EmblemHealth

Reimbursement Policy:
Coding Edit Rules
(Commercial, Medicare & Medicaid)

Review Date: 1/27/2025 | **Number: RP20210017**

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

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

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

Overview:

EmblemHealth utilizes internal and third-party code editing vendors to apply procedure and diagnosis code editing to professional and outpatient facility claims, including but not limited to, ambulance, DMEPOS providers and drugs.

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

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

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

REVISION HISTORY

EmblemHealth

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Coding Edits:

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

Claim Type	Medical Policy	Rule Description	Effective Date
P	Add-on Code Policy	Codes designated as "Add-on" codes are not payable with modifier -51.	1/01/2018
F, P	Add-on Code Policy	Add-on codes are not payable when the primary code is absent or has been denied for other reasons.	1/01/2018
P	Add-on Code Policy	Procedure codes billed with modifier 51 are not payable when submitted with an add-on procedure code.	1/01/2018
P	Allergy Testing	CPT code 86003 (Allergen specific IgE) is limited to 30 units within a five-year period when billed by any provider.	9/15/2021
F, P	Allergy Testing	CPT code 86003 (Allergen specific IgE) is limited to 30 units per year when billed by any provider.	1/01/2018-*Terminated effective 2/28/2023* *Updated to include Facility (HMOC & HMOMR) effective 11/16/2021* *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
F, P	Allergy Testing	CPT code 86003 (Allergen specific IgE) is limited to 40 units per year when billed by any provider.	3/1/2023
P	Allergy Testing	CPT codes 95024, 95027, 95028 (Intradermal tests with allergenic extracts) or 95044 (Patch tests) are limited to 40 units in a five-year period when billed by any provider.	9/15/2021
P	Allergy Testing	CPT codes 95004 (Percutaneous tests) or 95017-95018 (Allergy testing) are limited to 60 units in a five-year period when billed by any provider.	9/15/2021
F, P	Allergy Testing	Limit allergy studies (95004, 95017, 95018, 95024, 95027) to 137 units within one year.	3/1/2023
F, P	Allergy Testing	Limit 95165 (Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens) to 137 units per year when billed by any provider.	3/1/2023

Claim Type	Medical Policy	Rule Description	Effective Date
P	Ambulance Policy	Additional ambulance services and supplies billed with modifier QL are not payable.	1/01/2018
F, P	Ambulance Policy	Ambulance services for deceased patients must be reported at the basic life support level.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	Ambulance Policy	Ambulance services billed without an origin modifier combined with a destination modifier are not payable.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Ambulance Policy	Ambulance transport services not billed in Place of Service 41 or 42 are not payable.	1/01/2018
P	Ambulance Policy	Ambulance services submitted with non-covered origin and destination modifiers are not payable.	1/01/2018
P	Ambulance Policy	Ambulance mileage (or ambulance mileage when reported with response and treatment only) is not payable when an ambulance transport code has not been billed for the same date of service or has been denied by another policy.	1/01/2018
F, P	Ambulance Policy	Emergency ambulance services (HCPCS codes A0427, A0429, A0433) are not payable when billed and the destination modifier is not H (Hospital), I (Site of transfer [e.g. airport or helicopter pad] between modes of ambulance transport), or X (Intermediate stop at physician's office on way to hospital [destination code only]).	2/26/2019
P	Ambulance Policy	Additional ambulance services and supplies are not payable when billed with modifier QL.	1/01/2018
F, P	Ambulance Policy	Ambulance services are not payable when billed without an origin modifier combined with a destination modifier.	1/01/2018
P	Ambulance Policy	Ambulance transport services are not payable if billed without Place of Service 41 or 42.	1/01/2018
P	Ambulance Policy	Certain ambulance services are not payable when submitted with non-covered origin and destination modifiers.	1/01/2018
P	Ambulatory Surgical Center (ASC) Policy	Professional services are not payable when billed with modifier SG.	1/01/2018
P	Anesthesia Crosswalk - Without Anesthesia procedure code	Identifies claim lines submitted by anesthesiologists for non-anesthesia Procedure Codes that are not eligible to be cross walked to an anesthesia Procedure Code.	1/01/2018
P	Anesthesia Crosswalk - Without Anesthesia procedure code	Identifies claim lines submitted by anesthesiologists for non-anesthesia services that have a one-to-many	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
		relationship with anesthesia services. These services need to be reviewed to determine the appropriate anesthesia Procedure Code.	
P	Anesthesia Policy	Surgical codes billed by anesthesiologists or CRNAs are not payable unless crosswalk the surgical procedure code to the anesthesia service code. Exception: Surgery codes listed in the ASA Manual.	1/01/2018
P	Anesthesia Policy	Reimbursement and frequency for multiple general anesthesia service codes (00100-01999) are limited to the code with the highest submitted charge amount when billed with anesthesia modifier QX or QZ (CRNA services)	1/01/2018
F	Anesthesia Policy	Reimbursement and frequency for multiple general anesthesia service codes (00100-01999) when billed with Revenue Code 0964 (CRNA) to the code with the highest submitted charge amount.	1/01/2018
F, P	Anesthesia Policy	Anesthesia services (00100-01999) billed by a CRNA without the appropriate CRNA modifier (QX, or QZ) are not payable.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	Anesthesia Policy	Anesthesiologist's claims billed without medical supervision/direction modifiers are not payable if a CRNA claim with medical direction exists.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Anesthesia Policy	Reimbursement and frequency for multiple general anesthesia service codes (00100-01999) billed for the same day is limited to the code with the highest submitted charge amount.	1/01/2018
P	Anesthesia Policy	CRNA services billed with modifier QX or QZ are not payable when an anesthesia service performed personally by an anesthesiologist (Modifier AA) has been billed for the same date of service.	1/01/2018
P	Anesthesia Policy	An anesthesiologist's claim billed with modifier AA is not payable when a CRNA service billed with modifier QX or QZ has been previously paid for the same date of service.	1/01/2018
P	Anesthesia Policy	CPT 00100-01999 (Anesthesia services) are not payable if billed without an appropriate modifier.	1/01/2018
F, P	Anesthesia Policy	Daily hospital management of epidural or subarachnoid continuous drug administration (01996) is not payable when billed with anesthesia qualifying circumstance codes (99100-99140) and billed without an anesthesia procedure code (00100-01992, 01999).	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*

Claim Type	Medical Policy	Rule Description	Effective Date
P	Anesthesia Policy	Daily hospital management of epidural or subarachnoid continuous drug administration (01996) is not payable when billed with physical status modifiers P1-P6.	1/01/2018
P	Anesthesia Policy	Anesthesia and moderate sedation services (00300, 00400, 00600, 01935-01936, 01991-01992, 99152-99153, 99156-99157) when billed with pain management services, are payable only when billed and a surgical procedure (CPT 10021-69990) has been billed by any provider for a patient age 18 or older.	1/01/2018 *Updated to include CNY effective 8/01/2022*
F	Anesthesia Policy	Reimbursement and frequency for multiple general anesthesia service codes (CPT codes 00100-01999) billed for the same day will be limited to the code with the highest submitted charge amount.	1/1/2018
P	Anesthesia Policy	Any anesthesia code that is billed with multiple anesthesia modifiers on the same claim line is not payable.	1/01/2018
P	Anesthesia Policy	Reimbursement and frequency for multiple general anesthesia service codes (CPT code 00100-01999) will be limited to the code with the highest submitted charge amount when billed with anesthesia modifier QX or QZ (CRNA services).	1/01/2018
P	Anesthesia Policy	Reimbursement and frequency for multiple general anesthesia service codes (CPT codes 00100-01999) will be limited when billed with Revenue Code 0964 (CRNA) to the code with the highest submitted charge amount.	1/01/2018
P	Anesthesia Policy	Anesthesia services (CPT codes 00100-01999) are not payable when billed by a CRNA without the appropriate CRNA modifiers (QX, or QZ).	1/01/2018
F, P	Anesthesia Policy	Diagnostic and therapeutic epidural or subarachnoid injections (CPT codes 62320-62327) to eight times per region in a year.	1/01/2018 *Updated to include PPOC effective 8/01/2022*
P	Anesthesia Policy	Anesthesiologist claims without medical supervision/direction modifiers are not payable if a CRNA claim with medical direction exists.	1/01/2018
P	Anesthesia Policy	Reimbursement and frequency for multiple general anesthesia service codes (CPT codes 00100-01999) are limited to the billed for the same day to the code with the highest submitted charge amount.	1/01/2018
P	Assistant Surgeon Policy	CPT 59510 (Global obstetrical care, Cesarean delivery) is not payable when billed with an assistant surgeon modifier.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Assistant Surgeon Policy	CPT 59618 (Global obstetrical care, Cesarean delivery, following failed VBAC) is not payable when billed with an assistant surgeon modifier.	1/01/2018
P	Assistant Surgeon Policy	CPT 59622 (Cesarean delivery only, following failed VBAC, including postpartum care) is not payable when billed with an assistant surgeon modifier.	1/01/2018
P	Assistant Surgeon Policy	CPT 59515 (Cesarean delivery only, including postpartum care) is not payable when billed with an assistant surgeon modifier.	1/01/2018
P	Assistant Surgeon Policy	Only one assistant surgeon is allowed for a surgical procedure.	1/01/2018
P	Assistant Surgeon Policy	Assistant surgeon services are payable only when the code allows an assistant in accordance with CMS.	1/01/2018
P	Assistant Surgeon Policy	Clinical documentation is required for Assistant surgeon services in accordance with CMS.	1/01/2018
P	Assistant Surgeon Policy	Procedure codes billed as assistant surgeon are not payable when the codes are designated as codes to which the concept of Assistant Surgeon Does Not Apply. (CMS)	1/01/2018
P	Assistant Surgeon Policy	Primary surgeons that also bill for assistant surgeon under the same provider ID are not payable.	1/01/2018
F	Assistant Surgeon Policy	Services billed for assistant surgeon when the codes are designated as Assistant Surgeons Payment Restriction May Apply (CMS assistant surgeon indicator "2") and the bill type is 0850-085Z (Critical access hospital) and the revenue code is 0960-0989 (Professional fee).	1/01/2018 *Updated to include CNY, PPOC & PPOMR effective 8/01/2022*
F	Assistant Surgeon Policy	Services billed for an assistant surgeon are not payable when the codes are designated as Assistant Surgeon Not Allowed (CMS assistant surgeon indicator "1") and the bill type is 0850-085Z (Critical Access Hospital) and the revenue code is 0960-0989.	1/01/2018
F	Assistant Surgeon Policy	Services billed for an assistant surgeon are not payable when the codes are designated as Assistant Surgeon Not Allowed (CMS assistant surgeon indicator "9") and the bill type is 0850-085Z (Critical Access Hospital) and the revenue code is 0960-0989.	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
P	Assistant Surgeon Policy	Global obstetrical care, Cesarean delivery procedures are not payable when billed with an assistant surgeon modifier.	1/01/2018
P	Assistant Surgeon Policy	Global obstetrical care, Cesarean delivery, following failed VBAC is not payable when billed with an assistant surgeon modifier.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Assistant Surgeon Policy	Cesarean delivery only, following failed VBAC, including postpartum care (CPT code 59622) is not payable when billed with an assistant surgeon modifier.	1/01/2018
P	Assistant Surgeon Policy	Cesarean delivery only, including postpartum care (CPT code 59515) is not payable when billed with an assistant surgeon modifier.	1/01/2018
F, P	Assistant Surgeon Policy	Any claim with multiple assistant surgeon claims for the same surgical procedure is not payable.	1/01/2018
P	Assistant Surgeon Policy	Reimbursement for an assistant surgeon is not payable when billed by the primary surgeon.	1/01/2018
P	Assistant Surgeon Policy	Procedures are not payable when billed as assistant surgeon and the codes are designated as assistant surgeon not allowed.	1/01/2018
P	Assistant Surgeon Policy	Procedures are not payable when billed as assistant surgeon when the codes are designated as assistant surgeon payment restriction may apply.	1/01/2018
P	Assistant Surgeon Policy	In accordance with AMA, a procedure code is not payable when billed with modifier 80, 81, 82, or AS (Assistant Surgeon) when the same procedure code has not been billed without modifier 80, 81, 82, or AS (Primary Surgeon) by a different Provider ID.	4/15/2024
F, P	Asthma and Allergy Policy	Care management services (CPT codes 99487, 99489-99490, G2058) is not payable when billed within the same calendar month when certain services have already been paid.	1/01/2018
P	Bariatric Surgery Policy	Hiatal hernia repair CPT codes 43280, 43281, 43282, 43289, 43499 or 43659, when reported with bariatric surgery code ranges 43770–43775 and 43842–43848, 43644, 43645, 43886, 43887 or 43888, will deny as incidental/inclusive procedures. Modifier 59 will not override these codes as hiatal hernia repair is considered an integral part of bariatric surgery, in accordance with CMS guidelines.	4/15/2024
P	Bilateral Procedures Policy	Services reported with lateral anatomic modifier LT (Left side) or RT (Right side) are not payable when billed on the same line with modifier 50 (Bilateral procedure).	1/01/2018
P	Bilateral Procedures Policy	Procedure codes to which the bilateral concept does not apply are not payable when billed with modifier 50, LT or RT.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Bilateral Procedures Policy	Procedures that are bilateral in nature are not payable when billed with RT or LT to its counterpart unilateral code.	1/01/2018
P	Bilateral Procedures Policy	Bilateral procedures are payable when billed in accordance with the CMS Physician RVU file Bilateral designation.	1/01/2018
P	Bilateral Procedures Policy	According to our policy, when bilateral indicator "1" codes are rendered bilaterally, only one claim line with modifier 50 appended is payable.	1/01/2018
F, P	Bilateral Procedures Policy	Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation (CPT code 76519), or ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation (CPT code 92136) is not payable when billed twice on the same date of service, as either the global service or the technical service (with modifier TC).	1/01/2018
F, P	Bilateral Procedures Policy	Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation (CPT code 76519), or ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation (CPT code 92136) is not payable when billed globally and the same procedure is also billed with modifiers 26-LT and 26-RT.	1/01/2018
P	Bilateral Procedures Policy	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited (CPT code 76642) is not payable when billed by any provider on the same date of service for the same side an ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete (CPT code 76641) is performed.	1/01/2018
P	Bilateral Procedures Policy	If 76642 (Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited) is billed with modifier LT (Left side) on the same date of service as 76641 (Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete) billed with modifier LT (Left side) or 50 (Bilateral procedure) by any provider, then deny 76642 with reason Included In Primary Procedure.	1/01/2018
F, P	Bilateral Procedures-Modifiers 50, RT, LT	Identifies claim lines where the procedure code is submitted with modifier 50 and the line quantity is greater than 1. Procedures billed with modifier 50 indicate a bilateral procedure and a line quantity greater than one is not allowed.	2015

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

Claim Type	Medical Policy	Rule Description	Effective Date
		The default is set to override this edit if modifier -59 (distinct procedural service) is reported on the same claim line with modifier -50.	
P	Breast Milk Bag Frequency Policy	Disposable collection and storage bags for breast milk (K1005, A4287) are not payable when limit of 200 milk bags is exceeded within a calendar month	1/1/2023
F, P	Bundled Ambulance Services	This rule recommends the denial of any claim lines with a procedure code other than a valid ambulance HCPCS service or mileage code reported along with a valid ambulance HCPCS procedure code for the same beneficiary, same date of service, by the same provider and on Same Claim Only.	2018
F	Bundled Services Policy	Packaged HCPCS codes are not payable when billed by an ambulatory surgical center.	1/01/2018
F	Bundled Services Policy	Packaged HCPCS codes are not payable when billed by an ambulatory surgical center	1/01/2018
P	Bundled Services Policy	Codes with a status indicator T are not payable when other payable services (CMS) are billed on the same day.	1/01/2018
P	Bundled Services Policy	Bundled services (Status indicator P) are not payable when billed with other payable services on the same day.	1/01/2018
P	Bundled Services Policy	Bundled services for which payment is always routinely bundled into other services and supplies are not payable.	1/01/2018
P	Bundled Services Policy	As per the April 2021 AMA CPT Assistant for breast reconstruction revision, if CPT code 19380 is reported, no other codes should be reported for work related to the breast envelope (ie, scar revision, mastopexy, liposuction, capsule modification, etc.). Exchanging an implant (CPT code 19342) or autologous fat-grafting for increased volume or contouring (CPT codes 15571, 15772) may be reported separately.	4/01/2021
F	Bundled Services Policy	CMS has implemented a conditional package status indicator Q4 (Laboratory services subject to conditional packaging) that will identify laboratory codes when they are the only service rendered in the outpatient hospital (Bill Type 0130-013Z) in order to pay them separately under the Clinical Laboratory Fee Schedule (CLFS).	9/13/2023

Claim Type	Medical Policy	Rule Description	Effective Date
		The conditional packaging indicator designates services will be packaged if billed on the same claim as a HCPCS code that has an assigned OPPS payable status indicator. Conditionally packaged laboratory service codes (Status indicator Q4) will deny when billed with any non-laboratory service and the bill type is 0130-013Z (Hospital outpatient).	
F	Bundled Services Policy	According to CMS policy, certain ancillary HCPCS codes are considered integral to the delivery of other procedures and services and their payment is packaged into the payment for the other services. These packaged services are not separately reimbursable. These services have a status indicator of N (Items and services packaged into APC rates) and there is no separate APC payment. HCPCS Codes with Status Indicator N will deny when billed by an outpatient hospital.	9/13/2023
F	Bundled Services Policy	CMS has established a list of services that are considered packaged into the APC payment when billed with certain services; otherwise these services are separately payable. These specific service codes are considered packaged in the presence of any code with status indicator S, T or V (STV-Packaged). When one of these STV-Packaged services is reported on the same claim as a code with an APC status indicator of S, T or V, then the STV-Packaged service will be denied.	9/13/2023
F	Bundled Services Policy	According to CMS, certain service codes are considered packaged in the presence of any code with a status indicator T (T-Packaged). When one of these T-Packaged services is reported on the same day as a code with an APC status indicator of T, then the T-Packaged service will be denied.	9/13/2023
P	Bundled Services Policy	Per AMA CPT Assistant (Oct 2017, pg. 9) it is not appropriate to report code 14000 or 14001 in addition to code 19301, Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy), because simple, intermediate, and complex layered closure is included in the work represented by code 19301.	1/1/2018

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Bundled Services Policy	Codes described as exploratory procedures are not payable when billed with a major surgical procedure that was performed at the same anatomic site.	1/01/2018
P	CPAP and BIPAP Services	Identifies supply codes associated with the Continuous Positive Airway Pressure or Bi- level Positive Airway Pressure CPAP/BIPAP) therapy that are being submitted at a rate that exceeds the usual or customary rate. This rule will also identify those supply codes submitted without modifier –KX (Requirements specified in the medical policy have been met).	1/01/2018
P	Cardiology Policy	CPT 93970-93971 (Venous studies) are not payable when billed with 93922-93931 (Arterial studies) and a supporting diagnosis for the venous study is not present.	9/20/2019
P	Cardiology Policy	Evaluation and management services (CPT codes 99211-99480 or 99499) are not payable when billed without modifier 25 on the same date of service as implantable cardiac device monitoring services (CPT codes 93260-93261), cardiac device evaluation services (CPT codes 93279-93298, 0417T-0418T, 0521T, 0522T, 0528T, 0529T, 0575T-0576T, 0578T-0579T, G2066), or noninvasive physiologic studies (CPT codes 93724, 93740, 93750).	1/01/2018
P	Cardiology Policy	When more than one myocardial perfusion or cardiac blood pool imaging study (CPT codes 78451-78454, 78466-78469 or 78472, 78473, 78483, 78494) are billed the procedure with the lowest allowed amount for the same date of service will not be payable.	1/01/2018
F, P	Cardiology Policy	A complete transthoracic echocardiography is not payable when the same complete echocardiography has been billed within six months with the same diagnosis.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Cardiology Policy	CPT 93260-93261, 93282-93284, 93289 or 93292 (Programming/interrogation device evaluation [in person] defibrillator system) are not payable when billed greater than once in a three-month period for a diagnosis indicating the presence of an automatic (implantable) cardiac defibrillator.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Cardiology Policy	CPT 93922-93931 (Arterial studies) are not payable when billed with 93970-93971 (Venous studies) and a supporting diagnosis for the arterial study is not present.	1/01/2018
F, P	Cardiology Policy	Myocardial perfusion imaging; single study (CPT code 78451) is not payable when billed more than once on the same claim for the same or the previous date of service.	1/01/2018
F, P	Cardiology Policy	External mobile cardiovascular telemetry [MCT](CPT codes 93228-93229) or external patient activated ECG event recording (CPT codes 93268-93272) are not payable when billed more than once in a six month period by any provider.	1/01/2018 *Terminated effective 3/26/2023*
P	Cardiology Policy	Complete fetal echocardiography is not payable when the same complete echocardiography has been billed within six months with the same diagnosis.	1/01/2018
P	Cardiology Policy	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report (CPT code 93000) is not payable when billed in the office setting for a patient 18 years of age or older and the only diagnosis is a screening diagnosis code.	1/01/2018
F, P	Cardiology Policy	Evaluation of cardiovascular function with tilt table evaluation (CPT code 93660) is not payable when billed without a diagnosis of syncope and collapse.	1/01/2018
P	Cardiology Policy	Arterial studies (CPT codes 93922-93931) are not payable when billed with venous studies (CPT codes 93970-93971) and a supporting diagnosis for the arterial study is not present.	1/01/2018
P	Cardiology Policy	Venous studies (CPT codes 93970-93971) are not payable when billed with arterial studies (CPT codes 93922-93931) and a supporting diagnosis for the venous study is not present.	1/01/2018
P	Cardiology Policy	Duplex scan of extracranial arteries; complete bilateral study (CPT code 93880) or duplex scan of extracranial arteries; unilateral or limited study CPT code 93882) is not payable when billed with Place of Service 11 (Office), 12 (Home), 15 (Mobile Unit), 19 (Off campus-Outpatient Hospital, 20 (Urgent Care), 22 (On Campus-Outpatient Hospital), 24 (ASC), 32 (Nursing Facility), or 49 (Independent Clinic), the patient's age is 18 years or greater, and a carotid artery stenosis symptom diagnosis is not present on the claim.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Chemistry Lab Unbundled Policy	Unbundled individual components of a disease-oriented or chemistry panel are not payable when submitted for the same date of service by the same provider. Provider must bill the appropriate comprehensive panel or automated multichannel test code that includes the multiple test components.	All PPO 1/01/2022 HMOMR and HMOC 03/17/2021 HMOMD 10/01/2021
F	Claims Processing Parameters Policy	Any service when there exists an inpatient or outpatient claim with a discharge status of 20, 40, 41, or 42 (Patient deceased or expired) prior to the date of service will be denied.	1/01/2018 *Updated to include CNY, PPOC & PPOMR effective 8/01/2022*
F	Claims Processing Parameters Policy	A claim submitted with a no-pay bill type is not payable.	1/01/2018 *Updated to include CNY, PPOC &PPOMR effective 8/01/2022*
F	Claims Processing Parameters Policy	Any service when there exists an inpatient or outpatient claim with a discharge status of 20, 40, 41, or 42 (Patient deceased or expired) prior to the date of service is not payable.	1/01/2018
F, P	CMS Coverage Policies	Any combination of outpatient cardiac rehabilitation (CPT codes 93797-93798) that is beyond 36 units in 36 weeks by any provider is not payable unless reported with modifier KX (Requirements specified in the medical policy have been met).	1/01/2018
F	CMS Coverage Policies	CMS defined non-covered services are not payable. (CMS-1450)	1/01/2018 *Updated to include PPOMR effective 8/01/2022*
F	CMS Coverage Policies	Processing, preserving and transporting corneal tissue (HCPCS code V2785) is not payable when billed without a corneal transplant procedure (CPT codes 65710, 65730, 65750, 65755, 65756, 65765, 65767).	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
F, P	CMS Coverage Policies	FQHC visit, established patient (HCPCS code G0467) is not payable when reported for PPS payment and a qualifying visit code is not also present on the claim.	1/01/2018
F, P	CMS Coverage Policies	Services are not payable if billed with Bill Types 0771-077Z (FQHC) and Condition Code 65 is not present on the claim (i.e. reported for PPS payment) and a FQHC visit code (HCPCS codes G0466-G0470) are not also present on the claim.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	CMS Coverage Policies	Anesthesia for lower intestinal endoscopic procedures [screening colonoscopy] (CPT code00812) is not payable when billed with modifier 33 and colorectal cancer screening (HCPCS codes G0105, G0121) have not been billed for the same date of service by any provider.	1/01/2018
P	CMS Coverage Policies	Pneumococcal vaccine (CPT code 90670 or 90732) is not payable when billed by any provider and the same code has been billed in the patient's lifetime.	1/01/2018
P	CMS Coverage Policies	Pneumococcal vaccine (CPT 90670 or 90732) is not payable when billed and 90670 or 90732 has been billed in the previous 12 months.	1/01/2018
F, P	CMS Coverage Policies	Annual wellness visit (HCPCS code G0439) is not payable when billed and another annual wellness visit (HCPCS code G0438 or G0439) has been billed and paid in the previous 11 months by any provider.	1/01/2018
F, P	CMS Coverage Policies	Annual wellness visit (HCPCS code G0438 or G0439) is not payable when billed and initial preventive physical examination (HCPCS code G0402) has been billed and paid in the previous 11 months by any provider.	1/01/2018
F	CMS Coverage Policies	CMS defined non-covered services are not payable.	12/01/2019
F, P	CMS Coverage Policies	Any combination of CPT codes 93797-93798 (Outpatient cardiac rehabilitation) are limited to 36 units within a 36-week period by any provider unless reported with modifier KX (Requirements specified in the medical policy have been met).	1/01/2018
F	CMS Coverage Policies	Claims with revenue codes not recognized by CMS are not payable.	1/01/2018 *Updated to include PPOMR effective 8/01/2022*
F	CMS Coverage Policies	CMS-defined services not recognized by Medicare are not payable when billed with Bill Type 0120-012Z, 0130-013Z or 0140-014Z.	1/01/2018 *Updated to include PPOMR effective 8/01/2022*
P	CMS Coverage Policies	Deny items, services and procedures designated as Non-Covered Services (CMS).	4/30/2019
P	CMS Coverage Policies	Physician voluntary reporting program codes are not reimbursable with greater than $0.00.	1/01/2018
P	CMS Coverage Policies	HCPCS V2787 or V2788 are not payable.	1/01/2018
P	CMS Coverage Policies	HCPCS R0070 or R0075 (Transportation of portable x-ray equipment) is not payable when the accompanying radiological service has not been billed or paid for the same date of service by the same or different provider.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	CMS Coverage Policies	Performance measurement code with status indicator M are not payable >0.00 based on CMS designation.	1/01/2018
F, P	CMS Coverage Policies	Chiropractic manipulation (98940-98942) is not payable when billed without a primary diagnosis of subluxation and a secondary diagnosis for the symptoms associated with the diagnosis of subluxation is not present.	1/01/2018
F, P	CMS Coverage Policies	Chiropractic manipulation (98940-98942) is not payable when billed without modifier AT.	1/01/2018
P	CMS Coverage Policies	HCPCS G0372 (Physician service required to establish and document the need for a power mobility device) is not payable when billed and a face-to-face Evaluation and Management service has not been billed and paid on the same claim for the same date of service.	1/01/2018
F, P	CMS Coverage Policies	G0438 (Annual wellness visit; initial visit) is not payable when billed more than once in a patient's lifetime.	1/01/2018
P	CMS Coverage Policies	Major surgical procedures are not payable when billed by a non-physician practitioner (NPP) and modifier 80, 81, 82 or AS is not appended to the claim line.	1/01/2018
F, P	CMS Coverage Policies	Transportation of portable x-ray equipment, one patient seen (HCPCS code R0070) is not payable when billed with modifiers UN (Two patients served), UP (Three patients served), UQ (Four patients served), UR (Five patients served), or US (Six patients served).	1/01/2018
F	CMS Coverage Policies	CMS defined Services Not Recognized by OPPS are not payable when billed with Bill Types 0120-012Z, 0130-013Z or 0140-014Z.	1/01/2018 *Updated to include PPOMR effective 8/01/2022*
F, P	CMS Coverage Policies	Outpatient cardiac rehabilitation (CPT codes 93797-93798) or intensive cardiac rehabilitation (HCPCS codes G0422-G0423) are not payable when billed without a covered diagnosis on the claim.	1/01/2018
F	CMS Coverage Policies	Revenue code 0637 (Pharmacy-self-administered drugs) is not payable when billed without a HCPCS Code.	1/01/2018
P	CMS Coverage Policies	Items, services and procedures designated as Not Valid for Medicare are not payable.	1/01/2018
F, P	CMS Coverage Policies	Face-to-face educational services related to the care of chronic kidney disease (HCPCS code G0420-G0421) is not payable if not accompanied by a diagnosis of chronic kidney disease, stage IV, [severe].	1/01/2018
F	CMS Coverage Policies	Pulmonary rehabilitation (HCPCS code G0424) is not payable when billed with Bill Type 0130-013Z	1/01/2018 *Updated to include CNY, PPOC,*

Claim Type	Medical Policy	Rule Description	Effective Date
		(Outpatient hospital) and the revenue code is not 0948 (Pulmonary rehabilitation).	*PPOMR effective 8/01/2022*
F, P	CMS Coverage Policies	Injection, heparin sodium, [heparin lock flush], per 10 units (HCPCS code J1642) is not payable.	1/01/2018
F, P	CMS Coverage Policies	Pulmonary rehabilitation (HCPCS code G0424) is not payable when billed for more than 36 units in a patient's lifetime by any provider (excluding a repeat course of therapy appended with modifier KX).	1/01/2018
P	CMS Coverage Policies	Tissue marker, implantable, any type, each (HCPCS code A4648) or implantable radiation dosimeter, each (HCPCS code A4650) are not payable when billed and placement of soft tissue localization device, percutaneous, including imaging guidance (CPT codes 10035-10036), biopsy, breast, with placement of breast localization device and imaging of the biopsy specimen, percutaneous, including imaging (CPT codes 19081-19086), placement of breast localization device, including imaging (CPT codes 19281-19288), unlisted procedure, breast (CPT code 19499), placement of interstitial device for radiation therapy guidance, percutaneous, intra-thoracic (CPT code 32553), placement of interstitial device for radiation therapy guidance, percutaneous, intra-abdominal, intra-pelvic [except prostate], and/or retroperitoneum (CPT code 49411), or placement of interstitial device for radiation therapy guidance, prostate [via needle, any approach] (CPT code 55876) has not been billed or paid for the same date of service.	1/01/2018
F, P	CMS Coverage Policies	Pulmonary rehabilitation (HCPCS code G0424) is not payable beyond two units per date of service.	1/01/2018 *Updated to include PPOC, PPOMR effective 8/01/2022*
F, P	CMS Coverage Policies	Annual wellness visit; initial visit or subsequent visit (HCPCS codes G0438 or G0439) are not payable when billed by any provider greater than one unit per date of service.	1/01/2018
F, P	CMS Coverage Policies	Subsequent service, supply or device procedure codes are not payable when modifiers PM, P6 or QL have been reported in the past for the same patient by any provider.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
F	CMS Coverage Policies	High-cost skin substitute application procedures (CPT codes 15271-15278) are not payable when billed with bill types 0120-012Z (Inpatient Hospital-Part B), 0130-013Z (Outpatient Hospital-Part B), or 0140-014Z (Outpatient Hospital-other) and a qualifying high-cost skin substitute product code has not been either paid or denied for the same date of service.	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
F, P	CMS Coverage Policies	Set-up portable X-ray equipment (HCPCS code Q0092) is not payable when billed and transportation of portable x-ray equipment (HCPCS codes R0070 or R0075) has not been billed or paid for the same date of service by same or different provider.	1/01/2018
F, P	CMS Coverage Policies	Services submitted with a principal diagnosis found on the Outpatient Prospective Payment System (OPPS) Unacceptable Principal Diagnosis list are not payable.	10/15/2024
F, P	CMS Coverage Policies	Procedures or treatments are not payable when the only diagnosis on the claim line is for a procedure or treatment not carried out due to contraindication or other unspecified reason.	10/15/2024
F, P	CMS Coverage Policies	Procedures or treatments are not payable when the only diagnosis on the claim line is for a procedure or treatment not carried out due patient decision.	10/15/2024
F, P	CMS Coverage Policies	In accordance with CMS, when either the Mohs micrographic surgery procedure (CPT codes 17311 or 11713) or surgical pathology examination (codes 88300-88309, 88312, 88313, 88331, 88342, 88344) are reported separately for the same date of service by different providers, they will be denied.	10/15/2024
P	CMS Coverage Policies	Per CMS, outpatient cardiac rehabilitation or intensive cardiac rehabilitation services (93797-93798, G0422-G0423) are not payable unless billed in a physician's office (POS 11) or hospital outpatient setting (POS 19 or 22). (CMS-1500)	2/15/2025

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	CMS National Coverage Determinations (NCD) Policy	Aluminum (CPT code 82108) is not payable when billed more than once in a three-month period by any provider with a diagnosis of end-stage renal disease on the claim.	1/01/2018 *Updated to include Facility (HMOC, HMOMD, HMOMR) effective 11/16/2021* *Updated to include CNY, PPOC, PPOMR effective* 8/01/2022
F, P	CMS National Coverage Determinations (NCD) Policy	Ambulatory blood pressure monitoring (CPT code 93784) is not payable when a diagnosis of elevated blood pressure reading without diagnosis of hypertension is not present on the claim.	1/01/2018
P	CMS National Coverage Determinations (NCD) Policy	Peripheral arterial disease (PAD) rehabilitation, per session (CPT code 93668) is not payable when billed and a diagnosis of atherosclerosis with intermittent claudication is not present.	1/01/2018
P	CMS National Coverage Determinations (NCD) Policy	Cytogenetic studies (CPT codes 88230-88291) are not payable when billed without a CMS approved diagnosis on the claim.	1/01/2018
P	CMS National Coverage Determinations (NCD) Policy	HIV screening tests (HCPCS codes G0432, G0433, G0435, or G0475) are not payable when billed with a diagnosis of encounter for screening for HIV and the patient's age is greater than 65 years of age, and a diagnosis of high risk is not also present.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	HIV screening tests (HCPCS codes G0432, G0433, G0435, or G0475) are not payable when billed with a diagnosis of encounter for screening for HIV and the patient's age is less than 15 years of age, and a diagnosis of high risk is not also present.	1/01/2018
P	CMS National Coverage Determinations (NCD) Policy	HIV screening tests (HCPCS codes G0432, G0433, G0435, or G0475) are not payable when billed and the place of service is not 11 (Office), or 81 (Independent laboratory).	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Bioimpedance-derived physiologic cardiovascular analysis (CPT code 93701) is not payable when billed without an acceptable diagnosis on the claim.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	CMS National Coverage Determinations (NCD) Policy	Electrical osteogenesis stimulator (HCPCS code E0748) is not payable when billed and a diagnosis of post-surgical arthrodesis status is not present.	1/01/2018 *Updated to include CNY effective 8/01/2022*
F	CMS National Coverage Determinations (NCD) Policy	Vitrectomy (CPT codes 67005, 67010, 67036, 67039-67043) are not payable when billed and the revenue code is not 0360-0369 (Operating room services general classification) or 0490-0499 (Ambulatory surgical care general classification).	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
F, P	CMS National Coverage Determinations (NCD) Policy	Medical nutrition therapy (MNT) services for reassessment and subsequent intervention following second referral in same year (HCPCS code G0270 or G0271) is not payable when billed and MNT service codes (CPT codes 97802-97804) have not been billed within the same calendar year.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Subsequent billings of an initial medical nutritional service (CPT code 97802) is not payable when billed more than once within a calendar year.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Additional units of group medical nutrition therapy (CPT code 97804) is not payable when greater than 6 units have been billed within a calendar year.	1/01/2018 *Terminated 1/01/2020*
F, P	CMS National Coverage Determinations (NCD) Policy	Additional units of medical nutrition therapy (CPT codes 97802, 97803 or 97804) are not payable when greater than 12 combined units have been billed within a calendar year.	1/01/2018 *Terminated 1/01/2020*
F, P	CMS National Coverage Determinations (NCD) Policy	Additional units of medical nutrition therapy individual reassessment and intervention (CPT code 97803) is not payable when greater than 11 units have been billed within the same calendar year.	1/01/2018 *Terminated 1/01/2020*
P	CMS National Coverage Determinations (NCD) Policy	Obstetric panel [includes HIV testing] (CPT code 80081), G0432, G0433, G0435, or G0475 (HIV screening tests) are not payable when billed more frequently than three times by any provider per term of pregnancy.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Aprepitant, oral, 5 mg (HCPCS code J8501), unspecified oral dosage form, FDA approved prescription anti-emetic (HCPCS code J8501), netupitant 300 mg and palonosetron 0.5 mg, oral (HCPCS code J8655), or rolapitant, oral, 1 mg (HCPCS code J8670) are not payable when billed and a diagnosis indicating encounter is for antineoplastic chemotherapy (ICD-10 Z51.11) is not present.	1/01/2018
P	CMS National Coverage Determinations (NCD) Policy	CPT 88230-88291 (Cytogenetic studies) are not payable when billed without an approved diagnosis on the claim.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	CMS National Coverage Determinations (NCD) Policy	CPT 93668 (Peripheral arterial disease (PAD) rehabilitation, per session) is not payable when billed and a diagnosis of atherosclerosis with intermittent claudication is not present.	1/01/2018
P	CMS National Coverage Determinations (NCD) Policy	CPT 93784 (Ambulatory blood pressure monitoring) when billed with a diagnosis of elevated blood pressure reading, without diagnosis of hypertension is not payable.	1/01/2018
P	CMS National Coverage Determinations (NCD) Policy	CPT 82270 or G0328 (Colorectal cancer screening by fecal occult blood test) are not payable when billed by any provider more than once per year.	1/01/2018
P	CMS National Coverage Determinations (NCD) Policy	Electrical osteogenesis stimulator (HCPCS code E0747) is not payable when billed without a required diagnosis on the claim.	1/01/2018
P	CMS National Coverage Determinations (NCD) Policy	Ultrasonic osteogenesis stimulator (HCPCS code E0760) is not payable when billed without a required diagnosis on the claim.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Hemoglobin; glycosylated (A1C), CPT code 83036, is not payable when billed by any provider more than once per month and the diagnosis is diabetes mellitus in pregnant women.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Bilateral screening mammography, CPT codes 77063 or 77067, are not payable when billed and the patient is less than 35 years of age.	1/01/2018
P	CMS National Coverage Determinations (NCD) Policy	Ultrasonic osteogenesis stimulator, HCPCS code E0760, is not payable when billed by any provider and electrical osteogenesis stimulator, HCPCS codes E0747 or E0748 has been billed within the past month.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Smoking and tobacco cessation counseling visits, CPT codes 99406 or 99407, are not payable when billed in any combination more than eight units per year by any provider.	1/01/2018
P	CMS National Coverage Determinations (NCD) Policy	CPT 82728 (Ferritin) is not payable when the diagnosis is end-stage renal disease and 82728 has been billed more than once in a 90-day period by any provider for the same diagnosis.	1/01/2018
P	CMS National Coverage Determinations (NCD) Policy	Destruction of localized lesion of choroids, HCPCS codes 67221-67225 or Verteporfin, HCPCS code J3396, is not payable when billed and diagnostic imaging study (CPT codes 92133- 92134) and fluorescein angiography (CPT	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
		code 92235) has not been billed by any provider on the same day or within the past month.	
P	CMS National Coverage Determinations (NCD) Policy	As per CMS, CPT 99183 (Hyperbaric oxygen therapy) or G0277 (Hyperbaric oxygen under pressure, full body chamber, per 30-minute interval) are not payable when submitted without a requisite diagnosis.	1/01/2018
P	CMS National Coverage Determinations (NCD) Policy	HCPCS G0166 is not payable when greater than 35 units have been billed within a two-month period.	1/01/2018
P	CMS National Coverage Determinations (NCD) Policy	HCPCS G0102 or G0103 are not payable when billed more than once every 11 months.	1/01/2018
P	CMS National Coverage Determinations (NCD) Policy	HCPCS E0650-E0651, or E0655-E0673 (Pneumatic compressor/appliance device) are not payable when billed without a required diagnosis.	1/01/2018
P	CMS National Coverage Determinations (NCD) Policy	Knee arthroscopy (surgical) is not payable when billed with a primary diagnosis of osteoarthritis of the knee.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	HCPCS J0881, J0885 or Q5106 are not payable when billed with modifier EB.	1/01/2018
P	CMS National Coverage Determinations (NCD) Policy	J0881, J0885 or J0888 are not payable when billed with modifier EC and the diagnosis associated to the claim line is not approved for ESA treatment.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	J0881, J0885 or J0888 are required to be billed with modifier EA, EB or EC as applicable.	1/01/2018
P	CMS National Coverage Determinations (NCD) Policy	CPT 93025 (Microvolt T-wave alternans for assessment of ventricular arrhythmias) is not payable when billed without a covered diagnosis.	1/01/2018
P	CMS National Coverage Determinations (NCD) Policy	Medical nutrition therapy services (CPT codes 97802-97804 or G0270-G0271) are not payable when billed by a provider other than a registered dietician, nutritional professional, or hospital.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Medical nutrition therapy services (CPT codes 97802-97804 or HCPCS codes G0270-G0271) are not payable when there are paid dialysis services within the same calendar month.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Screening pelvic examinations (HCPCS code G0101) are not payable when billed by any provider more than once in a two-year period, except when a high-risk diagnosis is present.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Acupuncture (CPT codes 97810-97814) are not payable when the diagnosis is fibromyalgia.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, single interspace) (CPT	1/01/2018 *Updated to include CNY effective 8/01/2022*

Claim Type	Medical Policy	Rule Description	Effective Date
		code 22857) is not payable when billed and the patient's age is greater than 60 years.	
F, P	CMS National Coverage Determinations (NCD) Policy	Continuous passive motion exercise device (HCPCS code E0935) is limited to one unit per day when billed by any provider within three weeks of the original arthroplasty.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Bacterial urine cultures (CPT codes 87086 and 87088) are not payable when billed without a covered diagnosis.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Human immunodeficiency virus testing (CPT codes 86689, 86701-86703, 87390-87391, 87534-87535, 87537, or 87538) are not payable when billed without a covered diagnosis on the claim.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Blood count (CPT codes 85004-85008, 85013-85027, 85032, 85048-85049, G0306-G0307) are not payable when billed with a non-covered diagnosis and the non-covered diagnosis is the only diagnosis on the claim.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Thromboplastin time, partial [PTT]; plasma or whole blood (CPT code 85730) is not payable when billed without a covered diagnosis.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Prothrombin time (CPT code 85610) is not payable when billed without a covered diagnosis on the claim.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Ferritin (CPT code 82728), iron (CPT code 83540), iron binding capacity (CPT code 83550) or transferrin (CPT code 84466) are not payable when billed without a covered diagnosis.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Collagen crosslinks, any method (CPT code 82523) is not payable when billed without a covered diagnosis on the claim.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Glucose; quantitative, blood (CPT code 82947), glucose; blood, reagent strip (CPT code 82948) or glucose, blood by glucose monitoring device cleared by the FDA specifically for home use (CPT code 82962) are not payable when billed without a covered diagnosis.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Glycated protein (CPT code 82985) or hemoglobin; glycosylated (CPT code 83036) are not payable when billed without a covered diagnosis on the claim.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Thyroxine; total (CPT code 84436), thyroxine; free (CPT code 84439), thyroid stimulating hormone (CPT code 84443) or thyroid hormone uptake or thyroid hormone binding ratio (CPT code 84479) are not payable when billed without a covered diagnosis.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	CMS National Coverage Determinations (NCD) Policy	Lipid panel/testing CPT code 80061, 82465, 83700, 83701, 83704, 83718, 83721 or 84478) are not payable when billed without a covered diagnosis.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Alpha-fetoprotein; serum (CPT code 82105) is not payable when billed without a covered diagnosis.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Carcinoembryonic antigen (CPT code 82378) is not payable when billed without a covered diagnosis.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Gonadotropin, chorionic; quantitative (CPT code 84702) is not payable when billed without a covered diagnosis.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Immunoassay for tumor antigen, quantitative; CA 125 (CPT code 86304) is not payable when billed without a covered diagnosis.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Immunoassay for tumor antigen, quantitative; CA 15-3 [27.29] (CPT code 86300) is not payable when billed without a covered diagnosis.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Immunoassay for tumor antigen, quantitative; CA 19-9 (CPT code 86301) is not payable when billed without a covered diagnosis.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Prostate specific antigen [PSA], total (CPT code 84153) is not payable when billed without a required diagnosis.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Glutamyltransferase, gamma (CPT code 82977) when billed without a covered diagnosis.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Acute Hepatitis Panel (CPT code 80074) when billed without a covered diagnosis.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Blood, occult, by peroxidase activity, qualitative; feces, single specimen (CPT code 82272) when billed without a covered diagnosis on the claim.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Prostate cancer screening services (HCPCS codes G0102 and G0103) are not payable when billed and the diagnosis is not screening for malignant neoplasm of prostate.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Prostate cancer screening services (HCPCS codes G0102 or G0103) are not payable when billed and the patient is under 50 years of age.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Deny 84153 (Prostate specific antigen [PSA], total) when billed by any provider more than once per year and the diagnosis is indicative of lower urinary tract signs and symptoms.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Carcicoembryonic antigen testing (CPT code 82378) is not payable when billed more than twice in a patient's lifetime by any provider with a diagnosis of carcinoma in situ of the digestive organs.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	CMS National Coverage Determinations (NCD) Policy	Hyperbaric oxygen therapy (CPT code 99183) is not payable when billed and the place of service is not 11 (Office), 19 (Outpatient hospital-off campus), 21 (Inpatient hospital), 22 (Outpatient hospital-on campus), or 49 (Independent clinic).	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Laboratory tests are not payable when the only diagnosis code billed is one that is never covered by CMS.	1/01/2018
P	CMS National Coverage Determinations (NCD) Policy	Screening pap smear, examination (HCPCS code Q0091) for low risk diagnosis is not payable when billed by any provider more than once in a two-year period.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Injection, DMSO, dimethlsulfoxide, 50%, 50 ml (HCPCS code J1212) is not payable when billed and the diagnosis is not interstitial cystitis.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Ingestion challenge test (CPT code 95076) is not payable when billed and the only diagnoses on the claim is rheumatoid arthritis, depression, or respiratory disorders.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Vitrectomy (CPT codes 67005, 67010, 67036 or 67039-67043) is not payable when billed without a required diagnosis on the claim	1/01/2018 *Updated to include Facility (HMOMR) effective 11/16/2021* *Updated to include PPOMR effective 8/01/2022*
F, P	CMS National Coverage Determinations (NCD) Policy	Vitrectomy (CPT codes 67005, 67010, 67036, 67039-67043) is only payable when rendered to treat vitreous loss incident to cataract surgery, vitreous opacities due to vitreous hemorrhage or other causes, retinal detachments secondary to vitreous strands, proliferative retinopathy, and vitreous retraction.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	E/M services for patient with diabetic LOPS (HCPCS codes G0245-G0246) or routine foot care service for patient with diabetic LOPS (HCPCS code G0247) are not payable when billed and the diagnosis is not diabetes mellitus with neurological complications.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Routine foot care service for patient with diabetic LOPS (HCPCS code G0247) are not payable when billed without E/M for patient with diabetic LOPS (HCPCS codes G0245-G0246) on the same date of service.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	CMS National Coverage Determinations (NCD) Policy	E/M services for patients with diabetic LOPS, or routine foot care (HCPCS codes G0245-G0246, or G0247) are not payable when billed by any provider within six months of routine footcare services (CPT codes 11055-11057 or 11719-11721).	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Bioimpedance-derived physiologic cardiovascular analysis (CPT code 93701) is not payable when billed with the same date of service as cardiac bypass surgery (CPT codes 33510-33536).	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Bladder instillation of anticarcinogenic agent (CPT code 51720) is not payable when billed with injection, DMSO, dimethlsulfoxide, 50%, 50 ml (HCPCS code J1212) and the diagnosis is not interstitial cystitis.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Verteporfin (HCPCS codes J3396) is not payable when billed with destruction of localized lesion of choroids (CPT codes 67221-67225) and without a covered diagnosis.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Verteporfin (HCPCS code J3396) is not payable when billed and destruction of localized lesion of choroid (CPT codes 67221-67225) has not been billed or paid for the same date of service by any provider.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Screening pelvic examination (HCPCS codes G0101) are not payable when billed without a low-risk or high-risk requisite diagnosis.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Cryosurgical ablation of the prostate (CPT code 55873) is not payable when billed and the diagnosis on the claim is not prostate cancer.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Acupuncture (CPT codes 97810-97814) is not payable when the diagnosis is osteoarthrosis.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Diabetes self-management training (HCPCS codes G0108-G0109) is not payable when billed and the diagnosis is not diabetes mellitus.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Diabetes self-management training, per 30 minutes (HCPCS codes G0108-G0109) is not payable when billed by any provider with greater than 24 combined units of service within a year. Under Medicaid, the maximum is 40 units per year.	1/01/2018
P	CMS National Coverage Determinations (NCD) Policy	Screening mammography, bilateral (CPT codes 77063 or 77067) is not payable when billed without a screening mammography diagnosis.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Cellular Therapy (HCPCS code M0075) is a noncovered service.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	CMS National Coverage Determinations (NCD) Policy	Edetate disodium, 150 mg (HCPCS code J3520) and chelation-related administration services (CPT codes 96365, 96366, 96367, 96368, M0300, S9355) are not payable when billed with a diagnosis of atherosclerosis, arteriosclerosis, or calcinosis, and no other nonchemotherapy drug administered by intravenous infusion greater than an hour has been billed for the same date of service.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Liver transplantation (CPT code 47135) is not payable when billed without a CMS covered diagnosis and the patient's age is 18 or over.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	External counterpulsation therapy (HCPCS code G0166) is not payable when billed without a diagnosis on the claim of stable, disabling angina.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Injection, epidural, of blood or clot patch (CPT code 62273) is not payable when billed and the diagnosis on the claim is not due to severe headaches following performance of spinal anesthesia or spinal tap.	1/01/2018
P	CMS National Coverage Determinations (NCD) Policy	HCPCS codes J0882, J0887 or J0890 are not payable when billed with modifiers EA, EB or EC and the diagnosis is end stage renal disease.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Colorectal cancer screening (CPT/HCPCS codes 82270, G0104, G0106, or G0328) is not payable when billed and the patient is less than 50 years of age.	1/01/2018
P	CMS National Coverage Determinations (NCD) Policy	Hospital bed, institutional type includes: oscillating, circulating and Stryker frame, with mattress (HCPCS code E0270) is not payable when billed and the place of service is 04 (Homeless shelter), 12 (Home), 13 (Assisted living facility), 14 (Group home), 16 (Temporary lodging) or 33 (Custodial care).	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Application of electrical stimulation (CPT/HCPCS codes 97014, 97032, E0745, G0283), or electrical stimulator supplies (HCPCS code A4595) is not payable when billed and the only diagnosis on the claim is Bell's palsy.	1/01/2018 *Updated to include CNY effective 8/01/2022*
F, P	CMS National Coverage Determinations (NCD) Policy	Air fluidized bed (HCPCS code E0194) is not payable when billed and a diagnosis of a Stage III or Stage IV pressure ulcer is not present.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Photopheresis, extracorporeal (CPT code 36522) is not payable when billed and the diagnosis is not cutaneous T-cell lymphoma, acute cardiac allograft rejection, chronic graft-versus-host disease, or bronchiolitis obliterans syndrome following lung allograft transplantation.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	CMS National Coverage Determinations (NCD) Policy	Lipid testing (CPT codes 80061, 82465, 83718, 83721 or 84478) is not payable when billed more than six times per year in any combination by any provider.	1/01/2018
P	CMS National Coverage Determinations (NCD) Policy	HCPCS code J0881 or J0885 is not payable when billed without modifier EA, EB or EC.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Screening colonoscopy for high risk (HCPCS code G0105 is not payable when billed without a high-risk diagnosis on the claim.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Comprehensive electrophysiologic evaluation (CPT codes 93619, 93620, 93653, 93654, or 93656) is not payable when billed without a CMS requisite diagnosis on the claim.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Elastic garment/covering, each (HCPCS code A4466), surgical leggings (HCPCS codes A4490-A4510), incontinence garment (HCPCS code A4520), disposable underpads (HCPCS codes A4553 and A4554), surgical face mask (HCPCS code A4928), exercise equipment (HCPCS code A9300), bath and toilet aids (HCPCS codes E0240-E0245), bed boards (HCPCS code E0273), over bed tables (HCPCS code E0274), bed accessory: board, table, or support device, any type (HCPCS code E0315), patient lift, bathroom (HCPCS code E0625), whirlpool, portable (HCPCS code E1300), whirlpool tub, walk-in, portable (HCPCS code K1003), and diapers (HCPCS codes T4521-T4545) are non-covered services.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	PET services reported for an oncologic diagnosis are not payable when modifier PI or PS is not appended.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Medical nutritional therapy services (CPT codes 97802-97804 and HCPCS codes G0270-G0271) are not payable when billed without a requisite diagnosis on the claim.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	HIV screening tests (HCPCS codes G0432, G0433, G0435 or G0475) are not payable when billed and the diagnosis is not screening for human immunodeficiency virus (HIV).	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Evaluation and management service (CPT code 99202-99397 or 99417-99499) is not payable when billed with smoking and tobacco cessation counseling visit (CPT codes 99406 or 99407) on the same date of service.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Electrical stimulation, unattended, for chronic ulcers (HCPCS code G0281) or electromagnetic therapy, for chronic ulcers (HCPCS code G0329) are not payable when billed without an approved ulcer diagnosis on the claim.	1/01/2018 *Updated to include PPOC, PPOMR effective 8/01/2022*

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	CMS National Coverage Determinations (NCD) Policy	Photopheresis, extracorporeal (CPT code 36522) is not payable when billed with a diagnosis of chronic graft-versus-host disease and a diagnosis of complications of transplanted organ is not also present.	1/01/2018 *Updated to include PPOC, PPOMR effective 8/01/2022*
P	CMS National Coverage Determinations (NCD) Policy	Face-to-face behavioral counseling for obesity (HCPCS code G0447 or G0473) is not payable billed more than 22 times per year.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Face-to-face behavioral counseling for obesity (HCPCS code G0447 or G0473) is not payable when billed without a diagnosis of Body Mass Index 30 or greater.	1/01/2018 *Updated to include PPOC, PPOMR effective 8/01/2022*
F, P	CMS National Coverage Determinations (NCD) Policy	Photopheresis, extracorporeal (CPT code 36522) is not payable when billed with a diagnosis of bronchiolitis obliterans syndrome following lung allograft transplantation and a diagnosis of examination of participant in clinical trial is not also present.	1/01/2018 *Updated to include PPOC, PPOMR effective 8/01/2022*
F, P	CMS National Coverage Determinations (NCD) Policy	Photopheresis, extracorporeal (CPT code 36522) is not payable when billed with a diagnosis of bronchiolitis obliterans syndrome following lung allograft transplantation and clinical service modifier Q0 or Q1 is not also present.	1/01/2018 *Updated to include PPOC, PPOMR effective 8/01/2022*
F, P	CMS National Coverage Determinations (NCD) Policy	TENS device (HCPCS codes E0720 or E0730) are not payable when billed with a diagnosis of chronic low back pain and modifier KX (Requirements specified in the medical policy have been met) is not present.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Components of oral anti-emetic 3-drug combinations are not payable when all three drugs have not been billed for the same date of service on the same claim.	1/01/2018
F, P	CMS National Coverage Determinations (NCD) Policy	Dermal filler injections (HCPCS codes G0429, Q2026, or Q2028) are not payable when billed without a diagnosis of HIV and lipodystrophy on the claim.	1/01/2018
F	CMS National Coverage Determinations (NCD) Policy	Smoking and tobacco cessation counseling visit (CPT codes 99406 or 99407) is not payable when billed with bill types 0120-012Z (Hospital inpatient Part B), 0130-013Z (Hospital outpatient), 0220-022Z (SNF inpatient part B), 0230-023Z (SNF outpatient part B), 0340-034Z (Home health services not under a plan of treatment) and the revenue code is not 0942 (Education/training).	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	CMS National Coverage Determinations (NCD) Policy	HCPCS code 61715 (Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) for Tremor) is not payable when billed without a diagnosis of Tremor-Dominant Parkison's disease (TDPD) or Essential Tremor (ET) on the claim.	1/1/2025
P	CMS Status Indicators	Identifies claim lines containing procedure codes with a status indicator of C, I, M, N, P, R as defined by CMS on the Medicare Physician Fee Schedule. According to the Medicare Physician Fee Schedule, status codes indicate whether the code is in the fee schedule and if it is separately payable when the service is covered. This rule identifies codes subject to a payment review or denial according to their assigned status code defined by CMS.	2018
P	CMS Status Indicators	According to the Medicare Physician Fee Schedule, codes with a status indicator of I are defined as "not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services." These codes are not covered and are non-reimbursable.	2018
F	Co-Surgeon Policy	Procedures designated as co-surgeons allowed are not payable when billed without modifier 62 and the same procedure on the same claim has been billed with modifier 62 and the bill type is 0850-085Z (CAH) and the revenue code is 0960-0989 (Professional fees).	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
P	Co-Surgeon Policy	Procedures designated as co-surgeons concept does not apply will deny when billed with modifier 62	1/01/2018
P	Co-Surgeon Policy	Procedures billed with modifier 62 are not payable when designated as co-surgeons not allowed. (CMS)	1/01/2018
P	Co-Surgeon Policy	Procedures billed with modifier 62 are not payable without clinical documentation supporting the need for co-surgeons, when designated as co-surgeons payment restriction may apply. (CMS)	1/01/2018
P	Co-Surgeon Policy	Procedures designated as co-surgeons not allowed are not payable when billed without modifier 62 and there exists a previously processed claim for the same procedure code with modifier 62 by a different provider (CMS).	1/01/2018
P	Co-Surgeon Policy	Procedures designated as co-surgeons allowed and billed with modifier 62 will not be allowed when there exists a previously processed claim for the same procedure code by a different provider without modifier 62 (CMS).	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Co-Surgeon Policy	Co-surgeon procedures are not payable when both surgeons have the same subspecialty for procedures designated as co-surgeons are allowed. (CMS)	1/01/2018
P	Co-Surgeon Policy	Procedures billed with modifier 62 are not payable when designated as co-surgeons payment restriction may apply.	5/29/2019
P	Co-Surgeon Policy	Procedures billed with modifier 62 are not payable when designated as co-surgeons not allowed.	1/01/2018
P	Co-Surgeon Policy	Procedures designated as co-surgeons allowed when billed without modifier 62 and there exists a previously processed claim for the same procedure code with modifier 62 by a different provider are not payable.	1/01/2018
F	Co-Surgeon Policy	Procedures billed with modifier 62 are not payable when designated as co-surgeons not allowed and the bill type is 0850-085Z (CAH) and the revenue code is 0960-0989 (Professional fees)	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
F	Co-Surgeon Policy	Procedures billed with modifier 62 are not payable when designated as co-surgeons payment restriction may apply and the bill type is 0850-085Z (CAH) and the revenue code is 0960-0989 (Professional fees)	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
F	Co-Surgeon Policy	Procedures designated as co-surgeons concept does not apply when the bill type is 0850-085Z (CAH) and the revenue code is 0960-0989 (Professional fees). (CMS)	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
F	Co-Surgeon Policy	Procedures designated as co-surgeons allowed billed with modifier 62 are not payable when the same procedure has been billed without modifier 62 on the same claim and the bill type is 0850-085Z (CAH) and the revenue code is 0960-0989 (Professional fees) (CMS)	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
P	Continuous Intraoperative Neurophysiology Monitoring (IONM)	Continuous intraoperative neurophysiology monitoring in the operating room (CPT code 95940) is not payable when continuous intraoperative neurophysiology monitoring from outside the operating room (HCPCS code G0453 or CPT code 95940) is reported on the same day by the same provider.	3/01/2022
P	Deleted HCPCS Codes Policy	Deleted HCPCS codes will be denied as obsolete.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Device and Supply Policy	Imaging agents are not payable when billed without the requisite imaging procedures as defined by Regional CMS guidelines.	1/01/2018
P	Device and Supply Policy	Imaging agents are not payable when billed without the requisite imaging procedures as defined by National CMS guidelines.	1/01/2018
P	Device and Supply Policy	Imaging agents are not payable when billed without the requisite imaging procedures.	1/01/2018
P	Diagnosis Code Guideline Policy	Procedures or services received with a principal or primary diagnosis of external causes are not correct coding and not payable.	1/01/2018
P	Diagnosis Code Guideline Policy	ICD-10 Diagnosis codes are required to be reported in accordance with ICD-10 coding guidelines in the ICD-10 manual and CMS and NGS Medicare. • Code must be valid for the date of service • Code to the highest specificity • Manifestation or secondary diagnoses codes cannot be the only code on the claim. • Encounter diagnoses codes for chemo or immunotherapy administration procedures must be reported with a primary diagnosis for which the treatment is needed.	1/01/2018
P	Diagnosis Code Guideline Policy	When a diagnosis code is billed, and it indicates laterality (Right/Left), and the procedure/modifier code is conflicting, the service is not payable.	1/01/2018
P	Diagnosis Code Guideline Policy	When a diagnosis code is billed, and it indicates laterality (Right/Left), and the procedure/modifier code is conflicting, the service is not payable.	1/01/2018
P	Diagnosis Code Guideline Policy	Claim lines reported with mutually exclusive code combinations according to the ICD-10-CM Excludes 1 Notes guideline policy are not payable.	1/01/2018 *Will apply to preventative services effective 9/15/2023*
P	Diagnosis Code Guideline Policy	Any procedure or service received with a ICD-10-CM sequela (7th character "S") code billed as the only diagnosis on the claim is not payable.	1/01/2018
P	Diagnosis Code Guideline Policy	Any procedure or service received with a ICD-10-CM sequela (7th character "S") code billed in the primary, first listed or principal diagnosis position is not payable.	1/01/2018
F, P	Diagnosis Code Guideline Policy	Procedures or services received with a secondary diagnosis code as the only diagnosis on the claim are not payable.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Diagnosis Code Guideline Policy	Procedures or services received with a primary diagnosis of external causes as the only diagnosis on the claim are not payable.	1/01/2018
P	Diagnosis Code Guideline Policy	When a diagnosis code is available to specify whether the condition occurs on the Right, Left or Bilateral, it is not appropriate to report an unspecified code for the same condition	1/01/2018
F, P	Diagnosis Code Guideline Policy	When a diagnosis code indicates laterality, specifying that the condition occurs on both the left and right and the more specific bilateral code is available, it is not appropriate to report both the left and right code.	1/01/2018
F, P	Diagnosis Code Guideline Policy	Non-preventive evaluation and management services (excluding normal newborn care) billed with CPT codes 99381-99412, 99420, 99429 (Preventive medicine services) are not payable when reported with an ICD-10 "Z" diagnosis code as the only diagnosis on the claim.	1/01/2018
P	Diagnosis Code Guideline Policy	Claims received with a diagnosis of acute stroke (I63.-) or sepsis (A41.-) on will be denied when billed with the following Place of Service (POS) codes: • Office (POS 11) • Telehealth (Use POS 2 when patient and provider are in a facility; POS 10 for patients at home) • Off Campus outpatient hospital (POS 19) • On Campus outpatient hospital (POS 22) • Skilled nursing facility (POS 31) • Federally Qualified Health Center (POS 50)	12/06/2024
F, P	Diagnosis Procedure Policy	Debridement (CPT codes 11042-11047) are not payable when billed with a pressure ulcer stage 1 or stage 2 diagnosis and another pressure ulcer stage (3 or 4) or a non-pressure chronic ulcer diagnosis is not reported on the claim.	1/01/2018
F, P	Diagnosis Procedure Policy	Other peripheral nerve injection (CPT code 64450) is not payable when used for the treatment of multiple neuropathies or peripheral neuropathies caused by underlying systemic diseases.	1/01/2018 *Terminated effective 9/24/2023*

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Diagnosis Procedure Policy	Pulmonary diagnostic testing procedures (CPT codes 94010, 94060, 94070, 94200-94450, and 94680-94729) are payable when the evaluation of lung function is indicated to determine; 1. the presence of lung disease or abnormality of lung function, 2. the extent of abnormalities and the potential causative disease process, 3. the extent of pulmonary impairment due to abnormal lung function, 4. the progression or improvement of the disease, 5. the type of disease or pulmonary abnormality, 6. the response to a course of therapy in the treatment of the particular condition, or 6. the presence of lung disease or abnormality of lung function secondary to toxicity of medication.	1/01/2018
F, P	Diagnosis Procedure Policy	Debridement of muscle, fascia or bone (CPT codes 11043, 11044 or 11046, 11047) are not payable when billed with a pressure ulcer stage 3 diagnosis and a stage 4 pressure ulcer or a non-pressure chronic ulcer diagnosis is not reported on the claim.	1/01/2018
P	Diagnosis Procedure Policy	Procedures billed with a diagnosis which does not remedy a health state are not payable.	1/01/2018
P	Diagnosis Procedure Policy	All clinical trial procedures billed with modifier Q0 (Investigational clinical service provided in a clinical research study that is in an approved clinical research study), or Q1 (Routine clinical service provided in a clinical research study that is in an approved clinical research study) and the required diagnosis to indicate participation in a clinical trial or research study is not present will deny. The correct encounter code must be used.	1/01/2018
P	Diagnosis Procedure Policy	CPT 20610 or 20611 (Arthrocentesis, aspiration and/or injection; major joint or bursa [e.g., shoulder, hip, knee joint, subacromial bursa]) are not payable when submitted without an appropriate diagnosis code.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Diagnosis Procedure Policy	HCPCS Code A9615 is payable when submitted with FDA approved indications for breast cancer diagnosis codes only. LUMISIGHT (pegulicianine injection, 1mg), HCPCS Code A9615, is an optical imaging agent indicated for fluorescence imaging in the treatment of adults with breast cancer as an adjunct for the interoperative detection of cancerous tissue within the resection cavity following removal of the primary specimen during lumpectomy surgery. Lumisight is used with the Lumicell Direct Visualization System (DVS) or another fluorescence imaging device that is FDA-approved for use with pegulicianine for breast lumpectomy surgery.	1/1/2025
P	Diagnosis-Age Policy	Services reported with a maternity diagnosis are not payable when the member is less than nine years of age or 65 years of age or older.	1/01/2018
F, P	Diagnosis Specificity Policy	Claims submitted with diagnosis codes that are not in the full ICD-10 code format are not payable.	All PPO 1/01/2022 HMOMR and HMOC 03/17/2021 HMOMD 10/01/2021
F, P	Diagnosis Validity Policy	Claim lines are not payable if submitted without at least one diagnosis code is invalid and all diagnosis codes are not coded to the highest level of specificity or are invalid.	1/01/2018
F, P	Diagnosis Validity Policy	Claim lines submitted with diagnosis codes are not coded to the highest level of specificity are not payable.	1/01/2018
P	DME Rentals	Capped rentals are not payable when billed without modifier KH, KI, or KJ.	1/01/2022

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Drug and Biological Policy	Consistent with Centers for Medicare & Medicaid Services' (CMS) Internet Only Manual 100-04, Chapter 17, Section 40 –Drug Label Guidelines; drug and biological codes dispensed in single use vials/packaging when billed with modifier JW (Drug amount discarded/not administered to any patient) and the billed units equal or exceed the package insert/prescribing information units will be denied. Example: (Based on CMS Policy and the FDA-approved package insert/prescribing information) • Adenosine (J0153) is supplied in 60 mg and 90 mg single-dose vials. It is expected that a provider will use a combination of vial sizes that eliminates or minimizes drug wastage. The billed drug code will be denied when submitted with a modifier indicating the drug was discarded (JW) and the units equaled or exceeded 60.	1/01/2023
F, P	Drug and Biological Policy	Fluocinolone injection (HCPCS code J7313) is not payable when billed without intravitreal injection of a pharmacologic agent (CPT code 67028).	1/01/2018
F, P	Drug and Biological Policy	Leuprolide acetate injection (HCPCS code J1950) is not payable when billed and the diagnosis is prostate cancer.	1/01/2018 *Updated to include CNY effective 8/01/2022*
F, P	Drug and Biological Policy	Valrubicin injection (HCPCS code J9357) is not payable when billed and bladder instillation therapy (CPT code 51720) has not been billed by any provider for the same date of service.	1/01/2018
F, P	Drug and Biological Policy	Ocriplasminn injection (HCPCS code J7316) is not payable when billed and intravenous administration of pharmacologic agent (CPT code 67028) has not been billed for the same date of service by any provider.	1/01/2018 *Updated to include CNY effective 8/01/2022*
F, P	Drug and Biological Policy	Dexamethasone injection (HCPCS code J7312) is not payable when billed without intravitreal injection of a pharmacologic agent (CPT code 67028).	1/01/2018
F, P	Drug and Biological Policy	Ranibizumab injection (HCPCS code J2778) is not payable when billed without intravitreal injection of a pharmacologic agent (CPT code 67028).	1/01/2018
F, P	Drug and Biological Policy	Intravitreal injection of a pharmacologic agent (HCPCS code 67028) is not payable when billed with ranibizumab injection (HCPCS code J2778) and modifier	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
		LT (Left side), RT (Right side), or 50 (Bilateral procedure) is not appended to code 67028.	
F, P	Drug and Biological Policy	Intramuscular immune globulin injections (Procedures codes 90281, J1460, or J1560) are not payable when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.	1/01/2018 *Updated to include PPOC, PPOMR effective 8/01/2022*
F, P	Drug and Biological Policy	Aflibercept injections (HCPCS code J0178) is not payable when billed without intravitreal injection of a pharmacologic agent (CPT code 67028).	1/01/2018
F, P	Drug and Biological Policy	Intravitreal injection of a pharmacologic agent (CPT code 67028) is not payable when billed with HCPCS code J0178 and modifier LT (Left side), RT (Right side), or 50 (Bilateral procedure) is not appended to code CPT code 67028.	1/01/2018
F, P	Drug and Biological Policy	Modifier JW is not payable with any code that is not a drug code. Modifier JW = Drug amount discarded/not administered to any patient.	9/01/2021 *Updated to include PPOMR effective 8/01/2022*
F, P	Drug and Biological Policy	A drug billed with modifier JW (Drug amount discarded/not administered to any patient) Is not payable when another claim line does not exist for the same drug on the same date of service.	9/01/2021 *Updated to include PPOMR effective 8/01/2022* *Terminated effective 4/01/2024*
F, P	Drug and Biological Policy	Single-dose container drugs billed with modifier JW (Drug amount discarded/not administered to any patient) are not payable when another claim line does not exist for the same drug without modifier JW and JZ (Zero drug amount discarded/not administered to any patient) on the same date of service.	4/1/2024
F, P	Drug and Biological Policy	Drugs that are only packaged for multiple doses are not payable when billed with modifier JW (Drug amount discarded/not administered to any patient).	9/01/2021 *Updated to include PPOMR effective 8/01/2022* *Terminated effective 4/1/2024*

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Drug and Biological Policy	Drugs that are only packaged for multiple doses are not payable when billed with modifier JW (Drug amount discarded/not administered to any patient) or modifier JZ (Zero drug amount discarded/not administered to any patient).	4/01/2024
F, P	Drug and Biological Policy	HCPCS J9035, Q5107, or Q5118 are not payable when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 10.	9/01/2021 *Updated to include PPOMR effective 8/01/2022*
F, P	Drug and Biological Policy	HCPCS J9041 or J9044 are not payable when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 35.	9/01/2021 *Updated to include PPOMR effective 8/01/2022*
F, P	Drug and Biological Policy	HCPCS J9055 is not payable when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 10.	9/01/2021 *Updated to include PPOMR effective 8/01/2022*
F, P	Drug and Biological Policy	HCPCS J0585 is not payable when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 100.	9/01/2021 *Updated to include PPOMR effective 8/01/2022*
F, P	Drug and Biological Policy	HCPCS J1745, Q5103, Q5104, Q5109, or Q5121 are not payable when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 10.	9/01/2021 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
F, P	Drug and Biological Policy	HCPCS J0587 is not payable when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 25.	9/01/2021 *Updated to include PPOMR effective 8/01/2022*
F, P	Drug and Biological Policy	HCPCS J0588 is not payable when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 50.	9/01/2021 *Updated to include PPOMR effective 8/01/2022*
F, P	Drug and Biological Policy	HCPCS J9171 is not payable when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 20	9/01/2021 *Updated to include PPOMR effective 8/01/2022*
P	Duplicate Claim Logic for Drugs	Duplicate drug codes are not payable when the same code with the same units has been billed on a different claim by any provider for the same date of service.	9/15/2021

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Drug and Biological Policy	HCPCS code J0205 is not payable when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.	1/01/2018
F, P	Drug and Biological Policy	HCPCS code J0289 is not payable when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.	1/01/2018 *Updated to include Facility (HMOC, HMOMR, HMOMD) effective 11/16/2021* 11/16/2021 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
F, P	Drug and Biological Policy	Single-dose container drugs billed without modifier JW (Drug amount discarded/not administered to any patient) or modifier JZ (Zero drug amount discarded/not administered to any patient) are not payable when another claim line for the same drug with either modifier JW or JZ on the same date of service does not exist.	10/1/2024
F, P	Drug and Biological Policy	Single-dose container drugs billed without both modifier JW (Drug amount discarded/not administered to any patient) and modifier JZ (Zero drug amount discarded/not administered to any patient) are not payable when another claim line does not exist for the same drug with modifier JW on the same date of service.	10/1/2024
F, P	Duplicate Services Policy	Only one professional component for the same service is payable when billed by different providers.	1/01/2018
P	Duplicate Services Policy	Identical codes billed for the same date of service by a non-physician practitioner (NPP) with the same Tax ID and the primary diagnosis on the submitted claim matches any diagnosis (first three characters) on the different claim regardless of Provider ID and Specialty are not payable.	1/01/2018
P	Duplicate Services Policy	Duplicate services are not payable when the duplicate criteria have been met.	1/01/2018
P	Duplicate Services Policy	Duplicate professional component services are not payable when billed by different providers for the same service.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Duplicate Services Policy	Duplicate technical component services are not payable when billed by different providers for the same service.	1/01/2018
F	Duplicate Services Policy	Duplicate services are not payable when the duplicate criteria have been met.	1/01/2018
P	Duplicate Services Policy	Duplicate services are not payable when the duplicate criteria have been met.	1/01/2018
P	Duplicate Services Policy	Doxorubicin liposomal injections (HCPCS codes Q2049 or Q2050) are not payable when billed more than once every three weeks by any provider and the diagnosis is of adult T-cell leukemia/lymphoma, AIDS-related Kaposi's sarcoma, Castleman's disease, diffuse large B-cell lymphoma, follicular lymphoma (grade 1-2), multiple myeloma, ovarian cancer/fallopian tube cancer/primary peritoneal cancer, peripheral T-cell lymphoma, or primary cutaneous CD30+ T-cell lymphoproliferative disorder.	1/01/2018
P	Duplicate Services Policy	Duplicate professional component services are not payable when billed by different providers for the same service.	1/01/2018
P	Duplicate Services Policy	Duplicate technical component services are not payable when billed by different providers for the same service.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	30-day pharmacy dispensing fee (HCPCS code G0333 or Q0513) is not payable when billed by any provider on the same date of service of a 90-day dispensing fee (HCPCS code Q0514).	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Ultra-light material endoskeletal system additions (HCPCS codes L5940-L5960) are not payable when billed without a qualifying endoskeletal system or socket HCPCS code.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Addition to lower extremity orthosis, for custom fabricated orthosis only (HCPCS code L2755) is not payable when billed and an appropriate base device has not been billed within the previous three years.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Replacement lead wires (HCPCS code A4557) is not payable when billed by any provider within a year of billing a TENS device (HCPCS codes E0720, E0730).	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Toe extension/flexion device (HCPCS code E1830 or E1831) is not payable when billed without a toe anatomical modifier (TA-T9).	1/01/2018
P	Durable Medical Equipment and Supplies Policy	DME repair codes are not payable when billed the same day as a rental or purchase of a new or used piece of equipment.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Durable Medical Equipment and Supplies Policy	Finger extension/flexion device (HCPCS code E1825) is not payable when billed without a finger anatomical modifier (FA-F9).	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Home glucose monitoring supplies are not payable when billed without the requisite modifier.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Stationary oxygen delivery system rentals (HCPCS codes E0424, E0439, E1390, and E1391) are not payable when billed more than once a month in any combination.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Oxygen accessories and supplies are not payable when billed the same day or during the same month as a monthly oxygen rental billing.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Oximeters and oximeter replacement probes as convenience items that do not meet definition of DME are not payable.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Silicone breast prosthesis items, HCPCS code L8030, are not payable if billed more than one unit per side within a two-year period.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Mutually exclusive respiratory assist devices are not payable when billed within the same date of service or within a month.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Replacement lens shield cartridges for use with laser skin piercing device, HCPCS code A4257, or skin piercing devices for collection of capillary blood, laser, each HCPCS code E0620 are not payable.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Home blood glucose monitors (HCPCS codes E0607, E2100, and E2101) are not payable when billed in any combination more than once on the same date of service by any provider.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Diabetic shoes are not payable when billed more than two units within a calendar year.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Therapeutic shoe inserts/modifications for diabetics only are not payable when billed more than six units within a calendar year.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Custom molded shoes (HCPCS code L3250) are not payable when billed with leg prostheses (HCPCS codes L5010-L5600).	1/01/2018 *Updated to include PPOMR effective 8/01/2022*
F, P	Durable Medical Equipment and Supplies Policy	Walker with enclosed frame (HCPCS code E0144) are not payable.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Durable Medical Equipment and Supplies Policy	Walker wheel attachment (HCPCS code E0155) is not payable when billed on the same day, or within one month of a new or used nonwheeled walker (E0130, E0135, E0148).	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Durable Medical Equipment and Supplies Policy	Oxygen accessories and supplies are not payable.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Underarm, articulating, spring assisted crutch (HCPCS code E0117) is not payable.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	90-day pharmacy dispensing fee (HCPCS code Q0514) is not payable when billed by any provider within 83 days of a previous 90-day dispensing fee.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	30-day pharmacy dispensing fee (HCPCS code G0333 or Q0513) are not payable when billed by any provider within 83 days of a previous 90-day dispensing fee (HCPCS code Q0514).	1/01/2018
P	Durable Medical Equipment and Supplies Policy	30-da, or 90-day pharmacy dispensing fees (HCPCS codes G0333, Q0513, or Q0514) are not payable when the inhalation drug is not billed on the same claim.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Limit frequency of inhalation drugs based on CMS guidelines.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Walker, heavy duty, multiple braking system, variable wheel resistance (HCPCS code E0147) is not payable when billed without modifier KX.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Prosthesis and orthosis codes are not payable when billed without modifiers LT (Left) or RT (Right).	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Adhesive tape supply codes (HCPCS codes A4450 or A4452) are not payable when billed without modifiers AU, AV, AW, or AX and other TENS supply codes (HCPCS codes A4364, A4455, A4456, A4555, A4556, A4558, A4630, L7362, L7366) are not payable when billed on the same date or during the same month as TENS supply code, HCPCS code A4595, by any provider.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Any combination of HCPCS codes B4081-B4083 (Nasogastric tubes) is not payable when billed by any provider more frequently than three tubes every three months.	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
P	Durable Medical Equipment and Supplies Policy	Oxygen systems (HCPCS codes E0425, E0430, E0435, E0440) are not payable when presented for purchase.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Durable Medical Equipment and Supplies Policy	Oxygen contents (HCPCS codes E0441-E0444, E0447, S8120, S8121) are not payable when billed the same day or within the same month of an oxygen system rental (HCPCS codes E0424, E0439, E1390, E1391) by any provider.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Portable oxygen delivery systems (HCPCS codes E0431, E0433, E0434, E1392, K0738) are not payable when billed more than once a month in any combination.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Subsequent hospital beds are not payable if billed more than once within a month.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Subsequent parenteral pumps (HCPCS codes B9004-B9006) are not payable if billed more than once within a month.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Nutritional additives (HCPCS codes B4164, B4180, B4168-B4178, B4216) are not payable when billed with premix formula (HCPCS codes B4189-B4199, B5000-B5200).	1/01/2018
P	Durable Medical Equipment and Supplies Policy	IV pole (HCPCS code E0776) and parenteral pumps (HCPCS codes B9004-B9006) are only payable when billed in the patient's home (POS 04, 12, 13, 14 and 55), temporary lodging (POS 16), or in a custodial care facility (POS 33).	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Enteral feeding kits (HCPCS codes B4034-B4036) are not payable when billed by any provider for more than 31 feeding kits within a month's time.	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
F, P	Durable Medical Equipment and Supplies Policy	Syringe enteral feeding kit (HCPCS code B4034) or Gravity fed enteral feeding kit (HCPCS code B4036) are not payable when billed by any provider on the same day or within one month of an enteral nutrition infusion pump (HCPCS code B9002).	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022* *Updated to include Facility claims effect. 12/01/2021*
P	Durable Medical Equipment and Supplies Policy	Disposable nebulizers (HCPCS code A7008) are not payable.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Only one crutch code (HCPCS codes E0110-E0116) are allowed per date of service.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Durable Medical Equipment and Supplies Policy	DME rentals for the same code are not payable when billed more than once within a month's time by any provider.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Capped rentals are not payable when billed by any DME provider in excess of 13 months within a 60-month time period.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Commode chair mobile or stationary (HCPCS codes E0163-E0171) are not payable when billed without modifier KX.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Speech generating software (HCPCS code E2511) is not payable when billed with other speech generating devices (HCPCS codes E2500-E2510).	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Large volume ultrasonic nebulizer (HCPCS code E0575) or reservoir bottle, non-disposable, used with large volume ultrasonic nebulizer (HCPCS code A7009) are not payable.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Deluxe feature, depth in-lay shoe or custom-molded shoe (HCPCS code A5508) or direct formed, compression molded inserts (HCPCS code A5510) are not payable.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Therapeutic shoe inserts/modifications for diabetics only (HCPCS codes A5503-A5507 or A5512-A5514) are not payable when billed with orthopedic footwear (HCPCS codes L3215-L3253).	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	Durable Medical Equipment and Supplies Policy	Therapeutic shoe inserts/modifications for diabetics only (HCPCS codes A5503-A5507 or A5512-A5514) are not payable when billed more than six units per calendar year	1/01/2018 *Updated to include Facility (HMOC, HMOMR, HMOMD) effective 11/16/2021* *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
F, P	Durable Medical Equipment and Supplies Policy	Orthopedic shoe inserts (HCPCS codes L3000-L3090), heel stabilizers (HCPCS code L3170), orthopedic shoe lift elevation per inch (HCPCS codes L3300-L3334), orthopedic shoe wedges (HCPCS codes L3340-L3420), orthopedic shoe additions (HCPCS codes L3430-L3595), and misc. orthopedic shoe, addition modification or transfer (HCPCS code L3649) are not payable when billed with diabetic footwear (HCPCS codes A5500 or A5501).	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*

Claim Type	Medical Policy	Rule Description	Effective Date
P	Durable Medical Equipment and Supplies Policy	Prosthesis code are not payable when billed with modifier K0 or KO.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Advanced knees, ankles and feet durable medical equipment codes without the required K0-K4 functional modifiers are not payable.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Durable Medical Equipment and Supplies Policy	Advanced knees, ankles and feet durable equipment codes reported with the inappropriate K0-K4 functional modifiers are not payable.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Test sockets are not payable when billed with immediate prostheses.	6/30/2020 *Updated to include Facility claims effect. 12/01/2021*
F, P	Durable Medical Equipment and Supplies Policy	Additions to the preparatory prosthesis are not payable.	6/30/2020 *Updated to include Facility claims effect. 12/01/2021*
P	Durable Medical Equipment and Supplies Policy	Orthopedic shoes, additions, or modifications are not payable when billed without modifier KX.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Pneumatic appliances (sleeves) are not payable when rented from the corresponding compressor that was paid for within the same month or the purchased (new or used) corresponding compressor that was also paid for within the same year by any provider.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	IV pole (HCPCS code E0776) is not payable when billed with ambulatory infusion pump codes (HCPCS codes E0779-E0781, E0784, K0455) and billed without parenteral infusion pump, stationary, single or multi-channel (HCPCS code E0791) by any provider.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Durable Medical Equipment and Supplies Policy	Prosthetic device repair labor service, HCPCS code L7520, is not payable when billed with replacement sockets/prostheses or with prosthetics billed with RA/RB modifiers.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Any DMEPOS billed with Modifier EY (No physician or other licensed health care provider order for this item or service) will not be paid.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Deny frequently serviced items and oxygen systems when presented for purchase, repair or replacement.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Skin protection and positioning wheelchair seat cushions, HCPCS codes E2607, E2608, E2624, or E2625 are not payable when billed without the requisite diagnosis criteria.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Durable Medical Equipment and Supplies Policy	Replacement sockets are not payable when billed with lower limb prosthesis or a preparatory lower limb prosthesis.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Durable Medical Equipment and Supplies Policy	Prosthetic repair labor services, HCPCS code L7520, is not payable when billed within 3 months of lower limb prostheses, HCPCS codes L5000-L5420, or preparatory lower limb prostheses, HCPCS codes L5500-L5600, upper limb prostheses, HCPCS codes L6000-L6370, L6388-L6550, L6900-L6915, L6920-L6975, or preparatory upper limb prostheses, HCPCS codes L6570-L6590.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Surgical dressings billed without modifiers A1-A9, or GY are not payable.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Surgical dressings are not payable when submitted multiple times with different wound modifiers (A1-A9) by any provider for the same dressing.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Durable Medical Equipment and Supplies Policy	Non-surgical dressing codes are not payable when appended with surgical dressing modifiers A1-A9.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Gauze, impregnated, water or normal saline, HCPCS codes A6228-A6230 are not payable.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Ocular prosthesis enlargement, HCPCS code V2625, is payable once every five years.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Limit ocular prosthesis reduction (V2626) to once every five years.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Sterile saline, HCPCS codes A4216/A4217, is not payable when billed with oropharyngeal suction catheter, HCPCS code A4628, or when a tracheal suction catheter, HCPCS codes A4605/A4624, has not been billed within the same month.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Diagnostic sockets, HCPCS codes L5618-L5628, are not payable when more than two are reported for the same date of service and same anatomical site.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Intermittent urinary catheters, HCPCS codes A4351-A4353 are not payable for more than 600 combined units per three months.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Indwelling catheters, HCPCS codes A4311-A4313, A4314-A4316, A4338-A4346 are not payable when reported for more than three units when billed in any combination within three months.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Durable Medical Equipment and Supplies Policy	External urinary catheters, HCPCS code A4326, A4327-A4328, A4349 are not payable when billed within the same month as an indwelling urinary catheter, HCPCS codes A4311-A4316, A4338-A4346.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Intermittent catheter, HCPCS code A4351/A4352, is not payable when billed with catheter insertion tray, HCPCS code A4310, and lubricant, HCPCS code A4332, by the same provider on the same date of service.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Durable Medical Equipment and Supplies Policy	Supplies are not payable when billed with a new tracheostomy care kit, HCPCS codes A4625.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Amino acid and carbohydrate parenteral nutrition compounds, HCPCS codes B4189-B4199, are not payable beyond a maximum of 31 units within a month's time.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Parenteral supply kits, HCPCS codes B4220 and B4222 are not payable beyond a maximum of 31 units within a month.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Tape, HCPCS codes A4450 and A4452, are not payable when billed by a DME provider without modifiers AU, AV, AW.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	30-day pharmacy dispensing fee codes, HCPCS code G0333 or Q0513, are not payable when billed more than once per month.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	HCPCS codes E2300 and E2301 are non-covered services.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Dual mode battery charger, HCPCS code E2367, is not payable.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Drainage bags, HCPCS code A4357, are not payable when billed individually or as part of the catheter change (HCPCS codes A4314-A4316, A4354), for more than six units within a three-month span.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Tape, HCPCS codes A4450 and A4452, are not payable when billed with modifier AU (Urological Supply) on the same day as a male external catheter (HCPCS codes A4326 or A4349).	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Battery for use with ventricular assist device, replacement [not lithium-ion], HCCPS codes Q0496 or Q0503, are not payable if billed more than once within a six-month span.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	VAD accessories are not payable when billed more than one unit per year, unless billed with modifier RA or RB.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Disposable home glucose monitor, HCPCS code A9275, is not payable. This is a convenience item that does not meet definition of DME.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Durable Medical Equipment and Supplies Policy	Replacement batteries for an owned external infusion pump, HCPCS codes A4602 or K0601-K0605 are not payable when billed on the same day or within the previous month of an infusion pump rental (HCPCS codes E0779, E0781, E0784, E0791, or K0455) by any provider.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Non-sealed lead acid battery, HCPCS codes E2358, E2360, E2362, E2364, E2372, are not covered.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Automatic external defibrillator (with integrated electrocardiogram analysis), HCPCS codes K0606 or E0617) are not payable when billed by a DME supplier without modifier KX.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Any code billed by a DME provider that is not a DME code will not be paid.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Ambulatory infusion pump, insulin (HCPCS code E0784) or insulin for administration through DME (HCPCS code J1817) is not payable when billed without modifier KX.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Power wheelchair accessories are not payable when billed with a manual wheelchair.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Manual wheelchair accessories are not payable when billed with a power wheelchair.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Claims for HCPCS codes L1810-L1860 (Knee orthosis), L2275, L2320, L2330, L2385, L2390-L2397, L2405-L2492, L2750, L2755, L2780-L2830, L2999, L4002, or L9900 (Orthotic additions) that are missing required modifiers KX, GA, or GZ will deny.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	Insulin infusion supplies (HCPCS code A4224) are not payable when billed with previously paid infusion set for external insulin pump (HCPCS code A4230 or A4231) within one month's time.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Any service billed with a DME rental modifier (BR, RR, KI, KJ, KR, LL) or a DME purchase modifier (BP, NU, UE) is not payable if the same code has previously been billed for the same date of service with either a DME rental modifier or a DME purchase modifier.	1/1/2018
F, P	Durable Medical Equipment and Supplies Policy	Skin barrier, wipes or swabs, each (HCPCS code A5120) or Ostomy skin barrier, liquid (HCPCS code A4369) are not payable when billed within the same month, by any provider.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Durable Medical Equipment (DME) repair is not payable when billed with a frequently serviced rental item appended with modifier RR.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Durable Medical Equipment and Supplies Policy	Services related to the uterus that are performed after a total hysterectomy has been performed by any provider are not payable.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Compounded inhalation solutions (HCPCS codes J7604, J7607, J7609, J7610, J7615, J7622, J7624, J7627, J7628, J7629, J7632, J7634, J7635, J7636, J7637, J7638, J7640, J7641, J7642, J7643, J7645, J7647, J7650, J7657, J7660, J7667, J7670, J7676, J7680, J7681, J7683, J7684, or J7685) are not payable when billed.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Pharmacy supply fees are not payable when oral anti-cancer, oral anti-emetic or immunosuppressive drugs are not billed on the same claim.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Sterile water/saline (HCPCS code A4217) or distilled water (HCPCS code A7018) is not payable when billed with HCPCS code E0580 (Nebulizer, durable, for use with regulator of flowmeter) by any provider.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Additions included in primary procedure are not payable when billed with a prefabricated or custom fabricated base orthosis.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	National Correct Coding Initiative (NCCI) column two codes are not payable when billed with column one code.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Orthotic accessories (HCPCS codes L4002-L4130, or L4392) are not payable when billed with ankle foot orthotic (AFO) or knee ankle orthotic (KAFO) when provided at the same time.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Subsequent home blood glucose monitors (HCPCS codes E0607, E2100, E2101) are not payable when billed in any combination more than once within a year by any provider.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Negative wound therapy pressure pump (HCPCS codes A6550, A7000 or E2402) are not payable if reported without modifier KX, GA, or GZ.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Electric heat pad, moist (HCPCS code E0215), water circulating heat pad with pump (HCPCS code E0217), pump for water circulating pad (HCPCS code E0236), or pad for water circulating heat unit, for replacement only (HCPCS code E0249) are not payable when billed.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Urological supplies (HCPCS codes A4310-A4328, A4332-A4360, A5102-A5114 or K1010-K1012) are not payable when billed without modifier KX.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Durable Medical Equipment and Supplies Policy	Ankle-foot orthosis/knee-ankle-foot orthosis (HCPCS codes L1900-L1990, L2000-L2038, L2106-L2136, L2180-L2850, L2999, L4350-L4387, L4396-L4398 or L4631) are not payable when billed by a DME provider and modifier GA, GZ or KX is not reported.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Group I, Group II, or Group III pressure reducing support surface devices are not payable when billed without modifier KX, GA, or GZ.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Commode chair mobile or stationary (HCPCS codes E0163-E0171) is not payable when billed without modifier KX, GA, or GZ.	1/01/2018
P	Durable Medical Equipment and Supplies Policy	DMEPOS items are not payable when billed by a DMEMAC provider and the place of service is not 01 (Pharmacy), 04 (Homeless shelter), 09 (Prison), 12 (Home), 13 (Assisted living facility), 14 (Group home), 16 (Temporary Lodging), 33 (Custodial care facility), 54 (Intermediate care facility/individuals with intellectual disabilities), 55 (Residential substance abuse treatment facility), 56 (Psychiatric residential treatment center), or 65 (End stage renal disease (ESRD) treatment facility (POS valid for parenteral nutritional therapy)).	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Orthotic or prosthetic base procedures are not payable when billed and the same procedure has been paid within the previous five years by any provider.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Therapeutic shoes/inserts/modifications for diabetics only (HCPCS codes A5500-A5507 or A5512-A5514) are not payable when billed without modifier KX or GY.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Diabetic footwear (A5500-A5501) are not payable when more than 2 units are billed within a calendar year	1/01/2018 *Updated to include Facility (HMOC, HMOMR, HMOMD) effective 11/16/2021* *Updated to include CNY, PPOC, PPOMR Effective 8/01/2022*
F, P	Durable Medical Equipment and Supplies Policy	HCPCS "Pair" codes are not payable when billed with modifier RT or LT.	1/01/2018 *Updated to include PPOC, PPOMR Effective 8/01/2022*

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Durable Medical Equipment and Supplies Policy	Capped rental HCPCS codes are not payable when billed without modifier RR.	1/01/2018 *Updated to include PPOC, PPOMR effective 8/01/2022*
F, P	Durable Medical Equipment and Supplies Policy	Osteogenesis stimulator (HCPCS codes E0747-E0748, E0760, E0766) are not payable when billed without modifier KF.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Prosthesis or orthosis codes are not payable when billed with modifier 50.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Catheter/tube anchoring device (HCPCS code A5200) is not payable when billed the same day or within a month of an indwelling catheter (HCPCS codes A4311-A4316, A4338-A4346) and enteral nutrition (HCPCS codes B4081-B4088, B4149-B4162) has not been billed.	1/01/2018
F, P	Durable Medical Equipment and Supplies Policy	Urological supplies (HCPCS codes A4310-A4328, A4332-A4360, A5102-A5114 or K1010-K1012) are not payable when billed without modifier GA, GY, GZ or KX.	1/01/2018
P	End Stage Renal Disease (ESRD) Policy	Hemodialysis (CPT codes 90935 and 90937) are not payable when billed by any provider more than three times weekly with Place of Service 11 (Office), 12 (Home), 16 (Temporary lodging), 19 (Outpatient hospital - off campus), 22 (Outpatient hospital-on campus), or 65 (End-Stage Renal Disease treatment facility).	1/01/2018
F, P	ENT Policy	Removal of impacted cerumen (CPT codes 69209, 69210 or HCPCS code G0268) are not payable when billed without a diagnosis of impacted cerumen.	1/01/2018
P	ENT Policy	Audiologic function tests (CPT codes 92561-92564, 92571-92572, 92575-92576) as non-covered services.	1/01/2018
F, P	Evaluation and Management Services Policy	Telephone evaluation and management service provided to an established patient (CPT/HCPCS 99441-99443) or (HCPCS G2010, G2012 or G2252) are not payable when an E/M service has been billed on the same day, previous seven days, or following day with the same primary diagnosis to the 3rd digit by the same group practice (same Tax ID, any specialty).	3/01/2022
P	Evaluation and Management Services Policy	Initial observation care codes (CPT codes 99218-99220) or codes that include the initial observation care (CPT codes 99234-99236) are not payable when an initial observation care code has been billed for the previous day by any provider.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Evaluation and Management Services Policy	Reimbursement for additional services considered part of the pediatric critical care inter-facility transport codes (CPT codes 99466-99467) and critical care codes (CPT codes 99291-99292) is not allowed.	1/01/2018
F, P	Evaluation and Management Services Policy	Reimbursement for services considered part of the pediatric critical care interfacility transport E/M, CPT code 99466, are not payable.	1/01/2018
F, P	Evaluation and Management Services Policy	Care management services (CPT codes 99487, 99489-99490, and HCPCS code G2058) are not payable when billed within the same calendar month and certain services have already been paid.	1/01/2018
F, P	Evaluation and Management Services Policy	Preventive medicine initial or periodic visits (CPT code 99382 or 99392) is not payable when billed in any combination more than seven times in a four-year period and the patient is between one and four years of age.	1/01/2018
F, P	Evaluation and Management Services Policy	Preventive medicine initial or periodic visits (CPT code 99381 or 99391) is not payable when billed in any combination more than eight times in one year and the patient is less than one year of age.	1/1/2018
F, P	Evaluation and Management Services Policy	Transitional Care Management (TCM) services (CPT codes 99495-99496) are not payable when billed within 29 days of another TCM service and a discharge service has not been billed in the previous 30 days by any provider.	1/01/2018
F, P	Evaluation and Management Services Policy	Transitional Care Management (TCM) services (CPT codes 99495-99496) are not payable when billed by any provider ID, within the same Tax ID and specialty, within 29 days of another TCM service.	1/01/2018
F, P	Evaluation and Management Services Policy	Certain services are not payable when billed within the same month as care management services (CPT codes 99487, 99489-99490, G2058).	1/01/2018
F, P	Evaluation and Management Services Policy	Transitional Care Management (TCM) services (CPT codes 99495-99496) are not payable when billed and a facility E/M service has not been billed by any provider for the same date of service or in the previous 30 days, unless POS 21 is reported with any service for the same day or in the previous 30 days.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Evaluation and Management Services Policy	Services such as monitoring vital signs, cardiac output evaluation, chest x-rays, pulse oximetry measurement, blood gas, ECGs, intubation, temporary pacing, ventilation oversight, and any required vascular access are considered part of pediatric critical care interfacility transport E/M, CPT code 99466, and are not separately payable.	1/01/2018
F, P	Evaluation and Management Services Policy	Reimbursement for additional services considered part of the pediatric critical care inter-facility transport codes (99466-99467) and critical care codes (99291-99292) are not allowed.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	Evaluation and Management Services Policy	Initial observation care codes (99218-99220) or codes that include the initial observation care (99234-99236) are not payable when an initial observation care code has been billed for the previous day by any provider.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Evaluation and Management Services Policy	Peak expiratory flow rate physician services, HCPCS code S8110, are considered a component of the E/M or overall physician service, unless a distinct services modifier is appended to either code.	1/01/2018
F, P	Evaluation and Management Services Policy	Hospital discharge services (99238-99239) are not payable when 99238 or 99239 has been billed the previous day.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	Evaluation and Management Services Policy	Outpatient/office consultation services, CPT codes 99241-99245, billed in the office setting are not payable when any other evaluation and management service has been billed in any place of service in the previous year.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	Evaluation and Management Services Policy	Second initial hospital care service (99221-99223) are not payable when subsequent hospital care (99231-99233), or another initial hospital care service has been billed in the previous week for the same place of service, and a discharge service (99238-99239) has not also been reported in the previous week.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Evaluation and Management Services Policy	New patient visits are not payable when any face-to-face service has previously been billed by the same physician or a physician from the same group practice (with the same specialty and subspecialty) within the last three years.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Evaluation and Management Services Policy	HCPCS G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) or Q0091 (Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) are not payable when billed with 99384-99387 or 99394-99397 (Preventive medicine visits) by the same physician.	1/01/2018
P	Evaluation and Management Services Policy	When multiple preventive medicine E/M services are billed for the same date of service, the preventive medicine E/M service with the lower RVU price will be denied.	1/01/2018
F	Evaluation and Management Services Policy	Deny evaluation and management codes with the lowest RVU price when multiple evaluation and management services are billed for the same date of service and same revenue code.	1/01/2018
P	Evaluation and Management Services Policy	EKG reports are not separately payable when billed with an E/M service in the hospital setting.	1/01/2018
F, P	Evaluation and Management Services Policy	Bilateral quantitative visual acuity screening test, CPT code 99173 is not payable when reported with routine ophthalmological examinations (HCPCS codes S0620 or S0621)	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Evaluation and Management Services Policy	HCPCS codes S0610-S0613 are not payable when billed with 99384-99387 or 99394-99397.	1/01/2018
P	Evaluation and Management Services Policy	E/M code with the lower RVU price is not payable, when multiple E/M services are billed for the same date of service, provider group and specialty, except when modifier 25 is appended to the additional E/M service.	1/01/2018
P	Evaluation and Management Services Policy	Problem-oriented E/M services are not payable when billed with preventive medicine services, unless the E/M service is billed with modifier 25.	1/01/2018
P	Evaluation and Management Services Policy	E/M services are not payable when billed the same date as electromyography, nerve conduction tests, or reflex tests.	1/01/2018
P	Evaluation and Management Services Policy	E/M services are not payable when billed the same date of service as cardiovascular services (93260-93261, 93282-93284, 93287, 93289, 93292).	1/01/2018
P	Evaluation and Management Services Policy	E/M services (99201-99215, 99221-99223, 99231-99233, 99460) are not separately payable when billed with critical care service (99291) and the place of service is the same, except when evaluation and management services (including critical care services) are appended with modifier 25.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Evaluation and Management Services Policy	New patient visit, or an initial care visit are not payable when billed in excess of one unit.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Evaluation and Management Services Policy	Observation care discharge service, CPT code 99217, is not payable when billed and 99218-99220 (Initial observation care admission service), 99224-99226 (Subsequent observation care) or a 0, 10 or 90-day global service has not been billed by any provider within the previous three days.	1/01/2018
F, P	Evaluation and Management Services Policy	Inpatient hospital consult (99251-99255) is not payable if any type of inpatient visit (initial inpatient admission, inpatient hospital consult, subsequent hospital care) has been billed in the previous week for the same place of service, and an inpatient discharge visit (99238-99239) has not also been billed. Refer to a subsequent inpatient visit (99231-99233)	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Evaluation and Management Services Policy	Any combination of 99477-99480 (Neonatal intensive care) is limited to one unit per date of service by any provider.	1/01/2018
F, P	Evaluation and Management Services Policy	Initial neonatal and pediatric critical care codes 99468, 99471, and 99475 are not payable when the patient has had inpatient critical care services the previous day. Refer to subsequent neonatal and pediatric critical care codes 99475 to 99469, 99472, and 99476.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	Evaluation and Management Services Policy	Initial neonatal intensive care service 99477 is not payable when reported within 24 hours of admission.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Evaluation and Management Services Policy	Any combination of 99468-99476 (Neonatal and pediatric critical care) is limited to one unit per date of service by any provider.	1/01/2018
P	Evaluation and Management Services Policy	G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) or Q0091 (Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) are not payable when billed with S0610-S0612 (Annual GYN exam) by the same physician.	1/01/2018
P	Evaluation and Management Services Policy	Evaluation and management services reported with modifier 25 (same code) are limited to one unit when reported by the same provider ID.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Evaluation and Management Services Policy	Observation services 99218-99220, 99224-99226, 99234-99236 are not payable when billed for more than one unit per date of service in any combination by any provider and the place of service is 19 (Outpatient hospital - off campus), 21 (Inpatient hospital), 22 (Outpatient hospital - on campus), 23 (Emergency department), 24 (Ambulatory Surgical Center).	1/01/2018
P	Evaluation and Management Services Policy	Hospital discharge services (99238-99239) are not payable when 99238 or 99239 has been billed for the same date of service.	1/01/2018
F, P	Evaluation and Management Services Policy	A new patient visit is not payable when billed by a non-physician practitioner and any face-to-face service has previously been billed by the same group practice (same Tax ID, any specialty) within the last three years and the primary diagnosis on the new patient visit matches any diagnosis on the previous face-to-face service.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Evaluation and Management Services Policy	CPT 99487, 99489-99491, G2058 (Care management services) are not payable when billed without a secondary diagnosis.	1/01/2018
F, P	Evaluation and Management Services Policy	Medication therapy management; initial 15 minutes, new patient (CPT 99605) is not payable if billed within one year of a previous for 99605 or 99606.	1/01/2018
P	Evaluation and Management Services Policy	Digital rectal examination (HCPCS code G0102) is not payable when billed with preventive medicine E/M codes (CPT codes 99381-99387, 99391-99397, G0402) or wellness visits (HCPCS codes G0438-G0439).	1/01/2018
F, P	Evaluation and Management Services Policy	Observation care discharge (CPT code 99217) or hospital discharge day management (CPT codes 99238-99239) are not payable when billed and observation or inpatient hospital care including admission and discharge on the same day (CPT codes 99234-99236) was billed the previous day.	1/01/2018
P	Evaluation and Management Services Policy	Interprofessional telephone/Internet consultation (CPT code 99446-99449, 99451) are not payable when billed and a diagnosis for health supervision or routine examination is present.	1/01/2018
F, P	Evaluation and Management Services Policy	Observation care discharge day (CPT code 99217) is not payable when billed with CPT codes 99221-99223 (Initial hospital care) on the same date of service by the same provider.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Evaluation and Management Services Policy	Direct contact prolonged physician service in the inpatient or observation setting (CPT code 99356) is not payable if billed outside of an inpatient or observation facility setting.	1/01/2018
P	Evaluation and Management Services Policy	Observation care discharge day (CPT code 99217) is not payable when an initial hospital care service (CPT codes 99221-99223) was billed the previous day.	1/01/2018
F, P	Evaluation and Management Services Policy	Initial hospital or birthing center care code (CPT code 99460) is not payable when the newborn has received initial or subsequent newborn care services the previous day.	1/01/2018
F, P	Evaluation and Management Services Policy	Initial hospital or birthing center care, per day for evaluation and management of normal newborn infant admitted and discharged on same date (CPT code 99463) is not payable when billed and the newborn has previously received newborn care services the previous day.	1/01/2018
P	Evaluation and Management Services Policy	Initial care, per day, for evaluation and management of normal newborn infant seen in other than hospital or birthing center (CPT code 99461) is not payable when billed and the newborn has previously received newborn care services the previous day.	1/01/2018
F, P	Evaluation and Management Services Policy	Preventive medicine services are not payable when the problem-oriented E/M service has been previously processed for payment and modifier 25 was not reported.	1/01/2018
P	Evaluation and Management Services Policy	In accordance with CMS, complexity add-on code G2211 is not payable when reported with the outpatient/office Evaluation and Management visit (Codes 99202, 99205, 99211-99215) with payment modifier 25.	1/1/2024

Claim Type	Medical Policy	Rule Description	Effective Date
P	Evaluation and Management Services Policy	CPT Code 99459 is not payable when billed with Preventive medicine visits (CPT codes 99391-99397) or illness-related E/M services (CPT codes 99211-99215). CPT code 99459 was published by the American Medical Association (AMA) to report, "Pelvic examination (List separately in addition to code for primary procedure)." The AMA published this code as an add-on code to be used in conjunction with illness-related office Evaluation and Management (E/M) codes and preventive services E/M codes. It is intended to account for four minutes of staff time spent chaperoning a pelvic exam. The practice expense relative value unit (RVU) of existing E/M codes, both illness-related E/M codes (99211-99215) and preventive services E/M codes, accounts for clinical staff time. It is not consistent with RVU pricing to separate the staff time spent chaperoning a pelvic exam from other staff time included in E/M services. Therefore, the payment for CPT code 99459 is considered to be included for both preventive E/M Services and illness-related E/M services. No separate payment will be made and 99459 will deny.	1/1/2024
F, P	Female Only Diagnosis Codes	Identifies claims containing diagnoses that are inconsistent with the member's gender	1/01/2018
P	Fragmented Procedures Policy	Procedures identified as a separate component of a more comprehensive procedure or service are not payable when submitted and review of the current claim or history claim determines another component code within the same family of codes was also billed and paid for the same date of service by the provider.	All PPO 1/01/2022 HMOMR and HMOC 03/17/2021 HMOMD 10/01/2021
P	Frequency Policy	Care plan oversight and care coordination services are not payable when billed within the same calendar month of a monthly ESRD services code.	1/01/2018
F, P	Frequency Policy	HCPCS G0179 Physician recertification for home health services is not payable if billed more than once every two months.	1/01/2018
P	Frequency Policy	Non-Pre-Diabetic Screening Services: Diabetes screening tests are not payable with a diagnosis of screening for diabetes mellitus when billed more than once every year.	6/30/2020
F, P	Frequency Policy	Cardiovascular disease screening laboratory services with a screening diagnosis are not payable when billed more than once within a five-year period.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Frequency Policy	Nursing assessment evaluations are not payable when billed more than once a month.	1/01/2018
P	Frequency Policy	CPT 80305-80307 (Presumptive drug testing) is not payable when billed more than one combined unit per day.	1/01/2018
P	Frequency Policy	HCPCS G0480-G0483, G0659 (Definitive drug testing) are not payable when billed more than one combined unit per day.	1/01/2018
F, P	Frequency Policy	Chiropractic manipulative treatment (CPT codes 98940-98942) are not payable when billed more than once per day, when billed by any provider.	1/01/2018
F, P	Frequency Policy	Care plan oversight and care coordination services are not payable when billed within the same calendar month of a monthly ESRD services code.	1/01/2018
P	Gastroenterology Policy	CPT 43264 (Endoscopic retrograde removal of calculus/calculi from biliary and/or pancreatic duct[s]) is not payable when billed with 43274-43276 (Endoscopic retrograde cholangiopancreatography [ERCP] with placement of stent; removal of stent or foreign body; stent exchange; balloon dilation).	1/01/2018
F, P	Gastroenterology Policy	CPT 45335 (Sigmoidoscopy, flexible; with directed submucosal injection(s)) is not payable when billed with 45333, 45338, or 45346 (Sigmoidoscopy, flexible).	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
F, P	Gastroenterology Policy	CPT 45381 (Colonoscopy, flexible; with injection(s)) is not payable when billed with 45383-45385, 45388, or G6024 (Colonoscopy).	1/01/2018 *Updated to include CNY effective 8/01/2022*
F, P	Gender-Procedure Codes	Identifies claim lines containing Procedure Codes that are inconsistent with the member's gender.	1/01/2018
F, P	General Surgery Policy	Incision and drainage of pilonidal cyst (CPT codes 10080-10081) or excision of pilonidal cyst or sinus (CPT codes 11770-11772) are not payable when billed without a diagnosis of pilonidal cyst or pilonidal sinus on the claim.	1/01/2018
P	General Surgery Policy	CPT 10080-10081 (Incision and drainage of pilonidal cyst) or 11770-11772 (Excision of pilonidal cyst or sinus) are not payable when billed without a diagnosis of pilonidal cyst or pilonidal sinus on the claim.	1/01/2018
P	General Surgery Policy	CPT 15850 or 15851 (Removal of sutures under anesthesia [other than local]) is not payable when the patient's age is greater than 12 years.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	General Surgery Policy	Proctosigmoidoscopy (CPT codes 45300, 45303, 45317), or sigmoidoscopy (CPT codes 45330, 45334) are not payable when billed with partial or total colectomy (CPT codes 44140-44160) or laparoscopic partial or total colectomy (CPT codes 44204-44213).	1/01/2018
F, P	Genetic Testing Policy	Molecular pathology procedure; physician interpretation and report (HCPCS code G0452) is not payable when billed without modifier 26.	1/01/2018
F, P	Global Component	Identifies claim lines for which the sum of all payments (total, professional, technical) exceeds the payment expected for the total procedure. This rule will also detect when duplicate submissions have occurred for the total procedure or its components, across providers. The following scenarios are audited: • Global vs. Global • Global vs. Professional • Global vs. Technical • Professional vs. Global • Technical vs. Global • Professional vs. Professional • Technical vs. Technical Auditing could vary based upon a Facility or Non-facility claim.	2018
P	Global Obstetrical Policy	Subsequent billings of antepartum care only codes (CPT code 59425 or 59426) is not payable when either code has been previously billed.	1/01/2018
P	Global Obstetrical Policy	Global delivery codes are not payable when the provider has billed antepartum care in the last eight months.	1/01/2018
P	Global Obstetrical Policy	Subsequent delivery codes are not payable if more than one delivery code is billed for the same date of service or within the previous six months by any provider or specialty.	1/01/2018
P	Global Obstetrical Policy	Separate reimbursement for those services which are included in the global obstetrical package for uncomplicated maternity cases are not payable when billed on the same day as the delivery.	1/01/2018
P	Global Obstetrical Policy	Global delivery codes are not payable when a different provider group has billed for antepartum care only services in the last eight months.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Global Obstetrical Policy	Cerclage removal as included in the delivery fee, when the removal of a cerclage (CPT code 59871) is not payable when billed on the same date of service as the delivery code.	1/01/2018
F, P	Global Obstetrical Policy	Global delivery codes are not payable when a different provider group has billed for antepartum care only services in the last eight months.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Global Obstetrical Policy	Cerclage removal (59871) is not separately payable when billed on the same date of service as the delivery code.	1/01/2018
P	Global Obstetrical Policy	Services which are included in the global obstetrical package for uncomplicated maternity cases are not separately payable when billed on the same day as the delivery.	1/01/2018
F, P	Global Obstetrical Policy	Subsequent delivery codes are not payable if more than one delivery code is billed for the same date of service or within the previous six months by any provider or specialty.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Global Obstetrical Policy	Global delivery codes including antepartum care is not payable if the provider has billed antepartum care in the last eight months.	1/01/2018
F, P	Global Obstetrical Policy	Subsequent billings of antepartum care only codes (59425 or 59426) are not payable when either code has been previously billed.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Global Obstetrical Policy	E/M services or postpartum care are not payable when billed within 42 days (6 weeks) by the same Tax ID and specialty that performed a delivery that includes postpartum care.	1/01/2018
P	Global Obstetrical Policy	Antepartum care services for a normal pregnancy are not payable when billed for the same date of service or within 240 days (8 months) prior to the date of a delivery that includes antepartum care.	1/01/2018
F, P	Global Obstetrical Policy	Antepartum services billed with a date of service up to one week following a previous delivery is not payable.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*

Claim Type	Medical Policy	Rule Description	Effective Date
P	Global Obstetrical Policy	Evaluation and Management services are not payable when billed five months after the billing of antepartum only services and the diagnosis is normal pregnancy and there is no intervening history of ectopic pregnancy (59100-59151) or abortion (59812-59857, S0199, S2260, S2265-S2267).	1/01/2018
P	Global Obstetrical Policy	C-section delivery (CPT codes 59510-59515, 59618-59622) are not payable when billed more than once for the same date of service by any provider and the diagnosis is multiple gestation.	1/01/2018
P	Global Obstetrical Policy	Global package via vaginal delivery (CPT code 59400) is not payable when billed with global package via cesarean delivery (CPT code 59510) and the diagnosis is multiple gestation.	1/01/2018
P	Global Obstetrical Policy	Second global package via vaginal delivery (CPT code 59400) is not payable when billed with another global package via vaginal delivery (CPT code 59400) and the diagnosis is multiple gestation.	1/01/2018
P	Global Obstetrical Policy	Routine vaginal birth after cesarean (CPT code 59610) is not payable when billed with global cesarean delivery procedure (CPT code 59618) and the diagnosis is multiple gestation.	1/01/2018
F, P	Global Obstetrical Policy	Global package via vaginal delivery (CPT code 59400) is not payable when billed with global package via cesarean delivery (CPT code 59510) and the diagnosis is NOT multiple gestation.	1/01/2018
P	Global Obstetrical Policy	Second global vaginal delivery procedure (CPT code 59610) is not payable when the diagnosis is multiple gestation.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Global Obstetrical Policy	The following Category II CPT Codes must be included on a claim for each prenatal/postpartum service provided to a NYS Medicaid member when the provider is billing using global obstetric codes: 0500F (Initial Prenatal Visit), 0502F (Subsequent Prenatal Visit) or 0503F (Postpartum visit) for each corresponding visit provided to the patient within the obstetric global period being billed (see example below). *Claims submitted without the appropriate Category II CPT codes will be denied*. Example: Member with 8 prenatal visits, 1 post-partum visit, and 1 routine vaginal delivery would be reported: • 1 unit CPT 59400 • 1 unit of CPT 0500F • 7 units of CPT 0502F • 1 unit of CPT 0503F	4/15/2025
P	Global Surgery Policy	Daily management of epidural or subarachnoid drug administration (CPT code 01996) is not payable when billed with a 0-day, 10-day or 90-day surgical procedure.	1/01/2018
P	Global Surgery Policy	0-day, 10-day or 90-day surgical procedures with modifier 47 or P1-P6 are not payable when the same procedure has also been billed without modifier 47 or P1-P6.	1/01/2018
P	Global Surgery Policy	Evaluation and management services are not payable performed within 10 postoperative days of a 10-day medical or surgical service billed by the same Provider ID regardless of Tax ID and Specialty.	1/01/2018
P	Global Surgery Policy	Evaluation and management services are not payable when billed with modifier 25 on the same day as a procedure with a 0-day, 10-day, or 90-day postoperative period with the same primary diagnosis when also billed within 2 months of a face-to-face service with the same diagnosis.	1/01/2018
P	Global Surgery Policy	Evaluation and management services are not payable when billed with modifier 25 on the same day as a procedure with a 0-day, 10-day, or 90-day postoperative period with the same primary diagnosis when also billed within 2 months of a face-to-face service with the same diagnosis.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Global Surgery Policy	Care management services (CPT codes 99487-99491 and HCPCS codes G2058, G2064-G2065) or transitional care management services (CPT codes 99495-99496) are not payable when performed within 10 postoperative days of a 10-day medical or surgical service (CMS).	1/01/2018
P	Global Surgery Policy	Procedure codes with 0, 10 or 90-day global surgery periods billed with modifier 47 or P1-P6 are not payable when the same procedure has also been billed without modifier 47 or P1-P6 (CMS).	1/01/2018
P	Global Surgery Policy	CPT 01996 (Daily management of epidural or subarachnoid drug administration) is not payable when billed with a 0-day, 10-day or 90-day surgical procedure (CMS).	1/01/2018
F	Global Surgery Policy	Evaluation and management services are not payable when billed the same day as a medical or surgical service by an Outpatient Facility. (CMS-1450)	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
P	Global Surgery Policy	Evaluation and management services are not payable when billed on the same day as a 0-day medical or surgical service.	1/01/2018
P	Global Surgery Policy	Evaluation and management services are not payable when performed the same day as a 10-day medical or surgical service.	1/01/2018
P	Global Surgery Policy	Evaluation and management services are not payable performed within 10 postoperative days of a 10-day medical or surgical service element.	1/01/2018
P	Global Surgery Policy	Evaluation and management services are not payable when performed the day prior to a 90-day medical or surgical service.	1/01/2018
P	Global Surgery Policy	Evaluation and management services are not payable when performed the same day as a 90-day medical or surgical service.	1/01/2018
P	Global Surgery Policy	Evaluation and management services are not payable when performed within 90 postoperative days of a 90-day medical or surgical service.	1/01/2018
P	Global Surgery Policy	0, 10 or 90-day surgical procedures are not payable when performed within 90 days of a 90-day surgical procedure.	1/01/2018
P	Global Surgery Policy	Separate reimbursement for services typically considered part of a minor 10-day surgical procedure (CMS + Cotiviti Supplement).	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Global Surgery Policy	Deny separate reimbursement for services typically considered part of a major 90-day surgical procedure (CMS + Cotiviti Supplement).	1/01/2018
P	Global Surgery Policy	Evaluation and management services when performed the same day as a 90-day medical or surgical service are not payable when billed by the same Provider ID, regardless of Tax ID and Specialty.	1/01/2018
P	Global Surgery Policy	Evaluation and management services are not payable when performed within 90 postoperative days of a 90-day medical or surgical service when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of Provider ID and Specialty, and the E/M service has a primary diagnosis associated to the 90-day medical or surgical service (CMS).	1/01/2018
P	Global Surgery Policy	Evaluation and management services are not payable when performed within 90 postoperative days of a 90-day medical or surgical service when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of Provider ID and Specialty, and the diagnosis is a complication of surgical and medical care or an aftercare diagnosis (CMS).	1/01/2018
P	Global Surgery Policy	Evaluation and management services are not payable when performed within 10 postoperative days of a 10-day medical or surgical service when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of Provider ID and Specialty, and the E/M service has a primary diagnosis associated to the 10-day medical or surgical service (CMS).	1/01/2018
P	Global Surgery Policy	Evaluation and management services are not payable when performed within 10 postoperative days of a 10-day medical or surgical service when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of Provider ID and Specialty, and the diagnosis is a complication of surgical and medical care or an aftercare diagnosis (CMS).	1/01/2018
P	Global Surgery Policy	Evaluation and management services are not payable when billed with modifier 24 and a major surgical procedure with a 90-day postoperative period has been billed in the previous 90 days and the E/M service has a primary diagnosis associated to the 90-day medical or surgical service. (CMS + Cotiviti Supplement)	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Global Surgery Policy	Evaluation and management services are not payable when billed with modifier 24 and a major surgical procedure with a 90-day postoperative period has been billed in the previous 90 days and the E/M diagnosis is a complication of surgical and medical care or an aftercare diagnosis. (CMS + Cotiviti Supplement)	1/01/2018
P	Global Surgery Policy	Evaluation and management services are not payable when billed with modifier 24 and a minor surgical procedure with a 10-day postoperative period has been billed in the previous 10 days and the E/M service has a primary diagnosis associated to the 10-day medical or surgical service. (CMS + Cotiviti Supplement)	1/01/2018
P	Global Surgery Policy	Evaluation and management services are not payable when billed with modifier 24 and a minor surgical procedure with a 10-day postoperative period has been billed in the previous 10 days and the E/M diagnosis is a complication of surgical and medical care or an aftercare diagnosis. (CMS + Cotiviti Supplement)	1/01/2018
P	Global Surgery Policy	Supplies are not payable if billed on the same date of service as a 0-day, 10-day, or 90-day surgical procedure.	1/01/2018
P	Global Surgery Policy	Evaluation and management services performed within 90 postoperative days of a 90-day medical or surgical service is not payable when billed by the same Provider ID, regardless of Tax ID and Specialty.	1/01/2018
P	Global Surgery Policy	Evaluation and management services are not payable when performed the day prior to a 90-day medical or surgical service and billed by the same Provider ID, regardless of Tax ID and Specialty.	1/01/2018
P	Global Surgery Policy	0-day and 10-day surgical procedures performed within 10 postoperative days of a 10-day surgical procedure are not payable when submitted by the same provider ID, regardless of Tax ID and Specialty.	1/01/2018
P	Global Surgery Policy	Evaluation and management services when performed the same day as a 10-day medical or surgical service for the same Provider are not payable when submitted with any Tax Group or Specialty.	1/01/2018
P	Global Surgery Policy	0, 10 or 90-day surgical procedures billed by the same provider ID, regardless of Tax ID and Specialty within 90 days of a 90-day surgical procedure are not payable.	1/01/2018
P	Global Surgery Policy	Evaluation and management services when performed the same day as a 0-day medical or surgical service are not payable when billed by the same Provider ID, regardless of Tax ID and Specialty.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Healthplan Policy	Covid-19 specimen collection services (HCPCS codes G2023 and G2024) are considered integral to the performance of Covid testing. As such, the separate reimbursement is not warranted when a Covid is rendered.	3/1/2020
P	Healthplan Policy	CPT 99174 1 unit in 12-month period. Exception: Hospital, Ophthalmologist, Optometrist, Neurology, and Pediatric Neurology.	1/01/2018
P	Healthplan Policy	G0471 (Collection of venous blood by venipuncture or urine sample by catheterization from an individual in a skilled nursing facility (SNF) or by a laboratory on behalf of a home health agency (HHA)) is not payable when billed in Place of Service 11, 19, 21, 22, 23, or 24	1/01/2018
P	Healthplan Policy	In accordance with our policy, colonoscopies, sigmoidoscopies, and proctosigmoidoscopies are only covered with specific indications. Please refer to our policy for additional details- Colonoscopy Procedures-EmblemHealth	1/01/2018
P	Healthplan Policy	Procedure codes with a CMS Physician Fee schedule indicator of "B" are considered bundled services that are mutually exclusive to other services performed on the same day and are not separately payable under any circumstance.	1/01/2018
P	Healthplan Policy	COVID-19 specimen collection services (HCPCS codes G2023 and G2024) are considered integral to the performance of COVID testing. As such, the separate reimbursement is not warranted when a COVID test is rendered.	3/1/2020
P	Healthplan Policy	Change 36410 (Venipuncture, age 3 years or older, necessitating physician's skill [separate procedure], for diagnostic or therapeutic purposes [not to be used for routine venipuncture]) to 36415 (routine venipuncture) when billed without a covered diagnosis.	1/1/2018 *Terminated for Medicare effective 9/24/2023*
P	Inappropriate Age Code Use Policy	Procedures with an age/age range designation are not payable when submitted and the member's age does not correspond with the age/age range of the procedure.	1/01/2022
P	Inappropriate Age Code Use Policy	Diagnosis codes with an age/age range designation are not payable when submitted and the member's age does not correspond with the age/age range of the diagnosis code.	1/01/2022

Claim Type	Medical Policy	Rule Description	Effective Date
P	Inappropriate Use of Modifier Policy	Procedures that are submitted with modifier 26, 50 or TC and are designated as professional, bilateral or technical component as “not permitted for this procedure” or “concept does not apply” are not payable per the Payment Indicators within the CMS Medicare National Physician Fee Schedule Relative Value File (NPFSRVF).	All PPO 1/01/2022 HMOMR and HMOC 03/17/2021 HMOMD 10/01/2021
P	Inappropriate Use of Modifier Policy	Procedures that are not designated for telehealth/telemedicine are not payable when submitted with modifiers G0, GQ, GT, or 95.	1/01/2022
P	Incident To Services Policy	An "incident to" services are not payable when billed with a place of service code 02, 19, 21, 22, 23, 24, 26, 31, 34, 41, 42, 51, 52, 53, 56, or 61.	1/01/2018
P	Incident To Services Policy	Procedures designated as an "incident to" service are not payable when billed with a place of service code 02, 19, 21, 22, 23, 24, 26, 31, 34, 41, 42, 51, 52, 53, 56, or 61.	1/01/2018
P	Interprofessional Telephone/Internet Consultations	CPT codes 99446-99449, or 99451 (Interprofessional telephone/Internet consultation) are not payable when billed and any face-to-face service has been billed on the same date or within the previous 14 days.	1/26/2021
P	Interprofessional Telephone/Internet Consultations	CPT codes 99446-99449, or 99451 (Interprofessional telephone/Internet consultation), in any combination, are limited to one unit within seven days.	1/26/2021
F	Invalid Revenue Code/ Procedure Code Combination	Claims submitted with invalid HCPCS/CPT and Revenue code combinations are not payable and will be denied	10/1/2022
F, P	Laboratory-Pathology Policy	Any procedure billed with modifier QW (CLIA waived test) not designated as a CLIA waived test on the clinical laboratory fee schedule is not payable.	1/01/2018
P	Laboratory-Pathology Policy	Supplies (e.g. urine dipsticks for glucose or ketones, syringes, alcohol wipes, betadine or iodine swabs etc) are inherent to a laboratory Service when the supply must be routinely available for performance of the reported service.	1/1/2018
F, P	Laboratory-Pathology Policy	Surgical pathology gross & microscopic exam (CPT code 88305, 88307, or 88309) is not payable when the only diagnosis on the claim line is a hemorrhoid diagnosis code.	1/01/2018
F, P	Laboratory-Pathology Policy	Surgical pathology gross & microscopic exam (CPT code 88305, 88307, or 88309) is not payable when the only diagnosis on the claim line is a hydrocele or spermatocele diagnosis code.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Laboratory-Pathology Policy	Surgical pathology gross & microscopic exam (CPT code 88307, or 88309) is not payable when the only diagnosis on the claim line is polyp of stomach and duodenum.	1/01/2018
F, P	Laboratory-Pathology Policy	Surgical pathology gross & microscopic exam (CPT code 88305, 88307, or 88309) is not payable when the only diagnosis on the claim line is a cornea diagnosis code.	1/01/2018
F, P	Laboratory-Pathology Policy	Surgical pathology gross & microscopic exam (CPT code 88305, 88307, or 88309) is not payable when the only diagnosis on the claim line is ganglion cyst.	1/01/2018
F, P	Laboratory-Pathology Policy	Surgical pathology gross & microscopic exam (CPT code 88305, 88307, or 88309) is not payable when the only diagnosis on the claim line is an appendix diagnosis code.	1/01/2018
F, P	Laboratory-Pathology Policy	Surgical pathology gross & microscopic exam (CPT code 88305, 88307, or 88309) is not payable when the only diagnosis on the claim line is a gallbladder diagnosis code.	1/01/2018
P	Laboratory-Pathology Policy	Surgical pathology gross & microscopic exams (88305, 88307, or 88309) are not payable when the only diagnosis on the claim line is a gallbladder diagnosis code	1/01/2018
P	Laboratory-Pathology Policy	Surgical pathology gross & microscopic exams (88305, 88307, or 88309) are not payable when the only diagnosis on the claim line is an appendix diagnosis code	1/01/2018
P	Laboratory-Pathology Policy	Surgical pathology gross & microscopic exams (88305, 88307, or 88309) are not payable when the only diagnosis on the claim line is a ganglion cyst diagnosis code	1/01/2018
P	Laboratory-Pathology Policy	Surgical pathology gross & microscopic exams (88305, 88307, or 88309) are not payable when the only diagnosis on the claim line is a cornea diagnosis code	1/01/2018
P	Laboratory-Pathology Policy	Surgical pathology gross & microscopic exams (88305, 88307, or 88309) are not payable when the only diagnosis on the claim line is a polyp diagnosis code	1/01/2018
P	Laboratory-Pathology Policy	Surgical pathology gross & microscopic exams (88305, 88307, or 88309) are not payable when the only diagnosis on the claim line is a hydrocele or spermatocele diagnosis code	1/01/2018
P	Laboratory-Pathology Policy	Surgical pathology gross & microscopic exams (88305, 88307, or 88309) are not payable when the only diagnosis on the claim line is a hemorrhoid diagnosis code	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Laboratory-Pathology Policy	Modifier QW (CLIA waived test) is not payable when billed with a procedure code that is not designated as a CLIA waived test on the clinical laboratory fee schedule.	1/01/2018
P	Laboratory-Pathology Policy	Travel allowance one way in connection with medically necessary laboratory specimen (HCPCS codes P9603 or P9604) are not payable when billed without a specimen collection code.	1/01/2018
P	Laboratory-Pathology Policy	Supplies (e.g. urine dipsticks for glucose or ketones, syringes, alcohol wipes, betadine or iodine swabs etc) are inherent to a laboratory service when the supply must be routinely available for performance of the reported service.	1/01/2018
F, P	Laboratory-Pathology Policy	CPT code 86769 (Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)) is not payable when billed with 0224U (Antibody; severe acute respiratory syndrome coronavirus 2, includes titer(s), when performed) by any provider.	2/01/2022
F, P	Laboratory-Pathology Policy	CPT code U0004 (COVID-19 lab test non-CDC high throughput) is not payable when billed with U0002 (COVID-19 lab test non-CDC) by any provider.	2/01/2022
F, P	Laboratory-Pathology Policy	Nucleic-acid based SARS-CoV-2 viral tests (CPT codes 87631, 87635-87637, 87811, 0240U, 0241U, U0001, and U0003) will be limited to one unit per day, unless reported with modifier 59, by any provider.	2/01/2022
F, P	Laboratory-Pathology Policy	CPT code U0003 (COVID-19 infectious agent detection by nucleic acid, high throughput) is not payable when billed with 87635 (COVID-19 Infectious agent detection by nucleic acid) by any provider.	2/01/2022
F, P	Laboratory-Pathology Policy	CPT code 0224U (Antibody; severe acute respiratory syndrome coronavirus 2, includes titer(s)) is not payable when billed and 86769 (Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) has been previously billed and paid on the same date of service by any provider.	2/01/2022
F, P	Laboratory-Pathology Policy	CPT code U0002 (Covid-19 lab test non-CDC) is not payable when billed and U0004 (Covid-19 lab test non-CDC high throughput) has been previously billed and paid on the same date of service by any provider.	2/01/2022
F, P	Laboratory-Pathology Policy	CPT code 87635 (COVID-19 Infectious agent detection by nucleic acid) is not payable when billed and U0003 (COVID-19 infectious agent detection by nucleic acid, high throughput) has been previously billed and paid on the same date of service by any provider.	2/01/2022

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Laboratory-Pathology Policy	Surgical pathology gross & microscopic exam (88304, 88305, 88307 or 88309) are not payable when the only diagnosis on the claim line is an encounter for sterilization (Z30.2).	3/15/2023
F, P	LCD_PXDX_FREQ_MULTIDX	Identifies Professional and Outpatient Facility claim lines for certain procedure codes associated with a single diagnosis code/multiple diagnosis codes or no diagnosis code, modifier, age and frequency requirement where the procedure is not considered medically necessary, payable, or has payment constraints according to Local Coverage Determinations (LCDs). LCD's applicable to Connecticut, Massachusetts and New York are posted and maintained by NGS Medicare at the Medical Policy Center. https://www.ngsmedicare.com/	10/01/2021
F, P	LCD_MED_NEC_ICD10	Identifies Professional and Outpatient Facility claim lines for certain procedure codes associated with diagnoses where the procedure is not considered medically necessary, payable, or has payment constraints according to Part A and Part B Local Coverage Determinations (LCDs). LCD's applicable to Connecticut, Massachusetts and New York are posted and maintained by NGS Medicare at the Medical Policy Center. https://www.ngsmedicare.com/	10/01/2021
F, P	Male Only Diagnosis Codes	Identifies claims containing diagnoses that are inconsistent with the member's gender.	1/01/2018
F, P	Manifestation Diagnosis Codes	All services received with a manifestation diagnosis code as the only diagnosis or billed as primary, first listed or principal diagnosis position are not payable.	8/31/2021
P	Maximum Units Policy	Codes billed for a number of units that exceeds the allowed number of units are not payable.	9/29/2020

Claim Type	Medical Policy	Rule Description	Effective Date
P	Maximum Units Policy	Claims for a certain number of units that exceed the annual assigned allowable unit(s) for that procedure and the same member are not payable.	1/01/2018
P	Maximum Units Policy	As per the ICD manual, Maternal Fetal Medicine services 59000, 59020, 74713, 76802, 76810, 76812, 76814, 76816, 76818-78621, or 76825-76828 are payable based on diagnosis.	1/01/2018
P	Maximum Units Policy	Surgeries that allow multiple assistant surgeons are not payable when billed by same or different provider.	1/01/2018
P	Maximum Units Policy	Units of service greater than 1 are not payable when billed by any provider for a code with an anatomical modifier (E1-E4, FA-F9, TA-T9).	1/01/2018
P	Maximum Units Policy	Procedures are not payable when the same provider bills a certain number of units of team surgery or co-surgery that exceed the daily assigned allowable unit(s) for that procedure for the same member.	1/01/2018
P	Maximum Units Policy	As per the ICD-10 Manual, Obstetrical procedure codes 74713, 76802, 76810, 76812, 76814 are not payable when billed without the requisite diagnosis.	1/01/2018
P	Maximum Units Policy	"Certain procedures based on the code description or code guidelines, regardless of appended modifier, are limited to one unit per day. (CMS-1500)	1/01/2018
F, P	Maximum Units Policy	Excess units are not payable when any provider bills a certain number of units that exceed the daily assigned allowable unit(s) for that procedure for the same member.	1/01/2018
P	Maximum Units Policy	Excess units are not payable when any provider bills a certain number of units that exceed the annual assigned allowable unit(s) for that procedure for the same member.	1/01/2018
P	Medicaid - New York State Policy	According to New York Medicaid coding guidelines, CDT D1206 or CPT 99188 (Topical application of fluoride varnish) is limited to one unit in a three-month period when billed by any provider for a patient between six months and six years of age.	10/20/2019
P	Medicaid - New York State Policy	CPT 91110 (Gastrointestinal tract imaging, intraluminal [e.g. capsule endoscopy], esophagus through ileum) is not payable when billed and the only diagnosis on the claim is hematemesis.	1/01/2018
P	Medicaid - New York State Policy	According to New York Medicaid, CPT 59400-59410 (Vaginal Delivery), 59510-59515 (Cesarean Delivery) or 59610-59622 (VBAC Delivery) are not payable when billed without modifier U7, U8, or U9	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Medicaid - New York State Policy	CPT 91110 (Gastrointestinal tract imaging, intraluminal [e.g. capsule endoscopy], esophagus through ileum) is not payable when billed without a requisite diagnosis.	11/1/2024
P	Medicaid - New York State Policy	According to New York Medicaid guidelines, durable medical equipment, orthotics, prosthetics and supplies (DMEPOS) have been assigned a maximum number of units that may be billed regardless of the provider within a designated time frame. When the total number of billed units exceed the assigned number allowed, the units will be adjusted to match the assigned allowed units and the excess units will be denied when billed by any provider.	9/13/2023
P	Medicaid - New York State Policy	According to New York Medicaid guidelines, modifier RB (Replacement of part of a DME, orthotic or prosthetic item furnished as part of a repair) is not required when a code is available for a specific replacement part. Therefore, codes indicated as replacement parts will be denied when appended with modifier RB.	10/15/2024
P	Medicaid - New York State Policy	According to New York Medicaid guidelines, allergy testing, when billed by a provider specialty of alternative medicine, audiology, chiropractor, home health, nurse practitioner, physician assistant, midwife, occupational therapy, optometry, physical therapy, speech therapy or psychology, is not payable and will be denied.	10/15/2024
F, P	Medicaid - New York State-Home Health Care/ Home Infusion Drugs Policy	Home healthcare/ home infusion drugs (Place of Service 12) that are submitted for Medicaid members enrolled in mainstream Managed Care (MC) plans, Health and Recovery Plans (HARPs), and HIV-Special Needs (SNPs) must be submitted to the NYRx program directly or they will be denied.	4/23/2024

Claim Type	Medical Policy	Rule Description	Effective Date
F	Medically Unlikely Edits (MUE)- Outpatient	Identifies claim lines where the CMS Facility MUE has been exceeded for a CPT/HCPCS code with MUE adjudication indicator (MAI) = 1, 2 or 3, reported by the same provider, for the same member, on the same date of service. This rule will evaluate date ranges to determine if the MUE has been met or not. • MAI = 1 claim line edit. If a claim line quantity exceeds the MUE allowed value, that single claim line will be denied. • MAI = 2 date of service edits (based on policy). No Modifier override is allowed and will not be considered if appealed. • MAI = 3 date of service edits (based on clinical benchmarks). Modifier 59 will not override MAI of 3. Clinical documentation to support reimbursement for additional units may be submitted as an appeal.	10/01/2021
P	Medically Unlikely Edits (MUE)- Practitioner	Identifies claim lines where the CMS Professional MUE has been exceeded for a CPT/HCPCS code with MUE adjudication indicator (MAI) = 1, 2 or 3, reported by the same provider, for the same member, on the same date of service. This rule will evaluate date ranges to determine if the MUE has been met or not. • MAI = 1 claim line edit. If a claim line quantity exceeds the MUE allowed value, that single claim line will be denied. • MAI = 2 date of service edits (based on policy). No Modifier override is allowed and will not be considered if appealed. • MAI = 3 date of service edits (based on clinical benchmarks). Modifier 59 will not override MAI of 3. Clinical documentation to support reimbursement for additional units may be submitted as an appeal.	10/01/2021

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Modifier Policy	Intravenous home infusion codes are not payable when billed with modifier SJ (third or more concurrently administered infusion therapy) and another intravenous home infusion code has not been previously billed for the same date of service with modifier SH (second concurrently administered infusion therapy).	1/01/2018 *Updated to include PPOC, PPOMR effective 8/01/2022*
F, P	Modifier Policy	Procedures or services that are incompatible with modifier 92 are not payable.	1/01/2018 *Updated to include PPOC, PPOMR effective 8/01/2022*
F, P	Modifier Policy	X-ray transportation services are not payable when reported without an x-ray transportation modifier.	1/01/2018 *Updated to include PPOC, PPOMR effective 8/01/2022*
P	Modifier Policy	Procedure codes that are inappropriately billed with anatomical modifiers are not payable.	1/01/2018
F, P	Modifier Policy	Procedure codes defined as requiring an anatomical modifier that are billed without an associated anatomical modifier are not payable.	1/01/2018 *Updated to include Facility (HMOC, HMOMR, HMOMD) effective 11/16/2021* *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
P	Modifier Policy	Services billed with invalid modifier to procedure code combinations are not payable.	1/01/2018
P	Modifier Policy	All claims submitted with modifiers that are not recognized by the Centers of Medicare and Medicaid Services (CMS) or the American Medical Association (AMA) will be deemed as invalid.	7/01/2020
P	Modifier Policy	Anesthesia codes (00100-01999, 99100-99140 or D9223) inappropriately billed with distinct service modifiers are not payable.	1/01/2018
P	Modifier Policy	Procedures appended with modifier 76 (Repeat procedure/same physician) are not payable when the same procedure code has not been billed by the same	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
		Provider ID on the same date of service, or within the post-operative period of the billed procedure. (CMS)	
F, P	Modifier Policy	CPT 90476-90750, 90756 (Vaccines, toxoids), J3530 (Nasal vaccine inhalation), Q2034-Q2039 (Influenza virus vaccine, split vaccine) or S0195 (Pneumococcal conjugate vaccine, polyvalent, intramuscular, for children from five years to nine years of age who have not previously received the vaccine) are not payable when billed with modifier SL (State supplied vaccine) and the allowed amount is more than $0.01.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Modifier Policy	Procedure codes defined as requiring an anatomical modifier are not payable when billed without an associated anatomical modifier.	1/01/2018
P	Modifier Policy	Any procedures billed with modifier 27, 73, 74 or CA are not payable under a professional claim.	1/01/2018
F, P	Modifier Policy	Procedures appended with modifier 77 (Repeat procedure/different physician) are not payable when the same procedure code has not been billed by a different Provider ID on the same date of service or within the post-operative period of the billed procedure.	1/01/2018
F, P	Modifier Policy	Procedures appended with modifier 78 are not payable when the same or different 0, 10 or 90 day-procedure code has not been billed on the same day for a 0-day post-operative period, on the same day or in the previous 10-days for a code with a 10-day post-operative period, or on the same day or in the previous 90 days for a code with a 90-day post-operative period.	1/01/2018
P	Modifier Policy	Deny HPSA modifier QU after January 1, 2006.	1/01/2018
F, P	Modifier Policy	Procedures appended with modifier 77 (Repeat procedure/different physician) are not payable when the same procedure code has been billed by the same Provider ID on the same date of service or within the post-operative period of the original procedure billed.	1/01/2018
F	Modifier Policy	Services billed with modifier 53 (Discontinued service) are not payable when billed with Bill Type 0120-012Z (Inpatient-part B), 0130-013Z (Outpatient hospital), 0140-014Z (Outpatient hospital-other), or 0830-083Z (Ambulatory surgical center).	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
F, P	Modifier Policy	All evaluation and management services are not payable when billed with modifier 53.	1/01/2018
P	Modifier Policy	Laboratory panel codes are not payable when billed with modifier 52 or 53.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Modifier Policy	Physical medicine and rehabilitation services are not payable when billed without therapy modifiers GN, GO or GP.	1/01/2018
F, P	Modifier Policy	Services that are inappropriately billed with telehealth services modifier GQ (Telehealth services via asynchronous telecommunications system) are not payable.	1/01/2018
F, P	Modifier Policy	Services reported with modifier 95 (Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system) are not payable when billed with any code other than an approved telemedicine service code.	1/01/2018
F, P	Modifier Policy	Procedures appended with modifier 79 are not payable when the same or different 0, 10 or 90-day procedure code has not been billed on the same day for a code with a 0-day post-operative period, on the same day or in the previous 10 days for a code with a 10-day post-operative period, or on the same day or in the previous 90 days for a code with a 90-day post-operative period.	1/01/2018
F, P	Modifier Policy	Aligning with CMS guidelines, services are not allowed when submitted with modifier CS (Cost Share Waiver COVID-19)	10/1/2024
P	Multiple Endoscopy – Pay Percent	Identifies multiple endoscopy procedures, reported within the same family, and applies the multiple endoscopy reduction, per CMS guidelines. In addition, if more than one endoscopy family is reported and/or surgery procedures are reported, the rule will apply the multiple surgery cutback to the appropriate endoscopy family or families and surgery procedures. This rule will also recommend payment adjustments for other applicable payment modifiers and assign the appropriate pay percentage to the eligible line(s).as well as bilateral*, multiple quantity*, and assign the appropriate pay percentage to the eligible line(s).	9/01/2021
P	Multiple Procedure Reduction Policy	Modifier 51 appended to a procedure code not subject to Multiple Procedure Reduction based on CMS fee schedule is not payable.	1/01/2018
P	National Correct Coding Initiative Policy	Column two procedure codes are not payable when billed with an associated column one procedure code.	1/01/2018
P	National Correct Coding Initiative Policy	Column two procedure codes are not payable when billed with an associated mutually exclusive column one procedure code.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
F	National Correct Coding Initiative Policy	Column one procedure codes with revenue code 0960-0989 are not payable when the column two procedure code has been previously paid.	1/01/2018
F	National Correct Coding Initiative Policy	Column one procedure codes with revenue code 0960-0989 are not payable when the column two procedure code has been previously paid.	1/01/2018
P	National Correct Coding Initiative Policy	Column one procedure codes are not payable when billed by the same Provider ID, regardless of Tax ID or Specialty, and the Column two Code has been previously paid.	1/01/2018
P	National Correct Coding Initiative Policy	Column two procedure codes are not payable when billed with associated column one procedure code.	1/01/2018
P	National Correct Coding Initiative Policy	Column two procedure codes are not payable when billed with associated column one procedure code that is billed by the same Provider ID regardless of Tax ID and Specialty.	1/01/2018
P	National Correct Coding Initiative Policy	Column one procedure codes are not payable when mutually exclusive Column two procedure code has been previously paid. (CMS 1450)	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
P	National Correct Coding Initiative Policy	Column one procedure codes are not payable when a Column two procedure code has been previously paid.	1/01/2018
P	National Correct Coding Initiative Policy	NCCI PTP edits: Column two procedure code when billed with associated Mutually Exclusive Column one procedure code are not payable.	1/01/2018
P	National Correct Coding Initiative Policy	NCCI PTP edits: Column two procedure code when billed with associated Column one procedure code are not payable. Non-Mutually Exclusive Edits.	1/01/2018
P	National Correct Coding Initiative Policy	CMS NCCI column two procedure codes are not payable when billed with associated Column one procedure code when billed by the same Provider ID regardless of Tax ID and Specialty. Non-Mutually Exclusive Edits.	1/01/2018
P	National Correct Coding Initiative Policy	NCCI Column two procedure code is not separately payable when billed with associated Mutually Exclusive Column one procedure code when billed by the same Provider ID regardless of Tax ID and Specialty.	1/01/2018
P	National Correct Coding Initiative Policy	Column one procedure codes are not payable when a Column two procedure code has been previously paid for the same date of service. Non-Mutually Exclusive Edits.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
F	National Correct Coding Initiative Policy	CMS NCCI Mutually Exclusive code pair edits will result in denial of a Column two code when billed with column one code. (CMS-1450)	1/01/2018
F	National Correct Coding Initiative Policy	CMS NCCI non-Mutually Exclusive code pair edits will result in denial of a Column two code when billed with column one code. (CMS-1450)	1/01/2018
P	National Correct Coding Initiative Policy	IV infusion services billed without modifier 59 or modifier XE are not payable when billed with IV chemotherapy administration service codes.	1/01/2018
F, P	National Correct Coding Initiative Policy	Deny Column one procedure code when the Column two procedure code has been previously paid. Non-Mutually Exclusive Edits. (CMS-1450)	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
P	National Correct Coding Initiative Policy	Transesophageal echocardiography (TEE) (CPT codes 93318 or 93355) are not payable when billed with anesthesia services.	1/01/2018
F, P	National Correct Coding Initiative Policy	DME Column two codes are not payable when billed with an associated DME Column one code. Non-Mutually Exclusive Edits.	1/01/2018
F, P	National Correct Coding Initiative Policy	Transesophageal echocardiography (TEE) (CPT codes 93312-93317) when billed without a distinct services modifier are not payable when billed with anesthesia services (CPT codes 00100-01992).	1/01/2018 *Updated to include PPOMR effective 8/01/2022*
P	National Correct Coding Initiative Policy	Column one procedure codes are not payable when a Column two procedure code has been previously paid.	1/01/2018
F, P	National Correct Coding Initiative Policy	Column one procedure codes are not payable when billed by the same Provider ID, regardless of Tax ID or Specialty, and the Column two Code has been previously paid.	1/01/2018
F, P	National Correct Coding Initiative Policy	Column one procedure codes are not payable when billed by the same Provider ID, regardless of Tax ID or Specialty, and the Column two Code has been previously paid.	1/01/2018
F	National Correct Coding Initiative Policy	Column two procedure codes are not payable when billed with an associated Column one procedure code and the revenue code is 0960-0989.	1/01/2018
F	National Correct Coding Initiative Policy	Column two procedure codes are not payable when billed with associated mutually exclusive column one procedure code and the revenue code is 0960-0989.	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*

Claim Type	Medical Policy	Rule Description	Effective Date
P	National Correct Coding Initiative Policy	Column one procedure codes are not payable when the column two procedure code has been previously paid.	1/01/2018
P	National Correct Coding Initiative Policy	Column one procedure codes are not payable when billed by the same Provider ID, regardless of Tax ID or Specialty, and the column two code has been previously paid.	1/01/2018
P	National Correct Coding Initiative Policy	Column two procedure codes are not payable when billed with associated mutually exclusive column one procedure code.	1/01/2018
P	National Correct Coding Initiative Policy	Column two procedure codes are not payable when billed with an associated mutually exclusive column one procedure code by the same Provider ID regardless of Tax ID and Specialty.	1/01/2018
F, P	National Correct Coding Initiative Policy	Durable medical equipment column two procedure codes are not payable when billed with an associated mutually exclusive column one procedure code.	1/01/2018
F, P	National Correct Coding Initiative Policy	Durable medical equipment (DME) column one procedure codes are not payable when the DME column two procedure code has been previously paid.	1/01/2018
F, P	National Correct Coding Initiative Supplemental Policy	Temporary during COVID-19 Pandemic: CMS NCCI Column two procedure code is not payable when billed with associated Column one procedure code based on NCCI in place pre-pandemic.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	National Correct Coding Initiative Supplemental Policy	Temporary during COVID-19 Pandemic: CMS NCCI Column two procedure code is not payable when billed with associated Column one procedure code based on NCCI in place pre-pandemic.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	National Correct Coding Initiative Supplemental Policy	Temporary during COVID-19 Pandemic: CMS NCCI Column two procedure code is not payable when billed with associated Column one procedure code based on NCCI in place pre-pandemic.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	National Correct Coding Initiative Supplemental Policy	Temporary during COVID-19 Pandemic: CMS NCCI Column two procedure code is not payable when billed with associated Column one procedure code based on NCCI in place pre-pandemic.	1/01/2018
P	National Correct Coding Initiative Supplemental Policy	Temporary during COVID-19 Pandemic: CMS NCCI Column two procedure code is not payable when billed with associated Column one procedure code based on NCCI in place pre-pandemic.	1/01/2018
P	National Correct Coding Initiative Supplemental Policy	Temporary during COVID-19 Pandemic: CMS NCCI Column two procedure code is not payable when billed with associated Column one procedure code based on NCCI in place pre-pandemic.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
F	National Correct Coding Initiative Supplemental Policy	Temporary during COVID-19 Pandemic: CMS NCCI Column two procedure code is not payable when billed with associated Column one procedure code based on NCCI in place pre-pandemic.	1/01/2018
F	National Correct Coding Initiative Supplemental Policy	Temporary during COVID-19 Pandemic: CMS NCCI Column two procedure code is not payable when billed with associated Column one procedure code based on NCCI in place pre-pandemic.	1/01/2018
P	National Correct Coding Initiative Supplemental Policy	Temporary during COVID-19 Pandemic: CMS NCCI Column two procedure code is not payable when billed with associated Column one procedure code based on NCCI in place pre-pandemic.	1/01/2018
P	National Correct Coding Initiative Supplemental Policy	Temporary during COVID-19 Pandemic: CMS NCCI Column two procedure code is not payable when billed with associated Column one procedure code based on NCCI in place pre-pandemic.	1/01/2018
F	National Correct Coding Initiative Supplemental Policy	Temporary during COVID-19 Pandemic: CMS NCCI Column two procedure code is not payable when billed with associated Column one procedure code based on NCCI in place pre-pandemic.	1/01/2018
F	National Correct Coding Initiative Supplemental Policy	Temporary during COVID-19 Pandemic: CMS NCCI Column two procedure code is not payable when billed with associated Column one procedure code based on NCCI in place pre-pandemic.	1/01/2018
P	National Correct Coding Initiative Supplemental Policy	Consultation codes are not separately payable when billed with a primary procedure unless the consultation code is billed with modifier 25 and the clinical documentation supports the use of modifier 25.	1/01/2018
P	National Correct Coding Initiative Supplemental Policy	Consultation codes are not separately payable when billed with a primary procedure unless the consultation code is billed with modifier 25 and the clinical documentation supports the use of modifier 25.	1/01/2018
P	National Correct Coding Manual Policy	Intravenous infusions of lidocaine hydrochloride (HCPCS J2001) are not payable when billed with any service on the same day.	1/01/2018
P	National Correct Coding Manual Policy	E/M Services (99201-99239, 99281-99443, 99450-99499 or S0280-S0281) without modifier 25 are not separately payable when billed with 95004-95199 (Allergy testing or allergy immunotherapy).	1/01/2018
P	National Correct Coding Manual Policy	E/M services are not separately payable when billed on the same day as a cardiac stress test.	1/01/2018
P	National Correct Coding Manual Policy	CPT 69990 (Operating microscope) is payable only when billed with a code from the list of allowed procedures.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	National Correct Coding Manual Policy	Deny procedures considered to be inappropriately coded based on National Correct Coding Initiative Policies and Guidelines.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	National Correct Coding Manual Policy	E/M Services (99201-99499) are not payable when billed with Anesthesia Services (00100-01999) the day prior to or the day of surgery.	1/01/2018
P	National Correct Coding Manual Policy	Evaluation and management services are not payable when billed with a 0, 10, or 90 day global radiology service and the provider specialty is radiology.	1/01/2018
F, P	National Correct Coding Manual Policy	Daily hospital management of epidural or subarachnoid continuous drug administration (CPT code 01996) is not payable beyond one unit per date of service when reported by any provider.	1/01/2018
F, P	National Correct Coding Manual Policy	Urinalysis (CPT codes 81000-81003, 81005, 81099), creatinine (CPT code 82570), pH; body fluid (CPT code 83986), or spectrophotometry (CPT code 84311) are not payable when billed with toxicology procedures (CPT codes 0007U, 0051U), presumptive drug screen tests (CPT codes 80305-80307), or definitive drug tests (CPT codes 0006U, 0082U, 0093U, 0143U-0150U, 80320-80377, 83992, or HCPCS codes G0480-G0483, G0659).	1/01/2018
P	NCCI Comprehensive Component Policy	Procedures categorized as a Column II code are not payable when submitted by the same provider, for the same date of service as an associated comprehensive Column I code.	All PPO 1/01/2022 HMOMR and HMOC 03/17/2021 HMOMD 10/01/2021
P	NCCI Mutually Exclusive Policy	Procedures categorized as a Column II code are not payable when submitted by the same provider, for the same date of service as an associated mutually exclusive Column I code.	All PPO 1/01/2022 HMOMR and HMOC 03/17/2021 HMOMD 10/01/2021
F	NCCI PTP Facility Policy	Procedures categorized as a Column II code are not payable when submitted on the same date of service and by the same provider as the designated Column I code.	All PPO 1/01/2022 HMOMR and HMOC 03/17/2021 HMOMD 10/01/2021
F, P	NCD Procedure to Diagnosis: EXCLUSIONARY Lab Policy (NCD Exclusionary)	Identifies Professional and Outpatient Facility claim lines where laboratory procedures are not considered medically necessary or payable according to the Centers for Medicare and Medicaid Services (CMS) National Coverage Policy for Laboratory Procedures located at	10/01/2021

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

Claim Type	Medical Policy	Rule Description	Effective Date
		The Coverage Determinations manual is located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961	
F, P	NCD Procedure to Diagnosis: Covered (NCD_POLICY_INCL)	Identifies Professional and Outpatient Facility claim lines for procedure codes not submitted with a covered diagnosis and is therefore defined as non-covered or not payable according to the Centers for Medicare and Medicaid Services (CMS) National Coverage Determination Policy (NCD). CMS established National Coverage policies to evaluate clinical evidence to determine whether the evidence is of sufficient quality to support a finding that an item or service that falls within a benefit category is reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of the body. The Coverage Determinations manual is located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961	10/01/2021
F, P	NCD Procedure to Diagnosis Coverage (NCD_PXDX_COVERAGE)	Identifies Professional and Outpatient Facility claim lines for certain procedure codes associated with a single diagnosis code/multiple diagnosis codes or no diagnosis code, modifier, age and frequency requirement where the procedure is not considered medically necessary, payable, or has payment constraints according to National Coverage Determinations (NCDs). The Coverage Determinations manual is located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961	10/01/2021
P	Neurology Policy	CPT 95957 (EEG for epileptic spike analysis) is not payable when billed on same date of service as 95700-95726 (Long-term EEG monitoring) by any provider.	1/01/2018
F, P	Neurology Policy	Needle electromyography services (CPT codes 95963 and 95864) are not payable when the only diagnosis associated to the procedures is carpal tunnel syndrome.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*

Claim Type	Medical Policy	Rule Description	Effective Date
74	Neurology Policy	Needle electromyography services (CPT codes 95963 and 95864) are not payable when the only diagnosis associated to the procedures is tarsal tunnel syndrome.	1/01/2018
F, P	Neurology Policy	Neuromuscular junction testing, each nerve, any 1 method (CPT code 95937) is not payable beyond three units per day when the diagnosis on the claim is myoneural disorders.	1/01/2018
F, P	Neurology Policy	Neuromuscular junction testing, each nerve, any 1 method (CPT code 95937) is not payable beyond two units per day when the diagnosis on the claim is motor neuron disease, muscular dystrophies and other myopathies, weakness, fatigue, cramps, or involuntary movements, and a diagnosis which allows a higher study frequency is not also present.	1/01/2018
F, P	Neurology Policy	Polysomnography (CPT codes 95782, 95783, 95808, 95810 or 95811) are not payable when billed in any combination more than one unit per date of service by any provider.	1/01/2018
F, P	Neurology Policy	Polysomnography (CPT codes 95782, 95783, 95808, 95810 or 95811) are not payable when billed in any combination more than one unit in a two consecutive day period by any provider.	1/01/2018 *Terminated effective 9/24/2023*
P	Neurology Policy	Digital analysis of electroencephalogram [EEG] (CPT code 95957) is not payable when billed on same date of service as long-term EEG monitoring (CPT codes 95700-95726) by any provider.	1/01/2018
P	Neurology Policy	Continuous Intraoperative Neurophysiology Monitoring (IONM) codes are payable only when reported in Places of Service 19 (Outpatient Hospital-Off campus), 21 (Inpatient Hospital), 22 (Outpatient Hospital-On Campus) or 24 (Ambulatory Surgical Center).	2/15/2025
F, P	Never Events	Any procedure billed with modifier PA (Surgical or other invasive procedure on wrong body part), PB (Surgical or other invasive procedure on wrong patient), or PC (Wrong surgery or other invasive procedure on patient) is not payable.	9/01/2021 *Updated to include PPOMR effective 8/01/2022*
P	New Patient Code Frequency Policy	New patient codes are not payable when submitted and review of the current claim OR patient's history	All PPO 1/01/2022 HMOMR and HMOC 03/17/2021

Claim Type	Medical Policy	Rule Description	Effective Date
		determines a new patient code was previously billed and paid by the same provider within the past three (3) years	HMOMD 10/01/2021
F, P	Observation Services Policy	Observation services are not payable when billed with a bill type other than 13X or 85X.	1/01/2018 *Updated to include PPOMR effective 8/01/2022* *Updated to include Facility claims effect. 12/01/2021*
F	Observation Services Policy	Claims for HCPCS code G0379 will be denied when billed without a history of an allowed claim for HCPCS code G0378. (CMS-1450)	1/01/2018 *Updated to include PPOMR effective 8/01/2022*
F, P	Observation Services Policy	99217 (Observation care discharge) or 99238-99239 (Hospital discharge day management) are not payable when 99234-99236 (Observation or inpatient hospital care including admission and discharge on the same day) was billed the previous day.	1/01/2018 *Updated to include Facility (HMOC, HMOMR, HMOMD) effective 11/16/2021* *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
F, P	Obsolete Procedure Code Policy	Procedures that are deemed invalid are not payable.	All PPO 1/01/2022 HMOMR and HMOC 03/17/2021 HMOMD 10/01/2021
P	Obstetrics and Gynecology Policy	Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage (CPT code 57456), endocervical curettage (CPT code 57505) and cauterization of cervix (CPT code 57510) are not payable when billed with colposcopy of the cervix including upper/adjacent vagina (CPT code 57460).	1/01/2018 *Terminated effective 3/30/2021*
P	Obstetrics and Gynecology Policy	Pregnant uterus ultrasound services, CPT codes 76801-76812, are payable when billed with abortion services (CPT codes 59812-59857 or S2260-S2267).	1/01/2018 *Terminated effective 3/30/2021*
F, P	Obstetrics and Gynecology Policy	Complete and limited non-obstetric pelvic ultrasounds, CPT codes 76856 and 76857, are not covered when	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
		billed with transvaginal ultrasounds, CPT code 76830, during the same visit.	
P	Obstetrics and Gynecology Policy	Non-obstetric transvaginal ultrasound, CPT code 76830, is not payable when billed with obstetric transabdominal ultrasound, CPT code 76810, during the same visit.	1/01/2018 *Terminated effective 3/30/2021*
F, P	Obstetrics and Gynecology Policy	Initial obstetric ultrasound services, CPT codes 76805 or 76810-76812 are not payable when a previous initial obstetric ultrasound has been billed in the past five months.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Obstetrics and Gynecology Policy	Transvaginal ultrasound, CPT code 76817, is not payable when billed with transabdominal ultrasound, CPT codes 76801-76812.	1/01/2018 *Terminated effective 3/30/2021*
P	Obstetrics and Gynecology Policy	Complete non-obstetric pelvic ultrasounds, CPT code 76856, are not payable when billed with saline infusion sonohysterography (SIS), CPT code 76831, during the same visit.	1/01/2018
F, P	Obstetrics and Gynecology Policy	CPT 76801 or 76802 (Pregnant uterus ultrasound services) is not payable when 76801 or 76802 has been previously billed in the past three months.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	Obstetrics and Gynecology Policy	Trachelorrhaphy (CPT code 57720), dilation of cervical canal (CPT code 57800), subcutaneous infusion (CPT code 96369) or intra-arterial injection (CPT code 96373) are not payable when billed with abortion services.	1/01/2018
F, P	Obstetrics and Gynecology Policy	Detailed fetal anatomic ultrasound (CPT code 76811 or 76812) is not payable when billed and the only diagnosis on the claim is supervision of normal pregnancy, routine screening for malformations using ultrasonics, fetal anatomic survey, or antenatal screening of mother.	1/01/2018
P	Once Per Lifetime Services Policy	Subsequent claims after initial reimbursement is made for once in a lifetime services by any provider are not payable.	1/01/2018
P	Once Per Lifetime Services Policy	Codes for once in a life-time-procedures are not payable when previously reimbursed.	1/01/2018
F, P	Once Per Lifetime Services Policy	Certain services related to the uterus are not payable when reported after a total hysterectomy has been performed by any provider.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	Once Per Lifetime Services Policy	Subsequent claims are not payable after initial reimbursement is made for once in a lifetime services by any provider.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Once Per Lifetime Services Policy	Subsequent claims are not payable by any provider after initial reimbursement is made for once in a lifetime services per National CMS policy.	1/01/2018
F, P	Ophthalmology Policy	Scanning computerized ophthalmic diagnostic imaging, retina (CPT code 92134) is not payable when billed more than once within a 28-day period when the diagnosis is retinal disease.	1/01/2018 *Updated to include PPOC, PPOMR effective 8/01/2022* *Terminated effective 9/24/2023*
P	Ophthalmology Policy	Extended ophthalmoscopy with a retinal/optic nerve drawing, CPT codes 92201-92202, are not payable when billed and an appropriate diagnosis is not present on the claim.	4/28/2020
P	Ophthalmology Policy	Extended ophthalmoscopy with a retinal/optic nerve drawing, unilateral or bilateral (CPT codes 99201 and 99202) are not payable when billed with fundus photography (CPT code 92250).	2/25/2020
P	Ophthalmology Policy	Extended ophthalmoscopy with a retinal/optic nerve drawing, unilateral or bilateral (CPT codes 99201 and 99202) are not payable when billed more than two times per eye per year without an appropriate diagnosis on the claim.	2/25/2020
P	Ophthalmology Policy	Extended ophthalmoscopy with a retinal/optic nerve drawing, unilateral or bilateral (CPT codes 99201 and 99202) are not payable when billed more than four times per eye per year with a neoplasm diagnosis.	2/25/2020
P	Ophthalmology Policy	Extended ophthalmoscopy with a retinal/optic nerve drawing, unilateral or bilateral (CPT codes 99201 and 99202) are not payable when billed more than six times per eye per year with a diagnosis of disorders of the globe, choroid, retina, iris and ciliary body, or glaucoma.	2/25/2020
P	Ophthalmology Policy	Extended ophthalmoscopy with a retinal/optic nerve drawing, unilateral or bilateral (CPT codes 99201 and 99202) are not payable when billed more than 12 times per eye per year with a diagnosis of exudative senile macular degeneration.	2/25/2020

Claim Type	Medical Policy	Rule Description	Effective Date
P	Ophthalmology Policy	CPT 92250 (Fundus photography) is not payable when billed more than two units within one year except when specific diagnoses are present.	1/01/2018
F, P	Ophthalmology Policy	Comprehensive ophthalmological services are not payable when a previous comprehensive ophthalmological service has been billed in the previous six months. See Ophthalmology Reimbursement Policy.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	Ophthalmology Policy	CPT 76514 (Ophthalmic ultrasound, diagnostic; corneal pachymetry) is not payable when billed more than once in a patient's lifetime with a diagnosis of glaucoma or ocular hypertension (OHT).	1/01/2018 *Updated to include Facility claims effect. 1/1/2021*
P	Ophthalmology Policy	Extended ophthalmoscopy with a retinal/optic nerve drawing, unilateral or bilateral (CPT codes 99201 and 99202) are not payable when billed more than six times per eye per year with a diagnosis of disorders of the globe, choroid, retina, iris and ciliary body, or glaucoma.	2/25/2020
F, P	Ophthalmology Policy	As per CMS LCD Article A56551, Visual field examination (CPT codes 92081-92083) are not payable when billed without a requisite diagnosis.	1/01/2018
F, P	Ophthalmology Policy	Scanning computerized ophthalmic diagnostic imaging, anterior segment (CPT code 92132) is not payable when billed and an appropriate diagnosis is not present on the claim.	1/01/2018
F, P	Ophthalmology Policy	Scanning computerized ophthalmic diagnostic imaging, posterior segment (CPT code 92133 or 92134) is not payable when billed and an appropriate diagnosis is not present on the claim.	1/1/2018
F, P	Ophthalmology Policy	Ophthalmic ultrasound, anterior segment ultrasound, bio-microscopy (CPT code 76513) is not payable when billed with a diagnosis of glaucoma as the only diagnosis on the claim.	1/01/2018
P	Ophthalmology Policy	Extended ophthalmoscopy with a retinal/optic nerve drawing, unilateral or bilateral (CPT codes 92201-92202) are not payable when billed and an appropriate diagnosis is not present on the claim.	1/01/2018
P	Ophthalmology Policy	Extended ophthalmoscopy with a retinal/optic nerve drawing, unilateral or bilateral (CPT codes 92201-92202) are not payable when billed with fundus photography (92250).	1/01/2018
P	Ophthalmology Policy	Extended ophthalmoscopy with a retinal/optic nerve drawing, unilateral or bilateral (CPT codes 92201-92202) are not payable when billed more than two times per	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
		eye, per year, without an appropriate diagnosis on the claim.	
P	Ophthalmology Policy	Extended ophthalmoscopy with a retinal/optic nerve drawing, unilateral or bilateral (CPT codes 92201-92202) are not payable when billed more than four times per eye, per year, with a neoplasm diagnosis.	1/01/2018
P	Ophthalmology Policy	Extended ophthalmoscopy with a retinal/optic nerve drawing, unilateral or bilateral (CPT codes 92201-92202) are not payable when billed more than six times per eye, per year, with a diagnosis of disorders of the globe, choroid, retina, iris and ciliary body, or glaucoma.	1/01/2018
P	Ophthalmology Policy	Extended ophthalmoscopy with a retinal/optic nerve drawing, unilateral or bilateral (CPT codes 92201-92202) are not payable when billed more than 12 times per eye, per year, with a diagnosis of exudative senile macular degeneration.	1/01/2018
P	Ophthalmology Policy	CPT 66821 (Discission of secondary membranous cataract) is not payable when billed within three months of cataract surgery (66820-66821, 66830-66940, 66982-66984, 66987-66988).	2015 *Terminated effective 9/24/2023*
P	Orthopedic Policy	Any service billed with a DME rental modifier (BR, RR, KI, KJ, KR, LL) or a DME purchase modifier (BP, NU, UE) is not payable if the same code has previously been billed for the same date of service with either a DME rental modifier or a DME purchase modifier.	1/01/2018
F, P	Orthopedic Policy	Skin barrier, wipes or swabs, each (HCPCS code A5120) or ostomy skin barrier, liquid (HCPCS code A4369) is not payable when billed within the same month, by any provider.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	Orthopedic Policy	Arthroscopy of knee with abrasion arthroplasty (CPT code 29879) is not payable when billed with 29880-29881 (Arthroscopy of knee with meniscectomy).	1/01/2018
F, P	Orthopedic Policy	Arthroscopy, knee, diagnostic, with or without synovial biopsy (CPT code 29870) is not payable when billed with arthrotomy, knee; including joint exploration, biopsy, or removal of loose or foreign bodies (CPT code 27331).	1/01/2018
F, P	Orthopedic Policy	Arthroscopy of knee with abrasion arthroplasty (CPT code 29879) is not payable when billed with an arthroscopy of knee with meniscectomy (CPT codes 29880-29881).	1/01/2018
P	Orthopedic Policy	Intraoperative services are not payable when billed with an orthopedic procedure.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Pain Management Policy	Implantable neurostimulator electrode, each (HCPCS code L8680) is not payable when billed with percutaneous implantation of neurostimulator electrode array, epidural (CPT code 63650).	1/01/2018
F, P	Pain Management Policy	Any combination of trigger point injections (CPT codes 20552 and 20553) are not payable when billed more than three times within a 90-day period.	1/01/2018
P	PAY_PERCENT_PROF_EM	This rule applies pay percent recommendations to professional claims when a well visit/preventive exam, and any other Evaluation and Management (E&M) code(s), are billed for the same patient, same provider, and same date of service regardless of any modifiers. Same provider is defined as providers of the same group practice who have the same Federal Tax Identification Number (FTIN) and same primary specialty. Pay percent recommendations apply to procedure code groups with one well visit E&M and one or more other E&Ms. Groups are sorted and ranked based on the RVU value in the CMS Physician Relative Value file. • Rank 1 procedures with the highest RVU will receive a pay percent recommendation of 100%, • Rank 2 procedures with the next highest RVU will receive a pay percent recommendation of 50%, • Rank 3 to 5 procedures receive a pay percent recommendation of 0%.	10/01/2021
P	Pay Percent Reduction-Cardiology	Identifies claim lines that are eligible for a Multiple Procedure Payment Reduction- Technical Component (TC) of Diagnostic Cardiovascular Procedures. Assigns appropriate pay percentage to the eligible line(s), including adjustments for multiple procedure, as well as bilateral, multiple quantity, and additional payment modifiers.	8/14/2016

Claim Type	Medical Policy	Rule Description	Effective Date
P	Performance and Supervision of Electromyographic Testing Policy	In accordance with the recommendation of the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM), all needle electromyographic (EMG) examination services, nerve conduction studies, and associated services (CPT codes 95860-95887, 95905-95913, 96003-96004, and G0255) must be performed by a physician specially trained in electrodiagnostic (EDX) medicine.	1/7/2020
P	Physical Medicine Policy	CPT 95992 (Canalith repositioning procedure) is not payable when the diagnosis on the claim is not benign paroxysmal vertigo.	1/01/2018
P	Physician Visit Frequency Policy	Multiple office visits with a related diagnosis are not payable when submitted by the same provider for the same date of service.	All PPO 1/01/2022 HMOMR and HMOC 03/17/2021 HMOMD 10/01/2021
P	Place of Service Policy	Professional radiology services when billed by a provider other than an anesthesiologist, cardiologist, multi-specialist, neurologist, physical medicine specialist, radiologist, or radiation oncologist in the inpatient or outpatient hospital setting are not payable.	1/01/2018
P	Place of Service Policy	Medical and surgical supplies and DME are not payable when reported by professional providers with inpatient or facility places of service. (CMS-1500)	1/01/2018
P	Place of Service Policy	New and established office/outpatient visit (99201-99205 or 99211-99215) are not payable when billed in any place of service other than 01 (Pharmacy), 02 (Telehealth), 03 (School), 04 (Homeless shelter), 05 (Indian health service free-standing facility), 06 (Indian health service provider-based facility), 07 (Tribal 638 free-standing facility), 08 (Tribal 638 provider-based facility), 09 (Prison/correctional facility), 11 (Office), 14 (Group home), 15 (Mobile unit), 16 (Temporary lodging), 17 (Walk-in retail health clinic), 18 (Place of employment/worksite), 19 (Outpatient hospital - off campus), 20 (Urgent care facility), 22 (Outpatient hospital - on campus), 23 (Emergency room), 24 (Ambulatory surgical center), 25 (Birthing center), 26 (Military treatment facility), 49 (Independent clinic), 50 (Federally qualified health center), 53 (Community mental health center), 57 (Non-residential substance abuse treatment facility), 58 (Non-residential opioid treatment facility), 60 (Mass immunization center), 62 (Comprehensive outpatient rehabilitation facility), 65 (End-stage renal disease treatment facility), 71	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
		(State on local public health clinic), 72 (Rural health clinic), or 99 (Other place of service).	
P	Place of Service Policy	Evaluation and management services for inpatient neonatal and pediatric critical care (99468-99476) or initial and continuing intensive care (99477-99480) are not payable when billed in a place of service other than 02 (Telehealth) or 21 (Inpatient hospital).	1/01/2018
P	Place of Service Policy	Domiciliary/rest home E/M services (99324-99340) are not payable when billed in any place of service other than 13 (Assisted living facility), 14 (Group home), 33 (Custodial care facility), 55 (Residential substance abuse facility), or 99 (Other place of service), except when E/M services codes 99324-99328 or 99334-99337 are billed in POS 02 (Telehealth).	1/01/2018
P	Place of Service Policy	Emergency department visits (99281-99285, G0380-G0384) when billed in any place of service other than 23 (Emergency Department) are not payable, except when emergency department visit codes 99281-99285 are billed in POS 02 (Telehealth).	1/01/2018
P	Place of Service Policy	Initial hospital care services (99221-99223), follow-up hospital care services (99231-99233), and hospital discharge services (99238-99239) are not payable when billed in any place of service other than 02 (Telehealth), 06 (Indian health service provider-based facility), 08 (Tribal 638 provider-based facility), 21 (Inpatient hospital), 25 (Birthing center), 26 (Military treatment facility), 34 (Hospice), 51 (Psychiatric inpatient facility), 52 (Psychiatric partial hospitalization facility), and 61 (Comprehensive rehab facility), except when E/M services 99221-99223 or 99238-99239 are billed in POS 02 (Telehealth).	1/01/2018
P	Place of Service Policy	Nursing Facility E/M services (99304-99310, 99315-99316 or 99318) are not payable when billed in a place of service other than 31 (Skilled nursing facility), 32 (Nursing facility), 34 (Hospice), 54 (Intermediate care facility/individuals with intellectual disabilities), or 56 (Psychiatric residential treatment facility), except when Nursing Facility E/M services codes 99304-99310 or 99315-99316 are billed in POS 02 (Telehealth).	1/01/2018
P	Place of Service Policy	Outpatient observation services (99217-99220), subsequent observation care (99224-99226), observation or inpatient hospital care (99234-99236) are not payable when billed in any place of service other than 02 (Telehealth), 19 (Outpatient hospital - off	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
		campus), 21 (Inpatient hospital), 22 (Outpatient hospital - on campus), 23 (Emergency department), 24 (Ambulatory Surgical Center), 25 (Birthing center), 26 (Military treatment facility), 51 (Psychiatric inpatient facility), or 52 (Psychiatric facility partial hospitalization), except when E/M services codes 99217-99220 or 99234-99236 are billed in POS 02 (Telehealth).	
P	Place of Service Policy	Outpatient consultation services (99241-99245) are not payable when billed with a place of service 21 (Inpatient hospital).	1/01/2018
P	Place of Service Policy	Certain casting and strapping procedures provided by a physical or occupational therapist are not payable in a skilled nursing facility (SNF).	1/01/2018
P	Place of Service Policy	Inpatient only procedures (CMS) billed by professional providers with any place of service other than 21 are not payable.	10/29/2019
F	Place of Service Policy	Inpatient only, non-separate procedures (CMS), are not payable when billed by an outpatient hospital, unless it is reported with modifier CA.	1/01/2018 *Updated to include PPOMR effective 8/01/2022*
F	Place of Service Policy	Inpatient only, separate procedures (CMS), when billed by an outpatient hospital are not payable. (CMS-1450)	1/01/2018 *Updated to include PPOMR effective 8/01/2022*
F	Place of Service Policy	Any services billed on the same date of service as an inpatient only, non-separate procedure (CMS) and no other surgical, non-inpatient only procedures are billed, the claim will deny.	1/01/2018 *Updated to include PPOMR effective 8/01/2022*
F	Place of Service Policy	HCPCS "C "codes are not payable when billed with any bill type other than 0120-012Z (Hospital inpatient part B), 0130-013Z (Hospital outpatient), 0140-014Z (Hospital other part B), 0830-083Z (Hospital outpatient [ASC]), or 0850-085Z (Critical access hospital).	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
F, P	Place of Service Policy	HCPCS codes beginning with "C" are not payable when billed on claim type P (Professional).	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	Place of Service Policy	Posterior chamber IOL, HCPCS code V2632, astigmatism correcting IOL, HCPCS code V2787, or presbyopia correcting IOL, HCPCS code V2788, is not payable when billed and the place of service is 11 (Office) and a cataract removal surgery, CPT codes 66982-66988, has not also been billed.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*

Claim Type	Medical Policy	Rule Description	Effective Date
P	Place of Service Policy	Deny 99466-99467 (Critical care services delivered by a physician, face-to-face, during interfacility transport of a critically ill or critically injured pediatric patient) when billed in a place of service other than 41 (Ambulance - land) or 42 (Ambulance - air or water).	1/01/2018
P	Place of Service Policy	Physician direction of emergency medical systems [EMS] emergency care, advanced life support, CPT code 99288, supervision by control physician of interfacility transport care of the critically ill or critically injured pediatric patient, CPT codes 99485-99486, or trauma response team associated with hospital critical care services, HCPCS code G0390, are not payable when billed in a place of service other than 21 (Inpatient hospital) or 23 (Emergency Room).	1/01/2018
P	Place of Service Policy	Newborn care other than hospital or birthing center, CPT code 99461, is not payable when billed and the place of service is 21 (Inpatient hospital) or 25 (Birthing center).	1/01/2018
P	Place of Service Policy	Newborn care, CPT codes 99460, 99462-99465, are not payable when billed in a place of service other than 21 (Inpatient hospital) and 25 (Birthing center).	1/01/2018
P	Place of Service Policy	Comprehensive preventive medicine services, CPT codes 99381-99397, are not payable when billed in a place of service other than 03 (School), 04 (Homeless shelter), 05 (Indian health service free-standing facility), 06 (Indian health service provider-based facility), 07 (Tribal 638 free-standing facility), 08 (Tribal 638 provider-based facility), 09 (Prison), 11 (Office), 12 (Home), 13 (Assisted living facility), 14 (Group home), 15 (Mobile Unit), 16 (Temporary lodging), 17 (Walk-in retail health clinic), 18 (Place of employment/worksite), 19 (Outpatient hospital - off campus), 22 (Outpatient hospital - on campus), 26 (Military treatment facility), 33 (Custodial care facility), 49 (Independent clinic), 50 (Federally qualified health center), 71 (State or local public health clinic) or 72 (Rural health clinic).	1/01/2018
P	Place of Service Policy	Diagnostic imaging procedures 70370, 70371, and 74230 are not payable when billed in any place of service other than 11 (Office), 19 (Outpatient hospital-off campus), 21 (Inpatient hospital), 22 (Outpatient hospital-on campus),	1/01/2018 *Terminated effective 9/24/2023*

Claim Type	Medical Policy	Rule Description	Effective Date
		23 (Emergency room), 61 (Comprehensive inpatient rehab facility), or 62 (Comprehensive outpatient rehab facility). (CMS-1500)	
P	Place of Service Policy	Any service billed with modifier 53 (Discontinued service) is not payable when billed with Bill Type 0120-012Z (Inpatient-part B), 0130-013Z (Outpatient hospital), 0140-014Z (Outpatient hospital-other), or 0830-083Z (Ambulatory surgical center [ASC]).	1/01/2018
P	Place of Service Policy	Laboratory services (80000-89999) are not payable when billed in Place of Service 19 (Outpatient hospital-off campus), 21 (Inpatient hospital), 22 (Outpatient hospital-on campus), 23 (Emergency department), or 24 (ASC) by a provider with a specialty other than Dermatology, Genetics, Hematology, Laboratory, or Pathology.	1/01/2018
P	Place of Service Policy	Any service (other than inpatient care) billed by any professional provider on the same date of service as inpatient care but with a different place of service, is not payable when the member also received inpatient care the previous day and was not discharged on the same day, or on the subsequent day.	1/01/2018
P	Place of Service Policy	Any service billed in place of service 19 (Outpatient Hospital - Off campus), 22 (Outpatient Hospital - On campus) or 23 (Emergency Room - Hospital) by any professional provider on the same date of service as inpatient care, is not payable when the member also received inpatient care the previous day and was not discharged.	1/01/2018
F	Place of Service Policy	Medical/surgical supplies and DMEs are not payable when billed with professional fee revenue codes (0960-0989) in an outpatient facility or inpatient facility setting.	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
P	Place of Service Policy	Removal of benign skin lesions (CPT codes 11200-11201, 11300-11313, 11400-11446, 17106-17108, or 17340) are not payable when billed in an inappropriate place of service.	1/01/2018
F	Place of Service Policy	Radiology services (CPT codes 70010-79999) are not payable when billed with Bill Type 0140-014Z (Hospital-laboratory services to non-patients).	1/01/2018
P	Place of Service Policy	Destruction, benign or premalignant lesions (CPT codes 17000-17004, or 17110-17111) is not payable when billed in an inappropriate place of service.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
F	Place of Service Policy	Procedures billed with modifier Q0 (Investigational clinical service provided in a clinical research study that is in an approved clinical research study) or modifier Q1 (Clinical research study service) are not payable when condition code 30 (Qualifying clinical trial) and Bill Type 0130-013Z (Hospital-outpatient) are not present on the claim.	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
P	Place of Service Policy	Professional radiology services are not payable when billed by a provider other than an anesthesiologist, cardiologist, multi-specialist, neurologist, physical medicine specialist, radiologist, or radiation oncologist in the inpatient or outpatient hospital setting.	1/01/2018
P	Place of Service Policy	Medical and surgical supplies and DME are not payable when reported by professional providers with inpatient or facility places of service.	1/01/2018
P	Place of Service Policy	Evaluation and management add-on codes (CPT code 99050, 99051, 99053, 99056, 99058, or 99060) is not payable when billed with a place of service 20 (Urgent care facility) or when the provider specialty is urgent care.	1/01/2018
P	Place of Service Policy	Evaluation and management add-on codes (CPT codes 99026, 99050, 99051, 99053, 99056, 99058, or 99060) are not payable when billed with an emergency department visit (CPT codes 99281-99285, G0380-G0384) by a provider with the specialty of emergency medicine and place of service 23 (ER-hospital) or 20 (Urgent care facility).	1/01/2018
P	Place of Service Policy	New and established office/outpatient visit (CPT codes 99202-99205, 99211-99215) are not payable when billed in any place of service other than 01 (Pharmacy), 02 (Telehealth), 03 (School), 04 (Homeless shelter), 05 (Indian health service free-standing facility), 06 (Indian health service provider-based facility), 07 (Tribal 638 free-standing facility), 08 (Tribal 638 provider-based facility), 09 (Prison/correctional facility), 11 (Office), 14 (Group home), 15 (Mobile unit), 16 (Temporary lodging), 17 (Walk-in retail health clinic), 18 (Place of employment/worksite), 19 (Outpatient hospital - off campus), 20 (Urgent care facility), 22 (Outpatient hospital - on campus), 23 (Emergency room), 24 (Ambulatory surgical center), 25 (Birthing center), 26 (Military treatment facility), 49 (Independent clinic), 50	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
		(Federally qualified health center), 53 (Community mental health center), 57 (Non-residential substance abuse treatment facility), 58 (Non-residential opioid treatment facility), 60 (Mass immunization center), 62 (Comprehensive outpatient rehabilitation facility), 65 (End-stage renal disease treatment facility), 71 (State on local public health clinic), 72 (Rural health clinic), or 99 (Other place of service).	
P	Place of Service Policy	Evaluation and management services for inpatient neonatal and pediatric critical care (CPT codes 99468-99476) or initial and continuing intensive care (CPT codes 99477-99480) are not payable when billed in a place of service other than 02 (Telehealth) or 21 (Inpatient hospital).	1/01/2018
P	Place of Service Policy	Domiciliary/rest home E/M services (CPT codes 99324-99340) are not payable when billed in any place of service other than 13 (Assisted living facility), 14 (Group home), 33 (Custodial care facility), 55 (Residential substance abuse facility), or 99 (Other place of service), except when E/M services codes 99324-99328 or 99334-99337 are billed in POS 02 (Telehealth).	1/01/2018
P	Place of Service Policy	Emergency department visits (CPT codes 99281-99285, G0380-G0384) are not payable when billed in any place of service other than 23 (Emergency Department), except when emergency department visit codes 99281-99285 are billed in POS 02 (Telehealth).	1/01/2018
P	Place of Service Policy	Home visit E/M services (CPT codes 99341-99350) are not payable when billed in any place of service other than 02 (Telehealth) or 12 (Patient's home).	1/01/2018
P	Place of Service Policy	Initial hospital care services (CPT codes 99221-99223), follow-up hospital care services (CPT codes 99231-99233), and hospital discharge services (CPT codes 99238-99239) are not payable when billed in any place of service other than 02 (Telehealth), 06 (Indian health service provider-based facility), 08 (Tribal 638 provider-based facility), 21 (Inpatient hospital), 25 (Birthing center), 26 (Military treatment facility), 34 (Hospice), 51 (Psychiatric inpatient facility), 52 (Psychiatric partial hospitalization facility), and 61 (Comprehensive rehab facility), except when E/M services 99221-99223 or 99238-99239 are billed in POS 02 (Telehealth).	1/01/2018
P	Place of Service Policy	Nursing Facility E/M services (CPT codes 99304-99310, 99315-99316 or 99318) are not payable when billed in a place of service other than 31 (Skilled nursing facility),	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
		32 (Nursing facility), 34 (Hospice), 54 (Intermediate care facility/individuals with intellectual disabilities), or 56 (Psychiatric residential treatment facility), except when Nursing Facility E/M services codes 99304-99310 or 99315-99316 are billed in POS 02 (Telehealth).	
F, P	Place of Service Policy	Initial inpatient consultation, CPT codes 99251-99255, is not payable when billed in a place of service other than 02 (Telehealth), 06 (Indian health service, provider-based facility), 08 (Tribal 638 provider-based facility), 21 (Inpatient hospital), 25 (Birthing center), 26 (Military treatment facility), 31 (Skilled nursing facility), 32 (Nursing facility), 34 (Hospice), 51 (Psychiatric inpatient facility), 52 (Psychiatric partial hospitalization facility), 54 (Intermediate care facility/individuals with intellectual disabilities), 55 (Residential treatment center), 56 (Psychiatric residential treatment center), 61 (Comprehensive rehab facility), 99 (Other place of service).	1/01/2018
P	Place of Service Policy	Outpatient observation services (CPT codes 99217-99220), subsequent observation care (CPT codes 99224-99226), observation or inpatient hospital care (CPT codes 99234-99236) are not payable when billed in any place of service other than 02 (Telehealth), 19 (Outpatient hospital - off campus), 21 (Inpatient hospital), 22 (Outpatient hospital - on campus), 23 (Emergency department), 24 (Ambulatory Surgical Center), 25 (Birthing center), 26 (Military treatment facility), 51 (Psychiatric inpatient facility), or 52 (Psychiatric facility partial hospitalization), except when E/M services codes 99217-99220 or 99234-99236 are billed in POS 02 (Telehealth).	1/01/2018
P	Place of Service Policy	Outpatient consultation services (CPT codes 99241-99245) are not payable when billed with a place of service 21 (Inpatient hospital).	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Place of Service Policy	Office/outpatient consultation, CPT codes 99241-99245, is not payable when billed in a place of service other than 01 (Pharmacy), 02 (Telehealth), 03 (School), 04 (Homeless shelter), 05 (Indian health service free-standing facility), 06 (Indian health service provider-based facility), 07 (Tribal 638 free-standing facility), 08 (Tribal 638 provider-based facility), 09 (Prison-Correctional Facility), 11 (Office), 12 (Home), 13 (Assisted living facility), 14 (Group home), 15 (Mobile Unit), 16 (Temporary lodging), 17 (Walk-in retail health clinic), 18 (Place of employment/worksite), 19 (Outpatient hospital - off campus), 20 (Urgent care facility), 22 (Outpatient hospital - on campus), 23 (Emergency room hospital), 24 (Ambulatory surgical center), 25 (Birthing center), 26 (Military treatment facility), 33 (Custodial Care Facility), 49 (Independent clinic), 50 (Federally qualified health center), 53 (Community mental health center), 54 (Intermediate care facility/individuals with intellectual disabilities), 57 (Non-residential substance abuse treatment facility), 58 (Non-residential opioid treatment facility), 60 (Mass immunization center), 62 (Comprehensive outpatient rehabilitation facility), 65 (End-stage renal disease treatment facility), 71 (State or local public health clinic), 72 (Rural health clinic), 99 (Other place of service).	1/01/2018
P	Place of Service Policy	Certain casting and strapping procedures provided by a physical or occupational therapist in a skilled nursing facility (SNF) are not payable.	1/01/2018
P	Place of Service Policy	Inpatient only procedures billed by professional providers with any place of service other than 21.	1/01/2018
P	Place of Service Policy	Services with a Non-Facility NA Indicator of “N/A” are not payable when billed with place of service 11. (CMS)	1/01/2018
P	Podiatry Policy	CPT 11055-11057, 11719-11721, or G0127 (Routine foot care) are not payable when billed more than once within a two-month period.	6/25/2019
F, P	Podiatry Policy	As per CMS LCD Article A57759, CPT 11055-11057, 11719-11721, or G0127 (Nail paring, cutting, debridement, trimming) are not payable when billed without a requisite diagnosis on the claim.	1/01/2018
F, P	Podiatry Policy	Per CMS LCD Article A57759, CPT codes 11055-11057, or 11720-11721, (Nail paring, cutting, debridement, trimming) are not payable when billed with a diagnosis of thickened or mycotic nails and without a qualifying	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
		complication diagnosis or a systemic condition resulting in circulatory or neurologic impairment on the claim.	
F, P	Post-Operative Nasal Endoscopies	Post-operative nasal endoscopies with debridement (CPT Code 31237), after sinus surgery or sinus surgery combined with nasal surgery are not payable when billed more than 3 times within the six weeks following surgery. CPT code 31231 (diagnostic endoscopy) will not be reimbursed separately following a surgical procedure with a 10-day or 90-day global period.	8/30/2022
F, P	Primary Care Policy	Chest x-ray (CPT code 71045 or 71046) is not payable when the only diagnosis on the claim is screening for respiratory tuberculosis or testing for latent tuberculosis infection.	1/01/2018
P	Primary Care Policy	Influenza vaccines are not payable when the same or different vaccine code has been billed and paid within the previous three months and the patient is nine years of age or older.	1/01/2018
P	Primary Care Policy	Influenza vaccine is not payable when paid more than twice within the same calendar year and the patient is nine years of age or older.	1/01/2018
P	Primary Care Policy	HPV vaccinations (CPT codes 90649, 90650 or 90651) are not payable when billed and the patient is less than nine years of age.	1/01/2018
P	Primary Care Policy	HPV vaccination (CPT code 90651) is not payable when billed and the patient is 46 years of age or older.	1/01/2018
P	Primary Care Policy	HPV vaccination (CPT codes 90649, 90650 or 90651) is not payable when billed more than three times in the patient's lifetime by any provider.	6/25/2019
F, P	Procedure-Age Policy	Procedures submitted that are inconsistent with the patient's age based on the nature or indication for the procedure are not payable.	1/01/2018
F, P	Procedure-Age Policy	Procedures submitted that are inconsistent with the patient's age based on the code definition are not payable.	1/01/2018
F, P	Procedure-Age Policy	Procedures submitted that are inconsistent with the patient's age based on the code definition are not payable.	1/01/2018
F, P	Procedure-Age Policy	Procedures submitted that are inconsistent with the patient's age based on the code definition are not payable.	1/01/2018
P	Procedure-Age Policy	Procedures that are inconsistent with the patient's age based on the code definition are not payable.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Procedure-Age Policy	Procedure codes that are inconsistent with the patient's age based on the code definition are not payable.	1/01/2018
P	Procedure-Age Policy	Procedure codes that are inconsistent with the patient's age based on the code definition are not payable when a more appropriate code is available.	2/1/2019
P	Procedure-Age Policy	Procedures that are inconsistent with the patient's age based on the code definition are not payable.	1/01/2018
P	Procedure-Age Policy	Procedures submitted that are inconsistent with the patient's age based on the nature or indication for the procedure are not payable.	1/01/2018
F, P	Procedure Code Definition Policy	Procedures billed out of sequence are not payable.	1/01/2018
F, P	Procedure Code Definition Policy	Procedures are not payable when used against CPT and HCPCS procedure code definition.	1/01/2018
P	Procedure Code Definition Policy	Procedure codes and/or their related guidelines contain specific descriptive criteria for use. Services are not payable if they do not meet the code criteria. Examples: G0266 and 93298 are for a 30-day period; G0268 requires an audiologic function testing on same date of service; 93294 has a 90-day global period.	1/01/2018
F, P	Procedure Code Definition Policy	Procedures billed out of sequence are not payable.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	Procedure Code Definition Policy	Procedure codes and/or their related guidelines contain specific descriptive criteria for use. Services are not payable if they do not meet the code criteria. Example, CPT 17004 "Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g., actinic keratoses), 15 or more lesions" should not be reported with diagnosis B08.1 "Molluscum contagiosum".	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	Procedure Code Definition Policy	Procedure codes and/or their related guidelines contain specific descriptive criteria for use. Services are not payable if they do not meet the code criteria. Example: 71045 X-ray exam chest 1-view and 74019 X-ray exam abdomen 2-views should instead be coded as 74022 X-ray exam complete abdomen.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Procedure Code Definition Policy	HCPCS G0008, G0009, or G0010 are not payable if billed without the appropriate, corresponding vaccine code.	1/01/2018
F, P	Procedure Code Definition Policy	CPT codes for procedures billed out of sequence are not payable.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
			Updated to include Facility claims effect. 12/01/2021
F, P	Procedure Code Guideline Policy	Services that are coded inappropriately based on CPT/HCPCS Procedure Code Guidelines are not payable.	1/01/2018
F, P	Procedure Code Guideline Policy	Procedures billed out of sequence are not payable.	1/01/2018
P	Procedure Code Guideline Policy	Services that are coded inappropriately based on CPT/HCPCS Procedure Code Guidelines are not payable.	1/01/2018
F, P	Procedure Code Guideline Policy	Services that are coded inappropriately such as unbundled, when there is a single code that represents the unbundled services, will be denied based on CPT/HCPCS Procedure Code Guidelines.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Procedure Code Guideline Policy	Modifier 63 are not payable when billed with procedure codes to which this modifier does not apply, based on CPT/HCPCS Procedure Code Guidelines.	1/01/2018
P	Procedure Code Guideline Policy	Immunization administration (CPT codes 90460-90461, 90471-90474) are not payable when billed without a vaccine/toxoid code (90476-90750, 90756, J3530, Q2033-Q2039, or S0195) by any provider on the same date of service.	1/01/2018 HMOC and HMOMR in effect 1/01/2022
P	Procedure Code Guideline Policy	E/M services are not separately payable when billed with 94010-94799 (Pulmonary function testing), unless the E/M code is billed with modifier 25 and the clinical documentation supports the use of modifier 25.	1/01/2018
P	Procedure Code Guideline Policy	CPT 77371-77373 (Radiation treatment delivery, stereotactic radiosurgery), G0339 or G0340 (Image-guided robotic linear accelerator-based stereotactic radiosurgery) are not payable when billed more than five combined units in two weeks.	1/01/2018
P	Procedure-Diagnosis Incompatibility Policy	Procedures submitted with a diagnosis code that is not compatible with CMS National Government Services National Coverage and Local Coverage Determinations (NCD/LCD) are not payable.	1/1/2022 HMOMR 03/17/2021
P	Procedure Code Guideline Policy	CPT 99483 (Assessment of and care planning for patient with cognitive impairment) is not payable if billed more than once in a 180-day period.	9/1/2022
P	Procedure Inconsistent with Place of Service Policy	Procedures not related to Telehealth/Telemedicine, as per CMS, are not payable when reported with place of service "02".	1/01/2022

Claim Type	Medical Policy	Rule Description	Effective Date
P	Professional, Technical, and Global Services Policy	Diagnostic tests or radiology services are not payable when submitted by a provider in a facility place of service and modifier 26 is not appended.	1/1/2018
P	Professional, Technical, and Global Services Policy	Reimbursement of diagnostic tests and radiology services are not payable beyond the amount for the global service.	1/01/2018
F, P	Professional, Technical, and Global Services Policy	Clinical laboratory services with modifier 26 for those codes that do not have a separately payable professional service (CMS).	1/01/2018
P	Professional, Technical, and Global Services Policy	Separate reimbursement for radiology services with a modifier 26 is not payable when billed with an E/M service in the office.	1/01/2018
P	Professional, Technical, and Global Services Policy	Diagnostic tests or radiology services are not payable when billed with modifier TC in the inpatient or outpatient facility setting.	1/01/2018
F, P	Professional, Technical, and Global Services Policy	Procedures billed with modifier TC are not payable when submitted on a technical component only procedure code.	1/01/2018
F, P	Professional, Technical, and Global Services Policy	Procedures billed with modifier 26 are not payable when submitted with a code that is defined as professional component only.	1/01/2018
P	Professional, Technical, and Global Services Policy	X-ray services (which are also a diagnostic tests or radiology services) are not payable when billed with modifier TC in POS 12, 13, 31 or 32 and HCPCS codes R0070 and R0075 are not also present.	1/01/2018
P	Professional, Technical, and Global Services Policy	Modifier 26 submitted with a code that is defined as professional component only (CMS) is not payable.	1/01/2018
P	Professional, Technical, and Global Services Policy	Codes billed with modifier TC when submitted on a technical component only procedure code are not payable.	1/01/2018
P	Professional, Technical, and Global Services Policy	Diagnostic tests or radiology services billed with modifier TC is not payable to a professional provider in the inpatient or outpatient facility setting.	1/01/2018
P	Professional, Technical, and Global Services Policy	Radiology services with a modifier 26 are not payable when billed with an E/M service in the office.	1/01/2018
P	Professional, Technical, and Global Services Policy	Clinical laboratory services with modifier 26 are not payable for those codes that do not have a separately payable professional service (CMS).	1/01/2018
F, P	Professional, Technical, and Global Services Policy	Reimbursement of diagnostic tests and radiology services is limited to no more than the amount for the global service (CMS).	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*

Claim Type	Medical Policy	Rule Description	Effective Date
P	Professional, Technical, and Global Services Policy	Diagnostic tests or radiology services billed without modifier 26 are not payable when submitted by a provider in a facility place of service. (CMS)	1/01/2018
F, P	Professional, Technical, and Global Services Policy	Professional component procedures are not payable when billed by a facility and the Revenue Code is not 0960-0989 (Professional fees). (CMS-1450)	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022* *Updated to include Facility claims effect. 12/01/2021*
F, P	Professional, Technical, and Global Services Policy	Technical components are not payable when billed with Revenue Codes 0960-0989 (Professional fees).	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022* *Updated to include Facility claims effect. 12/01/2021*
P	Professional, Technical, and Global Services Policy	Technical component only procedures are not payable to professional providers in the inpatient or outpatient facility setting (CMS).	1/01/2018
P	Professional, Technical, and Global Services Policy	Physician service codes that do not have an associated professional or technical component (CMS) are not payable when billed with modifier 26.	1/01/2018
P	Professional, Technical, and Global Services Policy	Modifiers 26 and TC are not payable when appended to the same claim line.	1/01/2018
F, P	Professional, Technical, and Global Services Policy	Physician service codes that do not have an associated professional or technical component are not payable when billed with modifier TC (CMS).	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	Professional, Technical, and Global Services Policy	Technical component only services are not payable when billed with modifier 26 (CMS).	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	Professional, Technical, and Global Services Policy	Professional component only procedures are not payable when billed with modifier TC (CMS).	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Professional, Technical, and Global Services Policy	A Global Only code as identified in the CMS Physician Fee Schedule with PC/TC status '4', is not payable when billed by a professional in a facility setting. Only the professional component of this service is payable in the facility setting. It should be reported with the correct code.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	Professional, Technical, and Global Services Policy	A Global Only code as identified in the CMS Physician Fee Schedule with PC/TC status '4', is not payable when billed by a facility. Only the technical component of this service is payable in the facility setting. It should be reported with the correct code.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	Professional, Technical, and Global Services Policy	A Global Only code as identified in the CMS Physician Fee Schedule with PC/TC status '4', is not payable when billed by a professional in a facility setting. Only the professional component of this service is payable in the facility setting. It should be reported with the correct code.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	Professional, Technical, and Global Services Policy	A Global Only code as identified in the CMS Physician Fee Schedule with PC/TC status '4', is not payable when billed by a facility. Only the technical component of this service is payable in the facility setting. It should be reported with the correct code.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	Professional, Technical, and Global Services Policy	A Global Only code as identified in the CMS Physician Fee Schedule with PC/TC status '4', is not payable when billed by a professional in a facility setting. Only the professional component of this service is payable in the facility setting. It should be reported with the correct code.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	Professional, Technical, and Global Services Policy	A Global Only code as identified in the CMS Physician Fee Schedule with PC/TC status '4', is not payable when billed by a facility. Only the technical component of this service is payable in the facility setting. It should be reported with the correct code.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Professional, Technical, and Global Services Policy	X-ray services (which are also diagnostic tests or radiology services) billed without modifier 26 are not payable when submitted by a provider in POS 12, 13, 31, or 32 and R0070 and R0075 are not also present (CMS).	1/01/2018
P	Professional, Technical, and Global Services Policy	Codes reported with modifier 26 or modifier TC are not payable when the professional/technical component concept does not apply.	1/01/2018
F	Professional, Technical, and Global Services Policy	Technical component only services are not payable when billed with modifier 26.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Psychiatry-Psychology Policy	Subsequent TMS is not payable when billed and 90867 (TMS, initial), 90868 or 90869 (TMS, subsequent) has not been billed in the previous week.	1/01/2018
F, P	Psychiatry-Psychology Policy	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment is not payable when billed without a diagnosis of major depressive disorder without psychotic features for a patient 18 years of age or older.	1/01/2018
F, P	Pulmonary Policy	Chest x-ray (CPT codes 71045-71048) are not payable when billed and the only diagnosis on the claim is for lung cancer screening or nicotine use/dependence.	1/01/2018
P	Quality of Care Policy	Any procedure billed by an audiologist that is outside of the scope of audiology practice is not payable.	1/01/2018
P	Quality of Care Policy	Deny any procedure billed by a physical therapist that is outside the scope of physical therapy practice.	1/01/2018
P	Quality of Care Policy	Medical evaluation and management services as these are not considered within the scope of practice for Clinical Psychologists (CPs') and Clinical Social Workers (CSWs'). According to the Centers for Medicare and Medicaid Services (CMS), E/M services are medical in nature and therefore may not be furnished by psychologists or social workers.	1/01/2018
P	Quality of Care Policy	Procedures billed by a pathologist that are outside the scope of pathology practice are not payable.	1/01/2018
P	Quality of Care Policy	Procedures billed by a podiatrist that is outside the scope of podiatry practice are not payable.	1/01/2018
P	Quality of Care Policy	Manipulation of spine requiring anesthesia, any region (CPT code 22505) is not payable under the Chiropractor specialty.	1/01/2018
P	Quality of Care Policy	Determination of refractive state (CPT code 92015) is not payable if the provider specialty not Ophthalmology or Optometry.	1/01/2018
P	Radiation Oncology Policy	Radiation treatment management (CPT code 77427) is not payable when billed more than once in a five-day period by any provider.	1/01/2018
F, P	Radiology Policy	Abdominal ultrasound (CPT codes 76700-76705) are not payable when billed and the only diagnosis on the claim is infectious mononucleosis.	1/01/2018
F, P	Radiology Policy	Dual energy X-ray absorptiometry [DXA], bone density study (CPT code 77080 or 77081) is not payable when the only diagnosis on the claim is osteoporosis screening and the member is a male less than 70 years of age.	1/01/2018
F, P	Radiology Policy	Chest x-ray (CPT code 71045 or 71046) is not payable when billed and the only diagnosis on the claim is a	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
		general medical exam, pre-admission, administrative or pre-operative exam.	*Terminated effective 9/24/2023*
F, P	Radiology Policy	CPT 71101-LT (X-ray, ribs, unilateral, three views; left) is not payable when billed with 71101-RT (X-ray, ribs, unilateral, three views; right). CPT71111 (X-ray, ribs, bilateral, four views) is for bilateral.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	Radiology Policy	Additional rib x-ray series are not payable when another rib x-ray series (71100, 71101, 71110 or 71111) has been previously paid for the same date of service.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	Radiology Policy	CPT 71101-LT (X-ray, ribs, unilateral, three views; left) is not payable when billed with 71101-RT (X-ray, ribs, unilateral, three views; right). CPT71111 (X-ray, ribs, bilateral, four views) is for bilateral.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	Radiology Policy	CPT 71101-LT (X-ray, ribs, unilateral, three views; left) is not payable when billed with 71101-RT (X-ray, ribs, unilateral, three views; right). CPT71111 (X-ray, ribs, bilateral, four views) is for bilateral.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	Radiology Policy	CPT 71100 (X-ray, ribs, unilateral; 2 views) appended with modifier 50 is not payable.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
F, P	Radiology Policy	72100 (Radiologic exam, spine, lumbosacral, AP and lateral) is not payable when billed with 72040 (Radiologic exam, spine, cervical, AP and lateral) and 72070 (Radiologic exam, spine, thoracic; AP and lateral). 72084 (Radiologic exam, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed) is the comprehensive code.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Radiology Policy	Radiologic examination, knee; 1 or 2 views (CPT code 73560) or radiologic exam, knee, three views OR complete (CPT codes 73562-73564) is not payable when billed on the same date of service as radiologic examination, knee; both knees, standing, anteroposterior (CPT code 73565) and the modifiers are the same or blank.	1/01/2018
P	Radiology Policy	Transvaginal ultrasound (76830) is not payable when the only diagnosis on the claim is encounter for ovarian cancer screening (Z12.73).	2/15/2025

Claim Type	Medical Policy	Rule Description	Effective Date
P	Radiology Policy	Hip ultrasounds for infants (CPT codes 76885 or 76886) are not payable when billed with a screening or normal exam diagnosis (Z00.11-Z00.111, Z00.129, Z01.89, Z13.828, Z13.89, Z13.9)	2/15/2025
F, P	Related Services- to a Noncovered Procedure	Certain procedures are deemed to be non- covered by health plans based on their medical and/or payment policies. This rule identifies procedure codes or revenue codes billed by the same or a different provider, on the same or a different claim ten-days prior to, the same day as or within seven days after a non-covered service. The rule requires a match on the first three digits of a line's diagnosis code to determine if the deny line procedure or revenue code is related to the non-covered service. The rule also looks to see if the non-covered procedure was denied for payment. If the non-covered procedure was paid, then the related service would not be recommended for denial via this rule. This rule audits both facility and non-facility claims. The content of this rule is intended to be supplied by the health plan and should be based on their medical and/or payment policies. A "starter set" of data for this rule is provided and it contains procedures such as all lab, anesthesia, radiology, revenue and evaluation and management codes; HCPCS "J" codes for drugs; HCPCS "A" codes for supplies; select CPT surgery and medicine codes such as venipuncture and EKGs among others.	2016
F	Revenue Code Policy	Home health or hospice visits are not payable when the HCPCS code and the revenue code do not match.	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
F	Revenue Code Policy	Evaluation and Management services reported with Revenue Code 0450 are not payable when billed with another evaluation and management service reported with Revenue Code 0451 or 0452.	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*

Claim Type	Medical Policy	Rule Description	Effective Date
F	Revenue Code Policy	Claim lines submitted with Bill Type 0140-014Z and without Revenue Code 0300-0319 are not payable.	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
F	Revenue Code Policy	Claims where the revenue code is 0300-0319 (Laboratory/pathology) and the HCPCS code does not match are not payable.	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
F, P	Revenue Code Policy	Home health or hospice visits are not payable when the HCPCS code and the revenue code do not match.	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022* *Updated to include Facility claims effect. 12/01/2021*
F	Revenue Code Policy	Revenue codes that CMS indicates requires a HCPCS code are not payable when submitted with Bill Type 0120-012Z or 0140-014Z, without Condition Code 41, and without a HCPCS code.	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*
F	Revenue Code Policy	Revenue code 0452 is not payable when billed without revenue code 0451.	1/01/2018 *Updated to include CNY, PPOC, PPOMR effective 8/01/2022*

Claim Type	Medical Policy	Rule Description	Effective Date
F	Revenue Codes Requiring CPT or HCPCS Codes	The Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS) Detailed Program Edits require certain revenue codes to be reported with a Healthcare Common Procedure Coding System (HCPCS) code. Revenue codes are summary billing codes required on the UB-92 claim form to represent the type of service provided and where it was performed. According to CMS OPPS Detailed Program Edits, for certain bill types and certain revenue codes a HCPCS code must also be submitted. This rule recommends the denial of claim lines submitted with a revenue code that requires a HCPCS code and no HCPCS code is present. The OPPS Detailed Program Edits do not provide instruction as to which HCPCS code should be submitted with each revenue code. Therefore, this edit only fires if there is no HCPCS code on the claim.	1/1/2018
P	Secondary Diagnosis Codes	Procedures or services received with a secondary diagnosis code as the principal or primary diagnosis are not payable.	8/31/2021
F, P	Separate Procedures Policy	Separate procedures are not payable when billed with the associated major procedures.	1/01/2018
P	Separate Procedures Policy	Procedures designated as a “separate procedure” are not payable when submitted with a related major procedure by the same provider for the same date of service.	All PPO 1/01/2022 HMOMR and HMOC 03/17/2021 HMOMD 10/01/2021
P	Separate Procedures Policy	Add-on CPT codes are not payable when submitted and the primary code has not been billed AND paid for the same date of service by the same provider.	1/01/2022
P	Separate Procedures Policy	Procedures or services that are designated as a bundled/incidental or packaged per the CMS National Physician Fee Schedule Relative Value File (NPFSRVF), Outpatient Prospective Payment System (OPSI), or Ambulatory Payment Classifications (APC) are not payable.	All PPO 1/01/2022 HMOMR and HMOC 03/17/2021 HMOMD 10/01/2021
P	Smoking and Tobacco Use Cessation Counseling	CPT code 99406 or 99407 (Smoking and tobacco use cessation counseling visit) are not when billed without a diagnosis of tobacco or nicotine dependence.	9/15/2021

Claim Type	Medical Policy	Rule Description	Effective Date
F, P	Split Surgical Care Policy	Fracture or dislocation care codes billed in the office within 10 days of the same fracture or dislocation care code by any provider are not payable.	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Split Surgical Care Policy	Fracture or dislocation care codes billed in the office within two weeks of a different fracture or dislocation care code by any provider are not payable.	1/01/2018
P	Split Surgical Care Policy	Procedures billed with either modifier 54, 55 or 56 are not payable when another provider has billed the same code globally without a modifier.	1/01/2018
P	Split Surgical Care Policy	Procedures with a 90-day global surgical period are not payable to Emergency Medicine physician in the emergency room setting (POS 23) (CMS), unless billed with modifier 54 (Surgical care only).	1/01/2018
F, P	Split Surgical Care Policy	Procedures with a 90-day global surgery period are not payable when billed in the provider's office when any provider has billed this procedure code in the previous 90 days. (CMS)	1/01/2018 *Updated to include Facility claims effect. 12/01/2021*
P	Split Surgical Care Policy	Procedures billed without modifier 54, 55 or 56 are not payable when another provider has billed the same procedure with modifier 54, 55 or 56.	1/01/2018
P	Split Surgical Care Policy	Procedures inappropriately billed with modifiers 54, 55, and 56 are not payable.	1/01/2018
P	Split Surgical Care Policy	10-day fracture or dislocation care codes are not payable when it is billed in the office within 10 days of the same fracture or dislocation care code by any provider.	1/01/2018
P	Split Surgical Care Policy	Fracture or dislocation care codes are not payable when it is billed in the office within 2 weeks of a different fracture or dislocation care code billed by any provider.	1/01/2018
P	Split Surgical Care Policy	Procedures billed with either modifier 54, 55 or 56 are not payable when another provider has billed the same code globally without a modifier.	1/01/2018
P	Split Surgical Care Policy	Procedure codes with modifier 54 (Surgical care only) is not payable when billed by an Emergency Medicine physician in the emergency room setting (POS 23).	1/01/2018
P	Split Surgical Care Policy	Major procedures are not payable when billed in the provider's office by any provider who has billed this procedure code in the previous 90 days.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Surgical Global Fee Period Policy	Physician visits or procedures/services are not payable when billed by the operative provider with a related diagnosis within the postoperative period of a surgical procedure as defined within the CMS National Physician Fee Schedule Relative Value File (NPFSRVF).	All PPO 1/01/2022 HMOMR and HMOC 03/17/2021 HMOMD 10/01/2021
P	Team Surgery Policy	CPT codes not designated as allowed for Team Surgery are not payable when billed with modifier 66.	1/01/2018
P	Team Surgery Policy	Procedure billed without modifier 66 (Team Surgery) are not payable when there exists a previously processed claim for the same procedure code with modifier 66 by any provider (CMS).	1/01/2018
P	Team Surgery Policy	Medical and surgical procedures are not payable when billed with modifier 66 and the Team Surgery concept does not apply. (CMS)	1/01/2018
P	Team Surgery Policy	Procedures billed with modifier 66 are not payable when there exists a previously processed claim for the same procedure code without modifier 66 by any provider.	1/01/2018
P	Telehealth Services	Telehealth services are not payable when billed with modifier GQ (Via asynchronous telecommunications system) and the place of service is not 02 (Telehealth).	3/01/2020
P	Telehealth Services Modifiers G0, GQ and 95	Services that are inappropriately billed with telehealth services modifier G0 (Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke) are not payable.	3/01/2020
F	Telehealth Services Modifiers G0, GQ and 95	Services billed with Revenue Code 0960-0989 (Professional Services) that are inappropriately billed with telehealth services modifier G0 (Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke) are not payable.	3/01/2020
P	Telehealth Services Modifiers G0, GQ and 95	Services reported with modifier 95 (Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system) when billed with any code other than an approved telemedicine service code are not payable.	3/01/2020

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

Claim Type	Medical Policy	Rule Description	Effective Date
P	Unbundled Pair- CMS/AMA	Intraoperative neurophysiological monitoring is utilized during the performance of surgical procedures in order to assure that the nervous system has not been compromised or damaged during the primary surgical procedure. According, to CPT guidelines, when the monitoring service is performed by the operating surgeon or anesthesiologist, the professional services are included in the surgeon's or anesthesiologist's primary service codes for the procedure and should not be reported separately. In addition, nerve monitoring procedures will only be reimbursed when they are performed as a diagnostic service. This logic is also supported by the CMS guideline for Standard of Medical/Surgical Practice found in the National Correct Coding Policy Manual for Part B Medicare Carriers, Chapter I that states, "Examples of services integral to a large number of procedures include: isolation of structures limiting access to the surgical field such as bone, blood vessels, nerve, and muscles including stimulation for identification or monitoring."	1/1/2018
P	Unbundled Pair- CMS/AMA	Intraoperative neurophysiology testing services shall not be reported by the physician performing an operative or anesthesia procedure since it is included in the global package of the primary surgical procedure.	1/1/2018
P	Unbundled Pair- CMS	Identifies claim lines containing Procedure Codes that are typically not recommended for reimbursement when submitted with certain other Procedure Codes on the same date of service. Provider matching will be based on TIN and Specialty. Modifier override will include both the deny line and support line. This includes Incidental, Mutually Exclusive, Ultimate Parent Rebundling, and Visit codes that are not separately payable. The sources of this edit are the AMA CPT code guidelines, and/or CMS NCCI Policy Manual, and/or CMS Claims Processing Manual. Examples of incidental services are: • CPT 36415 Venipuncture when also billing for laboratory procedure codes.	10/01/2021

Claim Type	Medical Policy	Rule Description	Effective Date
		• CPT 81002 Urinalysis dipstick with an Evaluation and Management code unless appended with modifier 25	
P	Unbundled Pair- AMA	According to April 1991 CPT Assistant, evaluation of x-rays by a consulting or primary physician is considered to be an integral component of the global evaluation and management services for a patient. Thus, the reporting of CPT code 76140 with an evaluation and management service represents an overlap of service and duplication of effort that does not warrant separate reimbursement	1/1/2018
P	Unbundled Pair – AMA	According to the November 1999 CPT Assistant, "when acuity is measured as part of a general ophthalmological service or of an E/M service of the eye, it is part of the diagnostic examination and not a screening test". Screening test of visual acuity (CPT codes 99172 and 99173) is considered a component of a comprehensive evaluation and management visit and does not warrant separate reimbursement. If a separate and distinct screening of visual acuity is performed in addition to a problem-oriented E/M service which did not involve eye or vision testing additional reimbursement may be warranted for this unique clinical scenario. (Check code pair edits and make sure preventive E/Ms are excluded)	1/1/2018
P	Unbundled Pair – AMA	CPT code 37617 is used to describe the tying off of an abdominal artery completely (ligation), proximal and distal to the site of injury. According to CPT guidelines, if during an abdominal procedure involving the removal of tissue (organ) ligation of an artery is deemed necessary, the ligation of vessels would not be separately reported.	1/01/2018
P	Unbundled Pair – AMA	According to CPT guidelines, surgical preparation (CPT codes 15002-15005), are not to be reported with wound management and debridement services.	1/01/2018
P	Unbundled Pair – AMA	According to CPT guidelines for radiation treatment management (CPT code 77427), evaluation and management services are not reported separately. Thus, the reporting of an office visit with radiation treatment management represents overlapping of services and does not warrant separate reimbursement.	1/01/2018

Claim Type	Medical Policy	Rule Description	Effective Date
P	Unbundled Pair – CMS/AMA	Intraoperative neurophysiology testing services shall not be reported by the physician performing an operative or anesthesia procedure since it is included in the global package of the primary surgical procedure.	1/01/2018
P	Unbundled Pair – CMS/AMA	Intraoperative neurophysiological monitoring is utilized during the performance of surgical procedures in order to assure that the nervous system has not been compromised or damaged during the primary surgical procedure. According, to CPT guidelines, when the monitoring service is performed by the operating surgeon or anesthesiologist, the professional services are included in the surgeon's or anesthesiologist's primary service codes for the procedure and should not be reported separately. In addition, nerve monitoring procedures will only be reimbursed when they are performed as a diagnostic service. This logic is also supported by the CMS guideline for Standard of Medical/Surgical Practice found in the National Correct Coding Policy Manual for Part B Medicare Carriers, Chapter I that states, "Examples of services integral to a large number of procedures include: isolation of structures limiting access to the surgical field such as bone, blood vessels, nerve, and muscles including stimulation for identification or monitoring."	1/01/2018
P	Urology Policy	CPT 76857 (Ultrasound, pelvic [non-obstetric], limited or follow-up) is not payable when billed on same date of service as 51725-51729 (Simple or complex CMG), 51736 (Simple uroflowmetry), or 51741 (Complex uroflowmetry). Refer to CPT 51798 (Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging.	1/01/2018
P	Urology Policy	Nocturnal penile rigidity test (CPT code 54250) is not payable beyond two units in three consecutive days when billed by any provider.	1/01/2018

Revision history:

DATE	REVISION
1/27/2025	*Updates highlighted in yellow in policy above* • 2 new edits effective 1/1/2025
10/23/2024	*Updates highlighted in yellow in policy above* • 3 new edits effective 10/1/2024 • 1 new edit effective 11/1/2024 • 4 new edits effective 2/15/2025 • 1 new edit effective 4/15/2025 Drugs and Biologicals Policy updates: • 2 edits terminated and replaced by 2 new edits, effective 4/1/2024
7/30/2024	• *Update highlighted in yellow in policy above* 1 new edit effective 12/6/2024
6/18/2024	*Updates highlighted in yellow in policy above* • 6 new edits effective 10/15/2024
6/6/2024	*Update highlighted in yellow in policy above* • 1 new edit effective 1/1/2024
4/29/2024	• Updated edit to include HCPCS code A4553; now reads: "Elastic garment/covering, each (HCPCS code A4466), surgical leggings (HCPCS codes A4490-A4510), incontinence garment (HCPCS code A4520), disposable underpads (HCPCS codes **A4553 and** A4554) , surgical face mask (HCPCS code A4928), exercise equipment (HCPCS code A9300), bath and toilet aids (HCPCS codes E0240-E0245), bed boards (HCPCS code E0273), over bed tables (HCPCS code E0274), bed accessory: board, table, or support device, any type (HCPCS code E0315), patient lift, bathroom (HCPCS code E0625), whirlpool, portable (HCPCS code E1300), whirlpool tub, walk-in, portable (HCPCS code K1003), and diapers (HCPCS codes T4521-T4545) are non-covered services."
3/24/2024	• Updated edit "In accordance with our policy, colonoscopies, sigmoidoscopies, and proctosigmoidoscopies are only covered with specific indications. Please refer to our policy for additional details" with EmblemHealth policy hyperlink for clarification
3/8/2024	• Bilateral Procedures – Modifiers 50, RT, LT (Codes with Bilateral Indicator 1) edit rule description updated to clarify that "If the same code is reported once with modifier RT and once with modifier LT this is not allowed. Instead, the code should be reported with modifier 50 for 1 unit. The 150% payment adjustment will apply."
12/11/2023	*Updates highlighted in yellow in policy above* • 2 new edits effective 4/15/2024 • 1 new edit effective 1/1/2024

DATE	REVISION
10/23/2023	• Typo corrected in Procedure Code Definition Policy edit "Procedure codes and/or their related guidelines contain specific descriptive criteria for use. Services are not payable if they do not meet the code criteria. Examples: G0266 and 93298 are for a 30-day period; G0268 requires an audiologic function testing on same date of service; 93294 has a ***9-day global period.***" Corrected to read "90-day global period."
9/28/2023	• Termed Ophthalmology edit "Scanning computerized ophthalmic diagnostic imaging, retina (CPT code 92134) is not payable when billed more than once within a 28-day period when the diagnosis is retinal disease" **effective 9/24/2023**
9/11/2023	• 1 edit termed for Commercial, Medicare, & Medicaid **effective 3/26/2023** • 5 edits termed for Commercial, Medicare, & Medicaid **effective 9/24/2023** • 1 edit termed for Medicare **effective 9/24/2023**
9/1/2023	• Termed Allergy Testing edit "CPT code 86003 (Allergen specific IgE) is limited to **30** units per year when billed by any provider" **as of 2/28/2023** • Added edit "CPT code 86003 (Allergen specific IgE) is limited to **40** units per year when billed by any provider" with **effective date 3/1/2023**
7/17/2023	• Updated to correct typo for National Correct Coding Manual Policy edit; corrected "1000" to "81000"
6/12/2023	• Corrected edit "Complete and limited non-obstetric pelvic ultrasounds, CPT codes 76856 and 76857, are not covered when billed with transvaginal ultrasounds, CPT code 76830, during the same visit" to include Facility claim type
6/5/2023	• Added update to edit "Claim lines reported with mutually exclusive code combinations according to ICD-10-CM Excludes 1 Notes guideline policy are not payable" indicating that edit will apply to preventative services effective 9/15/2023
5/11/2023	• Updated policy to include 5 new edits **effective 9/13/2023**
1/30/2023	• Line of Business (LOB) column removed
11/09/2022	• 1 new edit effective 3/15/2023
10/04/2022	• Catalog of current Cotiviti edits updated • 1 new edits effective 1/01/2023
9/20/2022	• Ophthalmology Policy (CPT 92134) edit rule description updated to clarify that "Scanning computerized ophthalmic diagnostic imaging, retina (CPT code 92134) is not payable when billed more than once within a 28-day period when the diagnosis is retinal disease".
7/14/2022	• Catalog of current ClaimsXten and Cotiviti edits updated
5/02/2022	• Edits for outpatient services updated to include City of NY Commercial (CNY), PPO Commercial (PPOC), and/or PPO Medicare (PPOMR) lines of business effective 8/01/2022.

DATE	REVISION
1/24/2022	• 1 new edit effective 3/01/2022 • 3 edits terminated effective 1/01/2020
1/13/2022	• Catalog of current ClaimsXten and Cotiviti edits updated • Bilateral Procedures- Modifiers 50, RT, LT rule updated with clarification regarding CMS bilateral indicators 0, 2, 3 and 9
11/2021	• Updated policy to include one new edit effective 3/01/2022
10/2021	Corrections to effective dates noted in 9/2021: • 7 edits effective 2/01/2022 • 21 edits effective 1/01/2022
9/2021	• Updated policy to include 28 edits effective 1/01/2022
7/2021	• Updated policy to indicate 4 edits terminated effective 3/30/2021 • Updated policy to include one new edit effective 1/01/2022 • Updated edits to include Facility claims effective 12/01/2021 • Updated policy to include 5 edits effective 9/15/2021
6/2021	• Updated policy to include 13 new edits effective 9/01/2021 • Updated policy to include 11 new edits effective 10/01/2021 • Catalog of ClaimsXten, Cotiviti, and/or Zelis coding edit rules; transferred content to new template with new Reimbursement Policy Number