Payment Policy: Coding Edit Rules (Commercial & Medicare)

POLICY NUMBER	REVIEW DATE	APPROVED BY
R20200023	1/24/2022	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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Code Edits:

Line of Business (LOB): ConnectiCare Commercial (CCIC), ConnectiCare Medicare (CCIM)
Claim Type: Facility (F), Professional (P)

LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC, CCIM	P	Add-on Code Policy	Codes designated as "Add-on" codes are not payable with modifier -51.	2015
CCIC, CCIM	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
CCIC, CCIM	P	Add-on Codes	Identifies claim lines containing an add-on code billed without the presence of the related primary service/procedure.	2015
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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

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LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIM	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
CCIM	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
CCIC, CCIM	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
CCIC, CCIM	P	Anesthesia Policy	Anesthesia services (00100-01999) billed by a CRNA without the appropriate CRNA modifier (QX, or QZ) are not payable.	2015
CCIC, CCIM	P	Anesthesia Policy	Anesthesiologist's claims billed without medical supervision/direction modifiers are not payable if a CRNA claim with medical direction exists.	2015
CCIC, CCIM	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
CCIC, CCIM	P	Anesthesia Policy	CPT 00100-01999 (Anesthesia services) are not payable if billed without an appropriate modifier.	2015
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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

LOB	Claim Type	Medical Policy	Rule Description	Effective Date
			allowances of an Assistant at Surgery according to the Medicare Physician Fee Schedule.	
CCIC, CCIM	P	Assistant Surgeon Policy	CPT 59510 (Global obstetrical care, Cesarean delivery) is not payable when billed with an assistant surgeon modifier.	2015
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	P	Assistant Surgeon Policy	CPT 59515 (Cesarean delivery only, including postpartum care) is not payable when billed with an assistant surgeon modifier.	2015
CCIC, CCIM	F, P	Assistant Surgeon Policy	Only one assistant surgeon is allowed for a surgical procedure.	2015
CCIM	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
CCIC, CCIM	P	Assistant Surgeon Policy	Primary surgeons that also bill for assistant surgeon under the same provider ID are not payable.	2015
CCIC, CCIM	P	Assistant Surgeon Policy	Assistant surgeon services are payable only when the code allows an assistant in accordance with CMS.	2015
CCIC, CCIM	P	Assistant Surgeon Policy	Clinical documentation is required for Assistant surgeon services in accordance with CMS.	2015
CCIC	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
CCIC, CCIM	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

LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC, CCIM	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 **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
CCIC, CCIM	F, P	Bilateral Procedures Policy	Bilateral procedures are payable when billed in accordance with the CMS Physician RVU file Bilateral designation.	2015
CCIC, CCIM	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

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CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	P	Bundled Services Policy	Bundled services (Status indicator P) are not payable when billed with other payable services on the same day.	2015
CCIC, CCIM	P	Bundled Services Policy	Bundled services for which payment is always routinely bundled into other services and supplies are not payable.	2015
CCIC	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
CCIC	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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	1/01/2022

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			test code that includes the multiple test components.	
CCIM	P	CMS Coverage Policies	Physician voluntary reporting program codes are not reimbursable with greater than $0.00.	2015
CCIM	P	CMS Coverage Policies	HCPCS V2787 or V2788 are not payable.	2015
CCIM	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
CCIM	P	CMS Coverage Policies	Performance measurement code with status indicator M are not payable >0.00 based on CMS designation.	2015
CCIM	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
CCIM	P	CMS Coverage Policies	Chiropractic manipulation (98940-98942) is not payable when billed without modifier AT.	2015
CCIC, CCIM	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
CCIM	P	CMS Coverage Policies	G0438 (Annual wellness visit; initial visit) is not payable when billed more than once in a patient's lifetime.	2015
CCIC, CCIM	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
CCIM	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
CCIC, CCIM	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
CCIM	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
CCIM	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

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LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIM	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
CCIC, CCIM	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
CCIM	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
CCIM	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
CCIC	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
CCIM	P	CMS National Coverage Determinations (NCD) Policy	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
CCIM	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
CCIM	P	CMS National Coverage Determinations (NCD) Policy	HCPCS G0102 or G0103 are not payable when billed more than once every 11 months.	2015
CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC	P	CMS National Coverage Determinations (NCD) Policy	HCPCS J0881, J0885 or Q5106 are not payable when billed with modifier EB.	2015
CCIC, CCIM	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

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LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC, CCIM	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
CCIC, CCIM	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
CCIM	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
CCIM	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
CCIM	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
CCIC, CCIM	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*

LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC, CCIM	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
CCIC	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
CCIC, CCIM	P	Co-Surgeon Policy	Procedures billed with modifier 62 are not payable when designated as co-surgeons not allowed. (CMS)	2015
CCIC, CCIM	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
CCIC, CCIM	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
CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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

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LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIM	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
CCIC, CCIM	F, P	Deleted HCPCS Codes Policy	Deleted HCPCS codes will be denied as obsolete.	2015
CCIM	P	Device and Supply Policy	Imaging agents are not payable when billed without the requisite imaging procedures as defined by Regional CMS guidelines.	2015
CCIM	P	Device and Supply Policy	Imaging agents are not payable when billed without the requisite imaging procedures as defined by National CMS guidelines.	2015
CCIC, CCIM	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
CCIM	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
CCIM	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
CCIM	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
CCIM	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
CCIC, CCIM	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

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LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC, CCIM	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
CCIC, CCIM	F, P	Diagnosis-Age Policy	Procedures are not payable when the diagnosis and age do not match (except maternity diagnoses).	2015
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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

LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC, CCIM	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
CCIM	P	DME Rentals	Capped rentals are not payable when billed without modifier KH, KI, or KJ.	11/16/2021
CCIC, CCIM	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
CCIC, CCIM	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
CCIM	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
CCIM	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
CCIC	F, P	Drug and Biological Policy	HCPCS J0585 is not payable when billed and the diagnosis is facial wrinkles.	2015
CCIM	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
CCIC, CCIM	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
CCIC	F, P	Drug and Biological Policy	Rituximab J9312, Q5115, or Q5119 is not payable when billed and an FDA approved indication or an	2015

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LOB	Claim Type	Medical Policy	Rule Description	Effective Date
			approved off- labeled indication is not present on the claim.	
CCIC	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
CCIC	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
CCIC, CCIM	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
CCIM	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
CCIM	P	Drug and Biological Policy	HCPCS J9219 is not payable when billed more than once within a 12-month period by any provider.	2015
CCIC, CCIM	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
CCIC, CCIM	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
CCIC	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
CCIC	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
CCIC, CCIM	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

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LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIM	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
CCIM	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
CCIM	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*
CCIM	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
CCIC	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
CCIM	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*
CCIM	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
CCIM	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*
CCIM	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*
CCIM	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*
CCIM	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	2015

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LOB	Claim Type	Medical Policy	Rule Description	Effective Date
			peritoneal cancer, premenstrual syndrome, prostate cancer, stuttering priapism, or uterine leiomyomata.	
CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIM	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
CCIC	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
CCIC	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	F, P	Drug and Biological Policy	A drug billed with modifier JW (Drug amount discarded/not administered to any patient) Is not	2015

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LOB	Claim Type	Medical Policy	Rule Description	Effective Date
			payable when another claim line does not exist for the same drug on the same date of service.	
CCIC	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
CCIC	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
CCIC	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
CCIC	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
CCIC	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
CCIC	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
CCIC	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
CCIC	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
CCIC	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
CCIC	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
CCIC	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
CCIC	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

LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC, CCIM	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
CCIC, CCIM	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
CCIM	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*
CCIM	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*
CCIC	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
CCIC	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
CCIC	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
CCIC	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
CCIM	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
CCIM	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
CCIM	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

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LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIM	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
CCIM	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
CCIM	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
CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC	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
CCIC	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
CCIC	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
CCIM	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*
CCIM	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*
CCIM	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*
CCIM	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

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LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIM	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*
CCIM	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
CCIM	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
CCIM	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
CCIM	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
CCIM	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
CCIC, CCIM	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
CCIC	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
CCIC	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,	2015

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LOB	Claim Type	Medical Policy	Rule Description	Effective Date
			diabetic retinopathy, or neovascular (wet) age-related macular degeneration.	
CCIC	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
CCIC	F, P	Drug and Biological Policy	J0178 is not payable when billed without intravitreal injection of a pharmacologic agent (67028).	2015
CCIC	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	F, P	Drug and Biological Policy	HCPCS J7313 is not payable when billed without intravitreal injection of a pharmacologic agent (67028).	2015
CCIC	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
CCIC, CCIM	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
CCIC	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
CCIC	F, P	Duplicate Services Policy	Duplicate services are not payable. when the duplicate criteria have been met.	2015
CCIC, CCIM	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
CCIC, CCIM	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

LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC	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
CCIC, CCIM	P	Duplicate-Different Claim	Identifies duplicate claim lines that have been submitted on a previous claim.	2018
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC	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
CCIC, CCIM	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	2015

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LOB	Claim Type	Medical Policy	Rule Description	Effective Date
			practice (with the same specialty and subspecialty) within the last three years.	
CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	F, P	Evaluation and Management Services Policy	HCPCS S0610-S0613 are not payable when billed with 99384-99387 or 99394-99397.	2015
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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

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LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC	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
CCIC	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
CCIC	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
CCIC	P	Evaluation and Management Services Policy	Initial neonatal intensive care service 99477 is not payable when reported subsequent to the date of admission.	2015
CCIC	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
CCIM	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
CCIC	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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

Payment Policy:
Coding Edit Rules

(Commercial & Medicare)

LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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 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.	2018
CCIC, CCIM	F, P	Female Only Diagnosis Codes	Identifies claims containing diagnoses that are inconsistent with the member's gender	2018
CCIC, CCIM	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

Payment Policy:
Coding Edit Rules

(Commercial & Medicare)

LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC, CCIM	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
CCIM	P	Frequency Policy	HCPCS G0179 Physician recertification for home health services is not payable if billed more than once every two months.	2015
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	F, P	Frequency Policy	CPT 80305-80307 (Presumptive drug testing) is not payable when billed more than one combined unit per day.	2015
CCIC, CCIM	F, P	Frequency Policy	HCPCS G0480-G0483, G0659 (Definitive drug testing) are not payable when billed more than one combined unit per day.	2015
CCIC	P	Gastroenterology Policy	Colonoscopy (45378) is no payable when billed more than once within one year.	2015
CCIC	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

Payment Policy:
Coding Edit Rules

(Commercial & Medicare)

LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC, CCIM	P	Gastroenterology Policy	Deny 45335 (Sigmoidoscopy, flexible; with directed submucosal injection(s)) when billed with 45333, 45338, or 45346 (Sigmoidoscopy, flexible).	2015
CCIC, CCIM	P	Gastroenterology Policy	CPT 45381 (Colonoscopy, flexible; with injection(s)) is not payable when billed with 45383-45385, 45388, or G6024 (Colonoscopy).	2015
CCIC, CCIM	F, P	Gender-Procedure Codes	Identifies claim lines containing Procedure Codes that are inconsistent with the member's gender.	2018
CCIC	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	P	Global Obstetrical Policy	Cerclage removal (59871) is not separately payable when billed on the same date of service as the delivery code.	2015
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC	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

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LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC, CCIM	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
CCIC	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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

LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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 complication of surgical and medical care or an aftercare diagnosis. (CMS + Cotiviti Supplement)	2015

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Payment Policy: Coding Edit Rules

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LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC, CCIM	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
CCIC, CCIM	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
CCIM	P	Healthplan Policy	CPT 99174 1 unit in 12-month period. Exception: Hospital, Ophthalmologist, Optometrist, Neurology, and Pediatric Neurology.	2015
CCIC, CCIM	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
CCIC	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
CCIC, CCIM	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
CCIM	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
CCIC	P	Healthplan Policy	Services considered to be included in global obstetrical procedures are not separately payable.	2015
CCIC, CCIM	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

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Payment Policy:
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LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	F, P	Incomplete ICD-10 Diagnosis Code	Identifies claims containing incomplete ICD- 10 diagnosis codes	2018
CCIC, CCIM	F, P	Invalid ICD-10 Diagnosis Code	Identifies claims containing invalid diagnosis codes.	2018
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	F, P	Laboratory-Pathology Policy	Nucleic-acid based SARS-CoV-2 viral tests (CPT codes 87631-87633, 87635-87637, 87811, 0202U, 0223U, 0225U, 0240U, 0241U, U0001, and U0003) will be limited to one unit per day, unless reported with modifier 59, by any provider.	2/01/2022
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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-	2/01/2022

LOB	Claim Type	Medical Policy	Rule Description	Effective Date
			CoV-2) has been previously billed and paid on the same date of service by any provider.	
CCIC, CCIM	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
CCIC, CCIM	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
CCIM	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
CCIM	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 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/	10/01/2021
CCIC, CCIM	F, P	Male Only Diagnosis Codes	Identifies claims containing diagnoses that are inconsistent with the member's gender.	2018
CCIC, CCIM	F, P	Manifestation Diagnosis Code Policy	Diagnoses designated as manifestation codes are not payable when submitted as the primary diagnosis.	1/01/2022
CCIC, CCIM	F, P	Maximum Units Policy	Codes billed for a number of units that exceeds the allowed number of units are not payable.	2015
CCIC	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
CCIC, CCIM	F, P	Maximum Units Policy	Maternal Fetal Medicine services 59000, 59020, 74713,76802, 76810, 76812, 76814, 76816, 76818-78621, or 76825-76828 are payable based on diagnosis.	2015

LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC, CCIM	F, P	Maximum Units Policy	Surgeries that allow multiple assistant surgeons as indicated are not payable when billed by same or different provider.	2015
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	F, P	Maximum Units Policy	Obstetrical procedure codes 74713, 76802, 76810, 76812, 76814 are not payable when billed without the requisite diagnosis.	2015
CCIC, CCIM	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
CCIC	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
CCIC	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
CCIC, CCIM	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
CCIC, CCIM	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*
CCIC, CCIM	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*
CCIC, CCIM	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.	10/01/2021 *Replaces Medically Unlikely Edits (MUE) - Facility*

LOB	Claim Type	Medical Policy	Rule Description	Effective Date
			• 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.	
CCIC, CCIM	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*
CCIC, CCIM	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
CCIC, CCIM	F, P	Modifier Policy	Services billed with invalid modifier to procedure code combinations are not payable.	2015
CCIC	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
CCIC	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
CCIC, CCIM	F, P	Modifier Policy	Procedure codes that are inappropriately billed with anatomical modifiers are not payable.	2015
CCIC	F, P	Modifier Policy	Anesthesia codes (00100-01999, 99100-99140 or D9223) inappropriately billed with distinct service modifiers are not payable.	2015

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LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	F, P	Modifier Policy	Procedure codes defined as requiring an anatomical modifier are not payable when billed without an associated anatomical modifier.	2015
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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

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LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC, CCIM	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
CCIC	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
CCIC, CCIM	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
CCIC, CCIM	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

LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIM	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 Determinations (NCD) Coding Policy Manual and Change Report.	10/01/2021
CCIM	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	10/01/2021

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LOB	Claim Type	Medical Policy	Rule Description	Effective Date
			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.	
CCIM	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
CCIM	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). 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

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LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIM	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
CCIC, CCIM	F, P	Nail Care and Other Foot Care Services	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC	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
CCIC, CCIM	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
CCIC, CCIM	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	2015

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LOB	Claim Type	Medical Policy	Rule Description	Effective Date
			the same Provider ID regardless of Tax ID and Specialty.	
CCIC	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
CCIC	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
CCIC	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
CCIM	P	National Correct Coding Initiative Supplemental Policy	Separate payment is not allowed if CMS NCCI Procedure to Procedure component/comprehensive supplemental edits apply.	2015
CCIC	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
CCIC	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
CCIC, CCIM	F, P	National Correct Coding Manual Policy	Deny procedures considered to be inappropriately coded based on National Correct Coding Initiative Policies and Guidelines.	2015
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC	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

LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC	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
CCIC	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
CCIC	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
CCIC	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
CCIC, CCIM	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
CCIC	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
CCIC	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
CCIC, CCIM	P	New Patient Visit	Identifies claim lines containing new patient Procedure Codes that are submitted for established patients.	2015
CCIM	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
CCIC, CCIM	F, P	Obsolete Procedure Code Policy	Procedures that are deemed invalid are not payable.	1/01/2022
CCIC, CCIM	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
CCIC, CCIM	P	Obstetrics and Gynecology Policy	CPT 76805 or 76810-76812 (Initial obstetric ultrasound services) is not payable when 76805 or	2015

LOB	Claim Type	Medical Policy	Rule Description	Effective Date
			76810-76812 has been billed in the past five months.	
CCIC, CCIM	F, P	Once Per Lifetime Services Policy	Codes for once in a lifetime procedures are not payable when previously reimbursed.	2015
CCIC, CCIM	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
CCIC, CCIM	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
CCIM	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
CCIC	P	Orthopedic Policy	Intraoperative services are not payable when billed with an orthopedic procedure.	2015
CCIC	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
CCIC	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
CCIC	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%,	10/01/2021

Payment Policy:
Coding Edit Rules

(Commercial & Medicare)

LOB	Claim Type	Medical Policy	Rule Description	Effective Date
			• Rank 3 to 5 procedures receive a pay percent recommendation of 0%.	
CCIC	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
CCIC	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
CCIC	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
CCIC	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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	2015

LOB	Claim Type	Medical Policy	Rule Description	Effective Date
			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).	
CCIC, CCIM	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
CCIM	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
CCIM	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
CCIM	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
CCIC, CCIM	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
CCIM	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

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Payment Policy: Coding Edit Rules

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LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC, CCIM	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
CCIC, CCIM	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
CCIM	P	Place of Service Policy	HCPCS codes beginning with "C" are not payable when billed on claim type P (Professional).	2015
CCIM	P	Place of Service Policy	Surgical dressings are not payable when billed in the provider's office (POS 11).	2015
CCIC, CCIM	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
CCIC, CCIM	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
CCIC	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
CCIM	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

LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC, CCIM	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
CCIC	F	Place of Service Policy	Services submitted with Bill Type 0330-033Z are not payable.	2015
CCIC	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
CCIC, CCIM	F, P	Podiatry Policy	CPT 11055-11057, 11719-11721, or G0127 (Routine foot care) are not payable when billed more than once within a two-month period.	2015
CCIC, CCIM	P	Podiatry Policy	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
CCIC, CCIM	P	Post-operative Visits	Identifies Procedure Codes billed by the same provider within a procedure's post-operative global period.	2015
CCIC, CCIM	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
CCIC, CCIM	P	Pre-operative visits	Identifies Procedure Codes billed by the same provider within a procedure's pre-operative global period.	2015
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	F, P	Procedure Code Definition Policy	Procedures billed out of sequence are not payable.	2015
CCIC, CCIM	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	2015

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LOB	Claim Type	Medical Policy	Rule Description	Effective Date
			reported with diagnosis B08.1 "Molluscum contagiosum".	
CCIC, CCIM	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
CCIC, CCIM	F, P	Procedure Code Definition Policy	HCPCS G0008, G0009, or G0010 are not payable if billed without the appropriate, corresponding vaccine code.	2015
CCIC, CCIM	P	Procedure Code Definition Policy	CPT codes for procedures billed out of sequence are not payable.	2015
CCIC, CCIM	F, P	Procedure Code Guideline Policy	Services that are coded inappropriately based on CPT/HCPCS Procedure Code Guidelines are not payable.	2015
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIM	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
CCIC, CCIM	F, P	Procedure Code Guideline Policy	CPT 77371, 77372 (Radiation treatment delivery, stereotactic radiosurgery) or G0339 (Image-guided robotic linear accelerator-based stereotactic radiosurgery) are not payable when billed more than one combined unit in two weeks.	2015

LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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*
CCIC, CCIM	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*
CCIC, CCIM	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*
CCIC, CCIM	F, P	Procedure- Gender Policy	Newborn procedures that are specific to a gender, are payable for that gender.	2015 *Terminated 8/01/2021*
CCIC, CCIM	F, P	Procedure-Age Policy	Procedures that are inconsistent with the patient's age based on the code definition are not payable.	2015
CCIC, CCIM	F, P	Procedure-Age Policy	Procedure codes that are inconsistent with the patient's age based on the code definition are not payable.	2015

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LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	F, P	Procedures Inconsistent With Age	Identifies claim lines containing procedures that are inconsistent with the patient's age.	2015
CCIC, CCIM	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
CCIC, CCIM	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
CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC	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
CCIC, CCIM	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
CCIM	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
CCIM	P	Professional, Technical, and Global Services Policy	Modifiers 26 and TC are not payable when appended to the same claim line.	2015
CCIM	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

LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC, CCIM	F, P	Professional, Technical, and Global Services Policy	Technical component only services are not payable when billed with modifier 26 (CMS).	2015
CCIC, CCIM	F, P	Professional, Technical, and Global Services Policy	Professional component only procedures are not payable when billed with modifier TC (CMS).	2015
CCIC	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
CCIC	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
CCIC, CCIM	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
CCIC	F	Professional, Technical, and Global Services Policy	Professional component procedures are not payable when billed by a facility. (CMS-1500)	2015
CCIC, CCIM	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
CCIC	P	Quality of Care Policy	Procedures billed by a pathologist that are outside the scope of pathology practice are not payable.	2015
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	F, P	Radiology Policy	CPT 71100 (X-ray, ribs, unilateral; two views) is not payable if billed with units greater than one.	2015
CCIC, CCIM	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
CCIC, CCIM	F, P	Radiology Policy	CPT 71100 (X-ray, ribs, unilateral; 2 views) appended with modifier 50 is not payable.	2015

LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC, CCIM	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
CCIM	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
CCIC, CCIM	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
CCIC	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

Payment Policy:
Coding Edit Rules

(Commercial & Medicare)

LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	F, P	Separate Procedures Policy	Separate procedures are not payable when billed with the associated major procedures.	2015
CCIC, CCIM	P	Separate Procedures Policy	Procedures designated as a "separate procedure" are not payable when submitted with a related major	1/01/2022
CCIC, CCIM	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
CCIC, CCIM	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) are not payable.	1/01/2022
CCIM	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*

Payment Policy:
Coding Edit Rules

(Commercial & Medicare)

LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIM	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*
CCIC, CCIM	P	Specialty to Procedure Code Mismatch	Identifies claim lines containing procedures that are not typically associated with a specific provider type or specialty.	2018
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIM	P	Team Surgery Policy	CPT codes designated as Team Surgery is not allowed, are not payable when billed with modifier 66. (CMS)	2015
CCIM	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
CCIM	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
CCIC	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

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LOB	Claim Type	Medical Policy	Rule Description	Effective Date
CCIC, CCIM	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
CCIC, CCIM	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*
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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
CCIC, CCIM	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

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Revision history

DATE	REVISION
1/24/2022	*Highlighted in yellow* • 1 new edit effective 3/01/2022
1/13/2022	*Highlighted in yellow* • 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 *Highlighted in yellow*
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 *Highlighted in yellow*
9/2021	• Updated policy to include 28 new edits effective 1/01/2022 • Updated policy to include 1 new edit effective 1/19/2022 *Highlighted in yellow*
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 *Highlighted in yellow*
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

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