Administrative Claims Edits Guide

Summary of Updates

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The Administrative Claims Edits Guide – Summary of Updates outlines the changes made to Presbyterian's administrative claims payment edits. The table below identifies the administrative claim edit name, its effective date, a description of the claim edit and the line of business to which it applies.

Appendix A

To access and view all Laboratory Benefit Management (LBM) policies, please view Appendix A. Pending LBM policies can be found here.

Appendix B

For guidance on all Payment Policy Management (PPM) claims edits, view Appendix B.

Appendix C

For guidance on all Enhanced Claims Processing Program (ECPP) policies, view Appendix C.

Additional Resources

- Revised Emergency Department Outpatient Facility E/M Coding Policies
- Payment Policy Review Guide – Summary of Updates

Questions

Contact the Presbyterian Provider Line at (505) 923-5757.

Legend

ADA: The Americans with Disabilities Act

AMA: American Medical Association

ACS: American College of Surgeons

CMS: Centers for Medicare & Medicaid Services

CPT: Current Procedural Terminology

CRNA: Certified Registered Nurse Anesthetist

DME: Durable Medical Equipment

E/M: Evaluation and Management

FDA: Food and Drug Administration

HCPCS: Healthcare Common Procedure Coding System

ICD: International Classification of Diseases

LCD: Local Coverage Decisions

LOB: Lines of Business

NCCI/CCI: National Correct Coding Initiative

NCD: National Coverage Determination

OPPS: Hospital Outpatient Prospective Payment System

RVU: Relative Value Unit

2024-2026 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
Clinical Laboratory Improvement Amendments of 1988 (CLIA) Waived Tests without QW Modifier	3-9-2026	Enforcement of correct coding and billing guidelines regarding Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests without QW Modifier. CLIA waived tests are a group of 122 tests that are currently cleared by the FDA for home use. CMS identifies the maintenance of waived tests by the addition of modifier QW and, per the American Academy of Professional Coders (AAPC), the QW modifier must be submitted in the first modifier field. When a professional lab claim is billed in place of service 11 with one of the approved CLIA tests, a QW modifier is required. If a professional lab claim is submitted from POS 11 with CILA waived tests but the claim is missing the QW modifier, the claim/line will be denied.	ALL
4 Laboratory Benefit Management (LBM) policies were updated	3-1-26	The 4 LBM policies below were updated in ways that may affect how claims are processed. To see the pending versions of these policies, please click here. • Cervical Cancer Screening • Diagnostic Testing of Common Sexually Transmitted Infections • Oral Cancer Screening and Testing • Urine Culture Testing for Bacteria The currently enforced LBM policies can be accessed in Appendix A of this guide. For the full list of updates made to any LBM policy, please refer to the Revision History section at the end of each policy.	ALL
Fecal Calprotectin Testing in Adults	2-1-26	Policy retired. This policy will no longer be part of the Laboratory Benefit Management (LBM) program.	ALL
Incorrect Billing of Modifier 25 With a Level One E/M	2-1-26	Enforcement of correct coding and billing guidelines regarding the Incorrect Billing of Modifier 25 With a Level One E/M Service.	ALL

2024-2026 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
Service (Professional) View Tip Guide		A level one Evaluation and Management (E/M) service — typically billed under CPT code 99211 — represents the lowest level of care available for an established patient. It usually involves minimal presenting issues and may not require the presence of a physician. Because of this, there are no major decision-making or examination components associated with this code. In contrast, modifier 25 is used when a provider performs an additional, separate and significant service during the same visit as another procedure or E/M service. Thus, the use of modifier 25 in conjunction with CPT code 99211 is inherently contradictory. Therefore, when a professional claim line is submitted with E/M code 99211 and modifier 25 is appended, the line will be denied.	
7th Character and Therapy Codes	1-1-26	Enforcement of correct coding and billing guidelines regarding the 7th Character and Therapy Codes. On Oct. 1, 2015, several changes and additions went into effect during the transition from the ICD-9 coding system to ICD-10. One such addition is the correct use of an alphanumeric as the 7th character when billing specific ICD-10 codes to indicate if the member is receiving active treatment (A), subsequent treatment (D) or sequela (S). The ICD-10 states that active treatment occurs when a provider sees the patient and develops a plan of care. This means that when a patient is following the plan, that visit is considered a subsequent visit. Additionally, therapy treatments require a plan of care prior to those services being rendered, meaning all therapy billed with an ICD-10 requiring a 7th character should be billed as a subsequent treatment.	ALL

2024-2026 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
		If a claim for therapy codes (PT, OT, SLP) is billed with an ICD-10 code and contains an active (A) alphanumeric as the 7th character, the therapy code will be denied. If a modality procedure code is submitted on the same date of service, by the same provider, with the same diagnosis code as the therapy procedure code, the modality claim line will also be denied.	
Sexually Transmitted Infections (STI) Testing	1-1-26	Enforcement of correct coding and billing guidelines regarding Sexually Transmitted Infections (STI) Testing. Presbyterian Health Plan, Inc. is introducing a custom edit to ensure correct coding and billing for STI laboratory testing. When more than one single-organism CPT code (87491, 87591, 87661) is billed for the same member, provider and date of service, the claim will be denied and instead considered under the comprehensive CPT code 87801. This edit is designed to prevent unbundling of services and to support proper reimbursement practices across both professional and outpatient claims, effective January 2026. This approach is supported by national guidance and payer precedent. CMS's National Coverage Determination (NCD) sets clear limits on frequency and billing of STI screenings and counseling, emphasizing compliance with coding integrity.	ALL
The Payment Policy Review Guide – Summary of Updates launches with billing guidance for 5 payment policies	1-1-26	The purpose of the new guide is to prevent future payment errors and improve reimbursement processes. The intent is to provide guidance on payment policies that are being reshaped to align with CMS, CPT, and other federal and state guidelines. To access the guide, click here.	ALL
Medications Unbundled From End-Stage Renal	12-1-25	Enforcement of correct coding and billing guidelines regarding Medications	ALL

2024-2026 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
Disease (ESRD) Treatment		Unbundled From End-Stage Renal Disease (ESRD) Treatment. As of January 2011, federal law requires the Centers for Medicare & Medicaid Services (CMS) to bundle Medicare reimbursement for almost all ESRD treatments, including drugs that previously were separately billable, into one payment rate. Claim lines for drugs that are billed to ESRD patients should be bundled into the reimbursement for the ESRD dialysis treatment and issued by the same provider on the same date of service. If they are not bundled, the lines will be denied.	
5 Laboratory Benefit Management (LBM) policies were updated	12-1-25	The 5 LBM policies below were updated in ways that may affect how claims are processed: • General Inflammation Testing • Hepatitis Testing • Identification of Microorganisms Using Nucleic Acid Probes • Pancreatic Enzyme Testing for Acute Pancreatitis • Serum Testing for Evidence of Mild Traumatic Brain Injury The currently enforced LBM policies can be accessed in Appendix A of this guide. For the full list of updates made to any LBM policy, please refer to the Revision History section at the end of each policy.	ALL
44 Payment Policy Management (PPM) policies have been added to the program	11-21-25	The 44 PPM policies can be found in Appendix B.	ALL
The Enhanced Claims Processing Program (ECPP)	11-1-25	ECPP is a new claims program launching with 14 initial policies. Please refer to Appendix C for more information.	ALL

2024-2026 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
launches with 14 initial policies			
47 PPM policies have been added to the program	10-26-25	The 47 PPM policies can be found in Appendix B.	ALL
Presumptive Drug Testing	10-13-25	Enforcement of correct coding and billing guidelines regarding Presumptive Drug Testing. Drug testing for illicit substances is divided into two categories, presumptive and definitive. Only one presumptive and one definitive drug testing code may be billed per patient per day as indicated by the code description regardless of the provider. If more than one drug test per category is billed on a single patient on the same date of service, only the highest complexity code within each category will be reimbursed. Per CMS guidance.	ALL
Maximum Frequency per Day	10-13-25	Enforcement of correct coding and billing guidelines regarding Maximum Frequency per Day (MFD). An MFD is a unit-of-service edit for HCPCS/CPT codes for services rendered by a single provider/supplier to a single beneficiary on the same date of service. MFDs can be either claim line or date-of-service edits. The MFD coincides with the maximum units of service allowed for HCPCS/CPT codes on a single date of service. If the units of service billed on a claim line or for the date of service exceed the MFD value for that HCPCS/CPT code, then the claim line or units of service for that code will be denied. Per CMS guidance.	Commercial
Anatomical Modifier – Radiology	10-1-25	Enforcement of correct coding and billing guidelines regarding Anatomical Modifier – Radiology. Without the proper anatomical modifier applied to the procedure code, there is risk of duplicate claims payment, incorrect procedure to procedure bundling, incorrect frequency limitations and unnecessary medical record review. Claims containing radiology procedure codes	ALL

2024-2026 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
		requiring anatomical modifiers will be denied when the line does not contain an anatomical modifier.	
Multiple Procedure Payment Reduction for Indicators 2 & 3	10-1-25	Enforcement of correct coding and billing guidelines regarding Multiple Procedure Payment Reduction related to Indicators 2 & 3. Multiple Procedure Payment Reduction applies when multiple services are furnished to the same patient during the same session and on the same day, according to CMS guidance. Indicators 2 & 3 receive a flat 50% reduction on each additional service billed.	ALL
Multiple Procedure Payment Reduction for Indicator 4	10-1-25	Enforcement of correct coding and billing guidelines regarding Multiple Procedure Payment Reduction related to Indicator 4. Multiple Procedure Payment Reduction applies when multiple services are furnished to the same patient during the same session and on the same day, according to CMS guidance. Indicator 4 receives a percent reduction on each additional service billed. The percent reduction is based on the component billed: professional, technical or global.	ALL
Multiple Procedure Payment Reduction for Status T	10-1-25	Enforcement of correct coding and billing guidelines regarding Multiple Procedure Payment Reduction related to Status T indicators. For OPPS Methodology, services with Status T indicators are subject to a multiple procedure payment reduction per CMS guidance. Each additional service billed will receive a flat 50% reduction.	ALL
Hospice Overlap	9-1-25	Presbyterian will utilize CMS and New Mexico Health Care Authority guidelines to review claims that occur between the admission and discharge dates of a given member's hospice care. Claims that are determined to be ineligible for separate reimbursement from hospice care will be denied.	ALL

2024-2026 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
16 LBM policies were updated	8-15-25	The 16 LBM policies below were updated in ways that may affect how claims are processed: • Allergen Testing • Biomarker Testing for Autoimmune Rheumatic Disease • Colorectal Cancer Screening • Diagnosis of Vaginitis • Flow Cytometry • *Helicobacter pylori* Testing • Human Immunodeficiency Virus (HIV) • Onychomycosis Testing • Parathyroid Hormone, Phosphorus, Calcium and Magnesium Testing • Pediatric Preventive Screening • Prenatal Screening (Nongenetic) • Prescription Medication and Illicit Drug Testing in the Outpatient Setting • Prostate Specific Antigen (PSA) Testing • Salivary Hormone Testing • Thyroid Disease Testing • Urinary Tumor Markers for Bladder Cancer The currently enforced LBM policies can be accessed in Appendix A of this guide. For the full list of updates made to any LBM policy, please refer to the Revision History section at the end of each policy.	ALL
Surgical Procedure Anatomical Modifier – Fingers and Toes	7-1-2025	Enforcement of correct coding and billing guidelines regarding Surgical Procedure Anatomical Modifier – Fingers and Toes. Without the proper anatomical modifier applied to the procedure code, there is risk of duplicate claims payment, incorrect procedure to procedure bundling, incorrect frequency limitations and unnecessary	ALL

2024-2026 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
		medical record review. Claims containing finger and toe surgical procedure codes requiring anatomical modifiers will be denied when the line does not contain an anatomical modifier.	
Shoulder Arthroscopy Unbundling	7-1-2025	Enforcement of correct coding and billing guidelines regarding Shoulder Arthroscopy Unbundling. CMS considers the shoulder to be a single joint; therefore, providers cannot separate procedures by using an override modifier (59) to bypass shoulder arthroscopy code bundling pairs when the work performed was in the same operative space. This means that the Column Two shoulder arthroscopy procedure will be denied if reported with the Column One shoulder arthroscopy code when performed on the same side, by the same provider, on the same member, and on the same date of service regardless of an appended 59 modifier. Per CMS and NCCI guidelines.	ALL
Medically Unlikely Edits	5-16-2025	Enforcement of correct coding and billing guidelines regarding Medically Unlikely Edits (MUE). An MUE is a unit-of-service edit for HCPCS/CPT codes for services rendered by a single provider/supplier to a single beneficiary on the same date of service. MUEs can be either claim line or date-of-service edits. The MUE coincides with the maximum units of service allowed for HCPCS/CPT codes. If the units of service billed on a claim line or for the date of service exceeds the MUE value for that HCPCS/CPT code, then the claim line or units of service for that code will be denied. Per CMS guidance.	Medicare, Medicaid
Inpatient Readmissions	5-16-2025	Enforcement of correct coding and billing guidelines regarding Inpatient Readmissions. A readmission review applies when a patient is admitted to an acute, general, short-term hospital within 15 calendar days (Medicaid) or 31 calendar days (Medicare & Commercial) of discharge from	ALL

2024-2026 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
		the same or another short-term hospital for the same or a related diagnosis. If the readmission is deemed medically unnecessary, is due to a premature discharge, or if the patient left the hospital before completing initial treatment, payment for the readmission claim may be denied. Per CMS and New Mexico Health Care Authority guidelines for inpatient readmission reviews.	
Inpatient/ Outpatient Overlap	5-16-2025	Enforcement of correct coding and billing guidelines regarding Inpatient/Outpatient Overlap. CMS Guidelines state: "Outpatient service dates that fall totally within inpatient admission and discharge dates at the same or another provider or outpatient bill that overlaps an inpatient admission are considered exact duplicates and should be rejected." Presbyterian will follow CMS guidance regarding reimbursement for outpatient services that overlap an inpatient stay.	ALL
Skilled Nursing Facility/Durable Medical Equipment Overlap	5-16-2025	Enforcement of correct coding and billing guidelines regarding Skilled Nursing Facility (SNF)/Durable Medical Equipment (DME) Overlap. Presbyterian follows the CMS consolidated billing guidelines for SNFs, in which services a member receives during a SNF stay are included in the SNF reimbursement and not separately reimbursable. DME is not considered to be an exception to SNF consolidated billing and will not be reimbursed separately.	ALL
Inpatient/Physician Overlap	5-16-2025	Enforcement of correct coding and billing guidelines regarding Inpatient/Physician Overlap. Presbyterian will utilize CMS and New Mexico Health Care Authority guidelines to review physician claims that occur between the admission and discharge dates of a given member's inpatient stay. Physician claims that are determined to be ineligible for separate reimbursement from an inpatient stay will be denied.	ALL

2024-2026 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
Measurement of Thromboxane Metabolites for ASA Resistance	2-17-2025	Policy retired. This policy will no longer be part of the Laboratory Benefit Management (LBM) program.	ALL
Three-Day Payment Window & One-Day Payment Window	4-25-2025	Enforcement of correct coding and billing guidelines regarding Three-Day Payment Window and One-Day Payment Window. Presbyterian will follow CMS payment window policy stating that diagnostic or clinically related outpatient services rendered within a three-day window prior to a member's inpatient admission should be bundled into the inpatient claim. Specialty hospital types defined by CMS follow the same guidelines but are subject to a one-day payment window (psychiatric hospitals and units, inpatient rehabilitation hospitals and units, long-term care hospitals, children's hospitals and cancer hospitals). An initial retrospective review will be conducted in accordance with state regulations and guidance.	ALL
Three PPM policies have been added to the program	4-25-2025	Please see Appendix B of this guide for the newly added policies.	ALL
Seven LBM policies were updated	4-7-2025	The seven policies below were updated in ways that may affect how claims are processed. • Coronavirus Testing in the Outpatient Setting • Diabetes Mellitus Testing • Laboratory Procedures Reimbursement Policy • Prescription Medication and Illicit Drug Testing in the Outpatient Setting • Testing for Developmental Delay (was previously named "Testing for	ALL

2024-2026 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
		Autism Spectrum Disorder and Developmental Delay") • Vitamin B12 and Methylmalonic Acid Testing • Vitamin D Testing For the full list of updates made to any LBM policy, please refer to the Revision History section at the end of each policy. Note that all LBM policies can be found in Appendix A of this guide.	
Two LBM policies were updated	3-18-2025	The two policies below were updated in ways that may affect how claims are processed. • Cervical Cancer Screening • Prenatal Screening (Nongenetic) For the full list of updates made to any LBM policy, please refer to the Revision History section at the end of each policy. Note that all LBM policies can be found in Appendix A of this guide.	ALL
Procedure Not Performed	3-1-2025	Enforcement of correct coding guidelines regarding Procedure Not Performed. When diagnosis codes Z53.20, Z53.21 or Z53.29 are present on the claim indicating that the patient did not receive services billed, the claim will be denied.	ALL
Six PPM policies have been added to the program	2-27-2025	Please see Appendix B of this guide for the newly added policies.	ALL
19 LBM policies were updated	2-17-2025	The policies below were updated in ways that may affect how claims are processed. All LBM policies can be found in Appendix A. For the full list of updates made to any LBM policy, please refer to the Revision History section at the end of each policy.	ALL

2024-2026 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
		• Serum Testing for Hepatic Fibrosis in the Evaluation and Monitoring of Chronic Liver Disease • Diagnostic Testing of Common Sexually Transmitted Infections • Testing for Vector-Borne Infections • Flow Cytometry • Hepatitis Testing • Thyroid Disease Testing • Biochemical Markers of Alzheimer Disease and Dementia • Cardiovascular Disease Risk Assessment • Immunopharmacologic Monitoring of Therapeutic Serum Antibodies • Serum Tumor Markers for Malignancies • Pathogen Panel Testing • Pancreatic Enzyme Testing for Acute Pancreatitis • General Inflammation Testing • Beta-Hemolytic Streptococcus Testing • Gamma-glutamyl Transferase Testing in Adults • Venous and Arterial Thrombosis Risk Testing • Testing for Alpha-1 Antitrypsin Deficiency • Identification of Microorganisms Using Nucleic Acid Probes	

2024-2026 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
		• Oral Cancer Screening and Testing	
E/M with 57 Modifier and No Qualifying Surgical Procedure	2-1-2025	Enforcement of correct coding guidelines regarding E/M with 57 Modifier and No Qualifying Surgical Procedure. When an E/M CPT code is billed with modifier 57 appended in any position without a qualifying major surgical procedure billed on the same date of service or the day after for the same member, the claim will be denied.	ALL
Multiple Radiology and Cardiology Services	1-1-2025	Enforcement of correct coding guidelines regarding Multiple Radiology and Cardiology Services. The technical component (TC) of diagnostic imaging services is subject to a 50% reduction of the second and other subsequent imaging services when furnished by the same physician (or by multiple physicians in the same group practice; for example, same-group National Provider Identifiers) to the same beneficiary on the same day. Ex. When 70486-TC and 70450-TC are billed together, the 70450-TC is subject to a 50% reduction.	ALL
Appropriate Use of Modifier 78	1-1-2025	Enforcement of correct coding guidelines for Appropriate Use of Modifier 78. When procedures require an unplanned return to the operating room during the post-op period to deal with complications, the claim should be billed with modifier 78. Payment of the intraoperative portion of services relating to complications will be applied, per CMS guidance.	ALL
Appropriate Use of Modifier 73	1-1-2025	Enforcement of correct coding guidelines for Appropriate Use of Modifier 73. When outpatient hospital/ambulatory surgery center (ASC) procedures are discontinued prior to the administration of anesthesia but after the patient has been prepped and taken to the procedure room, the claim should be billed with modifier 73. It will be paid at 50% of the amount, per CMS guidance.	ALL

2024-2026 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
Appropriate Use of Modifier 52	1-1-2025	Enforcement of correct coding guidelines for Appropriate Use of Modifier 52. When radiology procedures and other services that do not require anesthesia are discontinued, partially reduced or canceled, the claim should be billed with modifier 52. It will be paid at a 50% rate, per CMS guidance.	ALL
10 PPM policies have been added to the program	11-27-2024	Please see Appendix B of this guide for the newly added policies.	ALL
17 LBM policies were updated	11-15-2024	These policies were updated to ensure they remain relevant and reflect existing research. However, the edits will not affect how claims are processed. All LBM policies can be found in Appendix A. For the full list of updates made to any policy, please refer to the Revision History section at the end of each policy.	ALL
Sepsis Length of Stay Less Than Three Days Discharged to Home	9-1-2024	Enforcement of correct coding guidelines for Sepsis Length of Stay Less Than Three Days Discharged to Home. Inpatient claims with an approved sepsis primary diagnosis code will be denied if the patient is discharged to home in less than three days.	ALL
Inappropriate Use of Modifier 78	9-1-2024	Enforcement of correct coding guidelines for Inappropriate Use of Modifier 78. When claim lines are submitted with a modifier 78 appended, but the place of service reported on the claim line is not an OR (POS 19, 21, 22, 23, 24, 25), the claim line will be denied.	ALL
Three LBM policies have been added to the program	8-1-2024	Therapeutic Drug Monitoring for 5-Fluorouracil RTM Testing of Homocysteine Metabolism-Related Conditions Testing for Autism Spectrum Disorders and Developmental Delay	ALL
Venipuncture Billing	8-1-2024	Enforcement of correct coding guidelines for Venipuncture Billing. When a	ALL

2024-2026 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
		venipuncture procedure (CPT code 36410 or 36415) is performed on a patient and billed for a place of service other than those listed here (office, home, assisted living facility, mobile unit, urgent care facility, inpatient hospital, outpatient hospital, emergency room, skilled nursing facility, nursing facility, clinic and independent laboratory), the venipuncture will be denied.	
Bilateral Breast Sonography	8-1-2024	Enforcement of correct coding guidelines for Bilateral Breast Sonography. When a breast sonography procedure is performed on both breasts on the same day on the same patient, the procedure must be billed as a bilateral procedure using CPT code 76641 or 76642 with a 50 modifier. Failure to code correctly will result in denial of the claim.	ALL
Units Billed Do Not Match the Dates of Service	7-15-2024	Enforcement of correct coding guidelines for Units Billed Do Not Match the Dates of Service. If a claim received has several billed units that do not match the number of days a patient received service (billed units must match the exact number of days the patient received service by date, not based on a 24-hour period), the claim will be denied.	Medicare and Commercial
Injection or Infusion Procedures	6-1-2024	Enforcement of correct coding guidelines regarding injection or infusion procedures. When an injection or infusion procedure is reported in the physician's office or the patient's home and the drug or substance administered was not reported, the claim will be denied.	ALL

2024-2026 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
Multiple Ultrasound Claims	6-1-2024 (Description updated 10-31-2024)	Enforcement of correct coding guidelines regarding Multiple Ultrasound Claims. The technical component (TC) of diagnostic imaging services is subject to a 50% reduction of the second and other subsequent imaging services when furnished by the same physician (or by multiple physicians in the same group practice; for example, same-group National Provider Identifiers) to the same beneficiary on the same day. Ex. When 76856-TC and 76830-TC are billed together, the 76856-TC is subject to a 50% reduction.	ALL
Procedures Performed on Patients Outside the Standard Age Group	6-1-2024	Enforcement of correct coding guidelines regarding procedures performed on patients outside the standard age group. When a procedure is performed on a patient who is normally outside the standard age group for that procedure, the (4563) code should be used. Failure to code correctly will result in denial of the claim.	ALL
Split Night Sleep Studies	6-1-2024	Enforcement of correct coding guidelines for split night sleep studies. The American Academy of Sleep Medicine states that the diagnostic portion and titration portion of a sleep study is not to be billed separately. CPT code 95811 is the appropriate code for a split night study and a PAP titration study. By billing these codes separately, providers essentially are billing for two procedures when only one was performed. Billing procedures separately will result in denial of the claim.	ALL
Emergency Department Claims Analyzer	5-1-2024	Emergency department visit level codes will be evaluated in the context of other claim data to ensure that they reasonably relate to the intensity of hospital resource utilization as required per CMS guidelines. Claims with improper coding will be denied or recoded. For more information, see the Revised	ALL

2024-2026 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
		Emergency Department Outpatient Facility Evaluation and Management Coding Policies resource.	
High-Level E/M With Preventive Medicine	5-1-2024	Professional claims with high-level problem-oriented E/M codes will be denied when billed by the same provider on the same date of service as a preventive E/M code.	ALL
R Codes as a Primary Diagnosis (Dx) for Pathology Claims	5-1-2024	Defined diagnosis should be provided in the first position as opposed to a symptom-based diagnosis (R Code). Claims with an R diagnosis code in the primary position for professional and outpatient pathology will be denied.	ALL
Surgical Procedure Anatomical Modifier	3-1-2024	Enforcement of correct coding guidelines regarding anatomical modifiers. Without the proper anatomical modifier applied to the procedure code, there is risk of duplicate claims payment, incorrect procedure to procedure bundling, incorrect frequency limitations and unnecessary medical record review.	ALL
Critical Care in the Emergency Room (ER), Patient Discharged to Home in Same Encounter	3-1-2024	The patient is discharged from the ER to home, and the patient is not critically ill as defined by the AMA and CMS guidelines.	ALL

2023 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOB
Unacceptable Principal Diagnosis ICD-10	7-1-2023	There is an unacceptable principal discharge status, which applies to all LOBs for inpatient (I/P) claims only, and the ICD-10 principal diagnosis is not equal to Z5189.	ALL
Hospice Value Code 61	7-1-2023	The type of bill that is in system list is identified as "DDR Hospice Type of Bills" and does not	Medicare Only

2023 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOB
		have code 0651 or 0652 associated with the claim and there is a condition code 61.	
Patient Discharge Status Missing	7-1-2023	The patient discharge status field is empty, and the current claim is denying due to missing state from date (i.e, "FTDf").	ALL

Appendix A

Effective July 1, 2024, Presbyterian implemented a new Laboratory Benefit Management (LBM) program with the goal of providing high-quality healthcare at the most affordable costs. All policies are directed at enforcing correct billing guidelines. The risk of billing for labs that do not meet indications of coverage criteria is denial of the claim. For more information about the LBM program, please view this FAQ.

To access and view all current policies that are included in the LBM program, click the links in the table below. Policies are listed alphabetically by column and continue on the next page.

Upcoming changes to LBM claims policies may be viewed here.

Laboratory Benefit Management Program Policies

LBM Policy Name (A-F)	LBM Policy Name (G-Ped)	LBM Policy Name (Pre-Z)
Allergen Testing	Gamma-glutamyl Transferase Testing in Adults	Prenatal Screening (Nongenetic)
Beta-Hemolytic Streptococcus Testing	General Inflammation Testing	Prescription Medication and Illicit Drug Testing in the Outpatient Setting
Biochemical Markers of Alzheimer Disease and Dementia	*Helicobacter pylori* Testing	Prostate Biopsy Specimen Analysis
Biomarkers for Myocardial Infarction and Chronic Heart Failure	Hepatitis Testing	Prostate Specific Antigen (PSA) Testing
Biomarker Testing for Autoimmune Rheumatic Disease	Human Immunodeficiency Virus (HIV)	Salivary Hormone Testing
Bone Turnover Markers Testing	Identification of Microorganisms Using Nucleic Acid Probes	Serum Biomarker Testing for Multiple Sclerosis and Related Neurologic Diseases
Cardiovascular Disease Risk Assessment	Immune Cell Function Assay	Serum Testing for Evidence of Mild Traumatic Brain Injury
Celiac Disease Testing	Immunohistochemistry	Serum Testing for Hepatic Fibrosis in the Evaluation and Monitoring of Chronic Liver Disease
Cervical Cancer Screening	Immunopharmacologic Monitoring of Therapeutic Serum Antibodies	Serum Tumor Markers for Malignancies
Colorectal Cancer Screening	Intracellular Micronutrient Analysis	Testing for Alpha-1 Antitrypsin Deficiency

Laboratory Benefit Management Program Policies

LBM Policy Name (A-F)	LBM Policy Name (G-Ped)	LBM Policy Name (Pre-Z)
Coronavirus Testing in the Outpatient Setting	In Vitro Chemoresistance and Chemosensitivity Assays	Testing for Developmental Delay^ (previously named "Testing for Autism Spectrum Disorder and Developmental Delay")
Diabetes Mellitus Testing	Laboratory Procedures Reimbursement Policy*	Testing for Diagnosis of Active or Latent Tuberculosis
Diagnosis of Idiopathic Environmental Intolerance	Laboratory Testing for the Diagnosis of Inflammatory Bowel Disease	Testing of Homocysteine Metabolism-Related Conditions^
Diagnosis of Vaginitis	Lyme Disease Testing	Testing for Vector-Borne Infections
Diagnostic Testing of Common Sexually Transmitted Infections	Measurement of Thromboxane Metabolites for ASA Resistance **(policy retired)**	Testosterone
Diagnostic Testing of Influenza	Metabolite Markers for Thiopurines Testing	Therapeutic Drug Monitoring for 5-Fluorouracil^
Diagnostic Testing of Iron Homeostasis & Metabolism	Nerve Fiber Density	Thyroid Disease Testing
Epithelial Cell Cytology in Breast Cancer Risk Assessment	Onychomycosis Testing	Urinary Tumor Markers for Bladder Cancer
Evaluation of Dry Eyes	Oral Cancer Screening and Testing	Urine Culture Testing for Bacteria
Fecal Analysis in the Diagnosis of Intestinal Dysbiosis and Fecal Microbiota Transplant Testing	Pancreatic Enzyme Testing for Acute Pancreatitis	Venous and Arterial Thrombosis Risk Testing
Fecal Calprotectin Testing **(will be retired on Feb. 1, 2026)**	Parathyroid Hormone, Phosphorus, Calcium and Magnesium Testing	Vitamin B12 and Methylmalonic Acid Testing
Flow Cytometry	Pathogen Panel Testing	Vitamin D Testing
Folate Testing	Pediatric Preventive Screening	

*Indicates a financial policy.

^Indicates a policy with an effective date later than July 1, 2024.

Appendix B

The Presbyterian Payment Policy Management (PPM) initiative is a set of policies being implemented to improve claims accuracy and maintain payment integrity. PPM policies initially went into effect on Sept. 1, 2024.*

To assist providers in navigating these policies, we have prepared an informational grid that includes current PPM policies, descriptions, helpful submission guidance and additional resources. Note that the examples provided in the policy descriptions do not cover all claim possibilities; they are only intended to give a single possible scenario.

To access the grid, click the button below. The grid will download to your device:

Payment Policy Management Policy Grid

Note: Presbyterian recommends checking this guide often as policies are updated and shared regularly. The version of the PPM grid you download may not remain accurate over time as PPM policies are added and updated.

**While the initial effective date for PPM was Sept. 1, 2024, additional revisions or new policies will have different effective dates.*

Appendix C

The Presbyterian Enhanced Claims Processing Program (ECPP) is a set of policies being implemented with the goal of improving claims accuracy and upholding payment integrity. ECPP policies initially go into effect on **Nov. 1, 2025**.*

For more information about these policies, affected product lines and more, please refer to the table below. An FAQ on the program is also available here.

**While the initial effective date for ECPP is Nov. 1, 2025, future revisions or new policies will have different effective dates.*

Enhanced Claims Processing Program Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
Column One and Column Two Procedure Codes	11-1-2025	If a Column Two procedure code is billed with a Column One procedure code and a bypass modifier has been billed, the claim will be reviewed for appropriate coding. Policies are based on CMS CCI and Policy Manual.	ALL
Multiple E/M Services on the Same Day	11-1-2025	When multiple E/M services are billed for the same date of service and have the same revenue code and a bypass modifier is billed, the claim will be reviewed for correct coding. Policies are based on CMS Outpatient Prospective Payment System, OCE Edits.	ALL
Duplicate Claim Lines Billed by Different Providers	11-1-2025	If claim lines are found to be duplicate but are billed by different providers on the same day, the line may be denied. Policies are based on Administrative Processing Rules for standard billing.	ALL
Incorrect Discharge Status Codes	11-1-2025	When inpatient claims are received with an incorrect discharge status code and the home health service date is within three days of the discharge date, the claim may be denied per CMS Medicare Carriers Manual.	ALL
Inpatient Repeat Admissions	11-1-2025	When an inpatient hospital claim is billed from the same facility within two weeks of the previous discharge date, the claim may be	ALL

Enhanced Claims Processing Program Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		denied per Pub 100-10 Medicare Quality Improvement Organization.	
ICD-10-PCS Procedure Code Definition	11-1-2025	If a claim is billed with an ICD-10 procedure code for respiratory ventilation, the length of stay will be compared to the billed ICD-10 procedure code. Policy is sourced from the ICD-10 Procedure Code manual.	ALL
Incorrect Discharge Status Codes	11-1-2025	When a claim is received with an incorrect discharge status code and the date of the second admission date is the same as the discharge date of the initial hospice claim, the second claim may be denied per Pub 100-4 Medicare Claims Processing.	ALL
Mutually Exclusive and Non-Mutually Exclusive CCI Edits	11-1-2025	If a Column Two procedure code is billed with a Column One procedure code and a bypass modifier has been billed, the claim will be reviewed for appropriate coding. Policies are based on CMS CCI.	ALL
Out-of-Sequence Claims	11-1-2025	If claims for procedures billed with modifiers are out of sequence, whether those codes are mutually exclusive or non-mutually exclusive, those claims may be denied per AMA CPT Manual.	ALL
Transesophageal Echocardiography (TEE) Billed in Conjunction With Anesthesia	11-1-2025	When a TEE procedure is billed in conjunction with anesthesia services by the same provider, along with a CCI modifier, the claim may be denied per CCI edits.	ALL
IV Infusion Services in Conjunction With Chemotherapy Services	11-1-2025	When IV infusion services are billed in conjunction with chemotherapy services and a CCI modifier, the IV services may be denied per CCI edits.	ALL
E/M Services Billed With Modifier 24	11-1-2025	If E/M services are billed with modifier 24 during the 10 days following a minor surgical procedure or the 90 days following a major surgical procedure, then the claim will be reviewed for correct coding.	ALL

Enhanced Claims Processing Program Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		Policies are based on CMS Pub 100-04.	
DME Column One and DME Column Two Procedure Codes	11-1-2025	If a DME Column Two procedure code is billed with a DME Column One procedure code with a bypass modifier, the claim will be reviewed for correct coding. Policies are based on CMS CCI.	ALL
E/M Services in Conjunction With Allergen Immunotherapy Services	11-1-2025	When E/M services with modifier 25 are billed in conjunction with allergen immunotherapy services, the claim will be reviewed for correct coding. Policies are based on CMS CCI and Policy Manual.	ALL