

Edit/Reimbursement Policy	RA Reason Code	Description:	Reimbursement, Billing Requirement or Clinical Review	Pricing Impact	Applies To:
Allow only one anesthesia service to be reimbursed per operative session (exception - add on codes such as additional labor anesthesia)	ANEGL	When more than one anesthesia service is provided during an operative session, payment will be denied for all codes except for the procedure with the highest base units will be allowed. If multiple surgeries are performed during one operative session, the anesthesiologist should report only the anesthesia code that represents the most complex procedure.	Clinical Review/Reimbursement	Will deny payment, provider will need to submit a corrected claim (potentially with notes for clinical review).	Professional
Modifier 50	BILAT OR INMOD	If the service indicates that it is bilateral in nature already, modifier 50 is not appropriate and the claim line will be denied. For bilateral services, only one unit should be billed. For bilateral services with an ASC category, only one unit on one line should be billed and the claim line will be paid at 150% of fee schedule. Note: other reductions, such as multiple procedure reduction, may also apply.	Billing Requirement	Will deny payment, provider will need to submit a corrected claim.	Professional/Facility
Revenue code requires HCPC code	CPTCD	In an outpatient hospital setting, certain revenue codes require that a CPT or HCPC be submitted. These claim lines will be denied if the revenue code is submitted without a CPT or HCPC.	Billing Requirement	Will deny payment, provider will need to submit a corrected claim.	Facility
Diagnosis code listed more than once	DUPDX	A diagnosis code may be listed only once on a claim form.	Billing Requirement	Will deny payment, provider will need to submit a corrected claim.	Professional/Facility
Return to the Operating Room/Modifier 79	FEESC	A patient returns to the operating room for an unrelated procedure during the post operative period of another procedure. These services are identified by the use of modifier 79.	Reimbursement	N/A	Professional
Incidental/Incident To Services	GLOBL or INCTO	Some services are not eligible for separate reimbursement when another service is performed the same day. These services are considered an incidental part of the physician's or facility's charges.	Reimbursement	Will deny global	Professional/Facility
Anesthesia Crosswalk	INACW	The anesthesiology service reported should match the surgical procedure as closely as possible.	Billing Requirement	Will deny payment, provider will need to submit a corrected claim.	Professional
Return to the Operating Room/Modifier 78	MODRD	A patient returns to the operating room for a procedure during the post operative period of another procedure. These services are identified by the use of modifier 78. The procedure will be paid using the intraoperative procedure percentage.	Reimbursement	Will reduce fee schedule	Professional

Multiple Radiology Reduction	RADRD	When more than one technical component of certain radiology services is performed (identified as billed either with no modifier or with the TC modifier in any position), the second service will be reduced by 25% of the fee schedule amount. This reduction also applies to any additional services on the same day. If the facility does not submit with the TC modifier, and contract indicates that technical component only is the underlying assumption of reimbursement, this guideline will apply.	Reimbursement	Will reduce fee schedule	Facility
Diagnosis code not appropriate for admission	UNPDX	Performs clinical match on diagnosis submitted against services rendered. Certain diagnosis codes cannot be used as admission diagnosis for inpatient hospital claims or as a primary diagnosis code.	Clinical Review	Will deny payment, provider will need to submit a corrected claim (potentially with notes for clinical review).	Facility