Code editing rules for the Louisiana Medicaid Program

Humana applies code editing rules to claims submitted for the Louisiana Medicaid Program. 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 claim payment system to align with Centers for Medicare & Medicaid Services (CMS) guidelines, Louisiana Medicaid guidance, correct-coding initiatives, national benchmarks and industry standards. These changes occur throughout the year.

Initial code editing rules for implementation of Louisiana Medicaid Program

Humana will apply the code editing rules listed in this document to Louisiana Medicaid claims submitted to Humana for dates of service beginning Jan. 1, 2023. These code editing rules will be applied the first day the Louisiana Medicaid plan goes in effect.

Code editing rules implemented after Jan. 1, 2023

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

How to submit questions about a specific code editing rule

You can submit questions about code edits through our code-editing questions tool on Availity Essentials.

If you are not registered on Availity Essentials:

1. 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 Essentials administrator to request access.

The rules

Rule number	LA001
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 guidance from CMS, certified registered nurse anesthetists must append an appropriate modifier describing the services rendered.

Rule number	LA002
Applies to	Physician/Healthcare Providers
Category	Anesthesia
Topic	Anesthesiologist and certified registered nurse anesthetist (CRNA) services performed on the same date of service

Code editing rule
We do not reimburse charges for anesthesiologist services billed with modifier AA if an anesthesia service has previously been billed on the same date of service by a CRNA with modifier QZ.

Additionally, we do not reimburse charges for CRNA services billed with modifier QZ if an anesthesia service has previously been billed on the same date of service by an anesthesiologist with modifier AA.

- Modifier AA – Anesthesia services performed personally by anesthesiologist
- Modifier QZ – CRNA service: without medical direction by a physician

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	LA003
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-anesthesiologic 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	LA004
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 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	LA306
Applies to	Inpatient/Outpatient Facility and Physician /Healthcare Providers
Category	Cardiology
Topic	Holter monitors

Code editing rule
We limit reimbursement of charges for external electrocardiographic recording services to once per 48-hour period.

The components of external electrocardiographic recording (scanning analysis with report, recording, and review and interpretation) will not be reimbursed if the comprehensive service representing all components has been billed in the previous 48 hours.

Why we apply this rule
According to the AMA, external electrocardiographic recording service codes are defined as up to 48 hours. Only one external electrocardiographic service code should be billed in any 48-hour period.

Rule number	LA005
Applies to	Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Additional or supplemental diagnosis codes as the principal diagnosis on a claim

Code editing rule
We do not reimburse charges for services billed with a principal diagnosis code that is considered additional or supplementary and not appropriate for use as a principal diagnosis code.

Why we apply this rule
According to guidance from the ICD-10-CM manual, it is inappropriate to report a diagnosis code that is supplemental or additional as the principal or only diagnosis code on a claim.

Rule number	LA006
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	Correct Coding
Topic	Add-on code billing

Code editing rule
We do not reimburse charges for add-on codes if:
- The requisite primary code has not been billed or has been previously denied
- 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 when reported as a stand-alone procedure. Further, add-on codes should not be billed with modifier 51, as they reflect only the intra-operative service and are not subject to further multiple procedure reductions.

Rule number	LA007
Applies to	Physician/Healthcare Providers
Category	Correct Coding
Topic	Add-on codes submitted without a primary code or with a primary code that received an edit

Code editing rule
We do not reimburse charges for add-on codes that are submitted without the requisite primary procedure code having been also properly submitted and processed.

Why we apply this rule
According to guidance from CMS, it is inappropriate to report charges for an add-on code without also reporting charges for its requisite base code.

Rule number	LA008
Applies to	Physician/Healthcare Providers
Category	Correct Coding
Topic	Age limitations for CPT code 99100 – Anesthesia for patient of extreme age, younger than 1 year and older than 70

Code editing rule
We do not reimburse charges for CPT code 99100, if submitted for patients younger than 1 and older than 70.

Why we apply this rule
According to the code definition for CPT code 99100, it is used only to describe anesthesia services rendered to patients younger than 1 or older than 70.

Rule number	LA009
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Age limitations for gene analysis services

Code editing rule
We do not reimburse charges for the following gene analysis codes if billed for patients younger than 19 or older than 70:

- CPT code 81307 – PALB2 (partner and localizer of BRCA2) (e.g., breast and pancreatic cancer) gene analysis; full gene sequence
- CPT code 81308 – PALB2 (partner and localizer of BRCA2) (e.g., breast and pancreatic cancer) gene analysis; known familial variant
- CPT code 81309 – PIK3CA (phosphatidylinositol-4, 5-biphosphate 3-kinase, catalytic subunit alpha) (e.g., colorectal and breast cancer) gene analysis, targeted sequence analysis (e.g., exons 7, 9 and 20)
- HCPCS code G0452 – Molecular pathology procedure; physician interpretation and report

Why we apply this rule
Louisiana Medicaid limits reimbursement for the gene analysis services described above to patients by the ages indicated above.

Rule number	LA010
Applies to	Physician/Healthcare Providers
Category	Correct Coding
Topic	Age limitations for laboratory and radiology services

Code editing rule

We limit reimbursement for charges of vision services to the age ranges and services listed on the Louisiana Medicaid Laboratory & Radiology Fee Schedule.

Why we apply this rule
The Louisiana Medicaid Laboratory & Radiology: (Non-Hospital) Fee Schedule established reimbursement limitations for vision services.

Rule number	LA 011
Applies to	Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Ambulance services

Code editing rule
We do not reimburse charges for ambulance services billed without both an ambulance service code and an ambulance mileage code on the same date of service.

We do not reimburse charges for services billed with revenue code 540 unless an ambulance service code and an ambulance mileage code are also be billed.

Why we apply this rule
According to CMS guidance, ambulance services are reported by indicating both the type of service provided and the distance for which the service was provided.

Rule number	LA012
Applies to	Physician/Healthcare Providers
Category	Correct Coding
Topic	Care management services billed within the postoperative period of a 10-day medical or surgical service

Code editing rule
We do not reimburse care management service CPT codes 99487 – 99490 if billed in the postoperative period of a 10-day medical or surgical service if billed by:

- The same provider
- A different provider with the same Tax Identification Number (TIN) and specialty as the provider who performed the 10-day medical or surgical service

We do not reimburse CPT codes 99487 – 99490 if performed within the postoperative period of a 10-day medical or surgical service by a nonphysician practitioner of the same TIN, regardless of specialty, if:

- The diagnosis is a complication of surgical and medical care or an aftercare diagnosis
- The primary diagnosis is associated with the diagnosis of the 10-day medical or surgical service

Why we apply this rule
According to guidance from Louisiana Medicaid and as supported by CMS, it is inappropriate to separately report a care management service associated with a 10-day medical or surgical service as described above.

Rule number	LA013
Applies to	Physician/Healthcare Providers
Category	Correct Coding
Topic	Care management services performed within the postoperative period of a 90-day medical or surgical service

Code editing rule

We do not reimburse charges for care management service CPT codes 99487 – 99490 if billed in the postoperative period of a 90-day medical or surgical service by:

- The same provider ID
- A different provider with the same TIN and specialty as the provider who performed the 90-day medical or surgical service

We do not reimburse charges for CPT codes 99487 – 99490, performed within the postoperative period of a 90-day medical or surgical service by a nonphysician practitioner of the same TIN, regardless of specialty, if:

- The diagnosis is a complication of surgical and medical care or an aftercare diagnosis
- The primary diagnosis is associated with the diagnosis of the 90-day medical or surgical service.

Why we apply this rule
According to guidance from Louisiana Medicaid and as supported by CMS, it is inappropriate to separately report a care management service associated with a 90-day medical or surgical service as described above.

Rule number	LA014
Applies to	Physician/Healthcare Providers
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 present are invalid or not coded to the highest level of specificity.

Why we apply this rule
According to guidance from the CMS internet-only manuals and the AMA, 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	LA015
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Claim lines with matching elements

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 Identification Number (TIN) or specialty.

We do not reimburse charges for CMS-1450 claim lines submitted with a different claim number than a previous claim but matching the previous claim's lines on all the following elements:

- Date of service
- Subscriber ID
- Dependent ID
- TIN
- 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 CMS guidelines, it is inappropriate to request duplicate payments for services rendered.

Rule number	LA0016
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	Correct Coding
Topic	Claims submitted with diagnosis codes that are not coded to the highest level of specificity

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, diagnosis codes submitted for reimbursement should reflect the highest level of specificity available.

Rule number	LA017
Applies to	Physician/Healthcare Providers
Category	Correct Coding
Topic	Claims with matching elements

Code editing rule
We do not reimburse a claim line on a subsequent claim that matches all the following elements on a previously submitted claim line:

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

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 TIN and one of the following specialties:

- Miscellaneous
- Multispecialty group
- Miscellaneous facility

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

Rule number	LA018
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Claims with matching elements

Code editing rule

We do not reimburse charges for the same codes when billed for the same date of service, same bill type, same submitted units and allowed amount and by the same NPI, regardless of Tax ID or provider ID.

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

Rule number	LA019
Applies to	Physician/Healthcare Providers
Category	Correct Coding
Topic	CPT code 96376 – Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure)

Code editing rule
We do not reimburse charges for CPT code 96376 if reported by professional providers.

Why we apply this rule

According to CMS guidance and as supported by the Louisiana Medicaid agency, it is inappropriate for professional providers to report services with the facility service code above.

Rule number	LA308
Applies to	Inpatient/Outpatient Facility and Physician /Healthcare Providers
Category	Correct Coding
Topic	CPT add-on codes without primary procedure code

Code editing rule
We do not reimburse add-on codes if submitted without an appropriate primary procedure code.

Why we apply this rule
The AMA advises that add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code.

Rule number	LA020
Applies to	Physician/Healthcare Providers
Category	Correct Coding
Topic	Deleted, missing, disabled and invalid HCPCS and CPT code

Code editing rule
We do not reimburse charges for deleted, missing, disabled or invalid HCPCS or CPT codes.

Why we apply this rule
According to CMS and AMA guidance, it is inappropriate to report charges with a HCPCS or CPT code that has been deleted or is missing, disabled or invalid.

Rule number	LA021
Applies to	Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Device-dependent procedure codes

Code editing rule

We do not reimburse charges for procedure codes that require the provision of a device if the code for the required device is not also billed.

Why we apply this rule
Some procedure codes represent services that are provided in conjunction with the provision of a medical device. It is inappropriate to report charges for these services, if the requisite device code is not also reported.

Rule number	LA022
Applies to	Physician/Healthcare Providers
Category	Correct Coding
Topic	Discharge services limitations

Code editing rule
We do not reimburse charges for hospital discharge service CPT codes 99238 – 99239 if either code has been billed for the previous date of service.

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
The limitation above is established based on guidance from the Louisiana Medicaid agency.

Rule number	LA023
Applies to	Physician/Healthcare Providers and Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Duplicate anesthesia claims

Code editing rule
We do not reimburse claims for anesthesia services, regardless of provider, if the claim matches all the following criteria for a previously rendered anesthesia service:
- 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 Medicaid guidelines, it is inappropriate to duplicate payments for services rendered.

Rule number	LA024
Applies to	Physician/Healthcare Providers
Category	Correct Coding
Topic	Evaluation and management (E/M) services billed on the same date as HCPCS code Q0091 – Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory

Code editing rule
We do not reimburse charges for E/M services billed on the same date of service as HCPCS code Q0091.

Why we apply this rule
Out-of-sequence claims involve procedures performed on the same date of service but billed on separate claims at different times. The claim with services that should be bundled is billed prior to billing a claim with a more comprehensive procedure.

Rule number	LA025
Applies to	Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	External cause of morbidity diagnosis codes

Code editing rule
We do not reimburse charges for services that are submitted with an external cause of morbidity diagnosis code in either the principal position or as the only diagnosis code submitted on the claim.

Why we apply this rule
External cause of morbidity codes describe the circumstances that caused an injury or the nature of an injury. According to the ICD-10 CM manual, it is not appropriate to report external cause of morbidity codes as the sole or primary diagnosis code on a claim.

Rule number	LA026
Applies to	Physician/Healthcare Providers
Category	Correct Coding
Topic	Invalid modifiers

Code editing rule
We do not reimburse charges for services that are billed with an invalid modifier.

Why we apply this rule
According to CMS and the AMA CPT manual, it is inappropriate to report charges with a modifier that is invalid.

Rule number	LA027
Applies to	Physician/Healthcare Providers
Category	Correct Coding
Topic	Invalid or deleted diagnosis codes

Code editing rule
We do not reimburse charges for services that are submitted with an invalid or deleted diagnosis code.

Why we apply this rule
According to the ICD-10-CM manual, it is inappropriate to report charges with invalid or deleted diagnosis codes.

Rule number	LA028
Applies to	Physician/Healthcare Providers
Category	Correct Coding
Topic	Invalid or missing place of service codes

Code editing rule
We do not reimburse charges for services that are billed with a missing or invalid place of service code.

Why we apply this rule

According to guidance from CMS and as supported by Louisiana Medicaid regulations, it is inappropriate to report services with a missing or invalid place of service code.

Rule number	LA029
Applies to	Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Invalid patient age

Code editing rule
We do not reimburse charges for services that are billed with a patient age greater than 125 years.

Why we apply this rule
It is inappropriate to report charges with a patient age that is outside of the reported maximum human lifespan.

Rule number	LA030
Applies to	Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Invalid procedure code for date of service billed

Code editing rule
We do not reimburse charges for an incomplete HCPCS or CPT code or for a code that is billed on a date of service for which the code is not valid.

Why we apply this rule
According to CMS guidelines and the American Medical Association, it is inappropriate to report a HCPCS or CPT code on a date of service for which the code reported is invalid. HCPCS and CPT codes are required to be complete and accurate, when reported.

Rule number	LA310
Applies to	Physician/Healthcare Providers
Category	Correct Coding
Topic	Irrigation of implanted venous access device for drug delivery systems

Code editing rule
We do not reimburse charges for the irrigation of implanted venous access device for drug delivery systems if submitted with another service.

Why we apply this rule
According to the AMA, irrigation of implanted venous access device for drug delivery systems should not be reported in conjunction with any other services.

Rule number	LA031
Applies to	Physician/Professional Providers
Category	Correct Coding
Topic	Laboratory claims with matching claim elements

Code editing rule
We do not reimburse 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 Medicaid guidelines, it is inappropriate to duplicate payments for services rendered.

Rule number	LA032
Applies to	Correct Coding
Category	Inpatient/Outpatient Facilities
Topic	Manifestation diagnosis codes

Code editing rule
We do not reimburse charges for services that are submitted with a manifestation diagnosis code in either the principal position or as the only diagnosis code submitted on the claim.

Why we apply this rule
Manifestation diagnosis codes describe the manifestation (signs or symptoms) of an underlying illness or disease, not the illness or disease itself. It is inappropriate for a manifestation diagnosis code to be reported as the principal, or only, diagnosis code on a claim.

Rule number	LA033
Applies to	Inpatient/Outpatient Facilities or Physician/Healthcare Providers
Category	Correct Coding
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	LA034
Applies to	Inpatient/Outpatient Facilities or Physician/Healthcare Providers
Category	Correct Coding
Topic	Matching charges for drugs and biologicals

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

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

Rule number	LA035
Applies to	Inpatient/Outpatient Facilities or Physician/Healthcare Providers

Category	Correct Coding
Topic	Matching claim lines for miscellaneous, not otherwise classified and unlisted HCPCS codes

Code editing rule
We do not reimburse claim lines for miscellaneous, not otherwise classified or unlisted codes for which the following elements are the same:

- Subscriber ID
- Dependent ID
- Date of service
- Procedure code
- Modifier(s)
- Bill type
- Submitted charge amount
- Allowed amount
- Tax ID
- Specialty

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

Rule number	LA036
Applies to	Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Missing date of birth

Code editing rule
We do not reimburse charges for services that are submitted for a patient if the patient's date of birth is missing or invalid.

Why we apply this rule
It is inappropriate to report charges without providing the necessary patient information to process and validate the charges submitted.

Rule number	LA037
Applies to	Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Missing or invalid admission date

Code editing rule
We do not reimburse charges for services that are billed with a missing or invalid admission date or time span.

Why we apply this rule
It is inappropriate to report charges without providing the necessary claim information to process and validate the charges submitted, such as a valid admission date.

Rule number	LA038
Applies to	Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Missing or invalid discharge status codes

Code editing rule
We do not reimburse charges for claims submitted with a missing or invalid discharge status code.

Why we apply this rule
According to CMS guidance, institutional claims are required to be reported with a valid patient discharge status code.

Rule number	LA039
Applies to	Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Missing, null and invalid type of bill codes

Code editing rule
We do not reimburse charges for claims submitted with a type of bill code that is missing, null or invalid.

Why we apply this rule
According to guidance from CMS and the Louisiana Medicaid agency, it is inappropriate to report claims with a missing, invalid or null type of bill code if the service or type of claim requires a valid type of bill claim to process.

Rule number	LA040
Applies to	Physician/Healthcare Providers
Category	Correct Coding
Topic	Multiple gestation delivery

Code editing rule
We do not reimburse charges for multiple gestation deliveries unless a diagnosis from category Z37 is present on the claim.

Why we apply this rule
According to the ICD-10-CM manual, multiple gestation deliveries must be reported with the proper diagnosis code to indicate the nature of the delivery.

Rule number	LA041
Applies to	Inpatient/Outpatient Facilities or Physician/Healthcare Providers
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.

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 NCCI editing, when appropriate.

Why we apply this rule
According to CMS guidelines, NCCI Column II procedure codes are inappropriate when submitted in conjunction with NCCI Column I procedure codes.

Rule number	LA042
Applies to	Physician/Healthcare Providers
Category	Correct Coding
Topic	Non-specific or incomplete diagnosis codes

Code editing rule
We do not reimburse charges for services that are submitted with a non-specific or incomplete diagnosis code.

Why we apply this rule
According to the ICD-10-CM manual, claims should be coded to the highest level of specificity available.

Rule number	LA043
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	Correct Coding
Topic	Procedure and age consistency

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	LA044
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	Correct Coding
Topic	Procedure and age consistency

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	LA045
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	Correct Coding
Topic	Procedure and gender consistency

Code editing rule
We do not reimburse charges for procedures that are not consistent with the patient's gender.

Why we apply this rule
Certain procedure codes, by definition or by nature of the procedure, are limited to one gender. These procedures are appropriate when submitted for a patient whose gender is consistent with the procedure definition.

Rule number	LA046

Applies to	Physician/Healthcare Providers
Category	Correct Coding
Topic	Procedure codes submitted as bilateral and with multiple units

Code editing rule
We do not reimburse more than one charge for the same procedure billed with modifier 50, bilateral procedure performed on both sides of the body.

Why we apply this rule
According to CMS guidance and as supported by the Louisiana Medicaid agency, it is inappropriate to report more than one charge for the same procedure that is performed bilaterally and reported with modifier 50.

Rule number	LA047
Applies to	Physician/Professional Providers
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:

- 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 and CMS guidance, 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	LA048
Applies to	Physician/Professional Providers
Category	Correct Coding
Topic	Prolonged services

Code editing rule
We do not reimburse charges for CPT code 99356 if not billed in an inpatient or observation facility setting

CPT code 99356 is described as, prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient or observation Evaluation and Management service).

Why we apply this rule
According to code definition, it is inappropriate to report prolonged services in the inpatient or facility setting for services that were not performed in the inpatient or facility setting.

Rule number	LA301
Applies to	Inpatient/Outpatient Facility and Physician /Healthcare Providers
Category	Correct Coding
Topic	Prostate specific antigen

Code editing rule
Prostate specific antigen will not be reimbursed when billed for a female patient.

Why we apply this rule
Based on Louisiana Medicare guidelines, this service is reserved for male gender patients.

Rule number	LA051
Applies to	Physician/Professional Providers
Category	Correct Coding
Topic	Services only reimbursed in an inpatient hospital or emergency room setting

Code editing rule
We do not reimburse charges for the following codes if billed with a place of service code other than 21, inpatient hospital, or 23, emergency room:

- 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 limitation above is established based on guidance from the Louisiana Medicaid agency.

Rule number	LA049
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	Correct Coding
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	LA052
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	Correct Coding
Topic	Age limitations for maternity services

Code editing rule
We do not reimburse charges for maternity services if the patient is younger than 10 or older than 60.

Why we apply this rule

According to Louisiana Medicaid guidelines and fee schedule, maternity services are appropriate for patients ages 10 to 60.

Rule number	LA319
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	Correct Coding
Topic	Care management services performed within the postoperative period of a 0-day medical or surgical service

Code editing rule

We do not reimburse charges for CPT codes 99487 – 99490, care management services, if billed in the postoperative period of a 0-day medical or surgical service by:

- The same provider ID
- A different provider with the same Tax Identification Number (TIN) and specialty as the provider who performed the 0-day medical or surgical service

We do not reimburse charges for CPT codes 99487 – 99490, performed within the postoperative period of a 0-day medical or surgical service by a nonphysician practitioner of the same TIN, regardless of specialty, if:

- The diagnosis is a complication of surgical and medical care or an aftercare diagnosis
- The primary diagnosis is associated with the diagnosis of the 0-day medical or surgical service.

Why we apply this rule

According to CMS guidance, it is inappropriate to separately report a care management service associated with a 0-day medical or surgical service as described above.

Rule number	LA053
Applies to	Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Supplementary or additional diagnosis codes

Code editing rule

We do not reimburse charges for services billed with a diagnosis code that is considered secondary, supplementary or additional to another code as the principal or only diagnosis code billed.

Why we apply this rule

According to guidance from the ICD-10-CM manual, it is inappropriate to report a diagnosis code that is supplemental or additional as the principal or only diagnosis code on a claim.

Rule number	LA054
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	Correct Coding
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	LA055
Applies to	Physician/Professional 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
According to guidance from the Louisiana Medicaid agency and as supported by CMS, technical-component-only procedures that are performed in a facility place of service should be reported by the inpatient or outpatient facility in which they were performed.

Rule number	LA056
Applies to	Inpatient/Outpatient Facilities
Category	Correct Coding
Topic	Type of bill frequency digits 2 or 3

Code editing rule
We do not reimburse charges for claims submitted with interim type of bill frequency digits 2 or 3 unless the discharge status code 30, still patient, is also submitted.

Why we apply this rule
According to CMS guidance, if an interim bill type frequency code is billed, the patient discharge status of 30 is used to indicate the patient is still a patient of the facility.

Rule number	LA057
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
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 CMS correct 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	LA300
Applies to	Inpatient/Outpatient Facility and Physician /Healthcare Providers
Category	Correct Coding
Topic	3-D rendering with routine pregnancy diagnosis

Code editing rule

3-D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality with image post-processing under concurrent supervision (either on an independent station or not) will not be reimbursed if submitted with a routine pregnancy diagnosis.

Why we apply this rule
According to the Humana coverage policy for noninvasive prenatal screening, 3-D rendering is not covered as a routine pregnancy ultrasound service.

Rule number	LA058
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	CPT
Topic	Age restrictions for Louisiana Medicaid services

Code editing rule
We do not reimburse charges for services when the patient's age on the date of service is outside of the age criteria listed on any Louisiana Medicaid fee schedule.

Why we apply this rule
According to Louisiana Medicaid guidelines, certain codes have minimum or maximum age restrictions. If the age of the patient on the date of service is outside of the listed age criteria, the service will not be reimbursed.

Rule number	LA059
Applies to	Physician/Professional Providers
Category	CPT
Topic	Audiology services frequency limitation

Code editing rule
We limit reimbursement of charges for the following audiology services to no more than one unit per code within a 180-day period: CPT codes 92552 – 92557, 92563 – 92568 or 92571 – 92584.

Why we apply this rule
The limitation above is established based on guidance from the Louisiana Medicaid agency.

Rule number	LA060
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	CPT
Topic	Chiropractic manipulative treatment age limitations

Code editing rule
We do not reimburse charges for CPT codes 98940 or 98941, chiropractic manipulative treatment, if billed for patients older than 21.

Why we apply this rule
The limitation above is established based on guidance from the Louisiana Medicaid agency.

Rule number	LA061
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	CPT
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 of charges 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	LA316
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	CPT
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 of charges for CPT code 99452 to no more than once in a 14-day period.

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

Rule number	LA062
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	CPT
Topic	Discontinued services in an outpatient setting

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

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

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

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

Rule number	LA063
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	CPT
Topic	Frequency limitation for CPT code 92521 – Evaluation of speech fluency (e.g., stuttering, cluttering)

Code editing rule

We limit reimbursement of charges for CPT code 92521 to no more than one unit within a 180-day period.

Why we apply this rule
According to guidance from the Louisiana Medicaid agency, it is inappropriate to report charges for a speech therapy evaluation more often than once within a 180-day period.

Rule number	LA064
Applies to	Inpatient/Outpatient Facilities
Category	CPT
Topic	Frequency limitation for occupational therapy evaluations

Code editing rule
We limit reimbursement of charges for CPT codes 97165, 97166 and 97167 to no more than one unit of any combination of these services within a 180-day period.

The CPT codes above are defined as:

- 97165 – Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1 – 3 performance deficits (i.e., relating to physical, cognitive or psychosocial skills) that result in activity limitations and/or participation restrictions; and clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s) and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.
- 97166 – Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive or psychosocial history related to current functional performance; An assessment(s) that identifies 3 – 5 performance deficits (i.e., relating to physical, cognitive or psychosocial skills) that result in activity limitations and/or participation restrictions; and clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.
- 97167 – Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (i.e., relating to physical, cognitive or psychosocial skills) that result in activity limitations and/or participation restrictions; and clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.

Why we apply this rule
According to guidance from the Louisiana Medicaid agency, it is inappropriate to report charges for an occupational therapy evaluation more often than once within a 180-day period.

Rule number	LA065
Applies to	Inpatient/Outpatient Facilities
Category	CPT
Topic	Frequency limitation for physical therapy evaluations

Code editing rule
We limit reimbursement of charges for CPT codes 97161, 97162 and 97163 to no more than one unit of any combination of these services within a 180-day period.

The CPT codes above are defined as:

- 97161 – Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1 – 2 elements from any of the following: body structures and functions, activity limitations and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family
- 97162 – Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1 – 2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations and/or participation restrictions; An evolving clinical presentation with changing characteristics; and clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.
- 97163 – Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.

Why we apply this rule
According to guidance from the Louisiana Medicaid agency, it is inappropriate to report charges for a physical therapy evaluation more often than once within a 180-day period.

Rule number	LA066
Applies to	Inpatient/Outpatient Facilities
Category	CPT
Topic	Frequency limitation for speech sound production evaluations

Code editing rule
We limit reimbursement of charges for CPT codes 92522 and 92523 to no more than one unit of either of these services within a 180-day period.

The CPT codes above are defined as:

- 92522 – Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria);
- 92523 – Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)

Why we apply this rule
According to guidance from the Louisiana Medicaid agency, it is inappropriate to report charges for a speech sound production evaluation more often than once within a 180-day period.

Rule number	LA067
Applies to	Inpatient/Outpatient Facilities
Category	CPT
Topic	Items, services and procedures billed before the Food and Drug Administration (FDA) approval date

Code editing rule
We do not reimburse charges for items, services or procedures submitted prior to FDA approval date with the following bill types:

- 0120 – 012Z: Inpatient hospital, part B
- 0130 – 013Z: Outpatient hospital, part B
- 0140 – 014Z: Outpatient hospital, other

Why we apply this rule
According to state-specific Medicaid guidance and FDA guidelines, and as supported by CMS, it is inappropriate to submit charges for an item, service or procedure that is not approved by the FDA.

Rule number	LA068
Applies to	Physician/Professional Providers
Category	CPT
Topic	Limitations for hospital evaluation and management (E/M) services

Code editing rule
We limit any combination of the following hospital E/M services to no more than one unit per date of service, if submitted by providers of the same specialty and sub-specialty:

- 99221 – 99223 – Initial hospital care codes
- 99231 – 99233 – Subsequent hospital care codes
- 99238 – 99239 – Hospital discharge day management codes

Why we apply this rule
The limitation above is established based on guidance from the Louisiana Medicaid agency.

Rule number	LA069
Applies to	Physician/Professional Providers
Category	CPT
Topic	Limitations for implantable tissue markers and radiation dosimeter

Code editing rule
We limit reimbursement of charges for HCPCS code A4648, tissue marker, implantable, any type, and HCPCS code A4650, implantable radiation dosimeter, each to claims for patients who have also had one of the following services billed on the same date of service:

- CPT codes 10035 and 10036: Placement of soft tissue localization device, percutaneous, including imaging guidance
- CPT codes 19081 – 19086: Biopsy, breast, with placement of breast localization device and imaging of the biopsy specimen, percutaneous, including imaging
- CPT codes 19281 – 19288: Placement of breast localization device, including imaging
- CPT code 19499: Unlisted procedure, breast

- CPT code 32553 – Placement of interstitial device for radiation therapy guidance, percutaneous, intra-thoracic
- CPT code 49411: Placement of interstitial device for radiation therapy guidance, percutaneous, intra-abdominal, intra-pelvic (except prostate) and/or retroperitoneum
- CPT code 55876: Placement of interstitial device for radiation therapy guidance, prostate (via needle, any approach)

Why we apply this rule
The limitation above is established based on guidance from the AMA CPT manual and the Louisiana Medicaid agency.

Rule number	LA070
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	CPT
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.

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 guidance from the American Medical Association, it is inappropriate to report these CPT codes listed above unless a diagnosis of multiple gestation is present.

Rule number	LA071
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	CPT
Topic	Non-reimbursable definitive drug testing

Code editing rule
We do not reimburse charges for the definitive drug testing CPT codes 80320 – 80377.

Why we apply this rule
According to guidance from the Louisiana Medicaid agency, the definitive drug testing services described above are not reimbursable services for the Louisiana Medicaid health plan.

Rule number	LA072
Applies to	Physician/Professional Providers
Category	CPT
Topic	Physician services billed in a non-facility place of service when the same service has been billed by a facility

Code editing rule
We do not reimburse physician services billed in a non-facility place of service if the same service was billed by a facility on the same date of service.

Why we apply this rule

According to Humana policy, it is inappropriate for a professional provider to submit services performed in an outpatient facility with a non-facility place of service code.

Rule number	LA073
Applies to	Physician/Professional Providers
Category	CPT
Topic	Special services, procedures and reports

Code editing rule
We do not reimburse for services provided in an office setting 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).

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 AMA CPT manual code description, these services should be performed only in an office setting. It is inappropriate to report after-hours charges for facilities routinely operating beyond the expected hours of an office facility.

Rule number	LA074
Applies to	Physician/Healthcare Providers
Category	CPT - Evaluation and Management
Topic	Complex care management services billed within the same month as certain other services

Code editing rule
We do not reimburse charges for complex care management services, CPT codes 99487 – 99491, if submitted in the same month as any of the following service types:

- CPT codes 90951 – 90970: End-stage renal disease service codes
- HCPCS codes G0180 – G0182: Physician supervision service codes
- HCPCS code G9678: Oncology Care Model (OCM) Monthly Enhanced Oncology Services (MEOS) payment for OCM-enhanced services. G9678 payments may only be made to OCM practitioners for OCM beneficiaries for the furnishment of enhanced services as defined in the OCM participation agreement

Why we apply this rule
According to guidance from the AMA CPT manual, complex care management services are included in the above service types; therefore, it is inappropriate to separately report charges for complex care management within the same month as any of the above services.

Rule number	LA305
Applies to	Physician/Healthcare Providers
Category	CPT - Evaluation and Management Services
Topic	Correct place of service for evaluation and management (E/M) services

Code editing rule
We do not reimburse E/M services if billed with an inappropriate place of service.

Why we apply this rule

According to CMS, AMA and Humana policies, E/M services can be limited to specific places of service. The descriptions of these codes indicate the appropriate place of service.

Rule number	LA303
Applies to	Physician/Healthcare Providers
Category	CPT-Medicine
Topic	Sequential IV push

Code editing rule
Humana does not reimburse charges for CPT code 96376 if submitted by physicians or healthcare professionals.

CPT code 96376 is defined as, therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure).

Why we apply this rule
According to the AMA, CPT code 96376 can be reported only by facilities. It is inappropriate for this code to be reported by providers in an office-based setting.

Rule number	LA302
Applies to	Inpatient/Outpatient Facility and Physician /Healthcare Providers
Category	CPT-Radiology
Topic	Portable X-Ray equipment

Code editing rule
We do not reimburse charges for the following HCPCS codes if submitted with a place of service other than the patient's place or residence:

- R0070 – Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen
- R0075 – Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen
- Q0092 – Set-up portable X-ray equipment

Why we apply this rule
According to the AMA, the transportation of portable X-ray equipment and personnel to the patient's home or nursing home is not reimbursable if the place of service is not that patient's place of residence.

Rule number	LA050
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Topic	Services included in pediatric critical care transport

Code editing rule
We do not reimburse charges for services that are considered a part of the pediatric critical care transport evaluation and management code 99466.

CPT code 99466 is described 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 guidance from the AMA CPT manual and the Louisiana Medicaid agency, it is inappropriate to separately report certain procedures that are an integral component in the performance of another procedure reported on the same date of service.

Rule number	LA075
Applies to	Physician/Healthcare Providers
Category	CPT - Evaluation and Management
Topic	Evaluation and management services in the global period of a surgical service

Code editing rule
We do not separately reimburse charges for an evaluation and management (E/M) service billed within the global period of a minor or major medical or surgical service, unless supporting information or documentation is provided.

Why we apply this rule
According to CMS guidance and as supported by the Louisiana state Medicaid agency, it is inappropriate for the same provider to report an E/M service during the global period of another service, unless supporting documentation is provided.

Rule number	LA076
Applies to	Physician/Healthcare Providers
Category	CPT - Evaluation and Management
Topic	Multiple evaluation and management services by the same provider

Code editing rule
We limit reimbursement of charges for evaluation and management (E/M) services to no more than one E/M code per date of service, unless supporting information or documentation is provided.

Why we apply this rule
According to CMS guidance and as supported by the Louisiana Medicaid agency, it is inappropriate for the same provider to report more than one E/M service code per date of service, unless supporting documentation is provided.

Rule number	LA077
Applies to	Inpatient/Outpatient Facilities
Category	CPT - Evaluation and Management
Topic	New patient charges for facility visits

Code editing rule
We do not reimburse charges for new patient evaluation and management services, CPT codes 99201 – 99205 and 99381 – 99387, if submitted with type of bill code 013X and the billing facility is one that the patient has seen in the previous 3 years.

Why we apply this rule
According to the AMA CPT manual, a new patient is one who has not received any services from a facility in the previous 3 years. It is inappropriate to report charges for an established patient with new-patient service codes.

Rule number	LA078
Applies to	Inpatient/Outpatient Facilities
Category	CPT - Evaluation and Management
Topic	New patient charges for ophthalmological services

Code editing rule
We do not reimburse charges for the following services if they are submitted with type of bill code 013X and the billing facility is one that the patient has seen in the previous 3 years:

- CPT code 92002 – Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
- CPT code 92004 – Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits

Why we apply this rule
According to the AMA CPT manual, a new patient is one who has not received any services from a facility in the previous 3 years. It is inappropriate to report charges for an established patient with new-patient service codes.

Rule number	LA079
Applies to	Physician/Healthcare Providers
Category	CPT - Evaluation and Management
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 3 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.

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	LA080
Applies to	Physician/Healthcare Providers
Category	CPT – Evaluation and Management
Topic	Technical and professional component billing

Code editing rule
We do not reimburse charges for services billed with modifier 26, professional services, or modifier TC, technical component, if a charge for the global service of the same code has been billed on the same date of service.

Why we apply this rule
According to CMS guidance, it is inappropriate to report a charge for a professional or technical component of a service if a global charge for the same service has been previously reported.

Rule number	LA081
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
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	LA082
Applies to	Physician/Professional Providers
Category	CPT - Evaluation and Management Services
Topic	Consultation codes

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 and 99451: Inter-professional 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	LA083
Applies to	Physician/Professional Providers
Category	CPT - Evaluation and Management Services
Topic	CPT code 99291 – Critical care, evaluation and management of the critically ill or critically injured patient; first 30 to 74 minutes

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

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	LA084
Applies to	Physician/Professional 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 after 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	LA085
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
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 to be utilized to report all services provided to a patient on discharge from outpatient hospital "observation status" if the discharge is on a date 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 is inappropriate to report a discharge service if an admission and discharge service was reported for the previous date of service.

Rule number	LA086
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	CPT - Evaluation and Management Services
Topic	Discharge services billed with initial hospital care

Code editing rule
We do not reimburse charges for 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.

For physician/healthcare 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	LA087
Applies to	Physician/Professional Providers
Category	CPT - Evaluation and Management Services
Topic	Evaluation and management (E/M) or preventive services billed on the same date of service as a 0-day medical or surgical service

Code editing rule
We do not reimburse charges for E/M services or preventive and preventive-like services billed on the same date of service as a 0-day medical or surgical service if billed by:

- The same provider ID, regardless of Tax Identification Number (TIN) and specialty
- A different provider with the same TIN and specialty as the provider who performed the 10-day medical or surgical service

Why we apply this rule
According to CMS guidance, it is inappropriate to separately report E/M services or preventive and preventive-like services that are reported on the same date of service as a 0-day medical or surgical service, as described above.

Rule number	LA088
Applies to	Physician/Professional Providers

Category	CPT - Evaluation and Management Services
Topic	Evaluation and management (E/M) services billed on the same date or within the postoperative period of a 10-day medical or surgical service

Code editing rule
We do not reimburse E/M services performed on the same date of service, or within the postoperative period of a 10-day medical or surgical service, if billed by:

- The same provider ID, regardless of specialty and Tax Identification Number (TIN
- A different provider with the same TIN and specialty as the provider who performed the 10-day medical or surgical service

We do not reimburse E/M services performed within the postoperative period of a 10-day medical or surgical service if billed by a nonphysician practitioner (NPP) of the same TIN, regardless of provider ID or specialty, when the following criteria are met:

- The diagnosis is a complication of surgical and medical care or an aftercare diagnosis
- The primary diagnosis is associated with the 10-day medical or surgical service

Why we apply this rule
According to CMS guidance, it is inappropriate to separately report an evaluation and management service that is associated with a 10-day medical or surgical service, as described above.

Rule number	LA089
Applies to	Physician/Professional Providers
Category	CPT - Evaluation and Management Services
Topic	Evaluation and management (E/M) services billed with modifier 25

Code editing rule
We limit reimbursement of charges for E/M services appended with modifier 25 to one per date of service same provider.

Modifier 25 is defined as, 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	LA090
Applies to	Physician/Professional 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 charges for 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	LA091
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	CPT - Evaluation and Management Services

Topic	Evaluation and management (E/M) services billed with pulse oximetry

Code editing rule
We do not reimburse charges for E/M services if 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 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	LA092
Applies to	Physician/Professional Providers
Category	CPT - Evaluation and Management Services
Topic	Evaluation and management (E/M) services billed within 90-day global period

Code editing rule
We do not reimburse E/M services performed the day before, on the same date of service or within the postoperative period of a 90-day medical or surgical service, if billed by:
- The same provider ID, regardless of specialty and Tax Identification Number (TIN)
- A different provider with the same TIN and specialty as the provider who performed the 90-day medical or surgical service

We do not reimburse E/M services performed within the postoperative period of a 90-day medical or surgical service if billed by a non-physician practitioner (NPP) of the same TIN, regardless of provider ID or specialty, when the following criteria are met:
- The diagnosis is a complication of surgical and medical care or an aftercare diagnosis
- The primary diagnosis is associated with the 90-day medical or surgical service

Why we apply this rule
According to CMS guidance, it is inappropriate to separately report an E/M service that is associated with a 90-day medical or surgical service, as described above.

Rule number	LA093
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	CPT - Evaluation and Management Services
Topic	Evaluation and management (E/M) services with preventive medicine visits

Code editing rule
We do not reimburse charges for problem-oriented E/M services submitted with a preventive medicine E/M service unless the appropriate modifier is appended to define the service as separate.

Why we apply this rule
According to AMA CPT manual coding guidelines, preventive medicine services include insignificant or trivial problems that are encountered during the process of a preventive exam. If a significant or pre-existing problem is addressed, the problem-oriented E/M can be reported separately.

Rule number	LA094
Applies to	Physician/Professional 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 Louisiana Medicaid guidelines, 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	LA095
Applies to	Physician/Professional Providers
Category	CPT - Evaluation and Management Services
Topic	Hospital discharge services

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 when billed in the following places of treatment:

- 19 – Outpatient hospital, off campus
- 21 – Inpatient hospital
- 22 – Outpatient hospital, on campus
- 23 – Emergency department
- 24 – Ambulatory surgical center

Why we apply this rule
According to Louisiana Medicaid guidelines and 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 in the place of treatment listed above.

Rule number	LA096
Applies to	Physician/Professional Providers
Category	CPT - Evaluation and Management Services
Topic	Indirect contact prolonged evaluation and management (E/M) services billed on the same date as hospital discharge services

Code editing rule
We do not reimburse charges for indirect contact prolonged E/M services, CPT code 99358 or 99359, if billed on the same claim and the same date of service as hospital discharge services, CPT codes 99238 – 99239.
The CPT codes above are described as:

- 99238 – Hospital discharge day management; 30 minutes or less
- 99239 – Hospital discharge day management; more than 30 minutes
- 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)

Why we apply this rule

The limitation above is based on guidance from the Louisiana Medicaid agency.

Rule number	LA097
Applies to	Physician/Professional Providers
Category	CPT - Evaluation and Management Services
Topic	Initial neonatal and pediatric critical care services with inpatient critical care services

Code editing rule
We do not reimburse charges for the following initial neonatal and pediatric care 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 critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days to 24 months old
- CPT code 99475 – Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 to 5 years old

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	LA098
Applies to	Physician/Professional 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	LA099
Applies to	Physician/Professional Providers
Category	CPT - Evaluation and Management Services
Topic	Multiple evaluation and management (E/M) services by the same provider group and specialty

Code editing rule
We limit reimbursement of charges for multiple E/M services billed for the same date of service by the same provider group and specialty to one per date of service. In these instances, the visit or visits with the lower relative value unit (RVU) price are not reimbursed.

Why we apply this rule
According to the AMA CPT manual and as supported by CMS, it is inappropriate to report more than one E/M service for the same provider group and specialty on a given date of service.

Rule number	LA100
Applies to	Inpatient/Outpatient Facilities
Category	CPT - Evaluation and Management Services
Topic	Multiple evaluation and management (E/M) services on the same day by an outpatient hospital

Code editing rule
We do not reimburse charges for more than one E/M service submitted with the same revenue code on the same date of service.

Why we apply this rule
According to AMA CPT manual coding guidelines, only one E/M service is allowed per date of service per facility for the same revenue code.

Rule number	LA101
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
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.

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	LA102
Applies to	Physician/Professional Providers
Category	CPT - Evaluation and Management Services
Topic	Neonatal and pediatric critical care services

Code editing rule
We limit reimbursement of charges for neonatal and pediatric critical care CPT service 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	LA103
Applies to	Physician/Professional Providers
Category	CPT - Evaluation and Management Services
Topic	Neonatal intensive care services

Code editing rule
We limit reimbursement of charges for neonatal intensive care CPT service 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	LA104
Applies to	Physician/Professional 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 included in the following CPT codes:

- 99291 – Critical care, evaluation and management of the critically ill or critically injured patient; first 30 to 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 old or younger; first 30 to 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 old 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	LA105
Applies to	Physician/Professional Providers
Category	CPT – Medicine
Topic	Age limitation for certain injectable medications

Code editing rule
We do not reimburse charges for certain injectable drugs if submitted for a patient who is younger than 18.

Why we apply this rule
According to guidance from the Louisiana Medicaid agency, it is inappropriate to report charges for certain injectable drugs for patients who are younger than 18.

Rule number	LA106
Applies to	Physician/Healthcare Providers
Category	CPT – Medicine
Topic	Behavioral health integration services billed with psychiatric collaborative care services

Code editing rule
We limit reimbursement of the following services to no more than one unit, regardless of which service category the service falls under, per month:

Behavioral health integration care management services:

- CPT code 99484 – Care management services for behavioral health conditions, 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: initial assessment or follow-up monitoring, including the use of applicable validated rating scales, behavioral healthcare planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes, facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation, and continuity of care with a designated member of the care team.

Psychiatric collaborative care management services:

- CPT code 99492 – Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral healthcare manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified healthcare professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified healthcare professional, initial assessment of the patient, including administration of validated rating scales,

with the development of an individualized treatment plan, review by the psychiatric consultant with modifications of the plan if recommended, entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant, and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies.

- CPT code 99493 – Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral healthcare manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified healthcare professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation, participation in weekly caseload consultation with the psychiatric consultant, ongoing collaboration with and coordination of the patient's mental healthcare with the treating physician or other qualified healthcare professional and any other treating mental health providers, additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant, provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies, monitoring of patient outcomes using validated rating scales, and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.

Why we apply this rule

According to CMS guidance and as supported by Louisiana Medicaid regulations, it is inappropriate to report charges for psychiatric collaborative care management services and behavioral health integration care management services in the same month.

Rule number	LA107
Applies to	Physician/Healthcare Providers
Category	CPT - Medicine
Topic	Home health services age limitations

Code editing rule

We limit reimbursement of charges for following home health service codes to members ages 0 – 20:

- HCPCS code G0299 submitted with modifier TT, U2 or U3
- HCPCS code G0300 submitted with modifier TT, U2 or U3
- HCPCS code S9123 or S9124submitted without a modifier or with modifiers TG, TN, TT, TV, UH or UJ

The codes and modifiers listed above are defined as:

- G0299 – Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes
- G0300 – Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice setting, each 15 minutes
- S9123 – Nursing care, in the home; by registered nurse, per hour (use for general nursing care only, not to be used when CPT codes 99500 – 99602 can be used)
- S9124 – Nursing care, in the home; by licensed practical nurse, per hour
- TG – High complexity
- TN – Rural, outside area
- TT – Multiple recipients
- TV – Holiday or weekend
- U2 – Second daily visit
- U3 – Third daily visit
- UH – Evening
- UJ –Night

Why we apply this rule

According to the Louisiana Medicaid Home Health Services Fee Schedule, the service and modifier combinations listed above should only be rendered to patients ages 0 – 20.

Rule number	LA108
Applies to	Physician/Healthcare Providers
Category	CPT - Medicine
Topic	CPT code 90650 – Human Papillomavirus vaccine, types 16, 18, bivalent (2vHPV), 3-dose schedule, for intramuscular use

Code editing rule
We limit reimbursement for charges of CPT 90650 to female patients.

Why we apply this rule
According to Louisiana Medicaid Immunization Fee Schedules, CPT 90650 is only reimbursed for females.

Rule number	LA109
Applies to	Physician/Healthcare Providers
Category	CPT - Medicine
Topic	Human papillomavirus vaccine (HPV) age limitations

Code editing rule
If not billed as part of the Vaccines for Children (VFC) program, we apply age limitations to reimbursement for the following HPV vaccines:

- CPT codes 90649 and 90650 are limited to patients ages 19 – 26
- CPT code 90651 is limited to patients ages 19 – 45

These codes are defined as:

- 90649 – HPV vaccine, types 6, 11, 16, 18, quadrivalent (4vHPV), 3-dose schedule, for intramuscular use
- 90650 – HPV vaccine, types 16, 18, bivalent (2vHPV), 3-dose schedule, for intramuscular use
- 90651 – HPV vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 2 or 3 dose schedule, for intramuscular use

Why we apply this rule
According to Louisiana Medicaid Immunization Fee Schedules, MMR vaccines not billed as part of the VFC program should be administered only within the age limits listed above.

Rule number	LA110
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
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	LA111
Applies to	Physician/Healthcare Providers
Category	CPT - Medicine
Topic	Influenza virus vaccine age limitations

Code editing rule
We apply age limitations to reimbursement for the following influenza vaccines:

- CPT code 90654 is limited to patients ages 19 – 64
- CPT code 90672 is limited to patients ages 19 – 49

These codes are defined as:

- 90654 – Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use
- 90672 – Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use

Why we apply this rule
According to Louisiana Medicaid Immunization Fee Schedules, influenza vaccines should be administered only within the age limits listed above.

Rule number	LA112
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	CPT - Medicine
Topic	Limitations for female contraceptives

Code editing rule
We do not reimburse charges for female contraceptive drugs that are submitted for patients younger than 10 or older than 60.

Why we apply this rule
According to guidance from the Louisiana Medicaid agency, it is inappropriate to report charges for certain female contraceptive drugs for patients who are younger than 10 or older than 60.

Rule number	LA113
Applies to	Physician/Healthcare Providers
Category	CPT - Medicine
Topic	Measles, mumps and rubella (MMR) vaccine CPT code 90707 and 90710

Code editing rule
If not billed as part of the Vaccines for Children (VFC) program, we apply age limitations to reimbursement for the following MMR vaccines:

- CPT code 90707 to members ages 19 – 60
- CPT code 90710 to members ages 19 – 20

These codes are defined as:

- 90707 – Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use
- 90710 – Measles, mumps, rubella and varicella vaccine (MMRV), live, for subcutaneous use

Why we apply this rule
According to Louisiana Medicaid Immunization Fee Schedules, MMR vaccines not billed as part of the VFC program should be administered only within the age limits listed above.

Rule number	LA114
Applies to	Physician/Professional Providers
Category	CPT - Medicine
Topic	National Drug Code (NDC) requirement for physician-administered drugs

Code editing rule

We do not reimburse charges for physician-administered drugs that require an NDC code if no NDC code is billed.

Why we apply this rule
The limitation above is established based on guidance from the Louisiana Medicaid agency.

Rule number	LA115
Applies to	Inpatient/Outpatient Facilities
Category	CPT - Medicine
Topic	NDC code requirement for physician-administered drugs billed with revenue code 0636

Code editing rule
We do not reimburse charges for physician-administered drugs that are billed with revenue code 0636 if no NDC code is billed.

Revenue code 0636 is defined as, pharmacy drugs requiring detailed coding.

Why we apply this rule
The limitation above is established based on guidance from the Louisiana Medicaid agency.

Rule number	LA116
Applies to	Physician/Professional Providers
Category	CPT - Medicine
Topic	Personal-care services

Code editing rule
We do not reimburse charges for personal-care services if submitted with either of the following age and modifier combinations:

- Patient is 21 or older and appended with modifier EP
- Patient is younger than 21 and appended with any of the following modifiers: UB, UN or UP

These modifiers are defined as:

- EP – Medicaid early periodic screening program
- UB – Long-term personal care services
- UN – Long-term personal care services shared by two participants

Why we apply this rule
According to Louisiana Medicaid guidelines, personal-care services performed as part of the early periodic screening and diagnosis treatment program are covered from birth through age 20 and are required to append modifier EP. Long-term personal care services are covered for patients 65 or older, or 21 or older with a disability. These services require appending of modifiers UB, UN or UP.

Rule number	LA117
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	CPT - Medicine
Topic	Proton beam treatment

Code editing rule
We do not reimburse charges for proton beam treatment when submitted for patients 21 or older.

Why we apply this rule
According to Louisiana Medicaid guidelines, proton beam treatment is not covered for patients 21 or older.

Rule number	LA118
Applies to	Physician/Healthcare Providers
Category	CPT - Medicine
Topic	Psychiatric collaborative care management

Code editing rule
We do not reimburse charges for initial psychiatric collaborative care management services if billed within six months of another psychiatric collaborative care management service.

We do not reimburse charges for subsequent psychiatric collaborative care management services if billed within the same calendar months as the initial psychiatric collaborative service.

Why we apply this rule
According to the AMA CPT Manual, a new episode of psychiatric collaborative care management starts after a break in episode of six calendar months or more. Also, subsequent psychiatric collaborative care management should not be reported in the same calendar month as the initial service.

Note: As of the date of this notice, we do not cover psychiatric collaborative care management. However, if psychiatric collaborative care management becomes coverable in the future, the following limitation will apply, without further notice.

Rule number	LA119
Applies to	Physician/Healthcare Providers
Category	CPT - Medicine
Topic	Vaccine for Children (VFC) age limitations

Code editing rule
We do not reimburse charges for vaccines submitted under the VFC program for patients 19 and older.

Why we apply this rule
These age limitations are set according to the Louisiana Medicaid Immunization Fee Schedule for children and adolescents from birth through age 18.

Rule number	LA120
Applies to	Physician/Healthcare Providers
Category	CPT - Medicine
Topic	Vision services age limitations

Code editing rule
We limit reimbursement for charges of vision services to the age ranges and services listed on the Louisiana Medicaid Vision (Eyewear) Services Fee Schedule.

Why we apply this rule
The above listed limitations are set according to the Louisiana Medicaid Vision (Eyewear) Services fee schedule.

Rule number	LA121
Applies to	Physician/Healthcare Providers
Category	CPT - Medicine
Topic	Age limitations for CPT code 90750 – Zoster (shingles) vaccine (HZV), recombinant, subunit, adjuvanted, for intramuscular use

Code editing rule

We limit reimbursement for charges for CPT code 90750, to patients ages 50 – 99.

Why we apply this rule
According to Louisiana Medicaid Immunization Fee schedule, the Zoster shingles vaccine should be administered only within the age limits listed above.

Rule number	LA122
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	CPT - Radiology
Topic	Imaging agents billed without the associated imaging procedure

Code editing rule
We do not reimburse for imaging agents billed without the correct imaging procedure.

Why we apply this rule
According to the AMA CPT manual and CMS guidance, certain imaging agents are applicable only to certain diagnostic or imaging services. It is inappropriate to bill for these imaging agents without also performing an imaging procedure.

Rule number	LA123
Applies to	Physician/Professional 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 charges for radiology services appended with modifier 26, professional component, if billed with an E/M service in the office.

Why we apply this rule
The professional component is included in the E/M service.

Rule number	LA124
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	CPT - Radiology
Topic	Screening mammography

Code editing rule
We do not reimburse charges for CPT codes 77063 or 77067 if submitted for patients younger than 40.

These CPT codes are defined as:
- 77063 – Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)
- 77067 – Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed

Why we apply this rule
According to Louisiana Medicaid guidelines, a screening mammography or bilateral tomosynthesis is not covered for patients younger than 40.

Rule number	LA125
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers

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	LA126
Applies to	Physician/Healthcare Providers
Category	Diagnosis
Topic	Diagnosis codes submitted in an incorrect position

Code editing rule
We do not reimburse charges for services submitted with a diagnosis code that is required to be the principal or first-listed diagnosis, if that diagnosis code is submitted in a position other than the principal or first-listed position.

Why we apply this rule
According to the ICD-10-CM manual, certain diagnosis codes must be reported in the principal or first-listed position unless there are multiple encounters on the same date of service and the records are combined. It is inappropriate to report charges with these diagnosis codes in a position other than the primary or first-listed position, except in the situation described above.

Rule number	LA127
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	Diagnosis
Topic	ICD-10 billing requirements

Code editing rule
We do not reimburse charges for any service billed with an ICD-9 diagnosis code.

Why we apply this rule
According to Louisiana Medicaid General Information and Administration Provider Manual, claims must use ICD-10 diagnosis codes after Oct. 1, 2015.

ICD-9 codes can be used only for claims with dates of service prior to Oct. 1, 2015.

Rule number	LA128
Applies to	Inpatient/Outpatient Facilities
Category	Diagnosis
Topic	Incomplete or invalid diagnosis codes

Code editing rule
We do not reimburse charges for services that are submitted with an incomplete or invalid diagnosis code.

Why we apply this rule
According to guidance from CMS and as supported by the ICD-10-CM manual, it is inappropriate to report services with an incomplete or invalid diagnosis code.

Rule number	LA314
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	Diagnoses
Topic	Manifestation code in the primary, first or principal diagnosis field

Code editing rule
We do not reimburse charges for services submitted with a manifestation code in the primary, first or principal diagnosis field.

Why we apply this rule
According to the AMA ICD-10-CM, when submitting a charge with a manifestation code, the underlying condition must be sequenced first, followed by the manifestation code. A manifestation code cannot be listed as the primary, first-listed, principal diagnosis, or as the only diagnosis on the claim.

Rule number	LA129
Applies to	Inpatient/Outpatient Facilities
Category	HCPCS
Topic	Breast tomosynthesis limitations

Code editing rule
We limit reimbursement of charges for HCPCS code G0279 to claims submitted with the revenue codes 0401, other imaging services diagnostic mammography, or revenue codes 0960 – 0969, professional fees.

HCPCS code G0279 is defined as, diagnostic digital breast tomosynthesis, unilateral or bilateral (list separately in addition to 77065 or 77066).

Why we apply this rule
The above limitation is based on guidance from the Louisiana Medicaid agency and is supported by CMS guidelines.

Rule number	LA130
Applies to	Physician/Healthcare Providers
Category	HCPCS
Topic	Federally qualified health clinic and rural health clinic services billed on professional claims

Code editing rule
We do not reimburse charges for the following federally qualified health clinic (FQHC) and rural health clinic (RHC) HCPCS codes if reported on a professional claim:

- G0071: Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only
- G0466 – G0470: FQHC visits
- G0511: RHC or FQHC only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA or CNM), per calendar month
- G0512: RHC or FQHC only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric COCM services directed by an RHC or FQHC practitioner (physician, NP, PA or CNM) and including services furnished by a behavioral healthcare manager and consultation with a psychiatric consultant, per calendar month
- G2025: Payment for a telehealth distant site service furnished by a RHC or FQHC only

Why we apply this rule
According to CMS guidance, the FQHC and RHC services above are performed in a facility setting and should not be reported on a professional claim.

Rule number	LA131
Applies to	Physician/Healthcare Providers
Category	HCPCS
Topic	Modifier limitations for HCPCS code V2102 – Sphere, single vision, plus or minus 7.12 to plus or minus 20.00d, per lens

Code editing rule
We require charges for HCPCS code V2102 to include one of the following modifiers:
- RT – Right side (used to identify procedures performed on the right side of the body)
- LT – Left side (used to identify procedures performed on the left side of the body)

Why we apply this rule
The limitation above is set in accordance with guidance from CMS and the Louisiana Medicaid agency.

Rule number	LA132
Applies to	Physician/Healthcare Providers
Category	HCPCS
Topic	Observation services billed on a professional claim

Code editing rule
We do not reimburse charges for observation service HCPCS codes G0378 – G0384 or G0463, if billed on a professional claim.

Why we apply this rule
According to CMS guidance, these observation codes are performed in a facility setting and should not be reported on a professional claim.

Rule number	LA133
Applies to	Physician/Healthcare Providers
Category	HCPCS
Topic	Age limitations for multisystemic therapy and assertive community treatment

Code editing rule
We limit reimbursement of charges for the following HCPCS codes to the ages listed below:
- Age 18 and older – HCPCS code H0039: Assertive community treatment, face-to-face, per 15 minutes
- Age 20 and younger – HCPCS code: Multisystemic therapy for juveniles, per 15 minutes

Why we apply this rule
These limitations are based on guidance from the Louisiana Medicaid agency.

Rule number	LA134
Applies to	Inpatient/Outpatient Facilities
Category	HCPCS - DMEPOS
Topic	Durable medical equipment (DME) billed by an inpatient or outpatient facility

Code editing rule
We do not reimburse charges for DME billed by an inpatient or outpatient facility.

Why we apply this rule
According to Louisiana Medicaid provider manual guidelines, it is inappropriate for an inpatient or outpatient facility to submit charges for durable medical equipment.

Rule number	LA135
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - DMEPOS
Topic	HCPCS code A4321 – Therapeutic agent for urinary catheter irrigation

Code editing rule
We do not reimburse charges for HCPCS code A4321.

Why we apply this rule
According to Humana internal review as and supported by Medicare local coverage determinations, HCPCS code A4321 is not reimbursable.

Rule number	LA136
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - DMEPOS
Topic	Non-reimbursable DMEPOS items

Code editing rule
We do not reimburse charges for the following DMEPOS HCPCS codes:
- HCPCS code A9283 ¬– Foot pressure off loading/supportive device, any type, each
- HCPCS code A9285 – Inversion/eversion correction device
- HCPCS code E0446 – Topical oxygen delivery system, not otherwise specified, includes all supplies and accessories

Why we apply this rule
The limitation above is established based guidance from local coverage determinations and the Louisiana Medicaid agency.

Rule number	LA137
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - DMEPOS
Topic	Purchase of oxygen systems

Code editing rule
We do not reimburse charges for the purchase of the following HCPCS codes:
- HCPCS code E0425 – Stationary compressed gas system, purchase; includes regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
- HCPCS code E0435 – Portable liquid oxygen system, purchase; includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing and refill adaptor
- HCPCS code E0440 – Stationary liquid oxygen system, purchase; includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing

Why we apply this rule
This is based on guidance from the Louisiana Medicaid agency and is supported by CMS guidelines.

Rule number	LA138
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - DMEPOS

Topic	Supplies and equipment provided in a facility setting

Code editing rule
We do not reimburse medical surgical supplies and durable medical equipment (DME) when either of the following apply:

- The claim is submitted by professional providers with an inpatient or facility place of service on a CMS-1500 claim form.
- 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
According to Medicaid inpatient and outpatient hospital service coverage regulations, 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	LA139
Applies to	Physician/Professional Providers
Category	HCPCS - DMEPOS
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, 10-day or 90-day medical or surgical procedure.

Why we apply this rule
According to CMS guidance, 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-day, 10-day or 90-day medical or surgical procedure.

Rule number	LA140
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - DMEPOS
Topic	Wheelchair batteries

Code editing rule
We limit reimbursement of charges for wheelchair batteries, HCPCS codes E2359 – E2365, to 2 units within a two-year period.

Why we apply this rule
According to the Medicaid durable medical equipment (DME) fee schedule, the batteries above are limited to 2 units within a two-year period.

Rule number	LA141
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	Age limitations for HCPCS code J0897 – Injection, denosumab, 1 mg

Code editing rule
We limit reimbursement of charges for HCPCS J0897 to patients who are:

- 12 or older, if billed with a diagnosis of giant-cell tumor of bone
- 18 or older, if billed with a diagnosis of bone metastases, glucocorticoid-induced osteoporosis, hypercalcemia of malignancy, intolerance to other available osteoporosis therapy, 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 appropriate when provided to patients as described above.

Rule number	LA142
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	Age limitations for infliximab and its biosimilars

Code editing rule
We do not reimburse charges for infliximab or its biosimilars if the patient is:
- Younger than 3 and the diagnosis on the claim is ankylosing spondylitis (adult) or juvenile idiopathic arthritis
- Younger than 15 and the diagnosis on the claim is aortic arch syndrome (Takayasu's disease)

Why we apply this rule
According to the FDA-approved package insert and prescribing information for infliximab and its biosimilars, the safety and efficacy of infliximab and its biosimilars have not been established in patients in these age groups for these diagnoses.

Rule number	LA143
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	Alpha 1-proteinase inhibitors age limitation

Code editing rule
We do not reimburse charges for alpha 1-proteinase inhibitor (human), 10 mg, if the patient is younger than 18 and the diagnosis on the claim is acute graft-versus-host disease due to complication of hematopoietic cell transplantation or alpha-1 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 alpha 1-proteinase inhibitor has not been established for patients younger than 18 for the indication listed above.

Rule number	LA144
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	Alpha 1-proteinase inhibitors frequency limitation

Code editing rule
We limit reimbursement of charges for alpha 1-proteinase inhibitor (human), 10 mg, to no more than once per week if submitted for a diagnosis of alpha-1 proteinase inhibitor deficiency with clinically evident emphysema.

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	LA145
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers

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 60 units per date of service for the following diagnoses:

- Glucocorticoid-induced osteoporosis
- Intolerance to osteoporosis therapy
- Osteoporosis in men
- Postmenopausal osteoporosis prophylaxis
- Postmenopausal osteoporosis treatment
- Postmenopausal women receiving aromatase inhibitors for early breast cancer
- Prostate cancer patients receiving androgen deprivation therapy
- Systemic mastocytosis

Additionally, we limit reimbursement of charges for HCPCS code J0897 to no more than 120 units per date of service if submitted with any of 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, if administered for the conditions above.

Rule number	LA146
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	Diagnosis limitation for rituximab and its biosimilars

Code editing rule
We do not reimburse charges for rituximab or its biosimilars if billed with a diagnosis of malignant ascites unless a diagnosis of B-cell lymphoma is not also present on the claim.

Why we apply this rule
This is established based on guidance from the AMA CPT manual.

Rule number	LA147
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	Drug wastage of infliximab and its biosimilars

Code editing rule
We limit reimbursement of charges for infliximab and its biosimilars to no more than 9 units per date of service 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 injection, infliximab, 10 mg, the smallest available vial size for this drug is 100 mg, which equates to 10 units of the drug. It is inappropriate for wastage of the drug to meet or exceed its smallest vial size.

Rule number	LA148

Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	Frequency limitation for infliximab and its biosimilars

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

- One visit per week if submitted for a diagnosis of acute graft-versus-host disease following peripheral blood stem cell transplantation.
- One visit every two weeks if submitted for a diagnosis of 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), or uveitis
- Seven visits every 26 weeks if submitted for a diagnosis of aortic arch syndrome (Takayasu's disease)
- Eight visits every 26 weeks and the diagnosis on the claim is granulomatosis with polyangiitis (Wegener's granulomatosis), or Juvenile idiopathic arthritis.

Why we apply this rule
According to the FDA-approved package insert and prescribing information for injection, infliximab and its biosimilars, it is inappropriate to report charges more frequently than listed for the diagnoses above.

Rule number	LA149
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
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:

- Three 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 above frequencies are not to be exceeded for denosumab.

Rule number	LA313
Applies to	Physician/Healthcare Providers
Category	HCPCS-DMEPOS
Topic	HCPCS code A7008 – Large volume nebulizer, disposable, prefilled, used with aerosol compressor

Code editing rule
We do not reimburse charges for HCPCS code A7008.

Why we apply this rule
According to CMS and Humana policies, disposable prefilled nebulizers are not covered under the durable medical equipment (DME) benefit because they are considered convenience items.

Rule number	LA304
Applies to	Inpatient/Outpatient Facility and Physician /Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	HCPCS code C9257 – Injection, bevacizumab, 0.25 mg

Code editing rule
We do not reimburse charges for HCPCS code C9257 unless submitted for an ophthalmic indication.

Why we apply this rule
HCPCS code C9257 represents the form of bevacizumab specific to ophthalmic indications. According to pharmaceutical compendia, injection, bevacizumab, 0.25 mg, should only be administered for ophthalmic indications.

Rule number	LA150
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	HCPCS code J0897 – Injection, denosumab, 1 mg

Code editing rule
We do not reimburse charges for HCPCS code J0897 if billed with a diagnosis of primary malignancy unless a diagnosis of bone metastases (secondary malignant neoplasm of bone and bone marrow) is also submitted.

Why we apply this rule
The above limitations are based on the FDA-approved package insert and prescribing information for denosumab and are supported by Humana policy.

Rule number	LA151
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
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 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 and are supported by Humana policy.

Rule number	LA152
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	HCPCS code J9312 – Injection, rituximab, 10 mg

Code editing rule

We limit reimbursement of HCPCS code J9312 to once in any two-week period if submitted with a diagnosis of Graves' disease ophthalmopathy, pemphigus foliaceus, prerenal transplant to suppress anti-HLA antibodies, rheumatoid arthritis or Sjogren's syndrome.

Why we apply this rule
According to the pharmaceutical compendia, one visit in any two-week period is the recommended frequency for this diagnosis.

Rule number	LA151
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	HCPCS code J0897 – Injection, denosumab, 1 mg

Code editing rule
We apply the following reimbursement limitations of charges for HCPCS code J0897:
- 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 and are supported by Humana policy.

Rule number	LA152
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	HCPCS code J9312 – Injection, rituximab, 10 mg

Code editing rule
We limit reimbursement of charges for HCPCS code J9312 to once in any two-week period if submitted with a diagnosis of Graves' disease ophthalmopathy, pemphigus foliaceus, prerenal transplant to suppress anti-HLA antibodies, rheumatoid arthritis or Sjogren's syndrome.

Why we apply this rule
According to the pharmaceutical compendia, one visit in any two-week period is the recommended frequency for this diagnosis.

Rule number	LA153
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	HCPCS code J9312 – Rituximab, 10 mg injection

Code editing rule
We limit reimbursement of charges for HCPCS code J9312 to 101 units per date of service for the following diagnoses:
- 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
- Evans syndrome
- Granulomatosis with polyangiitis (Wegener's granulomatosis)
- Hairy cell leukemia
- Hodgkin's lymphoma (nodular lymphocyte-predominant)
- Human herpesvirus 8 (HHV-8) infection
- Immune check point 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
- Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma

Why we apply this rule
According to the pharmaceutical compendia, this limitation is appropriate for rituximab, 10 mg, for the conditions listed above.

Rule number	LA154
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	HCPCS code J9312 – Injection, rituximab, 10 mg

Code editing rule
We limit reimbursement of charges for HCPCS code J9312 to 130 units per date of service for a diagnosis of chronic lymphocytic leukemia small lymphoma (CLL or SLL) or primary central nervous system lymphoma.

Why we apply this rule
According to the FDA-approved package insert and pharmaceutical compendia, 130 units of rituximab is the maximum recommended dosage for the indications above.

Rule number	LA155
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	Infliximab and its biosimilars billed with a live vaccine

Code editing rule
We do not reimburse charges for infliximab or its biosimilars if a live vaccine has been administered on the same date of service.

Why we apply this rule

According to the FDA-approved package insert and prescribing information, it is inappropriate to report infliximab and its biosimilars on the same date of service as the administration of a live vaccine.

Rule number	LA156
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	Infliximab and its biosimilars for pyoderma gangrenosum

Code editing rule
We do not reimburse for infliximab and its biosimilars if billed with a diagnosis of pyoderma gangrenosum and at least one of the following diagnoses is not also present:

- Crohn's disease
- Ulcerative colitis

Why we apply this rule
According to the pharmaceutical compendia, it is appropriate to provide infliximab, 10 mg, for a diagnosis of pyoderma gangrenosum only if a diagnosis of Crohn's disease or ulcerative colitis is also present.

Rule number	LA157
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	Infliximab and its biosimilars for rheumatoid arthritis

Code editing rule
We limit reimbursement of charges for infliximab and its biosimilars to no more than 41 units per date of service for a diagnosis of rheumatoid arthritis if infliximab, 10 mg, has not been billed within the previous 14 weeks.

Why we apply this rule
According to the FDA-approved package insert and prescribing information for infliximab, 10 mg, the above unit limitation is appropriate for a diagnosis of rheumatoid arthritis.

Rule number	LA158
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	Age limitations for rituximab, 10 mg

Code editing rule
We do not reimburse charges for injection, rituximab, 10 mg, if billed for patients younger than 18 and the diagnosis on the claim is any of the following:

- AIDS-related B-cell lymphoma
- ANCA-associated vasculitis
- Anti-MAG polyneuropathy
- Bullous pemphigoid
- Castleman's disease
- Chronic lymphocytic leukemia/small lymphocytic lymphoma [CLL/SLL]
- Cicatricial pemphigoid
- Component of Zevalin therapy
- Cryoglobulinemia
- Cryoglobulinemia-induced renal disease
- Epidermolysis bullosa acquisita
- Granulomatosis with polyangiitis [Wegener's granulomatosis]
- Graves’ disease ophthalmopathy, hairy cell leukemia

- Hodgkin's lymphoma [nodular lymphocyte-predominant]
- Human herpes virus 8 (HHV-8) infection
- Immune checkpoint inhibitor-related toxicities
- Leptomeningeal metastases
- Malignant ascites in non-Hodgkin's lymphoma
- Microscopic polyangiitis multiple sclerosis
- Myasthenia gravis
- Neuromyelitis optica
- Non-Hodgkin's lymphoma (B-cell lymphomas)
- Pemphigus foliaceus
- Pemphigus vulgaris
- Pre-renal transplant to suppress anti-HLA antibodies
- Primary central nervous system lymphoma
- Primary cutaneous B-cell lymphoma
- Rheumatoid arthritis
- Sjogren's syndrome Thrombotic thrombocytopenic purpura
- Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma.

Why we apply this rule
According to the FDA-approved package insert and prescribing information, the safety and efficacy of rituximab has not been established in pediatric patients for the diagnoses above.

Rule number	LA159
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	Drug wastage limitations for injection, rituximab, 10 mg

Code editing rule
We do not reimburse charges for more than 10 units of injection, rituximab, 10 mg, if billed with modifier JW, drug amount wasted/not administered to any patient.

Why we apply this rule
According to the FDA-approved package insert and prescribing information for injection, rituximab, 10 mg, the smallest vial size for this drug is 100 mg, which equates to 10 units. It is inappropriate to report more than a whole vial of wastage for a given date of service.

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

Rule number	LA160
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	Frequency limitations for injection, rituximab, 10 mg

Code editing rule
We limit reimbursement of charges for injection, rituximab, 10 mg, to:
- Once every three days for a diagnosis of leptomeningeal metastases or malignant ascites in non-Hodgkin's lymphoma
- Once per week for any of the following diagnoses: 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, chronic lymphocytic leukemia/small lymphocytic lymphoma [CLL/SLL], cicatricial pemphigoid, component of Zevalin therapy, cryoglobulinemia, cryoglobulinemia-induced renal disease, dermatopolymyositis, epidermolysis

bullosa acquisita, Epstein-Barr virus disease prophylaxis in stem cell transplantation, Evans 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, immune (idiopathic) thrombocytopenic purpura, lupus nephritis, microscopic polyangiitis, minimal change disease, multiple sclerosis, myasthenia gravis, neuromyelitis optica, non-Hodgkin's lymphoma (B-cell lymphomas), pemphigus vulgaris, post-transplant lymphoproliferative disorder [PTLD], primary central nervous system lymphoma, primary cutaneous B-cell lymphoma, systemic lupus erythematosus, thrombotic thrombocytopenic purpura or Waldestrom's macroglobulinemia/lyphoplasmacytic lymphoma

Why we apply this rule
According to clinical pharmacology, Micromedex and the FDA-approved package insert and prescribing information, rituximab should not be administered more than the frequencies above for these diagnoses.

Rule number	LA161
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	Injection, rituximab, 10 mg, if billed on the same date as a live vaccine

Code editing rule
We do not reimburse charges for injection, rituximab, 10 mg, if billed on the same date of service as a live vaccine.

Why we apply this rule
According to the FDA-approved package insert and prescribing information, injection, rituximab, 10 mg, should not be administered concurrently with a live vaccine.

Rule number	LA162
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	Injection, rituximab, 10 mg, lifetime frequency limitations

Code editing rule
We limit reimbursement of charges for injection, rituximab, 10 mg, to:
- Six in a patient's lifetime for a diagnosis of cryoglobulinemia-induced renal disease or hairy-cell leukemia
- Nine in a patient's lifetime for a diagnosis of acquired factor VIII deficiency
- 20 in a patient's lifetime for a diagnosis of AIDS-related B-cell lymphoma or non-Hodgkin's lymphoma (B-cell lymphomas)

Why we apply this rule
According to the FDA-approved package insert and prescribing information, rituximab should not be reported at a greater frequency than the above for these diagnoses.

Rule number	LA163
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	Unit limitations for injection, rituximab, 10 mg,

Code editing rule
We limit reimbursement of charges for injection, rituximab, 10 mg, to no more than:
- 100 units per date of service for the following diagnoses: cicatricial pemphigoid, cryoglobulinemia, dermatopolymyositis, Graves' 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
- 200 units per date of service for a diagnosis of Graves' disease ophthalmopathy or multiple sclerosis.

Why we apply this rule
According to the FDA-approved package insert and prescribing information, rituximab should not be reported at a quantity in excess of the above limitations.

Rule number	LA164
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	Diagnosis limitations for rituximab, 10 mg

Code editing rule
We limit reimbursement of charges for injection, rituximab, 10 mg, if billed for a diagnosis of renal tubule-interstitial disorders in diseases classified elsewhere to claims for which a diagnosis of cryoglobulinemia is also present.

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

Rule number	LA312
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - DMEPOS
Topic	Oxygen contents with oxygen system rental

Code editing rule
We do not reimburse portable or stationary oxygen contents if reported within 30 days of an oxygen system rental.

Why we apply this rule
Based on Humana policy and supported by CMS guidelines, portable or stationary oxygen contents are included in the fee for the oxygen system rental.

Rule number	LA165
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	Unit limitations for infliximab and its biosimilars

Code editing rule
We limit reimbursement of charges for infliximab and its biosimilars to no more than:
- 75 units per date of service if billed with a diagnosis of juvenile idiopathic arthritis
- 119 units per date of service if billed with a diagnosis of adult-onset Still's disease, ankylosing spondylitis (adult), granulomatosis with polyangiitis (Wegner's granulomatosis), hidradenitis suppurativa, immune checkpoint inhibitor-related toxicity, SAPHO syndrome or sarcoidosis
- 125 units per date of service if billed with a diagnosis of regional enteritis (Crohn's disease - pediatric) and the patient is younger than 18
- 136 units per date of service if billed with a diagnosis of 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), plaque psoriasis, psoriatic arthritis, pyoderma gangrenosum associated with inflammatory bowel disease, reactive arthropathy, regional enteritis (Crohn's disease - adult), ulcerative colitis (adult or pediatric) or uveitis

- 400 units in 26 weeks if billed with a diagnosis of the claim is juvenile idiopathic arthritis
- 504 units in 26 weeks if billed with a diagnosis of regional enteritis (Crohn's disease - adult) or ulcerative colitis (adult), and the patient is older than 18
- 875 units in 26 weeks by if billed with a diagnosis of Behcet's syndrome, rheumatoid arthritis, synovitis in rheumatoid arthritis or uveitis

Why we apply this rule
According to the FDA-approved package insert and prescribing information for infliximab and its biosimilars, it is inappropriate to report a unit quantity in excess of the limitations above.

Rule number	LA166
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	Unit limitations for rituximab and its biosimilars

Code editing rule
We limit reimbursement of charges for rituximab and its biosimilars to no more than:
- 392 units every 26 weeks by any provider and the diagnosis on the claim is bullous pemphigoid, dermatopolymyositis, lupus nephritis, mucous membrane pemphigoid, multifocal motor neuropathy or systemic lupus erythematosus
- 400 units every 26 weeks by any provider and the diagnosis on the claim is multiple sclerosis
- 608 units every 26 weeks by any provider and the diagnosis on the claim is cryoglobulinemia, cryoglobulinemia-induced renal disease, granulomatosis with polyangiitis (Wegener's granulomatosis), immune (idiopathic) thrombocytopenic purpura, microscopic polyangiitis or neuromyelitis optica
- 686 units every 26 weeks by any provider and the diagnosis on the claim is immune checkpoint inhibitor-related toxicity (myasthenia gravis, myalgia, myositis), or myasthenia gravis
- 912 units every 26 weeks by any provider and the diagnosis on the claim is anti-MAG polyneuropathy
- 1,114 units every 26 weeks by any provider and the diagnosis on the claim is AIDS-related B-cell lymphoma, B-cell lymphoma, chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) or pemphigus vulgaris
- 1,620 units every 26 weeks by any provider and the diagnosis on the claim is primary central nervous system lymphoma or primary cutaneous B-cell lymphoma

Why we apply this rule
According to the FDA-approved package insert and prescribing information for rituximab and its biosimilars, it is inappropriate to report a unit quantity in excess of the limitations above.

Rule number	LA167
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	HCPCS - Drugs & Biologicals
Topic	Weekly unit limitations for HCPCS code J0897 – Injection, denosumab, 1 mg

Code editing rule
We limit reimbursement of charges for HCPCS code J0897 to no more than one visit per week if the diagnosis on the claim is giant cell tumor of bone or hypercalcemia of malignancy.

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

Rule number	LA168
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	Modifiers

Topic	Add-on procedure codes billed with modifier 51

Code editing rule
We do not reimburse charges for add-on codes that are billed with modifier 51, multiple procedures.

Why we apply this rule
According to guidance from Louisiana Medicaid agency and as supported by the modifier definition for modifier 51, it is inappropriate to submit charges for an add-on code with modifier 51.

Rule number	LA169
Applies to	Physician/Healthcare Providers
Category	Modifiers
Topic	Ambulance services modifiers

Code editing rule
We require a valid ambulance modifier to be present if any of the following ambulance transport service HCPCS codes are billed:

- A0425 – Ground mileage, per statute mile
- A0426 – Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1)
- A0427 – Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 – emergency)
- A0428 – Ambulance service, basic life support, nonemergency transport, (BLS)
- A0429 – Ambulance service, basic life support, emergency transport (BLS, emergency)
- A0433 – Advanced life support, level 2 (ALS 2)
- A0434 – Specialty care transport (SCT)

Why we apply this rule
According to CMS guidance and as supported by Louisiana Medicaid regulations, it is inappropriate to report charges for the above services without including an appropriate transportation services modifier on the claim.

Rule number	LA170
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
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.

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	LA171
Applies to	Physician/Healthcare Providers
Category	Modifiers
Topic	Anesthesia modifiers

Code editing rule
We do not reimburse charges for anesthesia services unless submitted with at least one of the following modifiers:

- AA – Anesthesia services performed personally by the anesthesiologist
- QY – Medicaid direction of one CRNA
- QK – Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
- QX – CRNA service with direction by anesthesiologist
- QZ – CRNA service without medical direction by an anesthesiologist.

Why we apply this rule
According to the Louisiana Medicaid Professional Services Provider Manual, anesthesia services are required to be billed with one of the modifiers listed above.

Rule number	LA172
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	Modifiers
Topic	Anesthesia services billed with a distinct services modifier

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

Why we apply this rule
According to the AMA CPT manual and Louisiana Medicaid guidelines, a distinct services modifier should not be reported with an anesthesia service.

Rule number	LA317
Applies to	Inpatient/Outpatient Facilities and 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 with 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	LA173
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	Modifiers
Topic	Claims submitted with modifier 59 and modifiers 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 also 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 to 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.

Rule number	LA174
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	Modifiers
Topic	Inappropriate modifier for specialized behavioral health services

Code editing rule
We do not reimburse charges for the following CPT codes if billed with modifier HF, substance abuse program, appended to the claim line:
- 90785 – Interactive complexity (List separately in addition to the code for primary procedure)
- 90791 – Psychiatric diagnostic evaluation
- 90837 – Psychotherapy, 60 minutes with patient

Why we apply this rule
The limitation above is established based on guidance from the Louisiana Medicaid agency.

Rule number	LA175
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
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	LA176
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	Modifiers
Topic	Inappropriate modifiers for certain behavioral analysis services

Code editing rule
We do not reimburse charges for behavioral analysis CPT codes 96105, 90845, 90870, 90875, 90876, 96116 or 96121, if billed with any of the following modifiers:
- Modifier AH – Licensed clinical psychologist
- Modifier AJ – Licensed clinical social worker
- Modifier HF – Substance abuse program
- Modifier HO – Master's degree level
- Modifier HP – Clinical psychologist or doctoral level
- Modifier SA – Nurse practitioner

Why we apply this rule
The limitation above is established based on guidance from the Louisiana Medicaid agency.

Rule number	LA177
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	Modifiers
Topic	Inappropriate modifiers for certain behavioral health services

Code editing rule
We do not reimburse charges for certain behavioral health services if billed with any of the following modifiers:

- Modifier AH – Licensed clinical psychologist
- Modifier AJ – Licensed clinical social worker
- Modifier HF – Substance abuse program
- Modifier HO – Master's degree level

Why we apply this rule
The limitation above is established based on guidance from the Louisiana Medicaid agency.

Rule number	LA178
Applies to	Physician/Professional Providers
Category	Modifiers
Topic	Inappropriate modifiers for professional providers

Code editing rule
We do not reimburse charges for procedures billed with the following modifiers, if submitted by a professional provider:

- Modifier 27 – Multiple outpatient hospital evaluation and management (E/M) encounters on the same date
- Modifier 73 – Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure prior to the administration of anesthesia
- Modifier 74 – Discontinued outpatient hospital/ASC procedure after administration of anesthesia
- Modifier CA – Procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission

Why we apply this rule
According to guidance from the Louisiana Medicaid agency and as supported by the AMA CPT manual, the above modifiers are only used by facility providers.

Rule number	LA179
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	Modifiers
Topic	Intravenous (IV) infusion services billed with IV chemotherapy administration codes

Code editing rule
We do not reimburse charges for IV infusion services billed with IV chemotherapy services, unless one of the below 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 CMS guidance, it is inappropriate to report procedure codes from both above categories without appending a modifier to indicate the services were separate or distinct.

Rule number	LA309
Applies to	Physician/Healthcare Providers

Category	Modifiers
Topic	Modifier JW – Drug Wastage

Code editing rule
We limit reimbursement of charges for drug wastage to no more than the total units of the smallest single-use vial or package available.

Why we apply this rule
It is inappropriate to bill drug wastage that equals or exceeds the size of the smallest single-use vial or package.

Rule number	LA180
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
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 such procedures with either of the modifiers above.

Rule number	LA181
Applies to	Physician/Professional Providers
Category	Modifiers
Topic	Modifier requirement for telehealth services

Code editing rule
We do not reimburse charges for telehealth services billed with place of service (POS) codes 02 or 10, unless the claim line is appended with modifier 95

These codes are defined as:
- POS code 02 – Telehealth
- POS code 10 – Telehealth provided in patient's home
- Modifier 95 – Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications systems.

Why we apply this rule
The limitation above is established based guidance from the AMA CPT manual and the Louisiana Medicaid agency.

Rule number	LA315
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	Modifiers
Topic	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

Code editing rule

We do not reimburse charges for claims submitted with modifier 78 if the same or a different procedure has not been submitted on the same date of service or within the previous 10 days for a code with a 10-day global period, or within the previous 90 days for a code with a 90-day global period.

Why we apply this rule
According to 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	LA182
Applies to	Physician/Professional Providers
Category	Modifiers
Topic	Modifier TH requirement for obstetric services

Code editing rule
We do not reimburse office or other outpatient services CPT codes 99202 – 99205 or 99211 – 99215, if billed with a pregnancy diagnosis by a provider with an OB-GYN specialty, unless modifier TH, OB treatment/services, is also on the claim.

Why we apply this rule
The limitation above is established based on guidance from the Louisiana Medicaid agency.

Rule number	LA183
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
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 charge is outside the global period for a previous procedure.

The modifiers above are defined as:
- 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
- 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 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	LA184
Applies to	Physician/Professional Providers
Category	Modifiers
Topic	Modifiers QE, QF and QG

Code editing rule
We limit reimbursement of charges appended with the following modifiers to claims submitted for stationary oxygen systems:
- Modifier QE – Prescribed amount of stationary oxygen while at rest is less than 1 liter per minute (LPM)

- Modifier QF – Prescribed amount of stationary oxygen while at rest exceeds 4 liters per minute (LPM) and portable oxygen is prescribed
- Modifier QG – Prescribed amount of stationary oxygen while at rest exceeds 4 liters per minute (LPM)

Why we apply this rule
According to the AMA CPT Manual and as supported by guidance from the Louisiana Medicaid agency, the modifiers above are used only when submitting claims associated with stationary oxygen systems.

Rule number	LA185
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	Modifiers
Topic	Never-event related services

Code editing rule
We do not reimburse procedures submitted with one of the following modifiers:
- PA – Surgical or other invasive procedure on wrong body part
- PB – Surgical or other invasive procedure on wrong patient
- PC – Wrong surgery or other invasive procedure on patient

Why we apply this rule
According to Louisiana Medicaid guidance, services are not covered when they are performed on the wrong body part or wrong patient or when the wrong procedure is performed.

Rule number	LA186
Applies to	Inpatient/Outpatient Facilities
Category	Modifiers
Topic	Outpatient hospital or ambulatory surgical center claims billed with modifiers AS, 62, 66, 80, 81 or 82

Code editing rule
We do not reimburse charges for outpatient hospital or ambulatory surgical center claim lines submitted on a CMS 1450 or CMS 1500 form with any of the following modifiers: AS, 62, 66, 80, 81 or 82.

Why we apply this rule
According to the AMA CPT manual, the above modifiers are to be used only by healthcare providers and are not appropriate for facility use.

Rule number	LA187
Applies to	Physician/Healthcare Providers
Category	Modifiers
Topic	Professional providers billing with facility modifiers

Code editing rule
We do not reimburse charges for services that are billed by physicians or professional providers with either of the following modifiers appended to the claim:
- Modifier 73 – Discontinued outpatient/hospital ambulatory surgical center (ASC) procedures prior to the administration of anesthesia
- Modifier 74 – After anesthesia administration – discontinued ASC or outpatient hospital

Why we apply this rule

According to CMS guidance and as supported by the Louisiana Medicaid agency, it is inappropriate for physicians or professional providers to report services with the facility modifiers above.

Rule number	LA188
Applies to	Physician/Healthcare Providers
Category	Modifiers
Topic	Repeat laboratory services

Code editing rule
We do not reimburse charges for laboratory services that are submitted with modifier 91, repeat clinical diagnostic laboratory test, if the same procedure is not previously submitted in the member's claim history. Also, we do not reimburse multiple charges of the same laboratory service billed with modifier 91.

Why we apply this rule
According to guidance from CMS, it is inappropriate to report charges for a repeat laboratory service if the initial service has not also been reported. It is also inappropriate to report multiple instances of the repeat laboratory service.

Rule number	LA189
Applies to	Physician/Healthcare Providers
Category	Modifiers
Topic	Telehealth billing requirements for specialized behavioral health services

Code editing rule
When billing for telehealth, we do not reimburse charges for any specialized behavioral health services, as identified by the fee schedule, unless also submitted with place of service 02 and modifier 95 to identify the service as telehealth.

Note: When applicable, any additional modifiers identified on the Specialized Behavioral Health Services fee schedule must also be appended.

Why we apply this rule
According to the Louisiana Department of Health Informational Bulletins 20-4, 20-6 and 20-7, the above listed billing requirements need to be met for telehealth reimbursement of specialized behavioral health services.

Rule number	LA190
Applies to	Physician/Healthcare Providers
Category	Modifiers
Topic	Treatment in place transportation services

Code editing rule
We do not reimburse charges for the following ambulance services HCPCS codes if submitted with a treatment in place of transportation modifier:

- HCPCS code A0394 – ALS specialized service disposable supplies; IV drug therapy
- HCPCS code A0422 – Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation
- HCPCS code A0425 – Ground mileage, per statute mile
- HCPCS code A0427 – Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 – emergency)
- HCPCS code A0429 – Ambulance service, basic life support, emergency transport (BLS, emergency)
- HCPCS code A0433 – Advanced life support, level 2 (ALS 2)
- HCPCS code A0434 –Specialty care transport (SCT)

Treatment in place modifiers include modifiers DW, EW, GW, HW, IW, JW, NW, PW, RW and SW.

Why we apply this rule
According to guidance from the Louisiana Medicaid agency, it is inappropriate to report the above transportation services with a treatment in place modifier.

Rule number	LA191
Applies to	Inpatient/Outpatient Facilities
Category	Outpatient Prospective Payment System (OPPS)
Topic	C-codes (Supplies, implants, drugs, etc.)

Code editing rule
We limit reimbursement of charges for HCPCS C-codes 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	LA192
Applies to	Physician/Professional Providers
Category	Outpatient Prospective Payment System (OPPS)
Topic	C-codes (Supplies, implants, drugs, etc.)

Code editing rule
We do not reimburse charges for HCPCS C-codes if 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	LA193
Applies to	Physician/Professional Providers
Category	Outpatient Facility
Topic	Professional component procedures submitted by facilities

Code editing rule
We do not reimburse charges for professional component procedures that are submitted by facility providers.

Why we apply this rule
This limitation is established based on guidance from the Louisiana Medicaid agency.

Rule number	LA194
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	Place of Service
Topic	Initial inpatient consultation place of service limitations

Code editing rule

We do not reimburse charges for initial inpatient consultation service, CPT codes 99251 – 99255, if billed with a place of service code other than the following:

- 02 – Telehealth
- 06 – Indian health service, provider-based facility
- 08 – Tribal 638 provider-based facility
- 21 – Nursing facility
- 25 – Birthing center
- 26 – Military treatment facility
- 31 – Skilled nursing facility
- 32 – Nursing facility
- 34 – Hospice
- 51 – Psychiatric inpatient facility
- 52 – Psychiatric partial hospitalization facility
- 54 – Intermediate care facility/individuals with intellectual disabilities
- 55 – Residential treatment center
- 56 – Psychiatric residential treatment center
- 61 – Comprehensive rehab facility
- 99 – Other place of service

Why we apply this rule
The limitation above is established based on guidance from the AMA CPT manual and the Louisiana Medicaid agency.

Rule number	LA195
Applies to	Physician/Professional Providers
Category	Place of Service
Topic	Limitations for place of service 50 and 72

Code editing rule
We do not reimburse charges for services billed with place of service code 50 or 72 unless one of the following HCPCS codes is also on the claim:

- T1015 – Clinic visit/encounter, all-inclusive
- H2020 – Therapeutic behavioral services, per diem

These place of service codes are defined as:

- 50 – Federally qualified health center
- 72 – Rural health center

Why we apply this rule
The limitation above is established based on guidance from the Louisiana Medicaid agency.

Rule number	LA196
Applies to	Physician/Professional Providers
Category	Place of Service
Topic	Office/outpatient consultation place of service limitations

Code editing rule
We do not reimburse charges for office/outpatient consultation codes, CPT codes 99241 – 99245, if billed with a place of service code other than the following:

- 01 – Pharmacy

- 02 – Telehealth
- 03 – School
- 04 – Homeless shelter
- 05 – Indian health service free-standing facility
- 06 – Indian health service provider-based facility
- 07 – Tribal 638 free-standing facility
- 08 – Tribal 638 provider-based facility
- 09 – Prison-correctional facility
- 11 – Office
- 12 – Home
- 13 – Assisted living facility
- 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 hospital
- 24 – Ambulatory surgical center
- 25 – Birthing center
- 26 – Military treatment facility
- 33 – Custodial care facility
- 49 – Independent clinic
- 50 – Federally qualified health center
- 53 – Community mental health center
- 54 – Intermediate care facility/individuals with intellectual disabilities
- 57 – Non-residential substance abuse treatment facility
- 58 – Non-residential 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 limitation above is established based on guidance from the AMA CPT manual and the Louisiana Medicaid agency.

Rule number	LA197
Applies to	Physician/Healthcare Providers
Category	Place of Service
Topic	Place of service limitations for behavioral health services

Code editing rule
We do not reimburse charges for behavioral health services billed with modifier 95, unless the place of service code submitted is 02, telehealth services.

Modifier 95 is defined as, synchronous telemedicine service rendered via a real-time audio and video telecommunications system.

Why we apply this rule
According to guidance from the Louisiana Medicaid agency, services performed via telehealth or telemedicine technology are to be reported with a telehealth place of service.

Rule number	LA307
Applies to	Inpatient/Outpatient Facility and Physician /Healthcare Providers
Category	Place of Service
Topic	Place of service limitations

Code editing rule
We limit reimbursement of charges for the following CPT codes to those submitted with place of service code 11, office setting:

- 99050 – Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service
- 99051 – Service(s) provided in the office during regularly scheduled evening, weekend or holiday office hours, in addition to basic service
- 99058 – Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service

Why we apply this rule
According to the American Medical Association's CPT manual, CPT codes 99050, 99051 and 99058 are performed only in an office setting.

Rule number	LA198
Applies to	Physician/Healthcare Providers
Category	Place of Service
Topic	Place of service limitations for certain alcohol and behavioral health services

Code editing rule
We do not reimburse charges for the following HCPCS service code and modifier combinations, if the claim is submitted without place of service code 02, telehealth:

- H0001 appended with modifier HF
- H0004 appended with modifier HF
- H0005 appended with modifier HQ, HR or HS
- H0015 appended with modifier HF or 95

The HCPCS codes above are defined as:

- H0001 – Alcohol and/or drug assessment
- H0004 – Behavioral health counseling and therapy, per 15 minutes
- H0005 – Alcohol and/or drug services; group counseling by a clinician
- H0015 – Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education

Why we apply this rule

According to guidance from the Louisiana Medicaid agency, the services described above are to be reported in a telehealth place of service.

Rule number	LA199
Applies to	Physician/Professional Providers
Category	Place of Service
Topic	Place of service requirement for telehealth services

Code editing rule
We do not reimburse charges for telehealth or telemedicine services that are billed with modifier 95, synchronous telemedicine service rendered via real-time interactive audio and video telecommunications systems, but are not billed with one of the following places of service:

- Place of service 02 – Telehealth
- Place of service 10 – Telehealth provided in patient's home

Why we apply this rule
The limitation above is established based guidance from the AMA CPT manual and the Louisiana Medicaid agency.

Rule number	LA200
Applies to	Inpatient/Outpatient Facilities
Category	Revenue Codes
Topic	Missing or invalid revenue codes

Code editing rule
We do not reimburse charges for facility services unless billed with a valid revenue code.

Why we apply this rule
According to the Louisiana Medicaid Hospital Services Provider Manual, facilities must bill using a valid revenue code.

Rule number	LA201
Applies to	Inpatient/Outpatient Facilities
Category	Revenue Codes
Topic	Technical component charges submitted with professional fees revenue codes

Code editing rule
We do not reimburse charges for technical components that are billed with revenue codes 0960 – 0989, professional fees.

Why we apply this rule
The limitation above is established based on guidance from the Louisiana Medicaid agency.

Rule number	LA202
Applies to	Physician/Healthcare Providers
Category	Surgery
Topic	Assistant surgeon does not apply

Code editing rule
We do not reimburse charges for services that are submitted with modifier 80 or AS, if the assistant surgeon concept does not apply to the service code billed.

The modifiers above are described as:

- Modifier AS – Physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS) assistant at surgery services
- Modifier 80 – Assistant surgeon

Why we apply this rule
According to guidance from the Louisiana state Medicaid agency, it is inappropriate to report charges for assistant surgery services if the procedure code reported is not one that the assistant surgeon concept applies to.

Rule number	LA203
Applies to	Physician/Healthcare Providers
Category	Surgery
Topic	Global surgical period

Code editing rule
We do not reimburse charges for procedures billed within the global period of another minor or major surgical procedure, if billed by a provider for whom the global surgical concept applies, unless additional information is submitted that bypasses the global period editing.

Why we apply this rule
According to guidance from CMS, it is inappropriate for the same provider, or another provider for whom the global period applies, to report charges for a service rendered within the global period of another minor or surgical service.

Rule number	LA204
Applies to	Physician/Healthcare Providers
Category	Surgery
Topic	More than one assistant surgeon for a procedure that does not require more than one assistant

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

Why we apply this rule
According to the American College of Surgeons andLouisiana Medicaid guidelines, it is inappropriate to bill for more than one assistant surgeon when the surgery does not require the use of more than one assistant.

Rule number	LA205
Applies to	Physician/Professional Providers
Category	Units
Topic	Annual unit limitations

Code editing rule
We do not reimburse more than the annual allowable unit amount for certain services, items and procedures.

Why we apply this rule
Some services, items and procedures have a maximum annual number of units allowed, according to the Louisiana Medicaid agency, the AMA CPT manual, CMS guidance and other supporting services. When applicable, we apply these limitations.

Rule number	LA206
Applies to	Physician/Professional Providers

Category	Units
Topic	CPT code 99483 – Assessment of and care planning for patient with cognitive impairment

Code editing rule
We limit reimbursement of charges for CPT code 99483 to no more than once every 180 days.

Why we apply this rule
According to guidance from the Louisiana Medicaid agency and as supported by the AMA CPT manual, CPT code 99483 should not be reported more frequently than once every 180 days.

Rule number	LA207
Applies to	Physician/Healthcare Providers
Category	Units
Topic	Daily limitation for HCPCS code T1026 – Pediatric Day Healthcare (PDHC) 6 hours or less per day service code.

Code editing rule
We limit reimbursement of charges for HCPCS code T1026 to no more than 6 units per date of service.

Why we apply this rule
According to guidance from the Louisiana Medicaid agency, it is inappropriate to report more than 6 daily hours of pediatric day healthcare services with the code above. Any services rendered beyond six hours should be reported with the HCPCS code representing a full day of services, instead of the hourly code.

Rule number	LA208
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	Units
Topic	Limitations for definitive drug testing

Code editing rule
We limit reimbursement of charges for the following HCPCS codes to no more than one unit per date of service and no more than 12 units per year:

- G0480 – Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays [e.g., IA, EIA, ELISA, EMIT, FPIA] and enzymatic methods [e.g., alcohol dehydrogenase]), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 1-7 drug class(es), including metabolite(s) if performed
- G0481 – Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays [e.g., IA, EIA, ELISA, EMIT, FPIA] and enzymatic methods [e.g., alcohol dehydrogenase]), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 8-14 drug class(es), including metabolite(s) if performed

Why we apply this rule

According to guidance from the Louisiana Medicaid agency, it is inappropriate to report charges for definitive drug testing more frequently than described above.

Rule number	LA209
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	Units
Topic	Limitations for presumptive drug testing

Code editing rule
We limit reimbursement of charges for the following CPT codes to no more than one unit per date of service and no more than 24 units per year:

- 80305 – Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; capable of being read by direct optical observation only (e.g., utilizing immunoassay [e.g., dipsticks, cups, cards or cartridges]), includes sample validation when performed, per date of service
- 80306 – Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; read by instrument assisted direct optical observation (e.g., utilizing immunoassay [e.g., dipsticks, cups, cards or cartridges]), includes sample validation when performed, per date of service
- 80307 – Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; by instrument chemistry analyzers (e.g., utilizing immunoassay [e.g., EIA, ELISA, EMIT, FPIA, IA, KIMS or RIA]), chromatography (e.g., GC, HPLC), and mass spectrometry either with or without chromatography, (e.g., DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI or TOF) includes sample validation when performed, per date of service

Why we apply this rule
According to guidance from the Louisiana Medicaid agency, it is inappropriate to report charges for presumptive drug testing more frequently than described above.

Rule number	LA210
Applies to	Inpatient/Outpatient Facilities and Physician/Healthcare Providers
Category	Units
Topic	Partial or fractional units

Code editing rule
Services other than ambulance mileage and anesthesia are not eligible for reimbursement when submitted with partial or fractional units.

Why we apply this rule
According to the Medicare Claims Processing Manual, service units are to be reported in whole numbers, except ambulance mileage and anesthesia.