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, please view Appendix B.

Appendix C

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

Additional Resources: Revised Emergency Department Outpatient Facility E/M Coding Policies

Questions

For any questions regarding the following updates, providers should 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

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 Determinations

OPPS: Hospital Outpatient Prospective Payment System

RVU: Relative Value Unit

2024/2025 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
Medications Unbundled From End-Stage Renal Disease (ESRD) Treatment	12-1-25	Enforcement of correct coding and billing guidelines regarding Medications Unbundled From End Stage Renal Disease (ESRD) Treatment. As of Jan. 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.	ALL
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. To see the pending versions of these policies, please click here. • 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

2024/2025 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
The Enhanced Claims Processing Program (ECPP) launches with 14 initial policies	11-1-25	ECPP is a new claims program launching with 14 initial policies. Please refer to Appendix C for more information.	ALL
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,	ALL

2024/2025 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
		incorrect procedure to procedure bundling, incorrect frequency limitations and unnecessary medical record review. Claims containing radiology procedure codes 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	ALL

2024/2025 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
		reimbursement from hospice care will be denied.	
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	ALL

2024/2025 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
		of duplicate claims payment, incorrect procedure to procedure bundling, incorrect frequency limitations and unnecessary 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,	ALL

2024/2025 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
		general, short-term hospital within 15 calendar days (Medicaid) or 31 calendar days (Medicare & Commercial) of discharge from 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	ALL

2024/2025 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
		ineligible for separate reimbursement from an inpatient stay will be denied.	
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	ALL

2024/2025 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
		• Testing for Developmental Delay (was previously named "Testing for 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	ALL

2024/2025 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
		LBM policy, please refer to the Revision History section at the end of each policy. • 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	

2024/2025 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
		• Identification of Microorganisms Using Nucleic Acid Probes • 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	ALL

2024/2025 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
		should be billed with modifier 73. It will be paid at 50% of the amount, per CMS guidance.	
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	ALL

2024/2025 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
		Testing for Autism Spectrum Disorders and Developmental Delay	
Venipuncture Billing	8-1-2024	Enforcement of correct coding guidelines for Venipuncture Billing. When a 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.	ALL
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

2024/2025 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

2024/2025 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	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 with the goal of improving claims accuracy and upholding payment integrity. PPM policies initially went into effect on Sept. 1, 2024.*

For more information about these policies, affected product lines and more, view the table below. 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.

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

Payment Policy Management Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
Ambulance Services Bundled to the Facility Admission	11-21-2025	According to CMS rules, if a hospital patient needs to be taken by ambulance to another place for tests or special treatment, that ambulance ride is included in the hospital stay and is not billed separately. Except for the day the patient is admitted or discharged, all ambulance trips during the hospital stay are included in the hospital's payment and should not be billed on their own. This policy also covers when an ambulance service is billed on the same day the patient starts inpatient care, but no hospital has reported that it was the day of admission or discharge. In those cases, the ambulance charge may not be allowed per CMS guidance. Clinical Examples: • Pay Example – Ambulance supplies (A0021) were billed on the same day as 99231 (subsequent hospital inpatient care). Claim history supports the patient was discharged on the same day. • Deny Example – Ambulance supplies (A0021) were billed on the same day as 99231 (subsequent hospital inpatient care). Claim history does not support	ALL

Payment Policy Management Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		the patient was admitted or discharged to the facility on the same day. Payment is bundled into the inpatient admission.	
Anesthesia for Colorectal Cancer Screening Billed With 33 Modifier	11-21-2025	Per CMS policy, if a patient is getting a screening colonoscopy and the provider gives anesthesia during that procedure, special billing rules apply. When anesthesia is used during a lower intestinal endoscopic procedure (e.g., screening colonoscopy), modifier 33 should also be reported. If anesthesia for a screening colonoscopy using modifier 33 is being billed, make sure a screening colonoscopy is billed for that same date of service. If the anesthesia claim includes modifier 33, but no screening colonoscopy code is reported by any provider for that date of service, the anesthesia service will be denied per CMS guidance. Clinical Examples: • Pay Example – A claim is submitted for an anesthesia service reported with modifier 33; it includes a qualifying screening procedure reported for the same date of service. • Deny Example – The documentation does not support that a qualifying screening colonoscopy procedure was billed on the same date of service as the colon cancer screen appended with modifier 33.	ALL
Anesthesia for Colorectal Cancer Screening Billed With PT Modifier	11-21-2025	When a screening colonoscopy turns into a diagnostic or therapeutic procedure, CMS requires specific billing guidelines. One of these is using modifier PT to show the procedure started as a preventive screening but was changed to a diagnostic or treatment service during the same visit. If you're billing anesthesia for a colonoscopy and using modifier PT, you must also bill the actual	ALL

Payment Policy Management Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		diagnostic or surgical procedure that was done during the same visit. If no surgical or diagnostic procedure is billed on the same day, the anesthesia service with modifier PT will be denied. Per CMS guidance. Clinical Examples: • Pay Example – A claim is submitted for an anesthesia service reported with modifier PT; it includes a qualifying surgical procedure reported for the same date of service. • Deny Example – The documentation does not support that a surgical procedure was billed on the same date of service as the colon cancer screen appended with the PT modifier.	
Care Management Services	11-21-2025	Care management services should only be reported once per calendar month and may only be reported by the single provider who assumes the care management role with a particular patient for the calendar month. This policy identifies billed care management services (99487, 99490-99491) that have been reported within the same calendar month as an already reported care management service by any provider. Per AMA CPT Manual. Clinical Examples: • Pay Example – A corrected claim is submitted removing the additional care management CPT code. • Deny Example – More than one care management CPT code has been reported in the same calendar month.	ALL

Payment Policy Management Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
Care Management Services Add-On	11-21-2025	Care management services should only be reported once per calendar month and may only be reported by the single provider who assumes the care management role with a particular patient for the calendar month. This policy identifies billed care management add-on CPT codes (99437, 99439 or 99489) that have been reported within the same calendar month as an already reported care management service by a different provider. Per AMA CPT Manual. Clinical Examples: • Pay Example – A corrected claim is submitted removing the care management CPT code reported by the provider who did not assume the care management role. • Deny Example – A care management add-on CPT code has been reported by a different provider than the provider who assumed the care management role for the patient. The provider who assumed the care management role has reported care management services in the same calendar month.	ALL
Codes That Have Unilateral Professional Components and Bilateral in Nature Global/Technical Components	11-21-2025	Certain ophthalmic procedures — specifically CPT codes 76519 and 92136 — are considered inherently bilateral, meaning they are typically performed on both eyes as part of a single service. Because of this, billing these codes twice on the same date of service will lead to a denial of the second line item on the claim. Additionally, when billing the professional component only, it is acceptable to use LT and RT modifiers to indicate each eye. However, if you're submitting the professional components this way, you should not also bill the global code for the same date of service.	ALL

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		According to CMS, the professional portion of these codes is treated as unilateral and may be reimbursed separately for each side. The global and technical components are treated as bilateral and should only be billed once per date of service. To ensure proper reimbursement and avoid denials, please review how these services are submitted when performed on both eyes. Billing guidelines must align with CPT and CMS policy. Clinical Examples: • Pay Example – The provider bills 76519-26 (ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation) with 76519-TC. • Deny Example – The provider billed 76519 (ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation) with 76519-TC. The technical component will be denied as the global code has already been reported per CMS guidance.	
Diabetes Self-Management Training (DSMT) Services	11-21-2025	The National Coverage Determination for diabetes self-management training (DSMT) services is based on CMS guidelines for the reporting frequency of code G0108. This rule identifies situations in which G0108 has been reported over six units (or three hours) within a one-year period by any provider. According to the Medicare National Coverage Determinations Manual:	ALL

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		"The initial year for DSMT is the 12-month period following the initial date. Medicare will cover initial training that meets the following conditions: Is furnished to a beneficiary who has not previously received initial or follow-up training under HCPCS codes G0108 or G0109; Is furnished within a continuous 12-month period; Does not exceed a total of 10 hours* (the 10 hours of training can be done in any combination of 1/2 hour increments); With the exception of 1 hour of individual training, training is usually furnished in a group setting, which can contain other patients besides Medicare beneficiaries, and; One hour of individual training may be used for any part of the training including insulin training. "Medicare covers follow-up training under the following conditions: No more than 2 hours individual or group training per beneficiary per year; … Follow-up training for subsequent years is based on a 12-month calendar after completion of the full 10 hours of initial training; … Follow-up training is furnished in increments of no less than one-half hour." Following CMS guidelines, three hours of individual training reported with code G0108 (a maximum of six units) is allowed for reimbursement within a 12-month period. Clinical Examples: • Pay Example – DSMT services have been reported equal to or less than six units by any provider during the 12-month period.	

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		• Deny Example – DSMT services have been reported over six units by any provider during the 12-month period.	
Duplicate Claims From Same National Provider Identifier (NPI) Under Any Tax ID and Provider ID	11-21-2025	This edit identifies situations where claim lines have already been billed on another claim based on the following criteria: • Same subscriber/member number • Dependent number • Date of service • Procedure code • NPI number • Units • Bill type • Procedure code modifier Per CMS Policy, exact duplicate claims or claim lines that match another submission in all key details will be denied. Clinical Examples: • Pay Example – The documentation supports that the claim line was not a duplicate billing to the other claim on the same date of service, as the patient had the same service provided more than once on the same date of service. • Deny Example – The documentation supports the claim line is duplicate billing to the other claim on the same date of service.	ALL
Factors Influencing Health Status and Contact With Health Services Diagnoses and	11-21-2025	Based on the ICD-10-CM Manual, ICD codes Z53.0-Z53.09 (procedure and treatment not carried out because of contraindication), Z53.8 (procedure and treatment not carried out for other reasons), and Z53.9 (procedure and treatment not carried out, unspecified reason)	ALL

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Non-Routine Examinations		indicate that a procedure or treatment is not carried out due to contraindication or other reasons. This policy identifies procedures or services with a diagnosis that does not support the procedure. If the reported diagnosis indicates that the procedure was not carried out, it is not eligible for reimbursement. Clinical Examples: • Pay Example – A corrected claim is submitted appending an appropriate modifier to the procedure indicating a discontinued procedure. • Deny Example – A claim is submitted with Z53.0 as the only diagnosis code reported. The documentation supports that no procedures or services were carried out.	
Global Obstetrical Package	11-21-2025	This policy identifies situations when an E/M service is billed with a diagnosis related to postpartum, contraceptive management or family planning within 42 days (6 weeks) after a Delivery Care Only service, in which case the E/M service will be denied. Routine postpartum care and contraception discussion during this period are considered part of the postpartum care and should not be reported separately. Clinical Examples: • Pay Example – A Postpartum Care Only service code is the only service billed within the postpartum period. • Deny Example – An E/M service is billed with a diagnosis of encounter for contraceptive management 40 days	ALL

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Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		following a Delivery Care Only service code.	
Global Payment of Diagnostic Tests and Radiology Services	11-21-2025	This policy identifies situations when a diagnostic test or radiology service is billed twice by any provider, once with modifier 26 and once without modifier 26. The claim without modifier 26 will have modifier TC appended so it is coded appropriately. It is inappropriate to report a procedure without a modifier, indicating a global code, when the procedure has already been billed with a modifier for the professional component. Per AMA Principles of CPT Coding guidance.	ALL
Hydration Therapy	11-21-2025	According to CMS guidelines and the AMA CPT Manual, basic IV fluids (such as normal saline or dextrose) should not be billed separately when given as part of hydration therapy (96360). These fluids are already included in the payment for the hydration procedure. Do not bill the following IV fluid codes when they are used as part of hydration therapy provided by any provider: J7030, J7040, J7042, J7050, J7060, J7070, J7120, J7121. These fluids are considered part of hydration therapy code 96360. Clinical Examples: • Pay Example – The documentation supports a single IV dextrose/NS (J7042) infusion was submitted with 2 units and the diagnoses submitted on the claim support the initial hydration service was reported appropriately. • Deny Example – The documentation states that IV dextrose/NS (J7042) was included in the hydration solution.	ALL
Hydration Therapy of Patients 18 Years or Older	11-21-2025	According to CMS guidelines and the National Institute for Health and Care Excellence, giving 500 mL or less of fluids to an adult (18 years or older) is not considered medically necessary for	ALL

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		rehydration purposes. Also, if fluids like normal saline (J7040) are only used to deliver medications or other substances, this is called incidental hydration and should not be billed separately. If normal saline is given just to carry medicine or is less than 1000 mL, it should not be billed separately. Clinical Examples: • Pay Example – The documentation states 1 unit of J7040 (Normal Saline Solution) was administered therapeutically for hydration on a patient who is 16 years of age. • Deny Example – The documentation states that 1 unit of J7040 was reported with an antibiotic administration and no accompanying hydration solution. The patient's age is 19.	
Implantable Cardiac Defibrillators (ICDs)	11-21-2025	An ICD is an electronic device designed to diagnose and treat life-threatening ventricular tachyarrhythmias. The device consists of a pulse generator and electrodes for sensing and defibrillating. The following CPT codes are used to report cardiac defibrillator procedures: 33223, 33230, 33231, 33240, 33241, 33243, 33244, 33249, 33262, 33263, 33264, 33270, 33271, 33272, 33273 and G0448. According to CMS policy, implantable cardiac defibrillators must be reported with an appropriate diagnosis. If an approved diagnosis is not on the claim header, the ICD will be denied. Clinical Examples: • Pay Example – CPT code 33230 (insertion of implantable defibrillator pulse generator only; with existing dual	ALL

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		leads) was reported with an appropriate diagnosis code. • Deny Example – CPT code 33230 (insertion of implantable defibrillator pulse generator only; with existing dual leads) was not reported with an appropriate diagnosis code.	
Invalid or Deactivated National Provider Identifier (NPI)	11-21-2025	This policy identifies situations when any service is billed with an invalid or inactive rendering National Provider Identifier (NPI) for the billed date of service. The service will be denied because the NPI is invalid or deactivated. Clinical Examples: • Pay Example – A service is billed with an active NPI. • Deny Example – A service is billed with a deactivated NPI.	ALL
Lecanemab and Related Substances	11-21-2025	Medicare only covers Alzheimer's treatments like lecanemab (J0174) or donanemab (J0175) if the drug is given as part of an approved clinical research study. These treatments are still considered investigational, so Medicare wants to make sure they are only being used in carefully monitored research settings. When these drugs are billed to Medicare, the claim must include modifier Q0 to report investigational services or modifier Q1 for routine care in a research setting. If J0174 or J0175 is billed without Q0 or Q1, the claim will be denied. This policy ensures that coverage is only provided when the treatment is part of a properly approved clinical trial. Per CMS guidance. Clinical Examples: • Pay Example – The documentation supports J0175 was administered in an	ALL

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		approved clinical research study as indicated by the modifier Q0. • Deny Example – The documentation supports the administration of J0174; however, it was reported without an appropriate modifier to indicate it was administered in an approved clinical research study.	
Lung Cancer Screening With Low-Dose Computed Tomography (LDCT) for Patients Older Than 77	11-21-2025	Medicare covers lung cancer screening using a low-dose CT scan (71271) and a special counseling visit to talk about it (G0296) — but only for people who are between 50 and 77 years old. This is based on national Medicare rules. The counseling visit (G0296) helps patients understand the risks and benefits of lung cancer screening before they decide to move forward. Medicare won't pay for the screening or the counseling visit if the patient is older than 77, even if the doctor recommends it. This policy helps identify when the scan or the counseling session was done for someone outside the approved age range, which means it may not be paid. It's important for facilities to check the patient's age before scheduling or billing for these services. Clinical Examples: • Pay Example – A claim is submitted showing that the patient's age falls within the acceptable age range, and documentation supports the patient's age. • Deny Example – The documentation supports the patient received counseling (G0296) for LDCT. However, the patient's age is greater than 77 years of age. Per CMS guidance.	ALL

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Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
Lung Cancer Screening With LDCT for Patients Younger Than 50	11-21-2025	Medicare covers lung cancer screening with a low-dose CT scan (71271) and a counseling visit (G0296) to talk about the benefits and risks of screening. However, this coverage is only available for patients who are between 50 and 77 years old. These services are meant for people at higher risk of lung cancer due to their age and smoking history. If a patient younger than 50 or older than 77 years old is being screened, Medicare will deny the services. This policy helps identify cases where these services are given to patients outside the approved age range, which can result in denied claims. It's important for facilities to verify the patient's age before scheduling or billing for lung cancer screening services. Clinical Examples: • Pay Example – A claim is submitted showing that the patient's age falls within the acceptable age range, and documentation supports the patient's age. • Deny Example – A 40-year-old patient receives services related to lung cancer screening. This service is inappropriate to report based on the patient's age. Per CMS guidance.	ALL
Maximum Units for Hearing Services	11-21-2025	According to audiology industry publications, hearing aid batteries function from three to 22 days before needing replacement depending on the hearing aid and patient usage. This policy will identify claims for hearing aid batteries (HCPCS code V5266) to ensure they align with typical usage. If the provider is billing more than 48 units in a two-month period, the	ALL

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		claim will be adjusted to stay within the maximum allowed. Clinical Examples: • Pay Example – V5266 is billed with 22 units during a two-month period. • Deny Example – V5266 is billed with 54 units during a two-month period. The units will be adjusted so that they do not exceed the maximum allowed.	
Medical Nutrition Therapy Greater Than 11 Units Per Year	11-21-2025	Medicare helps cover Medical Nutrition Therapy (MNT) services for people with certain health conditions like diabetes or kidney disease. In the first year, Medicare allows up to 3 hours of MNT, which includes the first appointment (97802) for the initial assessment. This code can only be used once when a patient first starts MNT services. Follow-up MNT sessions are billed using code 97803, with each unit representing 15 minutes of one-on-one time with a dietitian. Medicare will only cover up to 11 units (which equals 2 hours and 45 minutes) of this code in the same calendar year. If more time is billed than allowed, Medicare may deny payment. This policy helps make sure services are billed appropriately and within covered time limits. Per CMS guidance. Clinical Examples: • Pay Example –The provider billed for MNT services and claim history supports that the billed services did not exceed three hours (11 units) in the same calendar year as the initial medical nutrition assessment 97802. • Deny Example – The provider billed for MNT services and claim history supports that the billed services exceeded three hours (11 units) in the same calendar	ALL

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		year as the initial medical nutrition assessment 97802.	
Medical Nutrition Therapy Greater Than 12 Units Per Year Combined	11-21-2025	Medicare covers up to three hours of Medical Nutrition Therapy (MNT) services each calendar year for people with certain health conditions, like diabetes or kidney disease. These services include an initial one-on-one session (97802), follow-up individual sessions (97803) and group sessions (97804). Each individual session is billed in 15-minute blocks, and group sessions are billed in 30-minute blocks. If the total time billed across the MNT services of 97802, 97803 and 97804 adds up to more than 12 units (which equals up to three hours), Medicare may not cover the extra time. This policy helps make sure that MNT is provided within the approved yearly limit, unless additional hours are approved under special circumstances. It's important for providers to track and combine all MNT session times to avoid billing beyond what's allowed. Per CMS guidance. Clinical Examples: • Pay Example – The provider billed for MNT services and the claim history supports that the billed services did not exceed three hours (12 units) in the initial calendar year. • Deny Example – The provider billed for MNT services and claim history supports that the billed services exceeded three hours (12 units) in the initial calendar year.	ALL
Medical Nutrition Therapy Subsequent Billings	11-21-2025	Medicare pays for nutrition counseling to help manage certain health conditions like diabetes or kidney disease. For the first visit, providers use the billing code 97802, which is for the initial nutrition assessment and counseling. This code covers the first one-on-one session and is billed in 15-minute blocks. Medicare only allows	ALL

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		one initial assessment (97802) per patient each calendar year. If a provider tries to bill for more than one initial visit in the same year, even if on different days, Medicare may deny the claim. This policy ensure that only the first session is treated as the initial one, and all other follow-up sessions should use a different code. Per CMS guidance. Clinical Examples: • Pay Example – Claim history supports that this is the first assessment for Medical Nutrition Therapy. • Deny Example – Claim history shows that the provider previously billed 97802 for the initial assessment in the same calendar year.	
Modifier 57 and Prior E/M Service With Same Diagnosis	11-21-2025	When an E/M service is billed with modifier 57 (decision for surgery) on the day before or the same day as a major surgical procedure (90-day global), it will deny under the following condition: if a previous E/M service was billed 56 days prior to the major surgical procedure — and the primary diagnosis code on the previous E/M line is the same as the primary diagnosis code on the major surgical procedure to the first three digits. The E/M service with modifier 57 will be denied as this is considered part of the global surgical package and not separately reimbursable. The E/M service is reimbursable only when it represents the initial decision to perform the surgery. If the patient has already received a prior E/M service for the same or similar diagnosis, and a subsequent E/M is billed with modifier 57 the day before or on the same date as the procedure, that E/M service will be denied. Modifier 57 should only be appended	ALL

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		when the E/M visit represents the first time the decision for surgery was made. Clinical Examples: • Pay Example: 99285-57 – Patient seen in the ER with severe abdominal pain. Patient is evaluated, and provider diagnoses acute appendicitis (K35.80) and decides to perform an emergency appendectomy (44950). • Deny Example: 99222-57 – Patient admitted to the hospital for a pre-planned mastectomy (19305). Decision for surgery was made 14 days prior in the physician's office and C50.211 (malignant neoplasm of upper-inner quadrant of right female breast) was billed on HCFA 1500 form along with 99204. Initial Inpatient E/M 99222-57 was billed with diagnosis code C50.211.	
Modifier 90	11-21-2025	According to CMS policy, modifier 90 may only be used by independent clinical laboratories for referred laboratory services. If a provider who is not a laboratory or pathology specialist bills using modifier 90, the services will be denied. According to CMS, "Independent laboratories shall use modifier 90 to identify all referred laboratory services. A claim for a referred laboratory service that does not contain the modifier 90 is returned as un-processable if the claim can otherwise be identified as being for a referred service. The name, address, and the Clinical Laboratory Improvement Amendments (CLIA) number of both the referring laboratory and the reference laboratory shall be reported on the claim."	ALL

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		The laboratory that performs the service will bill for the laboratory procedures. If the specialty is NOT Laboratory (LAB) or Pathology (PAT), the service will be denied if modifier 90 is appended. Per CMS guidance. Clinical Examples: • Pay Example – The laboratory reported 85027 (blood count; complete [CBC], automated Hgb, Hct, RBC, WBC and platelet count) with modifier 90 as they performed the service. The name, address and CLIA information of both the referring laboratory and the reference laboratory were included. • Deny Example – A family medicine physician bills CPT 85025 (blood count; complete [CBC], automated [Hgb, Hct, RBC, WBC and platelet count] and automated differential WBC count) appended with modifier 90.	
Modifier CS	11-21-2025	Per CMS policy, effective May 12, 2023, they will no longer accept CS as valid for any CPT or HCPCS code submissions. Clinical Examples: • Pay Example – A CPT code is submitted without modifier CS • Deny Example – A CPT code is submitted with modifier CS	ALL
Mutually Exclusive Edits for DME CCI	11-21-2025	Per the National Correct Coding Initiative (CCI) for Medicaid Services, certain DMEPOS codes are classified as mutually exclusive. This means they represent procedures or items that cannot be used together for the same patient during a single encounter; therefore, they cannot be billed together.	ALL

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		This policy outlines that when a Column Two DME code is billed together with a Column One DME code, then the Column Two code will be denied because it is considered mutually exclusive with the Column One code. Clinical Examples: • Pay Example – A Column Two DME code is billed independent of any other DME code. • Deny Example – A Column One DME code is billed with a Column Two DME code. The Column Two DME code will be denied.	
National Drug Code and Non-Specific Drug HCPCS Code Mismatch	11-21-2025	Per CMS policy, providers must report National Drug Codes (NDCs) with certain HCPCS codes, and the NDC must correspond accurately to the HCPCS code submitted. If a provider bills an HCPCS drug code that uses non-specific language, such as miscellaneous, unclassified, NEC, NOS, etc., with an NDC, the NDC must align with the non-specific HCPCS code in the NDC Crosswalk. If the NDC does not match, the claim will be denied. Per CMS guidance. Clinical Examples: • Pay Example – A corrected claim is submitted, appending a valid NDC number for the non-specific HCPCS drug code(s). • Deny Example – No corrected claim is submitted with the documentation.	ALL
National Drug Code Expired	11-21-2025	Based on Food and Drug Administration (FDA) policy, providers are required to report valid National Drug Code (NDC) numbers for the date of service documented. The policy outlines specific scenarios in which an NDC must be billed, and it requires that the NDC	ALL

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		number associated with the billed codes has not exceeded the origin extension days as listed in the Master NDC Table. This ensures that the NDC is **not** inactive or obsolete based on its listing in a nationally recognized drug information database. When a medication HCPCS code is reported with an associated NDC number, but the number is not valid, the line will be denied. Per CMS guidance. Clinical Examples: • Pay Example – A corrected claim is submitted, appending a valid NDC number for the code(s) and date of service. • Deny Example – A claim is submitted with an expired NDC number for a specific date of service, and no corrected claim is submitted with the documentation.	
National Drug Code Invalid	11-21-2025	When billing Medicare or other insurances for medications, providers must include the correct National Drug Code (NDC). This is a unique number that identifies the specific drug, including its manufacturer, strength and packaging. If the NDC number used does not match any official records, it is considered invalid and the claim won't be paid. This policy is used to catch mistakes when a drug is billed with an incorrect, outdated or made-up NDC number. For example, when a medication HCPCS code is reported with an associated NDC number, but the number is not valid, the line will be denied. Per CMS guidance.	ALL

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Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		Clinical Examples: • Pay Example – A corrected claim is submitted, appending a valid NDC number for the code(s). • Deny Example – A claim is submitted with an invalid NDC number, and no corrected claim is submitted with the documentation.	
Out-of-Sequence Edits for Practitioner Medicaid CCI	11-21-2025	Per the National Correct Coding Initiative for Medicaid Services, certain pairs of procedures are considered mutually exclusive, meaning they cannot be billed together. Mutually exclusive procedures cannot reasonably be performed at the same anatomic site or during the same patient encounter. This policy identifies situations when two mutually exclusive codes (a Column One and a Column Two) are billed; if the Column Two code has already been paid, the Column One code will be denied. The denial occurs because the codes were billed in the wrong order. Clinical Examples: • Pay Example – A Column One code is billed independent of its corresponding Column Two code. • Deny Example – A Column One code is billed, and a Column Two code has been previously paid. The Column One code will be denied.	ALL
Pneumatic Compression Devices	11-21-2025	Medicare may cover pneumatic compression devices when they are used to treat ulcers caused by venous insufficiency. For the claim to be approved, the provider must include both of the following diagnoses: venous insufficiency and a chronic ulcer with/without stages. If a provider submits a claim for a pneumatic device	ALL

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		without both required diagnoses, Medicare will likely deny payment. This policy helps ensure that the device is only used and covered for the medical conditions it was approved to treat. Accurate diagnosis coding is essential for Medicare to consider the service medically necessary. Per CMS guidance. Clinical Examples: • Pay Example – A corrected claim is submitted adding an appropriate diagnosis code for the pneumatic compressor. • Deny Example – A claim is submitted without an appropriate diagnosis code for the pneumatic compressor.	
Positron Emission Tomography (PET) Scans	11-21-2025	Medicare has a rule that limits how many times a person with cancer can get a PET scan to help plan their treatment. Under this rule, Medicare will only pay for up to three PET scans for the same cancer diagnosis if the scan is being used to help guide treatment decisions. These PET scans must include a special code, called modifier PS, which tells Medicare that the scan is being used to help decide the next steps in cancer treatment. Please note that modifier KX should not be appended in these cases. The reason for this rule is to help track and prevent unnecessary or excessive PET scans for the same cancer. If more than three PET scans are done for the same cancer without the right coding, Medicare might not pay for them. Per CMS NCD policy guidance. PET Scans (78608, 78811-78816) Clinical Examples: • Pay Example – According to the documentation, the patient had three previous PET scans; however, the	ALL

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		diagnosis on the claim supports the patient having a new tumor diagnosis. • Deny Example – According to the documentation, the patient had three previous PET scans for subsequent anti-tumor strategy. The diagnoses reported are the same (to the third digit), and modifier KX is not appended to the line.	
Posterior Tibial Nerve Stimulation (PTNS)	11-21-2025	New billing rules for Posterior Tibial Nerve Stimulation (PTNS) will go into effect to match CMS guidelines. According to CMS guidelines, PTNS should be billed no more than once every seven days. The standard treatment plan is one session per week, for 12 weeks, with each session lasting about 30 minutes. If PTNS is billed more often than once a week, the extra treatments may be denied. This policy helps ensure the proper use of PTNS, consistent billing practices and fewer denials based on overuse. Clinical Examples: • Pay Example – 64566 is billed on one date of service; the next time 64566 is billed is 7 days later. • Deny Example – 64566 is billed on one date of service; the next time 64566 is billed is under 7 days.	ALL
Presumptive and Definitive Drug Testing – Definitive Procedure Frequency	11-21-2025	Per NCCI, only one definitive drug test (G0480-G0483 or G0659) may be reported per date of service. Additional units will be denied as they exceed the maximum allowed amount. Clinical Examples: • Pay Example – G0480 is billed with one unit. The following day G0480 is billed again with one unit.	ALL

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		• Deny Example – G0483 is billed with two units for a single date of service. Only one unit will be paid.	
Presumptive and Definitive Drug Testing – Presumptive Procedure Frequency	11-21-2025	Per NCCI, only one presumptive drug testing code may be reported per date of service. For example, when a drug test 80305-80307 is billed greater than one unit per day, additional units will be denied as they exceed the maximum allowed amount. Clinical Examples: • Pay Example – 80305 is billed with one unit. The following day 80305 is again billed with one unit. • Deny Example – 80305 is billed with two units for a single date of service. Only one unit will be paid.	ALL
Provider Administered Drugs – National Drug Code (NDC)	11-21-2025	This policy outlines cases where drugs from the New Mexico Medicaid administered drug list are billed without a National Drug Code (NDC). Per New Mexico State Guidelines, all administered drugs must be reported with the appropriate NDC. Clinical Examples: • Pay Example – A drug from the New Mexico Medicaid providers administered drug list is billed with an NDC. • Deny Example – A drug from the New Mexico Medicaid providers administered drug list is billed without an NDC.	ALL
Remote Therapeutic Monitoring Services and Supplies	11-21-2025	This policy identifies situations when 98980 is billed more than once in 30 days. Based on the code definition and guidelines in the AMA CPT Manual, this code should not be reported more than once in 30 days. Additional billings of	ALL

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		98980 will be denied as they exceed clinical guidelines. CPT Code 98980: Remote therapeutic monitoring treatment management services; physician or other qualified healthcare professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes.	
Return to the OR for a Related Procedure During the Postoperative Period	11-21-2025	Per CMS policy, when modifier 78 is appended to a procedure code, it indicates an unplanned return to the operating room for a related procedure during the postoperative period of a surgery. If there is no prior procedure with a global postoperative period (i.e., 10 or 90 days) under which the new procedure falls, modifier 78 would not be valid. Clinical Examples: • Pay Example – CPT code 58150 is billed. Thirty days later the patient returns to the operating room due to postoperative hemorrhage. The provider performs exploration for postoperative hemorrhage (CPT code 35860). Modifier 78 would be appended to CPT code 35860. • Deny Example – Provider performs an appendectomy and appends modifier 78 to CPT code 44950, but there is no prior procedure noted in the claim history or documentation.	ALL
Screening Mammograms	11-21-2025	Code 77063 is used for digital breast tomosynthesis, also known as 3D mammography, which is often performed along with a regular screening mammogram to get a clearer image of the breast. This code is considered an add-on code and has to be billed in addition to a standard screening	ALL

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		mammogram and never on its own. If 77063 is billed without a screening mammogram code on the same day, Medicare will deny the claim. This is because add-on codes cannot be reported by themselves; they must always be connected to the main service. This policy helps identify billing mistakes when the 3D screening is reported without the required main mammogram code. Per AMA CPT Manual. Clinical Examples: • Pay Example – A screening mammography is identified and paid in claim history for the same date of service as the screening digital breast tomosynthesis. • Deny Example – A screening mammography is not identified, or is denied in claim history, for the same date of service as the screening digital breast tomosynthesis.	
Services for Claim Adjustment Requests	11-21-2025	The claim will be denied if any procedure or service is billed on CMS-1450, contains condition codes D5 or D6, but the bill type is not an adjustment ending in 8. Per CMS guidance. - D5 or D6 (cancellation only) - Bill Type xx8 (voiding/canceling prior claim) Clinical Examples: • Pay Example – A provider submits a claim with condition code D5 and a bill type ending in 8. • Deny Example – A provider submits a claim without an appropriate condition code and a bill type ending in 8.	ALL

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Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
Services for Claim Adjustment Requests on Bill Types Ending in Seven (XX7)	11-21-2025	According to CMS policy, a debit-only adjustment claim identified with a bill type ending in seven (xx7) should be reported with a condition code denoting the type of change/adjustment needed (D0, D1, D2, D3, D4, D7, D8, D9, E0). Adjustment bill types included in this policy are: 0117, 0127, 0137, 0147, 0187, 0217, 0227, 0237, 0287, 0327, 0347, 0417, 0437, 0657, 0667, 0717, 0727, 0737, 0747, 0757, 0767, 0777, 0787, 0797, 0817, 0827, 0837, 0857, 0867, 0877, 0897. Per CMS, "If the type of bill is equal to xx7 and the claim change reason code is not equal to D0-D4, D7-D9, or E0, the FI [Part A Fiscal Intermediaries] rejects the request back to the provider …" Clinical Examples: • Pay Example – A provider submits a claim with an adjustment bill type of 0747 and a condition code of D2. • Deny Example – A provider submits a claim with an adjustment bill type of 0747 and no condition code is listed.	ALL
Telehealth Services	11-21-2025	CMS policy states 99231-99233 (subsequent hospital inpatient or observation care, per day) cannot be billed more than once in a three-day period when using Place of Service 02 (telehealth). Subsequent hospital care services are limited to one telehealth visit every three days. Visits exceeding this frequency will result in a denial based on clinical guidelines. Clinical Examples: • Pay Example – 99231 is billed in Place of Service 02 on one date of service.	ALL

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		• Deny Example – 99233 is billed in Place of Service 02 on two subsequent dates of service.	
Telephone Services	11-21-2025	This policy identifies situations when a telephone assessment and management service (98966-98968) is billed **and** • an assessment and management service has been billed on the same day, within the previous seven days or one day after **and** • the primary diagnosis associated with the telephone assessment and management service claim line matches the primary diagnosis associated with the assessment and management service claim line (both to the first three digits) According to the AMA CPT Manual, telephone assessment and management services and assessment and management services should not be reported separately when the two services are related. The telephone assessment and management service will be denied because it is considered part of the previous or subsequent related assessment and management service. Clinical Examples: • Pay Example – CPT code 98966 is billed without an additional assessment and management service. • Deny Example – CPT code 98966 is billed on the same day as CPT code 90832 (psychotherapy) and the primary diagnosis for both services is the same. CPT code 98966 will be denied because it is considered part of CPT code 90832.	ALL

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Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
Transitional Care Management (TCM) Services	11-21-2025	Per CMS policy, Transitional Care Management (TCM) 99495-99496 must be reported within a specific time frame after discharge. TCM 99495 requirements include: • Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge • At least a moderate level of medical decision making during the service period face-to-face visit • Face-to-face visit must occur within 14 calendar days of the discharge TCM 99496 requirements include: • Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge • High level of medical decision making during the service period face-to-face visit • Face-to-face visit must occur within 7 calendar days of the discharge Documentation must support that the patient was discharged from an inpatient stay within the time constraints of the reported TCM code.	ALL
End of Batch –	11-21-2025	– Effective Date	
Ambulance Services and Required Modifiers	10-26-2025	This policy identifies situations when ambulance services are billed without an appropriate origin and destination modifier, or exceptions modifier, as defined in the HCPCS Level II Manual. According to CMS policy, all ambulance services require the presence of origin and destination modifiers. The first character of the	ALL

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		modifier represents the origin of the service, and the second character of the modifier represents the destination of the service Clinical Examples: • Pay Example – An ambulance supply code (A0021) is billed with appropriate ambulance origin and destination modifiers (RH, residence to hospital). • Deny Example – An ambulance service code (A0225) is billed without the appropriate ambulance origin and destination modifiers.	
Bariatric Surgery for Treatment of Morbid Obesity When Billed Without a Primary Diagnosis of Morbid Obesity	10-26-2025	The policy defines diagnosis requirements for bariatric procedures and identifies situations where bariatric surgery is reported without an appropriate diagnosis. Based on CMS policy, bariatric procedures (43644, 43645, 43770, 43775 or 43845-43847) are performed to treat comorbid conditions associated with morbid obesity. Therefore, CMS requires that a diagnosis indicating morbid obesity be present on the claim as the primary diagnosis. Per CMS National Determination Coverage guidance.	ALL
Bariatric Surgery for Treatment of Morbid Obesity When Billed Without a Requisite Comorbid Diagnosis on the Claim	10-26-2025	The policy defines diagnosis requirements for bariatric procedures and identifies situations where bariatric surgery is reported without an appropriate diagnosis. Based on CMS policy, bariatric procedures (43644, 43645, 43770, 43775 or 43845-43847) are performed to treat comorbid conditions associated with morbid obesity. Therefore, CMS requires that a diagnosis indicating morbid obesity be present on the claim. Per CMS National Determination Coverage guidance.	ALL

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Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
Blood Products and Transfusion	10-26-2025	This policy identifies situations when the outpatient hospital bills transfusion services without an accompanying blood product. Based on CMS and Outpatient Code Editor, transfusion services billed without an accompanying blood product code on the same claim when bill type is 0120-012Z, 0130-013Z or 0140-014Z will be denied. • **Transfusion Codes**: 36430, 36440, 36450, 36455, 36460 • **Blood Products**: P9010-P9040, P9043, P9044, P9048, P9050-P9060, P9070-P9071, P9073, P9099 Clinical Examples: • Pay Example – A push transfusion (36440) of platelets (P9019) was submitted on the same claim for services on bill type 0120 (hospital, inpatient). • Deny Example – A blood transfusion (36430) was billed without an accompanying blood product.	ALL
Bone (Mineral) Density Services	10-26-2025	The new policy defines diagnosis requirements for bone density studies. This policy identifies situations when the bone (mineral) density studies are performed without an approved diagnosis. Based on CMS NCD Policy, bone mass measurement (density) studies (76977, 77078, 77081, G0130) must be reported with an approved diagnosis for reimbursement. Per CMS NCD guidance.	ALL
Care Management Services or	10-26-2025	This policy will identify situations when a Care Management service or a Transitional Care Management service is billed within 90 days of	ALL

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
Transitional Care Management Services in the Postoperative Period of Major Procedures (*and the care management service or transitional care management service has a primary diagnosis associated to the 90-day medical or surgical service*)		a major surgical procedure by a non-physician practitioner with the same Tax ID as the provider who performed the surgical procedure, and the primary diagnosis on the claim is associated to the major surgical procedure. These E/M services are included in the global fee of the major surgical procedure because the global surgical package includes follow-up E/M visits during the postoperative period that are related to recovery from the surgery. If the E/M service is unrelated to the surgical procedure or if the E/M service resulted in an unplanned return to the operating room, then an appropriate modifier must be appended, indicating such. For example, if a care management service is billed 21 days following a major surgical procedure and the primary diagnosis on the claim is associated to the major surgical procedure, the care management service will be denied as this service is included in the global fee of the surgical procedure. Clinical Examples: • Pay Example – A transitional care management service is billed 45 days following a major surgical procedure. The E/M is for a separate and significant service that is unrelated to the major surgical procedure, and an appropriate modifier is appended, indicating such. • Deny Example – A care management service is billed 14 days following a major surgical procedure. The diagnosis indicates that the service is related to the surgical procedure, and there is not an appropriate modifier indicating	

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		otherwise. The E/M service will be bundled into the global fee of the major surgical procedure.	
Care Management Services or Transitional Care Management Services in the Postoperative Period of Major Procedures (*and the diagnosis is a complication of surgical and medical care or an aftercare diagnosis*)	10-26-2025	This policy will identify situations when a Care Management service or a Transitional Care Management service is billed within 90 days of a major surgical procedure by a non-physician practitioner with the same Tax ID as the provider who performed the surgical procedure, and the diagnosis on the claim is a complication of surgical and medical care or an aftercare diagnosis. These E/M services are included in the global fee of the major surgical procedure because the global surgical package includes follow-up E/M visits during the postoperative period that are related to recovery from the surgery. If the E/M is unrelated to the surgical procedure or if the E/M service resulted in an unplanned return to the operating room, then an appropriate modifier must be appended, indicating such. For example, if a care management service is billed 21 days following a major surgical procedure and the primary diagnosis on the claim is associated to the major surgical procedure, the care management service will be denied as this service is included in the global fee of the surgical procedure. Clinical Examples: • Pay Example – A transitional care management service is billed 45 days following a major surgical procedure. The E/M is for a separate and significant service that is unrelated to the major surgical procedure, and an appropriate modifier is appended indicating such.	ALL

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Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		• Deny Example – A care management service is billed 14 days following a major surgical procedure. The diagnosis indicates that the service is related to the surgical procedure, and there is not an appropriate modifier indicating otherwise. The E/M service will be bundled into the global fee of the major surgical procedure.	
CCI Edit for Detailed Discussion: Perioperative Transesophageal Echocardiography (TEE)	10-26-2025	The policy defines requirements (modifier, etc.) for TEE with Anesthesia Services. This policy will identify situations when a transesophageal echocardiography (93312-93317) is billed with an anesthesia service (00100-01992). The TEE will be denied as it is an included component of the anesthesia service. Per CMS guidance.	ALL
Column One and Column Two Code Edits for DME CCI	10-26-2025	This policy identifies situations when a Column Two code is billed with an associated DME Column One code. For example, if a Column Two code is billed with an associated DME Column One code, the Column Two code will be denied. Clinical Examples: • Pay Example – A Column Two code is billed, and there is not an associated DME Column One code that has been billed. • Deny Example – A Column Two code is billed with an associated DME Column One code.	ALL
Diabetes Self-Management Training (DSMT) Services	10-26-2025	The policy defines diagnosis requirements for Diabetes Self-Management Training (DSMT) services. This policy identifies situations when DSMT services are provided without an approved diagnosis.	ALL

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Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		Based on CMS NCD policy, DSMT services (G0108-G0109) must be reported with an approved diagnosis for reimbursement.	
Diagnostic Tests or Radiology Services Performed Outside the Office Setting	10-26-2025	This policy identifies situations when a diagnostic test or radiology service is billed in place of service 12, 13, 27, 31 or 32 and there is not a corresponding code indicating that the appropriate equipment was transported to the place of service. Modifier 26 will be appended indicating that only the professional component was rendered. Clinical Examples: • Pay Example – A radiology service is billed in place of service 12 with code R0070 (transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen), indicating that the equipment needed to perform the radiology service was transported to the place of service. • Deny Example – A radiology service is billed in place of service 13 without a corresponding equipment transport code. Modifier 26 will be appended to the radiology service code.	ALL
Discharge Services Billed and Paid for Subsequent Date of Service	10-26-2025	The policy defines requirements for Hospital Discharge Services (99238-99239). Based on the AMA CPT Manual, a hospital discharge service can only occur once per admission. Additionally, per CPT, these codes are to be utilized to report all services provided to a patient on the date of discharge, if other than the initial date of inpatient or observation status.	ALL

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Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		This policy identifies situations in which 99238-99239 is reported and 99238-99239 has been billed and paid on the subsequent date of service. Per CPT guidance.	
Discharge Services Billed Multiple Times for The Same Date of Service	10-26-2025	The policy defines requirements for Hospital Discharge Services (99238-99239). Based on CMS policy, only one hospital discharge day management service is payable per patient per hospital stay. In addition, only the attending physician of record reports the discharge day management service. Since an inpatient discharge service has already been processed, subsequent discharge services will be denied. This policy identifies when more than one discharge service was billed for the same date of service. Per CMS guidance.	ALL
Discharge Services Billed Two Days in a Row	10-26-2025	The policy defines requirements for Hospital Discharge Services (99238-99239). Based on the AMA CPT Manual, a hospital discharge service can only occur once per admission and must be preceded by a hospital admission code. Additionally, per CPT, these codes are to be utilized to report all services provided to a patient on the date of discharge, if other than the initial date of inpatient or observation status. This policy identifies situations in which 99238-99239 is reported and 99238-99239 has been reported on the previous day. Per CPT guidance.	ALL
E/M Service Performed by a Radiologist During Radiology Procedures	10-26-2025	This policy will identify situations when an E/M service is billed by a radiologist on the same day as a global radiology service. The E/M service will be denied as it is included in the fee for the global radiology service.	ALL

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Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		Clinical Examples: • Pay Example – CPT code 92012 is billed by a radiologist on the same date of service as a global radiology service. However, a modifier indicates that the E/M service is a significant and separately identifiable service, and the documentation supports the modifier appended. In this scenario, the E/M service will be paid. • Deny Example – CPT code 92014 is billed by a radiologist on the same date of service as a global radiology service. There is no modifier appended, and the documentation does not support a significant and separately identifiable service. The E/M service will be denied because it is included in the fee for the global radiology service.	
Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions	10-26-2025	This policy identifies situations when erythropoiesis stimulating agent (ESA) is being reported for Non-End Stage Renal Disease treatments and the required modifier is not appended. According to CMS policy, ESA treatment is not reasonable and necessary for beneficiaries with certain clinical conditions, either because of a deleterious effect of the ESA on their underlying disease or because the underlying disease increases their risk of adverse effects related to ESA use. CMS requires that providers utilize a modifier to define the circumstances for all Non-End Stage Renal Disease ESA use. The presence of modifier EA, EB or EC is required. Per CMS NCD guidance.	ALL
Extracorporeal Photopheresis	10-26-2025	This policy identifies situations where photopheresis, extracorporeal, is billed without an approved diagnosis of chronic graft-versus-	ALL

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		host disease and a diagnosis of complications of a transplanted organ is not also present on the claim header. Based on CMS National Coverage Determination, extracorporeal photopheresis is denied if not reported with a diagnosis of chronic graft-versus-host disease and a diagnosis of complications of a transplanted organ. Per CMS NCD guidance.	
Global Only Codes With a Single Professional and Technical Component	10-26-2025	This policy identifies situations when a global only code is billed with modifier TC. The global only code will be changed to its corresponding technical only code with modifier TC removed so it is coded appropriately. Per Administrative Processing Rules guidance.	ALL
Global Only Codes With Two Professional Components and a Single Technical Component	10-26-2025	This policy identifies situations when a global only code is billed with modifier TC. The global only code will be changed to its corresponding technical only code with modifier TC removed so it is coded appropriately. Per Administrative Processing Rules	ALL
Global Only Codes With Two Technical Components and a Single Professional Component	10-26-2025	This policy identifies situations when a global only code is billed with modifier TC. It will be denied as inappropriately coded because there is a specific code that represents the technical component of the service. Per Administrative Processing Rules guidance.	ALL
Heparin Lock Flush (J1642)	10-26-2025	This policy will identify and deny the Heparin Lock Flush administration code J1642 when billed for the irrigation of a catheter. Based on CMS policy, when heparin is used only for the irrigation of the catheter, the heparin itself is not separately billable. Medications given for a purpose other than the treatment of a particular condition, illness or injury are not covered unless otherwise specified in appropriate regulations. Per CMS and NCCI guidance.	ALL

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Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
Hydrophilic Contact Lenses	10-26-2025	This policy identifies situations when hydrophilic lenses were billed without an appropriate supporting diagnosis submitted. Based on CMS policy, hydrophilic contact lenses (V2520-V2526) are not covered when used in the treatment of disorders of refraction and accommodation. Per CMS NCD guidance.	ALL
Inpatient Neonatal and Pediatric Critical Care and Intensive Care Services	10-26-2025	The new policies define requirements for Initial Neonatal and Pediatric Critical Care (99468, 99471, 99475). Based on the AMA CPT Manual, it is not appropriate to report an initial inpatient critical care code if an initial or subsequent critical care code was reported for the previous day. This policy identifies situations in which an initial neonatal or pediatric critical care CPT code is reported and an initial or subsequent neonatal or pediatric critical care code was reported the previous day. Per CPT guidance.	ALL
Major Surgery: 90-Day Procedures Performed on the Same Day as a 90-Day Medical or Surgical Service	10-26-2025	Per CMS policy, the Global Surgical Package includes E/M visits rendered the same day as a major surgical procedure. Therefore, when an E/M visit is reported on the same day as a major surgical procedure, it will be bundled as part of the global surgical fee. This policy will identify situations when an E/M service has been reported and a major surgical procedure has been billed on the same day. Clinical Examples: • Pay Example – An E/M CPT code is billed on the same day as a major surgical procedure; however, the office visit notes validate that the visit was unrelated to the surgical procedure that was performed. Therefore, the code is	ALL

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Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		not included in the global fee of the major surgical procedure. • Deny Example – An E/M CPT code is billed on the same day as a major surgical procedure. The office visit notes validate that the visit was related to the surgical procedure that was performed. Therefore, the code will be included in the global fee of the major surgical procedure. Per CPT guidance.	
Major Surgery: 90-Day Procedures Performed Within 90 Postoperative Days of a 90-Day Medical or Surgical Service	10-26-2025	The policy defines modifier requirements for when E/M codes and a major surgical procedure have been billed in the previous 90 days. Per CMS policy, the Global Surgical Package includes follow-up E/M visits during the postoperative period of the surgery that are related to recovery from the surgery. Therefore, when an E/M visit is reported within 90 days of the major surgical procedure, it will be bundled as part of the global surgical fee. This policy will identify situations where an E/M service has been reported and a major surgical procedure has been billed in the previous 90 days. Per CPT guidance.	ALL
Major Surgery: 90-Day Procedures Performed Within 90 Postoperative Days of a 90-Day Medical or Surgical Service When Billed by a Non-physician Practitioner	10-26-2025	The policy defines requirements for E/M Services Billed Within the Global Period of a Major Surgical Procedure. This policy will identify situations when an E/M service is billed within 90 days of a major surgical procedure by a non-physician practitioner with the same tax ID as the provider who performed the surgical procedure — and the diagnosis on the claim is a complication of surgical and medical care or an aftercare diagnosis. These E/M services are	ALL

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		included in the global fee of the major surgical procedure because the global surgical package includes follow-up E/M visits during the postoperative period that are related to recovery from the surgery. If the E/M service is unrelated to the surgical procedure or if the E/M service resulted in an unplanned return to the operating room, then an appropriate modifier must be appended indicating such. For example, if an E/M service is billed 21 days following a major surgical procedure and the diagnosis on the claim indicates the visit is for surgical aftercare, the E/M service will be denied as this service is included in the global fee of the surgical procedure. Per CMS guidance.	
Minor Surgery: 10-Day Procedures and the Diagnosis Is a Complication of Surgical and Medical Care or an Aftercare Diagnosis	10-26-2025	The policy defines requirements for E/M Services Billed Within the Global Period of a Minor Surgical Procedure. This policy will identify situations when an E/M service is billed within 10 days of a minor surgical procedure by a non-physician practitioner with the same tax ID as the provider who performed the surgical procedure — and the diagnosis on the claim is a complication of surgical and medical care or an aftercare diagnosis. These E/M services are included in the global fee of the minor surgical procedure because the global surgical package includes follow-up E/M visits during the postoperative period that are related to recovery from the surgery. If the E/M service is unrelated to the surgical procedure or if the E/M service resulted in an unplanned return to the operating room, then	ALL

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Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		an appropriate modifier must be appended indicating such. For example, if an E/M service is billed three days following a minor surgical procedure and the diagnosis on the claim indicates the visit is for surgical aftercare, the E/M service will be denied as this service is included in the global fee of the surgical procedure. Per CMS guidance.	
Minor Surgery: 10-Day Procedures and the E/M Service Has a Primary Diagnosis Associated to the 10-Day Medical or Surgical Service.	10-26-2025	The policy defines requirements for E/M Services Billed Within the Global Period of a Minor Surgical Procedure. This policy will identify situations when an E/M service is billed within 10 days of a minor surgical procedure by a non-physician practitioner 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. These E/M services are included in the global fee of the minor surgical procedure because the global surgical package includes follow-up E/M visits during the postoperative period that are related to recovery from the surgery. For example, if an E/M care service is billed eight days following a minor surgical procedure and the primary diagnosis on the claim is associated to the minor surgical procedure, the E/M service will be denied as this service is included in the global fee of the surgical procedure. Per CMS guidance.	ALL
Modifier SL (State-Supplied Vaccine)	10-26-2025	The policy defines requirements for State-Supplied Vaccines. This policy identifies situations when a vaccine has been billed with modifier SL indicating that it is a state-supplied vaccine, and the allowed amount is more than $0.00. A vaccine or toxoid	ALL

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		provided by the state at no cost is not reimbursable. For example, if CPT code 90476 is billed with modifier SL and the allowed amount is more than $0.00, the vaccine will be denied because it has been provided by the state at no cost. Per CMS guidance.	
Multiple Inpatient Admission or Consultation Services in the Past Three Days	10-26-2025	The policy defines requirements for Initial Hospital Care Service (99221-99223). Based on the AMA CPT Manual, an initial hospital inpatient or observation care service reported within three days of a prior initial hospital inpatient or observation care service for the same diagnosis will be changed to a subsequent hospital inpatient or observation care service, because the services rendered for the same diagnosis represent a continuation of the same episode of care. This policy identifies situations in which an initial hospital care service was reported within three days of a prior initial hospital inpatient or observation care service for the same diagnosis. Per CPT guidance.	ALL
Multiple Inpatient Admission or Consultation Services in the Past Week	10-26-2025	The policy defines requirements for Inpatient or Observation Consultation (99251-99255). Per the AMA CPT Manual, an inpatient or observation consultation is reported for the first hospital inpatient or observation encounter. Services on subsequent days during the same episode of care are more appropriately reported using the subsequent hospital inpatient or observation care codes. This policy identifies situations in which an inpatient or observation consultation CPT code	ALL

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		has been reported within seven days of another inpatient or observation consultation (or subsequent hospital inpatient or observation care CPT code) without an intervening discharge in between. Per CPT guidance.	
Mutually Exclusive Places of Service	10-26-2025	This policy identifies situations when any service (other than inpatient care) is billed by any professional provider on the same date of service as inpatient care but with a different place of service, and the member also received inpatient care the previous day and was not discharged on the same day or subsequent day. The service will be denied because the place of service is inconsistent with other services billed as inpatient care. Per CMS guidance.	ALL
Newborn Care Services	10-26-2025	The policy defines requirements for Initial Hospital or Birthing Center Care (99460). Based on the AMA CPT Manual, it is not appropriate to report an initial normal newborn care code if an initial or subsequent normal newborn care code was reported for the previous day. This policy identifies situations in which an initial hospital or birthing center care CPT code is reported and an initial or subsequent newborn care CPT code was reported the previous day. Per CPT guidance.	ALL
Non-Covered Services That Are Informational Only	10-26-2025	This policy identifies situations where an HCPCS code is defined as an informational only service. Based on CMS policy, certain services are for informational purposes only and are considered non-covered services. Per CMS and OCE guidance.	ALL
Out-of-Sequence Edits for DME CCI	10-26-2025	This policy identifies situations when a Column One code is billed and an associated DME	ALL

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		Column Two code has been previously paid. The Column One code will be denied because the Column Two code has been previously paid. Per NCCI for Medicaid guidance.	
Out-of-Sequence Edits for Part B Medicare CCI	10-26-2025	This policy identifies situations when a Column One code is billed and the associated Column Two code has been previously paid. The Column One code will be denied because the Column Two code has been previously paid. Per NCCI for Medicare guidance.	ALL
Out-of-Sequence Edits for Practitioner Medicaid CCI	10-26-2025	The policy defines requirements for Out-of-Sequence Edits. This policy identifies situations when a Column One code is billed and a Column Two code has been previously paid and the codes were both billed by the same provider ID. The Column One code will be denied because the Column Two code has been previously paid. Per NCCI for Medicaid guidance.	ALL
Partial/Fractional Units	10-26-2025	The policy defines requirements for Partial Units. This policy identifies situations when a code is billed with partial units (i.e., not whole numbers). The only codes that may be billed with partial or fractional units are ambulance mileage codes. For example, if a CPT code that is not an ambulance mileage code is billed with partial units, it will be denied. Per CMS guidance.	ALL
Pass-Through and Non-Pass-Through Drugs and Biologicals Require an OPPS-Payable Procedure	10-26-2025	Newly approved pass-through and non-pass-through drugs and biologicals are assigned HCPCS codes to use for billing. This policy will identify and deny pass-through or non-pass-through drugs or biologicals when a required OPPS procedure was not submitted for the same date of service.	ALL

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Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		Based on CMS and OCE policy, a pass-through or non-pass-through drug or biological (other than a pass-through radiopharmaceutical or Edit 99 exception code) must be billed with an OPPS-payable procedure for the same date of service. Per OCE guidance.	
Procedures Billed With Diagnoses That Are Inappropriate Based on the Patient's Gender, Including Mother-Baby Claims	10-26-2025	Certain diagnosis codes are gender specific. This policy identifies situations where the diagnosis code billed is inappropriate for the gender of the patient. A sample situation is "male patient with typically female diagnoses." Newborns reported under mom's gender will also be identified and processed per health plan policy. Based on ICD 10 and CMS policies, gender-specific diagnosis codes should be reported for the appropriate gender. Exceptions are allowed for condition code 45 and modifier KX. • Condition code 45 – ambiguous gender category (transgender or hermaphrodite) • Modifier KX – requirements specified in the medical policy have been met Clinical Examples: • Pay Example – According to the documentation, the patient identifies as female. The patient's gender matches with the gender of the diagnosis code listed. • Deny Example – According to the documentation, the patient is male. The diagnosis listed, A34, obstetrical tetanus, is not consistent for this patient's gender.	ALL
Procedures That Are Bilateral in	10-26-2025	According to CMS, bilateral procedures are procedures performed on both sides of the body during the same operative session. A	ALL

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
Nature (Bilateral Indicator 2)		code with a bilateral indicator of 2 indicates that the 150% payment adjustment does not apply. Per the AMA Principles of CPT Coding, a bilateral code with an indicator of 2 should not be reported on more than one line. CPT/HCPCS codes are assigned bilateral indicators of 0, 1, 2, 3 or 9 based on the Physician Fee Schedule. The bilateral procedures rule will be applied to CPT codes with a bilateral indicator of 2. Bilateral Indicator of 2: Bilateral surgery rules do not apply because: a. The code descriptor specifically states that the procedure is bilateral b. The code descriptor states that the procedure may be performed either unilaterally or bilaterally; or c. The procedure is usually performed as a bilateral procedure. Clinical Examples: • Pay Example – CPT 58956 (Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy) is an example of a code with a bilateral surgery indicator of "2." The procedure descriptor itself indicates the bilateral nature of the procedure. • Deny Example – CPT 92133 (Computerized ophthalmic diagnostic imaging [e.g., optical coherence tomography or OCT], posterior segment, with interpretation and report, unilateral or bilateral; optic nerve) was	

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		reported on two lines with an LT and RT. The documentation supports that 92133 was performed; however, per CMS, this code is already priced bilaterally.	
Self-Administered Drugs	10-26-2025	This policy will identify and deny self-administered drugs when billed with Revenue code 0637 (Pharmacy – Self-Administered Drugs) and without an HCPCS code. Based on CMS policy, the billed self-administered drug is not a covered service. Per CMS and OCE guidance.	ALL
Services Following a Medical Event	10-26-2025	The policy defines requirements for Ophthalmology Services Performed Following an Enucleation, Evisceration or Exenteration. This policy will identify situations when an ophthalmology service that is bilateral in nature is billed and an enucleation, evisceration or exenteration of the eye has been previously billed by any provider, but an appropriate modifier indicating reduced services has not been appended. The ophthalmology service will be denied as inappropriately coded because it is not possible for this procedure to have been performed bilaterally if a previous enucleation, evisceration or exenteration was performed. Per CMS guidance.	ALL
Services Prior to the Date of National Coverage Determination (NCD) Approval	10-26-2025	The policy identifies items, services and procedures with a date of service prior to the effective date of the NCD. Based on CMS policy, certain services cannot be reported prior to the effective date of NCD approval in bill types 0120-012Z, 0130-013Z or 0140-014Z. Per CMS and OCE guidance.	ALL
Smoking and Tobacco-Use Cessation Counseling	10-26-2025	The policy defines NCD requirements for smoking cessation counseling. This policy identifies E/M services billed with a smoking and tobacco cessation counseling	ALL

Payment Policy Management Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		service on the same date without an appropriate modifier. According to CMS policy, E/M services are payable on the same day as smoking and tobacco-use cessation counseling services only when medically necessary, as indicated by the appropriate modifier. Per CMS NCD guidance.	
Telehealth Services	10-26-2025	The Telehealth Services Policy, Facility Originating Fee identifies situations when an E/M service is reported in a facility setting without an accompanying telehealth-eligible service. Based on CMS policy, telehealth facility charges should be reported with an appropriate telehealth eligible service on the same date of service, except when an ESRD monthly service code has been billed within the previous month. Per CMS and the AMA CPT Coding Manual guidance.	ALL
Transitional Care Management (TCM) Services When Billed and Another TCM Service Has Been Billed on the Same Date of Service by Any Provider	10-26-2025	The policy defines requirements for TCM codes 99495-99496. Based on the AMA CPT Manual, TCM services should be reported once per patient within 30 days of discharge, and only by one provider. Therefore, additional reporting of TCM will be denied. This policy identifies when more than one TCM service was billed for the same date of service. Per CPT guidance.	ALL
End of Batch –	10-26-2025	– Effective Date	
Partial Hospitalization Policy	4-25-2025	Partial hospitalization is a distinct and organized intensive outpatient day treatment. Partial hospitalization services are furnished by a hospital or community mental health center (CMHC). CMS reimburses partial hospitalization services on a per diem basis. These services	ALL

Payment Policy Management Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		should be reported with the appropriate condition codes and bill types. A mental health diagnosis code is also required.	
Observation Services Policy	4-25-2025	Observation services are services furnished on an outpatient basis on a hospital's premises and include the use of a bed and periodic monitoring by nursing or other staff. Such services are necessary to evaluate a patient's condition to determine the need for possible admission. Observation services are only covered when ordered by a physician and usually do not exceed one day. These observation services should be reported with the appropriate bill types, revenue codes, units and dates of service.	ALL
Claims Processing and Policy Guidelines	4-25-2025	This is informational only and explains concepts such as modifier exceptions, provider linking, HCPCS terminology and ranking options.	ALL
Deleted HCPCS Codes Policy	2-27-2025	Procedure codes, such as Level II HCPCS and AMA CPT-4 codes, undergo revision by their governing entities on a regular basis. Revisions typically include adding new procedure codes, deleting procedure codes, and redefining the description or nomenclature of existing procedure codes. These revisions are normally made on an annual basis by the governing entities with occasional quarterly updates. Claims received with deleted procedure codes will be validated against the date of service. If the procedure code is valid for the date of service, then the claim will continue processing. If the procedure code is no longer valid for the date of service, then the claim will be processed in one of two ways: mapping to the comparable new code or denying.	ALL
Diagnosis Validity Policy	2-27-2025	Diagnosis (ICD) codes undergo revision by their governing entities on a regular basis. Revisions typically include adding new diagnosis codes, deleting codes, and redefining the description or nomenclature of existing diagnosis codes. These revisions are normally made on an annual	ALL

Payment Policy Management Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		basis (effective Oct. 1) by the governing entities. Claims received with invalid diagnosis codes will be corroborated with the date of service. If the diagnosis code is valid for the date of service, then the claim will continue processing. If the diagnosis code is invalid for the date of service, then the claim line will be denied.	
Separate Procedures Policy	2-27-2025	The description for many CPT codes includes a parenthetical statement that the procedure represents a "separate procedure." The inclusion of this statement indicates that the procedure should not be reported when it is performed in conjunction with, and related to, a major service.	ALL
Multiple Procedure Reduction for Radiology Policy	2-27-2025	On Jan. 1, 2006, CMS implemented a multiple procedure reduction to the technical component of specific diagnostic imaging services, when more than one diagnostic imaging service from the same family is reported for the same date of service. Under these circumstances, CMS will apply a 25% payment reduction to the technical component for each additional related diagnostic imaging service. Since inception, CMS only applies this logic to physician offices and free-standing imaging centers. Effective Jan. 1, 2011, CMS changed the structure of the imaging families that are subject to the multiple imaging services reduction. Instead of 11 imaging families, all imaging services are currently included under a single family (Family 88). CMS has further revised this concept since its inception. At present, the reduction for the technical component is 50%. The reduction for the professional component has changed over time but is currently applied as a 5% reduction.	ALL
National Provider Identifier (NPI) Policy	2-27-2025	CMS requires that providers have active billing privileges at the time services are rendered to receive Medicare payments; therefore, an attending, billing and rendering provider must	ALL

Payment Policy Management Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		have a valid NPI that is also active for the specific date of service reported.	
Ambulatory Surgical Center (ASC) Policy	2-27-2025	CMS has established a list of procedures that may be performed safely in an ASC setting. These procedures are those that generally do not exceed 90 minutes in length and do not require more than four hours recovery or convalescent time. Physician services are covered separately and should be submitted to Medicare Part B. According to CMS policy, separate payment may be made for certain drugs and biologicals, certain radiology services, certain devices, and certain brachytherapy sources that are provided integral to a covered surgical procedure in an ASC. These services will be denied when billed without an ASC surgical procedure for the same date of service. In addition, payment is only allowed for the insertion of new technology intraocular lenses (NTIOLs) when performed in the ASC setting.	ALL
Bundled Facility Payment Policy	11-27-2024	According to CMS policy, outpatient services provided on either the date of inpatient admission or during the three calendar days immediately preceding the date of inpatient admission are included in the Inpatient Prospective Payment System (IPPS) payment when provided by the same admitting hospital. When these services are billed, they will be bundled into the inpatient payment, and separate payment will not be allowed. Certain other services are also bundled into the inpatient facility payment when these services, such as ambulance patient transportation, durable medical equipment, home health or home infusion services, are reported during an inpatient confinement. Services reported on the date of admission or on the date of discharge are not subject to bundling.	ALL

Payment Policy Management Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
Claims Processing Parameters Policy	11-27-2024	According to CMS policy, providers must have valid and active billing privileges at the time that services are rendered to receive Medicare payments. A provider may have his or her NPI deactivated under certain circumstances, such as when a provider is deceased or out of business. CMS will also exclude certain providers from federal programs. If a provider has been debarred, then the provider does not have active billing privileges, and claims submitted from these NPIs during the period of exclusion will also be denied.	ALL
Diagnosis – Age Policy	11-27-2024	Certain diagnosis codes are age specific. When one of these diagnoses is reported and it does not match the age of the patient for that date of service, then all services on the claim will be denied. For example, a newborn diagnosis must be associated with a member less than 30 days of age.	ALL
Diagnosis – Gender Policy	11-27-2024	Certain diagnosis codes are gender specific. When one of these diagnoses is reported and it does not match the gender of the patient, then all services on the claim will be denied.	ALL
Multiple Endoscopy Policy	11-27-2024	CMS has established payment guidelines when multiple endoscopic procedures are performed for the same date of service. Endoscopies can be classified as either "related" (e.g., two different upper GI endoscopies) or "unrelated" (e.g., an upper and a lower GI endoscopy). The underlying concept of multiple endoscopy rules is that for each family of endoscopies (e.g., upper GI), there is a "base" endoscopy procedure that is considered a component of all other endoscopies within that family. CMS reimbursement for multiple endoscopy procedures is based on 100% of the highest RVU endoscopy, plus the difference between	ALL

Payment Policy Management Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		the next highest valued endoscopy and the base endoscopy. Endoscopies subject to the multiple endoscopy rule contain an indicator of "3" on the Medicare Physician Fee Schedule.	
Once-Per-Lifetime Services Policy	11-27-2024	Certain procedures would be inappropriate to be reported more than once per lifetime due to anatomical and other considerations (e.g., appendectomy).	ALL
Procedure – Gender Policy	11-27-2024	Certain procedure codes, by definition or nature of the procedure, are limited to the treatment of one gender.	ALL
Quality-of- Care Policy	11-27-2024	Certain services are appropriate to be reported within the scope of a specific practice or specialty. Other services would be considered outside the scope of services for a specific specialty.	ALL
Revenue Code Policy	11-27-2024	Revenue codes are four digits in length and are used to identify a specific accommodation, ancillary service or billing calculation. The National Uniform Billing Committee (NUBC) defines the use of revenue codes. Certain revenue codes are required to be accompanied by an HCPCS code. Certain lab and x-ray codes should be reported with specific laboratory services revenue codes or x-ray services revenue codes; revenue codes that are not from the appropriate revenue code classification and not reported with the appropriate match will be denied. For example, a lab code cannot be reported with an x-ray revenue code, and a hematology lab code cannot be reported with an immunology revenue code.	ALL
Team Surgery Policy	11-27-2024	Under some circumstances, highly complex procedures are carried out by a team of physicians. In a team surgery setting, the physicians are typically of different specialties	ALL

Payment Policy Management Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		and often include other highly skilled, specially trained personnel. Only surgical codes identified by CMS as requiring a team to complete the procedure will be allowed when reported with modifier 66.	
Add-On Code Policy	9-1-2024	Certain procedure codes are commonly carried out in addition to the performance of a primary procedure. These additional or supplemental procedures are referred to as "add-on" procedures and describe additional services associated with the primary procedure. These codes are identified in the AMA CPT Manual with a plus mark ("+") symbol and are also listed in Appendix D of the CPT Manual. Add-on codes in the HCPCS Level II Manual and the ADA Dental Services Manual are identified with "list separately in addition to code for primary procedure" or "each additional" language within the code description. Add-on codes are always performed in addition to a primary procedure and should never be reported as a stand-alone service. When an add-on code is submitted and the primary procedure has not been identified on either the same or different claim, then the add-on code will not be recommended for payment as an inappropriately coded procedure. If the primary procedure is not paid for any reason, then the add-on code will not be reimbursed either.	ALL
Anesthesia Policy	9-1-2024	When multiple anesthesia services are reported for the same day for the same patient, the anesthesiologist should report only the general anesthesia service for the procedure with the highest base unit value, plus the time for all anesthesia services combined. Multiple anesthesia service codes will be processed according to the highest submitted charge as the primary procedure. The secondary anesthesia services will be denied.	ALL

Payment Policy Management Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		The HCPCS Manual identifies certain modifiers that indicate the number of qualified individuals for which an anesthesiologist is providing medical direction. When a claim is submitted by a CRNA or other qualified individual rendering anesthesia services, both the anesthesiologist and the CRNA are required to utilize appropriate modifiers indicating medical direction was provided.	
Assistant Surgeon Policy	9-1-2024	The modifiers used to indicate the services of an assistant surgeon are: 80 (assistant surgeon), 81 (minimal assistant surgeon), 82 (assistant surgeon [when qualified resident surgeon not available]), and AS (physician assistant, nurse practitioner or clinical nurse specialist services for assistant at surgery). Surgical codes identified by CMS or by the ACS as not requiring an assistant surgeon will be denied. In addition, CMS indicates procedures where assistant surgeons are not allowed unless documentation supports the need for an assistant surgeon; these "May Be Allowed" services will be denied.	ALL
Bilateral Procedures Policy	9-1-2024	A bilateral procedure is defined as a procedure that is performed on both sides of the body at the same session or on the same date of service. Procedures reported with a 50 modifier should only be reported with one unit of service. Some payors may require bilateral procedures to be reported on two lines - one with a 50 modifier and one without, and each with one unit of service. Procedures that are bilateral in nature should be reported on a single claim line, without any modifiers, and with one unit of service.	ALL
Bundled Services Policy	9-1-2024	There are a number of services/supplies for which payment is bundled into the payment for other related services, whether specified or not.	ALL

Payment Policy Management Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		The list of bundled services is based on the CMS National Physician Relative Value File.	
CMS Coverage Policies	9-1-2024	CMS has established a number of items and services that require specific reporting guidelines. These guidelines are based on specific CMS requirements such as are published in the Internet-Only Manuals, Physician Fee Schedules, and/or the Outpatient Prospective Payment System.	ALL
CMS NCD Policy	9-1-2024	CMS limits reimbursement of certain items and services to those that are reasonable and necessary for the treatment of an illness or injury. The policies that detail these requirements are known as NCDs. Each NCD is created through an evidence-based process and are published by CMS.	ALL
Co-Surgeon Policy	9-1-2024	Co-surgeons are two physicians (from different specialties or subspecialties) working together as primary surgeons, performing distinct parts of a procedure. The modifier used to indicate the services of a co-surgeon is modifier 62 (two surgeons). Only surgical codes identified by CMS as requiring a co-surgeon will be allowed when reported with modifier 62.	ALL
Device and Supply Policy	9-1-2024	CMS has established an implant procedure/device link. A device/implant procedure should be reported with an implant or device. We have also established an implant device/procedure link, based on the former edit in the OPPS program. On this basis, we will also assess that an implant device is reported with an appropriate implant procedure. CMS has also addressed the requirements of billing pass-through and non-pass-through drugs and biologicals, as well as blood products and brachytherapy sources, under OPPS payment.	ALL

Payment Policy Management Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
Diagnosis Code Guideline Policy	9-1-2024	All ICD codes should be reported based on the ICD Official Guidelines for Coding and Reporting. Each ICD code should be reported to the highest degree of certainty and specificity. According to these coding guidelines, there are certain defined categories of diagnosis codes that cannot be reported as the principal, first listed or only diagnosis on the claim. These defined categories of diagnosis codes include external causes (ICD-10 V-Y) diagnosis codes, manifestation codes, secondary only diagnosis codes and sequela (ICD-10 codes with 7th character) diagnosis codes. If any of these codes are reported under these circumstances, then the claim line will be denied. The guidelines also establish mutually exclusive diagnosis codes known as Excludes 1 Notes. If a claim line is reported with any of these mutually exclusive code combinations, it will be denied. Certain diagnosis codes contain specific laterality definitions within their code descriptions. These codes will contain right, left, bilateral and unspecified in their code descriptions. Reporting these laterality codes requires consistency between the diagnosis codes as well as modifiers reported.	ALL
Diagnosis Procedure Policy	9-1-2024	Certain sources such as national CMS policies (i.e., NCDs), Regional CMS policies (i.e. LCDs), industry publication, and other clinical expertise sources publish appropriate indications for procedures. Procedures reported with an inappropriate diagnosis will not be considered for reimbursement.	ALL
Drug and Biological Policy	9-1-2024	Drug and biological policies are derived from the following specific resources: Manufacturer's	ALL

Payment Policy Management Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
Processing and Policy Guidelines		prescribing information (drug label), Elsevier/Gold Standard Clinical Pharmacology, Truven Health Analytics Micromedex DRUGDEX, Wolters Kluwer Lexi-Drugs, American Hospital Formulary Service Drug Information, National Comprehensive Cancer Network, Drugs and Biologics Compendium, and LCDs. NDC number and the HCPCS code are required to match.	
Duplicate Services Policy	9-1-2024	Duplicate claims or claim lines are defined as claims or claim lines that have previously been processed and reimbursed. The duplicated claims are assessed against the member, date of service and procedure codes reports as well as various other claim elements depending on the nature of the duplicate processing. We support a variety of types of duplicate editing to assess services from professional and facility providers, as well as specific policies for non-physician practitioners, anesthesia services, global surgery procedures and professional services across claim form types for providers who have assigned their billing rights to a critical care hospital.	ALL
Durable Medical Equipment and Supplies Policy	9-1-2024	DME includes all items that fall under the definition of being, sturdy, long lasting items and appliances that can withstand repeated use, which are designed to serve a medical purpose but are not useful to a person in the absence of a medical condition, or injury. CMS includes the following services in their DME policy: DME, Supplies, Orthotics, Prosthetics, Drugs used with DME, Parenteral Nutrition and Enteral Nutrition. The above items can be either rented or purchased and are required to be reported with specific modifiers indicating whether the item	ALL

Payment Policy Management Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		was a rental or a purchased item. These services are also subject to Column One/Column Two edits and frequency and unit limitations as established by CMS guidelines.	
Evaluation and Management Services Policy	9-1-2024	The AMA defines a new patient as one who has not received any professional services from the physician or another physician of the same specialty and subspecialty who belongs to the same group practice within the past three years. Otherwise, the patient is considered an established patient. Only one E/M code should be billed for a single date of service by the same provider group and specialty, regardless of place of service. Gynecologic screening services are included in preventive medicine visits.	ALL
Frequency Policy	9-1-2024	Services should be reported with appropriate frequency.	ALL
Global Obstetrical Policy	9-1-2024	The AMA and the American College of Obstetricians and Gynecologists define the global obstetrical package for uncomplicated maternity cases as including certain services, such as antepartum care, office visits at a defined frequency during the pregnancy, delivery services, hospital admission and postpartum care. Separate reimbursement for those services which are included in the global obstetrical package for uncomplicated maternity cases is not allowed. If a provider provides all or part of the antepartum care but does not perform the delivery due to reasons such as termination of pregnancy by abortion or referral to another provider for delivery, then the provider should bill the antepartum care using the appropriate E/M or antepartum care only code.	ALL

Payment Policy Management Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		It is not appropriate for a single provider to bill more than one antepartum care code in any combination during the antepartum period.	
Global Surgery Policy	9-1-2024	The Global Surgery Package includes all necessary services normally furnished by the surgeon before, during and after a surgical procedure. The Global Surgery Package applies only to surgical procedures that have post-operative periods of 0, 10 and 90 days. The global surgery concept applies only to primary surgeons and co-surgeons. The following items are included in the Global Surgery Package: preoperative and same day E/M visits after the decision is made to operate; all post-operative E/M visits and services for 10-day and 90-day surgeries related to the primary procedure in accordance with CMS guidelines.	ALL
Incident To Services Policy	9-1-2024	Incident To services are those services furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an illness or injury according to CMS guidelines. Incident To services should not be reported in an inpatient hospital, outpatient department (including the emergency department), military treatment facility setting or other facility. The employer-employee relationship is an additional determinant of the ability to report incident to services; a professional provider would not employ the support personnel in a facility setting.	ALL
Maximum Limits Policy	9-1-2024	Certain procedure codes have been assigned a maximum number of units per day and/or a maximum number of visits annually that may be reported for a member regardless of the provider, based upon criteria such as, procedure code definition or nomenclature, anatomical site, CMS sources, clinical guidelines, or state sources.	ALL

Payment Policy Management Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
Modifier Policy	9-1-2024	Most modifiers have descriptions indicating that the procedure applies to a specific anatomic site, that the services were performed distinctly from other services, or that there were special circumstances surrounding the performance of the services. Inappropriate procedure-modifier combinations will not be considered for reimbursement. For example, procedural modifiers would be inappropriately reported on E/M codes. In addition, certain procedures should be reported for the specific site performed by appending an anatomic modifier, such as RT, LT or 50.	ALL
Modifier Processing Policy	9-1-2024	Modifiers play a significant role in claims processing. They are used to convey that a service has either been altered in some way or that a significant circumstance surrounds the service. Absence of an appropriate modifier or presence of an inappropriate modifier does not support correct coding.	ALL
Multiple Procedure Reduction Policy	9-1-2024	Multiple Procedure Reduction applies when a provider performs two or more surgical procedures on the same date of service that are subject to multiple surgery guidelines. The appropriate billing of multiple surgery claims by providers is to append modifier 51 (multiple procedures) to procedures that are secondary to the primary surgical procedure. CMS reimbursement for multiple surgical procedures is based on a 100%/50%/50% methodology. The procedure with the highest RVU price is reimbursed at 100% of the amount and all secondary procedures are reimbursed at 50% of the RVU price. This methodology only applies to procedures that have been identified by CMS as being subject to multiple procedure	ALL

Payment Policy Management Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		guidelines, which is a subset of all procedure codes.	
National Correct Coding Initiative Policy	9-1-2024	The NCCI is a collection of bundling edits created and sponsored by CMS that fall into two major categories: Column One and Column Two procedure code edits (previously referred to as "Comprehensive" and "Component"), and mutually exclusive procedure code edits. CCI edits are for services performed by the same provider on the same date of service only and do not apply to services performed within the global surgical period. Each CCI code pair edit is associated with a policy as defined in the NCCI Policy Manual.	ALL
National Correct Coding Initiative Supplemental Policy	9-1-2024	Some CPT and HCPCS codes are not addressed in the NCCI. This omission is primarily due to the fact that CMS either does not recognize the CPT or HCPCS code or because the service is excluded from the Medicare program. In some cases, CMS instructs providers to utilize a different code in place of a code not recognized by CMS. In instances where CMS does not address specific codes, CCI-equivalent policies have been created to capture inappropriate utilization.	ALL
National Correct Coding Manual Policy	9-1-2024	The NCCI Policy Manual is broken into 13 narrative chapters, with each chapter corresponding to a section of the AMA CPT Manual. Each chapter contains correct coding policies as they relate to the procedure codes contained within the chapter. In many cases, these policies are not incorporated, or are only partially incorporated, into the actual CCI edits. These chapters have been translated into policies that enhance the CCI edits.	ALL
Place of Service Policy	9-1-2024	Certain codes are allowable only in specific places of service. For example, hospital admission codes (99221-99223) can only be reported for hospital places of services such as POS 21 (inpatient hospital), or POS 51 (psychiatric inpatient facility).	ALL

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Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
Procedure Code Definition Policy	9-1-2024	The AMA CPT Manual assigns specific definitions to describe each procedure code. In order to support correct coding, these policies will either deny or change procedure codes based on the appropriateness of the code selection as directed by the definition and nature of the procedure code.	ALL
Procedure Code Guideline Policy	9-1-2024	The AMA CPT Manual includes specific reporting guidelines which are located throughout the Manual and at the beginning of each section. In order to ensure correct coding, these guidelines provide reporting guidance and should be followed when submitting specific procedure codes.	ALL
Procedure-Age Policy	9-1-2024	Certain procedure codes, by definition or nature of the procedure, are limited to the treatment of a specific age or age group. For example, preventive medicine services code 99382 is limited to patients 1 through 4 years of age.	ALL
Professional, Technical, and Global Services Policy	9-1-2024	Diagnostic tests and radiology services are procedure codes that include two components: professional and technical. The professional component describes the physician work portion of a procedure which consists of interpretation and a report and is represented by a procedure code with a modifier 26. The technical component describes the technical portion of a procedure, such as the use of equipment and staff needed to perform the service and is represented by a procedure code with modifier TC. The global service represents the sum of both the professional and technical components and is represented by the CPT/HCPCS code for the service without modifiers 26 and TC. Only procedure codes designated as diagnostic tests or radiology services have the two individual components. Reimbursement of diagnostic tests and radiology services is limited to no more than the amount for the global service.	ALL

Payment Policy Management Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		Diagnostic tests or radiology services submitted by professional providers with a place of service outside of the office setting should be reported using the appropriate professional component modifier. Professional radiology services should not be reported by a non-radiologist in the inpatient or outpatient hospital setting. Professional radiology services should not be reported in the office setting in conjunction with an E/M service when reading or overreading of outside films was the service performed. Professional Component Only services are stand-alone procedures that describe only the professional component of a given procedure (e.g., interpretation and report only). These codes identify the physician work portion of selected diagnostic procedures that have associated codes to describe the technical and global components of these procedures. It is inappropriate to bill these procedure codes with professional or technical component modifiers as neither of these modifiers is applicable to this group of procedure codes. Similarly, Technical Component Only services are those that are stand-alone and describe only the technical component of a given procedure without the use of the technical component modifier. Procedures should not be reported by a professional provider in the inpatient hospital, outpatient hospital, emergency department or ambulatory surgical center using a technical component modifier. The technical component of diagnostic tests and radiology services will be reported by the facility in these settings. Many clinical laboratory services do not have associated professional components. When a provider bills for one of these clinical laboratory	

Payment Policy Management Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		services with a professional component modifier, the clinical laboratory service will be denied. The interpretation of laboratory results is included in the payment for E/M services. It is inappropriate for pathologists to bill for laboratory oversight and supervision through use of this modifier. Reimbursement for laboratory oversight and supervision is obtained through the hospital or independent laboratory. Certain procedure codes, such as office visits and surgical procedures, describe physician services. These services do not have separate professional and technical components. Therefore, it is inappropriate to use professional and/or technical component modifiers with these procedure codes.	
Split Surgical Care Policy	9-1-2024	Split surgical care occurs when different physicians furnish either the pre-operative, intra-operative or post-operative portions of the global surgical package. Split surgical care is only applicable to providers of different Tax ID groups or providers within the same Tax ID group but with different specialties. Providers within the same Tax ID group and same specialty are treated as a single entity and may not bill split surgical care. When split surgical care occurs, each provider is reimbursed according to the portion of surgical care they provided. The three portions of surgical care are: Preoperative; Intraoperative (or Surgical Care Only); and Postoperative. Modifiers 54, 55 and 56 are appropriate for use only with procedure codes that have a 10-day or 90-day postoperative period. It is not appropriate to append these modifiers to E/M services, 0-day surgical services, or any other service that does not have a 10-day or 90-day postoperative period.	ALL

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