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 following:

- The administrative claims edit name
- Its effective date
- A description of the administrative claims edit
- The line of business to which the administrative claims edit applies

Appendix A

To access and view all Laboratory Benefit Management (LBM) policies, please view Appendix A.

Appendix B

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

Additional Resources

- Revised Emergency Department Outpatient Facility Evaluation and Management Coding Policies
- View All Upcoming LBM Claims Edits

Questions

Should providers have any questions regarding the following updates, then they 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: 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
Hospice Overlap	9-1-25	Presbyterian will utilize CMS and New Mexico Health Care Authority guidelines to review claims that occur between the admission and discharge dates of a given member's hospice care. Claims that are determined to be ineligible for separate reimbursement from hospice care will be denied.	ALL
16 Laboratory Benefit Management (LBM) policies were updated	8-15-25	The 16 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. • 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	ALL

2024/2025 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
		policy, please refer to the Revision History section at the end of each policy.	
Surgical Procedure Anatomical Modifier – Fingers and Toes	7-1-2025	Enforcement of correct coding and billing guidelines regarding Surgical Procedure Anatomical Modifier – Fingers and Toes. Without the proper anatomical modifier applied to the procedure code, there is risk of duplicate claims payment, incorrect procedure to procedure bundling, incorrect frequency limitations and unnecessary 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.	ALL
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 2 shoulder arthroscopy procedure will be denied if reported with the column 1 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	ALL

2024/2025 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
		HCPCS/CPT code, then the claim line or units of service for that code will be denied. Per CMS guidance.	
Inpatient Readmissions	5-16-2025	Enforcement of correct coding and billing guidelines regarding Inpatient Readmissions. A readmission review applies when a patient is admitted to an acute, general, short-term hospital within 15 calendar days (Medicaid) or 31 calendar days (Medicare & Commercial) of discharge from 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.	ALL
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

2024/2025 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
Inpatient/Physician Overlap	5-16-2025	Enforcement of correct coding and billing guidelines regarding Inpatient/Physician Overlap. Presbyterian will utilize CMS and New Mexico Health Care Authority guidelines to review physician claims that occur between the admission and discharge dates of a given member's inpatient stay. Physician claims that are determined to be ineligible for separate reimbursement from an inpatient stay will be denied.	ALL
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 Payment Policy Management (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.	ALL

2024/2025 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
		• Coronavirus Testing in the Outpatient Setting • Diabetes Mellitus Testing • Laboratory Procedures Reimbursement Policy • Prescription Medication and Illicit Drug Testing in the Outpatient Setting • Testing for Developmental Delay (was previously named "Testing for 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

2024/2025 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
Six PPM policies have been added to the program	2-27-2025	Please see Appendix B of this guide for the newly added policies.	ALL
19 LBM policies were updated	2-17-2025	The policies below were updated in ways that may affect how claims are processed. All LBM policies can be found in Appendix A. For the full list of updates made to any LBM policy, please refer to the Revision History section at the end of each policy. • 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	ALL

2024/2025 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
		• Gamma-glutamyl Transferase Testing in Adults • Venous and Arterial Thrombosis Risk Testing • Testing for Alpha-1 Antitrypsin Deficiency • Identification of Microorganisms Using Nucleic Acid Probes • 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

2024/2025 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
Appropriate Use of Modifier 73	1-1-2025	Enforcement of correct coding guidelines for Appropriate Use of Modifier 73. When outpatient hospital/ambulatory surgery center (ASC) procedures are discontinued prior to the administration of anesthesia but after the patient has been prepped and taken to the procedure room, the claim should be billed with modifier 73. It will be paid at 50% of the amount, per CMS guidance.	ALL
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

2024/2025 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
Three LBM policies have been added to the program	8-1-2024	Therapeutic Drug Monitoring for 5-Fluorouracil RTM Testing of Homocysteine Metabolism-Related Conditions Testing for Autism Spectrum Disorders and Developmental Delay	ALL
Venipuncture Billing	8-1-2024	Enforcement of correct coding guidelines for Venipuncture Billing. When a 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	ALL

2024/2025 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
		administered was not reported, the claim will be denied.	
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	ALL

2024/2025 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOBs
		improper coding will be denied or recoded. For more information, see the Revised 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

2023 Summary of Updates

Claims Edit Name	Effective Date	Claims Edit Description	Affected LOB
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 have code 0651 or 0652 associated with the claim and there is a condition code 61.	Medicare Only
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 will initially go into effect on **Sept. 1, 2024.*** For more information about these policies, affected product lines and more, view the table below.

***Note that Sept. 1, 2024, is the initial effective date for PPM. Future 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)
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 should be reported with the appropriate condition codes and bill types. A mental health diagnosis code is also required.	ALL
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	ALL

Payment Policy Management Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		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.	
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 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.	ALL
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	ALL

Payment Policy Management Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		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.	
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 have a valid NPI that is also active for the specific date of service reported.	ALL
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.	ALL

Payment Policy Management Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		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.	
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	ALL

Payment Policy Management Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
		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 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

Payment Policy Management Policies & Descriptions

Policy Name	Effective Date	Policy Description	Affected Lines of Business (LOB)
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 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.	ALL
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	ALL

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		highest submitted charge as the primary procedure. The secondary anesthesia services will be denied. 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

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		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

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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 Processing	9-1-2024	Drug and biological policies are derived from the following specific resources: Manufacturer's prescribing information (drug label), Elsevier/Gold Standard Clinical Pharmacology, Truven Health Analytics Micromedex DRUGDEX, Wolters Kluwer	ALL

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and Policy Guidelines		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 was a rental or a purchased item. These services are also subject to Column I/Column II edits and frequency and unit limitations as established by CMS guidelines.	ALL

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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. It is not appropriate for a single provider to bill more than one antepartum care code in any combination during the antepartum period.	ALL
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	ALL

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		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.	
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
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 evaluation and	ALL

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		management codes. In addition, certain procedures should be reported for the specific site performed by appending an anatomic modifier, such as RT, LT or 50.	
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 guidelines, which is a subset of all procedure codes.	ALL
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 I and Column II 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

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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
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.	ALL

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		For example, preventive medicine services code 99382 is limited to patients 1 through 4 years of age.	
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. 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 evaluation and management 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	ALL

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		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 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	ALL

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		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.	