = 3 date of service edits (based on clinical benchmarks). Modifier 59 will not override MAI of 3. Clinical documentation to support reimbursement for additional units may be submitted as an appeal.	10/01/2021 *Replaces Medically Unlikely Edits (MUE) - Facility*
P	Medically Unlikely Edits (MUE)- Practitioner	Identifies claim lines where the CMS Professional MUE has been exceeded for a CPT/HCPCS code with MUE adjudication indicator (MAI) = 1, 2 or 3, reported by the same provider, for the same member, on the same date of service. This rule will evaluate date ranges to determine if the MUE has been met or not. • MAI = 1 claim line edit. If a claim line quantity exceeds the MUE allowed value, that single claim line will be denied. • MAI = 2 date of service edits (based on policy). No Modifier override is allowed and will not be considered if appealed. • MAI = 3 date of service edits (based on clinical benchmarks). Modifier 59 will not override MAI of 3. Clinical documentation to support reimbursement for additional units may be submitted as an appeal.	10/01/2021 *Replaces Medically Unlikely Edits (MUE) - Professional*
P	Missing Modifier 26	Identifies claim lines where a modifier -26, denoting professional component, should have been reported for the procedure performed at the noted place of service.	2018

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Modifier Policy	Services billed with invalid modifier to procedure code combinations are not payable.	2015
F	Modifier Policy	Any service billed with modifier 53 (Discontinued service) is not payable when billed with Bill Type 0120-012Z (Inpatient-part B), 0130-013Z (Outpatient hospital), 0140- 014Z (Outpatient hospital-other), or 0830-083Z (Ambulatory surgical center [ASC]).	2015
F	Modifier Policy	Any service billed with modifier 53 (Discontinued service) is not payable when billed with Place of Service 19 (Outpatient hospital-off campus), 22 (Outpatient hospital-on campus) or 24 (Ambulatory surgical center [ASC]).	2015
F, P	Modifier Policy	Procedures appended with modifier 78 are not payable when the same or different 0, 10 or 90 day-procedure code has not been billed on the same day for a 0-day post-operative period, on the same day or in the previous 10-days for a code with a 10-day post-operative period, or on the same day or in the previous 90 days for a code with a 90-day post-operative period.	1/01/2018
F, P	Modifier Policy	Procedures appended with modifier 79 are not payable when the same or different 0, 10 or 90-day procedure code has not been billed on the same day for a code with a 0-day post-operative period, on the same day or in the previous 10 days for a code with a 10-day post-operative period, or on the same day or in the previous 90 days for a code with a 90-day post-operative period.	1/01/2018
F, P	Modifier Policy	Procedure codes that are inappropriately billed with anatomical modifiers are not payable.	2015
F, P	Modifier Policy	Anesthesia codes (00100-01999, 99100-99140 or D9223) inappropriately billed with distinct service modifiers are not payable.	2015
F, P	Modifier Policy	Procedures appended with modifier 76 (Repeat procedure/same physician) are not payable when the same procedure code has not been billed by the same Provider ID on the same date of service, or within the post-operative period of the billed procedure. (CMS)	2015
F, P	Modifier Policy	CPT 90476-90750, 90756 (Vaccines, toxoids), J3530 (Nasal vaccine inhalation), Q2034-Q2039 (Influenza virus vaccine, split vaccine) or S0195 (Pneumococcal conjugate vaccine, polyvalent, intramuscular, for children from five years to nine years of age who have not previously received the vaccine) are not payable when billed with modifier SL (State supplied vaccine) and the allowed amount is more than $0.01.	2015
F, P	Modifier Policy	Procedure codes defined as requiring an anatomical modifier are not payable when billed without an associated anatomical modifier.	2015

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Modifier Policy	Procedures appended with modifier 79 are not payable when the same or different 0, 10 or 90-day procedure code has not been billed on the same day for a code with a 0-day post-operative period, on the same day or in the previous 10 days for a code with a 10-day post-operative period, or on the same day or in the previous 90 days for a code with a 90-day post-operative period. (CMS)	2015
F, P	Modifier to Procedure Validation- Non-payment Modifiers	Identifies claim lines with invalid modifier to Procedure Code combinations for those modifiers identified as non-payment modifiers	2018
F, P	Modifier to Procedure Validation- Payment Modifiers	Identifies claim lines with invalid modifier to Procedure Code combinations for those modifiers identified as payment modifiers	2018
F	Multiple Evaluation and Management-Facility	Identifies multiple E&M codes and other visit codes submitted on the same date of service from the same facility with the same revenue code that lacks modifier -27. The Current Procedural Terminology (CPT) defines modifier -27 as "multiple outpatient hospital evaluation and management encounters on the same date". Per the Centers for Medicare & Medicaid Services (CMS), hospitals should append modifier -27 to the second and subsequent E&M codes that are billed on the same date of service. This rule recommends the denial of claims containing multiple E&M codes in which the second and/or subsequent visit code(s) lack modifier -27 or if multiple E&M visit codes are submitted with a quantity greater than one with modifier -27. CMS has assigned to each HCPCS/CPT code a letter called a status indicator that signifies whether Medicare will reimburse the service and how it will be reimbursed. Modifier -27 is only applicable to E&M codes with a status indicator of V (Clinic or Emergency Department Visit). Some evaluation & management codes have various status indicators based upon the OPPS Payment Status. When a date range is submitted with a line quantity greater than one, the claim line is denied and a line is added with the line quantity equal to the number of days within the range.	CCIM 2018, CCIC 11/1/2020
P	Multiple Endoscopy – Pay Percent	Identifies multiple endoscopy procedures, reported within the same family, and applies the multiple endoscopy reduction, per CMS guidelines. In addition, if more than one endoscopy family is reported and/or surgery procedures are reported, the rule will apply the multiple surgery cutback to the appropriate endoscopy family or families and surgery procedures. This rule will also recommend payment adjustments for other applicable payment modifiers and assign the appropriate pay percentage to the eligible line(s).as well as bilateral*, multiple quantity*, and assign the appropriate pay percentage to the eligible line(s).	9/01/2021

Claim Type	Medical Policy	Rule Description	Effective Date
P	Multiple Unbundled Codes- Re-bundle	Identifies claims containing two or more Procedure Codes used to report a service when a single, more comprehensive Procedure Code exists that more accurately represents the service performed. This is typically identified by the CPT code description of each code.	2015
F, P	Mutually Exclusive Places of Service	Any service (other than inpatient care) billed by any professional provider on the same date of service as inpatient care but with a different place of service, is not payable when the member also received inpatient care the previous day and was not discharged on the same day, or on the subsequent day.	5/25/2021
F, P	Mutually Exclusive Places of Service	Any service billed in place of service 19 (Outpatient Hospital - Off campus), 22 (Outpatient Hospital - On campus) or 23 (Emergency Room - Hospital) by any professional provider on the same date of service as inpatient care, is not payable when the member also received inpatient care the previous day and was not discharged.	5/25/2021
P	NCCI Comprehensive Component Policy	Procedures categorized as a Column II code are not payable when submitted by the same provider, for the same date of service as an associated comprehensive Column I code.	1/01/2022
P	NCCI Mutually Exclusive Policy	Procedures categorized as a Column II code are not payable when submitted by the same provider, for the same date of service as an associated mutually exclusive Column I code.	1/01/2022
F	NCCI PTP Facility Policy	Procedures categorized as a Column II code are not payable when submitted on the same date of service and by the same provider as the designated Column I code.	1/01/2022
F, P	NCD Procedure to Diagnosis: EXCLUSIONARY Lab Policy (NCD Exclusionary)	Identifies Professional and Outpatient Facility claim lines where laboratory procedures are not considered medically necessary or payable according to the Centers for Medicare and Medicaid Services (CMS) National Coverage Policy for Laboratory Procedures located at https://www.cms.gov/medicare/coverage/coveragegeninfo/downloads/manual201701_icd10.pdf This Exclusionary policy is based on the CMS defined list of "ICD-10-CM Codes That Do Not Support Medical Necessity." Denial of the procedure code will occur because of its submission with an ICD-10 diagnosis code that is part of the non-payable conditions list OR because of its submission with an ICD-10 diagnosis code that is part of the CMS defined list of "Non-covered ICD-10-CM Codes for All NCD Edits" in the Medicare National Coverage	10/01/2021

Claim Type	Medical Policy	Rule Description	Effective Date
		Determinations (NCD) Coding Policy Manual and Change Report.	
F, P	NCD Procedure to Diagnosis: Inclusionary Lab Policy NCD_INCLUSIONARY	Identifies Professional and Outpatient Facility claim lines where laboratory procedures are not considered medically necessary or payable according to the Centers for Medicare and Medicaid Services (CMS) National Coverage Policy for Laboratory Procedures located at https://www.cms.gov/medicare/coverage/coveragegeninfo/downloads/manual201701_icd10.pdf This Inclusionary policy is based on the CMS defined list of "ICD-10-CM Codes Covered by Medicare Program". Denial of the procedure code will occur because of its submission with an ICD-10 diagnosis code that is not part of the payable list OR because of its submission with an ICD-10 diagnosis code that is part of the CMS defined list of "Non-covered ICD-10-CM Codes for All NCD Edits" in the Medicare National Coverage Determinations (NCD) Coding Policy Manual and Change Report.	10/01/2021
F, P	NCD Procedure to Diagnosis: Non Covered (NCD_POLICY_EXCL)	Identifies Professional and Outpatient Facility claim lines submitted for procedure codes paired with specific diagnoses for which that code pair is defined as non-covered or not payable according to the Centers for Medicare and Medicaid Services (CMS) National Coverage Determination Policy (NCD). CMS established National Coverage policies to evaluate clinical evidence to determine whether the evidence is of sufficient quality to support a finding that an item or service that falls within a benefit category is reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of the body. The Coverage Determinations manual is located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961	10/01/2021
F, P	NCD Procedure to Diagnosis: Covered (NCD_POLICY_INCL)	Identifies Professional and Outpatient Facility claim lines for procedure codes not submitted with a covered diagnosis and is therefore defined as non-covered or not payable according to the Centers for Medicare and Medicaid Services (CMS) National Coverage Determination Policy (NCD).	10/01/2021

Claim Type	Medical Policy	Rule Description	Effective Date
		CMS established National Coverage policies to evaluate clinical evidence to determine whether the evidence is of sufficient quality to support a finding that an item or service that falls within a benefit category is reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of the body. The Coverage Determinations manual is located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961	
F, P	NCD Procedure to Diagnosis Coverage (NCD_PXDX_COVERAGE)	Identifies Professional and Outpatient Facility claim lines for certain procedure codes associated with a single diagnosis code/multiple diagnosis codes or no diagnosis code, modifier, age and frequency requirement where the procedure is not considered medically necessary, payable, or has payment constraints according to National Coverage Determinations (NCDs). The Coverage Determinations manual is located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961	10/01/2021
F, P	Nail Care and Other Foot Care Services	As per CMS LCD Article A57759; Nail pairing, cutting, debridement services (CPT 11055-11057, 11719-11721, or HCPCS G0127) are not payable when billed with a diagnosis of thickened or mycotic nails and without a qualifying complication diagnosis or a systemic condition resulting in circulatory or neurologic impairment on the claim.	8/31/2021
P	National Correct Coding Initiative (NCCI)-Professional	Identifies claims containing code pairs found to be unbundled according to the Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI).	2015
F	National Correct Coding Initiative (NCCI)-Facility	Identifies claims containing code pairs found to be unbundled according to Centers for Medicare and Medicaid Services (CMS) Outpatient Code Editor (OCE).	2016
F, P	National Correct Coding Initiative Policy	Q0091 is not separately payable with an E&M code unless the E&M code is billed with modifier 25. Documentation must support the use of the modifier.	2015
F, P	National Correct Coding Initiative Policy	IV infusion services billed without modifier 59 or modifier XE are not payable when billed with IV chemotherapy administration service codes.	2015
P	National Correct Coding Initiative Policy	NCCI PTP edits: Column two procedure code when billed with associated Mutually Exclusive Column one procedure code are not payable.	2015

Payment Policy:
Coding Edit Rules

(Commercial & Medicare)

Claim Type	Medical Policy	Rule Description	Effective Date
P	National Correct Coding Initiative Policy	NCCI PTP edits: Column two procedure code when billed with associated Column one procedure code are not payable. Non-Mutually Exclusive Edits.	2015
F	National Correct Coding Initiative Policy	CMA NCCI Procedure to Procedure column two code is not payable when billed with column one code. Non-Mutually Exclusive Edits. (CMS-1500)	2015
P	National Correct Coding Initiative Policy	CMS NCCI column two procedure codes are not payable when billed with associated Column one procedure code when billed by the same Provider ID regardless of Tax ID and Specialty. Non-Mutually Exclusive Edits.	2015
P	National Correct Coding Initiative Policy	NCCI Column two procedure code is not separately payable when billed with associated Mutually Exclusive Column one procedure code when billed by the same Provider ID regardless of Tax ID and Specialty.	2015
F	National Correct Coding Initiative Policy	NCCI Column two code is not payable when billed with column one code. Mutually Exclusive Edits. (CMS-1500)	2015
F	National Correct Coding Initiative Policy	CMS NCCI Mutually Exclusive code pair edits will result in denial of a Column two code when billed with column one code. (CMS-1450)	2015
F	National Correct Coding Initiative Policy	CMS NCCI non-Mutually Exclusive code pair edits will result in denial of a Column two code when billed with column one code. (CMS-1450)	2015
P	National Correct Coding Initiative Supplemental Policy	Separate payment is not allowed if CMS NCCI Procedure to Procedure component/comprehensive supplemental edits apply.	2015
F, P	National Correct Coding Initiative Supplemental Policy	Consultation codes are not separately payable when billed with a primary procedure unless the consultation code is billed with modifier 25 and the clinical documentation supports the use of modifier 25. Note: Consultation codes are not payable after 5/1/2020.	2015
P	National Correct Coding Initiative Supplemental Policy	Temporary during COVID-19 Pandemic: CMS NCCI Column two procedure code is not payable when billed with associated Column one procedure code based on NCCI in place pre-pandemic.	Terminated 10/1/2020
F, P	National Correct Coding Manual Policy	Deny procedures considered to be inappropriately coded based on National Correct Coding Initiative Policies and Guidelines.	2015
F, P	National Correct Coding Manual Policy	E/M Services (99201-99239, 99281-99443, 99450-99499 or S0280-S0281) without modifier 25 are not separately payable when billed with 95004-95199 (Allergy testing or allergy immunotherapy). Note: Consultation codes are not payable after 5/1/2020.	2015
F, P	National Correct Coding Manual Policy	E/M services are not separately payable when billed on the same day as a cardiac stress test.	2015
F, P	National Correct Coding Manual Policy	CPT 69990 (Operating microscope) is payable only when billed with a code from the list of allowed procedures.	2015

Claim Type	Medical Policy	Rule Description	Effective Date
P	National Correct Coding Manual Policy	E/M Services (99201-99499) are not payable when billed with Anesthesia Services (00100-01999) the day prior to or the day of surgery.	2015
P	New Patient Code Frequency Policy	New patient codes are not payable when submitted and review of the current claim OR patient's history determines a new patient code was previously billed and paid by the same provider within the past three (3) years	1/01/2022
F,P	Neurology Policy	Needle electromyography services (CPT codes 95863 and 95864) when billed with a diagnosis of tarsal tunnel syndrome.	3/01/2023
F, P	Neurology Policy	CPT 95860, 95861, 95863, or 95864 to 95870, or 95886 are not payable when the only diagnosis associated to the procedure is carpal tunnel syndrome.	2015
P	Neurology Policy	CPT 95812, 95813, 95816, 95819 or 95822 (EEG) are not payable when the only diagnosis on the claim is of headache or migraine.	2015
F, P	Neurology Policy	Nerve conduction study (95905) is not payable when billed without a needle electromyography (95860-95864) and the only diagnosis on the claim is radiculopathy.	2015
F, P	Neurology Policy	Nerve conduction study (95907-95913) is not payable when billed without a needle electromyography (95885, 95886) or continuous intraoperative neurophysiology monitoring (95940, 95941, G0453) and the only diagnosis on the claim is radiculopathy.	2015
F, P	Neurology Policy	Needle electromyography (95860-95864) is not payable when billed without a nerve conduction study (95905) or continuous intraoperative neurophysiology monitoring (95940, 95941, G0453) and the only diagnosis on the claim is radiculopathy.	2015
F, P	Neurology Policy	Polysomnography (CPT codes 95782, 95783, 95808, 95810 or 95811) are not payable when billed in any combination more than one unit in a two consecutive day period by any provider.	1/01/2018 *Terminated effective 9/24/2023*
F, P	Neurology Policy	CPT 95700, 95705-95726 or 95957 (EEG testing) are not payable when billed without a requisite diagnosis on the claim.	2015
P	Neurology Policy	CPT 95957 (EEG for epileptic spike analysis) is not payable when billed on same date of service as 95700-95726 (Long-term EEG monitoring) by any provider.	2015
F, P	Never Events	Any procedure billed with modifier PA (Surgical or other invasive procedure on wrong body part), PB (Surgical or other invasive procedure on wrong patient), or PC (Wrong surgery or other invasive procedure on patient) is not payable.	9/01/2021
P	New Patient Visit	Identifies claim lines containing new patient Procedure Codes that are submitted for established patients.	2015

Payment Policy:
Coding Edit Rules

(Commercial & Medicare)

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Noncovered Procedures	Identifies claim lines containing procedure codes that are considered to be non-covered based on health plan medical and/or payment policy.	2016
F, P	Obsolete Procedure Code Policy	Procedures that are deemed invalid are not payable.	1/01/2022
P	Obstetrical Package	This rule audits potential overpayments for obstetric care. It will evaluate claim lines to determine if any global obstetric care codes (defined as containing antepartum, delivery and postpartum services, i.e. 59400, 59510, 59610 and 59618) were submitted with another global OB care code or a component code such as the antepartum care, postpartum care, or delivery only services, during the average length of time of the typical pregnancy (and postpartum period as applicable) 280 and 322 days respectively.	11/1/2020
P	Obstetrics and Gynecology Policy	CPT 76805 or 76810-76812 (Initial obstetric ultrasound services) is not payable when 76805 or 76810-76812 has been billed in the past five months.	2015
F, P	Obstetrics and Gynecology Policy	Complete limited non-obstetric pelvic ultrasounds, CPT Codes 76856 and 76857 are not covered when billed with transvaginal ultrasounds, CPT code 76830, during the same visit.	1/1/2023
F, P	Once Per Lifetime Services Policy	Codes for once in a lifetime procedures are not payable when previously reimbursed.	2015
F, P	Ophthalmology Policy	CPT 92250 (Fundus photography) is not payable when billed more than two units within one year except when specific diagnoses are present.	2015
P	Ophthalmology Policy	CPT 66821 (Discission of secondary membranous cataract) is not payable when billed within three months of cataract surgery (66820-66821, 66830-66940, 66982-66984, 66987-66988).	2015 *Terminated effective 9/24/2023*
P	Ophthalmology Policy	CPT 76514 (Ophthalmic ultrasound, diagnostic; corneal pachymetry) is not payable when billed more than once in a patient's lifetime with a diagnosis of glaucoma or ocular hypertension (OHT).	2015
P	Orthopedic Policy	Intraoperative services are not payable when billed with an orthopedic procedure.	2015
F, P	Orthopedic Policy	CPT 29879 (Arthroscopy of knee with abrasion arthroplasty) is not payable when billed with 29880-29881 (Arthroscopy of knee with meniscectomy).	2015
P	Pay Percent Reduction-Cardiology	Identifies claim lines that are eligible for a Multiple Procedure Payment Reduction- Technical Component (TC) of Diagnostic Cardiovascular Procedures. Assigns appropriate pay percentage to the eligible line(s), including adjustments for multiple procedure, as well as bilateral, multiple quantity, and additional payment modifiers.	8/1/2020

Claim Type	Medical Policy	Rule Description	Effective Date
P	Pay Percent – Prof E/M	This rule applies pay percent recommendations to professional claims when a well visit/preventive exam, and any other Evaluation and Management (E&M) code(s), are billed for the same patient, same provider, and same date of service regardless of any modifiers. Same provider is defined as providers of the same group practice who have the same Federal Tax Identification Number (FTIN) and same primary specialty. Pay percent recommendations apply to procedure code groups with one well visit E&M and one or more other E&Ms. Groups are sorted and ranked based on the RVU value in the CMS Physician Relative Value file. • Rank 1 procedures with the highest RVU will receive a pay percent recommendation of 100%, • Rank 2 procedures with the next highest RVU will receive a pay percent recommendation of 50%, • Rank 3 to 5 procedures receive a pay percent recommendation of 0%.	10/01/2021
P	Pay Percent Reduction-Multiple Procedures	This rule will assign a Pay Percent value to each line that is deemed eligible for Pay Percent reduction when more than one surgical service is performed on the same patient, by the same physician, and on the same day.	8/1/2020
P	Pay Percent Reduction-Ophthalmology	Identifies claim lines that are eligible for a Multiple Procedure Payment Reduction- Technical Component (TC) of Diagnostic Ophthalmology Procedures. Assigns appropriate pay percentage to the eligible line(s), including adjustments for multiple procedure, as well as bilateral, multiple quantity, and additional payment modifiers.	8/1/2020
P	Pay Percent Reduction-Radiology	This rule will assign a pay percent to radiology procedures when more than 1 procedure within the same radiology family is submitted for the same provider and same date of service	8/1/2020
P	Physical Medicine Policy	CPT 97032, 97110-97124, 97129-97130, 97140, 97530-97542, 97760-97763, G0151-G0153, or G0157-G0161 (Time-based Physical Medicine services) are not payable when the total combined units exceed eight per date of service.	2015
F, P	Physical Medicine Policy	CPT 97033 (Iontophoresis) is not payable when billed and the diagnosis on the claim is not primary focal hyperhidrosis.	2015

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Physical Medicine Policy	CPT 95992 (Canalith repositioning procedure) is not payable when the diagnosis on the claim is not benign paroxysmal vertigo.	2015
P	Physician Visit Frequency Policy	Multiple office visits with a related diagnosis are not payable when submitted by the same provider for the same date of service.	1/01/2022
P	Place of Service Policy	Medical and surgical supplies and DME are not payable when reported by professional providers with inpatient or facility places of service. (CMS-1500)	2015
F, P	Place of Service Policy	New and established office/outpatient visit (99201-99205 or 99211-99215) are not payable when billed in any place of service other than 01 (Pharmacy), 02 (Telehealth), 03 (School), 04 (Homeless shelter), 05 (Indian health service free-standing facility), 06 (Indian health service provider-based facility), 07 (Tribal 638 free-standing facility), 08 (Tribal 638 provider-based facility), 09 (Prison/correctional facility), 11 (Office), 14 (Group home), 15 (Mobile unit), 16 (Temporary lodging), 17 (Walk-in retail health clinic), 18 (Place of employment/worksite), 19 (Outpatient hospital - off campus), 20 (Urgent care facility), 22 (Outpatient hospital - on campus), 23 (Emergency room), 24 (Ambulatory surgical center), 25 (Birthing center), 26 (Military treatment facility), 49 (Independent clinic), 50 (Federally qualified health center), 53 (Community mental health center), 57 (Non-residential substance abuse treatment facility), 58 (Non-residential opioid treatment facility), 60 (Mass immunization center), 62 (Comprehensive outpatient rehabilitation facility), 65 (End-stage renal disease treatment facility), 71 (State on local public health clinic), 72 (Rural health clinic), or 99 (Other place of service).	2015
F, P	Place of Service Policy	Evaluation and management services for inpatient neonatal and pediatric critical care (99468-99476) or initial and continuing intensive care (99477-99480) are not payable when billed in a place of service other than 02 (Telehealth) or 21 (Inpatient hospital).	2015
P	Place of Service Policy	Domiciliary/rest home E/M services (99324-99340) are not payable when billed in any place of service other than 13 (Assisted living facility), 14 (Group home), 33 (Custodial care facility), 55 (Residential substance abuse facility), or 99 (Other place of service), except when E/M services codes 99324-99328 or 99334-99337 are billed in POS 02 (Telehealth).	2015
P	Place of Service Policy	Emergency department visits (99281-99285, G0380-G0384) when billed in any place of service other than 23 (Emergency Department) are not payable, except when emergency department visit codes 99281-99285 are billed in POS 02 (Telehealth).	2015

Claim Type	Medical Policy	Rule Description	Effective Date
P	Place of Service Policy	E/M home visit services (99341-99350) are not payable when billed in any place of service other than 02 (Telehealth) or 12 (Patient's home).	2015
F, P	Place of Service Policy	Initial hospital care services (99221-99223), follow-up hospital care services (99231-99233), and hospital discharge services (99238-99239) are not payable when billed in any place of service other than 02 (Telehealth), 06 (Indian health service provider-based facility), 08 (Tribal 638 provider-based facility), 21 (Inpatient hospital), 25 (Birthing center), 26 (Military treatment facility), 34 (Hospice), 51 (Psychiatric inpatient facility), 52 (Psychiatric partial hospitalization facility), and 61 (Comprehensive rehab facility), except when E/M services 99221-99223 or 99238-99239 are billed in POS 02 (Telehealth).	2015
P	Place of Service Policy	Nursing Facility E/M services (99304-99310, 99315-99316 or 99318) are not payable when billed in a place of service other than 31 (Skilled nursing facility), 32 (Nursing facility), 34 (Hospice), 54 (Intermediate care facility/individuals with intellectual disabilities), or 56 (Psychiatric residential treatment facility), except when Nursing Facility E/M services codes 99304-99310 or 99315-99316 are billed in POS 02 (Telehealth).	2015
F, P	Place of Service Policy	Outpatient observation services (99217-99220), subsequent observation care (99224-99226), observation or inpatient hospital care (99234-99236) are not payable when billed in any place of service other than 02 (Telehealth), 19 (Outpatient hospital - off campus), 21 (Inpatient hospital), 22 (Outpatient hospital - on campus), 23 (Emergency department), 24 (Ambulatory Surgical Center), 25 (Birthing center), 26 (Military treatment facility), 51 (Psychiatric inpatient facility), or 52 (Psychiatric facility partial hospitalization), except when E/M services codes 99217-99220 or 99234-99236 are billed in POS 02 (Telehealth).	2015
F, P	Place of Service Policy	Outpatient consultation services (99241-99245) are not payable when billed with a place of service 21 (Inpatient hospital). Note: Consultations are no longer payable effective 5/1/2020.	2015
P	Place of Service Policy	HCPCS codes beginning with "C" are not payable when billed on claim type P (Professional).	2015
P	Place of Service Policy	Surgical dressings are not payable when billed in the provider's office (POS 11).	2015
F, P	Place of Service Policy	Home health/home infusion procedures are not payable when billed in any place of service other than 03 (School), 04 (Homeless shelter), 12 (Home), 13 (Assisted living facility), 14 (Group home), 16 (Temporary lodging), 33 (Custodial care facility), 54 (Intermediate care facility/individuals with intellectual disabilities), or 55 (Residential substance abuse treatment facility).	2015

Claim Type	Medical Policy	Rule Description	Effective Date
P	Place of Service Policy	Services with a Non-Facility NA Indicator of "N/A" are not payable when billed in place of service 11. (CMS)	2015
F	Place of Service Policy	CPT codes 31515-31571 (Direct laryngoscopy) are not payable for a patient less than two years of age when billed in any place of service other than 05 (Indian Health service freestanding facility), 06 (Indian health service provider-based facility), 07 (Tribal 638 freestanding facility), 08 (Tribal 638 provider-based facility), 19 (Outpatient hospital- off campus), 21 (Inpatient hospital), 22 (Outpatient hospital-on campus), 23 (Emergency room hospital), 24 (Ambulatory surgical center), or 26 (Military treatment facility).	Terminated 1/1/2021
P	Place of Service Policy	Diagnostic imaging procedures 70370, 70371, and 74230 are not payable when billed in any place of service other than 11 (Office), 19 (Outpatient hospital-off campus), 21 (Inpatient hospital), 22 (Outpatient hospital-on campus), 23 (Emergency room), 61 (Comprehensive inpatient rehab facility), or 62 (Comprehensive outpatient rehab facility). (CMS-1500)	2015 *Terminated effective 9/24/2023*
P	Place of Service Policy	Laboratory services (80000-89999) are not payable when billed in Place of Service 19 (Outpatient hospital-off campus), 21 (Inpatient hospital), 22 (Outpatient hospital-on campus), 23 (Emergency department), or 24 (ASC) by a provider with a specialty other than Dermatology, Genetics, Hematology, Laboratory, or Pathology.	2015
F	Place of Service Policy	Services submitted with Bill Type 0330-033Z are not payable.	2015
P	Place of Service Policy	Any physician service code is not payable when billed in a non-facility place of service by a professional provider and the same code was billed by any facility (on a CMS-1500) for the same date of service. (CMS)	2015
F, P	Podiatry Policy	As per CMS LCD Article A57759, CPT 11055-11057, 11719-11721, or G0127 (Routine foot care) are not payable when billed more than once within a two-month period.	2015
P	Podiatry Policy	As per CMS LCD Article A57759, CPT 11055-11057, 11719-11721, or G0127 (Nail paring, cutting, debridement, trimming) are not payable when billed without a requisite diagnosis on the claim.	2015
P	Post-operative Visits	Identifies Procedure Codes billed by the same provider within a procedure's post-operative global period.	2015
P	Pre- and Post-operative Visits – different diagnosis	Identifies visits billed by the same provider within another procedure's pre-operative and/or post-operative period when there is not an exact match between the diagnosis reported for the visit and the diagnosis reported for the procedure with the global surgical package. Modifiers are considered for potential override of the rule logic.	2018

Payment Policy:
Coding Edit Rules

(Commercial & Medicare)

Claim Type	Medical Policy	Rule Description	Effective Date
P	Pre-operative visits	Identifies Procedure Codes billed by the same provider within a procedure's pre-operative global period.	2015
P	Primary Care Policy	Influenza vaccine is not payable when paid more than twice within the same calendar year and the patient is nine years of age or older.	2015
F, P	Procedure Code Definition Policy	Procedure codes and/or their related guidelines contain specific descriptive criteria for use. Services are not payable if they do not meet the code criteria. Examples: G0266 and 93298 are for a 30-day period; G0268 requires an audiologic function testing on same date of service; 93294 has a 90-day global period.	2015
F, P	Procedure Code Definition Policy	Procedures billed out of sequence are not payable.	2015
F, P	Procedure Code Definition Policy	Procedure codes and/or their related guidelines contain specific descriptive criteria for use. Services are not payable if they do not meet the code criteria. Example, CPT 17004 "Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions" should not be reported with diagnosis B08.1 "Molluscum contagiosum".	2015
F, P	Procedure Code Definition Policy	Procedure codes and/or their related guidelines contain specific descriptive criteria for use. Services are not payable if they do not meet the code criteria. Example: 71045 X-ray exam chest 1 view and 74019 X-ray exam abdomen 2 views should instead be coded as 74022 X-ray exam complete abdomen.	2015
F, P	Procedure Code Definition Policy	HCPCS G0008, G0009, or G0010 are not payable if billed without the appropriate, corresponding vaccine code.	2015
P	Procedure Code Definition Policy	CPT codes for procedures billed out of sequence are not payable.	2015
F, P	Procedure Code Guideline Policy	Services that are coded inappropriately based on CPT/HCPCS Procedure Code Guidelines are not payable.	2015
F, P	Procedure Code Guideline Policy	Services that are coded inappropriately such as unbundled, when there is a single code that represents the unbundled services, will be denied based on CPT/HCPCS Procedure Code Guidelines.	2015
F, P	Procedure Code Guideline Policy	Modifier 63 are not payable when billed with procedure codes to which this modifier does not apply, based on CPT/HCPCS Procedure Code Guidelines.	2015
F, P	Procedure Code Guideline Policy	Immunization administration (90460-90461, 90471-90474) are not payable when billed without a vaccine/toxoid code (90476-90750, 90756, J3530, Q2033-Q2039, or S0195) by any provider on the same date of service.	2015

Claim Type	Medical Policy	Rule Description	Effective Date
P	Procedure Code Guideline Policy	E/M services are not separately payable when billed with 94010-94799 (Pulmonary function testing), unless the E/M code is billed with modifier 25 and the clinical documentation supports the use of modifier 25.	2015
F, P	Procedure Code Guideline Policy	CPT 61797 or 61799 (Stereotactic radiosurgery, each additional cranial lesion) are not payable when billed more than four visits in two weeks.	2015
P	Procedure Code Guideline Policy	CPT 77371-77373 (Radiation treatment delivery, stereotactic radiosurgery), G0339 or G0340 (Image-guided robotic linear accelerator-based stereotactic radiosurgery) are not payable when billed more than five combined units in two weeks.	2015
P	Procedure Codes- Count Limited to 1 per Date of Service	Identifies claim lines with procedure codes submitted more than once per date of service, when the maximum allowance is defined as once per date of service. This rule contains a rule filter that excludes certain lines from being evaluated by this rule. Claim lines with procedures codes audited in either the MUE_SINGLE_LINE_MADV or MUE_MULT_LINES_MADV rule (content sourced only to CMS) should not be audited in this rule (whose content is not solely sourced to CMS) to avoid overlapping or different auditing results. This rule recommends the denial of procedure codes not audited in the MUE_SINGLE_LINE_MADV or MUE_MULT_LINES_MADV rule when a procedure code description contains terminology that does not warrant multiple submissions of that procedure for a single date of service. This includes the following terms: Bilateral, Unilateral/Bilateral, or Single/Multiple. This edit also occurs when a procedure code is submitted multiple times, exceeding the maximum allowance that would be clinically appropriate.	2015
P	Procedure Codes-Count Limits per Date of Service	Identifies claim lines with procedure codes that have exceeded the maximum number of times allowed for a single date of service. This is reflective of the total number of times it is clinically possible or clinically reasonable to perform a given procedure on a single date of service across all anatomic sites. After reaching the maximum number of times allowed, additional submissions of the procedure are not recommended for reimbursement.	2015
P	Procedure Code Guideline Policy	CPT 99483 (Assessment of and care planning for patient with cognitive impairment) is not payable if billed more than once in a 180-day period.	9/2022
F, P	Procedure- Gender Policy	Procedures submitted that are inconsistent with the patient's gender, based on the code definition are not allowed unless billed with ICD-10 diagnosis F64.0, F64.1, F64.2, F64.8, F64.9, OR Modifier -KX.	2015 *Terminated 8/01/2021*

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Procedure- Gender Policy	Procedure codes that are inconsistent with the patient's gender are not payable, when a more appropriate code is not available unless billed with modifier KX or a transgender diagnosis.	2015 *Terminated 8/01/2021*
F, P	Procedure- Gender Policy	Newborn services based on the patient's gender are not payable when a more appropriate code is not available.	2015 *Terminated 8/01/2021*
F, P	Procedure- Gender Policy	Newborn procedures that are specific to a gender, are payable for that gender.	2015 *Terminated 8/01/2021*
F, P	Procedure-Age Policy	Procedures that are inconsistent with the patient's age based on the code definition are not payable.	2015
F, P	Procedure-Age Policy	Procedure codes that are inconsistent with the patient's age based on the code definition are not payable.	2015
F, P	Procedure-Age Policy	Procedure codes that are inconsistent with the patient's age based on the code definition are not payable when a more appropriate code is available.	2015
F, P	Procedure-Age Policy	Procedures submitted that are inconsistent with the patient's age based on the nature or indication for the procedure are not payable.	2015
P	Procedure-Diagnosis Incompatibility Policy	Procedures submitted with a diagnosis code that is not compatible with CMS National Government Services National Coverage and Local Coverage Determinations (NCD/LCD) are not payable.	1/01/2022
F, P	Procedures Inconsistent With Age	Identifies claim lines containing procedures that are inconsistent with the patient's age.	2015
P	Procedure Inconsistent with Place of Service Policy	Procedures not related to Telehealth/Telemedicine, as per CMS, are not payable when reported with place of service "02".	1/01/2022
F, P	Professional, Technical, and Global Services Policy	Modifier 26 submitted with a code that is defined as professional component only (CMS) is not payable.	2015
P	Professional, Technical, and Global Services Policy	Codes billed with modifier TC when submitted on a technical component only procedure code are not payable.	2015
P	Professional, Technical, and Global Services Policy	Diagnostic tests or radiology services billed with modifier TC is not payable to a professional provider in the inpatient or outpatient facility setting.	2015
P	Professional, Technical, and Global Services Policy	Radiology services with a modifier 26 are not payable when billed with an E/M service in the office.	2015
P	Professional, Technical, and Global Services Policy	Clinical laboratory services with modifier 26 are not payable for those codes that do not have a separately payable professional service (CMS).	2015

Payment Policy:
Coding Edit Rules

(Commercial & Medicare)

Claim Type	Medical Policy	Rule Description	Effective Date
P	Professional, Technical, and Global Services Policy	Reimbursement of diagnostic tests and radiology services is limited to no more than the amount for the global service (CMS).	2015
P	Professional, Technical, and Global Services Policy	Diagnostic tests or radiology services billed without modifier 26 are not payable when submitted by a provider in a facility place of service. (CMS)	2015
F	Professional, Technical, and Global Services Policy	Professional component procedures are not payable when billed by a facility and the Revenue Code is not 0960-0989 (Professional fees). (CMS-1450)	2015
P	Professional, Technical, and Global Services Policy	Technical component only procedures are not payable to professional providers in the inpatient or outpatient facility setting (CMS).	2015
P	Professional, Technical, and Global Services Policy	Physician service codes that do not have an associated professional or technical component (CMS) are not payable when billed with modifier 26.	2015
P	Professional, Technical, and Global Services Policy	Modifiers 26 and TC are not payable when appended to the same claim line.	2015
P	Professional, Technical, and Global Services Policy	Physician service codes that do not have an associated professional or technical component are not payable when billed with modifier TC (CMS).	2015
F, P	Professional, Technical, and Global Services Policy	Technical component only services are not payable when billed with modifier 26 (CMS).	2015
F, P	Professional, Technical, and Global Services Policy	Professional component only procedures are not payable when billed with modifier TC (CMS).	2015
F	Professional, Technical, and Global Services Policy	A Global Only code as identified in the CMS Physician Fee Schedule with PC/TC status '4', is not payable when billed by a professional in a facility setting. Only the professional component of this service is payable in the facility setting. It should be reported with the correct code.	2015
F	Professional, Technical, and Global Services Policy	A Global Only code as identified in the CMS Physician Fee Schedule with PC/TC status '4', is not payable when billed by a facility. Only the technical component of this service is payable in the facility setting. It should be reported with the correct code.	2015
P	Professional, Technical, and Global Services Policy	X-ray services (which are also diagnostic tests or radiology services) billed without modifier 26 are not payable when submitted by a provider in POS 12, 13, 31, or 32 and R0070 and R0075 are not also present (CMS).	2015
F	Professional, Technical, and Global Services Policy	Professional component procedures are not payable when billed by a facility. (CMS-1500)	2015
F, P	Psychiatry- Psychology Policy	Subsequent TMS is not payable when billed and 90867 (TMS, initial), 90868 or 90869 (TMS, subsequent) has not been billed in the previous week.	2015

Claim Type	Medical Policy	Rule Description	Effective Date
P	Quality of Care Policy	Procedures billed by a pathologist that are outside the scope of pathology practice are not payable.	2015
P	Radiology Policy	99201-99239 or 99241-99255 (Evaluation and Management) is not separately payable when billed with 77065-77066 (Mammography) and the provider's specialty is Radiology.	2015
F, P	Radiology Policy	Additional rib x-ray series are not payable when another rib x-ray series (71100, 71101, 71110 or 71111) has been previously paid for the same date of service.	2015
F, P	Radiology Policy	CPT 71101-LT (X-ray, ribs, unilateral, three views; left) is not payable when billed with 71101-RT (X-ray, ribs, unilateral, three views; right). CPT71111 (X-ray, ribs, bilateral, four views) is for bilateral.	2015
F, P	Radiology Policy	CPT 71100 (X-ray, ribs, unilateral; two views) is not payable if billed with units greater than one.	2015
F, P	Radiology Policy	CPT 75625 (Abdominal aortography) is not payable when billed with 75716 (Angiography, extremity, bilateral). CPT 75630 (Abdominal aortography plus bilateral iliofemoral lower extremity) represents both procedures.	2015
F, P	Radiology Policy	CPT 71100 (X-ray, ribs, unilateral; 2 views) appended with modifier 50 is not payable.	2015
F, P	Radiology Policy	72100 (Radiologic exam, spine, lumbosacral, AP and lateral) is not payable when billed with 72040 (Radiologic exam, spine, cervical, AP and lateral) and 72070 (Radiologic exam, spine, thoracic; AP and lateral). 72084 (Radiologic exam, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed) is the comprehensive code.	2015
F, P	Radiology Policy	Chest x-ray (CPT code 71045 or 71046) is not payable when billed and the only diagnosis on the claim is a general medical exam, pre-admission, administrative or pre-operative exam.	1/01/2018 *Terminated effective 9/24/2023*

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Related Services- to a Noncovered Procedure	Certain procedures are deemed to be non- covered by health plans based on their medical and/or payment policies. This rule identifies procedure codes or revenue codes billed by the same or a different provider, on the same or a different claim ten-days prior to, the same day as or within seven days after a non-covered service. The rule requires a match on the first three digits of a line's diagnosis code to determine if the deny line procedure or revenue code is related to the non-covered service. The rule also looks to see if the non-covered procedure was denied for payment. If the non-covered procedure was paid, then the related service would not be recommended for denial via this rule. This rule audits both facility and non-facility claims. The content of this rule is intended to be supplied by the health plan and should be based on their medical and/or payment policies. A "starter set" of data for this rule is provided and it contains procedures such as all lab, anesthesia, radiology, revenue and evaluation and management codes; HCPCS "J" codes for drugs; HCPCS "A" codes for supplies; select CPT surgery and medicine codes such as venipuncture and EKGs among others.	2016
F	Revenue Code Invalid	Identifies Revenue Codes that are invalid. According to the National Uniform Billing Committee (NUBC) and the Centers for Medicare and Medicaid Services (CMS), a revenue code is required on a UB-04 claim form. Revenue codes are validated using the current release of data files from the Integrated Outpatient Code Editor (I/OCE). This rule recommends the denial of claim lines containing invalid revenue codes. A null revenue code field causes the claim line to exit. By default, this rule will not audit CMS 1500 claim forms.	2016
F	Revenue Code Lab Services Policy	Claims with bill type 0140-014Z are not payable when billed without revenue codes 0300-0319. Revenue code for Bill Type 0140-014Z are the laboratory/pathology revenue codes (0300-0319).	1/01/2022

Claim Type	Medical Policy	Rule Description	Effective Date
F	Revenue Codes Requiring CPT or HCPCS Codes	The Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS) Detailed Program Edits require certain revenue codes to be reported with a Healthcare Common Procedure Coding System (HCPCS) code. Revenue codes are summary billing codes required on the UB-92 claim form to represent the type of service provided and where it was performed. According to CMS OPPS Detailed Program Edits, for certain bill types and certain revenue codes a HCPCS code must also be submitted. This rule recommends the denial of claim lines submitted with a revenue code that requires a HCPCS code and no HCPCS code is present. The OPPS Detailed Program Edits do not provide instruction as to which HCPCS code should be submitted with each revenue code. Therefore, this edit only fires if there is no HCPCS code on the claim.	2016
P	Same Day Visit	Identifies Procedure Codes billed by the same provider on the same date of service as a code with a global period.	2015
F, P	Separate Procedures Policy	Separate procedures are not payable when billed with the associated major procedures.	2015
P	Separate Procedures Policy	Procedures designated as a "separate procedure" are not payable when submitted with a related major	1/01/2022
P	Separate Procedures Policy	Add-on CPT codes are not payable when submitted and the primary code has not been billed AND paid for the same date of service by the same provider.	1/01/2022
P	Separate Procedures Policy	Procedures or services that are designated as a bundled/incidental or packaged per the CMS National Physician Fee Schedule Relative Value File (NPFSRVF), Outpatient Prospective Payment System (OPSI), or Ambulatory Payment Classifications (APC) are not payable.	1/01/2022
F	Specialty Pharmacy-Facility	This rule will audit outpatient facility claims involving specialty pharmaceuticals utilizing the following parameters: -- Drug Code and Diagnosis (defined as either Covered or Non-Covered) -- Drug Code and Maximum Billable Units -- Drug Code and Age -- Drug Code and Gender -- Drug Code and Place of Service --When the Drug code reported without JW- modifier deny based any of the reason above, the corresponding claim line reported with JW-modifier will also be denied. Drug Code with any combination of the elements listed above.	2017 *Terminated 8/01/2021*

Claim Type	Medical Policy	Rule Description	Effective Date
P	Specialty Pharmacy-Professional	This rule will audit professional claims involving specialty pharmaceuticals utilizing the following parameters: -- Drug Code and Diagnosis (defined as either Covered or Non-Covered) -- Drug Code and Maximum Billable Units -- Drug Code and Age -- Drug Code and Gender -- Drug Code and Place of Service --When the Drug code reported without JW- modifier deny based any of the reason above, the corresponding claim line reported with JW-modifier will also be denied. Drug Code with any combination of the elements listed above.	2017 *Terminated 8/01/2021*
P	Specialty to Procedure Code Mismatch	Identifies claim lines containing procedures that are not typically associated with a specific provider type or specialty.	2018
P	Split Surgical Care Policy	Procedures billed with either modifier 54, 55 or 56 are not payable when another provider has billed the same code globally without a modifier.	2015
P	Split Surgical Care Policy	Procedures with a 90-day global surgical period are not payable to Emergency Medicine physician in the emergency room setting (POS 23) (CMS), unless billed with modifier 54 (Surgical care only).	2015
P	Split Surgical Care Policy	Procedures with a 90-day global surgery period are not payable when billed in the provider's office when any provider has billed this procedure code in the previous 90 days. (CMS)	2015
P	Split Surgical Care Policy	Procedures billed without modifier 54, 55 or 56 are not payable when another provider has billed the same procedure with modifier 54, 55 or 56.	2015
P	Surgical Global Fee Period Policy	Physician visits or procedures/services are not payable when billed by the operative provider with a related diagnosis within the postoperative period of a surgical procedure as defined within the CMS National Physician Fee Schedule Relative Value File (NPFSRVF).	1/01/2022
P	Team Surgery Policy	CPT codes designated as Team Surgery is not allowed, are not payable when billed with modifier 66. (CMS)	2015
P	Team Surgery Policy	Procedure billed without modifier 66 (Team Surgery) are not payable when there exists a previously processed claim for the same procedure code with modifier 66 by any provider (CMS).	2015
P	Team Surgery Policy	Medical and surgical procedures are not payable when billed with modifier 66 and the Team Surgery concept does not apply. (CMS)	2015
P	Team Surgery Policy	Procedures billed with modifier 66 are not payable when there exists a previously processed claim for the same procedure code without modifier 66 by any provider (CMS).	9/01/2021

Claim Type	Medical Policy	Rule Description	Effective Date
P	Unbundled Pair- AMA	According to April 1991 CPT Assistant, evaluation of x-rays by a consulting or primary physician is considered to be an integral component of the global evaluation and management services for a patient. Thus, the reporting of CPT code 76140 with an evaluation and management service represents an overlap of service and duplication of effort that does not warrant separate reimbursement	1/1/2018
P	Unbundled Pair- AMA	According to CPT guidelines for radiation treatment management (CPT code 77427), evaluation and management services are not reported separately. Thus, the reporting of an office visit with radiation treatment management represents overlapping of services and does not warrant separate reimbursement.	1/1/2018
P	Unbundled Pair- AMA	According to CPT guidelines, surgical preparation (CPT codes 15002-15005), are not to be reported with wound management and debridement services.	1/1/2018
P	Unbundled Pair- AMA	According to the November 1999 CPT Assistant, "when acuity is measured as part of a general ophthalmological service or of an E/M service of the eye, it is part of the diagnostic examination and not a screening test". Screening test of visual acuity (CPT codes 99172 and 99173) is considered a component of a comprehensive evaluation and management visit and does not warrant separate reimbursement. If a separate and distinct screening of visual acuity is performed in addition to a problem-oriented E/M service which did not involve eye or vision testing additional reimbursement may be warranted for this unique clinical scenario. (Check code pair edits and make sure preventive E/Ms are excluded)	1/1/2018
P	Unbundled Pair- AMA	CPT code 37617 is used to describe the tying off of an abdominal artery completely (ligation), proximal and distal to the site of injury. According to CPT guidelines, if during an abdominal procedure involving the removal of tissue (organ) ligation of an artery is deemed necessary, the ligation of vessels would not be separately reported.	1/1/2018
P	Unbundled Pair – CMS AMA	Intraoperative neurophysiology testing services shall not be reported by the physician performing an operative or anesthesia procedure since it is included in the global package of the primary surgical procedure.	1/1/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Unbundled Pair – CMS/AMA	Intraoperative neurophysiological monitoring is utilized during the performance of surgical procedures in order to assure that the nervous system has not been compromised or damaged during the primary surgical procedure. According, to CPT guidelines, when the monitoring service is performed by the operating surgeon or anesthesiologist, the professional services are included in the surgeon's or anesthesiologist's primary service codes for the procedure and should not be reported separately. In addition, nerve monitoring procedures will only be reimbursed when they are performed as a diagnostic service. This logic is also supported by the CMS guideline for Standard of Medical/Surgical Practice found in the National Correct Coding Policy Manual for Part B Medicare Carriers, Chapter I that states, "Examples of services integral to a large number of procedures include: isolation of structures limiting access to the surgical field such as bone, blood vessels, nerve, and muscles including stimulation for identification or monitoring."	1/1/2018
F	Unbundled Services-Facility	This rule detects the unbundling of multiple surgical codes when submitted on facility claims. This rule is similar to the UNBUN_PAIRS rule, this rule audits facility claims. The clinical content for this rule may contain overlap with the OCE_CCI rule but will also fill in some gaps and include content not contained in the OCE_CCI rule.	2016
P	Unbundled Services-Professional	Identifies claim lines containing Procedure Codes that are typically not recommended for reimbursement when submitted with certain other Procedure Codes on the same date of service. This includes Incidental, Mutually Exclusive, Ultimate Parent Rebundling, and Visit codes that are not separately payable. The sources of this edit are the AMA CPT code guidelines, and/or CMS NCCI Policy Manual, and/or CMS Claims Processing Manual. Examples of incidental services are: · CPT 36415 Venipuncture when also billing for laboratory procedure codes. · CPT 81002 Urinalysis dipstick with an Evaluation and Management code unless appended with modifier 25	2015 *Terminated 10/01/2021 See CMS_UNBUN_PAIRS*
F, P	Unlisted Procedures	This rule will deny unlisted codes in accordance with the CCI Unlisted Code reimbursement policy.	CCIM 2016, CCIC 5/1/2020
P	Urology Policy	CPT 54235 (Inject corpora cavernosa with pharmacologic agents) is not payable when billed more than one visit within a year by any provider.	2015

Claim Type	Medical Policy	Rule Description	Effective Date
P	Urology Policy	CPT 76857 (Ultrasound, pelvic [non-obstetric], limited or follow-up) is not payable when billed on same date of service as 51725-51729 (Simple or complex CMG), 51736 (Simple uroflowmetry), or 51741 (Complex uroflowmetry). Refer to CPT 51798 (Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging.	2015
F, P	Valid Ambulance Services	This rule recommends the denial of inappropriate ambulance services for supplier and provider claims, as defined by CMS. Generally, two lines of coding (i.e. mileage code and transport/service code) are required in most ambulance billing scenarios. This rule also recommends the denial of claim lines, which lack the presence of an ambulance origin- destination modifier and institutional claim lines which lack appropriate arrangement modifiers as required. For unique Ambulance trip auditing, this will evaluate Ambulance Transport and mileage codes submitted on the Same Claim ID Only and by the same Provider ID, for same member and on same Date of Service.	11/1/2020

Revision history

DATE	REVISION
3/8/2024	• Bilateral Procedures – Modifiers 50, RT, LT (Codes with Bilateral Indicator 1) edit rule description updated to clarify that "If the same code is reported once with modifier RT and once with modifier LT this is not allowed. Instead, the code should be reported with modifier 50 for 1 unit. The 150% payment adjustment will apply."
12/22/2023	**Highlighted in yellow** • 2 new edits effective 4/15/2024 • 1 new edit effective 1/1/2024
9/11/2023	• 1 edit termed for Commercial & Medicare effective 3/26/2023 • 6 edits termed for Medicare effective 9/24/2023
6/12/2023	• Corrected edit "Complete and limited non-obstetric pelvic ultrasounds, CPT codes 76856 and 76857, are not covered when billed with transvaginal ultrasounds, CPT code 76830, during the same visit" to include facility type.
6/5/2023	• Added update to edit "Claim lines reported with mutually exclusive code combinations according to ICD-10-CM Excludes 1 Notes guideline policy are not payable" indicating that edit will apply to preventative services effective 9/15/2023
1/30/2023	• Line of Business (LOB) column removed
12/01/2022	• Updated to include 1 new edit effective 3/01/2023
11/09/2022	• Updated to include 3 new edits effective 3/15/2023

Payment Policy:
Coding Edit Rules
(Commercial & Medicare)

DATE	REVISION
10/04/2022	• Catalog of current edits updated • 1 new edit effective 1/01/2023
1/24/2022	• 1 new edit effective 3/01/2022
1/13/2022	• Correction to 6/2021 Revision: Total of 11 edits terminated effective 8/01/2021 • Bilateral Procedures- Modifiers 50, RT, LT rule updated with clarification regarding CMS bilateral indicators 0, 2, 3 and 9
11/2021	• 1 edit effective 3/01/2022
10/2021	• Corrections to effective dates noted in 9/2021: • 7 edits effective 2/01/2022 • 21 edits effective 1/01/2022 • 1 edit effective 11/30/2022
9/2021	• Updated policy to include 28 new edits effective 1/01/2022 • Updated policy to include 1 new edit effective 1/19/2022
8/2021	• Updated policy to include 1 new edit effective 11/16/2021
6/2021	• Updated policy to include 8 new edits effective 10/01/2021 • Updated policy to include 13 edits terminated effective 8/01/2021
5/2021	• Updated policy to include 3 new edits effective 10/01/2021; replacing 3 edits terminated as of 10/01/2021 • Updated policy to include 3 new edits effective 8/31/2021 • Updated policy to include 2 new edits effective 9/01/2021
3/2021	• Updated policy to include Cotiviti Edits; including new edits effective 5/25/2021
9/2020	• Catalog of ClaimsXten coding edit rules; transferred content to new template with new Reimbursement Policy Number