Molina Code-Editing Guidelines are based on publicly distributed guidelines from established industry sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state health care agencies and medical specialty professional societies.
CMS has directed all Federal agencies to implement NCCI as policy in support of Section 6507 of the Patient Affordable Care Act of March 23, 2010. Molina uses NCCI standard payment methodologies.

NCCI Procedure to Procedure edits prevent inappropriate payment of services that should not be bundled or billed together and to promote correct coding practices. Based on NCCI Coding Manual and CPT guidelines, some services/procedures performed in conjunction with an evaluation and management (E&M) code will bundle into the procedure when performed by same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures.

NCCI editing also includes Medically Unlikely Edits (MUEs), which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

Codes must be submitted in accordance with the chapter and code-specific guidelines set forth in the current/applicable version of the AMA CPT and HCPCS codebooks. In order to ensure proper and timely reimbursement, codes must be effective on the date of service (DOS) for which the procedure or service was rendered and not the date of submission.

Assistant at Surgery Services

Guideline	Action
Assistant Surgeons Not Allowed	Deny codes when billed as assistant surgeon when the codes are designated as *assistant surgeon not allowed*.

Add-on Codes

Guideline	Action
Add-on Code Policy	Deny claims when an add-on code is reported and the appropriate primary procedure is not paid on the same date of service.

Age Related Codes

Guideline	Action
Age Policy	Deny codes when the procedure or diagnosis definition do not match the member's age on file.

Bundled Services

Guideline	Action
Bundled Services Not Payable Under Any Circumstances	Deny bundled services for which payment is always routinely bundled into other services and supplies.

Co-Surgeon Services

Guideline	Action
Co-Surgeons Allowed and Specialty Requirements Are Met	Deny co-surgeon claims when both surgeons have the same specialty for procedures designated as *co-surgeons are allowed*.

Co-Surgeon Services Not Billed with Modifier 62	Deny procedures designated as co-surgeons allowed when billed without modifier 62 and there exists a previously processed claim for the same procedure code with modifier 62 by a different provider.
Co-Surgeon Services Billed with Modifier 62	Deny procedures designated as co-surgeons allowed when billed with modifier 62 when there exists a previously processed claim for the same procedure code by a different provider without modifier 62.

Diagnosis Policy

Guideline	Action
Diagnosis Related	Deny services when a valid diagnosis is not found on the claim. Examples of invalid diagnosis's: not a primary diagnosis, primary only, or the diagnosis is not coded to the highest level of specificity.

Drugs and Biological Policy

Guideline	Action
Drug and Biological Requirements Are Not Met	Deny claim line when the service provided does not meet the requirements of the published drug packaging instructions.

Duplicate Services

Guideline	Action
Duplicate Claim Logic for Anesthesia Services by Any Provider	Deny duplicate anesthesia service claims when billed by any provider.
Duplicate Claim Logic for Co-Surgeon Services	Deny co-surgeon procedures billed without modifier 62 when a previously processed claim exists for the same procedure with modifier 62 by a different provider.
Duplicate Claim Logic for Global Surgery Procedures	Deny 0-, 10- or 90-day procedures when the same code has been billed for the same date of service with the same number of submitted units by a different Tax ID, different Provider ID and any specialty.
Duplicate Claim Logic for Independent Laboratory Services	Deny claim lines reported by an independent laboratory when billed by a different Tax ID Number, any Provider ID or any specialty.
Duplicate Laboratory Services for Office and Independent Laboratory	Deny claim lines as duplicates when the duplicate criteria have been met.
Duplicate/Multiple Professional Components for the Same Service	Reimburse only one professional component for the same service when billed by different providers.
	Reimburse only one professional component for the same service when billed by different providers.

Evaluation and Management (E&M) Services

Guideline	Action
E&M services with Electrocardiogram (ECG)	Deny 93042 when billed with an E&M service in the hospital setting.
E&M Services with Critical Care	Deny E&M services (99201-99215, 99221-99223, 99231-99233, 99431, 99460, G0175) when billed with critical care service (99291) and the place of service is the same.
E&M Services with Pulmonary Diagnostic Procedures	Deny an E&M service when billed with 94010-94799 (Pulmonary function testing).

Multiple E&M Services on the Same Day	Allow the E&M code with the highest Relative Value Unit (RVU) price, when multiple E&M services are billed for the same date of service, provider group and specialty, except when modifier 25 is appended to the additional E&M service.
New Patient Visits	Deny a new patient visit when face-to-face service has previously been billed by the same physician or a physician from the same group practice (with the same specialty and subspecialty) within the last three years.
Discharge Services	Deny hospital discharge services (99238-99239) when 99238 or 99239 has been billed for the same date of service.
	Deny hospital discharge services (99238- 99239) when 99238 or 99239 was billed and allowed on the subsequent date of service.
Multiple Inpatient Admission or Consultation Services	Deny an initial hospital care (99221-99223) to a subsequent hospital care (99231-99233), if an initial hospital care has been billed in the previous three days with the same diagnosis by the same Tax ID and subspecialty.
Inpatient Neonatal and Pediatric Critical Care and Intensive Care Services	Limit any combination of 99468-99476 (Neonatal and pediatric critical care) to one unit per date of service by any provider.
Observation Services	Deny initial observation care codes (99218-99220) or codes that include the initial observation care (99234-99236) when an initial observation care code has been billed for the previous day by any provider.
	Deny 99218-99220, 99224-99226 (Observation services) when billed for more than one unit per date of service in any combination by any provider and the place of service is 19 (Outpatient hospital - off campus), 21 (Inpatient hospital), 22 (Outpatient hospital - on campus), 23 (Emergency department) or 24 (Ambulatory Surgical Center).
	Deny hospital discharge services (99238-99239) when 99238 or 99239 was billed the previous day.

Facility

Guideline	Action
Revenue Code Requirements Not Met	Deny claim line when the revenue code reported requires to be accompanied by a specific type of bill or CPT/HCPCS code.
Sepsis Diagnosis	Pend claims for review when type of bill is 011x, there is a sepsis diagnosis present in any position on the claim (A40.x, A41.x, R65.x) and length of stay is less than 5 days. Members with sepsis typically do not have such a short inpatient stay.
Patient Discharge Status is Invalid or Missing	Deny claim when the patient discharge status is invalid or missing.
Facility Inpatient Procedure Inconsistent with Length of Stay	Claim line will deny when the inpatient procedure is inconsistent with length of stay.

Gender Related Codes

Guideline	Action
Gender Policy	Deny codes when the procedure or diagnosis definition do not match the member's gender on file.

Global Surgery Services

Guideline	Action
Major Surgery: 90-Day Procedures	Deny E&M services when performed the day prior to a 90-day medical or surgical service.
	Deny E&M services when performed the same day as a 90-day medical or surgical service.
	Deny E&M services performed within 90 postoperative days of a 90-day medical or surgical service.
	Deny E&M services performed within 90 postoperative days of a 90-day medical or surgical service when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of Provider ID and specialty, and the E&M service has a primary diagnosis associated to the 90-day medical or surgical service.
	Deny E&M services performed within 90 postoperative days of a 90-day medical or surgical service when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of Provider ID and specialty, and the diagnosis is a complication of surgical and medical care or an aftercare diagnosis.
Minor Surgery: 0-Day Procedures	Deny E&M services when billed on the same day as a 0-day medical or surgical service.
	Deny E&M services when performed the same day as a 10-day medical or surgical service.
	Deny E&M services performed within 10 postoperative days of a 10-day medical or surgical service.
Modifier 24 with E&M Services During the Postoperative Period of Major Procedures	Deny E&M services when billed with modifier 24 and a major surgical procedure with a 90-day postoperative period has been billed in the previous 90 days and the E&M service has a primary diagnosis associated with the 90-day medical or surgical service.
	Deny E&M services when billed with modifier 24 and a major surgical procedure with a 90-day postoperative period has been billed in the previous 90 days and the E&M diagnosis is a complication of surgical and medical care or an aftercare diagnosis.
Modifier 24 with E&M Services During the Postoperative Period of Minor Procedures	Deny E&M services when billed with modifier 24 and a minor surgical procedure with a 10-day postoperative period has been billed in the previous 10 days and the E&M service has a primary diagnosis associated to the 10-day medical or surgical service.
	Deny E&M services when billed with modifier 24 and a minor surgical procedure with a 10-day postoperative period has been billed in the previous 10 days and the E&M diagnosis is a complication of surgical and medical care or an aftercare diagnosis.
Other Medical and Surgical Service during the Postoperative Period	Deny 0-, 10- or 90-day surgical procedures performed within 90 days of a 90-day surgical procedure.
	Deny separate reimbursement for services typically considered part of a minor 10-day surgical procedure.
	Deny 0-day and 10-day surgical procedures performed within 10 postoperative days of a 10-day procedure.
	Deny separate reimbursement for services typically considered part of a

	major 90-day surgical procedure.
	Deny 0-day and 10-day surgical procedures performed within 10 postoperative days of a 10-day surgical procedure when submitted by the same Provider ID, regardless of Tax ID and specialty.
	Deny 0-, 10- or 90-day surgical procedures billed by the same Provider ID, regardless of Tax ID and specialty within 90 days of a 90-day surgical procedure.
Incident To Services	Deny *incident to services* when billed with a place of service code 19, 21, 22, 23, 24, 26, 31, 34, 41, 42, 51, 52, 53, 56 or 61.
Surgical Procedure – Anatomical Modifier Required	Deny surgical procedures that are not reported with an appropriate laterality modifier. If the procedure is performed on one side only, the applicable anatomical modifier must be applied. If the procedure is performed on both sides, Modifier 50. These modifiers should not be used to report procedures that are bilateral by definition or their descriptions include the terminology such as “bilateral” or “unilateral".

NCD/LCD Policy

Guideline	Action
National Coverage Determination	Deny claim line when the service provided is not reported appropriately per the published NCD guidelines.
Local Coverage Determination	Deny claim line when the service provided is not reported appropriately per the published LCD guidelines.

Modifier Policy

Guideline	Action
Modifier is Inappropriate for the CPT Reported	Deny claim line when an inappropriate CPT code and modifier combination is present.
CPT Reported Without Required Modifier	Deny claim line when CPT code is not reported with the required modifier.

National Correct Coding Initiative (NCCI) Edits

Guideline	Action
Column One and Column Two Code Edits for Part B Medicare NCCI	Deny Column Two procedure code when billed with associated Column One procedure code. Non-Mutually Exclusive Edits.
Mutually Exclusive Edits for Part B Medicare NCCI	Deny Column Two procedure code when billed with associated Mutually Exclusive Column One procedure code.
Medically Unlikely Edits NCCI	Deny excess units when any provider bills a certain number of units that exceed the daily assigned allowable unit(s) for that procedure for the same member.

Place of Service

Guideline	Action
Laboratory Services Billed By Physicians	Deny laboratory services (80000-89999) when billed in Place of Service 19 (Outpatient hospital-off campus), 21 (Inpatient hospital), 22 (Outpatient hospital-on campus), 23 (Emergency department), or 24 (ASC) by a provider with a specialty other than Dermatology, Genetics, Hematology, Laboratory or Pathology.

Professional Component of Radiology Services in Facility Places of Service	Deny professional radiology services when billed by an anesthesiologist in the inpatient or outpatient hospital setting.
	Deny professional radiology services when billed by a radiation oncologist in the inpatient or outpatient hospital setting.
	Deny professional radiology services when billed by a cardiologist in the inpatient or outpatient hospital setting.
Supplies and Equipment Provided in the Facility Setting	Deny medical and surgical supplies and DME when reported by professional providers with inpatient or facility places of service (CMS-1500).

Procedure Code Rules/Guidelines

Guideline	Action
Procedure Code Definition Rules	Deny procedures based on CPT® and HCPCS procedure code definition (e.g., denial based on a code's stated inclusion of another code or denial of a code based on its defined frequency).
Procedure Code Guidelines	Deny services that are coded inappropriately based on CPT/HCPCS procedure code guidelines (e.g., denial of a particular code when billed in combination with other codes if the use of another code is more appropriate).

Professional, Technical and Global Services

Guideline	Action
Clinical Laboratory Services	Deny clinical laboratory services with modifier 26 for those codes that do not have a separately payable professional service.
Guideline	**Action**
Diagnostic Tests or Radiology Services	Deny claim lines for diagnostic tests or radiology services when submitted by a provider in a facility place of service that are not
Global Payment of Diagnostic Tests and Radiology Services	Limit professional reimbursement of diagnostic tests and radiology services to no more than the amount for the global service.
Technical Component in the Facility Setting	Deny diagnostic tests or radiology services billed with modifier TC in the inpatient or outpatient facility setting.
	Deny technical component only procedures in the inpatient or outpatient facility setting.

Multiple Procedure Reduction

Guideline	Action
Multiple Procedure Reduction - Advanced Imaging Procedures	According to the ODM rule if more than one advanced imaging procedure is performed by same provider the procedure with highest fee is considered primary. Primary 100%, each additional global/technical 50% and each professional is 95%. Ohio Administrative Code: Chapter 5160-4-25, Radiology and Imaging Services

Molina Coding Policies

Guideline	Action
Radiation Treatment Management Services (77427)	Deny 77427 (Radiation treatment management) when billed more than one unique date of service during a five day period. IOM 100-04, Chapter 13, Section 70.1; AMA CPT Manual; LCD: A/BMAC/J-F/L34080 /R-10-01-2017; ASTRO 2018 Radiation Oncology Coding Resource, Chapter 11
Therapeutic Port Films (77417)	Deny 77417 (Therapeutic port film[s]) when billed more often than once per week. IOM 100-04 Chapter 13, Section 70.3; ASTRO 2018 Radiation Oncology Coding Resource, Chapter 10
Services Included in Radiation Treatment Management and Brachytherapy	Deny services included in radiation treatment management or clinical brachytherapy when billed on the same date of service as the radiation treatment management/clinical brachytherapy. IOM 100-04, Chapter 13, Sections 70.2, 70.4.
Remote After-Loading High Intensity brachytherapy	Deny Q3001 (Brachytherapy element) when billed with remote after-loading high intensity brachytherapy. IOM 100-04, Chapter 12, Section 20.4.4; IOM 100-04, Chapter 13, Section 70.4
Stereotactic Body Radiation Therapy (SBRT)	Deny radiation oncology services when billed with SBRT services and a qualifying diagnoses has not also been billed. LCD: A/BMAC/J-F/L34151/R-10-01-2018; A/BMAC/J-N/L33410/R-10-01-2018; A/BMAC/J6, J-K/L35076/R-10-01-2018; BMAC/J-E/L34223/R-10-01-2018; A/BMAC/J-E/L34224/R-10-01-2015
Intensity Modulated Radiotherapy (IMRT)	Deny intensity modulated radiation therapy (IMRT) when billed without a qualifying diagnosis. LCD: BMAC/J-E/L34217/R-10-01-2018; A/BMAC/J-F/L34080/R-10-01-2018; A/BMAC/J-H/L36711/R-10-25-2018; A/BMAC/J-N/L36773/R-10-01-2018
Intensity Modulated Radiotherapy (IMRT)	Deny radiation oncology services when billed with IMRT services and a qualifying diagnosis has not also been billed. LCD: BMAC/J-E/L34217/R-10-01-2018; A/BMAC/J-F/L34080/R-10-01-2018; A/BMAC/J-H/L36711/R-10-25-2018; A/BMAC/J-N/L36773/R-10-01-2018
Radiation Therapy Treatment Devices	Deny 77332-77334 (Treatment devices, simple; intermediate; complex) when billed greater than seven units per day by any provider and the diagnosis is not head and neck

	cancer, or prostate cancer, and a complex therapy service has not been billed for the same date of service or within two weeks (before or after). ASTRO 2018 Radiation Oncology Coding Resource, Chapter 9
Special Treatment Procedure	Deny 77470 (Special treatment procedure [eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation]) when billed without a qualifying diagnoses, and a complex therapy service has not been billed for the same date of service or within two weeks (before or after). ASTRO 2018 Radiation Oncology Coding Resource, Chapter 11; LCD: A/BMAC/J-F/L34080/R-10-01-2018
Basic Radiation and Special Dosimetry	Deny 77300 (Basic radiation dosimetry calculation) when billed greater than six units per day by any provider and the diagnosis is not head & neck cancer, prostate cancer or Hodgkin's disease, and a complex therapy service has not been billed for the same date of service or within two weeks (before or after). ASTRO 2018 Radiation Oncology Coding Resource, Chapter 9; LCD: BMAC/J-E/L34223/R-10-01-2018;
Stereotactic Body Radiation Therapy (SBRT)	Deny stereotactic body radiation therapy (SBRT) when billed without a qualifying diagnoses. LCD: A/BMAC/J-F/L34151/R-10-01-2018; A/BMAC/J-N/L33410/R-10-01-2018; A/BMAC/J6, J-K/L35076/R-10-01-2018; BMAC/J-E/L34223/R-10-01-2018; A/BMAC/J-E/L34224/R-10-01-2015
Non-Invasive Vascular Diagnostic Studies	Deny 93880 or 93882 (Duplex scan of extracranial arteries, study) when billed in the office setting and the patient is older than 18 years of age and a carotid artery stenosis symptom diagnosis is not present. U.S. Preventive Services Task Force, Screening for Carotid Artery Stenosis
Electrocardiograms (ECGs)	Deny 93000 (Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report) when billed in the office setting with a screening or general routine exam diagnosis and the patient's age is 18 years or older, and an appropriate additional diagnosis is not present on the claim. U.S. Preventive Services Task Force, Coronary Heart Disease: Screening with Electrocardiography, Final Recommendation Statement, July 2012
Visual Field Examination	Deny 92081-92083 (Visual field examination) when billed without a requisite diagnosis. "American Academy of Ophthalmology: Preferred Practice Patterns for Comprehensive Adult Medical Eye Evaluation - 2015; Preferred Practice Patterns for Pediatric Eye Evaluations - 2012; LCD: A/BMAC/J5,J8/L34615/R10-01-2018; A/BMAC/J6, J-K/L33574/R10-01-2018; A/BMAC/J15/L34394/R10-01-2018; A/BMAC/J-N/L33766/R 10-01-2018

CT of the Abdomen and Pelvis	Deny 72192-72194, 74150-74170, or 74176-74178 (CT, abdomen/pelvis) when billed & the patient's age is less than 18 years & abdominal pain is the only diagnosis on the claim, & 72170-72190 (Radiological exam, pelvis), 72195-72197 (MRI, pelvis), 74000-74022 (Radiological exam, abdomen), 74181-74183 (MRI, abdomen), 76700-76705 (Ultrasound, abdominal), 76830 (Ultrasound, transvaginal), or 76856-76857 (Ultrasound, pelvic) has not also been billed on same day or in the previous 14 days by any provider in any claim type. American College of Radiology Practice Parameter for the Performance of Pediatric Computed Tomography - Revised 2014; American College of Radiology: ACR Appropriateness Criteria (2013), Clinical Condition: Right Lower Quadrant Pain Suspected Appendicitis; American College of Emergency Physicians Clinical Policy: Evaluation and Management of Suspected Appendicitis; American Academy of Family Practice: American Family Physician, 2003 Jun 1;67(11):2321-2327
CT of the Abdomen and Pelvis	Deny 72192-72194, 74150-74170, or 74176-74178 (CT, abdomen/pelvis) when billed and the patient's age is less than 18 years and an appropriate diagnosis is not present and 74000-74022 (Radiological examination, abdomen), 74181-74183 (MRI, abdomen), 76700- 76705 (Ultrasound, abdominal), 76830 (Ultrasound, transvaginal), or 76856-76857 (Ultrasound, pelvic) has not also been billed on the same day or in the previous 14 days by any provider in any claim type. American College of Radiology Practice Parameter for the Performance of Pediatric Computed Tomography - Revised 2014; American College of Radiology: ACR Appropriateness Criteria (2013), Clinical Condition: Right Lower Quadrant Pain-Suspected Appendicitis; American College of Emergency Physicians Clinical Policy: Evaluation and Management of Suspected Appendicitis; American Academy of Family Practice: American Family Physician, 2003 Jun 1;67(11):2321-2327
Intracranial and Extracranial Imaging (Duplex, CT, CTA, MRA, MRI) for Simple Syncope	Deny 70450, 70460, 70470 (CT, head or brain), 70496 (CTA), 70544, 70545, 70546 (MRA, head) or 70551, 70552, 70553 (MRI, brain) when the only diagnosis on the claim is syncope and collapse. American College of Emergency Physicians Clinical Policy: Critical Issues in the Evaluation and Management of Adult Patients Presenting to the Emergency Room (Annals of Emergency Medicine 2007; 49:431-444); American Heart Association/American College of Cardiology Foundation Scientific Statement on the Evaluation of Syncope (Circulation 2006; 113:316-327)
Intracranial and Extracranial Imaging (Duplex, CT, CTA, MRA, MRI) for Simple Syncope	Deny duplex scan of extracranial arteries (93880, 93882), computed tomographic angiography (CTA) of the neck (70498), or magnetic resonance angiography (MRA) of the neck (70547, 70548, 70549) when billed and the only diagnosis on the claim is syncope and collapse American College of Emergency Physicians Clinical Policy: Critical Issues in the Evaluation and Management of Adult Patients Presenting to the Emergency Room (Annals of Emergency Medicine 2007; 49:431-444); American Heart Association/American College of Cardiology Foundation Scientific Statement on the Evaluation of Syncope (Circulation 2006; 113:316-327)

Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)	Deny 92132 (Scanning computerized ophthalmic diagnostic imaging, anterior segment) when billed and an appropriate diagnosis is not present on the claim. American Academy of Ophthalmology Preferred Practice Pattern Guideline: Comprehensive Adult Medical Eye Evaluation--2015; American Academy of Ophthalmology Preferred Practice Pattern Guideline: Primary Angle Closure--2015; American Academy of Ophthalmology Preferred Practice Pattern Guideline: Primary Open Angle Glaucoma--2015; American Academy of Ophthalmology Preferred Practice Pattern Guideline: Primary Open-Angle Glaucoma Suspect 2015; LCD: A/BMAC/J-N/L33751/R-02-19-2019; A/BMAC/J5, J8/L34760/R-09-01-2018; A/BMAC/J-H, J-L/L35038/R-01-25-2018; A/BMAC/J6, J-K/L34380/R-01-01-2018
Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)	Deny 92133 or 92134 (Scanning computerized ophthalmic diagnostic imaging, posterior segment) when billed and an appropriate diagnosis is not present on the claim. American Academy of Ophthalmology Preferred Practice Patterns (PPP) Guidelines: Comprehensive Adult Medical Eye Evaluation-2015, Age-Related Macular Degeneration-2015, Idiopathic Macular Hole-2014, Posterior Vitreous Detachment, Retinal Breaks, and Lattice Degeneration-2014, Primary Angle Closure-2015, Primary Open Angle Glaucoma-2015, Diabetic Retinopathy-2016; LCD: A/BMAC/J-N/L33751/R-02-19-2019; A/BMAC/J5, J8/L34760/R-09-01-2018; A/BMAC/J-J, J-M/L34431/R-05-16-2018; A/BMAC/J15/L34061/R-04-01-2018; A/BMAC/J-H, J-L/L35038/R-01-25-2018; A/BMAC/J6, J-K/L34380/R-01-01-2018
Ophthalmoscopy	Deny 92225-92226 (Ophthalmoscopy, extended) when billed and an appropriate diagnosis is not present on the claim. American Academy of Ophthalmology Preferred Practice Pattern Guideline: Comprehensive Adult Medical Eye Evaluation-2015; LCD: A/BMAC/J6, J-K/L33567/R-01-01-2019; A/BMAC/J-J, J-M/L33467/R-03-15-2018; A/BMAC/J-N/L34017/R-10-01-2017; A/BMAC/J15/L34399/R-10-01-2017
Cardiovascular Evaluation with Tilt Table Testing	Deny evaluation of cardiovascular function with tilt table evaluation (93660) when billed with a diagnosis of syncope and collapse and external electrocardiographic monitoring (93000-93010) has not been billed in the previous 90 days by any provider. American Heart Association/American College of Cardiology/Heart Rhythm Society, 2017 ACC/AHA/HRS Guideline for the Evaluation and Management of Patients With Syncope, March 9, 2017; American Academy of Family Physicians, Syncope: Evaluation and Differential Diagnosis, website content, http://www.aafp.org/afp/2017/0301/p303.html

Cardiovascular Evaluation with Tilt Table Testing	Deny evaluation of cardiovascular function with tilt table evaluation (93660) when billed without a diagnosis of syncope and collapse. American Heart Association/American College of Cardiology Foundation Scientific Statement on the Evaluation of Syncope, 2006; National Institute for Health and Care Excellence (NICE) Guidance, Transient loss of consciousness ('blackouts') management in adults and young people, Oct 2014
Intracranial and Extracranial Imaging (Duplex, CT, CTA, MRA, MRI) for Simple Syncope	Deny 70450-70470 (CT, head or brain), 70496-70498 (CTA, head or neck), 70544-70546 (MRA, head), 70547-70549 (MRA, neck), 70551-70553 (MRI, brain [including brainstem], or 93880-93882 (Duplex scan of extracranial arteries) when billed with a diagnosis of syncope and collapse and 93000-93010 (Electrocardiogram) has not been billed for the same day or in the previous 90 days by any provider. American College of Emergency Physicians Clinical Policy: Critical Issues in the Management of Adult Patients Presenting to the Emergency Department with Syncope, April 2007; American Heart Association/American College of Cardiology Foundation Scientific Statement on the Evaluation of Syncope, 2006; National Institute for Health and Care Excellence (NICE) Guidance (CG109), Transient loss of consciousness ('blackouts') management in adults and young people, Oct 2014
Anesthesia for Pain Management Injections	Deny anesthesia and moderate sedation services (00300, 00400, 00600, 01935-01936, 01991-01992, 99152-99153, 99156-99157) when billed with pain management services and billed without a surgical code (10021-69990) by any provider for a patient 18 years of age or older. American Society of Anesthesiologists, Pain Medicine Committee: STATEMENT ON ANESTHETIC CARE DURING INTERVENTIONAL PAIN PROCEDURES FOR ADULTS, 2016; International Spine Intervention Society Guidelines (2nd edition) regarding the use of sedation for pain procedures
Ophthalmic Ultrasound	Deny 76513 (Ophthalmic ultrasound, anterior segment ultrasound, biomicroscopy) when billed with a diagnosis of glaucoma as the only diagnosis on the claim. American Academy of Ophthalmology, Preferred Practice Pattern for Primary Angle Open Glaucoma, 2015; Preferred Practice Pattern for Primary Angle Closure Glaucoma, 2015
Radiological Examination Chest	Deny 71045 or 71046 (Chest x-ray) when billed and the only diagnosis on the claim is a general medical exam, pre-admission, administrative or pre-operative exam. LCD: A/BMAC/J-F/L37549/R-06/22/2018; A/BMAC/J-E/L37547/R-06/22/2018; A/BMAC/J-6, J-K/L33629/R-10-01-2018; American College of Radiology "ACR Appropriateness Criteria Routine Chest Radiography", 2015; American College of Radiology and the Society for Pediatric Radiology "ACR-SPR PRACTICE PARAMETER FOR THE PERFORMANCE OF CHEST RADIOGRAPHY", 2014
Intracranial and Extracranial Imaging (Duplex, CT, CTA,	Deny 70450-70470 (CT, head or brain), 70496 (CTA, head), 70544-70546 (MRA, head), 70551-70553 (MRI, brain) or 76380 (CT follow-up) when the only diagnosis on the claim is migraine.

MRA, MRI) for Migraine	American College of Radiology, ACR Appropriateness Criteria, Headache: Chronic headache. No new features. Normal neurologic examination, 2013; American Academy of Neurology "Neurology", Practice parameter: Evaluation of children and adolescents with recurrent headaches, August 27, 2002, vol. 59, no. 4
Imaging Procedures for Sinusitis and Allergic Rhinitis	Deny 70210-70220, 70486-70488, 70540-70543, S9024 (Sinonasal imaging) or 76380 (Computed tomography) when billed and the only diagnosis is acute sinusitis. American Academy of Otolaryngology- Head & Neck Surgery publication: Otolaryngology-Head and Neck Surgery, April 2015, vol. 152 (2S); American College of Radiology, ACR Appropriateness Criteria, Clinical Condition: Sinonasal Disease (Updated 2017); American Academy of Pediatrics publication: Pediatrics, July 2013, vol. 132/issue 1; American Academy of Family Physicians publication: American Family Physicians, 2016 Jul 15;94(2)
Imaging Procedures for Sinusitis and Allergic Rhinitis	Deny 70486-70488 or 76380 (Computed tomography) when billed for a patient 18 years old or older and the only diagnosis is chronic sinusitis and a computed tomography (70486-70488 or 76380) was performed in the previous 90 days by any provider. American Academy of Otolaryngology-Head and Neck Surgery publication: Otolaryngology-Head and Neck Surgery, April 2015, vol 152(2S); American College of Radiology, ACR Appropriateness Criteria, Clinical Condition: Sinonasal Disease, (Updated 2012)
Imaging Procedures for Sinusitis and Allergic Rhinitis	Deny 70210-70220, 70486-70488, 70540-70543, S9024 (Sinonasal imaging) or 76380 (Computed tomography) when billed for a patient age 2 years or older and the only diagnosis is allergic rhinitis. American Academy of Otolaryngology-Head and Neck Surgery, Clinical Practice Guideline: Allergic Rhinitis, website content, http://oto.sagepub.com/content/152/1_suppl/S1.full.pdf+html; LCD: A/BMAC/J-F/L35175/ R-10-08-2018; AMAC/J-M, J-J/L34425/R-10-01-2018; A/BMAC/J-N/L33600/R-10-01-2015; A/BMAC/J-N/L34375/R-10-01-2015; American Academy of Family Physicians: Am Fam Physicians, 2006 May 1;73(9)
Nerve Conduction Studies (NCS) and Electromyography (EMG) for Radiculopathy	Deny nerve conduction study (95905) when billed without a needle electromyography (95860-95864) and the only diagnosis on the claim is radiculopathy. American Association of Neuromuscular & Electrodiagnostic Medicine- Recommended Policy for Electrodiagnostic Medicine; LCD: A/BMAC/J-J, J-M/L35048/R-10-01-2018; A/BMAC/J5, J8/L34594/R-12-01-2018; A/BMAC/J-N/L34859/R-10-01-2018; A/BMAC/J6, J-K/L35098/R-10-01-2018; A/BMAC/J-E/L36524/R-10-01-2018; A/BMAC/J-F/L36526/R-10-01-2018; A/BMAC/J-H, J-L/L35081/R-10-01-2018

Nerve Conduction Studies (NCS) and Electromyography (EMG) for Radiculopathy	Deny nerve conduction study (95907-95913) when billed without a needle electromyography (95885, 95886) and the only diagnosis on the claim is radiculopathy. American Association of Neuromuscular & Electrodiagnostic Medicine- Recommended Policy for Electrodiagnostic Medicine; LCD: A/BMAC/J-J, J-M/L35048/R-10-01-2018; A/BMAC/J5, J8/L34594/R-12-01-2018; A/BMAC/J-N/L34859/R-10-01-2018; A/BMAC/J6, J-K/L35098/R-10-01-2018; A/BMAC/J-E/L36524/R-10-01-2018; A/BMAC/J-F/L36526/R-10-01-2018; A/BMAC/J-H, J-L/L35081/R-10-01-2018
Nerve Conduction Studies (NCS) and Electromyography (EMG) for Radiculopathy	Deny needle electromyography (95860-95864) when billed without a nerve conduction study (95905) and the only diagnosis on the claim is radiculopathy. American Association of Neuromuscular & Electrodiagnostic Medicine- Recommended Policy for Electrodiagnostic Medicine; LCD: A/BMAC/J-J, J-M/L35048/R-10-01-2018; A/BMAC/J5, J8/L34594/R-12-01-2018; A/BMAC/J-N/L34859/R-10-01-2018; A/BMAC/J6, J-K/L35098/R-10-01-2018; A/BMAC/J-E/L36524/R-10-01-2018; A/BMAC/J-F/L36526/R-10-01-2018; A/BMAC/J-H, J-L/L35081/R-10-01-2018
Cervical Cancer Screening	Deny cervical or vaginal screening services for a female patient less than 21 years of age when the only diagnosis is a screening diagnosis code. American College of Obstetricians and Gynecologists-ACOG patient education Fact Sheet, PFS004:New Guidelines for Cervical Cancer Screening, September 2013; U.S. Preventive Services Task Force, Cervical Cancer: Screening, Final Recommendation Statement, March 2012.
Cervical Cancer Screening	Deny cervical or vaginal screening services for a female patient 21 years of age or older when the only diagnosis is a screening diagnosis code and any of these screening services has been reported in the previous 13 months. American College of Obstetricians and Gynecologists-ACOG patient education Fact Sheet, PFS004:New Guidelines for Cervical Cancer Screening, September 2013; U.S. Preventive Services Task Force, Cervical Cancer: Screening, Final Recommendation Statement, March 2012.
Human Papilloma Virus (HPV) Testing	Deny HPV testing (87624-87625, 0500T, G0476) for a female patient less than 30 years of age when the only diagnosis is a screening diagnosis code. American College of Obstetricians and Gynecologists-ACOG patient education Fact Sheet, PFS004:New Guidelines for Cervical Cancer Screening, September 2013; U.S. Preventive Services Task Force, Cervical Cancer: Screening, Final Recommendation Statement, March 2012.

Ultrasound	Deny abdominal ultrasound (76700-76705) when billed and the only diagnosis on the claim is infectious mononucleosis. American Medical Society for Sports Medicine, Mononucleosis and Athletic Participation: An Evidence-Based Subject Review, July 2008 American Academy of Family Physicians, Epstein-Barr Virus Infectious Mononucleosis, October 1, 2004
Chest X-Ray for Lung Cancer Screening	Deny 71045-71048 (Chest x-ray) when billed and the only diagnosis on the claim is for lung cancer screening or nicotine use/dependence American College of Chest Physicians: Screening for Lung Cancer: Diagnosis and Management of Lung Cancer, 3rd ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (2013); American College of Radiology: ACR Appropriateness Criteria Clinical Condition: Routine Chest Radiography (2015)
Epidural Steroid Injections	Deny epidural steroid injection (62320, 62321, 62322, 62323, 64479-64484, 0228T, 0229T, 0230T, 0231T) when axial spinal pain (back pain) is the only diagnosis. American Pain Society. Clinical Guideline for the Evaluation and Management of Low Back Pain 2009; American Society of Anesthesiologists. Practice Guidelines for Chronic Pain Management. Anesthesiology 2010
Transcranial Magnetic Stimulation (TMS)	Deny 90867-90869 (TMS) when billed without a diagnosis of major depressive disorder without psychotic features for a patient 18 years of age or older. FOOD AND DRUG ADMINISTRATION (FDA): Guidance for Industry and FDA Staff - Class II Special Controls Guidance Document: Repetitive Transcranial Magnetic Stimulation (rTMS) Systems, July 26, 2011; LCD: BMAC/J-J, J-M/L34869/R-02-14-2019; A/BMAC/J-N/L34522/R-01-22-2019; A/BMAC/J5, J8/L34641/R-11-01-2018; A/BMAC/J6, J-K/L33398/R-06-15-2018; A/BMAC/J-H, J-L/L34998/R-11-09-2017; A/BMAC/J15/L36469/R-02-08-2016
Chest X-Ray for Tuberculosis Screening	Deny 71045 or 71046 (Chest x-ray) when the only diagnosis on the claim is an encounter for screening for respiratory tuberculosis. Official American Thoracic Society/Infectious Diseases Society of America/Centers for Disease Control and Prevention Clinical Practice Guidelines: Diagnosis of Tuberculosis in Adults and Children, Clinical Infectious Disease, January 2017 Centers for Disease Control: Latent Tuberculosis Infection: A Guide for Primary Health Care Providers, 2013; AMERICAN ACADEMY OF FAMILY PHYSICIANS: American Family Physician: Update on Latent Tuberculosis Infection, June 2014
Genital Herpes Screening	Deny 86696 (Antibody; herpes simplex, type 2) when billed for a patient 13 years of age or older and the only diagnosis is a screening diagnosis code

	U.S. Preventive Services Task Force: U.S. Preventive Services Task Force, Genital Herpes Infection: Serologic Screening, Final Recommendation Statement, November 2016; American Academy of Family Physicians: Clinical Preventive Service Recommendation: Genital Herpes Simplex Virus Infection, 2016
Human Papilloma Virus (HPV) Testing	Deny HPV testing (87624-87625, 0500T, G0476) when billed more than once in a five year period by any provider for a female patient between 30 and 65 years of age when the only diagnosis is a screening diagnosis code. American College of Obstetricians and Gynecologists-ACOG Well-Woman Recommendations, 2016; ACOG Patient Education Fact Sheet, PFS004:New Guidelines For Cervical Cancer Screening, September 2013; U.S. Preventive Services Task Force, Cervical Cancer: Screening, Final Recommendation Statement, March 2012
Bacterial Vaginosis Screening	Deny bacterial vaginosis testing (82120, 83986, 87210, 87510, 87660 or 87905) when billed and the only diagnosis is normal pregnancy. U.S. Preventive Services Task Force, Bacterial Vaginosis in Pregnancy to Prevent Preterm Delivery: Screening, 2008; American College of Obstetricians and Gynecologists (ACOG). Assessment of risk factors for preterm birth. ACOG Practice Bulletin No. 31. Washington, DC: ACOG; October 2001; Centers for Disease Control (CDC): Bacterial Vaginosis, 2015
Radiological Examination Chest	Deny chest x-ray (71045 or 71046) when the patient is 21 years of age or younger, and the only diagnosis is uncomplicated asthma. National Institutes of Health, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007, http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines/; American Academy of Family Physicians, Management of Acute Asthma Exacerbations, 2011
Urinary Catheter for Incontinence	Deny catheter insertion (51702, 51703) when billed and the only diagnosis on the claim is urinary incontinence. Centers for Disease Control and Prevention. Guideline for Prevention of Catheter-associated Urinary Tract Infections, 2009; American Academy of Family Physicians. Urinary Catheter Management. Am Fam Physician. 2000 Jan 15;61(2) American Urological Association. Catheter-Associated Urinary Tract Infections.
Special Ophthalmological Services	Deny special ophthalmological services (92020-92287, 76510-76514, 76516, 76519) when encounter for general/routine/screening examination is the only diagnosis on the claim. AMA CPT MANUAL; American Academy of Ophthalmology Preferred Practice Pattern Guideline: Comprehensive Adult Medical Eye Evaluation-2015; American Academy of Ophthalmology Preferred Practice Pattern Guideline: Pediatric Eye Evaluations - 2012

Colonoscopy	Deny 45330 or 45378 for a patient who is less than 50 years of age and the only diagnosis on the claim is constipation. American Society for Gastrointestinal Endoscopy. The role of endoscopy in the management of constipation/2014; American Gastroenterological Association. American Gastroenterological Association Medical Position Statement on Constipation/2013, American Gastroenterological Association technical review on constipation. Gastroenterology. 2013 Jan;144(1); American Society of Colon and Rectal Surgeons. The American Society of Colon and Rectal Surgeons Clinical Practice Guideline for the Evaluation and Management of Constipation 2016
Colonoscopy	Deny endoscopic colorectal cancer screening (45300, 45330, 45378, 46600) for a patient who is less than 50 years of age and the only diagnosis on the claim is screening for malignant neoplasm of colon. American College of Physicians, Screening for Colorectal Cancer: A Guidance Statement From the American College of Physician. 2012; United States Preventive Services Task Force, Colorectal Cancer: Screening 2016; American Gastroenterological Association, Colorectal Cancer Screening and Surveillance: Clinical Guidelines and Rationale Update Based on New Evidence (2003); American College of Gastroenterology and the American Society for Gastrointestinal Endoscopy. Quality Indicators for Colonoscopy 2006.
Endometrial Biopsy for Infertility	Deny 58100 or 58110 (Endometrial biopsy) when the only diagnosis on the claim is infertility or infertility encounter. American Society of Reproductive Medicine. Diagnostic evaluation of the infertile female: a committee opinion. Fertility and Sterility. June 2015,Volume 103, Issue 6, Pages e44?e50; Diagnosis and Management of Female Infertility. JAMA. 2003;290(13):1767-1770; Histological dating of timed endometrial biopsy tissue is not related to fertility status. Fertility and Sterility. 2004 Nov;82(5); Endometritis does not predict reproductive morbidity after pelvic inflammatory disease. Am J Obstet Gynecol. 2003 Jan;188(1); A critical analysis of the accuracy, reproducibility, and clinical utility of histologic endometrial dating in fertile women. Fertility and Sterility. May 2004Volume 81, Issue 5
Intraoperative Neurophysiology Monitoring (IOM)	Deny 95940, 95941 or G0453 (Continuous intraoperative neurophysiology monitoring) when the place of service is not 19 (Outpatient hospital-off campus), 21 (Inpatient hospital), 22 (Outpatient hospital-on campus) or 24 (Ambulatory surgical center). American Academy of Neurology. Principles of Coding for Intraoperative Neurophysiologic Monitoring (IOM) and Testing. February 2010; revised 2012; LCD: A/BMAC/J-H, J-L/L35003/R-12-20-2018; CMS Transmittal 2679, 03-29-2013, CR 7631