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Payment Policies
Enhanced Code Editing

November 1, 2026

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Introduction

Purpose and Scope

The HMSA Payment Policy Manual provides clear, standardized guidance to assist providers in submitting accurate claims and understanding reimbursement processes. It supports transparency, consistency, and compliance with applicable regulations and coding standards, including:

- AMA CPT® guidelines
- ICD-10 coding standards
- CMS HCPCS guidelines
- CMS national and regional coverage policies
- National specialty society recommendations
- State Medicaid policies, as applicable

These policies apply to all providers billing HMSA for covered services and are intended to promote alignment with industry's best practices and payer requirements.

Coding Source Compliance

Providers must use the most current versions of the following coding systems:

- CPT® (American Medical Association)
- HCPCS Level I & II (Centers for Medicare & Medicaid Services)
- ICD-10-CM/PCS (CMS and CDC)
- National Correct Coding Initiative (NCCI) edits (CMS)

Policy Reference and Limitations

Reference Tool: These policies are intended as a reference to assist providers in submitting accurate claims and outline the basis for reimbursement of covered services. They apply to services rendered by all providers billing HMSA.

Subject to Change: The policies are subject to changes in industry coding rules and guidelines, such as those established by CPT®, HCPCS, ICD, and other nationally recognized standards. At times, coding changes may take effect before this manual is formally updated.

Regulatory and Contractual Revisions: Policies may be revised based on state or federal requirements, regulatory guidance, or modifications to provider agreements.

Limitations

- These payment policies do not constitute billing or coding advice.
- They do not guarantee payment or determine benefit coverage.
- They do not supersede member benefit documents, provider contracts, medical policies, or claim editing rules.
- They do not dictate how other Blue Cross and/or Blue Shield Plans set allowances for care rendered by their providers.
- They do not constitute medical advice or clinical guidance.

This manual should be used in conjunction with applicable benefit documents, provider agreements, medical policies, and claim editing rules. While it does not instruct providers on billing methods, it establishes expectations for coding accuracy and documentation compliance.

Version Control & Policy Updates

This manual is updated periodically to reflect changes in regulations, coding standards, and HMSA policies. Each version includes an effective date and summary of changes.

Version	Revision Date	Effective Date	Summary of Changes
1.0	November 1, 2025	Process date January 26, 2026, for services dates on or after November 1, 2025.	Initial release.
1.1	November 1, 2025	Process date January 26, 2026, for services dates on or after November 1, 2025.	Minor revisions to CMS National Coverage Determinations (NCD).
1.2	November 1, 2026	Process date for service dates on or after January 1, 2027.	Added new polices: • Ambulance Transportation and Mileage Services • Facility Bundling – Other Bundled Services: DMEPOS, home infusion/home therapy, portable x-ray transport/setup services • National Correct Coding Manual – E/M Services: XXX-Day Global Procedure Codes
		Process date on or after October 2, 2026.	Revised existing policies: • Frequency Editing/Preventive and Screening Services – Removed language “Allergen extract (CPT 86003) – 30 units per year. • CMS Coverage Policy/Modifier Code - Added language “Applicable to Medicare Advantage Only”

Version	Revision Date	Effective Date	Summary of Changes
1.3	November 1, 2026	Process date January 26, 2026, for services dates on or after November 1, 2025.	Minor revisions to National Correct Coding Initiative (NCCI)

Future updates will be communicated through official HMSA channels.

Add-On Code

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: AMA CPT Manual, AMA CPT Manual and/or CMS Type I Add-on Code Edits

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

Add-on codes are always performed in addition to a primary procedure and should never be reported as stand-alone services. Claims submitted with add-on codes as stand-alone procedures are denied.

If the primary procedure is denied for any reason (including coding validation or other edits), the associated add-on code will also be denied, whether billed on the same or a different claim.

These codes are exempt from multiple procedure reduction policy and should not be billed with modifier 51. If billed with modifier 51, the modifier will be removed.

Ambulance Services

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: CMS Internet Only Manuals

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

This policy ensures ambulance transportation and mileage services are billed in accordance with CMS guidelines.

Ambulance Mileage

Ambulance mileage services are separately reimbursable only when billed in conjunction with a corresponding ambulance transport service for the same date of service. Ambulance mileage is not separately reimbursable when transportation of the members does not occur

- Ambulance mileage (HCPCS A0380, A0390, A0425, A0435, A0436) billed without a corresponding ambulance transport service (HCPCS A0225, A0426-A0431, A0433, A0434, S9960, S9961) for the same date of service
- Ambulance mileage when the associated ambulance transport service has been denied.
- Ambulance mileage billed with response and treatment only services (HCPCS A0998) when no ambulance transport service is billed for the same date of service

Ambulance Transportation and Mileage Services

- Revenue Code 0540 (Ambulance General Classification) is limited to ambulance transportation and ambulance mileage services. Claims billed with Revenue Code

0540 and a procedure code that is not an ambulance transportation or ambulance mileage service will be denied.

- Valid ambulance transportation and ambulance mileage procedure codes include HCPCS A0425, A0426-A0436

Anesthesia

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Inpatient Facility (CMS 1450), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: American Society of Anesthesiologists, American Society of Gastrointestinal Endoscopy, CMS'S Correct Coding Initiative (CCI) and Policy Manual, CMS HCPCS Level II Manual, CMS Internet Only Manuals, CMS Transmittals/ Memos/Publications, Expert Specialty Review Panel, Federal Register, and Regional CMS Policy (Local Coverage Determination [LCD])

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

This policy ensures proper reporting of anesthesia services (CPT 00100-01999).

Anesthesia Modifiers

Physicians must report an appropriate anesthesia modifier to indicate whether the service was personally performed, medically directed or supervised, or represent monitored anesthesia care. CRNAs must also report an appropriate anesthesia modifier to indicate whether the service was performed with or without supervision by a physician.

Anesthesia services will be denied if billed without an appropriate anesthesia modifier.

Appropriate modifiers for anesthesia services include but are not limited to:

- AA - Anesthesia services performed personally by an anesthesiologist
- AD - Medical supervision by a physician: more than 4 concurrent anesthesia procedures

- QK - Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals
- QS - Monitored anesthesiology care services
- QX - Qualified nonphysician anesthetist with medical direction by a physician
- QY - Medical direction of one qualified nonphysician anesthetist by an anesthesiologist
- QZ - CRNA without medical direction by a physician

Duplicate Anesthesia Services

When an anesthesiologist personally administers anesthesia (modifier AA), a CRNA claim with modifier QX or QZ for the same date of service will be denied. Likewise, when a CRNA has been paid for modifier QX or QZ, then the anesthesiologist's claim with modifier AA will be denied.

Medical Supervision and Medical Direction

When a CRNA or other qualified individual reports anesthesia services rendered under medical direction, then the anesthesiologist must bill a modifier to indicate medical direction or supervision was provided. The anesthesiologist's claim will be denied when billed without a medical direction or supervision modifier, if a CRNA claim with medical direction exists. Additionally, the CRNA's claim will be denied when billed without a medical direction modifier, if an anesthesiologists claim with medical direction or supervision exists.

Multiple General Anesthesia Services

According to the National Correct Coding Initiative (NCCI) policy manual, only one anesthesia code should be reported for a single date of service unless the second anesthesia code is an add-on code or has an appropriate modifier appended. Therefore, the anesthesia service code will be denied when a different anesthesia code has been previously paid for the same date of service. This denial will also apply to nurse anesthetists (CRNA) claims with modifier QX or QZ appended.

Other Anesthesia Edits

- Surgical procedure codes billed by an anesthesiologist or CRNA will be denied. The anesthesiologist or CRNA should bill the appropriate anesthesia code.
- Daily hospital management of epidural or subarachnoid drug administration (CPT 01996) will be denied when billed with anesthesia qualifying circumstance codes (CPT 99100-99140) and an anesthesia service (CPT 00100-01992, 01999) is not also billed. In addition, daily hospital management of epidural (CPT 01996) will be denied when billed with physical status modifiers P1-P6.
- Epidural injections (CPT 62321, 62323, 64479, 64480, 64483, 64484) and facet injections (CPT 64490, 64493) will be denied when billed greater than eight visits per year by any provider. Sacroiliac joint injections (CPT 27096, 64451) will be limited to six sessions in a 12-rolling month period for any provider.
- Gastrointestinal endoscopic anesthesia services (CPT 00731, 00811, 00812) will be denied when billed with a gastrointestinal endoscopic procedure for a patient 18 – 70 years old without an appropriate diagnosis on the claim. In addition, moderate sedation services (HCPCS G0500) will be denied when a gastrointestinal endoscopic procedure is not reported by the same physician for the same date of service.
- Anesthesia and moderate sedation services (CPT 00300, 00400, 00600, 00620, 00630, 01937-01942, 01991-01992, 99152-99153, 99156-99157) billed with pain management services (CPT 20552, 20553, 20560, 20561, 27096, 62273, 62320-62323, 64405, 64451, 64479, 64480, 64483, 64484, 64490-64495, HCPCS G0260) will be denied when billed without a surgical non-pain management code by any provider for patients 18 years of age and older.
- Anesthesia for vaginal (CPT 01960, 01967) or cesarean delivery (CPT 01961, 01968 or 01969) will be denied when anesthesia for cesarean delivery has been billed in the past 240 days.
- Anesthesia services (CPT 00100, 00124, 00148, 00160, 00164, 00300, 00322, 00400, 00410, 00454, 00520, 00522, 00524, 00530, 00532, 00635, 00640, 00702,

00731, 00732, 00842, 00920, 00921, 01130, 01380, 01420, 01490, 01680, 01730, 01780, 01782, 01820, 01829, 01860, 01916, 01920, 01922, 01930, 01935, 01937-01942, 01991, 01992, 01999) appended with modifier QS will be denied when billed without an approved diagnosis on the claim.

Assistant Surgeon

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: AMA Coding with Modifiers, AMA CPT Manual, American College of Surgeons, CMS Internet Only Manuals

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

CMS defines an assistant surgeon as a physician or non-physician who actively assists the physician in charge of the case in performing a surgical procedure.

The Medicare Physician Fee Schedule (MPFS) includes a list of procedures where assistant surgeons are allowed.

Assistant Surgeon Modifiers

The modifier codes used to indicate the services of an assistant surgeon are:

- 80 - Assistant Surgeon
- 81 - Minimal Assistant Surgeon
- 82 - Assistant Surgeon (when qualified resident is not available)
- AS - Physician Assistant, Nurse Practitioner or Clinical Nurse Specialist services for assistant at surgery

The AMA's intended use of modifiers 80, 81, and 82 is for physicians to report assistant surgery services. These modifiers should not be used by non-physicians; services provided by non-physicians must be reported with modifier AS.

- Non-physicians billing with modifiers 80, 81, or 82 will be changed to AS.
- Procedure codes billed with modifier 80, 81, 82, or AS will be reviewed when the same procedure code has not been billed by the primary surgeon without a modifier. The review will validate that both the primary and assistant surgeon are reporting the same procedure code.
- When the primary surgeon bills a procedure code and the assistant surgeon bills with modifiers 80, 81, 82, or AS on the same date of service the claim will be reviewed. The primary surgeon code may deny if it's determined that the assistant surgeon billed a different code.

Assistant Surgeon Restrictions

The MPFS identifies certain codes are restricted from being billed with an assistant surgeon. Claims submitted under these circumstances will be denied:

- Codes designated as Assistant Surgeon Concept Does Not Apply.
- Codes designated as Assistant Surgeon Not Allowed.
- Codes designated as Assistant Surgeon Payment Restriction May Apply.

Assistant Surgeon for Obstetrical Deliveries

Assistant surgeons are not appropriate for global obstetrical deliveries, since they normally do not participate in prenatal or postpartum care. Claims for global obstetrical procedures (CPT 59510, 59618, 59622, 59515) billed with an assistant surgeon modifier will be denied.

Primary Surgeon and Assistant Surgeon Cannot be the Same Provider

It is considered inappropriate for the same physician to bill as both the primary surgeon and the assistant surgeon for the same procedure. Claims billed in this manner will be denied.

Second Assistant Surgeons Not Allowed

A second assistant surgeon is not allowed for most surgical services. When a second claim is received for which, an assistant surgeon has already been allowed, the second claim including any claim received with modifiers 80, 82, or AS will be denied.

Bilateral Procedures

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: AMA CPT Manual, AMA Principles of CPT Coding

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

Applies the current bilateral coding principles and guidelines as well as current claim processing logic for reimbursement of bilateral procedures reported with modifier -50 or -LT and -RT.

In addition to current bilateral logic this edit applies the five CMS classifications of bilateral procedures and process claims accordingly.

The five CMS classifications of bilateral procedures are as noted below:

- Procedures that are not payable at 150% when billed bilaterally (Bilateral Indicator 0)
- Procedures that are payable at 150% when billed bilaterally (Bilateral Indicator 1)
- Procedures that are bilateral in nature (Bilateral Indicator 2)
- Procedures that are payable at 100% for each side (Bilateral Indicator 3)
- Procedures to which the bilateral concept does not apply (Bilateral Indicator 9)

Bilateral Modifiers

When bilateral procedures are billed with modifiers LT (Left side) or RT (Right side) on the same line as modifier 50, the additional modifier(s) will be removed as inappropriate.

Procedures Not Payable at 150% (Bilateral Indicator 0)

Certain procedures are designated with a bilateral indicator of 0, meaning they are not payable at 150% when billed bilaterally. These procedures must be billed on a single claim line without bilateral modifiers. If billed with modifier 50, LT, or RT, the modifier will be removed.

Procedures that are Bilateral in Nature (Bilateral Indicator 2)

Procedures designated as bilateral in nature must be billed according to CMS guidelines:

- A bilateral in nature service billed with RT or LT instead of its unilateral counterpart will be recoded.
- When a bilateral in nature code is submitted with RT or LT, modifier 52 will be appended.
- CMS identifies certain procedures as bilateral in nature. When billed with modifiers 50, LT, or RT, or with units greater than one, the claim will be adjusted as inappropriately coded and will be denied.

Bilateral Concept Does Not Apply (Bilateral Indicator 9)

CMS policy indicates that the bilateral concept does not apply to procedures with a bilateral indicator of "9." When these services are billed with modifiers 50, LT, or RT, the inappropriate modifier will be removed, and the claim will be denied.

Codes that have Unilateral Professional Components and Bilateral in Nature Global/Technical Components

Certain codes are designated by CMS as having unilateral professional components payable at 100% for each side and bilateral global/technical component.

- When an inherently bilateral code is billed twice, the second line will be denied.
- Codes 76519 or 92136, when billed globally and billed with modifiers 26-LT and 26-RT, will be denied.

Bundled Facility

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Inpatient Facility (CMS 1450), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: CMS Internet Only Manuals

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

CMS policy considers certain outpatient services as bundled into the inpatient facility payment. This policy includes but is not limited to:

3-Day Window

- Modifier PD
    - According to CMS policy, when Modifier PD (Diagnostic or related non-diagnostic item or service provided in a wholly owned or operated physician office to a patient who is admitted as an inpatient within 3 days) is appended to a diagnostic test or a radiology service, a modifier indicating either the professional component (modifier 26) or technical component (modifier TC) must also be billed. Diagnostic tests or radiology services billed with modifier PD will be denied when billed without modifier TC or 26.
    - The technical component of a service rendered inpatient may only be reported by the inpatient facility. Therefore, diagnostic tests or radiology services billed with modifier PD and modifier TC will be denied on professional claims. Additionally, a technical component only service that is billed with modifier PD will be denied.
    - Global test only codes will be denied when billed with modifier PD.

- Pre-Admission Outpatient Services treated as Inpatient Services (Applicable to Medicare Advantage only)
    - Per CMS IPPS policy, outpatient services rendered by the same hospital within three days prior to or on the date of inpatient admission are considered part of the inpatient stay and are not separately payable.
    - Diagnostic services including not limited to (Revenue Codes 0254, 0255, 0300–0309, 0310–0319, 0320–0329, 0341, 0343, 0350–0359, 0371, 0372, 0400–0409, 0460–0469, 0471, 0481, 0489, 0482, 0483, 0530–0539, 0610–0619, 0620–0629, 0730–0739, 0740–0749, 0918, 0920–0929) are included in the inpatient payment and will be denied.
    - Nondiagnostic services, excluding ambulance (HCPCS A0021–A0999, S9960–S9961; Revenue Codes 0540–0549), are also included unless Condition Code 51 is present, and will be denied.
    - Services billed on the admission date or during the inpatient stay are denied if billed separately, except for ambulance.

Ambulance Services

Ambulance services provided during an inpatient admission and prior to discharge are considered bundled inpatient facility services. Therefore, ambulance transportation services (HCPCS A0021-A0999, S0207-S0215, S9960-S9961) will be denied when provided during an inpatient stay.

Ambulance transportation services appended with modifier HD (Hospital-diagnostic/therapeutic site) or DH (Diagnostic/therapeutic site-hospital) will be denied when billed with subsequent hospital care (CPT 99231-99233) and initial hospital care (CPT 99221-99223) is not billed on the same date of service by any provider.

Ambulance services (HCPCS A0021-A0999) appended with modifier DN (Diagnostic center-nursing facility transport) or ND (Nursing facility-diagnostic center transport) is considered bundled to the SNF payment rate and will be denied.

Home Health Services

Home health (HH) services are services that are furnished in the patient's home. HH services will be denied when the date of service is after a patient is admitted to an inpatient hospital, skilled nursing facility or swing bed hospital and prior to discharge.

Physical (PT), occupational (OT) and speech-language (SLT) therapy services provided under a HH plan of care are included in the HH payment rate. Therefore, PT, OT and SLT services will be denied when the date of service is after a patient is admitted to HH and prior to and including the date of discharge.

Hospice Admission

Services related to hospice care are included in the hospice rate. Therefore, any service billed during a hospice admission will be denied if billed with the same primary diagnosis by any provider and an appropriate modifier or condition code is not billed.

Inpatient Clinical Social Worker (CSW) Services

According to CMS policy, services of clinical social worker furnished in an inpatient hospital (POS 21) are included in the facility's payment. Therefore, services appended with modifier AJ (Clinical social worker) will be denied in POS 21.

Inpatient Hospital Repeat Admission

Inpatient hospital admission reported by the same facility will be flagged for coding validation when another inpatient hospital claim is within 30 days from the discharge date on the first claim. Coding validation assesses if the patient's claim history supports whether the second admission is related or not.

Other Bundled Services

The following services or supplies will be denied when the date of service is after a patient is admitted and prior to discharge.

- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) billed by a DME provider during any inpatient admission.
- Home Infusion/Home Therapy services provided during an inpatient hospital, skilled nursing facility, or swing bed hospital stay.
- Portable x-ray transport/setup codes (HCPCS R0070, R0075 or Q0092)

Skilled Nursing Facility (SNF) Services

Per CMS policy and CMS-1450 billing guidelines, services listed on the SNF consolidated billing code list are included in the SNF payment rate and are not separately reimbursed when provided during a SNF stay.

- Outpatient procedures reported during an SNF admission and prior to discharge are denied.
- Therapy services, including physical (Revenue Codes 0420–0429), occupational (Revenue Codes 0430–0439), and speech-language therapy (Revenue Codes 0440–0449), are included in the SNF rate and are not payable when billed on outpatient or professional claims during a SNF stay, including the date of discharge.

Bundled Services

Claim Type: Outpatient facility (CMS 1450), Professional (CMS 1500)

Source: CMS and Expert Specialty Review Panel, CMS Internet Only Manuals, CMS National Physician Relative Value File, and CMS Outpatient Prospective Payment System

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

CMS bundles certain services and supplies into the payment for related services.

These include services not separately payable when billed on the same day as other payable services (Status Indicator P), services not payable under any circumstances (Status Indicator B), and injection services (Status Indicator T).

Bundled Services Billed on the Same Day as Other Payable Services

According to CMS policy, bundled/excluded codes (Status Indicator P) billed with other payable services on the same date of service by the same tax group and specialty will be denied, but if billed without another payable procedure, they are separately allowed.

Bundled Services Not Payable Under Any Circumstances

Bundled services (Status Indicator B) are always routinely bundled into other services and supplies will be denied.

Injection Services

Injection services (Status Indicator T) will be denied when billed on the same date of service as other payable services. If billed without another payable service, they are separately allowed.

Packaged Services for Outpatient Hospitals (Applicable to Medicare only)

CMS Outpatient Prospective Payment System (OPPS) considers certain services and supplies to be incidental and included in the facility payment. These bundled or packaged services will be denied when billed by an outpatient hospital. Packaged service edits include but are not limited to:

- Status Indicator N - Items and services packaged into APC rates.
- Status Indicator Q4 - Laboratory services subject to conditional packaging.
- Status Indicator S, T or V.
    - S - Procedure or service not subject to multiple procedure discounting.
    - T - Procedure or service subject to multiple procedure discounting.
    - V - Clinic or emergency department visit.
- Packaged revenue codes without a HCPCS.

Packaged Revenue Code for CORFs/OPTs

CMS policy for Comprehensive Outpatient Rehabilitation Facilities (CORFs) or Outpatient Physical Therapy providers (OPTs) considers supplies as part of the practice expense and included in RVU calculation. CORFs/OPTs billing supplies under Revenue Code 0270 (Supplies and device) will be denied, except for splint and cast supplies HCPCS Q4001-Q4051.

CMS Coverage Policies

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Inpatient Facility (CMS 1450), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: AMA CPT Manual, CMS and Expert Specialty Review Panel, CMS HCPCS Level II Manual, CMS Internet Only Manuals, CMS Medicare Carriers Manual, CMS Outpatient Prospective Payment System, CMS Transmittals/ Memos/Publications, Drug Manufacturer, Federal Register, and Regional CMS Policy (Local Coverage Determination [LCD])

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

CMS coverage policies and the AMA identify certain items, services and procedures that when billed will be denied. The following CMS coverage policies will be applied to claims.

Certain services, modifiers, bill types and condition codes will be denied when billed.

- CMS Defined Services
  - Non-Covered Information only codes
  - Non-Covered for Statute Reasons (Applicable to Medicare Advantage only)
  - Non-Covered Under OPPS for Reasons other than Statute (Applicable to Medicare Advantage only)
  - Not payable by Medicare
- Condition Code
  - 20 - Beneficiary requests billing (Applicable to Medicare Advantage only)
  - 21 - Billing for denial notice (Applicable to Medicare Advantage only)
- Heparin Lock Flush (HCPCS J1642)
- Inpatient Prospective Payment System (IPPS) always non-covered ICD-10-PCS procedures
- Medicare Physician Fee Schedule Status Indicator
  - I - Not valid for Medicare purposes
  - M - Measurement codes
  - N - Non-covered service

- Modifier Code
  - GY - Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit. (Applicable to Medicare Advantage only)
  - GZ - Item or service expected to be denied as not reasonable and necessary.
- Sacroiliac Joint Injections and Procedures (CPT 64625)
- Services and procedures billed prior to the:
  - FDA approval date
  - NCD effective date (Applicable to Medicare Advantage only)
- Special Function Intraocular Lens (HCPCS V2787, V2788)
- Unlisted Service or Procedure (Applicable to Medicare Advantage only)

Claims will be denied if certain services, modifiers, revenue codes, condition codes, discharge statuses, or bill types are submitted without meeting CMS or AMA coverage criteria (e.g., diagnosis, frequency, place of service, provider specialty, bill type, modifier code, condition code).

- Anesthesia for Colorectal Cancer Screening (CPT 00811, 00812)
- Annual Wellness Visit (HCPCS G0438, G0439)
- Audiology Services (CPT 92507, 92508, 92537-92538, 92540-92549, 92552-92553, 92557)
- Bill Type
  - xx7 - Debit-Only adjustment claim
  - xx8 - Void/Cancel of prior claim
- Cardiac Rehabilitation (CPT 93797-93798, HCPCS G0422-G0423)
- Chiropractic Manipulation (CPT 98940-98942)
- CMS Services not recognized by Medicare and OPPS (Applicable to Medicare Advantage only)
- Condition Code
  - 63 - Incarcerated beneficiary
  - D5 – Cancel-only to correct insured or provider ID
  - D6 – Cancel-only to repay a duplicate or Office of Inspector General overpayment
- Discharge Status
  - 21 - Discharged/transferred to court/law enforcement
  - 87 - Discharged/transferred to court/law enforcement with a planned acute care hospital readmission
- Durable Medical Equipment

- Guiding an Improved Dementia Experience (GUIDE) Model (HCPCS G0519-G0528, G0529-G0531)
- Home Health Telecommunications (HCPCS G0320-G0322)
- Hydration Therapy (HCPCS J7030, J7040, J7042, J7050, J7060, J7070, J7120, J7121)
- Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea (CPT 64582)
- Implantable Neurostimulator (HCPCS L8679)
- Incorrect Discharge Status Codes on Inpatient Claims
- In-Home Preventive Vaccine Administration - Additional Payment (HCPCS M0201)
- Kidney Disease Patient Education Services (HCPCS G0420-G0421)
- Medicare Diabetes Prevention Program (MDPP) (HCPCS G9873-G9888, G9890-G9891)
- Modifier Code
    - CA - Procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission.
    - G7 - Pregnancy resulted from rape or incest or pregnancy certified by physician as life threatening. (Applicable to Medicare Advantage only)
    - P6 - A declared brain-dead patient whose organs are being removed for donor purposes.
    - PM – Postmortem.
    - QL - Patient pronounced dead after ambulance called.
- Non-Physician Practitioners (NPPs) Billing Major Surgical Procedures
- Opioid Treatment Programs (OTPs) (HCPCS G0137, G0532-G0536, G1028, G2067-G2080, G2215-G2216)
- Pharmacogenomic Testing for Warfarin Responsiveness (HCPCS G9143)
- Physician Payment for Implantable Tissue Markers and Radiation Dosimeters (HCPCS A4648, A4650)
- Pneumococcal Vaccinations (CPT 90670, 90671, 90677, 90684, 90732)
- Posterior Tibial Nerve Stimulation (PTNS) (CPT 64566)
- Power Mobility Device (PMD) Evaluation (HCPCS G0372)
- Pulmonary Rehabilitation (CPT 94625, 94626)
- Remote Therapeutic Monitoring Services (CPT 98975-98978, 98980, 99453-99454)
- Revenue Codes Non-Covered Under OPPS (Revenue Codes 0990-0999 Patient convenience item)
- Revenue Codes not recognized by Medicare

- Rural Health Clinic (RHC) Services or Federally Qualified Health Center (FQHC) Services
    - Including but not limited to General and Psychiatric Care Management Services (HCPCS G0512), Online Digital E/M Services (HCPCS G0071)
- Self-Administered Drugs (Applicable to Medicare Advantage only)
- Services not allowed for Part B Inpatient claims (Applicable to Medicare Advantage only)
- Skin Substitute Procedures and Products (CPT 15271-15278, HCPCS C5271-C5278)
- Telehealth Services (HCPCS Q3014)
- Transportation of Portable X-ray Equipment (HCPCS R0070, R0075, Q0092)
- Ultrasound Screening for Abdominal Aortic Aneurysm (AAA) (CPT 76706)
- Unauthorized COVID-19 Monoclonal Antibodies and Related Administration

CMS National Coverage Determinations (NCD)

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Inpatient Facility (CMS 1450), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: CMS Internet Only Manuals

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

CMS National Coverage Determinations (NCD) policies identify coverage based on specific guidelines. The following CMS NCD policies will be applied to claims. Claims that do not meet the guidelines in the NCD will be denied (e.g., diagnosis, modifier code, frequency, place of service, provider specialty, bill type). Refer to the CMS website for NCD details.

- Adult Liver Transplantation - NCD 260.1
- Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity - NCD 100.1
    - CPT 43842 will be denied as a noncovered service. (Applicable to QUEST Integration and Medicare Advantage only)
- Bone (Mineral) Density Studies - NCD 150.3

- Chimeric Antigen Receptor (CAR) T-cell Therapy - NCD 110.24
- Diabetes Outpatient Self-Management Training (DSMT) - NCD 40.1
- Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions - NCD 110.21
- Hyperbaric Oxygen Therapy - NCD 20.29
- Implantable Cardioverter Defibrillators (ICDs) - NCD 20.4
- Lumbar Artificial Disc Replacement (LADR) - NCD 150.10
- Medical Nutrition Therapy – NCD 180.1
- Wrong Surgical or Other Invasive Procedure Performed on a Patient - NCD 140.6
- Osteogenic Stimulators - NCD 150.2
- Pancreas Transplants - NCD 260.3
- Percutaneous Image-Guided Breast Biopsy - NCD 220.13
- Percutaneous Left Atrial Appendage Closure (LAAC) - NCD 20.34
    - CPT 33340 will be denied when secondary diagnosis and/or modifier guidelines are not met. (Applicable to Medicare Advantage only)
- Percutaneous Transluminal Angioplasty (PTA) - NCD 20.7
- Positron Emission Tomography (PET) Scans - NCD 220.6.17, NCD 220.6.19
- Stem Cell Transplantation (Formerly 110.8.1) - NCD 110.23
- Transcatheter Edge-to-Edge Repair (TEER) of Mitral Valve Regurgitation - NCD 20.33
    - CPT 0345T, 33418, or 33419 will be denied when condition code guidelines are not met. (Applicable to Medicare Advantage only)
- Vitrectomy - NCD 80.11

Clinical Diagnostic Laboratory Services NCDs

The following NCDs for clinical diagnostic laboratory services will be applied to claims. Claims that do not meet the guidelines in the NCD will be denied. In addition, CMS has identified a list of diagnosis codes that are considered never covered for diagnostic laboratory services. Laboratory tests billed with a diagnosis that CMS has indicated as non-covered will be denied.

- Alpha-fetoprotein - NCD 190.25
- Blood Counts - NCD 190.15
- Blood Glucose Testing - NCD 190.20
- Carcinoembryonic Antigen - NCD 190.26
- Collagen Crosslinks, any Method - NCD 190.19
- Cytogenetic Studies - NCD 190.3
- Digoxin Therapeutic Drug Assay - NCD 190.24

- Fecal Occult Blood Test - NCD 190.34
- Gamma Glutamyl Transferase - NCD 190.32
- Glycated Hemoglobin/Glycated Protein - NCD 190.21
- Hepatitis Panel/Acute Hepatitis Panel - NCD 190.33
- Human Chorionic Gonadotropin - NCD 190.27
- Human Immunodeficiency Virus (HIV) Testing (Diagnosis) - NCD 190.14
- Human Immunodeficiency Virus (HIV) Testing (Prognosis Including Monitoring) - NCD 190.13
- Lipid Testing - NCD 190.23
- Partial Thromboplastin Time (PTT) - NCD 190.16
- Prostate Specific Antigen - NCD 190.31
- Prothrombin Time (PT) - NCD 190.17
- Serum Iron Studies - NCD 190.18
- Thyroid Testing - NCD 190.22
- Tumor Antigen by Immunoassay CA 125 - NCD 190.28
- Tumor Antigen by Immunoassay CA 15-3/CA 27.29 - NCD 190.29
- Tumor Antigen by Immunoassay CA 19-9 - NCD 190.30
- Urine Culture, Bacterial - NCD 190.12

Medicare Preventive Services NCDs

The following NCDs for Medicare preventive services will be applied to claims. Claims that do not meet the guidelines in the NCD will be denied.

- Lung Cancer Screening with Low Dose Computed Tomography (LDCT) – NCD 210.14
- Prostate Cancer Screening – NCD 210.1
- Mammograms – NCD 220.4
- Screening Pap Smears and Pelvic Examinations for Early Detection of Cervical or Vaginal Cancer – NCD 210.2
- Counseling to Prevent Tobacco Use – NCD 210.4.1

Co-Surgeons

Claim Type: Professional (CMS 1500)

Source: CMS Internet Only Manuals

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

Co-surgeons are two physicians working together as primary surgeons, performing distinct parts of a procedure. Modifier 62 is used to indicate these services.

For Method II Critical Access Hospitals, co-surgeon services are payable by Medicare when billed on type of bill 0850–085Z with Revenue Code 0960–0969 and modifier 62.

The Medicare Physician Fee Schedule (MPFS) includes a list of procedures where co-surgeons are allowed.

- **Co-Surgeons Allowed and Specialty Requirements Are Met**

  Reimbursement is given to both surgeons when they are of different specialties. Co-surgeon claims billed when both surgeons have the same subspecialty will be denied.

- **Co-Surgeons Not Allowed/ Payment Restriction May Apply**

  Claims billed with modifier 62 for procedures not allowed will be denied. Claims billed with modifier 62 when designated as co-surgeons' payment restriction may apply will be denied.

- **Co-Surgeon Concept Does Not Apply**

  These are procedures that are not surgical in nature or do not require co-surgeons. Claims billed with modifier 62 for these procedures will be denied.

Co-Surgeons Not Billing with Modifier 62

Procedures designated as co-surgeons allowed, when billed either with modifier 62 and a previously processed claim exists without modifier 62, or when billed without modifier 62 and a previously processed claim exists with modifier 62 by a different provider, will be denied.

Deleted Procedure Code

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Inpatient Facility (CMS 1450), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: AMA CPT Manual

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

Procedure codes that are deleted or invalid will be denied. Codes are validated against their effective and termination dates to ensure compliance. The claim line will be denied. Providers must resubmit the claim as a corrected claim using the current, valid procedure code.

Device and Supply

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Inpatient Facility (CMS 1450), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: CMS Internet Only Manuals, CMS Outpatient Prospective Payment System, and Expert Specialty Review Panel

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

Ensures certain devices and supplies are billed with the appropriate procedure. Devices and supplies will be denied when not billed with the appropriate procedure.

Blood Products and Transfusion

Transfusion services will be denied if billed without an associated blood product.

Autologous blood collection (CPT 86890–86891 with Revenue Code 0391) will be denied when a blood product transfusion (HCPCS P9010–P9040, P9043, P9044, P9048, P9050–P9060, P9070–P9073, P9099) is billed for the same date of service.

Blood product transfusions (HCPCS codes listed above with Revenue Code 0391) will be denied when autologous blood collection and storage (CPT 86890–86891) has been paid for the same date of service.

Brachytherapy Sources

Brachytherapy sources will be denied when billed without an associated brachytherapy procedure.

Diagnostic and Therapeutic Imaging Radiopharmaceutical and Contrast Agents

Certain imaging agents are approved for use with specific diagnostic or therapeutic imaging procedures. Imaging agents will be denied if billed alone or with imaging procedures that are not consistent with their use.

Radiopharmaceuticals HCPCS A9500 and A9502 are limited to two units per date of service; excess units will be denied.

Drugs and Biologicals

A pass-through or non-pass-through drug or biological (excluding pass-through radiopharmaceuticals) will be denied if billed without an OPPS-payable procedure on the same date of service. Pass-through radiopharmaceuticals will be denied if billed without an OPPS-payable nuclear medicine procedure on the same claim and date of service.

Implant Device

Implantable devices will be denied if not billed with an associated implant procedure. Implant procedures will be denied if not billed with the corresponding device code(s).

Diagnosis Age Consistency

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Inpatient Facility (CMS 1450), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: CMS Outpatient Prospective Payment System

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

Certain diagnosis codes are age-specific and must align with the patient's age on the date of service. When a diagnosis is billed as the only code on a claim and the patient's age does not match the required age range for that diagnosis, all services on the claim will be denied. This edit applies to all diagnoses on a claim and enforces ICD-10-CM age-based coding requirements.

Diagnosis Code Guideline

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Inpatient Facility (CMS 1450), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: ICD Manual, CMS Internet Only Manuals

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

Identifies when diagnosis codes are not submitted in accordance with ICD-10-CM coding guidelines and CMS policies. Claims that do not meet these requirements will be denied under this edit.

ICD-10-CM coding guidelines provide a step-by-step tutorial and full official conventions and guidelines regulating the appropriate assignment and reporting of ICD-10-CM codes. As such we expect providers to bill with the highest level of accuracy and compliance with official coding sources and guidelines.

The Diagnosis Code Guideline Policy applies when a diagnosis code submitted for a procedure or service is reported inappropriately or in an invalid position on a professional or facility claim.

Claims must comply with the following ICD-10-CM guidelines including but not limited to:

- External cause codes reported as the ONLY diagnosis on the claim or claim line, the principal or primary diagnosis on a claim will be denied.
- Manifestation codes reported as the ONLY diagnosis on the claim or claim line, the principal or primary diagnosis on a claim will be denied.
- Secondary diagnosis codes as the ONLY diagnosis on the claim or claim line, the principal or primary diagnosis on a claim will be denied.
- ICD-10-CM sequela (“S” 7th character) codes as the ONLY diagnosis on the claim or claim line, the principal or primary diagnosis on a claim will be denied.

- Principal/primary diagnosis for chemotherapy encounters (e.g., Z51.11 and Z51.12 must accompany treatment codes) as the ONLY diagnosis on the claim or claim line, the principal or primary diagnosis on a claim will be denied.
- Factors influencing health status and contact with health services (Z codes) as the ONLY diagnosis on the claim or claim line, the principal or primary diagnosis on a claim will be denied.
- Health service codes for specific procedures/treatments not carried out reported as the ONLY diagnosis on the claim or claim line, the principal or primary diagnosis on a claim will be denied.
- ICD-10-CM "Excludes 1" notes – Diagnosis codes identified as mutually exclusive under "Excludes 1" notes must not be reported together. Claims containing these combinations will be denied.
- ICD-10-CM laterality – The laterality indicated in a diagnosis code must match the laterality of the procedure modifier. Multiple lateral diagnosis codes on the same claim must not conflict. Claims with conflicting laterality will be denied.
- ICD-10-CM mutually exclusive code combinations – Diagnosis codes identified as mutually exclusive in the ICD-10-CM coding guidelines must not be reported together. Claims containing these combinations will be denied.
- Questionable admission diagnosis codes are not sufficient to justify admission. When a questionable admission diagnosis is reported as the principal diagnosis the claim will be denied.
- Questionable obstetric admission (ICD-10-PCS 10D07Z3-10D07Z5, 10D07Z7, 10E0XZZ, 10D00Z0-10D00Z2) will be denied when billed without a secondary diagnosis describing the outcome of the delivery.

Diagnosis Gender Consistency

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Inpatient Facility (CMS 1450), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: ICD Manual

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

Certain diagnosis codes are gender-specific and must align with the patient's gender on the date of service. When a diagnosis is billed that does not match the patient's gender, services on the claim will be denied.

This edit enforces ICD-10-CM gender-based coding requirements.

Diagnosis Validity

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Inpatient Facility (CMS 1450), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: CMS Internet Only Manuals

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

Annually, diagnosis codes (ICD-10-CM) undergo revision by the governing entity. Revisions typically include adding new diagnosis codes, deleting diagnosis codes, and redefining descriptions of existing codes.

Based on CMS policy claims submitted with deleted ICD-10-CM codes will be denied. Providers must resubmit the claim as a corrected claim with a valid ICD-10-CM code at the highest level of specificity.

Diagnosis Specificity

Claims received with any diagnosis code not coded to the highest level of specificity will be denied. Providers must resubmit the claim as a corrected claim with an updated ICD-10-CM code at the highest level of specificity.

Invalid Diagnosis

Invalid diagnosis codes are defined as codes submitted by a provider that cannot be correlated to a diagnosis code valid at any point in time. Claims received with any invalid ICD-10-CM codes will be denied.

Deleted diagnosis codes are defined as codes that were once valid but have since been deleted or modified with greater/lesser specificity. All diagnosis codes are validated against their effective and termination dates. Therefore, any ICD-10-CM code not valid for the date of service is considered invalid and the claim will be denied.

Duplicate Services

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Inpatient Facility (CMS 1450), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: Administrative Processing Rules, CMS Internet Only Manuals

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

Duplicate claims and claim lines are identified using administrative processing rules. This edit will evaluate new claims against other claims in history and the same claim. Duplicate claims and claim lines will be denied or flagged for coding validation. Coding validation will determine if both services are appropriate, if determined not appropriate the duplicate service will be denied. The key elements of a claim that are evaluated include but are not limited to:

- Subscriber ID
- Dependent ID
- Date of service
- Procedure code
- Modifier code
- Revenue code
- Bill type
- Admission date
- Discharge date
- Units
- Claim type
- Tax ID
- Specialty

Evaluation and Management (E/M)

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Inpatient Facility (CMS 1450), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: AMA CPT Assistant, AMA CPT Manual, American Academy of Family Physicians, American Academy of Pediatrics, American Association of Neuromuscular and Electrodiagnostic Medicine, CMS'S Correct Coding Initiative (CCI) and Policy Manual, CMS HCPCS Level II Manual, and CMS Internet Only Manuals

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

This policy ensures proper reporting of evaluation and management (E/M) services.

New Patient Visits

A new patient visit will be denied when any face-to-face service has been previously billed within the last three years. This denial will apply to:

- Same physician or a physician group practice (with the same specialty and subspecialty)
- Same provider ID, regardless of Tax ID or specialty
- Non-physician practitioner's (i.e. Certified nurse midwife, clinical nurse specialist, nurse practitioner or physician assistant) new visit claim will be denied if any face-to-face services has been previously billed within the last three years by the same group practice (same Tax ID, any specialty) and the primary diagnosis matches

Outpatient Consultations

Outpatient or office consultations (CPT 99242-99245, 99446-99449, 99451, HCPCS S0285) will be denied when a face-to-face service or clinic visit has not been billed by a different provider on the same date of service or in the previous year. Follow-up outpatient or office

consultation services (CPT 99242-99245) billed in the office (place of service 11) will be denied when any other E/M service has been billed in the previous year.

Consultation with Annual Exam or Screening Diagnosis

Outpatient or office consultations or interprofessional telephone/Internet electronic health record consultations (CPT 99242-99245, 99446-99449, 99451) will be denied when billed with a diagnosis for health supervision or routine examination.

Multiple Inpatient Admission or Consultation Services

A second initial hospital care service (CPT 99221-99223) will be denied when billed if an inpatient consultation (CPT 99252-99255), subsequent hospital care (CPT 99231-99233) or another initial hospital care service was billed by the same provider group and same place of service within the same admission week without a discharge (CPT 99238-99239).

Discharge Services

Hospital inpatient or observation discharge services (CPT 99234-99236 or 99238-99239) will be denied if another discharge service (CPT 99234-99236 or 99238-99239) is billed for the same date of service for any provider. In addition, hospital discharge services (CPT 99238-99239) will be denied if another discharge service (CPT 99238-99239, 99234-99236) is billed the previous day or paid for a subsequent date of service. Prolonged services (CPT 99358-99359) will be denied when billed with discharge services (CPT 99238-99239) on the same claim and date of service.

Other E/M Services Edits

E/M services will apply edits in accordance with AMA CPT guidelines, definitions and limitations. Services will be denied when claims are not reported properly.

- Critical care services (CPT 99291)
- Inpatient Neonatal and Pediatric Critical Care and Intensive Care Services (CPT 99468-99472, 99475-99480)
- Transitional care management (CPT 99495-99496)
- Interprofessional telephone/internet/electronic health record consultations (CPT 98016, 99446-99449, 99451,99452, HCPCS G2010, G2252)

- Newborn care services (CPT 99460, 99461, 99463)
- Pediatric interfacility transport and critical care services (CPT 99291-99292, 99466-99467)
- Office-based treatment of opioid use disorders (HCPCS G2086, G2087)
- Online digital and telephone services (CPT 98970-98972, 99421-99423)
- Remote physiologic monitoring (CPT 99457, 99473-99474)
- Peak expiratory flow (HCPCS S8110)
- Visual acuity screening (CPT 99173)
- Electrocardiogram (CPT 90310, 93042)
- Cardiovascular services (CPT 93260-93261, 93282-93284, 93287, 93289, 93292)
- Electromyography, nerve conduction and reflex tests

Care Management Services

Care management services will apply edits in accordance with AMA CPT guidelines, definitions and limitations. Care management services will be denied when claims are not reported properly.

- Complex chronic care and chronic care management services (CPT 99424, 99426, 99427, 99437, 99439, 99487, 99489, 99490-99491, HCPCS G0506)
- Care management services (CPT 99424, 99426, 99487, 99490-99491) reported with End-stage renal disease (ESRD) related services (CPT 90951-90970), Telephone services (CPT 98966-98968) and medical team conference (CPT 99367-99368)
- Behavioral and Psychiatric care management services (CPT 99484, 99492-99494, HCPCS G0323, G2214)

Multiple E/M Services on the Same Day

A new patient or an initial care visit will be denied when billed with more than one unit per date of service.

Only one E/M code is allowed for a single date of service for the same provider group and specialty, regardless of service. If multiple E/M services are performed, then the E/M codes will be ranked based on RVU. The E/M with the lowest RVU will be denied unless an appropriate modifier is appended.

Separate and distinct E/M services reported with modifier 25 only be allowed with one unit per provider and date of service. Additional E/M services with modifier 25 will be denied if the use of the modifier is not supported.

Preventive Medicine Visits

E/M services billed with preventive medicine visits (CPT 99381-99397, HCPCS G0438-G0439) will apply edits in accordance with AMA CPT guidelines. Preventive medicine visits edits include but are not limited to:

- Problem-oriented E/M services (CPT 92002-92014, 98000-98016, 99202-99215, HCPCS S0620-S0621)
- Pediatric initial or periodic visits (CPT 99381, 99382, 99391, 99392)
- Auditory screening services (CPT 92551, 92560, HCPCS V5008)
- Digital rectal exam (HCPCS G0102)
- Gynecologic services (HCPCS G0101, Q0091, S0610-S0613)

Medication Therapy Management

Medication therapy management new patient (CPT 99605) will be recoded to established patient (CPT 99606) if billed withing one year of previous medication therapy management.

Facility Claims Processing

Claim Type: Ambulatory Surgical Center (CMS 1450), Inpatient Facility (CMS 1450) and Outpatient Facility (CMS 1450)

Source: CMS Internet Only Manuals, Non-AMA/ Non-CMS Coding Industry Publication

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

Facility claims processing edits will be applied to claims based on guidance from National Uniform Biling Committee (NUBC) and CMS. This policy is applied to facility claims to prevent incorrect payments and inappropriate billing. Facility claims processing edits include but is not limited to:

- No-pay bill type identified by '0' as the last digit of the bill type will be denied.
- Discharge status code 20, 40, 41 or 42 (patient deceased or expired). Any services rendered subsequent to an existing inpatient or outpatient claim with discharge status codes 20, 40, 41 or 42 will be denied.
- Discharge status code is required for certain bill types. A claim will be denied if the discharge status code is missing from certain bill types (e.g., bill type 011x inpatient hospital will be denied if the discharge status code is missing).
- Timely filing for inpatient claims. An inpatient claim will be denied when received more than 366 days after the date of service. (Applicable to Medicare Advantage only)
- Inpatient claims with invalid ICD-10-PCS codes and discharge status codes will be denied.

Frequency Editing

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Inpatient Facility (CMS 1450), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: AMA CPT Changes, CMS'S Correct Coding Initiative (CCI) and Policy Manual, CMS Internet Only Manuals, Expert Specialty Review Panel, and Regional CMS Policy (Local Coverage Determination [LCD])

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

CMS and AMA guidelines define frequency limits for services. This edit will deny services that exceed the frequency indicated below. Frequency limits for services include but are not limited to:

- Chiropractic Manipulation (CPT 98940-98942) – once per day
- Drug Testing
    - Presumptive drug testing (CPT 80305-80307) – one combined unit per day
    - Definitive drug testing (HCPCS G0480-G0483, G0659) – one combined unit per day
- Preventive and Screening Services
    - Integumentary photography – once per year
    - Cardiovascular disease screening lab service with a screening diagnosis - once in a five-year period (Applicable to QUEST Integration and Medicare Advantage only)
    - Ocular photography – twice per year
- Psychiatric Diagnostic Evaluation (any combination of CPT 90791 or CPT 90792) – three units per year

Global Obstetrical Package

Claim Type: Professional (CMS 1500)

Source: AMA CPT Assistant, AMA CPT Manual, American College of Obstetricians and Gynecologists, Expert Specialty Review Panel

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

The Global Obstetrical Package encompasses all routine antepartum, delivery, and postpartum care provided by the same physician or provider group for uncomplicated maternity cases.

This includes services such as evaluation and management during the postpartum period, antepartum visits within 240 days prior to delivery, and related care within 42 days following delivery.

Services that fall within these global periods or duplicate components of maternity care are considered part of the global package and are not separately reimbursable. Claims for services that overlap these timeframes will be denied.

Obstetrical Deliveries

When billing for obstetrical deliveries, services must follow specific coding rules to ensure proper reporting. Certain delivery code combinations are not appropriate and will result in either a denial or a recode.

- **Multiple Delivery**
    - Subsequent delivery codes billed for the same date of service or within six months by any provider or specialty will be denied. An exception will be applied for appropriate modifiers appended to the delivery code.
    - Subsequent delivery codes billed when more than one delivery code has already been previously billed and paid within six months (180 days) by any provider will be denied.

- **Multiple Gestation Pregnancy Delivery**
    - Global vaginal delivery (CPT 59400) billed with global cesarean delivery (CPT 59510) when the diagnosis is not multiple gestation will be denied.
    - C-section delivery codes (CPT 59510–59515, 59618–59622) billed more than once for the same date of service by any provider when the diagnosis is multiple gestation will be denied.
    - Global vaginal delivery (CPT 59400) billed with global cesarean delivery (CPT 59510) and the diagnosis is multiple gestation will be recoded to vaginal delivery only (CPT 59409).
    - When multiple global delivery procedure codes (e.g., CPT 59400, 59610) are billed for a multiple gestation diagnosis, only one delivery code will be allowed. The second global delivery procedure code will be denied.

Antepartum Care

Antepartum care refers to services provided before delivery. Reimbursement is dependent on whether the same or different provider group renders the services, and whether claims are billed in sequence according to AMA CPT Manual and coding guidelines.

- When the same provider group performs antepartum care but submits claims separately for individual visits, claims billed with antepartum care-only codes after these services have been previously billed and paid will be denied.
- Evaluation and Management (E/M) services billed more than five months after an antepartum service, when the diagnosis indicates pregnancy or abortion, will be denied.
- When a provider has already billed antepartum care within the last eight months, any subsequent global delivery claim will be denied.
- Out of Sequence claims involving antepartum care that has already been billed and paid within the same provider group will result in subsequent claims for antepartum services being denied.

- When antepartum care is rendered by a different provider group and a separate provider bills for global delivery, claims for the delivery will be denied.
- E/M services billed by the same provider group beyond the standard antepartum period or inappropriately overlapping antepartum codes will be denied.

Removal of Cerclage

When billed on the same date of service as the delivery code, the removal of a cerclage (CPT 59871) is considered included in the delivery fee and not separately reimbursable. If billed with an appropriate modifier indicating a distinct service, both procedures may be allowed; otherwise, the cerclage removal will be denied.

Global Surgery

Claim Type: Outpatient Facility (CMS 1450) and Professional (CMS 1500)

Source: AMA CPT Manual, CMS Outpatient Prospective Payment System, CMS and Expert Specialty Review Panel, and CMS Transmittals/ Memos/Publications

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

CMS defines the global surgical package, also called global surgery, as all services normally provided by a surgeon before, during, and after a procedure. The package applies only to surgical procedures with postoperative periods of 0, 10, or 90 days, as defined by CMS. The global surgery concept applies only to primary surgeons and co-surgeons.

Anesthesia or Postoperative Pain Management Provided by Surgeon

Anesthesia services and postoperative pain management performed by the operating surgeon are included in the 0-day, 10-day, or 90-day global surgical package and are not separately reportable. Claims that do not meet these requirements will be denied:

- Surgical procedures billed with a 0-day, 10-day, or 90-day global period with modifier 47 (anesthesia by surgeon) or P1-P6 (physical status modifiers) when the same procedure is also billed without these modifiers will be denied.
- Daily management of epidural or subarachnoid drug administration (CPT 01996) during the global period will be denied when billed with a 0-day, 10-day, or 90-day surgical procedure.

Major and Minor Surgery: Global Surgical Periods (0-Day, 10-Day, or 90-Day Procedures)

Evaluation and Management (E/M) and care management services associated with 0-day, 10-day, and 90-day major surgical procedures are included in the global package. Claims that fall outside of these rules will be denied.

- **Services on the Day Prior**
    - E/M services performed the day prior to a 90-day medical or surgical service will be denied.
    - Preventive or preventive-like services performed the day prior to a 90-day medical or surgical service will be denied.
- **Services on the Same Day**
    - E/M services billed or performed the same day as a 0-day, 10-day, or 90-day medical or surgical service will be denied.
    - Preventive services billed or performed the same day as a 0-day, 10-day, or 90-day medical or surgical service will be denied.
- **Services within the Postoperative Period**
    - E/M services performed within 10 or 90 postoperative days will be denied.
    - E/M services performed within 90 postoperative days of a 90-day medical or surgical service when billed by a non-physician practitioner (NPP) will be

denied when the primary diagnosis is related to the procedure, or the diagnosis is a complication of surgical and medical care or is classified as an aftercare diagnosis.

- Care management (CPT 99424, 99426, 99487-99491) and transitional care management (TCM) (CPT 99495-99496) services performed within the 10- or 90-day postoperative period will be denied.
- Care management and TCM services if billed by a NPP, will be denied when the primary diagnosis is related to the procedure, or the diagnosis is a complication of surgical and medical care or is classified as an aftercare diagnosis.

Modifier 24 – Postoperative E/M and Care Management Services

Evaluation and Management (E/M) and Care Management/Transitional Care Management (TCM) services billed with modifier 24 (unrelated E/M service by the same physician during a post-operative period) during postoperative periods are subject to the following restrictions:

- E/M services billed with modifier 24 during the 10-day or 90-day postoperative period when the primary diagnosis is related to the procedure will be denied.
- E/M services for a complication or aftercare diagnosis billed with modifier 24 during the 10-day or 90-day postoperative period will be denied.
- Care management or TCM services billed with modifier 24 during the 10-day or 90-day postoperative period when the primary diagnosis is related to the procedure will be denied.
- Care management or TCM services for a complication or aftercare diagnosis billed with modifier 24 during the 10-day or 90-day postoperative period will be denied.
- Coding validation: E/M services billed with modifier 24 when a minor surgical procedure has been billed in the previous 10 days, or a major surgical procedure in the previous 90 days, will be flagged for review. The review will determine whether

the use of modifier 24 is supported. If modifier 24 use is not supported, the claim line will be denied.

Modifier 25 – E/M Services Reported with Procedures

Evaluation and Management (E/M) services billed with modifier 25 must represent a significant, separately identifiable service performed on the same day as a procedure. Claims that do not meet these requirements will be denied or flagged for review:

- E/M services billed with modifier 25 on the same day as a 0-day, 10-day, or 90-day postoperative period with the same primary diagnosis, when a face-to-face service has been billed within two months for the same diagnosis, will be denied.
- E/M services billed with modifier 25 on the same day as a surgical procedure with a 0-, 10-, or 90-day global period will be flagged for review. The review will determine whether the use of modifier 25 is supported. If modifier 25 use is not supported, the claim line will be denied.

Modifier 57 – E/M Services During the Global Period

Evaluation and Management (E/M) services reported with modifier 57 (decision for surgery) must be billed correctly. Claims that do not meet these requirements will be denied or flagged for review:

- E/M services with modifier 57 billed with planned major surgical services will be denied.
- E/M services with modifier 57 billed when performed the day prior or the same day as a major surgical procedure, and another E/M service has been billed in the previous two months with the same primary diagnosis, will be denied.
- E/M services with modifier 57 billed the day prior or the same day to a major surgical procedure will be flagged for review. The review will determine whether the use of modifier 57 is supported. If modifier 57 use is not supported, the claim line will be denied.

Modifiers 58, 78, or 79 with 0-Day, 10-Day, or 90-Day Procedures

Surgical procedures (0, 10, or 90-day) billed with modifiers 58, 78, or 79 will be flagged for review when reported within global periods (10 or 90 days). The review will determine whether the use of the modifier is supported. If modifier use is not supported, the claim line will be denied.

- 58 - Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period.
- 78 - Unplanned return to the operating/procedure room by the same physician or other qualified healthcare professional following initial procedure for a related procedure during the postoperative period.
- 79 - Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period.

Other Medical and Surgical Services During the Postoperative Period

Evaluation and Management (E/M) and surgical services during the postoperative period are subject to denial when billed within restricted timeframes:

- 0, 10, or 90-day surgical procedures performed within 90 postoperative days of a 90-day procedure, including those billed by the same provider ID regardless of Tax ID or specialty, will be denied.
- 0 or 10-day surgical procedures performed within 10 postoperative days of a 10-day procedure, including those submitted by the same provider ID regardless of Tax ID or specialty, will be denied.

Supplies

Supplies are included in the global surgical package and are not separately billable. Claims that do not meet these requirements will be denied:

- Supplies billed on the same date of service as a 0-day, 10-day, or 90-day surgical procedure will be denied.
- Supplies billed on the same date of service as a 0-day, 10-day, or 90-day surgical procedure by the same Provider ID, regardless of Tax ID or Specialty, will be denied.

Medical Visits by an Outpatient Hospital (Applicable to Medicare Advantage only)

Medical visits are considered included in the global surgical package and will be denied when billed on the same day as a medical or surgical service by an outpatient facility.

Incident To Services

Claim Type: Professional (CMS 1500)

Source: CMS Internet Only Manuals

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

"Incident to" services are defined as services or supplies that are furnished as an integral, although incidental, part of a physician's ongoing treatment plan. An "incident to" service will be denied when billed with place of service including but not limited to:

- 02 (Telehealth)
- 19 (Outpatient hospital - off campus)
- 21 (Inpatient hospital)
- 22 (Outpatient hospital - on campus)
- 23 (Hospital emergency room)
- 24 (Ambulatory surgical center)
- 26 (Military treatment facility)
- 31 (Skilled nursing facility)
- 34 (Hospice)
- 41 (Ambulance land)
- 42 (Ambulance air or water)
- 51 (Inpatient psychiatric facility)
- 52 (Psychiatric facility partial hospitalization)
- 53 (Community mental health center)

- 56 (Psychiatric residential treatment center)
- 61 (Comprehensive inpatient rehabilitation center)

Maximum Limits

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Inpatient Facility (CMS 1450), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: AMA CPT Manual, American College of Surgeons, CMS and Expert Specialty Review Panel, CMS Internet Only Manuals, CMS Outpatient Prospective Payment System, Expert Specialty Review Panel, ICD Manual, and Regional CMS Policy (Local Coverage Determination [LCD])

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

Procedure code definition or nomenclature, anatomical site, CMS and AMA sources, and clinical guidelines indicate that certain procedure codes are assigned a maximum limit of units and/or visits that may be reported. This edit will deny services that exceed the maximum limits indicated for a procedure code. Edits for maximum units or visits include but are not limited to:

- Anatomical Modifiers (E1-E4, FA-F9, TA-T9) – One unit per given date of service
- Obstetrical Services (CPT 59000, 59020, 74713, 76802, 76810, 76812, 76814, 76816, 76818-78621, or 76825-76828) – Determined based on the diagnosis code.
    - Add-on codes (CPT 74713, 76802, 76810, 76812, 76814) must be billed with the appropriate multiple gestation diagnosis.
- Daily Maximum Units – All procedure codes are assigned a maximum number of units per day. The source for maximum daily units includes but is not limited to procedure code definition or nomenclature, anatomical site, CMS guidelines and

medically unlikely edits (MUEs), AMA CPT manual, clinical guidelines and expert specialty panels.

  - Team surgery or co-surgery daily maximum units are evaluated based on the same provider.
  - Certain procedures regardless of modifiers are limited to one unit per day.
  - Surgeries that allow multiple assistant surgeons are assigned daily maximum units.

- Partial/Fractional Units – Service units must be reported in whole numbers.
- Annual Maximum Units – Certain procedure codes are assigned a maximum number of visits per 12-month period. The source for maximum visits includes but is not limited to procedure code definition or nomenclature, anatomical site, CMS regional policies on once per lifetime, clinical guidelines and expert specialty panels.
- Durable Medical Equipment (DME) Maximum Units – DME and supply codes are assigned a maximum number of units that may be billed within a specified time frame. The source for DME maximum units includes but is not limited to CMS regional policies, other industry sources such as Medicaid policies and expert specialty panels.
  - DME and supply codes are assigned a maximum number of units for one time frame. Time frames defined in this edit are a month (28 days), 3 months (84 days), 6 months (168 days) and one year (365 days).
- Modifier 52 (reduced services) or 73 (discontinued prior to administration of anesthesia) – One unit per given date of service.

Medicaid Regulations

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: State of Hawaii Medicaid Guidelines

Line of Business: QUEST Integration

Description:

Hawai‘i Medicaid guidelines define eligibility, service scope, and billing practices to ensure compliance with program regulations.

Community Integration Services – Supportive Housing

Supportive housing (HCPCS H0044) is covered only for members aged 18 or older and limited to one unit per calendar month. Claims submitted for members under 18 or more than one unit per calendar month will be denied.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Exam

Early and periodic screening, diagnostic and treatment (EPSDT) exams are covered for Medicaid members under age 21. A comprehensive EPSDT exam is reimbursed at a global rate, which includes related services such as venipuncture and evaluation and management (E/M). These services are not separately reimbursed when provided by the same provider on the same date of service.

Venipuncture (CPT 36415) and E/M services (CPT 99202–99255, 99304–99499) billed with an EPSDT exam (CPT 99232, 99308, 99348, 99381–99385, 99391–99395, 99460, 99461 appended with modifier EP) by the same provider on the same date of service will be denied.

Modifier Editing

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Inpatient Facility (CMS 1450), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: AMA Coding with Modifiers, AMA CPT Manual, CMS HCPCS Level II Manual, CMS Internet Only Manuals, CMS Outpatient Prospective Payment System, and CMS Transmittals/ Memos/ Publications, Regional CMS Publication

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

Identifies claim lines billed with inappropriate modifiers in accordance with CMS, AMA CPT, and HCPCS guidelines.

This policy ensures modifiers are applied correctly to reflect the circumstances of the service or procedure performed.

When a modifier is billed inappropriately the service is subject to review and denial.

Anatomical Modifiers

Anatomical modifiers identify the body part where a procedure is performed (e.g., fingers, toes, eyelids, coronary arteries, left/right side, bilateral).

When an anatomical modifier is appended to a procedure code that does not match the anatomical site indicated by the modifier, the service will be denied.

Anatomical modifiers covered in this policy:

E1-E4 (Eyelids)
FA-F9 (Fingers)
TA-T9 (Toes)
LC (Left circumflex, coronary artery)
LD (Left anterior descending coronary artery)
LM (Left main coronary artery)
RC (Right coronary artery)
RI (Ramus intermedius)

LT (Left side)
RT (Right side)
50 (Bilateral side)

Concurrently Administered Infusion Therapy Modifiers SH and SJ

According to HCPCS Level II Manual, modifiers SH and SJ are used to indicate second and third (or more) concurrently administered infusion therapies.

When an IV home infusion service has not been previously billed without modifier SH for the same date of service, any claim billed with modifier SH will be denied.

Likewise, when modifier SJ is used for third or more concurrent infusions, but an SH-coded service has not been billed for the same date of service, the SJ service will be denied.

Consistency of Reduced or Discontinued Services Between Professional and Facility Providers

Claims must demonstrate consistency when reporting reduced or discontinued services between professional providers and outpatient facilities.

- Modifiers 52 (Reduced Services) and 53 (Discontinued Procedure) are used by professional providers to indicate reduced or discontinued services.
- Modifiers 73 (Discontinued outpatient/ASC procedure prior to the administration of anesthesia) and 74 (Discontinued outpatient/ASC procedure after administration of anesthesia) are used by outpatient facilities to indicate discontinued procedures, either before or after anesthesia.

If a facility bills with modifier 73 or 74, the professional provider must also use modifier 52 or 53 when reporting the same service. Failure to align these modifiers will result in denial.

Additionally, when an outpatient facility reports a discontinued service with modifier 73, any related anesthesia services billed by a professional provider on the same date of service by an outpatient facility will also be denied.

Diagnostic and Screening Mammogram Modifiers

Claims for mammography services must follow correct reporting rules when both screening and diagnostic mammograms are performed on the same date of service.

- Services billed with modifier GG (screening + diagnostic mammogram same day) must include a diagnostic mammogram code. If not, the claim will be denied.
- Diagnostic mammogram (CPT 77065, 77066, HCPCS G0204, G0206) billed with screening mammogram (CPT 77063, 77067) must include modifier GG. If not, the claim will be denied.
- Screening mammogram (CPT 77063, 77067) billed with diagnostic mammogram (CPT 77065, 77066, HCPCS G0204, G0206) must include modifier 59 or X-modifier (XE, XP, XS, XU). If not, the claim will be denied.

Anesthesia Services

Anesthesia codes that are billed with other than appropriate anesthesia modifiers, such as physical status modifiers and HCPCS anesthesia modifiers will be removed.

Modifier 59 (Distinct Procedural Service) and XE or XP or XS or XU

Modifier Combinations: Any code billed with modifier 59 and modifier XE (Separate Encounter), XP (Separate Practitioner), XS (Separate Structure), or XU (Unusual Non-Overlapping Service) appended will be denied.

Modifier 90 (Reference (Outside) Laboratory)

Modifier 90 may only be used for referred laboratory services performed by independent clinical laboratories. If a provider from a specialty other than laboratory or pathology bills referred laboratory services with modifier 90, the claim will be denied.

Modifier CS (Cost Share Waiver COVID-19)

According to CMS policy, effective May 12, 2023, any CPT or HCPCS code billed with modifier CS for COVID-19 cost-share waiver will be denied.

An exception applies when telehealth services are furnished by a Rural Health Clinic (RHC) or a Federally Qualified Health Center (FQHC) and billed with HCPCS G2025. In these cases, modifier CS may be reported to distinguish covered telehealth services.

If modifier CS is billed with any other code besides HCPCS G2025, the claim will be denied.

Modifier SL (State Supplied Vaccine)

According to the HCPCS Level II Manual, a vaccine or toxoid provided by the state and billed with Modifier SL is not reimbursable. Claims will be denied if submitted with Modifier SL when the allowed amount is more than $0.00.

Reduced and Discontinued Services Modifiers

Claims must comply with CMS and AMA guidance when reporting reduced or discontinued services using modifiers 52 and 53.

- Modifier 52 (Reduced Services) - Indicates a procedure was partially reduced at the physician's discretion. When reported, reimbursement is limited to 50% of the allowed amount.
- Modifier 53 (Discontinued Procedure) - Used when extenuating circumstances require the physician to terminate a surgical or diagnostic procedure. Modifier 53 is not valid with Evaluation and Management (E/M) services, and claims billed in this way will be denied. In addition, claims billed with modifier 53 with an inappropriate bill type will be denied.
- Radiologic Supervision and Interpretation (S&I) - When the same S&I service is reported by multiple providers, modifier 52 must be appended by both physicians if the work is split. If one provider has already been paid, duplicate claims by another provider will be denied.
- Laboratory Panels - If a laboratory panel code is billed with modifier 52 or 53, the claim will be denied.

Repeat and Related Procedures During the Postoperative Period

- Modifier 77 (Repeat Procedure by Another Physician) - Denied when the same procedure code has not been billed by a different provider ID on the same date of service or within the postoperative period.
- Modifier 76 (Repeat Procedure by Same Physician) - Denied when the same procedure code has not been billed by the same provider ID on the same date of service or within the postoperative period.
- Modifier 78 (Return to OR for Related Procedure) - Denied when the related procedure code has not been billed on the same date or during the postoperative period of the original service.
- Modifier 79 (Unrelated Procedure by Same Physician) - Denied when the unrelated procedure code has not been billed on the same date or during the postoperative period of the original service.

Telehealth Services Modifiers (G0, GQ, GT, 93, 95)

Claims must follow CMS and AMA CPT guidance when reporting telehealth services with modifiers G0, GQ, GT, 93, and 95.

- Modifier G0 is used for telehealth services related to the evaluation, diagnosis, or treatment of an acute stroke.
- Modifier GQ applies to services provided via asynchronous telecommunications systems.
- Modifier GT applies to audio and video telecommunications.
- Modifier 93 applies to synchronous telemedicine services rendered via telephone or other real-time interactive audio-only systems but only when tied to approved telehealth codes.
- Modifier 95 applies to synchronous telemedicine services rendered via real-time interactive audio and video systems but only when tied to approved telehealth codes.

Therapy and Assistant Therapy Service Modifiers (GN, GO, GP, CO, CQ)

Therapy services must be billed with the correct therapy modifier to identify the discipline providing the service:

- GN – Speech-language therapy
- GO – Occupational therapy
- GP – Physical therapy

Any therapy claim submitted without the appropriate modifier will be denied. This applies across therapy settings, including hospitals, skilled nursing facilities, rehabilitation clinics, and other covered providers.

- Deny non-therapy services when billed with therapy services modifier GN, GO, or GP.
- Deny physical medicine and rehabilitation services billed without GN, GO, or GP.
- Deny speech-language therapy services billed without GN.
- Deny occupational therapy services billed without GO.
- Deny physical therapy services billed without GP.
- Deny therapy services when billed with a combination of modifiers GN, GO or GP.

Assistant Therapy Services

Assistant therapy services must be billed with the correct assistant modifier to identify when services are provided by therapy assistants:

- CO – Outpatient occupational therapy assistant services
- CQ – Outpatient physical therapy assistant services

Any assistant therapy claim submitted without the appropriate modifier will be denied.

- Deny occupational therapy assistant services billed with CO and billed without GO.
- Deny physical therapy assistant services billed with CQ and billed without GP.

X-ray Transportation Modifiers (UN, UP, UQ, UR, US)

According to CMS policy, portable x-ray transportation services require the use of appropriate modifiers to indicate the number of patients served:

- UN (one patient)
- UP (two patients)
- UQ (three patients)
- UR (four patients)
- US (five or more patients)

If a transportation service is reported without one of these required modifiers, the claim will be denied.

Inappropriate Modifier Pairs – Facility Claims (CT, ER, FX, FY, PO, PN)

According to CMS policy there are certain modifier codes that should not be billed together because they are conflicting. Inappropriate modifier pairs will be denied when billed on the same claim line.

Modifier pairs include but are not limited to:

- PO (Excepted off-campus service) and PN (Non-excepted off-campus service)
- CT (Computed tomography services furnished using equipment that does not meet the national electrical manufacturers association (NEMA) XR-29-1013 standard) and FX (X-ray taken using film)
- FX and FY (X-ray taken using computed radiography technology/cassette-based imaging)
- CT and FY
- ER (Items and services furnished by a provider-based, off-campus emergency department) and PN
- ER and PO

National Correct Coding Initiative (NCCI)

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: CMS Correct Coding Initiative (CCI) and Policy Manual (Commercial and Medicare Advantage follows Medicare NCCI. QUEST Integration follows Medicaid NCCI.)

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

The National Correct Coding Initiative (NCCI) is a program established by the Centers for Medicare & Medicaid Services (CMS) to promote correct coding practices and prevent improper payments by identifying services that should not be reported together.

Procedure-to-Procedure Edits

Procedure-to-Procedure edits are applied to claims based on Medicare, Medicaid, and DME CCI guidelines. These edits prevent inappropriate reporting of code pairs (Column One and Column Two) that should not be billed together.

Claims that do not meet NCCI requirements will be denied or flagged for review.

- Column Two codes billed with associated Column One codes will be denied.
- Column Two codes billed by the same provider, regardless of Tax ID or specialty, will be denied.
- Column Two codes billed under the same or different provider IDs, with a CCI modifier, will be flagged for review. The review will determine whether the use of a modifier is supported. If modifier use is not supported, the claim line will be denied.
- Column Two codes billed with an unsupported modifier will be flagged for review. The review will determine whether the use of a modifier is supported. If modifier use is not supported, the claim line will be denied.

Mutually Exclusive Procedures

Mutually exclusive procedures are those that cannot reasonably be performed during the same encounter due to clinical or coding guidelines. Mutually exclusive edits are applied to claims based on Medicare, Medicaid, and DME CCI guidelines.

Claims that do not meet these requirements will be denied or flagged for review.

- Column Two codes billed with associated Mutually Exclusive Column One codes will be denied.
- Column Two codes billed by the same provider, regardless of Tax ID or specialty, will be denied.
- Column Two codes billed by the same provider with a CCI modifier will be flagged for review. The review will determine whether the use of a modifier is supported. If modifier use is not supported, the claim line will be denied.
- Column Two codes billed by a different provider under the same Tax ID and specialty, with a CCI modifier, will be flagged for review. The review will determine whether the use of a modifier is supported. If modifier use is not supported, the claim line will be denied.

Out of Sequence Edits

Out of Sequence Edits are applied to claims based on Medicare, Medicaid, and DME CCI guidelines. These edits prevent services from being reimbursed when billed in the wrong sequence or without appropriate modifier justification.

Claims that do not meet these requirements will be denied or flagged for review.

- Column Two codes billed when the Column One code has already been paid will be denied.
- Column Two codes billed by the same Provider ID, regardless of Tax ID or specialty, when the Column Two code has already been paid will be denied.
- Column Two codes resubmitted after prior payment for the same encounter will be denied.

- Column One procedure codes billed by the same Provider ID, regardless of Tax ID or specialty, when the Column Two code has already been previously paid will be denied.
- Column Two codes previously paid by a different Provider ID, same Tax ID and specialty, and with a CCI modifier will be flagged for review. The review will determine whether the coding on the claim is supported. If the coding on the claim is not supported, the claim line will be denied.
- Column Two codes billed by the same Provider ID, regardless of Tax ID or specialty, when the Column Two code has already been paid with a CCI modifier will be flagged for review. The review will determine whether the coding on the claim is supported. If the coding on the claim is not supported, the claim line will be denied.
- Column One DME codes billed after an associated Column Two code has already been paid will be denied.
- Column One DME codes resubmitted after prior payment when linked to associated Column Two codes will be denied.
- Column One or Column Two codes associated with previously paid codes, with a CCI modifier, will be flagged for review. The review will determine whether the coding on the claim is supported. If the coding on the claim is not supported, the claim line will be denied.

Other Services NCCI Edits

Claims for services must follow NCCI guidelines. Claims that do not meet these requirements will be denied or flagged for review. Other services that will apply NCCI edits include but is not limited to:

- IV Infusion with Chemotherapy Services (CPT 96360, 96365, 96372,96374 with CPT 96409, 96413, 96416)
- Perioperative Transesophageal Echocardiography (TEE) with anesthesia services (CPT 93312–93317, 93318 or 93355 with CPT 00100–01992)
- Pulse Oximetry (CPT 94760, 94761, 94762) and E/M Services (CPT 99202-99215, 99281-99285, 99304-99316, 99341-99350, 99483, or 99497, HCPCS G0463)

- Screening Pap Smear (HCPCS Q0091) and E/M Services (CPT 99202-99239, 99281-99285, 99291-99316, 99341-99350, 99358, 99360, 99416, 99431-99436, 99440, 99455-99456, 99460-99466, 99468-99472, 99475-99480, 99483, 99485, 99497 and HCPCS G0406-G0408)
- Visual Acuity Screening (CPT 99173) and E/M Services (CPT 99202-99380, 99401-99412, 99415-99416, 99446-99452, 99455-99456, 99460-99472,99475-99498), general eye exam (CPT 92002, 92004, 92012, 92014) or vision screening (CPT 99172, 99174, 99177)

Complex Coding Scenarios (Coding Validation)

Certain services require additional validation to ensure claims are coded accurately and completely. Examples include gastrointestinal (GI) endoscopy, chiropractic manipulation and physical therapy, podiatry and nail care, and physical therapy. Complex coding scenarios will be subject to validation review, claims not supported by accurate coding will be denied.

National Correct Coding Manual

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: CMS Correct Coding Initiative (CCI) and Policy Manual

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

Apply the National Correct Coding Initiative (NCCI) Policy Manual and denies procedures considered to be inappropriately coded based on NCCI Policies and Guidelines.

Correct Coding Initiative (CCI) Policies and Guidelines

Edits under the NCCI apply when procedures are reported inappropriately:

- Procedures determined to be inappropriately coded under CCI policies will be denied.
- If claim details and patient history do not support the use of a modifier to override the coding edit, the procedure will be denied.
- Out of sequence procedures considered to be inappropriately coded will be denied.
- Out of sequence procedures considered to be inappropriately coded under coding validation will be flagged for review. The review will determine whether the use of a modifier is supported. If modifier use is not supported, the claim line will be denied.

Daily Hospital Management of Continuous Epidural/Subarachnoid Drug Administration

According to the NCCI Policy Manual, payment for management of continuous epidural/subarachnoid drug administration is limited to one unit of service per postoperative day.

This applies regardless of the number of visits necessary to manage the catheter per postoperative day or the provider type.

- Daily hospital management of epidural or subarachnoid continuous drug administration will be limited to one unit per date of service when reported by any provider. Claims billed for more than one unit per date of service will be denied.

E/M Services

The NCCI restricts reporting of Evaluation and Management (E/M) services when performed on the same day as certain procedures, unless documentation supports that the E/M service is significant and separately identifiable.

- Radiology Procedures:
    - E/M services reported with a global radiology procedure by a radiologist without appropriate modifier will be denied.
    - E/M services reported with a global radiology procedure by a radiologist and appended with a modifier will be flagged for review. The review will determine whether the use of a modifier is supported. If modifier use is not supported, the claim line will be denied.
- Allergy Testing/Immunotherapy:
    - E/M services reported on the same day as allergy testing or immunotherapy without appropriate modifier will be denied.
    - E/M services reported on the same day as allergy testing or immunotherapy with a modifier will be flagged for review. The review will determine whether the use of a modifier is supported. If modifier use is not supported, the claim line will be denied.
- Anesthesia Services:
    - E/M services reported on the day prior to or the day of surgery when billed with anesthesia services will be denied.

- Cardiac Stress Test:
    - Low-level E/M services reported on the same day as a cardiac stress test without appropriate modifier will be denied.
- XXX-Day Global procedure Codes
    - E/M services reported with a procedure assigned a global surgery indicator of "XXX" without appropriate modifier will be denied
    - E/M services reported on the same day as procedure assigned a global surgery indicator of "XXX" with a modifier will be flagged for review. The review will determine whether the use of a modifier is supported. If modifier use is not supported, the claim line will be denied.

Lidocaine

According to the NCCI Policy Manual, lidocaine is bundled when used as a local anesthetic and is not separately reimbursable. Lidocaine billed with any service on the same day will be denied.

Operating Microscope

According to the NCCI, separate reimbursement for the operating microscope is only allowed when billed with approved procedures. Operating microscope services reported without an approved procedure will be denied.

Tympanometry with Preventive Medicine Services

According to the NCCI, tympanometry/impedance testing is considered included when performed with preventive medicine services. Separate reimbursement is not allowed. Tympanometry billed with a preventive medicine visit will be denied unless supported by an appropriate modifier.

Urine Specimen Validity Testing

According to the NCCI, specimen validity testing performed on urine drug test samples is generally bundled and not separately reportable. When reported in conjunction with urine drug testing without an appropriate modifier, the service will be denied.

National Drug Code (NDC)

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: Food and Drug Administration (FDA), CMS NDC-HCPCS Crosswalk

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

This policy ensures proper reporting of National Drug Code (NDC) numbers. Claims submitted with an NDC number that is invalid, expired or not approved will be denied. NDC numbers that do not match the submitted HCPCS or CPT code will be denied.

National Provider Identifier (NPI)

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Inpatient Facility (CMS 1450), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: CMS Transmittals/ Memos/Publications

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

To ensure compliance with federal regulations, payment is prohibited for services rendered, ordered, or prescribed by providers who are excluded or debarred from Federal health care programs, or by providers who lack active billing privileges and a valid National Provider Identifier (NPI) at the time of service.

Services billed using an invalid or inactive NPI will be denied.

Services billed by using an excluded or debarred NPI will be denied.

Observation Services

Claim Type: Outpatient Facility (CMS 1450, CMS 1500)

Source: CMS Internet Only Manuals, CMS Outpatient Prospective Payment System, CMS Transmittals/ Memos/Publication

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

This policy ensures observation services are billed correctly per CMS to maintain compliance and prevent payment errors.

- Bill Type
    - Only bill types 013X and 085X are valid for observation services. All others will be denied.
- Observation Revenue Code
    - Revenue Code 0762 must be billed only with valid observation service codes. Claims with other codes will be denied.
- Facility Observation Services
    - Direct Admission Without Observation (HCPCS G0379):
        - HCPCS G0379 requires HCPCS G0378 (Observation services per hour) on the same date to be reimbursed. Without it, HCPCS G0379 will be denied.
    - Direct Admission with Critical Care:
        - HCPCS G0379 is considered a packaged service when billed with CPT 99291 on the same date and will be denied.
    - Frequency of Observation Care:
        - Observation services HCPCS G0378 billed with greater than 72 units over a 3-day period will be denied. (Applicable to Medicare Advantage only)

Once Per Lifetime Services

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Inpatient Facility (CMS 1450), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: CMS Internet Only Manuals and Regional CMS Policy (Local Coverage Determination [LCD])

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

CMS national and regional guidelines indicate that certain procedures or services would only be done once in a patient's lifetime. According to CMS policy, procedures that remove an organ in the body such as the appendix or stomach are once per lifetime services. This edit will deny subsequent claims for procedures or services that has already been reimbursed once in a patient's lifetime. Once in a lifetime services include but are not limited to:

- Initial preventive physical examination
- Ultrasound for abdominal aortic aneurysm screening
- KidneyIntelX or KidneyIntelX.dkd test
- Bilateral Structure Services
    - Once per lifetime bilateral structure services will be limited to two.

Services Following a Medical Event

A patient may experience certain medical events that will impact the billing of future services. Services performed for anatomic structures that have been removed cannot be physically or technically carried out and are considered not reasonable or necessary under CMS guidelines. Therefore, services will be denied when applicable.

- Ophthalmology Services – Deny when performed on the same side as a prior eye enucleation, evisceration, or exenteration.
- Thyroid Services – Deny when performed after a total thyroidectomy.

- Upper or Lower Limb Services – Deny when performed on the same side as an upper or lower extremity amputation.
- Thoracic and Abdominal Region Services – Deny when performed after a total pneumonectomy, gastrectomy or nephrectomy.
- Uterine Services – Deny when performed after a total hysterectomy.

Partial Hospitalization

Claim Type: Outpatient Facility (CMS 1450)

Source: CMS Internet Only Manuals, CMS Outpatient Prospective Payment System

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

Ensures Partial Hospitalization Program (PHP) services are billed correctly in accordance with CMS guidelines to maintain compliance and prevent payment errors.

- Bill Type Restrictions
    - PHP claims submitted with Bill Type 0430–043Z (Religious Nonmedical Health Care Institution – Outpatient) and Condition Code 41 (Partial Hospitalization) will be denied.
    - PHP claims submitted with Bill Type 0130-013Z (Hospital-Outpatient) or 0760-076Z (Community Mental Health Centers (CMHC)) and Condition Code 41, will be denied if a PHP primary service has not been billed and paid for the same date of service. (Applicable to Medicare Advantage only)
- Mental Health Diagnosis Requirement
    - PHP claims must include a mental health diagnosis as the principal diagnosis. Claims without a qualifying mental health diagnosis will be denied.

    - Examples of Mental Health Diagnoses:
        - Alcohol abuse
        - Antisocial behavior
        - Alzheimer's disease
        - Conduct disorders
        - Dyslexia and alexia
- Activity and Occupational Therapy
    - Activity therapy (HCPCS G0176) and occupational therapy (HCPCS G0129) codes are applicable only to PHP claims. HCPCS G0176 or G0129 billed on any claim not associated with PHP services will be denied.

Place of Service

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Inpatient Facility (CMS 1450), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: AMA CPT Manual, CMS and Expert Specialty Review Panel, CMS Internet Only Manuals, CMS Outpatient Prospective Payment System, CMS Transmittals/ Memos/Publications, and Expert Specialty Review Panel

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

AMA CPT manual and CMS guidelines indicate that certain procedures or services are performed in specific settings. This edit will deny services that are billed with an inappropriate place of service (POS).

POS editing includes but is not limited to:

- CMS Inpatient Only Services
    - Deny when billed with a POS other than 21 (Inpatient hospital).
    - Deny inpatient only separate procedures billed by an outpatient hospital. (Applicable to Medicare Advantage only)

  - Deny inpatient only non-separate procedures billed by an outpatient hospital. Except when billed with modifier CA (Procedure payable only in the inpatient setting when performed emergently on an outpatient basis prior to admission). (Applicable to Medicare Advantage only)
  - Other services billed on the same date of service as an inpatient only procedure will deny, unless a non-inpatient surgical service is also billed. (Applicable to Medicare Advantage only)
- Coding for Physician Services – Deny any physician service code billed with a POS 11 (Office) when the same code is billed by any ambulatory surgical center or facility for the same date of service. In addition, deny any physician service code billed with a non-facility POS when the same code is billed by any facility for the same date of service.
- Condition Code 44 (Inpatient admission changed to outpatient) – Deny when billed with a bill type other than 0130-013Z (Hospital outpatient) or 0850-085Z (Critical access hospital).
- E/M Services – Examples include but are not limited to:
  - Deny outpatient consultation (CPT 99242-99245) when billed with a POS 21 (Inpatient hospital)
  - Deny inpatient neonatal and pediatric critical care (CPT 99468-99476) when billed with a POS other than 02 (Telehealth provided other than in patient's home) or 21 (Inpatient hospital).
  - Deny emergency department visits (CPT 99281-99285) when billed with a POS other than 23 (Emergency department). Exception POS 02 for CPT 99281-99285.
- Home Health/Home Infusion – Deny when billed with a POS other than 03 (School), 04 (Homeless shelter), 12 (Home), 13 (Assisted living facility), 14 (Group home), 16 (Temporary lodging), 27 (Outreach site/street), 33 (Custodial care facility), 54 (Intermediate care facility/individuals with intellectual disabilities), or 55 (Residential substance abuse treatment facility). In addition, deny home health/home infusion when patient is confined to an inpatient hospital or SNF.

- Mutually Exclusive Places of Service – Deny professional services, excluding inpatient care, when billed on the same date of service as inpatient care but with a different POS, if the member also received inpatient care on the previous day and was not discharged on the same day or subsequent day. In addition, deny professional services when billed with POS 19 (Outpatient hospital - off campus), 22 (Outpatient hospital - on campus) or 23 (Emergency room – hospital) on the same date of service as inpatient care, when the member received inpatient care the previous day and was not discharged.
- Outpatient ESRD Services (CPT 90951-90962) – Deny when billed with POS 21 (Inpatient hospital).
- Outpatient Radiology Services (CPT 70010-79999) – Deny when billed with bill type 0140-014Z (Hospital-laboratory services to non-patients).
- Physical Therapy (PT) and Occupational Therapy (OT) in Skilled Nursing Facility (SNF) – Deny certain casting and strapping procedures provided by a PT or OT in a SNF facility.
- Special Services Procedures and Reports
    - CPT 99050, 99051, 99058 - Deny when billed with a POS other than 11 (Office).
    - CPT 99053, 99056, 99060 - Deny special services when billed with a POS 11 (Office).
    - CPT 99050, 99051, 99053, 99056, 99058, or 99060 - Deny when billed with POS 20 (Urgent care facility) or when the provider specialty is urgent care.
    - CPT 99026, 99050, 99051, 99053, 99056, 99058, or 99060 - Deny when billed with an emergency department visit (CPT 99281-99285, G0380-G0384) with POS 23 (ER-hospital) or 20 (Urgent care facility) and the provider specialty is emergency medicine.
- Supplies and Equipment – Deny when billed with a POS 19 (Outpatient hospital - off campus), 21 (Inpatient hospital), 22 (Outpatient hospital - on campus), 23 (Emergency room) or 24 (Ambulatory surgical center).

- Telehealth Services – Deny when modifier GQ (Via asynchronous telecommunications system) and the POS is not 02 (Telehealth provided other than in patient's home).
    - Subsequent hospital care services (CPT 99231-99233) with POS 02 will be limited to one visit every three days.
    - Subsequent nursing facility care services (CPT 99307-99310) with POS 02 will be limited to one visit every 14 days.

Procedure Code Definition

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Inpatient Facility (CMS 1450), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: AMA CPT Manual, AMA Principles of CPT Coding, and CMS Internet Only Manuals

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

This policy ensures correct coding by applying edits based on the definition or nature of a procedure code or a combination of procedure codes. Procedures billed with inappropriate codes will be denied.

This edit applies to coding validations, mutually exclusive, and non-mutually exclusive edits.

This edit addresses multiple coding inconsistencies, including but not limited to:

- CPT/HCPCS and ICD-10-PCS Procedure Code Definitions – Procedures denied when billed outside their defined use.
- Modifiers – Edits remove or flag inappropriate use of RT, LT, and other modifiers when not aligned with CPT/HCPCS definitions.

- Out of Sequence Claims – Deny claims billed out of sequence when services that should be bundled are billed separately across multiple claims at different times.
- Coding Validation – Flag claims for review when modifiers, procedures or ICD-10-PCS are used in ways not supported by claim information or coding guidelines.

Modifiers included in this policy:
-24, -25, -57, -58, -78, -79, -27, -59, -91, -XE, -XS, -XP, -XU, -E1, -E2, -E3, -E4, -FA, -F1–F9, -TA, -T1–T9, -LT, -RT, -LC, -LD, -RC, -LM, -RI

Procedure Code Guideline

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Inpatient Facility (CMS 1450), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: AMA CPT Manual and AMA Principles of CPT Coding

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

This policy is based on the AMA CPT® Manual and CMS HCPCS Level II Manual, which provide instructions on appropriate code usage. The policy supports correct coding and applies edits to deny services that are inconsistent with CPT®/HCPCS Procedure Code Guidelines.

Examples of edits applied include:

Frequency Limits for Selected Services

Claims billed more frequently or in conflict with other covered services will be denied.

- Cognitive assessment and care plan services may only be reported once every 180 days.
- Physiological monitoring and referral services, including physiologic data collection, remote physiologic monitoring, treatment management, and interprofessional referral services, are restricted to specific intervals (once per 30 days or 14 days depending on the service).
- Radiosurgery and radiation therapy have strict limits by type of service, such as cranial and spinal stereotactic radiosurgery, additional lesion treatments, and special radiation management procedures.
    - These may only be billed once per defined interval (two weeks or eight weeks).
- Remote therapeutic monitoring services and supplies, including device codes, are limited to once per 30 days, and may not be billed with self-measured blood pressure devices in the same month or with physiologic monitoring on the same date of service.
    - Remote monitoring of external pulmonary fluid systems is restricted to one unit per 30 days.
- Telephone assessment and management services may not be billed separately when related to another evaluation within seven days before or after.
- Transcranial magnetic stimulation is limited to one treatment per episode of care, with services billed more than once in a 42-day period.

Evaluation and Management (E/M) Services with Pulmonary Diagnostic Procedures

Pulmonary diagnostic testing codes (CPT 94010–94799) include both the procedure and the interpretation of test results. An E/M service may only be reported when it is separately identifiable from the diagnostic testing. Claims that are not separately identifiable will be denied unless modifier 25 is appended.

Immunization Administration for Vaccines and Toxoids

Immunization administration must be reported with the appropriate corresponding vaccine or toxoid code. Claims submitted without the required product code or billed separately from the vaccine will be denied.

Immunization Administration for COVID-19

Administration of the COVID-19 vaccine must be reported with the applicable coronavirus vaccine code on the same date of service. Claims billed without the corresponding product code will be denied.

Infusion and Injection Services

Standard tubing, syringes, and supplies are included in the payment for infusion and injection services and should not be billed separately. Claims reporting these items separately will be denied.

Out of Sequence Claims and Coding Validation

Out of sequence claims occur when procedures performed on the same date of service are billed on multiple claims at different times. Claims that would usually be bundled are billed on a date prior to billing a claim with the more comprehensive procedure. When out of sequence claims are received, they may be denied or flagged for review. This includes procedures billed with inappropriate modifiers or modifiers applied out of sequence, whether mutually exclusive or non-mutually exclusive.

Procedure Code Compliance

Claims must comply with CPT/HCPCS procedure code guidance. Services that are coded inappropriately will be recoded or denied as follows:

- Modifier 63 (procedure performed on infants less than 4 kg) will be removed when appended inappropriately.
- Services that do not meet CPT/HCPCS procedure requirements will be recoded or denied.

Procedure Age

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Inpatient Facility (CMS 1450), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: AMA CPT Manual, American Society of Anesthesiologists, CMS HCPCS Level II Manual, Drug Manufacturer

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

Certain procedure codes are restricted by the nature of the service to specific age groups. When a claim is submitted with a procedure code that does not align with the patient's age, the service is considered inconsistent and will be denied.

Procedure-Gender

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Inpatient Facility (CMS 1450), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: AMA CPT Manual

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

Certain procedure codes are defined for only one gender. When a procedure is billed for a patient whose gender does not align with the code requirements, the procedure will be denied.

Professional, Technical, and Global Services Policy

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Inpatient Facility (CMS 1450), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: Administrative Processing Rules, AMA Principles of CPT Coding, CMS and Expert Specialty Review Panel, and CMS Transmittals/ Memos/Publications

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

Diagnostic tests and radiology services may include two components: professional and technical. The professional component represents the physician's work portion of the procedure, while the technical component represents the use of equipment, supplies, and staff required to perform the service.

A global service represents the combination of both the professional and technical components. Services that are designated as diagnostic or radiology typically include both portions unless billed separately using appropriate modifiers.

Modifiers 26 (Professional Component) and TC (Technical Component)

Claims should not include both modifier 26 and modifier TC on the same claim line, as these modifiers represent distinct components of a service. When both modifiers are billed together, it indicates incorrect coding. Both modifiers will be removed.

Global Payment of Diagnostic Tests and Radiology Services

Payment for diagnostic tests and radiology services will be limited to no more than the global service amount, regardless of whether billing is from the same or different provider, specialty, or tax ID.

When components of the same global service are billed separately, claims will be adjusted to allow only the global service. An exception applies when a valid modifier 50 (bilateral surgery) is reported.

Diagnostic Tests or Radiology Services Performed Outside the Office Setting

This topic ensures professional components are correctly identified and billed for diagnostic and radiology services performed in facility settings.

- When diagnostic tests or radiology services are performed in a facility setting, the professional component must be reported by appending modifier 26 for the following place-of-service codes:
    - 12 (Home)
    - 13 (Assisted living facility)
    - 19 (Outpatient hospital-off campus)
    - 21 (Inpatient hospital)
    - 22 (Outpatient hospital-on campus)
    - 23 (Hospital emergency room)
    - 24 (Ambulatory surgical center) (excludes pathology/lab codes 80000-89999)
    - 26 (Military treatment center) (excludes radiology codes 70000-79999)
    - 31 (Skilled nursing facility)
    - 32 (Nursing facility)
    - 34 (Hospice)
    - 41 (Ambulance-land)
    - 42 (Ambulance-air or water)
    - 51 (Inpatient psychiatric facility)
    - 52 (Psychiatric facility-partial hospitalization)
    - 53 (Community mental health center)
    - 56 (Psychiatric residential treatment center)
    - 61 (Comprehensive inpatient rehabilitation center)
    - 62 (Comprehensive outpatient rehabilitation center)
    - 65 (End-stage renal disease treatment facility)
- When x-ray services (which are also diagnostic tests or radiology services) are billed by a provider in POS 12, 13, 27, 31, or 32, and transportation codes HCPCS R0070 or R0075 are not submitted, modifier 26 will be appended.

Professional Component Billed in the Office Setting

When a provider bills the professional component on a radiology procedure performed globally in the office and in conjunction with an E/M service, separate reimbursement will not be allowed.

Professional Component Only Services

Professional component-only services describe procedures that identify the physician work portion of selected diagnostic procedures.

- When submitted with a code defined as professional component only, modifier 26 will be removed.
- When billed with a technical component modifier, professional component-only procedures will be denied.

Physician Service Codes

- Certain physician service codes, such as office visits and surgical procedures, do not have separate professional or technical components. When billed with modifier 26, the modifier will be removed.
- Physician service codes billed with modifier TC that do not have an associated professional or technical component will be denied.

Professional Component Billed by a Facility

When a facility provider bills the professional component with Revenue Codes 0960-0989 (Professional fees), the professional component will be denied.

Technical Component Services

Technical component services must be billed correctly based on place of service and modifier usage.

- Modifier TC submitted on a technical component only procedure code will be removed.
- Technical component only services billed with modifier 26 will be denied.
- Diagnostic tests or radiology services billed with modifier TC in the inpatient or outpatient facility setting will be denied.
- X-ray services billed with modifier TC in POS 12, 13, 21, 31, or 32 when HCPCS R0070 and R0075 are not also present will be denied.

- Technical component only procedures billed in the inpatient or outpatient facility setting will be denied.
- Technical component procedures billed with Revenue Codes 0960-0989 (Professional fees) will be denied.

Clinical Laboratory Services

Clinical laboratory services (CPT 80048–89399) do not have associated professional components. Claims billed with modifier 26 for codes that do not have a separately payable professional service will be denied.

Concept of the Professional/Technical Component Does Not Apply

Codes with a PC/TC Indicator of "9" cannot be split into professional or technical components. The concept of PC/TC does not apply. Claims billed with modifier 26 or TC will be denied.

Global Only Codes

Global Only codes represent services with both professional and technical components billed under one comprehensive code. Global only codes will be processed according to CMS and administrative processing rules. Global only codes may be changed to its associated professional or technical code or denied.

Revenue Code

Claim Type: Ambulatory Surgical Center (CMS 1450), Inpatient Facility (CMS 1450), Outpatient Facility (CMS 1450)

Source: CMS Internet Only Manuals, CMS Outpatient Prospective Payment System, CMS Transmittals/ Memos/Publication, Food and Drug Administration (FDA), Non-AMA/ Non-CMS Coding Industry Publication, Uniform Billing Editor (UBE)

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

This policy ensures appropriate use of revenue codes in facility billing to ensure compliance with national standards, including but not limited to those established by National Uniform Billing Committee (NUBC) and CMS. Inaccurate use will result in denials.

Invalid Revenue Codes

Claim lines submitted with revenue codes not recognized as valid by the NUBC will be denied.

Laboratory Services

Per CMS policy, bill type 0140–014Z - “Hospital – laboratory services provided to non-patients”- is limited to non-patient laboratory specimens and may include only Revenue Codes 0300–0319 (Laboratory, Specialized Pathology, and Testing). Any claim lines billed with bill type 0140–014Z and revenue codes outside the 0300–0319 range will be denied.

Mandatory HCPCS Reporting

- CMS requires certain revenue codes to be submitted with a valid HCPCS code; otherwise, the claim will be denied.
- CMS requires HCPCS codes for certain revenue codes billed under bill type 0120–012Z or 0140–014Z, unless Condition Code 41 is used. Claims without the required HCPCS code will be denied.
- CMS requires revenue codes billed with modifiers to include a HCPCS code on the same claim line; otherwise, the claim will be denied.

Revenue and HCPCS Code Alignment

- Revenue Codes 0300–0319 (Laboratory/Pathology) require a corresponding HCPCS code; otherwise, the claim line will be denied.
- Revenue Codes 0320–0359 (Nuclear Medicine), 0400–0409 (Radiology), and 0610–0619 (MRI) require a corresponding HCPCS code; otherwise, the claim line will be denied.
- Revenue Code 0636 (Drugs requiring detailed coding) requires a corresponding HCPCS code; otherwise, the claim line will be denied.
- Revenue Code 0278 (Other implants) requires a corresponding HCPCS code; otherwise, the claim line will be denied.

Room and Board in Outpatient Settings

Revenue Codes 0100–0219 (Room and Board) are intended exclusively for inpatient hospital billing and are inappropriate for use under outpatient hospital bill types (0120–014Z). Claims submitted with these revenue codes under outpatient bill types will be denied.

Home Health Services

CMS requires home health and hospice visits to be reported using discipline-specific HCPCS codes paired with the corresponding discipline-specific revenue codes. Claims that do not reflect this alignment will be denied.

Mandatory Therapy Services Modifier Reporting

CMS requires therapy services billed under Revenue Codes 0420–0429 (Physical Therapy), 0430–0439 (Occupational Therapy), or 0440–0449 (Speech-Language Pathology) to include the appropriate therapy services modifier (GP - Physical Therapy, GO - Occupational Therapy, or GN - Speech-Language Pathology) on the same claim line. Claims missing the correct modifier or using a mismatched modifier will be denied.

Blood and Blood Product Services

Applicable to Bill Types 0120–012Z (Hospital-inpatient Part B), 0130–013Z (Hospital-outpatient), and 0140–014Z (Hospital-laboratory services provided to non-patients).

- **Packed Red Cells (Revenue Code 0381)**
    - Revenue Code 0381 (Packed Red Cells) must be billed with one of the following HCPCS codes on the same claim line: P9016, P9021, P9022, P9027, P9038, P9039, P9040, P9051, P9054, P9057, or P9058; otherwise, the claim will be denied for missing a corresponding packed red cell product code.
- **Whole Blood (Revenue Code 0382)**
    - Revenue Code 0382 (Whole Blood) must be billed with one of the following HCPCS codes on the same claim line: P9010, P9051, P9054, or P9056; otherwise, the claim will be denied for missing a corresponding whole blood product code.

- **Blood and Blood Product Charges**
  - Charges for blood and blood products must be billed under Revenue Codes 0380–0389 (Blood and Blood Components) and accompanied by a valid HCPCS code. Acceptable HCPCS codes include: C9507, P9010–P9040, P9043, P9044, P9048, P9051–P9060, P9070–P9071, P9073, P9099. Claims submitted without a valid HCPCS code will be denied.
  - Modifier BL (Special acquisition of blood and blood products) is required when blood or blood products are billed under Revenue Codes 0380–0389; otherwise, claim will be denied.
- **Blood Processing and Storage Charges**
  - Charges for blood processing and storage must be billed separately using Revenue Codes 0390–0399 (Blood Storage and Processing).
  - When both Revenue Codes 0380–0389 (Blood and Blood Components) and 0390–0399 (Blood Storage and Processing) are billed for the same date of service, the HCPCS code and units must match; otherwise, the claim will be denied.
    - Modifier BL (Special acquisition of blood and blood products) is required when blood or blood products are billed under Revenue Codes 0390–0399; otherwise, claim will be denied.
  - Revenue Codes 0390–0399 (Blood Storage and Processing) may be appropriately billed alone.
    - Modifier BL is not required when Revenue Codes 0390 –0399 are billed alone.

Separate Procedures

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Outpatient Facility (CMS 1450, CMS 1500) and Professional (CMS 1500)

Source: AMA CPT Manual

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

Certain CPT codes include a parenthetical statement identifying them as "separate procedures." This indicates the procedure should not be reported when performed in conjunction with, and related to, a major service.

However, in instances where the separate procedure is carried out independently from, or is unrelated to, the major procedure, then the service may be reported with a distinct services modifier as appropriate to the circumstance.

Split Surgical Care

Claim Type: Professional (CMS 1500)

Source: AMA Principles of CPT Coding, CMS and Expert Specialty Review Panel, and CMS Internet Only Manuals

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

Split surgical care occurs when different physicians provide the distinct components of the global surgical package- the pre-operative, intra-operative, or post-operative services. It applies only to providers in different Tax ID groups or specialties; providers in the same Tax ID group and specialty may not bill split surgical care. Modifiers 54 (surgical care only), 55

(post-operative management only) and 56 (pre-operative management only) are used to indicate split surgical care. These modifiers should only be used with procedures that have a 10- or 90-day global postoperative period.

Billing Split Surgical Care

Split surgical care must be billed with the appropriate modifiers. Claims that do not meet these requirements will be denied:

- Procedures billed with a modifier 54, 55 or 56 when another provider has billed the same procedure globally without a modifier will be denied.
- Procedures billed without the required modifier 54, 55 or 56 when another provider has billed the same procedure with a modifier 54, 55 or 56 will be denied.
- Procedures reported with multiple modifiers on the same claim line that conflict with one another will be denied.
- Surgical procedures with a 10-day or 90-day global period that are reported with incompatible modifier combinations on the same claim line will be denied.

Emergency Room Services

For 90-day surgical procedures performed by an Emergency Medicine physician in the emergency room setting, the claim must include the appropriate modifier to reflect surgical care only.

Same Procedure & Fracture/Dislocation Care in the Post-Operative Period

Claims for the same or related procedures billed in the post-operative period must meet policy rules. Claims that do not meet policy rules will be denied or flagged for review:

- A major procedure billed in the office within 90 days of the same procedure previously billed by any provider will be denied or flagged for review. The review will determine whether the use of a modifier is supported. If modifier use is not supported, the claim line will be denied.

- A 10-day fracture or dislocation care code billed in the office within 10 days of the same code previously billed by any provider will be denied or flagged for review. The review will determine whether the use of a modifier is supported. If modifier use is not supported, the claim line will be denied.
- A fracture or dislocation care code billed in the office when a same or similar fracture care code was billed by any provider in the previous two weeks (14 days) will be denied.
- A fracture or dislocation care code billed in the office within two weeks (14 days) of a same or similar code billed by any provider will be flagged for review. The review will determine whether the use of a modifier is supported. If modifier use is not supported, the claim line will be denied.

Team Surgery

Claim Type: Professional (CMS 1500)

Source: CMS and Expert Specialty Review Panel

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

Certain complex procedures may require participation by a team of physicians, often from different specialties, and other skilled personnel.

The Medicare Physician Fee Schedule (MPFS) identifies procedures for which team surgery is allowed.

- **Team Surgery Not Allowed/Payment Restriction**

  Claims billed with modifier 66 (team surgery) for procedures where team surgery is not permitted will be denied.

- **Concept Does Not Apply**

  Procedures and services where the team surgery concept does not apply, such as minor or non-surgical procedures, will be denied when billed with modifier 66.

Team Surgeons Not Billing with Modifier 66

When a claim is submitted with or without modifier 66 and a previously processed claim for the same procedure code with or without modifier 66 exists, the second claim will be denied.

Durable Medical Equipment, Prosthetic Devices, Prosthetics, Orthotics, & Supplies (DMEPOS)

DME CMS Coverage Determinations

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Inpatient Facility (CMS 1450), Outpatient Facility (CMS 1450, CMS 1500), Professional (CMS 1500)

Source: CMS HCPCS Level II Manual, CMS Internet Only Manuals, CMS Transmittals/ Memos/Publications, Regional CMS Policy (Local Coverage Determination [LCD])

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

This policy outlines claims handling per CMS Coverage determinations and policies. Coverage criteria sources include but are not limited to: Local Coverage Determinations (LCD) and Policy Articles (PA), CMS transmittals, memos, and publications, Noridian Joint DME MAC publications. Claims that do not meet the guidelines may be denied. Refer to the Noridian and CMS website for further information.

- External Infusion Pumps – LCD L33794/PA A52507
- Glucose Monitors – LCD L33822/PA A52464
    - HCPCS A9276 – A9279 will deny as a non-covered service (Applicable to Medicare Advantage only)
- Knee Orthoses – LCD L33318/PA A52465
- Manual Wheelchair Bases – LCD L33788/PA A52497
- Negative Pressure Wound Therapy – LCD L33821/PA A52511
- Oxygen and Oxygen Equipment – LCD L33797/PA A52514
    - Oximeters and oximeter replacement probes will deny as convenience items that do not meet the definition of DME (Applicable to Medicare Advantage Only)

- Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea – LCD L33718/PA A52467
- Power Mobility Devices – LCD L33789/PA A52498
- Respiratory Assist Devices – LCD L33800/PA A52517
- Scoliosis Braces – DME MAC and PDAC Joint Publication
- Surgical Dressings – LCD L33831/PA A54563
    - The following are examples of wound care items which are non-covered under the surgical dressing benefit because they do not meet the statutory definition of a dressing (not all-inclusive): HCPCS A4465, A4490 – A4510, A6250, A6260, A6413 (Applicable to Medicare Advantage only)
- Transcutaneous Electrical Nerve Stimulation (TENS) – LCD L33820/PA A52520
- Urological Supplies – LCD L33803/PA A52521
- Wheelchair Options/Accessories – LCD L33792/PA A52504
- Wheelchair Seating – LCD L33312/PA A52505

DME Code Guidelines

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Outpatient Facility (CMS 1450, CMS 1500), Professional (CMS 1500)

Source: CMS HCPCS Level II Manual, Expert Specialty Review Panel

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

This policy addresses billing standards and correct coding. Coding edits are applied based on the definition or characteristics of a DMEPOS item, or a combination of such items. Edits are also applied based on the submitting provider's specialty and the appropriateness of the submitted code. Procedures billed with inappropriate codes will be denied.

This edit applies to provider specialty coding validations, code descriptions, frequency, mutually exclusive, and non-mutually exclusive edits.

Durable Medical Equipment (DME) Providers

- Any code billed by a DME provider when the code is not a DME code will be denied.

Wheelchair Options/Accessories

- HCPCS E1225 will be denied when billed with HCPCS E1226.
    - E1225 – Wheelchair accessory, manual semi-reclining back, (recline greater than 15 degrees, but less than 80 degrees), each)
    - E1226 – Wheelchair accessory, manual fully reclining back, (recline greater than 80 degrees), each
- Manual wheelchair accessories when billed with a power wheelchair will be denied.
- Power wheelchair accessories when billed with a manual wheelchair will be denied.

Respiratory Assist Devices (RAD), Airway Pressure Devices and Oral Appliances/Devices

- Respiratory assist devices (RAD) are considered mutually exclusive items. Additional RAD devices when billed for the same date of service or within one month will be denied.
- Tubing used with PAP devices, HCPCS A7037, will be denied when HCPCS A4604 has been billed by any provider for the same date of service or within the previous three months.
    - A7037 – Tubing used with positive airway pressure device
    - A4604 – Tubing with integrated heating element for use with positive airway pressure device

Glucose Monitors

- HCPCS A4250 (Urine test or reagent strips or tablets (100 tablets or strips)) will be denied as these are not used with a glucose monitor.
- Additional subsequent home blood glucose monitors (HCPCS E0607, E2100, E2101) when billed in any combination more than once within a year by any provider will be denied.

DME Correct Coding Initiative

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Outpatient Facility (CMS 1450, CMS 1500), Professional (CMS 1500)

Source: Regional CMS Policy (Local Coverage Determination [LCD])

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

The Durable Medical Equipment Medicare Administrative Contractor (DME MAC) has developed bundling policies where a Column II code is denied when billed on the same date of service as a Column I code. When a Column I and Column II code are billed on the same date of service, it is subject to denial. When a Column II code is billed with a modifier on the same date of service as a Column I code, the service will be flagged for review. The review will determine whether the use of a modifier is supported. If modifier use is not supported, the claim line will be denied.

The DME MAC bundling policies are found in the Noridian LCD and related billing article.

Refer to the examples below (includes but not limited to) of LCDs and related billing articles which include Column I and Column II bundling policies. (The LCD or article criteria are subject to change according to CMS discretion.)

- L37792/A52504 – Wheelchair Options/Accessories
- L33830/A52489 – Pressure Reducing Support Surfaces - Group 1
- L33803/A52521 – Urological Supplies

DME Modifier Editing

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Inpatient Facility (CMS 1450), Outpatient Facility (CMS 1450, CMS 1500), Professional (CMS 1500)

Source: Regional CMS Policy (Local Coverage Determination [LCD])

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

Identifies claim lines billed with inappropriate modifiers in accordance with CMS, AMA CPT, and HCPCS guidelines. This policy ensures modifiers are applied correctly to reflect the circumstances of the service or procedure performed. When a modifier is billed inappropriately the service will be denied.

HCPCS modifiers have been established for use when items are furnished in conjunction with various supplies listed in multiple DME MAC Local Coverage Determinations (LCD) and related Policy Articles (PA).

Modifier editing includes but is not limited to the following listed below.

Anatomical Modifiers

Anatomical modifiers identify the body part of which a prostheses or orthoses is for. Prostheses and orthoses, specifically dynamic adjustable devices and static progressive stretch devices, when billed without appropriate anatomical modifiers will be denied.

Anatomical modifiers covered in this policy:

- FA-F9 (Fingers)
- TA-T9 (Toes)
- LT (Left side)
- RT (Right side)
- 50 (Bilateral side)

Reference: Noridian Joint DME MAC Publication “Dynamic Adjustable Devices, Static Progressive Stretch Devices, and Use of Modifiers – Revised”

Functional Modifiers

Advanced lower limb prostheses when billed without the appropriate functional modifier or billed with an inappropriate functional modifier will be denied. According to Noridian Local Coverage Determination policies, a lower limb prosthesis is medically necessary based on the member's potential functional abilities.

Functional modifiers covered in this policy:

- K0-K4 (To define ability)

Reference: Lower Limb Prostheses - LCD L33787/PA A52496

No Order for Item or Service

All durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items require a prescription (physician's order). All DMEPOS items require a standard written order prior to billing. DMEPOS billed with modifier EY will be denied.

- EY – No physician or other licensed health care provider order for this item or service

Reference: Noridian Topic "Modifier EY"

IV Pole for Enteral Nutrition

When an IV pole (HCPCS E0776) is used for enteral nutrition administered by gravity or a pump, the BA modifier should be added to the code. Other codes incorrectly billed with modifier BA will be denied.

- BA – Item furnished in conjunction with parenteral enteral nutrition (PEN) services

Reference: Enteral Nutrition - LCD L33736/PA A58833

Modifiers for Supplies/Equipment That May Be Covered Under More Than One DMEPOS Benefit Category

Modifiers AU, AV, and AW are used to identify supplies and/or equipment that may be covered under more than one DMEPOS category.

- AU - Item furnished in conjunction with a urological, ostomy, or tracheostomy supply
- AV - Item furnished in conjunction with a prosthetic device, prosthetic or orthotic

- AW - Item furnished in conjunction with a surgical dressing

The HCPCS codes listed below are required to be billed with one of these modifiers. Items billed without one of these modifiers will be denied. Items other than the ones listed that are inappropriately billed with modifiers AU, AV, or AW will be denied.

HCPCS modifier editing includes but is not limited to the following:

- Tape: A4450 or A4452
- Skin barrier, wipes, swabs: A5120
- Sterile water: A4217

Reference: Noridian Joint DME MAC Publication "Correct Coding – Modifiers AU, AV and AW"

DMEPOS Item Delivered via Mail

Modifier KL is used for diabetic supplies as outlined in the referenced Noridian publication. These supplies are ordered remotely and delivered to the member's residence by common carriers. All other items billed with modifier KL will be denied.

- KL – DMEPOS item delivered via mail

Reference: Noridian Topic "Modifier KL"

Class III Devices

Modifier KF is used for to indicate a Class III device. External defibrillators and osteogenesis stimulators that are classified as a class III device billed without modifier KF will be denied.

- KF – Item designated by FDA as Class III Devices

Class III device includes but is not limited to the following HCPCS:

- External defibrillator: E0617, K0606
- Osteogenesis Stimulator: E0747, E0748, E0760 or E0766

Reference: Automatic External Defibrillators - LCD L33690/PA A52458; Osteogenesis Stimulators - LCD L33796/PA A52513; Tumor Treatment Field Therapy (TTFT) - LCD L34823/PA A52711

Osteogenesis Stimulators

Osteogenesis stimulators must be billed with a modifier to indicate if the coverage criteria in the CMS policy have been met. Modifier KX, GA or GZ must be billed to indicate coverage, or the device will be denied.

- KX – Requirements specified in the medical policy have been met
- GA – Waiver of liability statement issued as required by payer policy, individual case
- GZ – Item or service expected to be denied as not reasonable or necessary

Reference: Osteogenesis Stimulators - LCD L33796/PA A52513

Spinal Orthoses: TLSO and LSO

Select spinal orthoses as outlined in the referenced Article must be billed with modifier CG or GY. Items without these modifiers will be denied.

- CG – Policy criteria applied
- GY – Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit

Reference: Spinal Orthoses: TLSO and LSO - LCD L33790/PA A52500

Invalid Combination Modifiers

The following combination of modifiers are invalid based on the modifier definition. Any HCPCS code billed with these combinations will be denied.

- Modifier NU (new equipment) and Modifier UE (used durable medical equipment)
- Modifier NU (new equipment) and Modifier RR (rental)

The following combination of modifiers are invalid according to CMS policy. Any HCPCS code billed with these combinations will be denied.

- Modifier RB (replacement of a part of a DME, orthotic or prosthetic item furnished as part of a repair) billed with any of the modifiers below:
    - KY - DMEPOS item subject to DMEPOS competitive bidding program number 5
    - KE - Bid under round one of the DMEPOS competitive bidding program for use with noncompetitive bid base equipment
    - RR - Rental

DME Orthotic and Prosthetic Useful Lifetime

Claim Type: Ambulatory surgical (CMS 1500, CMS 1450), Inpatient Facility (CMS 1450), Outpatient facility (CMS 1500, CMS 1450), Professional (CMS 1500),

Source: Federal Register

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified

Description:

This policy outlines claim handling for orthotic and prosthetic base procedures to ensure compliance with replacement frequency standards. Claims for orthotic or prosthetic items are reviewed to confirm that billing does not exceed the established useful lifetime limit.

The following billing standards for orthotic and prosthetic useful lifetime:

An orthotic or prosthetic base procedure when billed and the same procedure has been paid within the previous five years by any provider will be denied or flagged for review. The review will determine whether the use of a modifier is supported. If modifier use is not supported, the claim line will be denied.

DME Place of Service

Claim Type: Professional (CMS 1500)

Source: CMS Internet Only Manuals, CMS Transmittals/ Memos/Publications

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

DMEPOS billable items are only covered when billed by a DMEMAC (Durable Medical Equipment Medicare Administrative Contractor) provider in a covered place of service (POS) as listed in the DME Supplier Manual. The place of service for DMEPOS claims is considered the location where a beneficiary will primarily use the item.

Coverage for DMEPOS items will be considered when the place of service is listed below. Items will be denied if the POS is not listed below.

DMEPOS editing includes but is not limited to:

- 01 (Pharmacy)
- 04 (Homeless shelter)
- 09 (Prison)
- 12 (Home)
- 13 (Assisted living facility)
- 14 (Group home)
- 16 (Temporary lodging)
- 27 (Outreach site/street)
- 33 (Custodial care facility)
- 54 (Intermediate care facility/individuals with intellectual disabilities)
- 55 (Residential substance abuse treatment facility)
- 56 (Psychiatric residential treatment center)
- 65 (End stage renal disease (ESRD) treatment facility (POS valid for parenteral nutritional therapy))

J9039 (blinatumomab) POS information for DMEMAC Providers

HCPCS J9039, blinatumomab, (Blincyto®), reported by a DMEMAC provider is allowed only when administered in an unsupervised home setting and will be denied when administered in other settings, such as a hospital, physician's office, etc.

Allowed places of service:

- 04 (Homeless shelter)
- 09 (Prison)
- 12 (Home)
- 13 (Assisted living facility)
- 14 (Group home)
- 16 (Temporary lodging)
- 27 (Outreach site/street)
- 33 (Custodial care facility)
- 54 (Intermediate care facility/individuals with intellectual disabilities)
- 55 (Residential substance abuse treatment facility)
- 56 (Psychiatric residential treatment center)

DME Rentals

Claim Type: Ambulatory Surgical Center (CMS 1450, CMS 1500), Outpatient Facility (CMS 1450, CMS 1500), Professional (CMS 1500)

Source: Administrative Processing Rules, CMS Internal Only Manuals, CMS Transmittals/Memos/Publications

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

The CMS Internet Only Manual clarifies that a subset of DMEPOS items will be considered for coverage when they are rented instead of purchased. DMEPOS items that are rented typically have a reasonable useful lifetime (RUL) of 5 years. Capped rental items are a subset of DMEPOS items that are reimbursed at a fixed monthly rate for up to 13 months.

Rental items editing includes but is not limited to the following:

Frequency

- More than one rental for the same code when billed within a month by any provider may be flagged for review and may be denied. The review will determine whether the use of a modifier is supported. If modifier use is not supported, the claim line will be denied.
- More than one rental for the same capped rental code when billed within the previous 13 months by any provider may be flagged for review and may be denied. The review will determine whether the use of a modifier is supported. If modifier use is not supported, the claim line will be denied.
- Capped rentals billed by any DME provider in excess of 13 months in a five-year time will be denied.

Modifiers

- Capped rentals and oxygen rentals when billed without appropriate rental modifiers or billed with inappropriate modifiers will be denied.
    - RR – Rental (use the RR modifier when DME is to be rented)
    - KH – DMEPOS item, initial claim, purchase or first month rental
    - KI – DMEPOS item, second or third month rental
    - KJ – DMEPOS item, parenteral enteral nutrition (PEN) pump or capped rental, months four to fifteen
    - NU – New equipment
    - UE – Used durable medical equipment
- Capped rentals, except oxygen equipment, billed with modifier MS (Six month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty) will be denied.
- Capped rentals with modifiers KH, KI, or KJ will be denied if the same item with the same modifier was billed by any provider within the past 13 months.
- Services billed with a DME rental modifier (BR, RR, KI, KJ, KR, LL) or a DME purchase modifier (BP, NU, UE) will be denied if the same code has been previously billed for the same date of service with either a DME rental modifier or DME purchase modifier.
    - BP – The beneficiary has been informed of the purchase and rental options and has elected to purchase the item
    - BR – The beneficiary has been informed of the purchase and rental options and has elected to rent the item
    - KR – Rental item, billing for partial month
    - LL – Lease/rental (Use the LL modifier when DME equipment rental is to be applied against the purchase price)
    - NU – New equipment
    - UE – Used durable medical equipment

Oxygen and Oxygen Equipment

- Stationary oxygen delivery system rentals (HCPCS E0424, E0439, E1390, E1391) when billed more than once a month in any combination will be denied.
- Portable oxygen delivery systems (HCPCS E0431, E0433, E0434, E1392, K0738) when billed more than once in a month in any combination will be denied.
- Oxygen system rentals (HCPCS E0424, E0439, E1390, E1391) or oxygen concentrator rentals (HCPCS E1390, E1391) when billed more than 36 units every 5 years will be denied.
- Portable oxygen delivery systems (HCPCS E0431, E0433, E0434, E1392, or K0738) when billed more than 36 units every 5 years by any DME provider will be denied.

Transcutaneous Electrical Nerve Stimulation (TENS)

- Claims for additional units of a TENS device (HCPCS E0720 or E0730) will be denied if a TENS device has been purchased within the past five years.

Items Requiring Frequent Service

- Frequently serviced items (HCPCS E0465-E0468, E0500, E0766, E0935, or K0455) are only available as rentals until medical necessity ends. When these items are billed without modifier RR, the claim will be denied.

DME Replacement

Claim Type: Ambulatory Surgical Center (CMS 1450), Ambulatory Surgical Center (CMS 1500), Outpatient Facility (CMS 1450), Professional (CMS 1500)

Source: CMS Internet Only Manuals, CMS Transmittals/ Memos/Publications, Regional CMS Policy (Local Coverage Determination [LCD])

Line of Business: Commercial, QUEST Integration, and Medicare Advantage (unless otherwise specified)

Description:

This policy outlines claim handling for replacement of durable medical equipment (DME) billed with modifiers RR (Rental), NU (New equipment), or UE (Used equipment).

Payment restrictions apply when the same equipment has been previously billed or paid within a defined period or when billed under inappropriate circumstances.

The following billing standards will apply for DME replacement and will identify claims subject to denial or review:

- Any piece of DME that is billed with modifier RR, NU, or UE will be denied or flagged for review if the same equipment has been paid with either a UE or NU modifier within five years by any provider. The review will determine whether the use of a modifier is supported. If modifier use is not supported, the claim line will be denied.
- HCPCS K0672 (Replacement interface material, lower extremity orthoses) if not billed in Place of Service 04 (Homeless shelter), 12 (Home), 13 (Assisted living facility), 14 (Group home), 27 (Outreach site/street), 31 (Skilled nursing facility), 32 (Nursing facility), 33 (Custodial care facility), 54 (Intermediate care facility/individuals with intellectual disabilities), 55 (Residential substance abuse treatment facility), or 56 (Psychiatric residential treatment center) will be denied.
- HCPCS A7020 (Replacement interface for cough stimulating device) will be denied when a cough stimulating device (HCPCS E0482) has also been billed by any provider on the same day or within the previous month.