Code editing rules for South Carolina Medicaid

Humana applies code editing rules to claims submitted for the South Carolina Medicaid plan. We apply these rules to better align with American Medical Association Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS) and International Classification of Diseases (ICD) code sets. We also update our claims process throughout the year to align with Centers for Medicare & Medicaid Services (CMS) guidelines, South Carolina Medicaid guidance, correct-coding initiatives, national benchmarks and industry standards.

Initial code editing rules for the South Carolina Medicaid implementation

Humana will apply the code editing rules listed in this document to South Carolina Medicaid claims submitted to Humana for dates of service beginning July 1, 2021. These rules will be applied on the first day the plan is in effect.

Code editing rules implemented after July 1, 2021

This document will not be updated when new code editing rules are implemented. We will notify you via **Humana.com/edits** about new code editing rules at least 90 days before they are implemented.

How to submit questions about a specific code editing rule

You can submit questions about code edits through our code-editing questions tool on the Availity multipayer web portal.

1. If you are not registered on Availity, go to Availity.com and select “REGISTER” to sign up.
2. Once logged in, select the “More” tab.
3. Under the “Claims” heading, select the “Research Procedure Code Edits” link to access the tool. If you do not see this link, contact your Availity administrator to request access.

The Rules

Rule number	SC001
Applies to	Physician/Healthcare Providers
Category	Anesthesia
Topic	Anesthesia services performed by a certified registered nurse anesthetist (CRNA)

Code editing rule
We do not reimburse charges for anesthesia services submitted by a CRNA without modifier QZ.

Modifier QZ is defined as “CRNA without medical direction.”

Why we apply this rule
According to Humana policy and as supported by guidance from the Centers for Medicare & Medicaid Services, certified registered nurse anesthetists must append an appropriate modifier describing the services rendered.

Rule number	SC002
Applies to	Physician/Healthcare Providers
Category	Anesthesia
Topic	Anesthesiologists billing surgical codes

Code editing rule
We limit reimbursement of charges submitted by anesthesiologists or certified registered nurse anesthetists (CRNAs) to anesthesia service codes. We do not reimburse anesthesiologists or CRNAs for surgical codes or other non-anesthesiological codes.

Why we apply this rule
The American Society of Anesthesiologists publishes an annual crosswalk list of diagnostic and therapeutic codes that correspond to appropriate anesthesia service codes. It is inappropriate for anesthesiologists to report a diagnostic or therapeutic service code if a more appropriate anesthesia code is available.

Rule number	SC003
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Anesthesia
Topic	CPT code 01996 – Daily hospital management of epidural or subarachnoid continuous drug administration

Code editing rule
We limit reimbursement of a charge for CPT code 01996 to no more than one unit per date of service.

Why we apply this rule
According to South Carolina Medicaid and NCCI guidance, payment for management of epidural or subarachnoid drug management is limited to one unit of service per postoperative day regardless of the number of visits necessary to manage the catheter.

Rule number	SC004
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Anesthesia
Topic	CPT code 01996 – Daily hospital management of epidural or subarachnoid continuous drug administration

Code editing rule
We do not reimburse charges for CPT code 01996 if:

- A physical status modifier of P1 – P6 is present.
- It is submitted with one of the anesthesia qualifying-circumstance codes (CPT codes 99100 – 99140), and an anesthesia procedure code (CPT codes 00100 – 01992 or 01999) is not also present.

Why we apply this rule
According to the American Society of Anesthesiologists, CPT code 01996 is subject to the above limitations.

Rule number	SC005
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Add-on code billing

Code editing rule
We do not reimburse add-on codes under the following circumstances:
- If the requisite primary code has not been billed or has previously been denied
- If modifier 51, multiple procedures, has been appended

Why we apply this rule
According to the AMA CPT Manual and the CMS HCPCS Level II Manual, an add-on code is not appropriate if reported as a stand-alone procedure. Further, add-on codes should not be billed with modifier 51, as they reflect only the intraoperative service and are not subject to further multiple procedure reductions.

Rule number	SC006
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Claim lines with an invalid ICD-10 code and all ICD-10 codes are invalid or not at the highest level of specificity

Code editing rule
We do not reimburse charges for claim lines with at least one invalid ICD-10 code if all ICD-10 codes on the claim are invalid or not coded to the highest level of specificity.

Why we apply this rule
According to guidance from the American Medical Association, it is inappropriate to report a claim line with an invalid diagnosis code when all other diagnosis codes are either nonspecific or invalid.

Rule number	SC007
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Deleted CPT codes

Code editing rule
We do not reimburse claims submitted with deleted CPT codes.

Why we apply this rule
According to the AMA CPT Manual, it is inappropriate to use deactivated or deleted CPT codes when submitting a charge.

Rule number	SC008
Applies to	Physician/Healthcare Providers
Category	Correct Coding
Topic	Duplicate anesthesia claims

Code editing rule
We do not reimburse claims for anesthesia services, regardless of provider, if the claims duplicate\s a previously rendered anesthesia service by matching all of the following criteria:
- Subscriber ID
- Dependent ID

- Date of service
- Procedure code
- Modifier(s)
- Units
- Claim type

Why we apply this rule
According to South Carolina Medicaid guidelines, it is inappropriate to duplicate payments for services rendered.

Rule number	SC009
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Duplicate charges for drugs and biologicals

Code editing rule
We do not reimburse duplicate drug codes if the same code with the same unit amount has previously been billed on a different claim for the same date of service.

Why we apply this rule
According to South Carolina Medicaid guidelines, it is inappropriate to duplicate payments for services rendered.

Rule number	SC010
Applies to	Physician/Healthcare Providers
Category	Correct Coding
Topic	Duplicate claim lines

Code editing rule
We do not reimburse duplicate claim lines in which the duplicate claim matches the original claim line on all of the following elements:

- Subscriber ID
- Dependent ID
- Date of service
- Procedure code
- Modifiers
- Units
- Claim type
- Specialty
- Tax ID

Additionally, we do not reimburse claims in which the same code is billed for the same date of service with the same charge amounts if the diagnosis code is the same to the first three digits and the provider has the same Tax ID and one of the following specialties:

- Miscellaneous
- Multispecialty group
- Miscellaneous facility

Why we apply this rule
According to South Carolina Medicaid guidelines, it is inappropriate to duplicate payments for services rendered.

Rule number	SC011
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Duplicate claim lines

Code editing rule
We do not reimburse charges for the same codes billed for the same date of service when billed by a provider with the same provider ID, regardless of Tax ID or specialty.

Additionally, we do not reimburse charges for duplicate CMS-1450 claim lines in which the duplicate claim has a different claim number than the original, but matches the original claim line on all of the following elements:

- Date of service
- Subscriber ID
- Dependent ID
- Tax ID
- Procedure code
- Modifier combinations
- Units
- Revenue code (only if a HCPCS code is absent)
- Charge amount
- Bill type

Why we apply this rule
According to South Carolina Medicaid guidelines, it is inappropriate to duplicate payments for services rendered.

Rule number	SC012
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Duplicate laboratory services

Code editing rule
We do not reimburse duplicate charges for laboratory services in which the place of service on one claim is office and the place of service on the other claim is independent laboratory, if all of the following are the same on both claims:

- Subscriber ID
- Dependent ID
- Date of service
- Procedure code
- Modifier(s)
- Units
- Claim type

Why we apply this rule
According to South Carolina Medicaid guidelines, it is inappropriate to duplicate payment for services rendered.

Rule number	SC013
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Duplicate miscellaneous, not otherwise classified and unlisted HCPCS codes

Code editing rule
We do not reimburse claims for duplicate miscellaneous, not otherwise classified and unlisted HCPCS codes, regardless of provider, if the claim duplicates a previously rendered anesthesia service by matching all of the following criteria:

- Same subscriber ID
- Same dependent ID
- Same date of service
- Same procedure code
- Same modifier(s)
- Same units
- Same claim type

Why we apply this rule
According to South Carolina Medicaid guidelines, it is inappropriate to duplicate payments for services rendered.

Rule number	SC014
Applies to	Physician/Healthcare Providers
Category	Correct Coding
Topic	Evaluation and management (E/M) services billed with anesthesia services

Code editing rule
We do not reimburse a charge for E/M services if, for the same date of service or the next date of service, the same provider submits any charge for an anesthesia service.

Why we apply this rule
According to South Carolina Medicaid and NCCI guidance, it is standard practice for an anesthesia practitioner to perform a patient examination and evaluation prior to surgery. This service is considered a component of the anesthesia code and is not separately reimbursable.

Rule number	SC015
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Evaluation and management (E/M) services billed with pulse oximetry

Code editing rule
We do not reimburse E/M services billed with the following pulse-oximetry service CPT codes:

- 94760 – Noninvasive ear or pulse oximetry for oxygen saturation; single determination
- 94761 – Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (e.g., during exercise)
- 94762 – Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure)

Why we apply this rule
According to South Carolina Medicaid and CMS correct coding guidance, E/M services should not be reported separately from the above pulse oximetry services unless appended with an appropriate modifier.

Rule number	SC016
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Evaluation and management (E/M) services billed with screening Pap smear

Code editing rule
We do not reimburse E/M services billed without modifier 25 if submitted on the same date of service as a screening Pap smear, HCPCS code Q0091.

Why we apply this rule
According to the CMS Medicaid Technical Guidance Manual, a modifier is required to bypass the National Correct Coding Initiative (NCCI) procedure-to-procedure edit above.

Rule number	SC017
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Inappropriately coded claims

Code editing rule
We do not reimburse claims that are coded inappropriately based on guidelines for HCPCS and CPT coding.

Why we apply this rule
Coding guidelines explain the correct usage for CPT and HCPCS codes. Claims that are inconsistent with coding guidelines are not reimbursable.

Rule number	SC018
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Intravenous (IV) infusion services billed with IV chemotherapy administration codes

Code editing rule
We do not reimburse IV infusion services billed with IV chemotherapy services, unless one of these modifiers is present on the IV infusion services claim line:

- Modifier 59 – Distinct procedural service
- Modifier XE – Separate encounter, a service that is distinct because it occurred at a separate encounter

Why we apply this rule
According to South Carolina Medicaid guidance, it is inappropriate to report procedure codes from both of the above categories without appending a modifier to indicate the services were separate and/or distinct.

Rule number	SC019
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	National Correct Coding Initiative (NCCI) Column I/Column II editing

Code editing rule
We apply NCCI Column I/Column II editing. We do not reimburse charges for NCCI Column II procedure codes billed with an associated NCCI Column I procedure code. This also applies to mutually exclusive NCCI Column I codes and associated durable medical equipment (DME) NCCI Column I codes.

Additionally, we do not reimburse charges for NCCI Column I procedure codes if an NCCI Column II procedure code has previously been paid for the same date of service.

Note: Certain modifiers may be used to bypass some NCCI editing, if appropriate.

Why we apply this rule
NCCI Column II procedure codes are inappropriate when submitted in conjunction with NCCI Column I procedure codes.

Rule number	SC020
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	National Correct Coding Initiative (NCCI) inappropriate coding

Code editing rule
We do not reimburse charges that are inconsistent with NCCI policies and guidelines.

Why we apply this rule
The National Correct Coding Policy Manual is broken into 12 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.

Rule number	SC021
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Nonspecific Healthcare Common Procedure Coding System (HCPCS) Level II code billed with an inappropriate National Drug Code (NDC)

Code editing rule
We do not reimburse any charge for a nonspecific HCPCS Level II code for a drug if that charge is submitted with an NDC that is not appropriate to the nonspecific HCPCS Level II code submitted.

Why we apply this rule
A submitted NDC should be valid and appropriate for the nonspecific HCPCS code submitted with the NDC

Rule number	SC022
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Out-of-sequence billing

Code editing rule
We do not reimburse charges for procedures billed out of sequence.

Why we apply this rule
It is inappropriate to bill a separate claim for a service that should be bundled with a more comprehensive procedure. Out-of-sequence claims involve procedures performed on the same date of service but billed on separate claims at different times. For example, a claim for services that should be bundled but that is billed prior to billing a claim with the more comprehensive bundled procedure code will not be reimbursed.

Rule number	SC024
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Procedure code definition

Code editing rule
We do not reimburse for procedures or services that are not supported by correct coding guidelines.

Why we apply this rule
According to the National Correct Coding Initiative (NCCI) and as supported by the AMA CPT Manual, the HCPCS Level II manual, the ADA Dental Procedure Codes manual and the ICD-10-PCS manual, a procedure or service should be billed with the code that accurately identifies the procedure or service performed.

Example 1: If CPT code 25390 (osteoplasty, radius OR ulna; shortening) is billed with CPT code 25392 (osteoplasty, radius AND ulna; shortening) for the same side of the body, CPT 25390 will be denied because it is included in CPT 25392.

Example 2: If ICD-10-PCS code 5A1955Z (respiratory ventilation, greater than 96 consecutive hours) is billed and the total length of stay is less than five days, the service will be denied.

Rule number	SC025
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Procedure and gender

Code editing rule
Unless it is reported with modifier KX, indicating the medical necessity of the procedure, we will not reimburse a charge for a sex-specific procedure when the sex specific to the procedure differs from the patient's gender.

Why we apply this rule
Plans cover medically necessary procedures. When a sex-specific procedure doesn't seem to be medically necessary but is, in fact, necessary, modifier KX is used to state that the procedure was medically necessary.

Rule number	SC026
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Procedure and age

Code editing rule
We do not reimburse charges for procedures that, based on the procedure code definition, nature or indication, are inconsistent with the patient's age.

Why we apply this rule
According to AMA CPT Manual guidelines, the code definition, nature and indication for a procedure must be consistent and appropriate for the patient's age.

Rule number	SC027
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Professional and technical component reimbursement of diagnostic and radiological services

Code editing rule
We limit reimbursement of charges for diagnostic and radiological service codes on a date of service basis to no more than:

- One charge for a given code appended with modifier 26, professional component
- One charge for a given code that is defined as professional component only
- One charge for a given code appended with modifier TC, technical component
- One charge for a given code that is defined as technical component only

Note: Under certain circumstances, the above editing rule may be bypassed by appending an appropriate modifier to the subsequent claim.

Why we apply this rule
According to coding guidelines, it is inappropriate for multiple providers to submit charges for the same professional or technical components of a given code, unless the need for the second service is clearly indicated by an appropriate modifier.

Rule number	SC028
Applies to	Physician/Healthcare Providers
Category	Correct Coding
Topic	Technical-component-only procedures in the inpatient or outpatient facility setting

Code editing rule
We do not reimburse professional providers for charges for technical-component-only procedures submitted with an inpatient or outpatient facility place of treatment.

Why we apply this rule
Technical-component-only procedures performed in a facility place of service should be reported by the inpatient or outpatient facility in which they were performed.

Rule number	SC029
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Transesophageal echocardiography billed with anesthesia services

Code editing rule
We do not reimburse charges for transesophageal echocardiography CPT codes 93312 – 93317, billed with anesthesia services CPT codes 00100 – 01992, unless a distinct services modifier is appended.

Additionally, for physician/healthcare providers, we do not reimburse charges for perioperative transesophageal echocardiography CPT codes 93318 or 93355 if billed with anesthesia services CPT codes 00100 – 01992 regardless of the modifier applied.

For inpatient/outpatient facilities providers, we do not reimburse charges for CPT codes 99318 or 93355 billed with CPT codes 00100 – 01992 unless a distinct services modifier is appended.

Why we apply this rule
According to correct coding guidelines, claims for transesophageal echocardiography must have a modifier indicating the service was distinct if reported with anesthesia services. For professional providers, perioperative transesophageal echocardiography does not have a modifier bypass if billed with anesthesia services.

Rule number	SC030
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Visual acuity screening billed with evaluation and management (E/M), preventive services or eye exams

Code editing rule
We do not reimburse charges for CPT code 99173 if billed with charges for E/M services, preventive services, general eye exams or vision screenings.

CPT code 99173 is defined as “Screening test of visual acuity, quantitative, bilateral.”

Why we apply this rule
According to South Carolina Medicaid coding guidelines, it is inappropriate to report a visual acuity screening in addition to the services above, unless an appropriate modifier is appended.

Rule number	SC031
Applies to	Physician/Healthcare Providers
Category	CPT
Topic	Educational services for pregnancy diagnosis requirement

Code editing rule
If billed with modifier TH, obstetrical services, we do not reimburse charges for educational services in a group setting, CPT code 99078, unless also billed with a diagnosis of pregnancy on the claim.

Why we apply this rule
According to the South Carolina Medicaid Coverage for Centering Pregnancy Group Prenatal Care, providers must submit a claim for a group clinical visit for the management of pregnancy using procedure code 99078 and modifier TH. The claim must include a pregnancy diagnosis code.

Rule number	SC032
Applies to	Physician/Healthcare Providers
Category	CPT
Topic	Family psychotherapy unit limitations

Code editing rule
We apply the following reimbursement limitations on charges for family psychotherapy services, CPT code 90846 or 90847:

- No more than one unit of the same code per day
- No more than four units of the same code per month

Why we apply this rule
According to the South Carolina Medicaid Rehabilitative Behavioral Health Services (RBHS) Provider Manual, a family psychotherapy encounter can be rendered only once per day and up to four sessions per month.

Rule number	SC033
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	CPT
Topic	Obstetric educational services maximum frequency

Code editing rule
If billed with modifier TH, obstetrical services, we limit reimbursement of educational services provided in a group setting to no more than 10 times within a gestational period.

Why we apply this rule
According to the South Carolina Medicaid Physicians Provider Manual, the birth outcome initiative recommends up to 10 group clinical visits prior to delivery may be covered.

Rule number	SC034
Applies to	Physician/Healthcare Providers
Category	CPT
Topic	Provider specialties for add-on after-hour services

Code editing rule
We do not reimburse of charges for services provided after hours, CPT codes 99050 and 99051, if billed without one of the following provider specialties:

- Pediatrics
- Family Practice
- General Practice
- Internal Medicine
- Obstetrics and Gynecology

Why we apply this rule
According the South Carolina Medicaid Physicians Services Provider Manual, only the provider specialties listed above may bill after-hour services.

Rule number	SC035
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	CPT
Topic	Topic: Special services, procedures and reports

Code editing rule
We do not reimburse charges for services provided in the office at times other than regularly scheduled office hours or on days when the office is normally closed (e.g., holidays, Saturday or Sunday) if billed in any place of service other than 11, office.

Additionally, we do not reimburse special services provided in the office if the provider's specialty or place of service is urgent care, or if these services are billed in conjunction with an emergency department visit, CPT codes 99281 – 99285, by a provider with a specialty of emergency medicine in place-of-service 23, emergency room, or 20, urgent care facility.

Why we apply this rule
According to the AMA CPT Manual code description, these services should be performed only in an office setting.

Rule number	SC036
Applies to	Physician/Healthcare Providers
Category	CPT – Evaluation and Management Services
Topic	Behavioral health integration care management billed with psychiatric collaborative care management

Code editing rule
We do not reimburse charges for CPT code 99484, behavioral health integration care management, if billed in the same calendar month as any of the psychiatric collaborative care management CPT codes, 99492, 99493 or 99494.

Additionally, if CPT code 99484 has been billed within a calendar month, we do not reimburse for CPT codes 99492, 99493 or 99494.

Why we apply this rule
According to the AMA CPT Manual, behavioral health integration care management and psychiatric collaborative care management may not be reported by the same professional in the same month.

Rule number	SC037
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	CPT – Evaluation and Management Services
Topic	Care plan oversight and care coordination services billed within the same month as end-stage renal disease (ESRD) services

Code editing rule
We do not reimburse charges for care plan oversight or care coordination services that are billed within the same month of a monthly ESRD service code.

Why we apply this rule
According to CMS guidance and code definitions, a care plan oversight or care coordination service is not reported separately from a monthly ESRD service code because these services are considered as included in the monthly ESRD service code.

Rule number	SC038
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	CPT – Evaluation and Management Services
Topic	Chronic and complex care management services

Code editing rule
We do not reimburse CPT code 99490, chronic care management, or CPT codes 99489 – 99491, complex care management, if a primary and secondary diagnosis is not present.

Why we apply this rule
According to AMA CPT Manual guidelines, the services above are to be reported when the patient has at least two chronic continuous or episodic conditions that are expected to last 12 months or until death.

Rule number	SC039
Applies to	Physician/Healthcare Providers
Category	CPT – Evaluation and Management Services
Topic	Consultation services for a health supervision or routine examination diagnosis

Code editing rule
We do not reimburse charges for the following consultation services if billed with a diagnosis of health supervision or routine examination:

- CPT codes 99241 – 99245: Office consultation for a new or established patient
- CPT codes 99446 – 99449 or 99451: Interprofessional telephone/internet consultations

Why we apply this rule
According to the AMA CPT Manual, consultations are requested to address a specific problem or concern; therefore, it is inappropriate to perform a consultation with one of the diagnoses above.

Rule number	SC040
Applies to	Physician/Healthcare Providers
Category	CPT – Evaluation and Management Services
Topic	CPT code 99291 – Critical care services

Code editing rule
We do not reimburse charges for more than one unit of CPT code 99291 per date of service.

CPT code 99291 is defined as “Critical care, evaluation and management of the critically ill or critically injured patient; first 30 – 74 minutes.”

Why we apply this rule
According to the AMA CPT Manual, CPT code 99291 is used to report the first 30 to 74 minutes of critical care services on a given date and should be used only once per date of service.

Rule number	SC041
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	CPT – Evaluation and Management Services
Topic	CPT code 99356 – Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour

Code editing rule
We limit reimbursement for 99356 to claims submitted for an inpatient or observation facility setting.

Why we apply this rule
According to the code description, this code is to be used only for services performed in an inpatient or observation setting.

Rule number	SC042
Applies to	Physician/Healthcare Providers
Category	CPT – Evaluation and Management Services
Topic	CPT code 99460 – Initial hospital or birthing center care

Code editing rule
We do not reimburse charges for CPT code 99460 if the patient has received initial or subsequent newborn care services the previous day.

Why we apply this rule
According to code definitions and the AMA CPT Manual, it is inappropriate to report initial care services for services rendered on subsequent dates of service.

Rule number	SC043
Applies to	Physician/Healthcare Providers
Category	CPT – Evaluation and Management Services
Topic	CPT code 99461 – Initial care, per day, for evaluation and management of normal newborn infant seen in other than hospital or birthing center

Code editing rule
We do not reimburse charges for 99461 if the patient has received newborn care services the previous day.

Why we apply this rule
According to code definitions and the AMA CPT Manual, it is inappropriate to report initial care services for services rendered on subsequent dates of service.

Rule number	SC044
Applies to	Physician/Healthcare Providers
Category	CPT – Evaluation and Management Services
Topic	CPT code 99463 – Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant admitted and discharged on the same date

Code editing rule
We do not reimburse charges for CPT code 99463 if the patient has received newborn care services the previous day.

Why we apply this rule
According to code definitions and the AMA CPT Manual, it is inappropriate to report initial care services for services rendered on subsequent dates of service.

Rule number	SC045
Applies to	Physician/Healthcare Providers
Category	CPT – Evaluation and Management Services
Topic	CPT code 99477 – Initial neonatal intensive care services

Code editing rule
We do not reimburse charges for CPT code 99477 if submitted for a date subsequent to the date of admission.

Why we apply this rule
According to code definitions and the AMA CPT Manual, CPT code 99477 represents the initial day of inpatient care provided to a child. It is inappropriate to report initial care services for subsequent dates of service.

Rule number	SC046
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	CPT – Evaluation and Management Services
Topic	CPT code 99483 – Assessment and care plan for a patient with cognitive impairment

Code editing rule
We do not reimburse charges for CPT code 99483 more than once in a 180-day period.

Why we apply this rule
According to the AMA CPT Manual, it is inappropriate to report CPT code 99483 more than once within a 180-day period.

Rule number	SC047
Applies to	Physician/Healthcare Providers
Category	CPT – Evaluation and Management Services
Topic	CPT codes 99468 – 99476: Neonatal and pediatric critical care services

Code editing rule
We limit reimbursement of charges for CPT codes 99468 – 99476 to one total unit per date of service, regardless of which code is billed.

Why we apply this rule
According to the AMA CPT Manual, it is inappropriate to report more than one of the above codes for any given date of service.

Rule number	SC048
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	CPT – Evaluation and Management Services
Topic	CPT codes 99487 – 99490, care management services

Code editing rule
We do not reimburse charges for the following CPT codes if CPT codes 99487 – 99490, care management services, have been billed by the same physician within the same calendar month:

- 90951 – 90970 – ESRD services
- 98960 – 98962, 99071 or 99078 – Education and training
- 99080 – Preparation of special reports
- 99090 or 99091 – Analysis of data

- 99339, 99340 or 99374 – 99378 – Care plan oversight services
- 99358 or 99359 – Prolonged services without direct patient contact
- 99363 or 99364 – Anticoagulant management
- 99366 – 99368 – Medical team conferences
- 98966 – 98968 or 99441 – 99443 – Telephone services
- 98969 or 99444 – On-line medical evaluation
- 99495 or 99496 – Transitional care management services
- 99605 – 99607 – Medication therapy management services

Additionally, if a physician billed one of the above services within the current month, we do not reimburse the care management service.

Why we apply this rule
According to the AMA CPT Manual, care management services should be reported once per month and, when reported, the above services should not be separately reported in addition to care management services.

Rule number	SC049
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	CPT – Evaluation and Management Services
Topic	Discharge services billed the day after an admission and discharge service

Code editing rule
We do not reimburse charges for the following services if observation or inpatient hospital care that includes admission and discharge on the same day (CPT codes 99234 – 99236) has been billed for the previous date of service:

- CPT code 99217 – Observation care discharge day management (This code is used to report all services provided to a patient upon discharge from outpatient hospital "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234 – 99236 as appropriate.])
- CPT code 99238 – Hospital discharge day management; 30 minutes or less
- CPT code 99239 – Hospital discharge day management; more than 30 minutes

Why we apply this rule
According to code definitions and the AMA CPT Manual, it would be inappropriate to report a discharge service if an admission and discharge service was reported for the previous date of service.

Rule number	SC050
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	CPT – Evaluation and Management Services
Topic	Discharge services billed with initial hospital care

Code editing rule
We do not reimburse CPT code 99217, observation care discharge day, if billed by the same provider and on the same date of service as CPT codes 99221 – 99223, initial hospital care.

Additionally, for professional providers only, we do not reimburse:

- CPT code 99217 if CPT codes 99221 – 99223 were billed for the previous date of service; or
- CPT codes 99221 – 99223 if CPT code 99217 was paid for the subsequent date of service

Why we apply this rule
According to the AMA CPT Manual, it is inappropriate for the same physician to report the above codes on the same date of service. Additionally, it is inappropriate for a patient to discharge from observation status the day after being admitted as an inpatient.

Rule number	SC051
Applies to	Physician/Healthcare Providers
Category	CPT – Evaluation and Management Services
Topic	Electrocardiogram (ECG) with evaluation and management services

Code editing rule
We do not reimburse charges for CPT code 93010 when submitted with an E/M service unless CPT code 93005 is also billed.

The CPT codes above are defined as:
- 93005 – Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report
- 93010 – Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only

Why we apply this rule
According to the AMA CPT Manual, the medical decision-making component of an E/M service includes review of diagnostic tests and other reports. The reporting of an ECG interpretation represents the review and analysis of the tracing and should not be reported separately.

Rule number	SC052
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	CPT – Evaluation and Management Services
Topic	Electromyography, nerve conduction study and reflex tests with evaluation and management (E/M) services

Code editing rule
We do not reimburse charges for E/M services when submitted on the same date of service as electromyography (EMG), nerve conduction study (NCS) or reflex tests.

Why we apply this rule
According to the American Association of Neuromuscular and Electrodiagnostic Medicine, and supported by the AMA CPT Manual, a level of evaluation is inherent to the procedure and not part of the cognitive performance of the EMG, NCS or reflexive test. Therefore, the E/M service does not warrant separate reimbursement.

Rule number	SC053
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	CPT – Evaluation and Management Services
Topic	Evaluation and management (E/M) services billed with allergy testing or immunotherapy

Code editing rule
We do not reimburse separately for an E/M services charge reported the same day as allergy testing or allergy immunotherapy services, unless the E/M charge is submitted with an appropriate modifier indicating that the service was significant and separately identifiable.

Why we apply this rule
According to NCCI guidance, E/M codes reported with allergy testing or allergy immunotherapy are appropriate only if a significant, separately identifiable service is performed. Obtaining informed consent is included in the immunotherapy service.

Rule number	SC054
Applies to	Physician/Healthcare Providers
Category	CPT – Evaluation and Management Services
Topic	Evaluation and management (E/M) services billed with global radiology services

Code editing rule
We do not reimburse charges for E/M services that are billed on the same date of service as a global radiology procedure if the provider's specialty is radiology.

Why we apply this rule
According to NCCI guidance, it is inappropriate for a radiologist to report an E/M service in addition to a global radiology service.

Rule number	SC055
Applies to	Physician/Healthcare Providers
Category	CPT – Evaluation and Management Services
Topic	Evaluation and management (E/M) services billed with pulmonary function testing

Code editing rule
We do not reimburse an E/M service if billed with a pulmonary function test, CPT codes 94010 – 94799.

Why we apply this rule
According to the AMA CPT Manual, it is inappropriate to submit for an E/M service and a pulmonary function test on the same date of service.

Rule number	SC056
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	CPT – Evaluation and Management Services
Topic	Evaluation and management (E/M) services billed with stress test, stress echocardiography or myocardial perfusion imaging (PET)

Code editing rule
We do not reimburse separately for a charge for E/M services reported the same day as a stress test, stress echocardiography or myocardial PET unless the E/M charge is submitted with an appropriate modifier indicating that the service was significant and separately identifiable.

Why we apply this rule
According to NCCI guidance, if a physician in attendance for a cardiac stress test obtains a history and performs a limited physical examination related to the cardiac stress test, a separate E/M code shall not be reported unless a significant, separately identifiable E/M service is performed unrelated to the performance of the cardiac stress test.

Rule number	SC057
Applies to	Physician/Healthcare Providers
Category	CPT – Evaluation and Management Services
Topic	Hospital discharge services

Code editing rule
We do not reimburse charges for hospital discharge services, CPT codes 99238 or 99239, if either code has previously been billed for the same date of service or the day prior.

The CPT codes above are defined as:
- 99238 – Hospital discharge day management; 30 minutes or less
- 99239 – Hospital discharge day management; more than 30 minutes

Why we apply this rule
According to code definitions and the AMA CPT Manual, the hospital discharge management services above are to be used once to report the total duration of time spent by the discharging physician. Additionally, discharge codes are to be performed once per admission. Unless the patient was readmitted after discharge the day prior, it would be inappropriate to bill for discharge management on subsequent dates of service.

Rule number	SC058
Applies to	Physician/Healthcare Providers
Category	CPT – Evaluation and Management Services
Topic	Initial neonatal and pediatric critical care services: CPT codes 99468, 99471 and 99475

Code editing rule
We do not reimburse the following initial neonatal and pediatric care CPT codes if the patient has received inpatient critical care services the previous day:

- CPT code 99468 – Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger
- CPT code 99471 – Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age
- CPT code 99475 – Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age

Why we apply this rule
According to the AMA CPT Manual, it is inappropriate to report an initial critical care service if another critical care service was reported the day prior.

Rule number	SC059
Applies to	Physician/Healthcare Providers
Category	CPT – Evaluation and Management Services
Topic	Initial observation care

Code editing rule
We do not reimburse charges for initial observation care codes, or codes that include initial observation care, if an initial observation care code has been billed the previous day.

Why we apply this rule
According to the AMA CPT Manual and code definitions, it is inappropriate to bill for initial observation care services on two consecutive dates of service.

Rule number	SC060
Applies to	Physician/Healthcare Providers
Category	CPT – Evaluation and Management Services
Topic	Limitations for prolonged evaluation and management (E/M) service

Code editing rule
We do not reimburse charges for CPT codes 99358 or 99359 if billed on the same date of service as either CPT codes 99238 and 99239.

- 99358 – Prolonged evaluation and management service before and/or after direct patient care; first hour
- 99359 – Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)
- 99238 – Hospital discharge day management; 30 minutes or less
- 99239 – Hospital discharge day management; more than 30 minutes

Why we apply this rule
According to the AMA CPT Manual and CMS guidance, it is inappropriate to report the prolonged E/M services above on the same date as a hospital discharge day management service.

Rule number	SC061
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	CPT – Evaluation and Management Services
Topic	Multiple new-patient or initial-care visits

Code editing rule
We limit reimbursement of new-patient visits or initial-care visits to one unit per date of service per provider or provider group within the same specialty.

Why we apply this rule
According to the AMA CPT Manual, it is inappropriate to bill for more than one unit of a new-patient or initial-care visit per date of service.

Rule number	SC062
Applies to	Physician/Healthcare Providers
Category	CPT – Evaluation and Management Services
Topic	CPT codes 99477 – 99480, Neonatal intensive care services

Code editing rule
We limit reimbursement of charges for neonatal intensive care services, CPT codes 99477 – 99480, to one total unit for a given date of service, regardless of the codes billed.

Why we apply this rule
According to the AMA CPT Manual, it is inappropriate to report more than one unit of the above codes per date of service.

Rule number	SC063
Applies to	Physician/Healthcare Providers
Category	CPT – Evaluation and Management Services
Topic	New-patient evaluation and management (E/M) services

Code editing rule
We do not reimburse charges for a new-patient E/M visit if a face-to-face service has previously been billed within the previous three years by the same physician or another physician of the same group who is of the same specialty and subspecialty.

Additionally, we do not reimburse charges for a new-patient E/M visit if any face-to-face service has previously been billed by the same provider ID, regardless of Tax ID or specialty.

Why we apply this rule
According to the AMA CPT Manual, a new patient is one who has not received any professional services from a physician or another physician of the same specialty and subspecialty practicing within the same group. It is inappropriate to report charges for an established patient with new-patient service codes.

Rule number	SC064
Applies to	Physician/Healthcare Providers
Category	CPT – Evaluation and Management Services
Topic	Observation services unit limitations

Code editing rule
We limit reimbursement of charges for CPT codes 99218 – 99220, initial observation services, and CPT codes 99234 – 99236, observation or inpatient admission and discharge services, to one unit per date of service.

Why we apply this rule
According to the code definitions and as supported by CMS guidance, it is inappropriate to report more than one initial observation service or observation admission and discharge for a given date of service.

Rule number	SC065
Applies to	Physician/Healthcare Providers
Category	CPT – Evaluation and Management Services
Topic	Psychiatric collaborative care management services

Code editing rule
We apply the following reimbursement limitations to psychiatric collaborative care management services, CPT codes 99492 or 99493:

- No more than one total unit per month, regardless of which code is billed
- For inpatient and outpatient facilities, no more than one total unit per month if billed with revenue code 0510 – 0529, regardless of which code is billed

Also, we do not reimburse CPT code 99492, initial psychiatric collaborative care management, if it was billed the previous month.

Why we apply this rule
According to the AMA CPT Manual, the services above are appropriate no more than once per month. Further, it is inappropriate to have an initial psychiatric collaborative care management charge in two consecutive months.

Rule number	SC066
Applies to	Physician/Healthcare Providers
Category	CPT – Evaluation and Management Services
Topic	Services included in pediatric critical care interfacility transport and critical care codes

Code editing rule
We do not separately reimburse charges for services that are considered as included in the following CPT codes:

- 99291 – Critical care, evaluation and management of the critically ill or critically injured patient; first 30 – 74 minutes
- 99292 – Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service.)
- 99466 – Critical care face-to-face services, during an interfacility transport of critically ill or critically injured pediatric patient, 24 months or younger; first 30 – 74 minutes of hands-on care during transport
- 99467 – Critical care face-to-face services, during an interfacility transport of critically ill or critically injured pediatric patient, 24 months or younger; each additional 30 minutes (List separately in addition to code for primary service.)

Why we apply this rule
According to the AMA CPT Manual, it is inappropriate to separately report services that are considered an integral component of the above CPT codes.

Rule number	SC067
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	CPT – Evaluation and Management Services
Topic	Services submitted with CPT code 99466, “Critical care face-to-face services during an interfacility transport of critically ill or critically injured pediatric patient”

Code editing rule
We do not reimburse charges for services that are considered a part of CPT code 99466, pediatric critical care interfacility transport.

CPT code 99466 is defined as “Critical care face-to-face services, during an interfacility transport of critically ill or critically injured pediatric patient, 24 months of age or younger; first 30 – 74 minutes of hands-on care during transport.”

Why we apply this rule
According to the AMA CPT Manual, it is inappropriate to separately report services that are considered an integral component of CPT code 99466. Examples include routine monitoring evaluations of heart rate, respiratory rate, blood pressure and pulse oximetry.

Rule number	SC068
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	CPT – Evaluation and Management Services
Topic	Unit limit for care management service CPT codes 99487, 99490 or 99491

Code editing rule
We limit reimbursement to one total unit per month of any of the following CPT codes, regardless of which code is billed:

- 99487 – Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation or functional decline; establishment or substantial revision of a comprehensive care plan; moderate or high-complexity medical decision-making; 60 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month
- 99490 – Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation or functional decline; comprehensive care plan established, implemented, revised or monitored
- 99491 – Chronic care management services, provided personally by a physician or other qualified healthcare professional, at least 30 minutes of physician or other qualified healthcare professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation or functional decline; comprehensive care plan established, implemented, revised or monitored

Note: We also do not reimburse more than one unit of these codes if one claim is submitted with revenue codes 0510 – 0529 and the other claim is submitted with revenue codes 0510 – 0529 by the same or another provider.

Why we apply this rule
According to the AMA CPT Manual, the care management services above should be reported only once per calendar month and only by the physician who assumed the care management role of the patient.

Rule number	SC069
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	CPT – Medicine
Topic	Chiropractic services frequency

Code editing rule
We limit reimbursement of charges for chiropractic manipulative treatments to no more than six units in one fiscal year (July 1 through June 30).

Why we apply this rule
According to the South Carolina Medicaid Physicians Services Provider Manual, no more than six chiropractic visits are allowed per year, commencing July 1 of each year.

Rule number	SC070
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	CPT – Medicine
Topic	CPT code 99452 – Interprofessional telephone/Internet/electronic-health-record referral service(s) provided by a treating/requesting physician or other qualified healthcare professional, 30 minutes

Code editing rule
We limit reimbursement for CPT code 99452 to once in a 14-day period.

Why we apply this rule
According to the AMA CPT Manual, procedure code 99452 should not be reported more than once in a 14-day period.

Rule number	SC071
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	CPT – Medicine
Topic	Immunization administration billed without a vaccine or toxoid code

Code editing rule
We do not reimburse charges for an immunization administration service if billed without a vaccine or toxoid code.

Why we apply this rule
According to the AMA CPT Manual, it is inappropriate to perform an immunization administration without also providing a vaccine or toxoid.

Rule number	SC072
Applies to	Physician/Healthcare Providers
Category	CPT – Medicine
Topic	Out-of-scope services for chiropractors

Code editing rule
If billed by a chiropractor, we do not reimburse charges for services other than the following:

- 72020 – Radiologic examination, spine, single view, specify level
- 72040 – Radiologic examination, spine; cervical, two or three views
- 72070 – Radiologic examination, spine; thoracic, two views
- 72080 – Radiologic examination, spine; thoracolumbar junction, minimum of two views
- 72100 – Radiologic examination, spine; lumbosacral, two or three views
- 98940 – Chiropractic manipulative treatment (CMT); spinal, 1 – 2 regions
- 98941 – Chiropractic manipulative treatment (CMT); spinal, 3 – 4 regions
- 98942 – Chiropractic manipulative treatment (CMT); spinal, 5 regions

Why we apply this rule
According to the South Carolina Medicaid Physicians Services Provider Manual and the Chiropractic Services Fee Schedule, only the services listed above are appropriate to be billed by a chiropractor.

Rule number	SC073
Applies to	Inpatient/Outpatient Facilities
Category	CPT – Radiology
Topic	Outpatient radiology services

Code editing rule
We do not reimburse charges for radiology services when submitted with bill types 0140 – 014Z (hospital – laboratory service to nonpatients).

Why we apply this rule
According to the Uniform Billing Editor, radiology services should not be submitted with bill types 0140 – 014Z.

Rule number	SC074
Applies to	Physician/Healthcare Providers
Category	CPT – Radiology
Topic	Radiology services billed with modifier 26 and reported with an evaluation and management (E/M) service in the office

Code editing rule
We do not separately reimburse radiology services appended with professional component modifier 26 if billed with an E/M service in the office.

Why we apply this rule
When a provider bills the professional component of a radiology procedure that was not performed globally in the provider's office in conjunction with an E/M service, the professional component is denied because it is included in the E/M service. A second physician's interpretation is allowed only if the appropriate modifiers are appended.

Rule number	SC075
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Diagnoses
Topic	Claims with a primary diagnosis in the external-cause-of-morbidity category

Code editing rule
We do not reimburse claims submitted with a principal, primary or only diagnosis within the external-causes-of-morbidity category.

Why we apply this rule
According to ICD-10-CM guidelines and CMS guidance, external-cause-of-morbidity diagnoses are not appropriate as the principal, primary or only diagnosis on a claim.

Rule number	SC076
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Diagnoses
Topic	Evaluation and management (E/M) services billed with preventive medicine services and submitted with “Z” diagnosis codes

Code editing rule
We do not reimburse E/M services billed with preventive medicine services if the only diagnosis present is an ICD-10 “Z” diagnosis code.

Note: The above editing rule does not apply to normal newborn care or claims submitted with a “Z” pacemaker diagnosis code.

Why we apply this rule
According to the ICD-10 manual, it is inappropriate for an E/M service billed with a preventive service to have only a diagnosis code in the “Z” series.

Rule number	SC077
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Diagnoses
Topic	ICD-10-CM laterality

Code editing rule
We do not reimburse services billed with an inappropriate combination of diagnosis code(s) to diagnosis code(s) or diagnosis code(s) to modifier(s).

Why we apply this rule
According to the ICD-10 CM manual, some ICD-10-CM diagnosis codes indicate that a condition occurs on the left, on the right or bilaterally, while some state that laterality is "unspecified." These codes should be billed to increase specificity. Specificity determines if the assessed lateral diagnosis associated with the same claim line is appropriate.

For example, if a claim line is billed with a diagnosis indicating it was performed on the right side, it is inappropriate to use a diagnosis code which is bilateral by definition. Furthermore, procedure code modifier specificity must be consistent with ICD-10-CM diagnosis specificity.

Rule number	SC078
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Diagnoses
Topic	Manifestation, sequela or secondary diagnosis codes

Code editing rule
We do not reimburse claims billed with a manifestation, sequela or secondary diagnosis code as the primary or only diagnosis code on the claim.

Note: A sequela code is an ICD-10-CM code with a seventh character of "S."

Why we apply this rule
According to ICD-10-CM guidelines, it is inappropriate to have a manifestation, sequela or secondary diagnosis code as the primary or only diagnosis code on a claim.

Rule number	SC080
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Diagnoses
Topic	Topic

Code editing rule
We do not reimburse charges for procedures, items or services that have been billed with a diagnosis code that is not consistent with the patient's age.

Why we apply this rule
According to code definitions and as supported by CMS guidance, it is inappropriate to report charges for a procedure, item or service with a diagnosis code that is not consistent with the age of the patient for whom the procedure, item or service was rendered.

Rule number	SC081
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Diagnoses
Topic	Services with a maternity diagnosis for patients younger than 12 or older than 56

Code editing rule
We do not reimburse services submitted with a maternity diagnosis if the patient is younger than 12 or older than 56.

Why we apply this rule
According to the ICD-10-CM manual, maternity services are limited to patients aged 12 to 56.

Rule number	SC082
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS
Topic	Family support services age, frequency and modifier limitations

Code editing rule
We limit reimbursement of charges for family support services, HCPCS code S9482, to no more than 32 units per day for patients 21 or younger if billed with one of the following modifiers:

- AF – Psychiatrist
- AH – Licensed Psychologist
- AM – Physician team member (PA)
- HM – Less than bachelor's degree
- HN – Bachelor's level
- HO – Master's level
- HP – Doctoral level (MD)
- SA – Nurse practitioner (APRN)
- TD – Registered nurse (RN)
- TE – Licensed Practical Nurse (LPN)

Why we apply this rule
According to the South Carolina Rehabilitative Behavioral Health Services (RBHS) Provider Manual, the above-listed limitations apply to family support services.

Rule number	SC083
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS
Topic	Maximum units for presumptive and definitive drug testing

Code editing rule
We apply the following reimbursement limitations to charges for presumptive drug testing, CPT codes 80305 and 80307, or definitive drug testing, HCPCS code G0480:

- No more than one unit per procedure per date of service
- No more than 18 total units per year

Why we apply this rule
The limitations listed above are included in the South Carolina Medicaid Physicians Services Provider Manual.

Rule number	SC084
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS
Topic	Therapeutic behavioral services age and frequency limitations

Code editing rule
We apply the following reimbursement limitations of charges for therapeutic behavioral services, HCPCS code H2019:

- For patients 21 or younger
- No more than four units per week

Why we apply this rule
According to the South Carolina Medicaid Autism Spectrum Disorder (ASD) Services Provider Manual and the ASD fee schedule, the ASD benefit is covered only for beneficiaries age 0 to 21 for a maximum of one hour, which equates to four units of HCPCS H2019, per week.

Rule number	SC085
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – DMEPOS
Topic	Durable medical equipment (DME) maximum units

Code editing rule
We do not reimburse charges for DME and supplies that represent a quantity greater than the maximum unit amount allowed within a given time frame.

Why we apply this rule
Based on code definitions, clinical guidelines and CMS guidance, procedures, services and items are often limited by a maximum-allowable-unit quantity per date of service. Units in excess of the daily allowable quantity for a specific procedure, service or item are denied.

Rule number	SC086
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – DMEPOS
Topic	HCPCS code A4321 – Therapeutic agent for urinary catheter irrigation

Code editing rule
We do not reimburse HCPCS code A4321.

Why we apply this rule
According to Humana internal review and supported by South Carolina Medicaid guidance, HCPCS code A4321 is not reimbursable.

Rule number	SC087
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – DMEPOS
Topic	HCPCS code A4360 – Disposable external urethral clamp or compression device, with pad and/or pouch, each

Code editing rule
We do not reimburse charges for HCPCS code A4360.

Why we apply this rule
According to South Carolina Medicaid guidance and CMS policy, the urological supply above is not reimbursable.

Rule number	SC088
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – DMEPOS
Topic	Non-reimbursable orthotics

Code editing rule
We do not reimburse charges for the following HCPCS codes:

- A9283 – Foot pressure off-loading/supportive device, any type, each
- A9285 – Inversion/eversion correction device

Why we apply this rule
According to South Carolina Medicaid guidance and CMS policy, the above orthotics are not reimbursable.

Rule number	SC089
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – DMEPOS
Topic	Supplies and equipment provided in the facility setting

Code editing rule
We do not reimburse medical surgical supplies and durable medical equipment (DME) if the claim is submitted on a CMS-1450 form with professional fee revenue codes (0960 – 0989) in an outpatient or inpatient facility setting.

Why we apply this rule
Medical and surgical supplies and DME billed in a facility setting are not reimbursable as professional services. The supplies and equipment are typically billed by the facility or a DME supplier.

Rule number	SC090
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – DMEPOS
Topic	Wheelchair accessories billed for the incorrect wheelchair type

Code editing rule
We do not reimburse power wheelchair accessories billed with a manual wheelchair. Additionally, we do not reimburse manual wheelchair accessories billed with a power wheelchair.

Why we apply this rule
By code definition, manual wheelchair accessories are to be used with manual wheelchair devices, and power wheelchair accessories are appropriate only for use with power wheelchair devices.

Rule number	SC091
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – DMEPOS
Topic	Wheelchair reclining-back accessories

Code editing rule
We do not reimburse HCPCS code E1225 if billed with HCPCS code E1226.

The HCPCS codes above are defined as:

- E1225 – Wheelchair accessory, manual semi-reclining back, (recline greater than 15 degrees, but less than 80 degrees), each.
- E1226 – Wheelchair accessory, manual fully reclining back, (recline greater than 80 degrees), each.

Why we apply this rule
According to the HCPCS Level II Manual definition of these codes, HCPCS code E1225 is for a tilt greater than 15 degrees and less than 80 degrees, whereas HCPCS code E1226 is for a tilt greater than 80 degrees. Therefore, it is inappropriate to bill both of these reclining-back accessories for a patient's wheelchair.

Rule number	SC092
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	Age limitations for HCPCS code J0897 – Injection, denosumab, 1 mg

Code editing rule
We do not reimburse charges for HCPCS J0897 for patients who are:

- Younger than 12, if billed with a diagnosis of giant-cell tumor of bone
- Younger than 18, if billed with a diagnosis of bone metastases, hypercalcemia of malignancy, multiple myeloma, osteoporosis in men, postmenopausal osteoporosis prophylaxis, postmenopausal osteoporosis treatment, postmenopausal women receiving aromatase inhibitor therapy for early breast cancer or prostate cancer patients receiving androgen deprivation therapy

Why we apply this rule
According to the FDA-approved package insert and prescribing information, denosumab is not indicated for the ages and diagnoses listed above.

Rule number	SC093
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	Alpha 1-proteinase inhibitors

Code editing rule
We limit reimbursement for alpha 1-proteinase inhibitor (human), 10 mg, to once per week.

Why we apply this rule
According to the FDA-approved package insert and prescribing information, alpha 1-proteinase inhibitors should be administered no more than once per week.

Rule number	SC094
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	Alpha1-proteinase inhibitors with clinically evident emphysema

Code editing rule
We do not reimburse alpha1-proteinase inhibitor (human), 10 mg, for patients younger than 18 when the diagnosis is alpha1-proteinase inhibitor deficiency with clinically evident emphysema.

Why we apply this rule
According to the FDA-approved package insert and prescribing information, the safety and effectiveness of alpha1-proteinase inhibitor has not been established for patients younger than 18 for the indication listed above.

Rule number	SC095
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	Bevacizumab and biosimilars

Code editing rule
We limit reimbursement of charges for bevacizumab and its biosimilars to no more than one injection every three weeks for any of the following indications:

- Cervical cancer
- Endometrial carcinoma
- Malignant mesothelioma
- Non-small-cell lung cancer
- Soft tissue sarcoma
- Vulvar cancer

Why we apply this rule
The above limitations were established by the FDA-approved package insert and prescribing information or the pharmaceutical compendia.

Rule number	SC096
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	Bevacizumab and its biosimilars for opthalmic indications

Code editing rule
We limit reimbursement of a charge for bevacizumab and its biosimilars to no more than two units per date of service if submitted with a diagnosis for ophthalmic indications.

Why we apply this rule
The above limitation is based on the FDA-approved package insert and prescribing information for bevacizumab and its biosimilars.

Rule number	SC097
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	Date-of-service unit limitations for HCPCS code J0897 – Injection, denosumab, 1 mg

Code editing rule
We limit reimbursement of HCPCS code J0897 to no more than 60 units per date of service, if billed for the following diagnoses:

- Intolerance to other osteoporosis therapy
- Men receiving androgen deprivation therapy for prostate cancer
- Men with osteoporosis at high risk for fracture
- Postmenopausal women with osteoporosis at high risk for fracture
- Prevention of postmenopausal osteoporosis
- Women receiving aromatase inhibitor therapy for breast cancer
- Glucocorticoid-induced osteoporosis
- Systemic mastocytosis

Why we apply this rule
According to the FDA-approved package insert and prescribing information, these limitations are appropriate for denosumab, when administered for the conditions above.

Rule number	SC186
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	HCPCS code J7170 – Injection, emicizumab-kxwh, 0.5 mg (brand name Hemlibra)

Code editing rule
We apply the following reimbursement limitations for HCPCS code J7170:

- Must be submitted with a diagnosis of hemophilia A with or without factor VIII inhibitors
- No more than one injection per week
- No more than 11,250 units per 26 weeks
- No more than 59 units, if submitted with modifier JW, drug amount discarded/not administered to any patient

Why we apply this rule
The above limitations accord with the FDA-approved package insert and prescribing information for injection, emicizumab-kxwh, 0.5 mg.

Note: For additional information on drug wastage, refer to the Humana claims payment policy page and search by keyword "JW."

Rule number	SC187
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	Bevacizumab and its biosimilars

Code editing rule
We limit reimbursement of charges for HCPCS J9035, Q5107 or Q5118 to the following:

- No more than 20 mg, or two units, per date of service for ophthalmic indications
- No more than 1,250 mg, or 125 units, per date of service for an indication of colorectal cancer or renal-cell carcinoma
- No more than 620 mg, or 62 units, per date of service for an indication of hereditary hemorrhagic telangiectasia
- No more than 20 mg, or two units, when submitted earlier than one month following a major surgery regardless of provider
- No more than 90 mg, or nine units, when submitted with modifier JW (Drug amount discarded/not administered to any patient)

The HCPCS codes above are defined as follows:

- J9035 – Injection, bevacizumab, 10 mg
- Q5107 – Injection, bevacizumab-awwb, biosimilar, (Mvasi), 10 mg
- Q5118 – Injection, bevacizumab-bvcr, biosimilar, (Zirabev), 10 mg

Why we apply this rule
The FDA-approved package insert and prescribing information and the pharmaceutical compendia have established the maximum daily dosages of bevacizumab and its biosimilars.

Notes: If any units are denied, the provider may dispute the decision through the appropriate process. The provider may submit information, including medical notes indicating the patient's body weight, that substantiates the medical necessity of the additional units.

For additional information on drug wastage, refer to the Humana claims payment policy page and search by keyword "JW."

Rule number	SC188
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	Injection, bevacizumab and biosimilars

Code editing rule
We limit reimbursement of charges for bevacizumab and its biosimilars within any 26-week period to no more than:

- 5,000 mg, or 500 units, when submitted with a diagnosis of hereditary hemorrhagic telangiectasia
- 17,500 mg, or 1,750 units, when submitted with a diagnosis of breast cancer, colorectal cancer or ovarian cancer

Why we apply this rule
The above limitations were established by the FDA-approved package insert and prescribing information or the pharmaceutical compendia.

Note: The FDA-approved package insert and prescribing information and pharmaceutical compendia establish maximum daily dosages of bevacizumab and biosimilars. The limitations described above are based on maximum dosages established in FDA-approved package insert and prescribing information and the pharmaceutical compendia. If any units are denied, the provider may dispute the decision through the appropriate process. The provider may submit information, including medical notes showing the patient's body weight, that substantiates the medical necessity of the additional units.

For additional information on drug wastage, refer to the Humana claims payment policy page and search by keyword "JW."

Rule number	SC189
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	HCPCS code J9308 – Injection, ramucirumab, 5 mg

Code editing rule
We apply the following reimbursement limitations on charges for HCPCS code J9308:

We do not reimburse HCPCS code J9308 if the patient is under 18.

For a patient 18 or older, we do not reimburse HCPCS code J9308 unless submitted with one of the following indications:

- Colorectal cancer
- Esophageal cancer
- Esophagogastric junction cancer
- Gastric cancer
- Hepatocellular carcinoma
- Non-small-cell lung cancer
- Urothelial carcinoma

We limit reimbursement of HCPCS code J9308 to no more than 200 units per date of service and no more than one injection in any two-week period, for any of the following indications:

- Colorectal cancer
- Esophageal cancer
- Esophagogastric junction cancer
- Gastric cancer
- Hepatocellular carcinoma

We limit reimbursement of HCPCS code J9308 to no more than 272 units per date of service and no more than one injection in any two-week period for an indication of non-small-cell lung cancer or urothelial carcinoma

We limit reimbursement for HCPCS code J9308 submitted with modifier JW to no more than 19 units per date of service.

Why we apply this rule
The above limitations were established by the FDA-approved package insert and prescribing information or the pharmaceutical compendia.

Notes: The limitations described above are based on maximum dosages established in mg. If any units are denied, the provider may dispute the decision through the appropriate process. The provider may submit information, including medical notes showing the patient's body weight, that substantiates the medical necessity of the additional units.

For additional information on drug wastage, refer to the Humana claims payment policy page and search by keyword "JW."

Rule number	SC190
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	HCPCS code J9299 – Injection, nivolumab, 1 mg

Code editing rule
We limit reimbursement of charges for HCPCS code J9299 to 5,712 mg, or 5,712 units, within a 26-week period for any of the following indications:

- Anal carcinoma
- Gestational trophoblastic neoplasia
- Head and neck cancer
- Hepatocellular carcinoma
- Hodgkin lymphoma (classical)
- Melanoma
- Merkel cell carcinoma
- Microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) cancer
- Non-small-cell lung cancer
- Renal-cell carcinoma
- Small-cell lung cancer
- Urothelial carcinoma

Why we apply this rule
The above limitations were established by the FDA-approved package insert and prescribing information or the pharmaceutical compendia.

Note: The limitations described above are based on maximum dosages established in mg. If any units are denied, the provider may dispute the decision through the appropriate process. The provider may submit information, including medical notes showing the patient's body weight, that substantiates the medical necessity of the additional units.

Rule number	SC191
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	General limitations for HCPCS code J2350 – Injection, ocrelizumab, 1 mg

Code editing rule
We limit reimbursement of charges for HCPCS code J2350 to claims submitted with a diagnosis of relapsing or primary progressive multiple sclerosis for patients who are 18 or older.

Additionally, we limit reimbursement for HCPCS code J2350 to no more than:

- 600 units per date of service
- 600 units per month
- 1,200 units in six months
- One visit every two weeks
- Two visits per month
- Three visits every six months

Why we apply this rule
According to the FDA-approved package insert and prescribing information and the pharmaceutical compendia, ocrelizumab, 1 mg, is appropriate only for the indication and the quantity/frequencies above.

Rule number	SC192
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	Infliximab and biosimilars

Code editing rule
We limit reimbursement of charges for infliximab and its biosimilars to no more than:

- 41 units per date of service when the diagnosis on the claim is rheumatoid arthritis and infliximab or one of its biosimilars has not been billed in the previous 14 weeks.
- 75 units per date of service and the diagnosis is juvenile idiopathic arthritis.
- 119 units per date of service when the diagnosis is one of the following:
  - Adult-onset Still's disease
  - Ankylosing spondylitis (adult)
  - Granulomatosis with polyangiitis (Wegner's granulomatosis)
  - Hidradenitis suppurativa
  - Immune checkpoint inhibitor-related toxicity
  - Plaque psoriasis
  - Psoriatic arthritis
  - SAPHO syndrome
  - Sarcoidosis
- 125 units per date of service when billed with any of the following diagnoses
  - Acute graft-versus-host disease following peripheral blood stem cell transplantation
  - Aortic arch syndrome (Takayasu's disease)
  - Behcet's syndrome
  - Mucocutaneous lymph node syndrome (Kawasaki disease)
  - Pyoderma gangrenosum associated with inflammatory bowel disease
  - Reactive arthropathy
  - Regional enteritis (Crohn's disease - adult)
  - Ulcerative colitis (adult or pediatric)
  - Uveitis
- One injection per week if the diagnosis is acute graft-versus-host disease following peripheral blood stem cell transplantation.
- One injection every two weeks for any of the following diagnoses:
  - Adult-onset Still's disease
  - Ankylosing spondylitis (adult)
  - Behcet's syndrome
  - Granulomatosis with polyangiitis (Wegener's granulomatosis)

- Hidradenitis suppurativa
- Immune checkpoint inhibitor-related toxicity
- Juvenile idiopathic arthritis
- Plaque psoriasis
- Psoriatic arthritis
- Pyoderma gangrenosum associated with inflammatory bowel disease
- Reactive arthropathy
- Regional enteritis (Crohn's disease - adult or pediatric)
- Rheumatoid arthritis
- SAPHO syndrome
- Sarcoidosis
- Synovitis in rheumatoid arthritis
- Ulcerative colitis (adult or pediatric)
- Uveitis

- Four visits every 26 weeks and the diagnosis on the claim is acute graft-versus-host disease following peripheral blood stem cell transplantation or hidradenitis suppurativa
- Seven visits every 26 weeks and the diagnosis is aortic arch syndrome (Takayasu's disease)
- Nine units per date of service when submitted with modifier JW, drug amount discarded/not administered to any patient

Additionally, we do not reimburse charges for infliximab or any of its biosimilars in any of the following situations:

- If billed with a diagnosis of pyoderma gangrenosum unless an additional diagnosis of either regional enteritis (Crohn's disease - adult or pediatric) or ulcerative colitis (adult or pediatric) is also present on the claim
- For patients younger than 3 years if billed with a diagnosis of either ankylosing spondylitis or juvenile idiopathic arthritis
- For patients younger than 17 when billed with a diagnosis of aortic arch syndrome (Takayasu's disease)
- If a live vaccine has been billed for the same date of service

Why we apply this rule
The limitations above were established by the FDA-approved package insert and prescribing information and the pharmaceutical compendia.

Notes: The limitations described above are based on maximum dosages established in mg. If any units are denied, the provider may dispute the decision through the appropriate process. The provider may submit information, including medical notes showing the patient's body weight, that substantiates the medical necessity of the additional units.

For additional information on drug wastage, refer to the Humana claim payment policy page and search by keyword "JW."

Rule number	SC193
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	HCPCS Code J3380 – Injection, vedolizumab, 1 mg

Code editing rule
We limit reimbursement for HCPCS Code J3380 to:

- Patients older than 18 who have a diagnosis of Immune checkpoint inhibitor-related toxicity, regional enteritis (Crohn's disease) or ulcerative colitis
- No more than 300 units per date of service
- No more than one injection every two weeks
- No more than four injections per 26-week period and the diagnosis on the claim is immune checkpoint inhibitor-related toxicity
- No more than five injections per 26-week period and the diagnosis on the claim is regional enteritis (Crohn's disease) or ulcerative colitis

Why we apply this rule
The limitations above are based on the FDA-approved package insert and prescribing information for injection, vedolizumab, 1 mg.

Rule number	SC098
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	Date-of-service unit limitations for HCPCS code J0897, injection, denosumab, 1 mg

Code editing rule
We limit reimbursement for HCPCS code J0897 to no more than 120 units per date of service for the following diagnoses:

Bone metastases
- Giant-cell tumor of bone
- Hypercalcemia of malignancy
- Multiple myeloma

Why we apply this rule
According to the FDA-approved package insert and prescribing information, these limitations are appropriate for denosumab when administered for the conditions above.

Rule number	SC099
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	Diagnosis limitations for rituximab and its biosimilars

Code editing rule
We do not reimburse charges for rituximab and its biosimilars if billed with a diagnosis of:

- AIDS, unless a diagnosis of B-cell lymphoma is not also present
- Malignant ascites, unless a diagnosis of non-Hodgkin's lymphoma (B-cell lymphomas) is also present

Why we apply this rule
The above limitations were established by the FDA-approved package insert and prescribing information and pharmaceutical compendia guidance for rituximab and its biosimilars.

Rule number	SC100
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	Drug wastage for bevacizumab and its biosimilars

Code editing rule
We limit reimbursement for bevacizumab and its biosimilars to no more than 9 units per date of service, if submitted with modifier JW.

Modifier JW is defined a "Drug amount discarded/not administered to any patient."

Why we apply this rule
According to South Carolina Medicaid guidance, the National Correct Coding Initiative and the FDA-approved package insert and prescribing information for bevacizumab, it is inappropriate to report drug wastage in an amount that is greater than the smallest vial size of a drug. The smallest vial size of bevacizumab is 100 mg, which is equal to 10 units.

Note: For additional information, refer to the Humana claims payment policy page and search by keyword "JW."

Rule number	SC101
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	Drug wastage for rituximab and its biosimilars

Code editing rule
We limit reimbursement of charges for rituximab and its biosimilars to no more than 9 units if billed with modifier JW (Drug amount discarded/not administered to any patient)

Why we apply this rule
According to the FDA-approved package insert and prescribing information for rituximab and its biosimilars, and guidance from South Carolina Medicaid agencies, it is inappropriate to bill wastage equal to or in excess of the smallest vial size of a drug or biological agent.

Note: For additional information, refer to the Humana claims payment policy page and search by keyword "JW."

Rule number	SC102
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	Frequency limitation for HCPCS code J9299 – Injection, nivolumab, 1 mg

Code editing rule
We limit reimbursement of charges for HCPCS code J9299 to no more than once every two weeks if billed with the following diagnoses:

- Anal carcinoma
- Gestational trophoblastic neoplasia
- Head and neck cancer
- Hepatocellular carcinoma
- Hodgkin's lymphoma (classical)
- Malignant pleural mesothelioma
- Melanoma
- Merkel cell carcinoma
- Microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) cancer
- Non-small-cell lung cancer
- Renal-cell carcinoma

- Small-cell lung cancer
- Urothelial carcinoma

Why we apply this rule
According to the FDA-approved package insert and prescribing information and the pharmaceutical compendia, nivolumab, 1 mg, should be administered no more than once in a two-week period for the indications listed above.

Rule number	SC103
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	Frequency limitations for HCPCS code J0897, injection, denosumab, 1 mg

Code editing rule
We limit reimbursement for HCPCS code J0897 to the following:

- One injection per week or four injections per month for a diagnosis of giant-cell tumor of bone or hypercalcemia of malignancy
- One injection per month for a diagnosis of bone metastases or multiple myeloma
- One injection per six months for a diagnosis of intolerance to other osteoporosis therapy, osteoporosis in men, postmenopausal osteoporosis treatment, postmenopausal women receiving aromatase inhibitor therapy for early breast cancer or prostate cancer patients receiving androgen deprivation therapy

Why we apply this rule
According to the FDA-approved package insert and prescribing information, the frequencies listed above are not to be exceeded for denosumab.

Rule number	SC104
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	HCPCS code J0897 – Injection, denosumab, 1 mg

Code editing rule
We apply the following reimbursement limitations for HCPCS code J0897:

- If billed for a diagnosis of bone metastases, a diagnosis of primary malignancy also must be present
- If billed with a diagnosis of intolerance to other available osteoporosis therapy, a diagnosis of osteoporosis also must be present
- If billed with a diagnosis of long-term use of aromatase inhibitors and a diagnosis of personal history of breast cancer, a diagnosis of disorder of bone and cartilage also must be present
- If billed with a diagnosis of long-term use of other medications and a diagnosis of personal history of prostate cancer, a diagnosis of disorder of bone and cartilage also must be present

Why we apply this rule
The above limitations are based on the FDA-approved package insert and prescribing information for denosumab, 1mg.

Rule number	SC105
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	HCPCS code J2350 – Injection, ocrelizumab, 1 mg, billed with a live vaccine

Code editing rule
We do not reimburse a charge for a live vaccine if HCPCS code J2350 has been submitted for a date of service within the previous 27 weeks.

Additionally, we do not reimburse charges for HCPCS code J2350 if a live vaccine has been billed on the same date of service or for a date of service within the previous four weeks.

Why we apply this rule
The above limitation has been established by the FDA-approved package insert and prescribing information or the pharmaceutical compendia.

Rule number	SC106
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	HCPCS code J7170 – Injection, emicizumab-kxwh, 0.5 mg

Code editing rule
We do not reimburse charges for HCPCS code J7170 unless billed with a diagnosis of hemophilia A with or without factor VIII inhibitors.

Why we apply this rule
The above limitations were established by the FDA-approved package insert and prescribing information or the pharmaceutical compendia.

Rule number	SC107
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	HCPCS code J9173 – Injection, durvalumab, 10 mg

Code editing rule
We limit reimbursement of charges for HCPCS code J9173 to claims submitted with a diagnosis of non-small-cell lung cancer or urothelial carcinoma.

We also limit reimbursement for HCPCS code J9173 to:

- No more than 125 units per date of service
- No more than one unique visit every two weeks
- No more than 11 units if modifier JW, drug amount discarded/not administered to any patient, is appended
- Patients age 18 or older

Why we apply this rule
The limitations and restrictions described above are based on the FDA-approved package insert and prescribing information for injection, durvalumab, 10 mg.

Note: For additional information, refer to the Humana claims payment policy page and search by keyword "JW."

Rule number	SC108
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	HCPCS code J9299 – Injection, nivolumab, 1 mg

Code editing rule
We do not reimburse charges for HCPCS code J9299 for patients younger 18 if billed with the following diagnoses:

- Anal carcinoma
- Gestational trophoblastic neoplasia
- Head and neck cancer
- Hepatocellular carcinoma
- Hodgkin's lymphoma (classical)
- Malignant pleural mesothelioma
- Melanoma
- Merkel cell carcinoma
- Non-small-cell lung cancer
- Renal-cell carcinoma
- Small-cell lung cancer
- Urothelial carcinoma

Why we apply this rule
According to the FDA-approved package insert and prescribing information and the pharmaceutical compendia, nivolumab, 1 mg, is indicated only for patients 18 and older for the indications listed above.

Rule number	SC109
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	Age limitation for HCPCS code J9299 – Injection, nivolumab, 1 mg, with a diagnosis of microsatellite instability-high (MSI-H) or mismatch repair deficient cancer (dMMR)

Code editing rule
We do not reimburse for HCPCS code J9299 for patients younger than 12 who have a diagnosis of MSI-H or dMMR.

Why we apply this rule
According to the FDA-approved package insert and prescribing information, nivolumab, 1 mg, is indicated only for adult patients and pediatric patients 12 and older for the indication of MSI-H or dMMR.

Rule number	SC110
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	HCPCS code J9299 – Injection, nivolumab, 1 mg, with a diagnosis of microsatellite instability-high (MSI-H) or mismatch repair deficient cancer (dMMR)

Code editing rule
We limit reimbursement for HCPCS code J9299 if billed for a diagnosis of MSI-H or dMMR cancer to claims for patients who have previously received one of the following:

- MSI-H or dMMR testing
- Nivolumab, 1 mg

Why we apply this rule
According to the FDA-approved package insert and prescribing information, nivolumab, 1 mg, should be administered for a diagnosis of MSI-H or dMMR only if previous MSI-H or dMMR testing or the same drug has been administered in the patient's lifetime.

Rule number	SC111
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	HCPCS code J9299 – Injection, nivolumab, 1 mg, wastage

Code editing rule
We do not reimburse for more than 39 units of nivolumab, 1 mg, if submitted with modifier JW, drug amount discarded/not administered to any patient.

Why we apply this rule
According to the FDA-approved package insert and prescribing information and the pharmaceutical compendia, the smallest vial size for nivolumab, 1 mg, is 40 mg, single use (equivalent to 40 units), for IV infusion. It is inappropriate to bill drug wastage that equals or exceeds the size of the smallest single-use vial or package.

Note: For additional information, refer to the Humana claims payment policy page and search by keyword "JW."

Rule number	SC112
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	HCPCS J9308 – Injection, ramucirumab, 5 mg

Code editing rule
We limit reimbursement for HCPCS code J9308 to the following diagnoses:

- Colorectal cancer
- Esophageal cancer
- Esophagogastric junction cancer
- Gastric cancer

Why we apply this rule
The above limitations are based on the FDA-approved package insert and prescribing information for injection, ramucirumab, 5 mg.

Rule number	SC113
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	Injection, bevacizumab and its biosimilars billed after a major surgery

Code editing rule
We limit reimbursement of charges for injection, bevacizumab and its biosimilars, to no more than two units if billed within a month after a major surgery.

Why we apply this rule
This limitation is based on the FDA-approved package insert and prescribing information for bevacizumab and its biosimilars.

Rule number	SC114
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	Intravenous (IV) push chemotherapy when billed with HCPCS J9308 – Injection, ramucirumab, 5 mg

Code editing rule
We do not reimburse a charge for IV push chemotherapy administration when billed with HCPCS J9308.

Why we apply this rule
According to the FDA-approved package insert and prescribing information, injection, ramucirumab, 5 mg, is administered only by IV infusion.

Rule number	SC115
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	Limitations for rituximab and its biosimilars

Code editing rule
We limit reimbursement of charges for rituximab and its biosimilars to no more than:

- Six visits per year for a diagnosis of Hodgkin's lymphoma (nodular lymphocyte-predominant) or rheumatoid arthritis
- Eight visits per year for a diagnosis of Epstein-Barr virus disease prophylaxis in stem-cell transplantation or post-transplant lymphoproliferative disorder (PTLD)
- 15 visits per year and the diagnosis is anti-MAG polyneuropathy
- Six visits in a patient's lifetime and the diagnosis is cryoglobulinemia-induced renal disease or hairy cell leukemia
- Nine visits in a patient's lifetime and the diagnosis is acquired factor VIII deficiency
- 20 visits in a patient's lifetime and the diagnosis is AIDS-related B-cell lymphoma or non-Hodgkin's lymphoma (B-cell lymphomas)

Additionally, we do not reimburse charges for rituximab or its biosimilars if billed on the same date of service as the administration of a live vaccine.

Why we apply this rule
The above limitations were established by the FDA-approved package insert and prescribing information and pharmaceutical compendia guidance for rituximab and its biosimilars.

Rule number	SC116
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	National Drug Code (NDC)

Code editing rule
We do not reimburse a charge for a drug or biological HCPCS code that is:

- Submitted with an invalid National Drug Code (NDC), or
- Submitted with an NDC that is not appropriate to the specific HCPCS Level II code that is submitted

Why we apply this rule
According to state-specific Medicaid guidance, a submitted NDC should be valid and appropriate for the HCPCS code with which it is submitted.

Rule number	SC118
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	Physician-administered drugs National Drug Code (NDC) requirement

Code editing rule
We do not reimburse charges for physician-administered drugs billed on a CMS-1500 claim for or with revenue code 0636 (pharmacy drugs required detailed coding) on a CMS-1450 claim form unless also billed with a NDC number.

Why we apply this rule
According to the South Carolina Medicaid Physicians Services Provider Manual, the Hospital Services Provider Manual and the Pharmacy Services Provider Manual, NDC numbers are required for billing physician-administered drugs.

Rule number	SC119
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	Rituximab and its biosimilars

Code editing rule
We limit reimbursement of charges for rituximab or its biosimilars to no more than:

- 100 units per date of service if billed with a diagnosis of cicatricial pemphigoid, cryoglobulinemia, dermatopolymyositis, Grave's disease ophthalmopathy, immune (idiopathic) thrombocytopenic purpura, lupus nephritis, minimal change disease, neuromyelitis optica, pemphigus foliaceus, pemphigus vulgaris, pre-renal transplant to suppress anti-HLA antibodies, rheumatoid arthritis, Sjogren's syndrome or systemic lupus erythematosus.
- 101 units per date of service if billed with a diagnosis of acquired factor VIII deficiency, acute lymphoblastic leukemia, AIDS-related B-cell lymphoma, ANCA-associated vasculitis, anti-MAG polyneuropathy, autoimmune hemolytic anemia, bullous pemphigoid, Castleman's disease, chronic graft-versus-host disease, cryoglobulinemia-induced renal disease, epidermolysis bullosa acquisita, Epstein-Barr virus disease prophylaxis in stem-cell transplantation, Evan's syndrome, granulomatosis with polyangiitis (Wegener's granulomatosis), hairy cell leukemia, Hodgkin's lymphoma (nodular lymphocyte-predominant), human herpesvirus 8 (HHV-8) infection, immune checkpoint inhibitor-related toxicities, malignant ascites in non-Hodgkin's lymphoma, microscopic polyangiitis, myasthenia gravis, non-Hodgkin's lymphoma (B-cell lymphomas), post-transplant lymphoproliferative disorder (PTLD), primary cutaneous B-cell lymphoma, thrombotic thrombocytopenic purpura or Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma
- 135 units per date of service if billed with a diagnosis of chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) or primary central nervous system lymphoma
- 200 units per date of service if billed with a diagnosis of indication of multiple sclerosis
- 400 units every 26 weeks if billed with a diagnosis of multiple sclerosis

- 405 units every 26 weeks for a diagnosis of bullous pemphigoid, dermatopolymyositis, lupus nephritis, mucous membrane pemphigoid, multifocal motor neuropathy, systemic lupus erythematosus
- 608 units every 26 weeks if billed with a diagnosis of ANCA-associated vasculitis, granulomatosis with polyangiitis (Wegener's granulomatosis) or microscopic polyangiitis.
- 709 units every 26 weeks if billed with a diagnosis of immune checkpoint inhibitor-related toxicity or myasthenia gravis
- 1,114 units every 26 weeks if billed with a diagnosis of AIDS-related B-cell lymphoma, B-cell lymphoma, chronic lymphocytic leukemia (CLL), also known as small lymphocytic lymphoma (SLL)
- 1,620 units every 26 weeks if billed with a diagnosis of primary central nervous system lymphoma
- 600 units per year for a diagnosis of multiple sclerosis
- 816 units per year for a diagnosis of lupus nephritis, minimal change disease or systemic lupus erythematosus
- 612 units within a member's lifetime for a diagnosis of immune (idiopathic) thrombocytopenic purpura or myasthenia gravis
- 1,114 units within a member's lifetime for a diagnosis of pemphigus vulgaris

We also do not reimburse charges for rituximab or its biosimilars if billed with a diagnosis of glomerular disorders in diseases classified elsewhere unless a diagnosis of cryoglobulinemia is also present on the claim. Additionally, we do not reimburse charges for rituximab or its biosimilars for patients younger than 18 if submitted with a diagnosis of:

- Multifocal motor neuropathy
- Eosinophilic granulomatosis with polyangiitis (Churg-Strauss)
- Immune checkpoint inhibitor-related toxicity – bullous dermatosis
- Immune checkpoint inhibitor-related toxicity – encephalitis
- Immune checkpoint inhibitor-related toxicity – myasthenia gravis
- Nodular lymphocyte-predominant Hodgkin's lymphoma

Why we apply this rule
The above limitations were established by the FDA-approved package insert and prescribing information and the pharmaceutical compendia.

Note: The limitations described above are based on maximum dosages established in mg. If any units are denied, the provider may dispute the decision through the appropriate process. The provider may submit information, including medical notes showing the patient's body weight, that substantiates the medical necessity of the additional units.

Rule number	SC120
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	Rituximab and biosimilars

Code editing rule
We limit reimbursement of charges for rituximab or its biosimilars as follows:

No more than one injection every week if billed with any of these diagnoses:

- Mucous-membrane pemphigoid
- Multifocal motor neuropathy
- Nephrotic syndrome

One injection every two weeks if billed with a diagnosis of immune checkpoint inhibitor-related toxicity (bullous dermatosis)

One injection every three weeks if billed with any of the following diagnoses:

- Acute lymphoblastic leukemia
- B-cell lymphoma
- Chronic lymphocytic leukemia (CLL, also), as known as small lymphocytic lymphoma (SLL)
- Pediatric aggressive mature B-cell lymphoma
- Primary central nervous system lymphoma
- Primary cutaneous B-cell lymphoma
- Thrombotic thrombocytopenic purpura

Why we apply this rule
The above limitations were established by the FDA-approved package insert and prescribing information and the pharmaceutical compendia.

Note: The limitations described above are based on maximum dosages established in mg. If any units are denied, the provider may dispute the decision through the appropriate process. The provider may submit information, including medical notes showing the patient's body weight, that substantiates the medical necessity of the additional units.

Rule number	SC121
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	Rituximab and its biosimilars for cicatricial pemphigoid

Code editing rule
We limit reimbursement of charges for rituximab and its biosimilars to no more than 400 units in a patient's lifetime for a diagnosis of cicatricial pemphigoid.

Why we apply this rule
The above limitations were established by the FDA-approved package insert and prescribing information and the pharmaceutical compendia.

Rule number	SC122
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	HCPCS – Drugs & Biologicals
Topic	Rituximab and its biosimilars for pemphigus foliaceus

Code editing rule
We limit reimbursement of charges for rituximab and its biosimilars to no more than 250 units per year for a diagnosis of pemphigus foliaceus.

Why we apply this rule
The above limitation was established by the FDA-approved package insert and prescribing information and pharmaceutical compendia.

Rule number	SC123
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	ICD-10 Coding
Topic	ICD-10 Coding

Code editing rule
We do not reimburse claims submitted with ICD-10 diagnosis codes that are not coded to the highest level of specificity.

Why we apply this rule
According to the ICD-10 Manual, submitted diagnosis codes should reflect the highest level of specificity available.

Rule number	SC124
Applies to	Physician/Healthcare Providers
Category	Incidental
Topic	Charges for services that are considered “incident to” services

Code editing rule
We do not reimburse charges for "incident to" services that are billed with any of the following place-of-service (POS) codes: 02, 19, 21, 22, 23, 24, 26, 31, 34, 41, 42, 51, 52, 53, 56 or 61.

Why we apply this rule
According to South Carolina Medicaid guidance and as supported by CMS policy, it is not appropriate to make separate payment for procedures, including incidental services, that are part of a more comprehensive service. Because "incident to" services are incidental by nature, there is no separate payment for these services when performed in the above places of service.

Rule number	SC125
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Incidental
Topic	HCPCS code J2001 – Injection, lidocaine HCl for intravenous infusion, 10 mg

Code editing rule
We do not reimburse charges for HCPCS code J2001 if for the same date of service as any associated service.

Why we apply this rule
According to the National Correct Coding Initiative Policy Manual and Humana policy, if lidocaine HCl is used as a local anesthetic, it is considered as included with the services rendered at the same time.

Rule number	SC126
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Incidental
Topic	Separate procedures billed with an associated major procedure

Code editing rule
We do not reimburse charges for separate procedures billed with an associated major procedure.

Why we apply this rule
According to the AMA CPT Manual, separate procedures should not be reported when performed in conjunction with, and related to, a major service.

Rule number	SC127
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Incidental
Topic	Supplies and equipment billed with therapeutic, prophylactic or diagnostic injections or infusions

Code editing rule
We do not reimburse charges for supplies or equipment billed by a provider who has also submitted charges for a therapeutic, prophylactic or diagnostic injection or infusion.

Why we apply this rule
According to the AMA CPT Manual and HCPCS Level II Manual, standard tubing, syringes and supplies are included in the payment for infusion and injection services and should not be separately reported.

Rule number	SC128
Applies to	Physician/Healthcare Providers
Category	Incidental
Topic	Supplies billed on the same date as a global service

Code editing rule
We do not reimburse charges for supplies billed the same date of service as a 0-day or 30-day medical or surgical procedure.

Why we apply this rule
According to South Carolina Medicaid guidelines and as supported by CMS policy, the practice expense for these procedures includes payment for associated supplies. Therefore, it is inappropriate to report separate charges for supplies on the same date as a 0, 30-day medical or surgical procedure.

Rule number	SC129
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Incidental
Topic	Urinalysis, creatinine, spectrophotometry or pH; body fluid

Code editing rule
We do not reimburse charges for the following services if billed with presumptive or definitive drug testing:

- CPT codes 81000, 81001, 81002, 81003 or 81005 – Urinalysis services
- CPT code 82570 – Creatinine
- CPT code 83986 – pH; body fluid
- CPT code 84311 – Spectrophotometry

Why we apply this rule
According to NCCI guidance and as supported by CMS policy, providers should not separately report charges for validity testing performed on urine samples used for drug testing.

Rule number	SC130
Applies to	Physician/Healthcare Providers
Category	Modifiers
Topic	10-day or 90-day surgical procedures billed with both modifiers 55 and 78

Code editing rule
We do not reimburse charges for a 10-day or 90-day surgical procedure with both of the following modifiers on the same claim line:

- Modifier 55 – Postoperative management only
- Modifier 78 – Unrelated return to the operating/procedure room by the same physician or other qualified healthcare professional following initial procedure for a related procedure during the postoperative period.

Why we apply this rule
According to modifier definition and as supported by the AMA CPT Manual, it is inappropriate for a procedure to be reported with both of the above modifiers.

Rule number	SC131
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Modifiers
Topic	Anatomical modifiers

Code editing rule
We do not reimburse charges for procedures that require an anatomical modifier if the requisite anatomical modifier is not present. Additionally, we do not reimburse charges for procedures that are billed with an inappropriate anatomical modifier.

Why we apply this rule
According to guidelines established by the AMA CPT Manual and as supported by the CMS HCPCS Level II Manual, it is appropriate to use anatomical modifiers to identify the anatomical region on which a procedure was performed. Anatomical modifiers also must be used appropriately; claims submitted with inappropriate usage will not be reimbursed. For example, modifier E4, an eyelid modifier, when used in conjunction with a colonoscopy, is not appropriate and will not be reimbursed.

Rule number	SC132
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Modifiers
Topic	Anesthesia services billed with a distinct services modifier

Code editing rule
We do not reimburse anesthesia services billed with a distinct services modifier.

Why we apply this rule
According to the AMA CPT Manual, a distinct services modifier should not be reported with a service for which the modifier is not appropriate.

Rule number	SC133
Applies to	Physician/Healthcare Providers
Category	Modifiers
Topic	Anesthesia services billed with modifier 47

Code editing rule
We do not reimburse for anesthesia services appended with modifier 47, anesthesia by surgeon.

Why we apply this rule
According to the AMA CPT Manual, modifier 47 should not be used when billing anesthesia services.

Rule number	SC134
Applies to	Physician/Healthcare Providers
Category	Modifiers
Topic	Assistant surgeon service submitted by a nonphysician

Code editing rule
We do not reimburse charges submitted by a nonphysician if the charges include any of the following modifiers:

- Modifier 80 – Assistant surgeon
- Modifier 81 – Minimum assistant surgeon
- Modifier 82 – Assistant surgeon (when qualified assistant surgeon not available)

Why we apply this rule
According to guidance from the AMA CPT Manual, it is inappropriate to report assistant surgeon services performed by nonphysician practitioners with any of the above modifiers.

Rule number	SC135
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Modifiers
Topic	Claims appended with both modifiers 26 and TC

Code editing rule
We do not reimburse claim lines appended with both modifier 26, professional component, and TC, technical component.

Why we apply this rule
Based on AMA guidance, it is inappropriate for a single claim line to be appended with both of the above modifiers.

Rule number	SC136
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Modifiers
Topic	Claims submitted with modifier 59 and modifier XE, XP, XS or XU

Code editing rule
We do not reimburse claims submitted with modifier 59, distinct procedural service, if any of the following modifiers are present:

- Modifier XE – Separate encounter, a service that is distinct because it occurred during a separate encounter

- Modifier XP – Separate structure, a service that is distinct because it was performed on a separate organ or structure
- Modifier XS – Separate practitioner, a service that is distinct because it was performed by a different practitioner
- Modifier XU – Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service

Why we apply this rule
According Humana policy and as supported by modifier definitions and CMS guidance, modifiers XE, XP, XS and XU are more descriptive versions of modifier 59. Therefore, it is inappropriate for one claim line to have both modifier 59 and an XE, XP, XS or XU modifier appended.

Note: For additional information, refer to the Humana claims payment policies and search by title "Modifiers X{EPSU}."

Rule number	SC137
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Modifiers
Topic	Discontinued services in an outpatient setting

Code editing rule
We do not reimburse charges for services billed with modifier 53, discontinued service, in any of the following places of service or bill types:

Place of service codes:
- 19 – Outpatient hospital – off campus
- 22 – Outpatient hospital – on campus
- 24 – Ambulatory surgical center

Type of bill codes:
- 0120 – 012Z – Inpatient part B
- 0130 – 013Z – Outpatient hospital
- 0140 – 014Z – Outpatient hospital – other
- 0830 – 083Z – Ambulatory surgical center

Why we apply this rule
According to South Carolina Medicaid guidance and as supported CMS policy, discontinued services appended with modifier 53 are not appropriate in the above places of service or with the bill types above.

Rule number	SC138
Applies to	Physician/Healthcare Providers
Category	Modifiers
Topic	Evaluation and management (E/M) services billed with modifier 25

Code editing rule
We limit reimbursement of charges for E/M service procedure codes appended with modifier 25 to no more than one unit of the same E/M service procedure code per date of service.

Modifier 25 is defined as a significant, separately identifiable evaluation and management service by the same physician or other qualified healthcare professional on the same day of the procedure or other service.

Why we apply this rule
According to the AMA CPT Manual, modifier 25 is used to report a separately identifiable E/M service performed on the same date of service. It is inappropriate to report services with this modifier more than once on a given date.

Rule number	SC139
Applies to	Physician/Healthcare Providers
Category	Modifiers
Topic	Global maternity delivery services submitted with an assistant surgeon modifier

Code editing rule
We do not reimburse charges for global maternity delivery services if any of the following modifiers are appended to the claim line:

- Modifier 80 – Assistant surgeon
- Modifier 81 – Minimum assistant surgeon
- Modifier 82 – Assistant surgeon (when qualified resident surgeon is not available)
- Modifier AS – Physician assistant, nurse practitioner or clinical nurse specialist services for assistant at surgery

Why we apply this rule
A global maternity delivery service can be submitted only by a sole practitioner or group that provided a full package of maternity care, and it always includes antepartum care, delivery and postpartum care. Because a global maternity delivery service is a full package, it is inappropriate to use a global maternity delivery service code to bill for anything less than a full global maternity package, such as using a modifier to indicate that the submitting practitioner assisted the primarily responsible practitioner.

Rule number	SC140
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Modifiers
Topic	Global procedures and modifier TC

Code editing rule
We do not reimburse charges for a global procedure if charges for the same procedure have already been paid for the same service with modifier TC.

Why we apply this rule
According to guidance from the American Academy of Professional Coders, a global service includes both the professional and technical components of a single service. Therefore, it is inappropriate to report modifier TC if the code has already been billed and paid for the global service.

Rule number	SC141
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Modifiers
Topic	Inappropriate modifier usage

Code editing rule
We do not reimburse charges for services, items or procedures that are appended with a modifier that is not used appropriately.

Why we apply this rule
According to guidance from the HCPCS Level II Manual and as supported by CMS guidelines, it is inappropriate to bill modifiers with procedures that do not match the intended use of the modifier.

Rule number	SC142
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Modifiers
Topic	Inappropriate use of modifiers 26 or TC

Code editing rule
We do not reimburse charges for claim lines appended with modifier 26, professional component, if the code submitted:

- Is defined as professional component only
- Does not have an associated professional or technical component
- Is defined as technical component only

Additionally, we do not reimburse for claim lines appended with modifier TC, technical component, if the code submitted:

- Is defined as professional component only
- Does not have an associated professional or technical component
- Is a diagnostic test or radiology service performed in an inpatient or outpatient facility setting

Why we apply this rule
According to guidance from the American Academy of Coding Professionals, it is inappropriate to report modifiers 26 or TC in the situations outlined above.

Rule number	SC143
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Modifiers
Topic	Modifier 26 or TC appended to codes for which the professional or technical concept does not apply

Code editing rule
We do not reimburse charges for codes appended with modifier 26, professional component, or modifier TC, technical component, if the professional or technical component concept does not apply.

Why we apply this rule
There are certain procedures for which the professional or technical component concept does not apply. It is inappropriate to bill these procedures with either of the modifiers above.

Rule number	SC144
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Modifiers
Topic	Modifier 92

Code editing rule
We limit reimbursement of services appended with modifier 92 to the following HIV-testing CPT codes: 86701, 86702, 86703 and 87389.

Why we apply this rule
According to the AMA CPT Manual, the codes above are the only appropriate codes for billing with modifier 92.

Rule number	SC145
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Modifiers
Topic	Modifiers 78 and 79

Code editing rule
We do not reimburse charges for claims submitted with modifiers 78 or 79 if the same or a different procedure has not been submitted on the same date of service for a 0-day procedure, or on the same date of service or within the previous 30 days for a code with a 30-day global period.

The modifiers above are defined as:

- Modifier 78 – Unplanned return to the operating/procedure room by the same physician or other qualified healthcare professional following initial procedure for a related procedure during the postoperative period.
- Modifier 79 – Unrelated procedure or service by the same physician or other qualified healthcare professional during the postoperative period.

Why we apply this rule
According to South Carolina Medicaid guidelines and the AMA Coding with Modifiers manual, it is inappropriate to use a modifier indicating that a procedure was performed during the postoperative period of another procedure if no other procedure has been performed.

Rule number	SC146
Applies to	Physician/Healthcare Providers
Category	Modifiers
Topic	Procedures appended with modifiers 56 and 78

Code editing rule
We do not reimburse a charge for a procedure code submitted with both of these modifiers appended:

- Modifier 56 – Preoperative management only
- Modifier 78 – Unplanned return to the operating/procedure room, by the same physician or other qualified healthcare professional, following an initial procedure for a related procedure during the postoperative period

Why we apply this rule
According to modifier definition and as supported by the AMA CPT Manual, it is inappropriate to report both of the above modifiers on the same claim line.

Rule number	SC147
Applies to	Physician/Healthcare Providers
Category	Modifiers
Topic	Professional charges with modifiers 27, 73, 74 or CA

Code editing rule
We do not reimburse charges for the following modifiers if submitted by professional providers:

- Modifier 27 – Multiple outpatient hospital E/M encounters on the same date
- Modifier 73 – Discontinued outpatient procedure prior to anesthesia administration

- Modifier 74 – Discontinued outpatient procedure after anesthesia administration

Why we apply this rule
According to CMS guidance, the modifiers above are appropriate only for facility or ambulatory service centers.

Rule number	SC148
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Modifiers
Topic	Services inappropriately appended with modifier 63, Procedure Performed on Infants less than 4 kg

Code editing rule
We do not reimburse charges for services that are inappropriately appended with modifier 63.

Why we apply this rule
According to its definition, modifier 63 is inappropriate for use on patients who do not fit the listed criteria.

Rule number	SC149
Applies to	Inpatient/Outpatient Facilities
Category	Modifiers
Topic	Services submitted with modifiers PO and PN

Code editing rule
We do not reimburse charges for services billed with both modifier PO, excepted off-campus service, and modifier PN, non-excepted off-campus service.

Why we apply this rule
According to modifier defination, it is inappropriate to report a single claim line with both of these modifiers attached.

Rule number	SC150
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Modifiers
Topic	Vaccines billed with modifier SL, state-supplied vaccine

Code editing rule
We do not reimburse for the following vaccine codes if submitted with modifier SL, state-supplied vaccine:

- CPT codes 90476 – 90750 and 90756
- HCPCS codes J3530, Q2034 – Q2039 and S0195

Why we apply this rule
According to the HCPCS Level II Manual, a vaccine or toxoid provided by the state at no cost is not separately reimbursable.

Rule number	SC151
Applies to	Inpatient/Outpatient Facilities
Category	Outpatient Facility
Topic	Professional component services billed by a facility

Code editing rule
We do not reimburse charges for services billed with modifier 26, professional component, by a facility provider.

Why we apply this rule
According to modifier definition and as supported by CMS guidelines, it is inappropriate for facility services to be billed with a professional service modifier.

Rule number	SC152
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Outpatient Facility
Topic	Professional component procedures billed by a facility

Code editing rule
We limit reimbursement of charges for professional component procedures billed by a facility to claims submitted with a revenue code of 0960 – 0989, professional fees.

Why we apply this rule
According to the Uniform Billing Editor and CMS guidance, the revenue codes above are appropriate for facilities reporting professional component procedures.

Rule number	SC153
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Outpatient Prospective Payment System (OPPS)
Topic	C codes

Code editing rule
We limit reimbursement of charges for HCPCS C codes (supplies, implants, drugs, etc.) to claims submitted with the following bill types:

- 0120 – 012Z: Hospital inpatient Part B
- 0130 – 013Z: Hospital outpatient
- 0140 – 014Z: Hospital other Part B
- 0830 – 083Z: Hospital outpatient (ASC)
- 0850 – 085Z: Critical access hospital

Why we apply this rule
According to the HCPCS Level II Manual and the Outpatient Prospective Payment System (OPPS), C codes can be reported only for facility (technical) services in the bill types listed above.

Rule number	SC154
Applies to	Physician/Healthcare Providers
Category	Outpatient Prospective Payment System (OPPS)
Topic	C codes

Code editing rule
We do not reimburse charges for HCPCS C codes (supplies, implants, drugs, etc.) when submitted on a professional claim type.

Why we apply this rule
According to the HCPCS Level II Manual and the Outpatient Prospective Payment System (OPPS), C codes can be reported only for facility (technical) services.

Rule number	SC155
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Place of Service
Topic	Domiciliary/rest-home evaluation and management (E/M) services place of service limitations

Code editing rule
We limit reimbursement of charges for domiciliary/rest-home E/M service CPT codes 99324 – 99340 to claims billed with one of the following place-of-service codes:

- 13 – Assisted living facility
- 14 – Group home
- 33 – Custodial care facility
- 55 – Residential substance-abuse facility
- 99 – Other place of service

This rule does not apply if E/M codes 99324 – 99328 or 99334 – 99337 are billed with telehealth place-of-service code 02.

Why we apply this rule
The above limitation was established by the AMA CPT Manual code definition and CMS guidance for the above E/M services.

Rule number	SC156
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Place of Service
Topic	Emergency department visit place-of-service limitations

Code editing rule
We limit reimbursement of charges for E/M visits, CPT codes 99281 – 99285 and HCPCS codes G0380 – G0384, to claims billed with emergency department place-of-service code 23.

This rule does not apply if E/M codes 99281 – 99285 are billed with telehealth place-of-service code 02.

Why we apply this rule
The above limitation was established by the AMA CPT Manual code definition and CMS guidance for the above E/M services.

Rule number	SC157
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Place of Service
Topic	Home visit evaluation and management (E/M) place-of-service limitations

Code editing rule
We limit reimbursement of charges for home visit E/M CPT codes 99341 – 99350 to claims submitted with one of the following place-of-service codes:

- 02 – Telehealth
- 12 – Patient's home

Why we apply this rule
The limitations above were established by the AMA CPT Manual code definitions and CMS guidance for the above E/M services.

Rule number	SC158
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Place of Service
Topic	Initial hospital care services, follow-up hospital care services and hospital discharge services place-of-service limitations

Code editing rule
We limit reimbursement of charges for initial hospital care CPT codes 99221 – 99223, follow-up hospital care CPT codes 99231 – 99233 and hospital discharge CPT codes 99238 and 99239 to claims submitted with one of the following place-of-service codes:

- 02 – Telehealth
- 06 – Indian health service provider-based facility
- 08 – Tribal 638 provider-based facility
- 21 – Inpatient hospital
- 25 – Birthing center
- 26 – Military treatment facility
- 34 – Hospice
- 51 – Psychiatric inpatient facility
- 52 – Psychiatric partial hospitalization facility
- 61 – Comprehensive rehab facility

Why we apply this rule
The limitations above were established by the AMA CPT Manual code definitions and CMS guidance for the above E/M services.

Rule number	SC159
Applies to	Physician/Healthcare Providers
Category	Place of Service
Topic	Inpatient neonatal and pediatric critical care and intensive case place-of-service limitations

Code editing rule
We limit reimbursement of charges for E/M services for inpatient neonatal and pediatric critical care CPT codes 99468 – 99476, or initial and continuing intensive care CPT codes 99477 – 99480 to claims billed with one of the following place-of-service codes:

- 02 – Telehealth
- 21 – Inpatient hospital

Why we apply this rule
The above limitation was established by the AMA CPT Manual code definition and CMS guidance for the above E/M services.

Rule number	SC160
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Place of Service
Topic	Interfacility transport physician critical care place-of-service limitations

Code editing rule
We limit reimbursement of charges for interfacility transport physician critical care services, CPT codes 99466 – 99467, to claims billed with place-of-service code 41, ambulance – land or 42, ambulance – air or water.

Why we apply this rule
The above limitation was established by the AMA CPT Manual code definition and CMS guidance for the evaluation and management services above.

Rule number	SC161
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Place of Service
Topic	New and established office/outpatient visit place-of-service limitations

Code editing rule
We limit reimbursement of charges for new and established office/outpatient visit CPT codes 99201 –99205 or 99211 – 99215 to claims submitted with one of the following place-of-service codes:

- 01 – Pharmacy
- 02 – Telehealth
- 03 – School
- 04 – Homeless shelter
- 05 – Indian Health Service freestanding facility
- 06 – Indian Health Service provider-based facility
- 07 – Tribal 638 freestanding facility
- 08 – Tribal 638 provider-based facility
- 09 – Prison/correctional facility
- 11 – Office
- 14 – Group home
- 15 – Mobile unit
- 16 – Temporary lodging
- 17 – Walk-in retail health clinic
- 18 – Place of employment/worksite
- 19 – Outpatient hospital – off campus
- 20 – Urgent care facility
- 22 – Outpatient hospital – on campus
- 23 – Emergency room
- 24 – Ambulatory surgical center
- 25 – Birthing center
- 26 – Military treatment facility
- 49 – Independent clinic
- 50 – Federally qualified health center
- 53 – Community mental health center
- 57 – Nonresidential substance-abuse treatment facility
- 58 – Nonresidential opioid treatment facility
- 60 – Mass immunization center
- 62 – Comprehensive outpatient rehabilitation facility

- 65 – End-stage renal disease treatment facility
- 71 – State or local public health clinic
- 72 – Rural health clinic
- 99 – Other place of service

Why we apply this rule
The above limitations were established by the AMA CPT Manual code definition and CMS guidance for the above E/M services.

Rule number	SC162
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Place of Service
Topic	Nursing facility evaluation and management place-of-service limitations

Code editing rule
We limit reimbursement of charges for nursing facility E/M services, CPT codes 99304 – 99310, 99315 – 99316 or 99318, to claims billed with one of the following place-of-service codes:

- 31 – Skilled nursing facility
- 32 – Nursing facility
- 34 – Hospice
- 54 – Intermediate care facility/individuals with intellectual disabilities
- 56 – Psychiatric residential treatment facility

This rule does not apply if the nursing facility E/M codes, 99304 – 99310 or 99315 – 99316, are billed with telehealth place-of-service code 02.

Why we apply this rule
The above limitation was established by the AMA CPT Manual code definition and CMS guidance for the above E/M services.

Rule number	SC163
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Place of Service
Topic	Observation services place-of-service limitations

Code editing rule
We limit reimbursement of charges for outpatient observation service CPT codes 99217 – 99220, subsequent observation care CPT codes 99224 – 99226 and observation or inpatient hospital care CPT codes 99234 – 99236 to claims billed with one of the following places of service:

- 02 – Telehealth
- 19 – Outpatient hospital-off campus
- 21 – Inpatient hospital
- 22 – Outpatient hospital
- 23 – Emergency department
- 24 – Ambulatory surgical center
- 25 – Birthing center
- 26 – Military treatment facility
- 51 – Psychiatric inpatient facility
- 52 – Psychiatric partial hospitalization facility

Why we apply this rule
The above limitations were established by the AMA CPT Manual code definition and CMS guidance for the above E/M services.

Rule number	SC164
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Place of Service
Topic	Outpatient consultation services place-of-service limitations

Code editing rule
We do not reimburse charges for outpatient consultation services, CPT codes 99241 – 99245, if submitted with place-of-service 21, inpatient hospital.

Why we apply this rule
The above limitation was established by the AMA CPT Manual code definition and CMS guidance for the above E/M services.

Rule number	SC165
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Place of Service
Topic	Place of service limitations for CPT codes 99288, 99485, 99486 and HCPCS code G0390

Code editing rule
We limit reimbursement of charges for the following codes to claims billed with inpatient hospital place-of-service code 21 or emergency room place-of-service code 23:

- CPT code 99288 – Physician or other qualified healthcare professional direction of emergency medical systems (EMS) emergency care, advanced life support
- CPT code 99485 – Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 months of age or younger, includes two-way communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report; first 30 minutes
- CPT code 99486 – Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 months of age or younger, includes two-way communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)
- HCPCS code G0390 – Trauma response team associated with hospital critical care service

Why we apply this rule
The above limitation was established by the AMA CPT Manual code definition and CMS guidance for the above E/M services.

Rule number	SC166
Applies to	Physician/Healthcare Providers
Category	Place of Service
Topic	Supplies and equipment provided in the facility setting

Code editing rule
We do not reimburse charges for medical surgical supplies and durable medical equipment (DME) if the claim is submitted by professional providers with an inpatient or facility place of service on a CMS-1500 claim form.

Why we apply this rule
Medical and surgical supplies and DME billed in a facility setting are not reimbursable as professional services. The supplies and equipment are typically billed by the facility or a DME supplier.

Rule number	SC167
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Revenue Codes
Topic	Noncovered revenue codes in an outpatient hospital setting

Code editing rule
We do not reimburse charges for revenue codes that are defined by South Carolina Medicaid as not appropriate for the outpatient hospital setting if submitted with bill type 0130 – 013Z, hospital outpatient

Why we apply this rule
According to the South Carolina Medicaid Hospital Services Provider Manual and the Provider Administrative and Billing Manual, revenue codes for services other than those appropriate for outpatient hospital settings are considered noncovered if submitted with bill type 0130 – 013Z.

Rule number	SC168
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Revenue Codes
Topic	Outpatient hospital pharmacy drugs

Code editing rule
When the following service codes are submitted with bill type 0130 – 013Z, we do not reimburse charges unless they are billed with revenue code 0636:

- CPT code 90378 – Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use
- HCPCS code J1050 – Injection, medroxyprogesterone acetate
- HCPCS code – Etonogestrel (contraceptive) implant system

Why we apply this rule
According to the South Carolina Medicaid Hospital Services Provider Manual, the drugs listed above must be reported with revenue code 0636 when provided in the outpatient hospital setting.

Rule number	SC169
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Revenue Codes
Topic	Revenue codes 0450, 0459, 0510 or 0511 billed on the same claim

Code editing rule
We do not reimburse charges for revenue codes 0450, 0459, 0510 or 0511 if billed in combination on the same claim.

The codes listed above are defined as:
- 0450 – Emergency room – general
- 0459 – Emergency room – other
- 0510 – Clinic – general
- 0511 – Clinic – chronic pain center

Why we apply this rule
According to the South Carolina Medicaid Clinic Services Provider Manual Appendix, these revenue codes should never appear in combination on the same claim.

Rule number	SC170
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Revenue Codes
Topic	Revenue combinations billed on the same day

Code editing rule
We do not reimburse charges for the following revenue code combinations if billed on the same date of service:

- 0760 billed with 0762
- 0760 billed with 0769
- 0762 or 0769 billed with 0762 or 0769

The revenue codes listed above are defined as:

- 0760 – Specialty services – general
- 0762 – Specialty services – observation hours
- 0769 – Specialty services – other

Why we apply this rule
According to the South Carolina Medicaid Hospital Services Provider Manual Appendix, these revenue codes cannot be used in combination for the same day.

Rule number	SC171
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Surgery
Topic	Assistant surgeon charges for procedures that are not on the assistant surgeon codes list

Code editing rule
We do not reimburse assistant surgeon charges for procedures that the South Carolina Medicaid agency has not included on its assistant surgeon codes list.

Why we apply this rule
According to guidance from the South Carolina Medicaid agency, it is inappropriate to reimburse charges for assistant surgeon services if the service rendered does not have an assistant surgeon allowed amount.

Rule number	SC172
Applies to	Physician/Healthcare Providers
Category	Surgery
Topic	Assistant surgeon charges for services to which the assistant surgeon concept does not apply

Code editing rule
We do not reimburse assistant surgeon charges for procedures that the South Carolina Medicaid agency has not included on its assistant surgeon codes list.

Why we apply this rule
According to guidance from the South Carolina Medicaid agency, it is inappropriate to reimburse charges for assistant surgeon services if the service rendered does not have an assistant surgeon allowed amount.

Rule number	SC173
Applies to	Physician/Healthcare Providers
Category	Surgery
Topic	Global procedures billed with modifiers 54, 55 or 56

Code editing rule
We do not reimburse a charge for a procedure submitted with any of the following modifiers if any other provider submits a charge for the same global procedure without any of those modifiers:

- Modifier 54 – Surgical care only
- Modifier 55 – Postoperative management only
- Modifier 56 – Preoperative management only

Why we apply this rule
According to modifier definition and as supported by the AMA CPT Manual, it is inappropriate to report charges for a procedure that has already been reported as a global procedure.

Rule number	SC174
Applies to	Inpatient/Outpatient Facilities
Category	Surgery
Topic	High-cost skin substitute application procedures

Code editing rule
We do not reimburse high-cost skin substitute application procedures, CPT codes 15271 – 15278, if billed with any of the following bill types and a qualifying high-cost skin substitute product code has not also been billed:

- 0120 – 012Z: Inpatient hospital Part B
- 0130 – 013Z: Outpatient hospital Part B
- 0140 – 014Z: Outpatient hospital – Other

Why we apply this rule
According to the Uniform Billing Editor, it is inappropriate to perform a high-cost skin substitute application procedure without also providing a high-cost skin substitute product.

Rule number	SC175
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Surgery
Topic	Multiple assistant surgeons

Code editing rule
We do not reimburse charges for the services of more than one assistant surgeon during a single surgical procedure.

Why we apply this rule
According to South Carolina Medicaid guidance and as supported by CMS policy, it is inappropriate for more than one provider to submit assistant surgeon charges for a single procedure.

Rule number	SC176
Applies to	Inpatient/Outpatient Facilities
Category	Surgery
Topic	Skin-substitute procedures and products

Code editing rule
We limit reimbursement of charges for low-cost or high-cost skin-substitute application procedures to claims for which the corresponding skin-substitute product was billed for the same date of service. Additionally, we require that these products be billed with the following bill types:

- 012X Hospital inpatient Part B
- 013X Hospital outpatient
- 014X Hospital other Part B

Why we apply this rule
According to the Uniformed Billing Editor, skin-substitute application procedures should be used only in combination with the corresponding skin-substitute products and should be billed with the above-listed bill types.

Rule number	SC177
Applies to	Physician/Healthcare Providers
Category	Units
Topic	Annual service limitations

Code editing rule
We do not reimburse units in excess of the maximum unit quantity allowed on an annual basis.

Why we apply this rule
Reimbursement for certain procedure codes is limited to a specific quantity on an annual basis by code definition, pharmaceutical guidance, state fee schedules and CMS guidance or by nature of the procedure.

Rule number	SC178
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Units
Topic	Excess units billed with anatomical modifiers

Code editing rule
We do not reimburse charges for more than one unit of a service appended with the following anatomical modifiers:

- E1 – E4
- FA – F9
- TA – T9

Why we apply this rule
According to AMA guidance, it is not appropriate to report more than one unit of a service appended with the above anatomical modifiers.

Rule number	SC179
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Units
Topic	Maximum units

Code editing rule
We do not reimburse units in excess of the maximum unit quantity allowed on a given date of service.

Additionally, we limit certain services to one unit per date of service, regardless of the modifier(s) appended.

Why we apply this rule
Based on code definitions, clinical guidelines and guidance from state and national Medicaid authorities, procedures, services and items are often limited by a maximum-allowable-unit quantity per date of service. Units in excess of the daily allowable quantity for a specific procedure, service or item are denied.

Some services are defined as accounting for either one or multiple procedures at the same site or for the same condition. It is inappropriate for these procedures to be reported at a quantity greater than one per date of service.

Rule number	SC181
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Units
Topic	Maximum units for outpatient facilities

Code editing rule
We do not reimburse charges in excess of the maximum allowed daily unit quantity for a given service.

Why we apply this rule
Based on code definitions, clinical guidelines and guidance from state and national Medicaid authorities, procedures, services and items are often limited by a maximum-allowable-unit quantity per date of service. Units in excess of the daily allowable quantity for a specific procedure, service or item are denied.

Rule number	SC182
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Units
Topic	Maximum units per day for certain obstetrical services

Code editing rule
We do not reimburse charges for more than one unit per date of service for the following obstetrical CPT codes unless a diagnosis of multiple gestation is present: 59000, 59020, 74713, 76802, 76810, 76812, 76814, 76816, 76818, 76819, 76825, 76826, 76827 or 76828.

Additionally, we do not reimburse charges for the following obstetrical CPT codes, unless a diagnosis of multiple gestation is present: 74713, 76802, 76810, 76812 or 76814.

Why we apply this rule
According to code definitions and AMA guidance, it is inappropriate to report these CPT codes in the manner described above unless a diagnosis of multiple gestation is present.

Rule number	SC183
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Units
Topic	Medical nutrition therapy frequency and age limitations

Code editing rule
For members 21 or younger, we apply the following reimbursement limitations on charges for medical nutrition therapy services CPT codes 97802 or 97803:

- No more than two units per day
- No more than 12 units of CPT code 97802 or 97803 per year
- No more than 10 units of CPT code 97803 per year

Why we apply this rule
According to the South Carolina Medicaid Physician's Services Provider Manual, the nutritional counseling program is eligible for children 21 or younger with the above-listed frequency limitations.

Rule number	SC184
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Units
Topic	Ophthalmology services for children

Code editing rule
If billed for patients 20 or younger, we limit reimbursement of charges for ophthalmological services CPT codes 92004 or 92014 to no more than one unit per 365-day period.

Why we apply this rule
According to the South Carolina Medicaid Physicians Services Provider Manual, one complete comprehensive eye exam is covered within a 365-day period for children younger than 21.

Rule number	SC185
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Units
Topic	Partial or fractional units

Code editing rule
We limit reimbursement of charges billed with a fractional or partial unit amount to ambulance mileage charges.

Why we apply this rule
According to guidance from South Carolina's Medicaid agency and as supported by CMS guidance, fractional units are inappropriate for the purpose of billing most medical services and DMEPOS items. Fractional billing is appropriate in certain circumstances when billing for transportation services.