UnitedHealthcare Smart Edits

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As Returned on the 277CA Clearinghouse Rejection Report

Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Informational Edit	040CCO	INFORMATIONAL The procedure code is identified as a component of another procedure on the same service date, where the use of a modifier is not appropriate. Please refer to National Correct Coding Initiative (NCCI) Edits for more information.	(u040CCO) Mutually Exclusive/NCCI Code 2 of a Pair (GOAL) (Maint. Update) Facilities are billing and being reimbursed for procedures that are mutually exclusive and defined by the National Correct Coding Initiative (NCCI) as an incorrect code combination.	8/29/2019	Commercial	Institutional
Return Edit	10ADN	Diagnosis code <1> is not appropriate for the age of this patient <2>. The typical age range for this diagnosis is <3>-<4>. Update code(s) as applicable for services rendered.	(10ADN) DX Not Typical for Age UnitedHealthcare Community Plan develops edits for age for certain codes based on code descriptions, publications and guidelines from sources such as professional specialty societies or similar institutions and from the entities that create the codes (WHO, CMS, AMA). These guidelines can be either definitive or interpretive. UnitedHealthcare Community Plan will apply age edits when diagnosis &/or procedure codes are reported for the appropriate patient's age. Diagnosis &/or procedure codes reported inappropriately will be considered billing errors and will not be reimbursed. Please refer to the Age to Diagnosis Code & Procedure Code Policy, Professional on UnitedHealthcare Community Plans	3/7/2019	Medicaid	Professional
Return Edit	ADODN	Procedure <1> is an add-on code and must be reported with the primary code. It is recommended the Add-on and primary code be reported on the same claim form. Update code(s) as applicable for services rendered.	(ADODN) Add On Codes Add-on codes are reimbursable services when reported in addition to the appropriate primary service by the Same Individual Physician or Other Qualified Health Care Professional reporting the same Federal Tax Identification Number on the same date of service unless otherwise specified within the policy. Add-on codes reported as Stand-alone codes are not reimbursable services in accordance with Current Procedural Terminology (CPT®) and the Centers for Medicare and Medicaid Services (CMS) guidelines. Please refer to the Add-On Codes Reimbursement Policy on UnitedHealthcare Commercial Plans for further information.	7/11/2019	Commercial	Professional
Return Edit	ADODN	The procedure <1> is an add-on code and is not separately reimbursable. Add-on procedures must be reported with the primary procedure for the same date of service.	(ADODN) Add-On Codes Add-on codes reported as Stand-alone codes are not reimbursable services in accordance with Current Procedural Terminology (CPT®) and the Centers for Medicare and Medicaid Services (CMS) guidelines. Please refer to the Add-On Codes Reimbursement Policy on UnitedHealthcare Community Plans on UHCprovider.com for further information.	10/4/2018	Medicaid	Professional
Return Edit	AHC	Procedure <1> is not appropriate in <2> Place of Service.	(AHC) After Hours Care After hours or weekend care is reimbursable, within limitations, when an individual physician or other health care professional is required to provide services outside of regular posted office hours to treat a patient's urgent illness or condition. UnitedHealthcare Community Plan will reimburse after hours CPT code 99050 when reported with basic services and CPT code 99051 in addition to acute care services (not preventive medicine codes) in one of the following CMS non-facility Place of service (POS) designations only (Unless there is a State Exception): • School (CMS POS 03) • Indian Health Service Free-standing Facility (CMS POS 5) • Tribal 638 Free-Standing Facility (CMS POS 7) • Office (CMS POS 11) • Independent Clinic (CMS POS 49) • Federally Qualified Health Center (CMS POS 50) • State or Local Public Health Clinic (CMS POS 71) • Rural Health Clinic (CMS POS 72) Please refer to the After Hours and Weekend Care reimbursement policy at UHCprovider.com for further information.	11/14/2018	Medicaid	Professional

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Return Edit	AHCAD	Procedure is not a separately reimbursable service.	(AHCAD) After Hours Care After hours or weekend care (CPT®) codes represent services provided, when an individual physician or other health care professional is required to render the services outside of regular posted office hours to treat a patient's urgent illness or condition. Refer to After Hours policy for when after hours or weekend care codes are considered for separate reimbursement. Please refer to the After Hours and Weekend Care Policy on UHCprovider.com	11/7/2019	Medicaid	Professional
Return Edit	AHCPM	Procedure <1> is included in Procedure <2> on this or a previously submitted claim. Under appropriate circumstances, a designated modifier may be required to identify distinct services.	(AHCPM) After Hours with Prev Med Denial The Centers for Medicare and Medicaid Services (CMS) considers reimbursement for Current Procedural Terminology (CPT®) codes 99050, 99051, 99053, 99056, 99058 and 99060 to be bundled into payment for other services not specified. UnitedHealthcare Community Plan, however, will provide additional compensation to physicians for seeing patients in situations that would otherwise require more costly urgent care or emergency room settings by reimbursing CPT code 99050 in addition to basic services. Please refer to the After Hours and Weekend Care reimbursement policy at UHCprovider.com for further information.	6/13/2009	Medicaid	Professional
Return Edit	AHCSD	Procedure <1> is not a appropriate when submitted in <2> Place of Service for the state of <3>. Update code(s) as applicable for services rendered.	(AHCSD) After Hours POS State Denial The Centers for Medicare and Medicaid Services (CMS) considers reimbursement for Current Procedural Terminology (CPT®) codes 99050, 99051, 99053, 99056, 99058 and 99060 to be bundled into payment for other services not specified. Please refer to the After Hours and Weekend Care Policy, Professional on UnitedHealthcare Community Plans on UHCprovider.com for further information.	3/7/2019	Medicaid	Professional
Return Edit	ANSAD	Procedure code <1> is not appropriate when submitted with an anesthesia modifier. Update code(s) or modifier as applicable for services rendered.	(ANSAD) Anes Management Service Anesthesia services must be submitted with a CPT anesthesia code in the range 00100-01999, excluding 01953 and 01996, and are reimbursed as time-based using the Standard Anesthesia Formula. All services reported for anesthesia management services must be submitted with the appropriate HCPCS modifiers. These modifiers identify monitored anesthesia and whether a procedure was personally performed, medically directed, or medically supervised. Consistent with CMS, UnitedHealthcare Community Plan will adjust the allowance by the modifier percentage indicated in the table policy. Please refer to the Anesthesia Policy, Professional on UnitedHealthcare Community Plans on UHCprovider.com for further information.	3/28/2019	Medicaid	Professional

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Return Edit	ANSDM	Procedure code <1> is not appropriate when billed without or with an invalid modifier. Update code(s) or modifier as applicable for services rendered.	(ANSDM) Anesthesia Modifier Missing UnitedHealthcare Community Plan's reimbursement policy for anesthesia services is developed in part using the American Society of Anesthesiologists (ASA) Relative Value Guide (RVG®), the ASA CROSSWALK®, and Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Policy manual, CMS NCCI edits and the CMS National Physician Fee Schedule. Current Procedural Terminology (CPT®) codes and modifiers and Healthcare Common Procedure Coding System (HCPCS) modifiers identify services rendered. These services may include, but are not limited to, general or regional anesthesia, Monitored Anesthesia Care, or other services to provide the patient the medical care deemed optimal. The Anesthesia Policy addresses reimbursement of procedural or pain management services that are an integral part of anesthesia services as well as anesthesia services that are an integral part of procedural services. All services described in this policy may be subject to additional UnitedHealthcare Community Plan reimbursement policies including but not limited to the "CCI Editing Policy." Refer to UnitedHealthcare Community Plan's "Add-on Policy" for further details on reimbursement of CPT code 01953. Please refer to the Anesthesia Policy, Professional on UnitedHealthcare Community Plans on UHCprovider.com for further information.	5/30/2019	Medicaid	Professional
Return Edit	ANSQC	Procedure code <1> is inappropriate when submitted without an anesthesia service. Update code(s) as applicable for services rendered.	(ANSQC) Anesthesia Qualifying Circumstance Qualifying circumstances codes identify conditions that significantly affect the nature of the anesthetic service provided. Qualifying circumstances codes should only be billed in addition to the anesthesia service with the highest Base Unit Value. The Modifying Units identified by each code are added to the Base Unit Value for the anesthesia service according to the above Standard Anesthesia Formula. Please refer to the Anesthesia Policy, Professional at UHCProvider.com for further information.	5/9/2019	Commercial	Professional
Return Edit	ASUNE	Procedure code <1> is not eligible for assistant surgeon.	(ASUNE) Assistant Surgeon Not Eligible Reimbursement for Assistant Surgeon services, when reported by the Same Individual Physician or Other Health Care Professional, is based on whether the Assistant Surgeon is a Physician (designated by modifiers 80, 81 or 82) or another Health Care Professional (designated by modifier AS) acting as the surgical assistant. The services of only one Assistant Surgeon are reimbursable for each procedure on the Assistant Surgeon Eligible List. No exceptions to this policy are made for teaching hospitals or hospital bylaws. Please refer to the Assistant Surgeon reimbursement policy at UHCprovider.com for further information.	11/14/2018	Commercial	Professional
Return Edit	BIL	Procedure <1> is not appropriate when billed with a bilateral modifier.	(BIL) Bilateral Procedure Not Eligible Bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate CPT or HCPCS code. The procedure should be billed on one line with modifier 50 and one unit with the full charge for both procedures. A procedure code submitted with modifier 50 is a reimbursable service as set forth in this policy only when it is listed on the UnitedHealthcare Bilateral Eligible Procedures Policy List. Commercial/Medicaid: Please refer to the Bilateral Procedures Reimbursement Policy on UHCProvider.com for further information.	1/31/2019	Commercial Medicaid	Professional

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Return Edit	BILDN	Procedure code <1> submitted with more than one unit is not appropriate when billed with a bilateral modifier. Update code(s) or modifier as applicable for services rendered.	(BILDN) AC Bilateral Denial Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes on the UnitedHealthcare Community Plan Bilateral Eligible Procedures Policy List describe unilateral procedures that can be performed on both sides of the body during the same session by the Same Individual Physician or Other Qualified Health Care Professional. CPT or HCPCS codes with bilateral in their intent or with bilateral written in their description should not be reported with the bilateral modifier 50, or modifiers LT and RT, because the code is inclusive of the Bilateral Procedure Please refer to the Bilateral Procedure Policy, Professional on UnitedHealthcare Community Plans on UHCprovider.com for further information.	3/28/2019	Medicaid	Professional
Return Edit	C00002PD	Procedure Code <1> is not reimbursable when billed in POS <2>. Update codes(s) as applicable for services rendered.	(C00002PD) Procedure to Place of Service This edit addresses appropriate places of service for certain CPT and HCPCS procedure codes. Descriptions of some CPT and HCPS codes included in what places of service the code may be used. For example, it would not be appropriate to submit place of service “inpatient” for a code that states “office or outpatient visit”. United Healthcare Community Plan has established a list of CPT and HCPCS codes along with their appropriate places of service. For any code that is not on the list, the place of service is not limited. Please refer to the Procedure to Place of Service Policy on UHCprovider.com for further information.	11/14/2019	Medicaid	Professional
Return Edit	c00002WI	Procedure <1> submitted in Place Of Service <2> is not appropriate. Update code(s) as appropriate based on services rendered.	(c00002WI) Procedure to Place of Service WI Medicaid Denial UnitedHealthcare Community Plan follows Current Procedural Terminology (CPT®) code descriptions/guidelines and Healthcare Common Procedure Coding System (HCPCS) procedure code definitions/guidelines that indicate a POS in their descriptions when assigning the applicable places of service. Please refer to the Procedure to Place of Service Policy, Professional on UnitedHealthcare Community Plans on UHCprovider.com for further information.	5/2/2019	Medicaid	Professional
Return Edit	C01DN	Diagnosis <1> is not appropriate with procedure <2> per the Clinical Diagnostic Lab Policy for Carcinoembryonic Antigen.	(C01DN) Carcinoembryonic Antigen This edit will allow clinical diagnostic lab procedure(s) when submitted with a diagnosis code found on the allowed diagnosis code list. When the clinical diagnostic lab procedure is billed as a routine screening service, as evidenced by the diagnosis code not found on the allowed diagnosis code list, the procedure code will deny. Please refer to the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	11/14/2018	Medicaid	Professional
Return Edit	C02DN	Diagnosis <1> is not appropriate with procedure <2> per the Clinical Diagnostic Lab Policy for Alpha-fetoprotein Serum.	(C02DN) Alpha-fetoprotein Serum This edit will allow clinical diagnostic lab procedure(s) when submitted with a diagnosis code found on the allowed diagnosis code list. When the clinical diagnostic lab procedure is billed as a routine screening service, as evidenced by the diagnosis code not found on the allowed diagnosis code list, the procedure code will deny. Please refer to the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	11/14/2018	Medicaid	Professional
Return Edit	C03DN	Diagnosis <1> is not appropriate with procedure <2> per the Clinical Diagnostic Lab Policy for Partial Thromboplastin Time.	(C03DN) Partial Thromboplastin Time This edit will allow clinical diagnostic lab procedure(s) when submitted with a diagnosis code found on the allowed diagnosis code list. When the clinical diagnostic lab procedure is billed as a routine screening service, as evidenced by the diagnosis code not found on the allowed diagnosis code list, the procedure code will deny. Please refer to the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	11/14/2018	Medicaid	Professional

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Return Edit	C04DN	Diagnosis <1> is not appropriate with procedure <2> per the Clinical Diagnostic Lab Policy for Prostate Specific Antigen.	(C04DN) Prostate Specific Antigen This edit will allow clinical diagnostic lab procedure(s) when submitted with a diagnosis code found on the allowed diagnosis code list. When the clinical diagnostic lab procedure is billed as a routine screening service, as evidenced by the diagnosis code not found on the allowed diagnosis code list, the procedure code will deny. Please refer to the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	11/14/2018	Medicaid	Professional
Return Edit	C05DN	Diagnosis <1> is not appropriate with procedure <2> per the Clinical Diagnostic Lab Policy for Urine Culture, Bacterial.	(C05DN) Urine Culture, Bacterial This edit will allow clinical diagnostic lab procedure(s) when submitted with a diagnosis code found on the allowed diagnosis code list. When the clinical diagnostic lab procedure is billed as a routine screening service, as evidenced by the diagnosis code not found on the allowed diagnosis code list, the procedure code will deny. Please refer to the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	11/14/2018	Medicaid	Professional
Return Edit	C06DN	Diagnosis <1> is not appropriate with procedure <2> per the Clinical Diagnostic Lab Policy for Serum Iron.	(C06DN) Serum Iron This edit will allow clinical diagnostic lab procedure(s) when submitted with a diagnosis code found on the allowed diagnosis code list. When the clinical diagnostic lab procedure is billed as a routine screening service, as evidenced by the diagnosis code not found on the allowed diagnosis code list, the procedure code will deny. Please refer to the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	11/14/2018	Medicaid	Professional
Return Edit	C07DN	Diagnosis <1> is not valid with current line procedure code <2> per the Clinical Diagnostic Lab Policy for Thyroid Testing. Procedure code submitted is not found on the allowed diagnosis code list.	(C07DN) Thyroid Testing This edit will allow clinical diagnostic lab procedure(s) when submitted with a diagnosis code found on the allowed diagnosis code list. When the clinical diagnostic lab procedure is billed as a routine screening service, as evidenced by the diagnosis code not found on the allowed diagnosis code list, the procedure code will deny. Please refer to the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	10/4/2018	Medicaid	Professional
Return Edit	C08DN	Diagnosis <1> is not valid with current line procedure code <2> per the Clinical Diagnostic Lab Policy for Lipids Testing. Procedure code submitted is not found on the allowed diagnosis code list.	(C08DN) Lipids Testing This edit will allow clinical diagnostic lab procedure(s) when submitted with a diagnosis code found on the allowed diagnosis code list. When the clinical diagnostic lab procedure is billed as a routine screening service, as evidenced by the diagnosis code not found on the allowed diagnosis code list, the procedure code will deny. Please refer to the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	10/4/2018	Medicaid	Professional
Return Edit	C09DN	Diagnosis <1> is not appropriate with procedure <2> per the Clinical Diagnostic Lab Policy for Human Chorionic Gonadotropin.	(C09DN) Human Chorionic Gonadotropin This edit will allow clinical diagnostic lab procedure(s) when submitted with a diagnosis code found on the allowed diagnosis code list. When the clinical diagnostic lab procedure is billed as a routine screening service, as evidenced by the diagnosis code not found on the allowed diagnosis code list, the procedure code will deny. Please refer to the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	11/14/2018	Medicaid	Professional

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Return Edit	C10DN	Diagnosis <1> is not appropriate with procedure <2> per the Clinical Diagnostic Lab Policy for Prothombin Time (PT) Testing.	(C10DN) Prothombin Time (PT) Testing This edit will allow clinical diagnostic lab procedure(s) when submitted with a diagnosis code found on the allowed diagnosis code list. When the clinical diagnostic lab procedure is billed as a routine screening service, as evidenced by the diagnosis code not found on the allowed diagnosis code list, the procedure code will deny. Please refer to the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	11/14/2018	Medicaid	Professional
Return Edit	C11DN	Diagnosis <1> is not appropriate with procedure <2> per the Clinical Diagnostic Lab Policy for Tumor Antigen by Immunoassay CA 125 Testing.	(C11DN) Tumor Antigen by Immunoassay CA 125 Testing This edit will allow clinical diagnostic lab procedure(s) when submitted with a diagnosis code found on the allowed diagnosis code list. When the clinical diagnostic lab procedure is billed as a routine screening service, as evidenced by the diagnosis code not found on the allowed diagnosis code list, the procedure code will deny. Please refer to the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	11/14/2018	Medicaid	Professional
Return Edit	C12DN	Diagnosis <1> is not appropriate with procedure <2> per Clinical Diagnostic Lab Policy for Tumor Antigen by Immunoassay CA 15-3/CA 27.29 Testing.	(C12DN) Tumor Antigen by Immunoassay CA 15-3/CA 27.29 Testing This edit will allow clinical diagnostic lab procedure(s) when submitted with a diagnosis code found on the allowed diagnosis code list. When the clinical diagnostic lab procedure is billed as a routine screening service, as evidenced by the diagnosis code not found on the allowed diagnosis code list, the procedure code will deny. Please refer to the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	11/14/2018	Medicaid	Professional
Return Edit	C13DN	Diagnosis <1> is not appropriate with procedure <2> per the Clinical Diagnostic Lab Policy for Tumor Antigen by Immunoassay CA 19-9 Testing.	(C13DN) Clinical Diagnostic Lab Policy for Tumor Antigen by Immunoassay CA 19-9 Testing This edit will allow clinical diagnostic lab procedure(s) when submitted with a diagnosis code found on the allowed diagnosis code list. When the clinical diagnostic lab procedure is billed as a routine screening service, as evidenced by the diagnosis code not found on the allowed diagnosis code list, the procedure code will deny. Please refer to the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	11/14/2018	Medicaid	Professional
Return Edit	C14DN	Diagnosis <1> is not appropriate with procedure <2> per the Clinical Diagnostic Lab Policy for Gamma Glutamyl Transferase Testing.	(C14DN) Gamma Glutamyl Transferase Testing This edit will allow clinical diagnostic lab procedure(s) when submitted with a diagnosis code found on the allowed diagnosis code list. When the clinical diagnostic lab procedure is billed as a routine screening service, as evidenced by the diagnosis code not found on the allowed diagnosis code list, the procedure code will deny. Please refer to the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	11/14/2018	Medicaid	Professional
Return Edit	C15DN	Diagnosis <1> is not appropriate with procedure <2> per the Clinical Diagnostic Lab Policy for Hepatitis Panel/Acute Hepatitis Panel Testing.	(C15DN) Hepatitis Panel/Acute Hepatitis Panel Testing This edit will allow clinical diagnostic lab procedure(s) when submitted with a diagnosis code found on the allowed diagnosis code list. When the clinical diagnostic lab procedure is billed as a routine screening service, as evidenced by the diagnosis code not found on the allowed diagnosis code list, the procedure code will deny. Please refer to the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	11/14/2018	Medicaid	Professional

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Return Edit	C18DN	Diagnosis <1> is not valid with current line procedure code <2> per the Clinical Diagnostic Lab Policy for Glycated Hemoglobin/Glycated Protein. Code is not found on the allowed diagnosis code list	(C18DN) Glycated Hemoglobin Protein Based on the CMS National Coverage Determination (NCD) coding policy manual, services that are excluded from coverage include routine physical examinations and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury. Please refer to the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	10/4/2018	Medicaid	Professional
Return Edit	CAG	Procedure Code <1> is not typical for a patient whose age is <2> <3>.	(CAG) Procedure Code Not Typical for Age Age designations are assigned to selected procedure codes within the Knowledgebase based on the code descriptor; information from professional specialty societies; and/or guidelines from the current CPT® Professional Edition; Food and Drug Administration (FDA); American Medical Association (AMA); International Classification of Diseases, Tenth Revision Clinical Modification (ICD-10-CM); the current HCPCS Level II Expert; and the American Hospital Association (AHA) Coding Clinic. If the code descriptor does not contain a specific age or an industry source is not found to support an age assignment then an age range is not assigned. This indicates the procedure is appropriate for any age. National coding guidelines (see Policy Description for entities.)	3/28/2019	Medicare	Professional
Return Edit	CBSC4	Procedure code <1> is missing appropriate modifier.	(CBSC4) Brace Supply Codes: Limit braces according to the list attached to include Consideration for anatomical modifier (LT/RT when appropriate). CMS has guidelines around the reasonable useful lifetime (RUL) limits for braces, orthotics and other joint supports and accessories. To be consistent with the RULs recognized by CMS, United will deny claims for braces, orthotics and other joint supports and accessories when they exceed the RUL for the applicable device. This applies for both contracted and non-contracted providers. Please refer to the CMS RUL Limits available at CMS Code of Federal Regulations for further information.	1/17/2019	Medicare	Professional
Return Edit	CCIDD	Procedure <1> is included with procedure <2> on the current or previously submitted claim. Under appropriate circumstances, a designated modifier may be required to identify distinct services.	(CCIDD) CCI NCCI DME Denial Consistent with CMS, UnitedHealthcare utilizes the procedure-to-procedure (PTP) durable medical equipment (DME) edits developed by Medicaid in October of 2012, and will not separately reimburse PTP column two codes unless appropriately reported with one of the NCCI designated modifiers recognized by UnitedHealthcare under this policy. When one of the designated modifiers is appended to either the PTP column one or column two code rendered to the same patient, on the same date of service and by the Same Individual Physician or Other Health Care Professional, and there is an NCCI modifier indicator of "1", UnitedHealthcare will consider both services and/or procedures for reimbursement. Please refer to the "Modifiers" section of this policy for a complete listing of acceptable modifiers. Please refer to the CCI Editing Policy, Professional available on UHCProvider.com for further information.	5/9/2019	Commercial	Professional

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Return Edit	CCIMD	Procedure <1> is included with procedure <2> on the current or previously submitted claim.	(CCIMD) Medicaid CCI Unbundle Denial UnitedHealthcare Community Plan uses this policy to administer the "Column One/Column Two" National Correct Coding Initiative (NCCI) edits not otherwise addressed in UnitedHealthcare Community Plan reimbursement policies to determine whether CPT and/or HCPCS codes reported together by the Same Individual Physician or Other Health Care Professional for the same member on the same date of service are eligible for separate reimbursement. When reported with a column one code, UnitedHealthcare Community Plan will not separately reimburse a column two code unless the codes are appropriately reported with one of the NCCI designated modifiers recognized by UnitedHealthcare Community Plan under this policy. When one of the designated modifiers is appended to the column one or column two edit code for a procedure or service rendered to the same patient, on the same date of service and by the Same Individual Physician or Other Health Care Professional, and there is an NCCI modifier indicator of "1", UnitedHealthcare Community Plan will consider both services and/or procedures for reimbursement. Please refer to the "Modifiers" section of this policy for a complete listing of acceptable modifiers and the description of modifier indicators of "0" and "1". Consistent with CMS, UnitedHealthcare Community Plan utilizes the procedure-to-procedure (PTP) durable medical equipment (DME) edits developed by Medicaid in October of 2012, and will not separately reimburse PTP column two codes unless appropriately reported with one of the NCCI designated modifiers recognized by UnitedHealthcare Community Plan under this policy. When one of the designated modifiers is appended to the PTP column one or column two edit code rendered to the same patient, on the same date of service and by the Same Individual Physician or Other Health Care Professional, and there is an NCCI modifier indicator of "1", UnitedHealthcare Community Plan will consider both services and/or procedures for reimbursement. Please refer to the "Modifiers" section of this policy for a complete listing of acceptable modifiers. Please refer to the CCI Editing Policy, Professional and Facility Reimbursement Policy on UHCprovider.com for further information.	5/2/2019	Medicaid	Professional
Return Edit	CCIUN	Under appropriate circumstances, a designated modifier may be required to identify distinct services.	(CCIUN) CCI Unbundling Deny UnitedHealthcare administers the "Column One/Column Two" National Correct Coding Initiative (NCCI) edits not otherwise addressed in UnitedHealthcare reimbursement policies to determine whether CPT and/or HCPCS codes reported together by the Same Individual Physician or Other Health Care Professional for the same member on the same date of service are eligible for separate reimbursement. When reported with a column one code, UnitedHealthcare will not separately reimburse a column two code unless the codes are appropriately reported with one of the NCCI designated modifiers recognized by UnitedHealthcare under this policy. When one of the designated modifiers is appended to the column two edit code for a procedure or service rendered to the same patient, on the same date of service and by the Same Individual Physician or Other Health Care Professional, and there is an NCCI modifier indicator of "1", UnitedHealthcare will consider both services and/or procedures for reimbursement. Please refer to the "Modifiers" section of this policy for a complete listing of acceptable modifiers and the description of modifier indicators of "0" and "1". Please refer to the CCI Editing Policy, Professional Reimbursement Policy – UnitedHealthcare Commercial Plans on UHCprovider.com for further information.	4/25/2019	Commercial	Professional

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Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	CPO	Procedure code <1> is not appropriate as Care Plan Oversight services do not involve direct patient contact. Update code(s) as applicable for services rendered.	(CPO) Care Oversight Plan Care Plan Oversight (CPO) Services refer to physician and other qualified health care professional supervision of patients under the care of home health agencies, hospice, or nursing facilities. Care Plan Oversight services are reported separately from codes for office/outpatient, hospital, home, nursing facility, or domiciliary services. Code selection for Care Plan Oversight Services is determined by the complexity and approximate time spent by the physician or other qualified health care professional within a 30-day period. UHG DOES NOT REIMBURSE FOR CARE PLAN OVERSIGHT SERVICES THAT ARE BILLED UNDER CPT CODES 99374, 99377, 99379, 99380, G0179 and G0180 BECAUSE THEY DO NOT INVOLVE DIRECT PATIENT CONTACT. Please refer to the Care Plan Oversight Policy Reimbursement policy at UHCprovider.com for further information.	3/14/2019 3/28/2019	Commercial Medicaid	Professional
Return Edit	CPO	Procedure code <1> is not appropriate as Care Plan Oversight services do not involve direct patient contact. Update code(s) as applicable for services rendered.	(CPO) Care Plan Oversight Care Plan Oversight (CPO) Services refer to physician and other health care professional supervision of patients under the care of home health agencies, hospice, or nursing facilities. Care Plan Oversight services are reported separately from codes for office/outpatient, hospital, home, nursing facility, or domiciliary services. Code selection for Care Plan Oversight Services is determined by the complexity and approximate time spent by the physician or other health care professional within a 30-day period The following codes are not reimbursable for Care Plan Oversight Services: • CPT codes 99339, 99374, 99377, 99379 • HCPCS codes S0220, S0221, S0250, S0270, S0271, S0272 Pease refer to the Community Plan Care Plan Oversight Policy on UHCprovider.com for further information.	3/28/2019	Medicaid	Professional
Return Edit	CPT	Procedure Code <1> is invalid.	(CPT) Inactive DX/CPT/HCPC Please refer to ICD 10 guidelines.	9/26/2019	Commercial	Professional
Return Edit	CSPDN	Consultation Services Procedure <1> is not reimbursable based on the Consultation Services Policy. Update to an appropriate evaluation and management procedure code.	(CSPDN) Consultation Codes Effective for claims with dates of service on or after Oct. 1, 2019, UnitedHealthcare aligns with CMS and does not reimburse consultation services procedure codes 99241-99245, 99251-99255, including when reported with telehealth modifiers for any practice or care provider, regardless of the fee schedule or payment methodology applied. The codes eligible for reimbursement are those that identify the appropriate Evaluation and Management (E/M) procedure code which describes the office visit, hospital care, nursing facility care, home service or domiciliary/rest home care service provided to the patient. Please refer to the Consultation Services Policy on UHCprovider.com for further information.	1/30/2020	Commercial	Professional
Return Edit	CSU2	Procedure code <1> submitted with modifier 62 is not appropriate. Update code(s) or modifier as applicable for services rendered.	(CSU2) Cosurgeon Non-Eligible The Co-Surgeon and Team Surgeon Policy identifies which procedures are eligible for Co-Surgeon and Team Surgeon services as identified by the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS). Please refer to the Co-Surgeon & Team Surgeon Policy, Professional on UHCprovider.com for more information.	5/2/2019	Medicaid	Professional
Return Edit	CTPM	Per CMS Coding Guidelines, Therapy Procedure Code <1> requires a valid modifier.	(CTPM) Custom Therapy Procedure to Modifier Effective January 1, 2018, CMS started requiring providers to bill with the appropriate modifiers for OT, PT, ST and Always therapy codes. CMS has published listed for each grouping and claims are to be denied if not appended with the correct modifier. Please refer to the Procedure to Modifier Reimbursement Policy on UHCprovider.com for more information.	3/14/2019	Medicare	Professional

UnitedHealthcare Smart Edits

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As Returned on the 277CA Clearinghouse Rejection Report

Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	DMED3	Durable Medical Equipment code <1> is not appropriate when billed without a purchase or repair modifier. Update code(s) or modifier as applicable for services rendered.	(DMED3) AC Purchase Repair Denial This policy describes how UnitedHealthcare Community Plan reimburses for the rental and/or purchase of certain items of Durable Medical Equipment (DME), Prosthetics and Orthotics. The provisions of this policy apply to the Same Specialty Physicians and Other Health Care Professionals, which includes DME, Prosthetic and Orthotic vendors, renting or selling DME, Prosthetics or Orthotics. Please refer to the Durable Medical Equipment, Orthotics and Prosthetics Policy, Professional (2/10/2019) Reimbursement Policy on UHCprovider.com for further information.	3/28/2019	Medicaid	Professional
Return Edit	DMED5	Durable Medical Equipment code <1> is not appropriate when billed without a Purchase modifier. Update code(s) or modifier as applicable for services rendered.	(DMED5) AC Purchase Denial. This policy describes how UnitedHealthcare Community Plan reimburses for the rental and/or purchase of certain items of Durable Medical Equipment (DME), Prosthetics and Orthotics. The provisions of this policy apply to the Same Specialty Physicians and Other Health Care Professionals, which includes DME, Prosthetic and Orthotic vendors, renting or selling DME, Prosthetics or Orthotics. Please refer to the Durable Medical Equipment, Orthotics and Prosthetics Policy, Professional (2/10/2019) Reimbursement Policy on UHCprovider.com for further information.	2/21/2019	Medicaid	Professional
Return Edit	DMED6	Durable Medical Equipment code <1> is not appropriate when billed without a Rental modifier. Update code(s) or modifier as applicable for services rendered.	(DMED6) AC Rental Denial This policy describes how UnitedHealthcare Community Plan reimburses for the rental and/or purchase of certain items of Durable Medical Equipment (DME), Prosthetics and Orthotics. The provisions of this policy apply to the Same Specialty Physicians and Other Health Care Professionals, which includes DME, Prosthetic and Orthotic vendors, renting or selling DME, Prosthetics or Orthotics. Please refer to the Durable Medical Equipment, Orthotics and Prosthetics Policy, Professional (2/10/2019) Reimbursement Policy on UHCprovider.com for further information.	3/28/2019	Medicaid	Professional
Return Edit	DMEDN	Procedure <1> has exceeded the maximum allowed units. Under appropriate circumstances, a designated modifier may be required to identify distinct services.	(DMEDN) Multiple Frequency Total reimbursement of fees reported for a single code (modified with RR and/or NU) from a single vendor is limited to either the purchase price of the item or a maximum number of rental months, whichever is less. These rental limits do not apply to oxygen equipment or to ventilators. There may be situations where a physician or other qualified health care professional reports units accurately and those units exceed the established MFD value. In such cases, UnitedHealthcare will consider additional reimbursement if reported with an appropriate modifier such as modifier 59, 76, 91, XE, XS, or XU. Medical records are not required to be submitted with the claim when modifiers 59, 76, 91, XE, XS, or XU are appropriately reported. Documentation within the medical record should reflect the number of units being reported and should support the use of the modifier. Please refer to the Durable Medical Equipment, Orthotics and Prosthetics Policy, Professional-Reimbursement Policy UnitedHealthcare Commercial Plans on UHCProvider.com for further information.	5/30/2019	Commercial	Professional
Return Edit	DMEMD	Modifiers RT and LT submitted on the same line with procedure code <1> for DME, orthotics, or prosthetics are not appropriate. Update code(s) or modifiers as applicable for services rendered.	(DMEMD) DME Mod Denial This policy describes how UnitedHealthcare Community Plan reimburses for the rental and/or purchase of certain items of Durable Medical Equipment (DME), Prosthetics and Orthotics. The provisions of this policy apply to the Same Specialty Physicians and Other Health Care Professionals, which includes DME, Prosthetic and Orthotic vendors, renting or selling DME, Prosthetics or Orthotics. Medicaid Please refer to the Durable Medical Equipment, Orthotics and Prosthetics Policy reimbursement policy at UHCprovider.com for further information. Commercial Please refer to the Durable Medical Equipment, Orthotics and Prosthetics Policy, Professional (2/10/2019) Reimbursement Policy on UHCprovider.com for further information.	3/28/2019 4/4/2019	Medicaid Commercial	Professional

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Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	DMEMM	Durable Medical Equipment code <1> is not appropriate when billed without a modifier. Update code(s) or modifier as applicable for services rendered.	(DMEMM) AC DME Missing Modifier. This policy describes how UnitedHealthcare Community Plan reimburses for the rental and/or purchase of certain items of Durable Medical Equipment (DME), Prosthetics and Orthotics. The provisions of this policy apply to the Same Specialty Physicians and Other Health Care Professionals, which includes DME, Prosthetic and Orthotic vendors, renting or selling DME, Prosthetics or Orthotics. Please refer to the Durable Medical Equipment, Orthotics and Prosthetics Policy, Professional (2/10/2019) Reimbursement Policy on UHCprovider.com for further information.	2/21/2019	Medicaid	Professional
Return Edit	DMEMR	Procedure code <1> is a DME code that requires a rental or purchase modifier. Update code(s) as applicable.	(DMEMR) DME Multiple Freq Setup Some DME items are eligible for rental as well as for purchase. The codes representing these items must be reported with the appropriate rental or purchase modifier in order to be considered for reimbursement. Please refer to the Durable Medical Equipment, Orthotics and Prosthetics Policy, Professional-Reimbursement Policy UnitedHealthcare Commercial Plans on UHCProvider.com for further information.	5/30/2019	Commercial	Professional
Return Edit	DMERD	Procedure <1> is a Rental Only item that requires a rental modifier. Update code(s) as applicable for the services billed.	(DMDRD)DME Multiple Frequency Some DME items are eligible for rental only. The codes must be reported with the appropriate rental modifier in order to be considered for reimbursement. Total reimbursement of fees reported for a single code (modified with RR and/or NU) from a single vendor is limited to either the purchase price of the item or a maximum number of rental months, whichever is less. These rental limits do not apply to oxygen equipment or to ventilators. Rental Modifiers The following modifiers indicate that an item has been rented: - RR Rental - KH Initial Claim, purchase or first month rental - KI Second or third monthly rental - KJ Capped rental months four to fifteen - KR Partial month Please refer to Durable Medical Equipment, Orthotics and Prosthetics Policy, Professional Reimbursement Policy – UnitedHealthcare Commercial Plans on UHCprovider.com for further information.	4/4/2019	Commercial	Professional
Return Edit	DXIDN	Diagnosis Code <1> is an incomplete diagnosis. Please update to a complete diagnosis code.	(DXIDN) Incomplete Diagnosis Code. Commercial ICD 10 Diagnosis code. Submitted claim missing completed appropriate ICD-10 diagnosis code. Medicaid Validation edit, ICD-10 Please review this link for additional information: https://www.cdc.gov/nchs/icd/icd10cm.htm	2/21/2019 3/28/2019	Commercial Medicaid	Professional
Informational Edit	EDC	This claim has been identified as being billed with an Emergency Department EM Code at a higher level than expected. For more information refer to the Emergency Department Facility EM Coding Policy at UHCProvider.com	(EDC) Emergency Visit Claim Sent to Adjustment Claim was identified as being billed with an Emergency Department EM Code at a higher level than expected, and will be adjusted to an appropriate level. Emergency Department (ED) Facility Evaluation and Management (E&M) Coding Policy: UB-04 Claims for services rendered in an emergency department should be complete and include all diagnostic services and diagnosis codes relevant to the emergency department visit and be billed at the appropriate E/M level. Commercial/Medicaid/Medicare Please refer to the Emergency Department Facility Evaluation and Management Coding Reimbursement Policy on UHCProvider.com for further information.	2/18/2018 9/20/2018	Commercial Medicaid Medicare	Professional

UnitedHealthcare Smart Edits

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As Returned on the 277CA Clearinghouse Rejection Report

Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Informational Edit	EMPI5	INFORMATIONAL - This claim has been identified as being billed with an Emergency Department EM code at a higher level than expected. For more information refer to the professional E/M policy guidelines at uhcprovider.com.	(EMPI5) EM Pro Per American Medical Association supported by CMS guidelines, Emergency Department (ED) Evaluation and Management (E/M) charges must meet or exceed the three components (History, Exam, and Medical Decision Making) to qualify for Level 5 procedure codes. This ACE Informational message gets sent when the E/M Pro tool identifies that the indicators for these components cannot be found on the claim or in the member's history for a Level 5 procedure code in an Emergency Room place of service (23). Commercial: Please refer to the January Network Bulletin, page 38, for more information on the E/M Pro tool, and reference the Commercial Evaluation and Management Policy at UHCprovider.com for reimbursement and coding requirements. Medicare: Please refer to the February Network Bulletin, page 28, for more information on the E/M Pro tool, and reference the Medicare Advantage Evaluation and Management Policy at UHCprovider.com for reimbursement and coding requirements. Medicaid: Please refer to your state-specific Community and State portal for updates, and the UHC Community Plan Evaluation and Management Policy at UHCprovider.com for reimbursement and coding requirements.	2/20/2020	Commercial Medicare Medicaid	Professional
Return Edit	f01756PD	Procedure <1> is not appropriate in <2> Place of Service for the State of <3>. Update code(s) as applicable for services rendered.	(f01756PD) Procedure to POS Denial This policy addresses the appropriate Places of service for certain CPT and HCPCS procedure codes. Descriptions of some CPT and HCPS codes included in what Places of service the code may be used. For example, it would not be appropriate to submit Place of service “inpatient” for a code that states “office or outpatient visit”. Please refer to the Procedure to Place of Service Policy, Professional (2/10/2019) Reimbursement Policy on UHCprovider.com for further information.	3/7/2019	Medicaid	Professional
Return Edit	FTADX	Diagnosis <1> is not appropriate when submitted with procedure code <2>. Update code(s) as applicable for services rendered.	(FTADX) Fetal Aneuploidy Diagnosis Denial DNA-based noninvasive prenatal tests of fetal aneuploidy are proven and medically necessary as screening tools for trisomy 21 (Down syndrome), trisomy 18 (Edwards syndrome) or trisomy 13 (Patau syndrome) in ANY ONE of the following circumstances: • Maternal age of 35 years or older at delivery • Fetal ultrasound findings indicating an increased risk of aneuploidy • History of a prior pregnancy with a trisomy • Positive first- or second-trimester screening test results for aneuploidy • Parental balanced Robertsonian translocation with an increased risk of fetal trisomy 13 or trisomy 21 DNA-based noninvasive prenatal tests are unproven and not medically necessary for all other fetal conditions Please refer to Fetal Aneuploidy Testing Using Cell-Free Fetal Nucleic Acids in Maternal Blood Commercial Medical & Drug Policies on UHCProvider.com for further information.	4/4/2019	Commercial	Professional

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Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	GDPIN	Procedure <1> is included in the global period of code <2> on this or a previously submitted claim. Under appropriate circumstances, a designated modifier may be required to identify distinct services.	(GDPIN) E/M Included in Global Package The Global Period assignment or Global Days Value is the time frame that applies to certain procedures subject to a Global Surgical Package concept whereby all necessary services normally furnished by a physician (before, during and after the procedure) are included in the reimbursement for the procedure performed. Modifiers should be used as appropriate to indicate services that are not part of the Global Surgical Package. For purposes of this policy, Same Specialty Physician or Other Qualified Health Care Professional is defined as physicians and/or other qualified health care professionals of the same group and same specialty reporting the same Federal Tax Identification number (TIN). Commercial/Medicaid Please refer to the Global Days Policy, Professional Reimbursement Policy on UHCProvider.com for further information.	4/25/2019 5/30/19	Commercial Medicaid	Professional
Return Edit	I01DN	Procedure <1> for tendon Sheath, Ligament, Ganglion Cyst, Carpal or Tarsal Tunnel is not appropriate with the primary diagnosis submitted. If applicable, update your submission.	(I01DN) ICD10 Filters Denial for Inj TSL_GC_CTT UnitedHealthcare Community Plan reimburses for injections into the tendon/tendon sheath, or ligament (CPT codes 20550, 20551) ganglion cyst (CPT code 20612), carpal tunnel or tarsal tunnel (CPT code 20526) when one of the diagnosis codes are listed on a claim denoting problems with one of these regions. UnitedHealthcare Community Plan will not reimburse when the treatment rendered is without inclusion of one of the ICD-10-CM diagnostic codes being included on the claim accurately reflecting the member's condition. Please refer to the Injections into Tendon Sheath, Ligament, Ganglion Cyst, Carpal and Tarsal Tunnel Policy Reimbursement Policy on UHCProvider.com for further information.	1/31/2019	Medicaid	Professional
Return Edit	I05DN	Procedure <1> for Viral Hepatitis Serology Testing is not appropriate with the primary diagnosis submitted. If applicable, update your submission.	(I05DN) ICD10 Filters Denial for Viral_Hep_Ser_Tst UnitedHealthcare Community Plan reimburses for viral hepatitis serology testing (Current Procedural Terminology (CPT ®) codes 86704, 86705, 86706, 86707, 86708, 86709, 86803, 86804, 87340, 87341, 87350, 87902, 87912, G0472 and G0499 when one of the diagnosis codes listed on a claim indicates the presence of liver disease, liver abnormalities, or testing for these indications during pregnancy or infertility treatment. UnitedHealthcare Community Plan will not reimburse when the test is rendered without inclusion of one of the ICD-10-CM diagnostic codes being included on the claim accurately reflecting the member's condition. Please refer to the Viral Hepatitis Serology Testing Policy, Professional Reimbursement Policy on UHCProvider.com for further information.	1/31/2019	Medicaid	Professional
Return Edit	I06DN	Procedure <1> for Audiologic/Vestibular Function Testing is not appropriate with the primary diagnosis submitted. If applicable, update your submission.	(I06DN) ICD10 Filters Denial for Audio_Vest_Fxn_Tst UnitedHealthcare Community Plan reimburses for audiologic/vestibular function testing (CPT codes 92540, 92541, 92542, 92543, 92544, 92545, 92546, 92547, 92550, 92553, 92555, 92556, 92557, 92561, 92562, 92563, 92564, 92565, 92567, 92568, 92570, 92571, 92572, 92575, 92576, 92577, 92582, 92583, 92584, 92585, 92597, 92620, 92621, 92625) when one of the diagnosis codes are listed on a claim denoting problems associated with either balance or hearing. UnitedHealthcare Community Plan will not reimburse when the treatment rendered is without inclusion of one of the ICD-9/ICD-10 diagnostic codes being included on the claim accurately reflecting the member's condition. Please refer to the Audiologic Vestibular Function Testing Policy Reimbursement Policy on UHCProvider.com for further information.	1/31/2019	Medicaid	Professional
Return Edit	I07DN	Procedure <1> for Radioallergosorbent (RAST) Type Testing is not appropriate with the primary diagnosis submitted. If applicable, update your submission.	(I07DN) ICD10 Filters Denial for RAST_Type_Tst UnitedHealthcare Community Plan reimburses for radioallergosorbent (RAST) type tests (CPT code 86003) when one of the diagnosis codes are listed on a claim denoting allergic symptoms. UnitedHealthcare Community Plan will not reimburse when the test is rendered is without inclusion of one of the ICD-9/ICD-10 diagnostic codes being included on the claim accurately reflecting the member's condition. Please refer to the Radioallergosorbent (RAST) Type Tests Policy Reimbursement Policy on UHCProvider.com for further information.	1/31/2019	Medicaid	Professional

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Return Edit	IAG	Diagnosis code(s) <1> is not typical for a patient whose age is <2>.	(IAG) Diagnosis Not Typical for Patient Age CMS and ICD-10 billing guidelines describe diagnosis code to age relationships. CMS ICD-10 CM guidelines: https://www.cms.gov/medicare/coding/icd10/	6/13/2019	Medicare	Professional
Informational Edit	IDCD	INFORMATIONAL Per the ICD-10 CM Excludes 1 note guideline, diagnosis codes <1>, <2> identify two conditions that cannot be reported together except when the two conditions are unrelated.	(IDCD) Inappropriate Diagnosis Combination The current ICD-10-CM official conventions state, "An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition." Please refer to the ICD-10 CM Coding Guidelines for further information on Excludes 1.	6/6/2019	Commercial Medicare Medicaid	Professional
Return Edit	IMC	Modifier <1> is invalid with modifier <2> and cannot be submitted on the same claim line.	(IMC) Inappropriate Modifier Combination The IMC flag identifies CPT® and/or HCPCS modifier combinations that are inappropriate when submitted together on the same claim line. The IMC table is used in the IMC rule to ensure that submitted modifiers are valid together on the same claim line. The IMC rule checks for the combination of the first modifier plus the second modifier. If not found, it looks for the combination of the second modifier plus the first modifier. For example, a program memorandum from the CMS requires that modifier 50 be appended to the procedure code on a single claim line with one unit for a procedure performed on paired body parts at the same operative session. Modifiers LT/RT should not be used when modifier 50 applies. Based on this rationale, it would be inappropriate to submit modifiers 50 and RT or modifiers 50 and LT on the same claim line. The IMC flag fires when modifiers 50 and RT or modifiers 50 and LT are submitted on the same claim line and identifies modifier combinations that are inappropriate when submitted together on the same claim line. Please refer to the Procedure to Modifier Reimbursement Policy on UHCprovider.com for more information.	8/16/2018	Medicare	Professional
Return Edit	IMO	The modifier code(s) <1> are invalid.	(IMO) Invalid Modifier The IMO edit identifies a claim line containing a modifier that is not found in the table of valid CPT®, HCPCS, or user-defined modifiers. Please refer to the Procedure to Modifier Reimbursement Policy – UnitedHealthcare Medicare Advantage on UHCprovider.com for further information.	8/16/2018	Medicare	Professional
Info Banner	INFO	For supporting documentation regarding this edit refer to UnitedHealthcare policies for the Smart Edits Policy Reference guide at UHCProvider.com/SmartEdits. If applicable, update your submission.	(INFO) Info Banner The INFO edit is exhibited on all claims receiving smart edits. The intent of the INFO edit is to provide resources for further information on smart edits and the associated policies.	1/31/2019	Medicaid, Medicare, Commercial	All
Return Edit	IPDDN	Diagnosis code <1> is an inappropriate primary diagnosis code.	(IPDDN) Inappropriate Primary Diagnosis Code Inappropriate Primary Diagnosis Codes Policy states appropriate primary diagnosis codes must be billed in order to receive reimbursement for procedure codes. UnitedHealthcare will deny claims where an inappropriate diagnosis is pointed to or linked as primary in box 24E (Diagnosis Pointer) on a CMS-1500 claim form or its electronic equivalent. When a code on the Inappropriate Primary Diagnosis List is pointed to or linked as the primary diagnosis on the claim form, the associated claim line(s) will be denied. Please refer to the Inappropriate Primary Diagnosis Codes Reimbursement Policy – UnitedHealthcare Commercial Plans on UHCprovider.com for further information.	10/4/2018	Commercial	Professional

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Return Edit	LABAD	Procedure code <1> is incorrect. Drug Assay services may be reported with a more appropriate HCPCS code.	(LABAD) Lab Auto Deny Consistent with CMS, Drug Assay CPT codes 80320-80377 are considered non-reimbursable. These services may be reported under an appropriate HCPCS code. Please refer to the Laboratory Services reimbursement policy at UHCprovider.com for further information.	11/14/2018	Commercial	Professional
Return Edit	LABDU	This procedure <1> has been previously submitted by this or another provider. Update code(s) as applicable for services rendered.	(LABDU) Duplicate Lab Only one laboratory provider will be reimbursed when multiple individuals report Duplicate Laboratory Services. Multiple individuals may include, but are not limited to, any physician or other qualified health care professional, Independent Laboratory, Reference Laboratory, Referring Laboratory or pathologist reporting duplicate services. Please refer to the Laboratory Services Policy, Professional for further information.	5/9/2019	Commercial	Professional
Return Edit	LABDU	This procedure <1> has been previously submitted by this or another provider. Update code(s) as applicable for services rendered.	(LABDU) Duplicate LAB This policy describes the reimbursement methodology for laboratory panels and individual Component Codes, as well as reimbursement for venipuncture services, laboratory services performed in a facility setting, laboratory handling, surgical pathology and clinical pathology consultations. The policy also addresses place of service and date of service relating to laboratory services. Duplicate laboratory code submissions by the same or multiple physicians or other health care professionals, as well as certain laboratory services provided in a facility place of service, are also addressed in this policy. Note this policy does not address reimbursement for all laboratory codes. Coding relationships for laboratory topics not included within this policy are administered through the UnitedHealthcare Community Plan “Rebundling” and “CCI Editing” policies. Please refer to the Laboratory Services Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	5/30/2019	Medicaid	Professional
Return Edit	LABNC	Procedure <1> is included with procedure <2> on the current or a previously submitted claim. Under appropriate circumstances, a designated modifier may be required to identify distinct services.	(LABNC) Lab Not Covered This policy describes the reimbursement methodology for laboratory panels and individual Component Codes, as well as reimbursement for venipuncture services, laboratory services performed in a facility setting, laboratory handling, surgical pathology and clinical pathology consultations. The policy also addresses place of service and date of service relating to laboratory services. Duplicate laboratory code submissions by the same or multiple physicians or other health care professionals, as well as certain laboratory services provided in a facility place of service, are also addressed in this policy. Note this policy does not address reimbursement for all laboratory codes. Coding relationships for laboratory topics not included within this policy are administered through the UnitedHealthcare Community Plan “Rebundling” and “CCI Editing” policies. Please refer to the Laboratory Services Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	5/30/2019	Medicaid	Professional

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Return Edit	LABUN	Procedure <1> is unbundled from code <2>[<1>, etc.....]. A comprehensive laboratory Panel Code is more appropriate.	(LABUN) Lab Bundling The LAB edit fires when lab charges are billed in conjunction with other lab charges. Laboratory Services Policy: This policy describes the reimbursement methodology for laboratory panels and individual Component Codes, as well as reimbursement for venipuncture services, laboratory services performed in a facility setting, laboratory handling, surgical pathology and clinical pathology consultations. The policy also addresses place of service and date of service relating to laboratory services. Please refer to the Laboratory Services Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	10/4/2018	Medicaid	Professional
Return Edit	LABVDU	This procedure <1> has been previously submitted by this or another provider. Update code(s) as applicable for services rendered.	(LABVDU) Lab Venipuncture Duplicate Lab Service This policy describes the reimbursement methodology for laboratory panels and individual Component Codes, as well as reimbursement for venipuncture services, laboratory services performed in a facility setting, laboratory handling, surgical pathology and clinical pathology consultations. The policy also addresses place of service and date of service relating to laboratory services. Duplicate laboratory code submissions by the same or multiple physicians or other health care professionals, as well as certain laboratory services provided in a facility place of service, are also addressed in this policy. Note this policy does not address reimbursement for all laboratory codes. Coding relationships for laboratory topics not included within this policy are administered through the UnitedHealthcare Community Plan “Rebundling” and “CCI Editing” policies. Please refer to the Laboratory Services Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	5/30/2019	Medicaid	Professional
Return Edit	LABVDU	Procedure <1> is a duplicate lab service to a service on the current or previously submitted claim. Under appropriate circumstances, a designated modifier may be allowed to identify distinct services.	(LABVDU) Duplicate Lab Separate consideration will be given to repeat procedures (i.e., two laboratory procedures performed the same day) by the Same Group Physician or Other Qualified Health Care Professional when reported with modifier 91. Modifier 91 is appropriate when the repeat laboratory service is performed by a different individual in the same group with the same Federal Tax Identification number. Please refer to the Laboratory Services Policy on UHCprovider.com	11/7/2019	Commercial	Professional

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As Returned on the 277CA Clearinghouse Rejection Report

Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	mAM	Per CMS guidelines, HCPCS Code <1> is identified as an ambulance code and requires an ambulance modifier appended.	(mAM) Medicare Ambulance Origin and Destination Modifiers For ambulance service claims, institutional-based providers and suppliers must report an origin and destination modifier for each ambulance trip provided in HCPCS/Rates. Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of X, represents an origin code or a destination code. The pair of alpha codes creates one modifier. The first position alpha code equals origin; the second position alpha code equals destination. The following are the origin and destination codes and their descriptions: D = Diagnostic or therapeutic site other than P or H when these are used as origin codes E = Residential, domiciliary, custodial facility (other than 1819 facility) G = Hospital based ESRD facility H = Hospital I = Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport J = Freestanding ESRD facility N = Skilled nursing facility P = Physician's office R = Residence S = Scene of accident or acute event X = Intermediate stop at physician's office on way to hospital (destination code only) The mAM edit identifies claim lines that contain an ambulance HCPCS code without an ambulance modifier appended that has a first character of D, E, G, H, I, J, N, P, R or S and a second character of D, E, G, H, I, J, N, P, R, S or X. When an ambulance HCPCS code without an appropriate ambulance modifier is on the current claim, the mAM edit is triggered. Please refer to the Procedure to Modifier Reimbursement Policy on UHCprovider.com for further information.	8/16/2018	Medicare	Professional
Return Edit	mANM	Per Medicare guidelines, anesthesia code <1>-<2>on claim line ID <3> requires an appropriate modifier.	(mANM) Medicare Anesthesia Modifier The mANM edit uses the CMS Medicare Claims Processing Manual to identify anesthesia services that were submitted without an anesthesia modifier. This edit fires on all claim lines that contain an anesthesia code, excluding CPT code 01996, submitted without modifier AA, AD, QK, QX, QY or QZ appended. Physicians must append the appropriate anesthesia modifier to denote whether the service was personally performed, medically directed or medically supervised. Payment for the service is determined by the use of these modifiers. Specific anesthesia modifiers include: AA – Anesthesia Services performed personally by the anesthesiologist AD – Medical Supervision by a physician; more than four concurrent anesthesia procedures QK – Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals QS – Monitored anesthesia care service QX – CRNA service with medical direction by a physician QY – Medical direction of one certified registered nurse anesthetist by an anesthesiologist QZ – CRNA service without medical direction by a physician The mANM edit identifies claim lines that contain an anesthesia code without an anesthesia modifier appended. Please refer to the Anesthesia Services Reimbursement Policy on UHCprovider.com for further information.	10/4/2018	Medicare	Professional

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As Returned on the 277CA Clearinghouse Rejection Report

Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	mAS	Medicare statutory payment restriction for assistants at surgery applies to the Procedure <1>.	(mAS) No Payment for Assistant Surgeons The mAS edit utilizes the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine eligibility of a CPT® code for the assistant surgeon modifiers 80, 81, 82, and AS. This edit will fire on all claim lines containing codes that have an indicator of "1" in the assistant surgeon column of the NPFS that are submitted with modifier 80, 81, 82, or AS appended. The NPFS defines the indicator 1 in the assistant surgeon column as follows: "1 = Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid." The mAS edit identifies claim lines that contain procedure codes with modifier 80, 81, 82 or AS appended inappropriately under Medicare rules. Medicare has designated codes that are identified by the indicator of 1 in the assistant surgeon column of the NPFS as ineligible for modifiers 80, 81, 82 and AS. Please refer to the Surgical Assistant Services Reimbursement Policy on UHCprovider.com for further information.	8/16/2018	Medicare	Professional
Return Edit	mCO	Per Medicare guidelines, billing for co-surgeons is not permitted for procedure code <1>.	(mCO) Co-Surgeons not permitted - Modifier 62 Co-Surgeon policy information lists codes that allow reimbursement for co-surgeons as well as the guidelines for providing documentation to support medical necessity. Please refer to the Co-Surgeon/Team Surgeon Policy, Professional on UHCprovider.com	6/13/2019	Medicare	Professional
Return Edit	MFDUALL	Procedure <1> with an allowed daily frequency of <2> has been exceeded by <3>. Under appropriate circumstances, a designated modifier may be required to identify distinct procedural services.	(MFDUALL) Maximum Frequency per Day Denial UHC has established MFD values, which are the highest number of units eligible for reimbursement of services on a single date of service. Service denies if code submitted with a specific daily frequency has been exceeded. There may be situations where a physician or other qualified health care professional reports units accurately and those units exceed the established MFD value. In such cases, UnitedHealthcare will consider additional reimbursement if reported with an appropriate modifier such as modifier 59, 76, 91, XE, XS, or XU. Medical records are not required to be submitted with the claim when modifiers 59, 76, 91, XE, XS, or XU are appropriately reported. Documentation within the medical record should reflect the number of units being reported and should support the use of the modifier. Please refer to the Maximum Frequency Per Day Policy, Professional on UHCProvider.com for further information.	5/9/2019	Commercial	Professional
Return Edit	mGT	Per Medicare guidelines, modifier <1> is inappropriately appended to procedure code <2>.	(mGT) Modifier 26 or TC applied inappropriately - Global Service The Professional/Technical Component policy lists codes that are appropriate for a PC/TC modifier and reimbursement guidelines for the professional and technical components of global services. Please refer to the Professional/Technical Component, Professional - Reimbursement Policy - UnitedHealthCare Medicare Advantage	6/13/2019	Medicare	Professional
Return Edit	mMFLf	Per Medicare guidelines, the associated administration code for vaccine procedure code <1> is invalid. Please update administration code as appropriate.	(mMFLf) Flu Shot Invalid Admin Code (90471) The ACE Smart Edit (mMFL) will apply when the influenza vaccine drugs HCPCS/CPT codes are reported on a claim without the influenza drug administration code. Please refer to the Medicare Claims Processing Manual, chapter 18, section 10.	8/8/2019	Medicare	Institutional
Return Edit	MMRRM	Diagnosis code is not appropriate for the procedure code <1> submitted. Update code(s) as applicable per the proven diagnosis code list unless a prior authorization has been approved.	(MMRRM) Medical Management Review. cade® (infliximab) is the preferred infliximab product. Coverage will be provided for Remicade® contingent on the coverage criteria in the Diagnosis-Specific Criteria section. Please refer to Infliximab (Remicade®, Inflectra™, Renflexis™) Commercial Medical & Drug Policies on UHCProvider.com for further information.	2/21/2019 4/18/2019	Commercial Medicaid	Professional

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As Returned on the 277CA Clearinghouse Rejection Report

Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	mNP	Per Medicare Guidelines, Procedure Code <1> is not typically performed by a physician in a Place of Service <2>.	(mNP) Medicare Non-Physician Service UnitedHealthcare Medicare Advantage will not allow reimbursement to physicians and other healthcare professionals for "Incident To" codes identified with a CMS PC/TC indicator 5 when reported in a facility POS regardless of whether a modifier is reported with the code. Please refer to the Professional/Technical Component reimbursement policy at UHCprovider.com for further information.	11/14/2018	Medicare	Professional
Return Edit	MOD	Use of Modifier <1> is inappropriate for Procedure Code <2>. Reimbursement for a procedure code/modifier combination is allowed only when the modifier has been used appropriately.	(MOD) Inappropriate Modifier In accordance with correct coding, UnitedHealthcare will consider reimbursement for a procedure code/modifier combination only when the modifier has been used appropriately per the procedure to modifier list. Commercial/Medicaid Please refer to the Procedure to Modifier reimbursement policy at UHCprovider.com for further information.	10/4/2018	Medicaid, Commercial	Professional
Return Edit	MODSD	Modifier is not valid with procedure code . Update code(s) as applicable for services rendered.	(MODSD) Procedure to Modifier In accordance with correct coding, UnitedHealthcare Community Plan will consider reimbursement for a procedure code/modifier combination only when the modifier has been used appropriately. Note that any procedure code reported with an appropriate modifier may also be subject to other UnitedHealthcare Community Plan reimbursement policies. Please Refer to the UnitedHealthcare Community Plan “Modifier Reference Policy” for a listing of UnitedHealthcare Community Plan reimbursement policies that discuss specific modifiers and their usage within those reimbursement policies.	11/7/2019	Medicaid	Professional
Return Edit	mPC	Per Medicare guidelines, procedure code <1> describes the physician work portion of a diagnostic test. Modifier 26 or TC on current line is not appropriate.	(mPC) Modifier 26 or TC applied inappropriately - Professional Component The Professional/Technical Component policy lists codes that are appropriate for a PC/TC modifier and reimbursement guidelines for the professional and technical components of diagnostic testing. Please refer to the Professional/Technical Component, Professional - Reimbursement Policy - UnitedHealthCare Medicare Advantage	6/13/2019	Medicare	Professional
Return Edit	mPI	Per the Medicare Physician Fee Schedule, Procedure Code <1> describes a physician interpretation for this service and is inappropriate in Place of Service <2>.	(mPI) Medicare Physician Interpretation The mPI edit uses the CMS NPFS to determine eligibility of a CPT code to be split into professional and technical components. This edit will fire on all claim lines containing codes that have an indicator of 8 in the PC/TC column of the NPFS that are submitted with a TC modifier. Attachment A of the NPFS defines the indicator 8 in the PC/TC column as follows: “8 = Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. This applies only to code 85060. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate. No payment is recognized for code 85060 furnished to hospital outpatients or non-hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test.” The mPI edit identifies claim lines that contain codes that have the modifier TC appended inappropriately or that are billed with a place of service other than inpatient. The concept of professional and technical component splits (PC/TC) does not apply since these codes describe professional inpatient services. Billing of the technical component is inappropriate by the physician as the facility should be responsible for submitting it. CMS has designated place of service 21 as inpatient (CES place of service indicator is 3) and it is the only recognized place of service designation when the PC/TC indicator is 8. All other place-of-service designations are inappropriate. Please refer to the Professional/Technical Component Reimbursement Policy on UHCprovider.com for further information.	8/16/2018	Medicare	Professional

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As Returned on the 277CA Clearinghouse Rejection Report

Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	mPS	Per Medicare guidelines, procedure code <1> describes the physician service. Use of modifier 26 or TC is not appropriate.	If the procedure code has modifier 26 or modifier TC on it and the Medicare MPFS PC/TC indicator for the procedure code = 0, then CES will generate this flag. Procedure codes with PC/TC indicator =0 describes the physician services. Use of modifier 26 or TC is not appropriate. Please refer to the Professional/Technical Component Reimbursement Policy on UHCprovider.com for further information.	7/25/2019	Medicare	Professional
Return Edit	mSB	Add-on procedure code <1> has been submitted without an appropriate primary procedure code.	(mSB) Medicare Add-On Procedure code without Primary Procedure Code Add on codes submitted as primary procedure codes are not reimbursable. Please refer to the Add-On Codes Policy found on UHCprovider.com for further information.	10/3/2019	Medicare	Professional
Return Edit	MSUDN	Procedure code <1> is not appropriate with modifier SU. Update code(s) as applicable for services rendered.	(MSUDN) SU Modifier Denial. The Centers for Medicare and Medicaid Services (CMS) indicates that the Health Care Common Procedure Coding System (HCPCS) modifier SU, Procedure performed in physician's office (to denote use of facility and equipment), is not payable. CMS establishes Relative Value Units (RVU) for CPT and HCPCS codes that include the costs of running an office (such as rent, equipment, supplies and nonphysician staff costs) which are referred to as the practice expense RVU. In accordance with CMS, UnitedHealthcare does not allow reimbursement for services appended with modifier SU in an office Place of service since the use of the office facility and equipment is included in the practice expense RVU, or the costs associated with operating an office. If the charges associated with the use of the modifier SU are submitted by a different provider than the physician performing the office procedure, they will not be considered for separate reimbursement since these practice expenses are considered included in the reimbursement for the physician performing the service. Commercial/Medicaid Please refer to the Modifier SU Policy, Professional Reimbursement Policy on UHCprovider.com for further information.	2/21/2019 4/18/2019	Commercial Medicaid	Professional
Return Edit	mTC	Per Medicare guidelines, procedure code <1> describes only the technical portion of a service or diagnostic test. Modifier 26 or TC is not appropriate.	(mTC)Technical Component Only Policy If the procedure code has modifier 26 or modifier TC on it and the Medicare MPFS PC/TC indicator for the procedure code = 3, then CES will generate this flag If the procedure code has modifier 26 or modifier TC on it and the Medicare MPFS PC/TC indicator for the procedure code = 3, then CES will generate this flag. Please refer to the Professional/Technical Component reimbursement policy at UHCprovider.com for further information.	7/18/2019	Medicare	Professional
Return Edit	mTS	Per Medicare guidelines, team surgery is not permitted for procedure code <1>.	(mTS) Team Surgeons Not Permitted If the claim is for a team surgery and the procedure code indicates that team surgery is not permitted, CES will generate this flag. This is based on the TEAM SURG = 0 on the CMS National Fee Schedule. Please refer to the Co-Surgeon / Team Surgeon Policy, Professional Reimbursement Policy on UHCProvider.com for further information.	7/18/2019	Medicare	Professional

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Return Edit	MUEUALL	Procedure <1> with an allowed daily frequency of <2> has been exceeded by <3>. Under appropriate circumstances, a designated modifier may be required to identify distinct procedural services.	(MUEUALL) AC MUE Max Freq Auto Denial Medically Unlikely Edits (MUEs) define for many HCPCS / CPT codes the maximum allowable number of units of service by the same provider, for the same beneficiary, for the same date of service, on the same claim line. Reported units of service greater than the MUE value are unlikely to be correct (e.g., a claim for excision of more than one gallbladder or more than one pancreas). For Professional claims, billed claim lines with a unit-of-service value greater than the established MUE value for the HCPCS / CPT code are denied payment for units above the MUE value. For Facility claims, when claim lines with a unit-of-service value greater than the established MUE value for the HCPCS / CPT code are reported, all units on the claim line will be denied. Please refer to the Medically Unlikely Edits (MUE) Policy, Professional and Facility Reimbursement Policy Community Plan on UHCProvider.com for further information.	5/30/2019	Medicaid	Professional
Return Edit	mUN	Per Medicare CCI guidelines, procedure code has an unbundle relationship with procedure code.	(mUN) Medicare Unbundled CCI editing policies vary per procedure. Billing bundled services separately requires a modifier for payment consideration. Please refer to the CCI Editing policy found on UHCprovider.com for further information.	10/10/2019	Medicare	Professional
Return Edit	NAGDN	Procedure <1> is not typical for patients aged, <2>. The typical age range for this procedure is <3>-<4>. Diagnosis and/or procedure codes reported inappropriately will not be reimbursed.	(NAGDN) Procedure Code not Typical for Age Age to Diagnosis Code & Procedure Code Policy addresses edits involving diagnosis (ICD10-CM) codes and CPT codes with age limitations. Age designations are assigned to select World Health Organization (WHO) International Classification of Diseases, Tenth Revision ICD10-CM) codes based on code descriptions or on publications and guidelines from sources such as professional specialty societies, the CMS, the American Medical Association (AMA) or the AHA (American Hospital Association) Coding Clinic. Reimbursement Guidelines UnitedHealthcare Community Plan develops edits for age for certain codes based on code descriptions, publications and guidelines from sources such as professional specialty societies or similar institutions and from the entities that create the codes (WHO, CMS, AMA). These guidelines can be either definitive or interpretive. UnitedHealthcare Community Plan will apply age edits when diagnosis and/or procedure codes are reported for the appropriate patient's age. Diagnosis and/or procedure codes reported inappropriately will be considered billing errors and will not be reimbursed. Please refer to the Age to Diagnosis Code & Procedure Code Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	10/4/2018	Medicaid	Professional
Return Edit	NDCCL	Procedure code <1> must be billed with valid NDC. Required elements are the valid 11 digit NDC number without spaces or hyphens, the unit of measure and units dispensed.	(NDCCL) Invalid NDC The UnitedHealthcare National Drug Code (NDC) reimbursement policy requires that claims submitted for reimbursement for drug-related revenue codes, Healthcare Common Procedure Coding System (HCPCS) and CPT® codes for certain UnitedHealthcare members must include: • A valid NDC number • The quantity • A unit of measure (UOM) Please refer to the National Drug Code Requirement Reimbursement Policy on UHCprovider.com for further information.	6/13/2019	Medicare	Professional

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Return Edit	NDCCL	Procedure <1> is missing the required NDC data. Resubmissions should include all required elements including valid (11 digit) NDC number without spaces or hyphens, the unit of measure, and units dispensed.	(NDCCL) Missing National Drug Code NDC Requirement Policy outlines that a valid NDC number, NDC unit of measure and NDC units dispensed for the drug administered will be required for reimbursement of professional drug claims on a1500 Health Insurance Claim Form (a/k/a CMS-1500)) or the 837 professional transaction. Correct NDC number must be billed with its corresponding code to receive reimbursement. Codes not billed with their correct NDC number will be denied. Please refer to the National Drug Code Requirement Reimbursement Policy on UHCprovider.com for further information.	10/4/2018	Commercial	Professional
Return Edit	NDCDN	Procedure code <1> must be billed with valid NDC. Required elements are the valid 11 digit NDC number without spaces or hyphens, the unit of measure and units dispensed.	(NDCDN) Invalid NDC The UnitedHealthcare National Drug Code (NDC) reimbursement policy requires that claims submitted for reimbursement for drug-related revenue codes, Healthcare Common Procedure Coding System (HCPCS) and CPT® codes for certain UnitedHealthcare members must include: • A valid NDC number • The quantity • A unit of measure (UOM) Please refer to the National Drug Code Requirement Reimbursement Policy on UHCprovider.com for further information.	10/4/2018	Commercial	Professional
Return Edit	NDCUD	Submission of an unlisted code <1> must be billed with valid NDC data. Required elements are a valid (11 digit) NDC number without spaces or hyphens, unit of measure, and units dispensed.	(NDCUD) NDC Unlisted Denial A valid NDC number, NDC unit of measure and NDC units dispensed for the drug administered will be required for reimbursement of professional drug claims on a1500 Health Insurance Claim Form (CMS-1500)) or the 837 professional transaction. Correct NDC number must be billed with corresponding code to receive reimbursement. Codes not billed with their correct NDC number, will be denied. Please refer to the National Drug Code Requirement reimbursement policy at UHCprovider.com for further information.	11/14/2018	Commercial	Professional
Return Edit	NIRDN	Procedure <1> is not appropriate. Status E and Status X codes are not appropriate when reported by health care professionals. Update code(s) as applicable for services rendered.	(NIRDN) Codes Not for Health Pros Consistent with CMS and in accordance with correct coding, UnitedHealthcare will deny select status indicator E and X codes reported on a CMS-1500 form or its electronic equivalent. Please refer to the Services and Modifiers Not Reimbursable to Healthcare Professionals, Professional Reimbursement Policy Commercial Plans located on UHCProvider.com for further information.	5/30/2019	Commercial	Professional
Return Edit	NIRMD	The modifier submitted is not appropriate with procedure <1> when reported by a physician or other health care professional. Update code(s) as applicable for services rendered.	(NIRMD) Mod Not for Reimburse Modifiers 27, 73, 74, PO have been approved and designated for use by ambulatory surgery centers (ASC) or in the outpatient hospital setting. UnitedHealthcare will deny codes appended with these modifiers when reported by a physician or other health care professional. Please refer to the Services and Modifiers Not Reimbursable to Healthcare Professionals, Professional Reimbursement Policy Commercial Plans located on UHCProvider.com for further information.	5/30/2019	Commercial	Professional
Return Edit	OBGUA	Urinalysis Procedure <1> is not allowed as a separate charge when billed with primary OBGYN diagnosis of <2>. Update code(s) as applicable for services rendered.	(OBGUA) OBGYN Urinalysis denial Urinalysis code submitted is not a separately reimbursable service when POS billed is an OBGYN and primary diagnosis billed is an OBGYN diagnosis. UHC follows ACOG coding guidelines and considers an E/M service to be separately reimbursed in addition to an OB ultrasound procedures (CPT codes 76801-76817 and 76820-76828) only if the E/M service has modifier 25 appended to the E/M code. Please refer to the Obstetrical Policy, Professional on UHCProvider.com for further information.	5/9/2019	Commercial	Professional

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Return Edit	OBGUA	Urinalysis Procedure <1> is not appropriate when billed with an OBGYN primary diagnosis <2>. If applicable, update your submission.	(OBGUA) Urinalysis Denial As defined by the American Medical Association (AMA), "the total obstetric package includes the provision of antepartum care, delivery, and postpartum care." When the Same Group Physician and/or Other Health Care Professional provides all components of the OB package, report the global OB package code. The Current Procedural Terminology (CPT®) book identifies the global OB codes as: • 59400 - Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care • 59510 - Routine obstetric care including antepartum care, cesarean delivery and postpartum care • 59610 - Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery • 59618 - Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery. UnitedHealthcare Community Plan reimburses for these global OB codes when all of the antepartum, delivery and postpartum care is provided by the Same Group Physician and/or Other Health Care Professional. UnitedHealthcare Community Plan will adjudicate claims submitted with either a single date of service or a date span when submitting global OB codes. To facilitate claims processing, report one unit, whether submitted with a date span or a single date of service. Please refer to the Obstetrical Services Policy, Professional Reimbursement Policy on UHCProvider.com for further information	1/31/2019	Medicaid	Professional
Return Edit	OBGUS	Procedure <1> is included in procedure code <2> submitted on the current or a previously submitted claim. Update code(s) as applicable for services rendered.	(OBGUS) E/M Included in OBGYN Ultrasound UHC follows ACOG coding guidelines and considers an E/M service to be separately reimbursed in addition to an OB ultrasound procedures (CPT codes 76801-76817 and 76820-76828) only if the E/M service has modifier 25 appended to the E/M code. Please refer to the Obstetrical Policy, Professional Reimbursement Policy Commercial Plans on UHCProvider.com for further information.	5/30/2019	Commercial	Professional
Return Edit	OCMFD	Procedure <1> performed in a facility Place of service <2> is not appropriate. The payment for this service is included in the payment to the facility. Update code(s) as applicable for services rendered.	(OCMFD) Included in Facility Payment Services Reported in a CMS Facility Place of Service UnitedHealthcare Community Plan will not provide reimbursement to a physician or other qualified health care professional for High Osmolar Contrast Materials (HOCM), Low Osmolar Contrast Materials (LOCM) or Radiopharmaceutical Materials submitted with HCPCS codes A4641, A4642, A9500-A9700, J1245, Q3001, Q9951, Q9953, Q9954, Q9956, Q9957 and Q9958-Q9968 with a facility POS. Please refer to the Contrast and Radiopharmaceutical Materials Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	4/18/2019	Medicaid	Professional
Return Edit	OCMIP	Contrast or Radiopharmaceutical Material code <1> must be billed with an eligible imaging or therapeutic procedure. Update code(s) as applicable for services rendered.	(OCMIP) Contrast or Radiopharmaceutical Materials UnitedHealthcare will only allow separate reimbursement for contrast and Radiopharmaceutical Materials when reported with an eligible imaging and therapeutic or nuclear medicine procedure that is also eligible for reimbursement. Please refer to the Contrast and Radiopharmaceutical Materials Policy on UHCprovider.com	11/7/2019	Commercial	Professional

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Return Edit	ODSDD	Procedure code <1> submitted for diabetic shoes is not appropriate with the diagnosis code submitted. Update code(s) as applicable for services rendered.	(ODSDD) Diabetic Shoe Denial This policy identifies circumstances in which UnitedHealthcare Community Plan will reimburse physicians or other qualified health care professionals for orthotics and specialty shoes. Reimbursement Guidelines UnitedHealthcare Community Plan reimburses for orthotics and specialty shoes when billed with the appropriate Health Care Procedural Coding System (HCPCS®) code along with the appropriately corresponding ICD-10 diagnostic code. UnitedHealthcare Community Plan will not reimburse for diabetic shoes or orthotics provided to patients without a diagnosis of diabetes reflected on the claim. Similarly, UnitedHealthcare Community Plan will not reimburse for non-diabetic shoes or orthotics to patients with a diagnosis of diabetes reflected on the submitted claim, as there are more appropriate codes that should be utilized. The attached procedure to diagnosis lists were derived by identifying correct coding between HCPCS® and ICD-10. Claims for codes on the "Diabetes Shoes" list should be submitted with a diagnosis from the "Diabetes Diagnosis" list. Claims for codes on the "Orthopedic Shoes" list should not be submitted with a diagnosis from the "Diabetes Diagnosis" list. Please refer to the Diabetic and Other Orthopedic Shoes, Professional Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	4/25/2019	Medicaid	Professional
Return Edit	ODSDO	Procedure code <1> submitted for orthopedic shoes is not appropriate with the diagnosis code submitted. Update code(s) as applicable for services rendered.	(ODSDO) Orthopedic Shoes Denial This policy identifies circumstances in which UnitedHealthcare Community Plan will reimburse physicians or other qualified health care professionals for orthotics and specialty shoes. Reimbursement Guidelines UnitedHealthcare Community Plan reimburses for orthotics and specialty shoes when billed with the appropriate Health Care Procedural Coding System (HCPCS®) code along with the appropriately corresponding ICD-10 diagnostic code. UnitedHealthcare Community Plan will not reimburse for diabetic shoes or orthotics provided to patients without a diagnosis of diabetes reflected on the claim. Similarly, UnitedHealthcare Community Plan will not reimburse for non-diabetic shoes or orthotics to patients with a diagnosis of diabetes reflected on the submitted claim, as there are more appropriate codes that should be utilized. The attached procedure to diagnosis lists were derived by identifying correct coding between HCPCS® and ICD-10. Claims for codes on the "Diabetes Shoes" list should be submitted with a diagnosis from the "Diabetes Diagnosis" list. Claims for codes on the "Orthopedic Shoes" list should not be submitted with a diagnosis from the "Diabetes Diagnosis" list. Please refer to the Diabetic and Other Orthopedic Shoes, Professional Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	4/25/2019	Medicaid	Professional
Return Edit	ORTDM	Procedure code <1> requires medical records to be submitted. Update code(s) or submit medical records as applicable for services rendered.	(ORTDM) Medical records required denial. According to the Centers for Medicare and Medicaid Services, HCPCS code L3000 (Foot insert, removable, molded to patient model, UCB type, Berkeley Shell, each) is not payable by Medicare. Please refer to the Orthotics (L3000) Policy, Professional UnitedHealthcare Community Plans on UHCProvider.com for further information.	5/30/2019	Medicaid	Professional

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Return Edit	P04UALL	Procedure <1> with a combined daily frequency of <2> has been exceeded by <3> for date of service <4>. Under appropriate circumstances, a designated modifier may be required to identify distinct services.	(P04UALL) Physical Medicine Max Frequency Per Day There may be situations in which therapy services are provided by professionals from different specialties (e.g., physical therapist, occupational therapist) belonging to a multi-specialty group and reporting under the same Federal Tax Identification number. In such cases,UnitedHealthcare will allow reimbursement for up to four (4) timed procedures/modalities reported from the list above per date of service for each specialty provider within the group. HCPCS modifiers GN, GO and GP may be reported with the codes listed above to distinguish timed procedures provided by different specialists within a multi-specialty group Please refer to the Physical Medicine & Rehabilitation Maximum Combined Frequency Per Day Policy on UHCprovider.com for further information.	11/14/2019	Commercial	Professional
Return Edit	PAPDN	Procedure code <1> is not appropriate in <2> Place of service.	(PAPDN) UHG Proc and Place of Service Denial The Procedure and Place of Service policy addresses the reimbursement of Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes that are reported in a Place of service (POS) considered inappropriate based on the code's description or available coding guidelines when reported by a physician or other health care professional. Please refer to the Procedure and Place of Service reimbursement policy at UHCprovider.com for further information.	11/14/2018	Commercial	Professional
Return Edit	PPSCD	Procedure <1> billed on mmddyyyy is not a separately reimbursable service in <2> Place Of Service for the State of <3>. A more appropriate procedure code may be suitable for the Place of service.	(PPS) Procedure to Place of Service UnitedHealthcare Community Plan follows CPT code descriptions/guidelines and HCPCS procedure code definitions/guidelines that indicate a POS in their descriptions when assigning the applicable places of service. Reimbursement Guidelines This policy addresses the appropriate places of service for certain CPT and HCPCS procedure codes. Descriptions of some CPT and HCPS codes included in what places of service the code may be used. For example, it would not be appropriate to submit place of service as "inpatient" for a code that states "office or outpatient visit." UnitedHealthcare Community Plan has established a list of CPT and HCPCS codes along with their appropriate places of service. For any code that is not on the list, the place of service is not limited. Note that any procedure code reported with an appropriate place of service may also be subject to other UnitedHealthcare Community Plan reimbursement policies. Please refer to the Procedure to Place of Service Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	10/4/2018	Medicaid	Professional
Return Edit	PRMIN	Procedure code <1> is included in the primary procedure code <2> on the current or previously submitted claim.	(PRMIN) Preventive Service Included in Primary Procedure UnitedHealthcare will reimburse the preventive medicine service plus 50% of the Problem-Oriented E/M service code when that code is appended with modifier 25. If the Problem-Oriented service is minor, or if the code is not submitted with modifier 25 appended, it will not be reimbursed. When a Preventive Medicine service and Other E/M services are provided during the same visit, only the Preventive Medicine service will be reimbursed. Please refer to the Preventative Medicine and Screening Reimbursement Policy on UHCprovider.com for further information.	10/4/2018	Commercial	Professional

UnitedHealthcare Smart Edits

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As Returned on the 277CA Clearinghouse Rejection Report

Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	PRMPL	Prolonged or Counseling Procedure <1> is included in the primary procedure <2> on this or a previously submitted claim. Update code(s) as applicable for services rendered.	(PRMPL) Preventive Med Prolonged and Counseling Denial Screening services include cervical cancer screening; pelvic and breast examination; prostate cancer screening; digital rectal examination; and obtaining, preparing and conveyance of a Papanicolaou smear to the laboratory. These screening procedures are included in (and are not separately reimbursed from) the Preventive Medicine service rendered on the same day for members age 22 years and over. Prolonged services are included in (and not separately reimbursed from) Preventive Medicine codes. Counseling services are included in (and not separately reimbursed from) Preventive Medicine codes. Medical Nutrition Therapy services are included in (and not separately reimbursed from) Preventive Medicine codes. Please refer to the Preventative Medicine and Screening Reimbursement Policy on UHCprovider.com for further information.	7/18/2019	Medicaid	Professional
Return Edit	PTCAM	Procedure code <1> submitted in a facility place of service <2> is not appropriate. Update code(s) as applicable for services rendered.	(PTCAM) ProTech Facility Place of Service Reimbursement of the Professional Component, the Technical Component, and the Global Service for codes assigned a PC/TC indicator 1, 2, 3, 4, 5, 6, 8 or 9 subject to the PC/TC concept according to the National Physician Fee Schedule Relative Value File are based upon physician and other qualified health care professional specialty and CMS POS code set, as described below. For the purposes of this policy, a facility POS is considered POS 19, 21, 22, 23, 26, 34, 51, 52, 55, 56, 57 and 61. All other POS are considered non-facility. Please refer to the Professional/Technical Component reimbursement policy at UHCprovider.com for further information.	5/2/2019	Medicaid	Professional
Return Edit	PTCDM	Modifier 76 or 77 is inappropriate for Procedure <1>.	(PTCDM) ProTech, Incorrect Modifier Professional Technical Component Policy: • Modifier 76 - Same physicians or other qualified health care professionals • Modifier 77 - Different physicians or other qualified health care professionals. Please refer to the Professional/Technical Component reimbursement policy at UHCprovider.com for further information.	11/14/2018	Commercial	Professional
Return Edit	PTCDU	Procedure <1> has been previously submitted by the Same Group Physician or other Health Care Provider. Under appropriate circumstances, a designated modifier may be required to identify distinct services.	(PTCDU) ProTech Duplicate When services are eligible for reimbursement under this policy, only one physician or other qualified health care professional will be reimbursed when Duplicate or Repeat Services are reported. Duplicate or Repeat Services are defined as identical CPT or HCPCS codes assigned a PC/TC indicator 1, 2, 3, 4, 6 or 8 submitted for the same patient on the same date of service on separate claim lines or on different claims regardless of the assigned Maximum Frequency per Day (MFD) value. For services that have both a Professional Component and a Technical Component (i.e., PC/TC Indicator 1, Diagnostic Tests) UnitedHealthcare will also review the submission of modifier 26 and TC appended to the code to identify whether a Duplicate or Repeat Service has been reported. Should the Same Individual Physician or Other Qualified Health Care Professional report the Professional Component (modifier 26) and the Technical Component (modifier TC) for the same PC/TC Indicator 1 service separately, UnitedHealthcare will consider both services eligible for reimbursement unless subject to other portions of this policy. Please refer to the Professional/Technical Component Policy, Professional - Reimbursement Policy UnithedHealthcare Plans on UHCProvider.com for further information.	5/30/2019	Commercial	Professional

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Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	PTCFD	Procedure <1> submitted in a facility Place of Service <2> is not appropriate when submitted by a Health Care Professional. Update code(s) as applicable for services rendered.	(PTCFD) Non Pro Tech Lab Code Any services that are provided in a facility POS and that are subject to the PC/TC concept or that have both a Professional Component and a Technical Component according to the CMS PC/TC indicators, UnitedHealthcare will reimburse the interpreting physician or other qualified health care professional only the Professional Component as the facility is reimbursed for the Technical Component of the service. Please refer to the Professional/Technical Component Policy on UHCprovider.com for further information.	11/14/2019	Commercial	Professional
Return Edit	PTCFD	Procedure <1> submitted in a facility Place of Service <2> is not appropriate when submitted by a Health Care Professional. Update code(s) as applicable for services rendered.	(PTCFD) Non ProTech Lab code denial Reimbursement of the Professional Component, the Technical Component, and the Global Service for codes assigned a PC/TC indicator 1, 2, 3, 4, 5, 6, 8 or 9 subject to the PC/TC concept according to the National Physician Fee Schedule Relative Value File are based upon physician and other qualified health care professional specialty and CMS POS code set, as described below. For the purposes of this policy, a facility POS is considered POS 19, 21, 22, 23, 26, 34, 51, 52, 55, 56, 57 and 61. All other POS are considered non-facility. Please refer to the Professional/Technical Component reimbursement policy at UHCprovider.com for further information.	5/2/2019	Medicaid	Professional
Return Edit	PTCHD	Procedure <1> is not appropriate in a facility setting. Update code(s) as applicable for services rendered.	(PTCHD) ProTech Deny Hospital Service Consistent with CMS, UnitedHealthcare will not allow reimbursement to physicians and other qualified health care professionals for "Incident To" codes identified with a CMS PC/TC indicator 5 when reported in a facility POS regardless of whether a modifier is reported with the code. In addition, CPT coding guidelines for many of the PC/TC Indicator 5 codes specify that these codes are not intended to be reported by a physician in a facility setting. For services with a CMS PC/TC indicator 4 (stand-alone Global Test Only Codes), UnitedHealthcare will not reimburse the physician or other qualified health care professional when rendered in a facility POS. Global Test Only Codes with a PC/TC indicator 4 identify Stand-alone Codes that describe selected diagnostic tests for which there are separate associated codes that depict the Professional Component only (PC/TC indicator 2) and Technical Component only (PC/TC indicator 3). Please refer to the Professional/Technical Component Policy, Professional Reimbursement Policy UnitedHealthcare Commercial Plans on UHCProvider.com for further information.	5/30/2019	Commercial	Professional

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Return Edit	PTCHD	Procedure <1> is not appropriate in a facility setting. Update code(s) as applicable for services rendered.	(PTCHD) ProTech Deny Hospital Service UnitedHealthcare Community Plan uses the Center for Medicare and Medicaid Services' (CMS) PC/TC indicators as set forth in the "CMS Payment Policies" under the National Physician Fee Schedule Relative Value File to determine whether a CPT or HCPCS procedure code is eligible for separate professional and technical services reimbursement. CPT or HCPCS codes assigned a CMS PC/TC Indicator 1 are comprised of a Professional Component and a Technical Component which together constitute the Global Service. The Professional Component (PC), (supervision and interpretation) is reported with modifier 26, and the Technical Component (TC) is reported with modifier TC. The term "professional/technical split" is used to reference a Global Service assigned a PC/TC Indicator 1 that may be "split" into a Professional and Technical Component. CPT or HCPCS codes assigned a PC/TC Indicator 1 are listed in the National Physician Fee Schedule Relative Value File. Each Global Service is listed on a separate row followed immediately by separate rows listing the corresponding Technical Component, and Professional Component. CPT or HCPCS codes with CMS PC/TC indicators 0, 2, 3, 4, 5, 7, 8, and 9 are not considered eligible for reimbursement when submitted with modifiers 26 and/or TC. CPT or HCPCS codes with CMS PC/TC indicator 6 are not considered eligible for reimbursement when submitted with modifier TC. CMS publishes this information in the "Physician Fee Schedule, PFS Relative Value Files" page, accessible through the following website: Please refer to the Professional/Technical Component Policy, Professional Reimbursement policy UnitedHealthcare Community Plan on UHCProvider.com for further information.	5/30/2019	Medicaid	Professional
Return Edit	PTCIM	Modifier 26 or TC is not appropriate for procedure code <1>. Update code(s) as applicable for services rendered.	(PTCIM) ProTech Incorrect Modifier CPT or HCPCS codes with CMS PC/TC indicators 0, 2, 3, 4, 5, 7, 8, and 9 are not considered eligible for reimbursement when submitted with modifiers 26 and/or TC. Please refer to the Professional/Technical Component Reimbursement Policy, Professional on UHCprovider.com for further information.	4/25/2019	Commercial	Professional
Return Edit	PTCIM	Modifier 26 or TC is not appropriate for procedure code <1>. Update code(s) as applicable for services rendered.	(PTCIM) ProTech Incorrect Modifier UnitedHealthcare Community Plan uses the Center for Medicare and Medicaid Services' (CMS) PC/TC indicators as set forth in the "CMS Payment Policies" under the National Physician Fee Schedule Relative Value File to determine whether a CPT or HCPCS procedure code is eligible for separate professional and technical services reimbursement. CPT or HCPCS codes assigned a CMS PC/TC Indicator 1 are comprised of a Professional Component and a Technical Component which together constitute the Global Service. The Professional Component (PC), (supervision and interpretation) is reported with modifier 26, and the Technical Component (TC) is reported with modifier TC. The term "professional/technical split" is used to reference a Global Service assigned a PC/TC Indicator 1 that may be "split" into a Professional and Technical Component. CPT or HCPCS codes assigned a PC/TC Indicator 1 are listed in the National Physician Fee Schedule Relative Value File. Each Global Service is listed on a separate row followed immediately by separate rows listing the corresponding Technical Component, and Professional Component. CPT or HCPCS codes with CMS PC/TC indicators 0, 2, 3, 4, 5, 7, 8, and 9 are not considered eligible for reimbursement when submitted with modifiers 26 and/or TC. CPT or HCPCS codes with CMS PC/TC indicator 6 are not considered eligible for reimbursement when submitted with modifier TC. CMS publishes this information in the "Physician Fee Schedule, PFS Relative Value Files" page, accessible through the following website: Please refer to the Professional/Technical Component Policy, Professional Reimbursement policy UnitedHealthcare Community Plan on UHCProvider.com for further information.	5/30/2019	Medicaid	Professional

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Return Edit	PTCPP	Procedure <1> has been previously submitted by the Same Group Physician or other Health Care Provider. Under appropriate circumstances, a designated modifier may be required to identify distinct services.	(PTCPP) ProTech Previously Processed When services are eligible for reimbursement under this policy, only one physician or other qualified health care professional will be reimbursed when Duplicate or Repeat Services are reported. Duplicate or Repeat Services are defined as identical CPT or HCPCS codes assigned a PC/TC indicator 1, 2, 3, 4, 6 or 8 submitted for the same patient on the same date of service on separate claim lines or on different claims regardless of the assigned Maximum Frequency per Day (MFD) value. For services that have both a Professional Component and a Technical Component (i.e., PC/TC Indicator 1, Diagnostic Tests) UnitedHealthcare will also review the submission of modifier 26 and TC appended to the code to identify whether a Duplicate or Repeat Service has been reported. Should the Same Individual Physician or Other Qualified Health Care Professional report the Professional Component (modifier 26) and the Technical Component (modifier TC) for the same PC/TC Indicator 1 service separately, UnitedHealthcare will consider both services eligible for reimbursement unless subject to other portions of this policy. Please refer to the Professional/Technical Component Policy, Reimbursement Policy UnitedHealthcare Commercial Plans on UHCProvider.com for further information.	5/30/2019	Commercial	Professional
Return Edit	RCPDN	Procedure Code <1> is not an appropriate code for services provided. Report the Status A (active) code that best describes the service provided.	(RCPDN) Replacement code denial Replacement codes allow for additional code specificity so that the appropriate reimbursement and beneficiary coverage can be applied for the service provided. UnitedHealthcare will not separately reimburse for specific CPT or HCPCS codes assigned a status code "I" on the NPFS Relative Value File. This indicates another code (replacement code) is used to report the procedure or service and that replacement code has an assigned RVU. Codes from the NPFS with a status of "I" addressed in other UnitedHealthcare reimbursement policies, codes with no identified replacement code and those where the replacement code does not have an RVU are not included in this policy. The physician or healthcare professional is required to report the replacement code that best describes the service provided. Commercial/Medicaid Please refer to the Replacement Codes reimbursement policy at UHCprovider.com for further information.	11/14/2018 4/25/2019	Commercial Medicaid	Professional
Return Edit	REB	Procedure is included with procedure <1> on the current or a previously submitted claim. Under appropriate circumstances, a designated modifier may be required to identify distinct services.	(REB) Rebundle to Appropriate Code UnitedHealthcare Community Plan uses this policy to determine whether CPT and/or HCPCS codes reported together by the Same Individual Physician or Health Care Professional for the same member on the same date of service are eligible for separate reimbursement. UnitedHealthcare Community Plan will not reimburse services determined to be Incidental, Mutually Exclusive, Transferred, or Unbundled to a more comprehensive service unless the codes are reported with an appropriate modifier. UnitedHealthcare Community Plan sources its Rebundling edits to methodologies used and recognized by third party authorities. Those methodologies can be Definitive or Interpretive. A Definitive source is one that is based on very specific instructions from the given source. An Interpreted source is one that is based on an interpretation of instructions from the identified source (please see the Definitions section below for further explanations of these sources). The sources used to determine if a Rebundling edit is appropriate are as follows: • Current Procedural Terminology book (CPT) from the American Medical Association (AMA); • CMS National Correct Coding Initiative (CCI) edits; • CMS Policy; and Specialty Societies (e.g., American Academy of Orthopaedic Surgeons (AAOS), American Congress of Obstetricians and Gynecologists (ACOG), American College of Cardiology (ACC), and Society of Cardiovascular Interventional Radiology (SCIR). Please refer to the Rebundling Policy, UnitedHealthcare Community Plan at UHCProvider.com for further information.	5/30/2019	Medicaid	Professional

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Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	S14DN	Diagnosis <1> is not appropriate when submitted with procedure code <2> for Laser Treatment for Lesion. Update code(s) as applicable for services rendered.	(S14DN) Invalid Procedure Diagnosis Medicaid Pulsed dye laser therapy is proven and medically necessary for treating the following: • Port-wine stains • Cutaneous hemangiomata Light and laser therapy including but not limited to intense pulsed light, light phototherapy, photodynamic therapy, and pulsed dye laser are unproven and not medically necessary for treating the following due to insufficient evidence of efficacy: • Rossmarteditsa • Rhinophyma • Acne vulgaris Laser hair removal is unproven and not medically necessary for treating pilonidal sinus disease due to insufficient evidence of efficacy. Commercial Invalid Procedure Diagnosis: Diagnosis is not appropriate with listed procedure code. Service to Diagnosis – Laser Treatment of Cutaneous Vascular Lesion policy states viral warts or plantar warts are not considered to be vascular proliferative lesions. Therefore, laser therapy used to treat warts should not be reported with CPT codes 17106, 17107 or 17108. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Commercial/Medicaid Please refer to the Light and Laser Therapy for Cutaneous Lesions and Pilonidal Disease reimbursement policy at UHCprovider.com for further information.	3/14/2019	Medicaid, Commercial	Professional
Return Edit	S16DN	Procedure code <2> submitted with diagnosis <1> is an excluded service on most benefit plans.	(S16DN) Service to Diagnosis - Routine Foot Care. Routine foot care for members with diabetes or who are at risk for neurological or vascular disease arising from diseases such as diabetes is a Covered Health Care Service.	3/7/2019	Commercial	Professional
Return Edit	S03DN	Diagnosis <1> is not appropriate with procedure code <2>.	(S03DN) Invalid Procedure Diagnosis Service to Diagnosis - High Frequency Chest Wall Oscillation: PAGES 1-8 High-frequency chest wall compression (HFCWC), as a form of chest physical therapy, is proven and medically necessary for treating or preventing pulmonary complications of the following conditions: • Cystic fibrosis (CF) • Bronchiectasis Please refer to the High Frequency Chest Wall Compression Devices Medical Policy on UHCprovider.com	11/15/2018	Commercial	Professional

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Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	S20AD	Diagnosis <1> is not appropriate when submitted with procedure code <2> for Sodium Hyaluronate. Update code(s) as applicable for services rendered.	(S20AD) Invalid Procedure Diagnosis Sodium hyaluronate, also referred to as hyaluronic acid (HA) or hyaluronan, is a component of normal synovial fluid, which lubricates the joints and absorbs shock. Intra-articular injections of HA help replace or supplement that which is lost. Commercially prepared and ready for injection, HA products differ by molecular weight and cross-linkage, and may be derived from bacterial fermentation or extracted from avian products (Hayes, 2017). HA preparations have been approved by the FDA as a device for the treatment of pain in knee OA in individuals who have not responded to exercise, physical therapy (PT) and non-prescription analgesics. HA gels have also been approved by the FDA for treatment of wrinkles and other facial contouring disorders. There is no evidence that use of one intra-articular hyaluronan product is superior to another. Commercial/Medicaid Please refer to the Sodium Hyaluronate Medical Policy on UHCprovider.com for further information.	3/14/2019 5/2/2019	Medicaid Commercial	Professional
Return Edit	S20DN	Diagnosis <1> is not appropriate when submitted with procedure code <2>. Update code(s) as applicable for services rendered.	(S20DN) Service to Diagnosis Sodium Hyaluronate The following are proven and medically necessary: • Intra-articular injections of sodium hyaluronate when administered according to U.S. Food and Drug Administration (FDA) labeled indications for treating pain due to: Knee osteoarthritis (OA), Temporomandibular joint osteoarthritis, Temporomandibular joint disc displacement ... . • Repeated courses of intra-articular hyaluronan injections may be considered ... . Intra-articular injections of sodium hyaluronate are unproven and not medically necessary for treating any other indication not listed above as proven due to insufficient evidence of efficacy. Hyaluronic acid gel preparations to improve the skin's appearance, contour and/or reduce depressions due to acne, scars, injury or wrinkles are considered cosmetic. Please refer to Sodium Hyaluronate Commercial Medical & Drug Policies on UHCProvider.com for further information.	4/4/2019	Commercial	Professional
Return Edit	S21DN	Diagnosis <1> is not appropriate with procedure code <2>.	(S21DN) Invalid Procedure Diagnosis Manipulation under anesthesia (MUA) is proven and medically necessary for: • Elbow joint for arthrofibrosis following elbow surgery or fracture • Knee joint for arthrofibrosis following total knee arthroplasty, knee sur			
Return Edit	S21DN	Diagnosis <1> is not appropriate when submitted with procedure code <2> for Manipulation Under Anesthesia. Update code(s) as applicable for services rendered.	(S21DN) Invalid Procedure Diagnosis Service to Diagnosis - Laser Treatment of Cutaneous Vascular Lesion: Pages 2+3 of 15: "Coding Clarification: Viral warts or plantar warts are not considered to be vascular proliferative lesions. Therefore, laser therapy used to treat warts should not be reported with CPT codes 17106, 17107 or 17108", The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Please refer to the Light and Laser Therapy for Cutaneous Lesions and Pilonidal Disease Policy on UHCprovider.com.	11/15/2018	Commercial	Professional

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Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	S23DN	Diagnosis <1> is not appropriate because it is not a proven diagnosis with procedure code <2>. Update code(s) as applicable for services rendered unless a prior authorization has been approved.	(S23DN) Invalid Procedure Diagnosis Service to Diagnosis - Sandostatin Somatostatin analogs are unproven and not medically necessary for treating the following conditions: • Chylothorax • Dumping syndrome • Pancreatitis • Persistent hyperinsulinemic hypoglycemia of infancy • Prevention of postoperative complications following pancreatic surgery • Short bowel syndrome Somatostatin analogs are unproven for treating other conditions not listed above as proven due to the lack of published clinical evidence of safety and/or efficacy in published peer-reviewed medical literature. Please refer to Somatostatin Analogs Commercial Medical & Drug Policies on UHCProvider.com for further information.	3/14/2019	Commercial	Professional
Return Edit	S23DN	Diagnosis <1> is not appropriate when submitted with procedure code <2> for Sandostatin. Update code(s) as applicable for services rendered.	(S23DN) Invalid Procedure Diagnosis Coverage will be provided for Somatostatin Analogs contingent on the coverage criteria in the Diagnosis-Specific Criteria section of the Somatostatin Analogs Medical Policy. Please refer to the Somatostatin Analogs Medical Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	3/14/2019	Medicaid	Professional
Return Edit	S24DN	Diagnosis <1> is not appropriate because it is not a proven diagnosis with procedure code <2> . Update code(s) as applicable for services rendered unless a prior authorization has been approved.	(S24DN) Invalid Procedure Diagnosis The following are proven and medically necessary: • Epidural Steroid Injections (ESI) for treating lumbar radicular pain caused by spinal stenosis, disc herniation or degenerative changes in the vertebrae • ESI for the short-term management of low back pain when the following criteria are met: o The pain is associated with symptoms of nerve root irritation and/or low back pain due to disc extrusions and/or contained herniations; and o The pain is unresponsive to Conservative Treatment, including but not limited to pharmacotherapy, exercise or physical therapy • Diagnostic Facet Joint Injection (FJI) and/or facet nerve block (e.g., medial branch block) to localize the source of pain to the facet joint in persons with spinal pain The following are unproven and not medically necessary due to insufficient evidence of efficacy: • The use of ultrasound guidance for ESIs and FJIs • ESI for all other indications of the lumbar spine not included above • Therapeutic FJI for treating chronic spinal pain Epidural Steroid Injection Limitations • A maximum of three (3) ESI (regardless of level, location, or side) in a year will be considered medically necessary when criteria (indications for coverage) are met for each injection • A session is defined as one date of service in which ESI injection(s) are performed • A year is defined as the 12-month period starting from the date of service of the first approved injection. Please refer to the Epidural Steroid and Facet Joint Injections for Spinal Pain - UnitedHealthcare Commercial Medical Policy on UHCProvider.com for further information.	5/30/2019	Commercial	Professional

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Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	S25DN	Diagnosis <1> is not appropriate with procedure code <2>.	(S25DN) Invalid Procedure Diagnosis Service to Diagnosis - Epidural and Facet Injection - EPIDURAL STEROID AND FACET INJECTIONS FOR SPINAL PAIN. Correct diagnosis codes must be billed with correct procedure codes in order to receive reimbursement. The policy has a section for "applicable codes" which lists out the correct codes to use and it also has an excel file attached with "ICD-10 Diagnosis Codes" that are appropriate to bill along with the procedure codes. Please refer to the Epidural Steroid and Facet Injections for Spinal Pain Policy on UHCprovider.com	10/4/2018	Commercial	Professional
Return Edit	S27DN	Diagnosis <1> is not appropriate because it is not a proven diagnosis with procedure code <2>. Update code(s) as applicable for services rendered unless a prior authorization has been approved.	(S27DN) Invalid Procedure Diagnosis - Service to Diagnosis - Orencia Service to Diagnosis - Orencia Orencia is unproven and not medically necessary for the treatment of: • Multiple sclerosis • Systemic lupus erythematosus • Graft versus host disease (GVHD) • Uveitis associated with Behçet's disease Please refer to Orencia® (Abatacept) Injection for Intravenous Infusion Commercial Medical & Drug Policies on UHCProvider.com for further information.	3/14/2019	Commercial	Professional
Return Edit	S31DN	Diagnosis <1> is not appropriate with procedure code <2>.	(S31DN) Invalid Procedure Diagnosis Service to Diagnosis - Hepatitis Screening. Hepatitis Screening- Policy Number: 2018T0548Q. Correct diagnosis codes must be billed with correct procedure codes in order to receive reimbursement. The policy has a section for "APPLICABLE CODES" which lists out the correct codes to use and it also has an excel file attached with "ICD-10 Diagnosis Codes" that are appropriate to bill along with the proc codes. Please refer to the Hepatitis Screening Policy on UHCprovider.com for further information.	10/4/2018	Commercial	Professional
Return Edit	S32DN	Diagnosis <1> is not appropriate with procedure code <2> when submitted for <3>.	(S32DN) Invalid Procedure Diagnosis UnitedHealthcare Community Plan will deny CPT codes 92558, 92587 and 92588 when not submitted with a diagnosis on the attached diagnosis list for members age 4 years and over. Neonatal hearing screening using otoacoustic emissions (OAEs) is medically necessary for infants who are 90 days or younger. Otoacoustic emissions (OAEs) testing is medically necessary for the evaluation of hearing loss in the following: • infants and children age 3 years (up to, but not including, 4th birthday) or younger • children and adults who are or who are unable to cooperate with other methods of hearing testing (e.g. individuals with autism or stroke) Auditory screening or diagnostic testing using otoacoustic emissions (OAEs) is not medically necessary for all other patient populations and conditions including ototoxic hearing changes in individuals treated with ototoxic medications. Please refer to the Otoacoustic Emissions Testing Policy on UHCprovider.com	1/31/2019	Medicaid	Professional
Return Edit	S38DN	Diagnosis <1> is not appropriate because it is not a proven diagnosis with procedure code <2>. Update code(s) as applicable for services rendered unless a prior authorization has been approved.	(S38DN) Invalid Procedure Diagnosis Service to Diagnosis/Max Units - Stelara Stelara is proven and medically necessary for the treatment of: I. Crohn's disease, II. Plaque psoriasis, and III. Psoriatic arthritis. Stelara is unproven and not medically necessary for the treatment of multiple sclerosis. In available studies, Stelara does not demonstrate efficacy in the treatment of multiple sclerosis. Please refer to Stelara® (Ustekinumab) Commercial Medical & Drug Policies on UHCProvider.com for further information.	3/14/2019	Commercial	Professional

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As Returned on the 277CA Clearinghouse Rejection Report

Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	S41DN	Diagnosis <1> is not appropriate because it is not a proven diagnosis with procedure code <2> . Update code(s) as applicable for services rendered unless a prior authorization has been approved.	(S41DN) Service to Diagnosis - Benlysta . Benlysta (belimumab) is proven and medically necessary for the treatment of systemic lupus erythematosus when ALL of the following criteria are met: I. Diagnosis of active systemic lupus erythematosis; and II. One of the following: A. Anti-nuclear antibody (ANA) titer ≥ 1:80 B. Anti-double-stranded DNA (anti-dsDNA) level ≥ 30 IU/mL]1,3-5 and III. Currently receiving at least one standard of care treatment for active systemic lupus erythematosus (e.g., antimalarial, corticosteroids, or immunosuppressant)1-7,10; and IV. Benlysta is initiated and titrated according to US Food and Drug Administration labeled dosing for SLE up to a maximum of 10mg/kg every 4 weeks.1 Benlysta is unproven and not medically necessary for: • Severe active lupus nephritis1 • Severe active central nervous system (CNS) lupus1 • Use in combination with other biologics or intravenous cyclophosphamide1 • Waldenström macroglobulinemia • Sjögren's syndrome • Rheumatoid arthritis Please refer to Benlysta® (Belimumab) Commercial Medical & Drug Policies on UHCProvider.com for further information.	3/7/2019	Commercial	Professional
Return Edit	S42DN	Diagnosis <1> is not appropriate because it is not a proven diagnosis with procedure code <2>. Update code(s) as applicable for services rendered unless a prior authorization has been approved.	(S42DN) Invalid Procedure Diagnosis. This policy refers only to Actemra (tocilizumab) injection for intravenous infusion for the treatment of rheumatoid arthritis, polyarticular juvenile idiopathic arthritis, systemic juvenile idiopathic arthritis, & cytokine release syndrome. Actemra, for self-administered subcutaneous injection, is obtained under the pharmacy benefit and is indicated in the treatment of rheumatoid arthritis and giant cell arteritis. Actemra is proven and medically necessary for the treatment of: I. Polyarticular juvenile idiopathic arthritis II. Rheumatoid arthritis III. Systemic juvenile idiopathic arthritis IV. Cytokine Release Syndrome Please refer to Actemra® (Tocilizumab) Injection for Intravenous Infusion Commercial Medical & Drug Policies on UHCProvider.com for further information.	2/21/2019	Commercial	Professional
Return Edit	S43DN	Diagnosis <1> is not appropriate with HCPC code <2> for Vascular Endothelial Growth Factor (VEGF) Inhibitors.	(S43DN) Invalid Procedure Diagnosis This policy provides information about the use of certain specialty pharmacy medications administered by the intravitreal route for ophthalmologic conditions. This policy refers to the following drug products, all of which are vascular endothelial growth factor (VEGF) inhibitors: • Eylea™ (aflibercept) • Avastin® (bevacizumab) • Macugen® (pegaptanib) • Lucentis® (ranibizumab) Please refer to the Vascular Endothelial Growth Factor Inhibitors reimbursement policy at UHCprovider.com for further information.	11/15/2018	Commercial	Professional

UnitedHealthcare Smart Edits

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As Returned on the 277CA Clearinghouse Rejection Report

Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	S43DN	Diagnosis <1> is not appropriate when submitted with procedure code <2> for Vascular Endothelial Growth Factor. Update code(s) as applicable for services rendered.	(S43DN) Invalid Procedure Diagnosis This policy provides information about the use of certain specialty pharmacy medications administered by the intravitreal route for ophthalmologic conditions. This policy refers to the following drug products, all of which are vascular endothelial growth factor (VEGF) inhibitors: • Eylea™ (aflibercept) • Avastin® (bevacizumab) • Macugen® (pegaptanib) • Lucentis® (ranibizumab) Please refer to the Vascular Endothelial Growth Factor Inhibitors reimbursement policy at UHCprovider.com for further information.	3/7/2019	Medicaid	Professional
Return Edit	S45DN	Procedure has not been billed with an appropriate diagnosis code for a patient <1> years of age or older. Update code(s) as applicable for services rendered unless a prior authorization has been approved.	(S45DN) Service to Diagnosis Ocular Screening. Service to Diagnosis- Omnibus Policy (iCES edit only supports Ocular Screening). Omnibus Codes. Policy Number: 2018T0535YY. Pages 1-128. Correct procedure must be billed with correct diagnosis in order to receive reimbursement for these services. There is a list of codes on the policy. Please refer to Omnibus Codes - Commercial Medical Policies on UHCProvider.com for further information.	3/7/2019	Commercial	Professional
Return Edit	S46DN	Diagnosis <1> is not appropriate with procedure code <2>.	(S46DN) Invalid Procedure Diagnosis Service to Diagnosis -. Occipital Neuralgia and Headache Treatment. Correct procedure must be billed with correct diagnosis in order to receive reimbursement for these services. Please refer to the Occipital, Neuralgia and Cervicogenic, Cluster and Migrain Headaches Policy on UHCprovider.com.	10/4/2018	Commercial	Professional
Return Edit	S47DN	Diagnosis <1> is not appropriate because it is not a proven diagnosis with procedure code <2>. Update code(s) as applicable for services rendered unless a prior authorization has been approved.	(S47DN) Invalid Procedure Diagnosis Service to Diagnosis - Simponi Aria Simponi Aria is proven and/or medically necessary for the treatment of: I. Ankylosing spondylitis, II. Psoriatic arthritis III. Rheumatoid arthritis. Please refer to Simponi Aria® (Golimumab) Injection for Intravenous Infusion Commercial Medical & Drug Policies on UHCProvider.com for further information.	3/14/2019	Commercial	Professional

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As Returned on the 277CA Clearinghouse Rejection Report

Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	S51DN	Diagnosis <1> is not appropriate because it is not a proven diagnosis with procedure code <2>. Update code(s) as applicable for services rendered unless a prior authorization has been approved.	(S51DN) Invalid Procedure Diagnosis Service to Diagnosis - Entyvio Entyvio (vedolizumab) is proven and medically necessary for the treatment of I. Crohn's disease, II. Ulcerative colitis Entyvio is indicated for treatment of adult patients with moderately to severely active ulcerative colitis (UC) who have had an inadequate response with, lost response to, or were intolerant to a tumor necrosis factor (TNF) blocker or immunomodulator; or had an inadequate response with, were intolerant to, or demonstrated dependence on corticosteroids for the following:1 • Inducing and maintaining clinical response • Inducing and maintaining clinical remission • Improving endoscopic appearance of the mucosa • Achieving corticosteroid-free remission It is also indicated for treatment of adult patients with moderately to severely active Crohn's Disease (CD) who have had an inadequate response with, lost response to, or were intolerant to a TNF blocker or immunomodulator; or had an inadequate response with, were intolerant to, or demonstrated dependence on corticosteroids for the following: 1 • Achieving clinical response • Achieving clinical remission • Achieving corticosteroid-free remission Please refer to Entyvio® (Vedolizumab) Commercial Medical & Drug Policies on UHCProvider.com for further information.	3/14/2019	Commercial	Professional
Return Edit	S53DN	Diagnosis <1> is not appropriate because it is not a proven diagnosis with procedure code <2>. Update code(s) as applicable for services rendered unless a prior authorization has been approved.	(S53DN) Invalid Procedure Diagnosis Service to Diagnosis/Max Units- Xolair I. Patients with moderate to severe persistent asthma. II. Patients with chronic urticaria who continue to remain symptomatic despite H1 antihistamine [e.g., cetirizine (Zyrtec), fexofenadine (Allegra)] treatment Xolair is unproven and not medically necessary in the following: • Seasonal allergic rhinitis • Perennial allergic rhinitis • Atopic dermatitis • Peanut allergy • Acute bronchospasm or status asthmaticus Please refer to Xolair® (Omalizumab) Commercial Medical & Drug Policies on UHCProvider.com for further information.	3/14/2019	Commercial	Professional

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As Returned on the 277CA Clearinghouse Rejection Report

Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	S54DN	Diagnosis <1> is not appropriate because it is not a proven diagnosis with procedure code <2>. Update code(s) as applicable for services rendered unless a prior authorization has been approved.	(S54DN) Invalid Procedure Diagnosis. Cinqair (reslizumab) Cinqair is approved by the U.S. Food and Drug Administration (FDA) for the add-on maintenance treatment of patients with severe asthma aged 18 years and older, who have an eosinophilic phenotype. Cinqair is not indicated for the treatment of other eosinophilic conditions or for acute bronchospasm or status asthmaticus. Because of the risk of anaphylaxis, healthcare providers administering Cinqair should observe patients closely for an appropriate period of time and be prepared to manage anaphylaxis that can be life-threatening.2 Fasenra (benralizumab) Fasenra is approved by the U.S. Food and Drug Administration (FDA) for the add-on maintenance treatment of patients with severe asthma aged 12 years and older, who have an eosinophilic phenotype. Fasenra is not indicated for the treatment of other eosinophilic conditions or for acute bronchospasm or status asthmaticus.10 Nucala (mepolizumab) Nucala is approved by the U.S. Food and Drug Administration (FDA) for the add-on maintenance treatment of patients with severe asthma aged 12 years and older, who have an eosinophilic phenotype. Nucala is not indicated for the treatment of other eosinophilic conditions or for acute bronchospasm or status asthmaticus. Nucala is also indicated for the treatment of adult patient with eosinophilic granulomatosis with polyangiitis (EGPA). Please refer to Respiratory Interleukins (Cinqair®, Fasenra®, and Nucala®) Commercial Medical & Drug Policies on UHCProvider.com for further information.	2/21/2019	Commercial	Professional
Return Edit	S56DN	Diagnosis <1> is not appropriate because it is not a proven diagnosis with procedure code <2>. Update code(s) as applicable for services rendered unless a prior authorization has been approved.	(S56DN) Invalid Procedure Diagnosis Service to Diagnosis/Max Units-Policy Number: 2018D0049F Soliris (eculizumab) is proven for the treatment of: I. Atypical Hemolytic Uremic Syndrome (aHUS) II. Paroxysmal Nocturnal Hemoglobinuria (PNH) III. Generalized Myasthenia Gravis1. Soliris is unproven and not medically necessary for treatment of Shiga toxin E. coli-related hemolytic uremic syndrome (STEC-HUS) Please refer to Soliris® (Eculizumab) Commercial Medical & Drug Policies on UHCProvider.com for further information.	3/14/2019	Commercial	Professional
Return Edit	S58DN	Diagnosis <1> is not appropriate with procedure code <2>	(S58DN) Invalid Procedure Diagnosis Service to Diagnosis - Continuous Glucose Monitoring Continuous glucose monitoring (CGM) devices continuously monitor and record interstitial fluid glucose levels and have three components: a sensor, transmitter and receiver. Some CGM systems are designed for short-term diagnostic or professional use. These devices store retrospective information for review at a later time. Other CGM systems are designed for long-term personal use and display information in real-time allowing the individual to take action based on the data (AMA, 2009). For most devices, glucose measurements provided during continuous monitoring are not intended to replace standard self-monitoring of blood glucose (SMBG) obtained using fingerstick blood samples, but can alert individuals of the need to perform SMBG. These long-term devices are available with or without an integrated external insulin pump. Implantable continuous glucose monitoring includes a small sensor, smart transmitter and mobile application. Based on fluorescence sensing technology, the sensor is designed to be inserted subcutaneously and communicate with the smart transmitter to wirelessly transmit glucose levels to a mobile device.	11/15/2018	Commercial	Professional

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Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	SBY	Procedure code <1> is not appropriate as physician standby services do not involve direct patient contact. Update code(s) as applicable for services rendered.	(SBY) Standby Physician Services: In accordance with CMS, UnitedHealthcare Community Plan does not reimburse physician or other qualified health care professional standby services submitted with CPT code 99360. If a specific service is directly rendered to the patient by the standby physician or other qualified health care professional (i.e., tissue examination of frozen section biopsy), the service or procedure would be reported under the appropriate CPT code (i.e., 88331). Please refer to the Standby Services Policy, Professional on UnitedHealthcare Community Plans on UHCprovider.com for further information.	4/4/2019	Medicaid	Professional
Return Edit	SUPDD	Procedure <1> is not appropriate in Place of service <2>. Update code(s) as applicable for services rendered.	(SUPDD) Denial of DME Supplies In alignment with the CMS PPS reimbursement methodology, UnitedHealthcare considers payment for certain DME, orthotics, prosthetics and related supply items on the CMS Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule to be included in the payment to a skilled nursing facility (POS 31) and nursing facility (POS 32) and not reimbursed separately when reported by a physician or other qualified health care professional on a CMS-1500 claim form. Supply DME Codes in a Skilled Nursing Facility For the purposes of this policy, skilled nursing facility and nursing facility Places of service are considered POS 31 and 32. Please refer to the Supply Policy, Professional Reimbursement Policy at UHCprovider.com for further information.	3/14/2019	Commercial	Professional
Return Edit	SUPDN	Procedure <1> is not appropriate for casting and splint supplies. A temporary Q procedure code may be more appropriate for casting and splint supplies.	(SUPDN) Supply service is not reimbursable Casting and Splint Supplies HCPCS codes A4570, A4580, and A4590 which were previously used for billing of splints and casts are invalid for Medicare use effective July 1, 2001, and new temporary Q codes were established to reimburse physicians and other practitioners for the supplies used in creating casts. Consistent with CMS, UnitedHealthcare does not reimburse HCPCS codes A4570, A4580, and A4590 for casting and splint supplies. Physicians and other qualified health care professionals should use the temporary Q codes (Q4001-Q4051) for reimbursement of casting and splint supplies. For the purposes of this policy, an office and other nonfacility Place of service is considered POS 1, 3, 4, 9, 11, 12, 13, 14, 15, 16, 17, 20, 33, 49, 50, 54, 55, 57, 60, 62, 65, 71, 72, 81 and 99. Please refer to the Supply Policy, Professional Reimbursement Policy on UHCProvider.com for further information.	1/31/2019	Commercial	Professional
Return Edit	SUPDN	Procedure <1> for casting and/or splint supplies are not appropriate. Update code(s) as applicable for services rendered.	(SUPDN) Deny Supply Service. Pursuant to CMS policy, certain HCPCS supply codes are not separately reimbursable as the cost of supplies is incorporated into the Practice Expense Relative Value Unit (RVU) for the Evaluation and Management (E/M) service or procedure code. Consistent with CMS, UnitedHealthcare Community Plan will not separately reimburse the HCPCS supply codes when those supplies are provided on the same day as an E/M service and/or procedure performed in a physician's or other health care professional's office and other nonfacility Places of service. Please refer to the Supply Policy, Professional on UnitedHealthcare Community Plans on UHCprovider.com for further information.	3/7/2019	Medicaid	Professional

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As Returned on the 277CA Clearinghouse Rejection Report

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Return Edit	SUPDP	Procedure <1> in Place of service <2> may be inappropriate when submitted without a modifier or with a purchase modifier. Update code(s) or modifier as applicable for services rendered.	(SUPDP) Denial of DME supplies Pursuant to CMS policy, certain HCPCS supply codes are not separately reimbursable as the cost of supplies is incorporated into the Practice Expense Relative Value Unit (RVU) for the Evaluation and Management (E/M) service or procedure code. Consistent with CMS, UnitedHealthcare Community Plan will not separately reimburse the HCPCS supply codes when those supplies are provided on the same day as an E/M service and/or procedure performed in a physician's or other health care professional's office and other nonfacility place of service. Please refer to the Supply Policy, Professional Reimbursement Policy on UHCprovider.com for further information.	2/21/2019	Medicaid	Professional
Return Edit	SUPFJ	Procedure <1> is not appropriate in a facility place of service <2>. Update code(s) as applicable for services rendered.	(SUPFJ) JCodes Denial of service in Facility POS The UnitedHealthcare Supply Policy Codes List contains the codes that are not separately reimbursable in an office and other nonfacility places of service. It is developed based on the CMS NPFS Relative Value File and consists of codes that based on their descriptions, CMS considers part of the practice expense and not separately reimbursable. Certain HCPCS supply codes are not separately reimbursable as the cost of supplies is incorporated into the Practice Expense Relative Value Unit (RVU) for the Evaluation and Management (E/M) service or procedure code. Consistent with CMS, UnitedHealthcare will not separately reimburse the HCPCS supply codes when those supplies are provided on the same day as an E/M service and/or procedure performed in a physician's or other qualified health care professional's office and other non facility places of service. Please refer to the Supply Policy, Professional Reimbursement Policy UnitedHealthcare Commercial Plans on UHCProvider.com for further information.	5/30/2019	Commercial	Professional
Return Edit	SUPFJ	Procedure <1> is not appropriate in a facility place of service <2>. Update code(s) as applicable for services rendered.	(SUPFJ) JCodes Denial of service in Facility POS This policy describes the reimbursement methodology for Healthcare Common Procedure Coding System (HCPCS) codes representing supplies, drugs and other items based on the Place of Service (POS) submitted and Centers for Medicare and Medicaid Services (CMS). The website containing the POS code set can be accessed via this link: CMS POS Code Set. Please refer to the Supply Policy, Professional Reimbursement Policy UnitedHealthcare Community Plan on UHCProvider.com or further information.	5/30/2019	Medicaid	Professional
Return Edit	SUPFP	Procedure <1> is not appropriate in a facility place of service <2>. Update code(s) as applicable for services rendered.	(SUPFP) Denial for service billed in Facility POS The UnitedHealthcare Supply Policy Codes List contains the codes that are not separately reimbursable in an office and other nonfacility places of service. It is developed based on the CMS NPFS Relative Value File and consists of codes that based on their descriptions, CMS considers part of the practice expense and not separately reimbursable. Certain HCPCS supply codes are not separately reimbursable as the cost of supplies is incorporated into the Practice Expense Relative Value Unit (RVU) for the Evaluation and Management (E/M) service or procedure code. Consistent with CMS, UnitedHealthcare will not separately reimburse the HCPCS supply codes when those supplies are provided on the same day as an E/M service and/or procedure performed in a physician's or other qualified health care professional's office and other non facility places of service. Please refer to the Supply Policy, Professional Reimbursement Policy UnitedHealthcare Commercial Plans on UHCProvider.com for further information.	5/30/2019	Commercial	Professional

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As Returned on the 277CA Clearinghouse Rejection Report

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Return Edit	SUPFP	Procedure <1> is not appropriate in a facility place of service <2>. Update code(s) as applicable for services rendered.	(SUPFP) Denial for service billed in Facility POS This policy describes the reimbursement methodology for Healthcare Common Procedure Coding System (HCPCS) codes representing supplies, drugs and other items based on the Place of Service (POS) submitted and Centers for Medicare and Medicaid Services (CMS). The website containing the POS code set can be accessed via this link: CMS POS Code Set. Please refer to the Supply Policy, Professional Reimbursement Policy UnitedHealthcare Community Plan on UHCProvider.com or further information.	5/30/2019	Medicaid	Professional
Return Edit	SUPNC	Procedure code <1> is not appropriate because it is non-specific. Update code(s) as applicable for services rendered.	(SUPNC) Supply Aug18 For reimbursement of covered medical and surgical supplies, an appropriate Level II HCPCS code must be submitted. The non-specific CPT code 99070 (supplies and materials, except spectacles, provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered [list drugs, trays, supplies, or materials provided]) is not reimbursable in any setting. Please refer to the Supply Policy, Professional - Reimbursement Policy UnitedHealthcare Commercial Plan on UHCProvider.com for further information.	5/30/2019	Commercial	Professional
Return Edit	SUPNC	Procedure <1> for supplies are not appropriate. Update code(s) as applicable for services rendered.	(SUPNC) Supply Non Covered Service. Pursuant to CMS policy, certain HCPCS supply codes are not separately reimbursable as the cost of supplies is incorporated into the Practice Expense Relative Value Unit (RVU) for the Evaluation and Management (E/M) service or procedure code. Consistent with CMS, UnitedHealthcare Community Plan will not separately reimburse the HCPCS supply codes when those supplies are provided on the same day as an E/M service and/or procedure performed in a physician's or other health care professional's office and other nonfacility place of service. Please refer to the Supply Policy, Professional on UnitedHealthcare Community Plans on UHCprovider.com for further information.	3/7/2019	Medicaid	Professional
Return Edit	THIEM	Evaluation/management service <2> is included in the Therapeutic or diagnostic injection procedure <1>. Under appropriate circumstances, a designated modifier may be required to identify distinct EM service.	(THIEM) Therapeutic Injection E/M services provided in a non-facility setting are considered an inherent component for providing an Injection service. CPT indicates these services typically require direct supervision for any or all purposes of patient assessment, provision of consent, safety oversight, and intra-service supervision of staff. When a diagnostic and therapeutic Injection procedure is performed in a POS other than 19, 21, 22, 23, 24, 26, 51, 52, and 61 and an E/M service is provided on the same date of service, by the Same Individual Physician or Other Health Care Professional, only the appropriate therapeutic and diagnostic Injection(s) will be reimbursed and the EM service is not separately reimbursed. If a significant, separately identifiable EM service is performed unrelated to the physician work (Injection preparation and disposal, patient assessment, provision of consent, safety oversight, supervision of staff, etc.) required for the Injection service, Modifier 25 may be reported for the EM service in addition to 96372-96379. If the E/M service does not meet the requirement for a significant separately identifiable service, then Modifier 25 would not be reported and a separate E/M service would not be reimbursed. Exceptions CPT 99211 Please refer to the Injection and Infusion Services Policy, Professional on UHCProvider.com for further information.	5/9/2019	Commercial	Professional

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Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	THIEM	Evaluation/management service <2> is included in the therapeutic or diagnostic injection procedure <1>. Under appropriate circumstances, a designated modifier may be required to identify distinct EM service.	(THIEM) Therapeutic Injection This UnitedHealthcare Community Plan reimbursement policy is aligned with the American Medical Association (AMA) Current Procedural Terminology (CPT®) and Centers for Medicare and Medicaid Services (CMS) guidelines. This policy describes reimbursement for therapeutic and diagnostic Injection services (CPT codes 96372-96379) when reported with evaluation and management (E/M) services. This policy also describes reimbursement for Healthcare Common Procedure Coding System (HCPCS) supplies and/or drug codes when reported with Injection and Infusion services (CPT codes 96360-96549 and G0498). Please refer t o the Injection and Infusion Services Policy, Professional-Reimbursement Policy UnitedHealthcare Community Plan for further information.	5/30/2019	Medicaid	Professional
Return Edit	TSTDN	T status procedure <1> is included in procedure <2> on this or a previously submitted claim by the same provider for the same date of service. Update code(s) or modifier as applicable for services rendered.	(TSTDN) T Status Code Deny All codes published on the NPFS Relative Value File are assigned a status code. The status code indicates whether the code is separately payable if the service is covered. Per the public use file that accompanies the NPFS Relative Value File, the following is stated for status indicator of T: "There are RVUs and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made." Please refer to the T Status Codes Policy, Professional - Reimbursement Policy UnitedHealthcare Community Plan for further information.	5/30/2019	Medicaid	Professional
Return Edit	TSU2	Procedure code <1> submitted with modifier 66 is not appropriate because this procedure is not eligible for team surgeon. Update code(s) as applicable for services rendered.	(TSU2) TSU TEAM SURGEON NON-ELIGIBLE Team Surgeon Services Modifier 66 identifies Team Surgeons involved in the care of a patient during surgery. Each Team Surgeon should submit the same CPT code with modifier 66. Each Team Surgeon is required to submit written medical documentation describing the specific surgeon's involvement in the total procedure. For services included on the Team Surgeon Eligible List (see below), UnitedHealthcare will review each submission with its appropriate medical documentation and will make reimbursement decisions on a case-by-case basis. Team Surgeon Eligible Lists are developed based on the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) Relative Value File status indicators. All codes in the NPFS with the status code indicators "1" or "2" for "Team Surgeons" are considered by UnitedHealthcare to be eligible for Team Surgeon services as indicated by the team surgeon modifier 66. Please refer to the Co-Surgeon / Team Surgeon Policy, Professional Reimbursement Policy on UHCProvider.com for further information.	3/14/2019	Commercial	Professional
Informational Edit	uATT	Our records show that your demographic data review and attestation is due. Please access the My Practice Profile app on Link at UHCProvider.com/MPP. For My Practice Profile help, please call 866-842-3278, option 1, 7 am – 9 pm CST M-F.	(uATT) Provider Attestation Due Provider informational message to renew CMS attestation through the My Practice Profile application on LINK.	6/6/2019	Commercial Medicare Medicaid	Professional

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Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	uBPPB	Per Medicare NCCI guidelines, procedure code <8830X> is not appropriate when billed with procedure code <55700-55706> for prostate needle biopsy specimen assessment. Please update codes as applicable.	(uBPPB) Incorrect Billing of 8830X Per Medicare CCI Manual, Chapter 10 page 19, pathologists are incorrectly submitting 8830X codes when assessing prostate needle biopsy specimens obtained when performing CPT codes 55700-55706. There is specific guidance for accurate billing of these services. Please refer to https://www.cms.gov/medicare/coding/nationalcorrectcodinited/index.html	1/30/2020	Medicare	Professional
Return Edit	uCAEM	Per NCD 160.22, diagnosis code <1,2,3,4> is not listed for procedure code <5>. Update codes(s) as applicable for services rendered.	(uCAEM) Custom Ambulatory EEG Monitoring Per Medicare NCD 160.22: Ambulatory EEG Monitoring services require specific coding for diagnostic tests provided. These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/30/2020	Medicare	Professional
Return Edit	uCAP	<1> is not valid for member state <member state 2>. Please update with an appropriate CPT or HCPCS code.	(uCAP) OPS Facility (Z-Codes) California-specific procedure codes cannot be billed for members who are not in California.	8/8/2019	Medicaid	Institutional
Return Edit	uCBB	Procedure code <1> is a comprehensive code and is only billable once per date of service. Please refer to Control of Bleeding Educational letter sent on 12.26.18 and update accordingly.	(uCBB) Control Bleed Bundled Code Control of Bleeding of Endoscopic Procedures A procedure code that is a component of a submitted comprehensive code cannot be billed separately. Letters were mailed December 26, 2018 to impacted providers advising correct billing guidelines. Specific coding requirements can be found at cms.gov. NCCI policy guidelines can be downloaded at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html	5/30/2019	Commercial Medicare Medicaid	Professional
Return Edit	uCBD	Procedure code <1> is a comprehensive code and is only billable once per date of service. Please refer to Control of Bleeding Educational letter sent on 12.26.18 and update accordingly.	(uCBD) Control Bleed Duplicate Code Control of Bleeding of Endoscopic Procedures A comprehensive procedure code may only be billed once per date of service. Letters were mailed December 26, 2018 to impacted providers advising correct billing guidelines. Specific coding requirements can be found at cms.gov. NCCI policy guidelines can be downloaded at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html	5/30/2019	Commercial Medicare Medicaid	Professional
Return Edit	uCDME	Procedure code <1> is not covered by Medicare.	(uCDME) Custom DME Non Covered Charges Per CMS guidelines, some durable medical equipment is not covered for payment. Please refer to the National Coverage Determination policy specific to the DME charges billed. Policies pertaining to this edit include charges for: Home Blood Glucose Monitors Home Use of Oxygen Home Oxygen Use To Treat Cluster Headache (CH) Enteral and Parenteral Nutrition Therapy Pneumatic Compression Devices Biofeedback Therapy Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds Mobility Devices (Ambulatory) and Accessories Hospital Beds Electrical Nerve Stimulators Hyperbaric Oxygen Therapy	1/30/2020	Medicare	Professional
Return Edit	uCNB3	Procedure code <1> is not covered by Medicare.	(uCNB3) Nebulizers Certain Nebulizer CPT codes are not covered by Medicare. Please refer to the Nebulizer Policy found on UHCprovider.com for further information.	10/3/2019	Medicare	Professional

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Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	uCPKX	Per CMS guidelines, an appropriate modifier is required for procedure code <1>. Update code(s) or modifier as applicable for services rendered.	(uCPKX) KX Modifier Per CMS guidelines, supplier usage of the KX modifier identifies that the requirements identified in the medical policy have been met. Please refer to the KX Modifier – Medicare Advantage Policy Guideline.	1/30/2020	Medicare	Professional
Return Edit	UCSDN	Procedure code <1> is not appropriate because it does not describe the specific services performed. Update code(s) as applicable for services rendered.	(UCSDN) Urgent Care Services Consistent with CPT® and CMS, physicians and other healthcare professionals should report the evaluation and management, and /or procedure code(s) that specifically describe the service(s) performed. Additionally, a Place of service code should be utilized to report where service(s) were rendered. The following codes are not reimbursable for Urgent Care services: • S9088 - Services provided in an urgent care center (list in addition to code for service) is not reimbursable. Report the specific codes for the services provided. • S9083 - Global fee urgent care centers is not reimbursable in specific states. Report the specific codes for the services provided. The change to not allow reimbursement for S9083 is being implemented in a phased approach by state of provider practice (refer to State Application Table). Please refer to the Urgent Care Policy-Reimbursement Policy for UnitedHealthcare Commercial Plans for further information.	3/7/2019	Commercial	Professional
Return Edit	UCSTD	Procedure code <1> is not reimbursable. Update code(s) as applicable for services rendered.	(UCSTD) Urgent Care Service Global Fee In accordance with correct coding methodology, UnitedHealthcare determines reimbursement based on coding which specifically describes the services provided. S9088 (Services provided in an urgent care center (list in addition to code for service)) is considered informational only as it pertains to the place of service and not the components of the specific service(s) provided, and S9083 (Global fee urgent care centers) is a global code which does not provide encounter level specificity. Please refer to the Urgent Care Policy on UHCprovider.com for further information.	11/14/2019	Commercial	Professional
Return Edit	uCUDC	Procedure code <1> has been submitted for <diagnosis code 2>, which could be an unproven or off-label use of this drug per FDA guidelines. Please evaluate and update as applicable.	(uCUDC) Medicaid Unproven Drug An off-label/unlabeled use of a drug is defined as a use for a non-FDA approved indication, that is, one that is not listed on the drug's official label/prescribing information. An indication is defined as a diagnosis, illness, injury, syndrome, condition, or other clinical parameter for which a drug may be given. Off-label use is further defined as giving the drug in a way that deviates significantly from the labeled prescribing information for a particular indication. Please refer to the Coverage of Drugs and Biologicals for Label and Off-Label Uses on UHCprovider.com for further information.	11/21/2019	Medicaid	Professional
Return Edit	uCUDCf	Procedure code <1> could be an unproven or off-label use of this drug per FDA guidelines for the diagnosis codes submitted on this claim. Please evaluate and update as applicable.	(uCUDCf) Medicaid Facility Unproven Drug An off-label/unlabeled use of a drug is defined as a use for a non-FDA approved indication, that is, one that is not listed on the drug's official label/prescribing information. An indication is defined as a diagnosis, illness, injury, syndrome, condition, or other clinical parameter for which a drug may be given. Off-label use is further defined as giving the drug in a way that deviates significantly from the labeled prescribing information for a particular indication. Please refer to the following Policy Guideline on UHCprovider.com: Coverage of Drugs and Biologicals for Label and Off-Label Uses.	1/30/2020	Medicaid	Institutional
Return Edit	uEUDCf	Procedure code <1> could be an unproven or off-label use of this drug per FDA guidelines for the diagnosis codes submitted on this claim. Please evaluate and update as applicable.	(uEUDCf) Unproven Use of High Cost Drugs An off-label/unlabeled use of a drug is defined as a use for a non-FDA approved indication, that is, one that is not listed on the drug's official label/prescribing information. An indication is defined as a diagnosis, illness, injury, syndrome, condition, or other clinical parameter for which a drug may be given. Off-label use is further defined as giving the drug in a way that deviates significantly from the labeled prescribing information for a particular indication. Please refer to the following Policy Guideline on UHCprovider.com: Coverage of Drugs and Biologicals for Label and Off-Label Uses.	1/30/2020	Commercial	Institutional

UnitedHealthcare Smart Edits

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As Returned on the 277CA Clearinghouse Rejection Report

Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	uDSA	Procedure Code 95957 typically requires an hour of work by the technician and 20-30 minutes of physician review. Please ensure documentation supports this extra work.	(uSDA) Spike EEG Analysis Per the American Academy of Neurology, CPT Code 95957 is used when substantial additional digital analysis was performed, such as 3D dipole localization. In general, this would entail an extra hour's work by the technician to process the data from the digital EEG, and an extra 20–30 minutes of physician time to review the technician's work and review the data produced.	10/31/2019	Commercial Medicare Medicaid	Professional
Return Edit	uEAI	The diagnosis code submitted <1> appears to be related to a work injury. Claim is missing an employment accident indicator. Update the accident indicator and accident date if applicable.	(uEAI) Workman's Comp Services related to an accident where benefits may be payable under another plan such as Workers' Compensation should indicated on the claim by the accident indicator field. Please refer to the claim submission requirements section of the administrative guide on UHCProvider.com	7/25/2019	Commercial	Professional
Return Edit	UED	<1> and <2> on the current or previously submitted claim is an inappropriate coding combination. Under appropriate circumstances, a designated modifier may be required to identify distinct services.	(UED) Coding Relationship Error UnitedHealthcare Community Plan uses this policy to determine whether CPT and/or HCPCS codes reported together by the Same Individual Physician or Health Care Professional for the same member on the same date of service are eligible for separate reimbursement. UnitedHealthcare Community Plan will not reimburse services determined to be Incidental, Mutually Exclusive, Transferred, or Unbundled to a more comprehensive service unless the codes are reported with an appropriate modifier. Please refer to the Rebundling Policy, Professional (4/8/2019) on UHCProvider.com for additional information.	7/25/2019	Medicaid	Professional
Return Edit	uEUDC	Procedure code <1> has been submitted for <diagnosis code 2>, which could be an unproven or off-label use of this drug per FDA guidelines. Please evaluate and update as applicable.	(uEUDC) Commercial Unproven Drug Charges An off-label/unlabeled use of a drug is defined as a use for a non-FDA approved indication, that is, one that is not listed on the drug's official label/prescribing information. An indication is defined as a diagnosis, illness, injury, syndrome, condition, or other clinical parameter for which a drug may be given. Off-label use is further defined as giving the drug in a way that deviates significantly from the labeled prescribing information for a particular indication. Please refer to the Coverage of Drugs and Biologicals for Label and Off-Label Uses on UHCprovider.com for further information.	11/21/2019	Commercial	Professional
Return Edit	uIBC	Billing CLIA ID submitted on the claim is not valid based on QIES and CDC database. Submit claim with a valid CLIA ID.	(uIBC) Invalid Billing CLIA ID CLIA applies to all laboratories that examine "materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings." This applies if even one test is to be performed. CLIA regulatory requirements vary according to the kind of test(s) each laboratory conducts. All entities that meet the definition of a "Laboratory" under the CLIA statutes and regulations must obtain an appropriate CLIA certificate prior to conducting patient testing. For purposes of this policy, a valid CLIA Certificate Identification number will be required for reimbursement of clinical laboratory services reported on a 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent. Any claim that does not contain the CLIA ID, invalid ID, and/or the complete servicing provider demographic information will be considered incomplete and rejected or denied. Claim line edits will also be applied if the lab certification level does not support the billed service code. Laboratory service providers who do not meet the reporting requirements and/or do not have the appropriate level of CLIA certification for the services reported will not be reimbursed. Commercial/Medicaid/Medicare Please refer to the Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com for further information.	1/17/2019	Medicaid Medicare Commercial	Professional

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As Returned on the 277CA Clearinghouse Rejection Report

Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	uISC	Servicing CLIA ID submitted on the claim is not valid based on QIES and CDC database. Submit claim with a valid CLIA ID	(uISC) Invalid Servicing CLIA ID Any claim that does not contain the CLIA ID, invalid ID, and/or the complete servicing provider demographic information will be considered incomplete and rejected or denied. Claim line edits will also be applied if the lab certification level does not support the billed service code. Laboratory service providers who do not meet the reporting requirements and/or do not have the appropriate level of CLIA certification for the services reported will not be reimbursed. CLIA applies to all laboratories that examine "materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings." This applies if even one test is to be performed. CLIA regulatory requirements vary according to the kind of test(s) each laboratory conducts. All entities that meet the definition of a "Laboratory" under the CLIA statutes and regulations must obtain an appropriate CLIA certificate prior to conducting patient testing. For purposes of this policy, a valid CLIA Certificate Identification number will be required for reimbursement of clinical laboratory services reported on a 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent. Any claim that does not contain the CLIA ID, invalid ID, and/or the complete servicing provider demographic information will be considered incomplete and rejected or denied. Claim line edits will also be applied if the lab certification level does not support the billed service code. Laboratory service providers who do not meet the reporting requirements and/or do not have the appropriate level of CLIA certification for the services reported will not be reimbursed. Commercial/Medicaid/Medicare Please refer to the Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com for further information.	1/17/2019	Medicaid Medicare Commercial	Professional
Return Edit	umAT	Beginning 4/01/20, therapy charges must be billed with the required modifier GP, GN, or GO. Claims submitted on or after that date must have a required modifier. Please repair now in advance of this deadline.	(umAT) Always Therapy Effective with dates of service on or after April 1, 2020, the GN, GO, or GP modifiers will be required on "Always Therapy" codes to align with the Centers for Medicare & Medicaid Services (CMS). The umAT flag looks at procedure codes used by all three specialties, and if an appropriate modifier is not sent, will send a Smart Edit back to the submitter. For more information please see CMS Transmittal R386. Please also refer to our January 2020 Network Bulletin.	1/30/2020	Medicaid Commercial	Professional
Return Edit	uMLOHf	Revenue code 762 with observation code G0378 should be billed on a single line with total number of observation hours and date of service being the date observation was initiated. Update claim line as applicable.	(uMLOHf) Multiple Lines of Observation If a period of observation spans more than 1 calendar day, all the hours for the entire period of observation must be included on a single line and the date of service for that line is the date that observation care was initiated. Please refer to the Claims Processing Manual: CPM Chapter 4, Part B Hospital, Section 290.2.2	1/30/2020	Medicare	Institutional
Return Edit	umONP	Beginning 4/01/20, therapy charges must be billed with the required modifier GP, GN, or GO. Claims submitted on or after that date must have a required modifier. Please repair now in advance of this deadline.	(umONP) Always Therapy, Speech Therapy Effective with dates of service on or after April 1, 2020, the GN, GO, or GP modifiers will be required on "Always Therapy" codes to align with the Centers for Medicare & Medicaid Services (CMS). This umONP informational edit will fire on speech therapy charges that are missing modifier GN. CMS Transmittal R386. Please refer to our January 2020 Network Bulletin.	1/30/2020	Medicaid Commercial	Professional

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As Returned on the 277CA Clearinghouse Rejection Report

Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	umONP	Beginning 4/01/20, therapy charges must be billed with the required modifier GP, GN, or GO. Claims submitted on or after that date must have a required modifier. Please repair now in advance of this deadline.	(umONP)Always Therapy, Physical Therapy Effective with dates of service on or after April 1, 2020, the GN, GO, or GP modifiers will be required on "Always Therapy" codes to align with the Centers for Medicare & Medicaid Services (CMS). This umONP informational edit will fire on physical therapy charges that are missing modifier GP. CMS Transmittal R386. Please refer to our January 2020 Network Bulletin.	1/30/2020	Medicaid Commercial	Professional
Return Edit	umONP	Beginning 4/01/20, therapy charges must be billed with the required modifier GP, GN, or GO. Claims submitted on or after that date must have a required modifier. Please repair now in advance of this deadline.	(umONP)Always Therapy, Occupational Therapy Effective with dates of service on or after April 1, 2020, the GN, GO, or GP modifiers will be required on "Always Therapy" codes to align with the Centers for Medicare & Medicaid Services (CMS). This umONP informational edit will fire on occupational therapy charges that are missing modifier GO. CMS Transmittal R386. Please refer to our January 2020 Network Bulletin.	1/30/2020	Medicaid Commercial	Professional
Return Edit	uMCID	CLIA ID was not submitted on the claim. Submit claim with a valid CLIA ID.	(uMCID) Missing CLIA ID CLIA applies to all laboratories that examine "materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings." This applies if even one test is to be performed. CLIA regulatory requirements vary according to the kind of test(s) each laboratory conducts. All entities that meet the definition of a "Laboratory" under the CLIA statutes and regulations must obtain an appropriate CLIA certificate prior to conducting patient testing. For purposes of this policy, a valid CLIA Certificate Identification number will be required for reimbursement of clinical laboratory services reported on a1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent. Any claim that does not contain the CLIA ID, invalid ID, and/or the complete servicing provider demographic information will be considered incomplete and rejected or denied. Claim line edits will also be applied if the lab certification level does not support the billed service code. Laboratory service providers who do not meet the reporting requirements and/or do not have the appropriate level of CLIA certification for the services reported will not be reimbursed. Commercial/Medicaid/Medicare Please refer to the Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com for further information.	1/17/2019	Medicaid Medicare Commercial	Professional

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As Returned on the 277CA Clearinghouse Rejection Report

Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	umDT	Per the Medicare Physician Fee Schedule, Procedure Code <1> describes a diagnostic procedure that requires a professional component modifier in this Place of service <2>.	(umDT) Medicare Diagnostic Test The mDT edit uses the CMS NPFS to determine eligibility of a CPT code to be split into professional and technical components. This edit will identify codes that have an indicator of 1 in the PC/TC column of the NPFS that are submitted without modifier 26 appended with a location of inpatient hospital, outpatient hospital or skilled nursing facility. Attachment A of the NPFS defines the indicator 1 in the PC/TC column as follows: "1 = Diagnostic Tests for Radiology Services – Identifies codes that describe diagnostic tests. Examples are pulmonary function tests or therapeutic radiology procedures, e.g., radiation therapy. These codes have both a professional and technical component. Modifiers 26 and TC can be used with these codes. The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier include values for physician work, practice expense and malpractice expense." The mDT edit identifies claim lines that contain codes that do not have the modifier 26 appended appropriately when submitted with a place of service of inpatient hospital, outpatient hospital or skilled nursing facility under Medicare rules. The concept of professional and technical component splits (PC/TC) does apply to these codes that are identified by the indicator of 1 in the PC/TC column of the NPFS. When billing these services in an inpatient hospital, outpatient hospital or skilled nursing facility, only the professional component should be billed by the physician. Billing of the technical component is inappropriate by the physician as the facility should be responsible for submitting it. Modifiers 26 and TC can be used with these codes. Please refer to the Professional/Technical Component Reimbursement Policy on UHCprovider.com for further information.	8/16/2018	Medicare	Professional
Return Edit	umIM	Modifier <1> is inappropriate for Procedure Code <2>.	(umIM) Medicare Inappropriate Modifier The umIM edit uses the CMS NPFS to determine if a procedure code is submitted with an inappropriate modifier. Please refer to the Procedure to Modifier Reimbursement Policy on UHCprovider.com for further information.	8/16/2018	Medicare	Professional
Return Edit	umMFL	Per Medicare guidelines, the associated administration code for vaccine procedure code <1> is invalid. Please update administration code as appropriate.	(umMFL) Medicare Influenza Vaccine requires Admin Code Smart Edit (umMFL) will apply when the influenza vaccine drugs HCPCS/CPT codes are reported on a claim without the influenza drug administration code. Please refer to Medicare Claims Processing Manual, chapter 18, section 10.	8/8/2019	Medicare	Professional
Return Edit	umMFLf	Per Medicare guidelines, the associated administration code for vaccine procedure code <1> is invalid. Please update administration code as appropriate.	Smart Edit (umMFLf) will apply when the influenza vaccine drugs HCPCS/CPT codes are reported on a claim without the influenza drug administration code. Please refer to Medicare Claims Processing Manual, chapter 18, section 10.	8/8/2019	Medicare	Institutional
Return Edit	uMODAN	Procedure code <1> is not appropriate when billed without a valid anesthesia modifier. Update code(s) or modifier as applicable for services rendered.	(uMODAN) Anesthesia Modifiers All anesthesia services including Monitored Anesthesia Care must be submitted with a required anesthesia modifier in the first modifier position. These modifiers identify whether a procedure was personally performed, medically directed, or medically supervised. Please refer to the Oxford Anesthesia Policy on UHCprovider.com for further information.	1/9/2020	Commercial (Oxford)	Professional

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As Returned on the 277CA Clearinghouse Rejection Report

Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	umMPN	Per Medicare guidelines, the associated administration code for vaccine procedure code <1> is invalid. Please update administration code as appropriate.	(umMPN) Medicare Pneumonia Vaccine Without Admin Code Smart Edit (umMPN) will apply when the Pneumonia vaccine drugs HCPCS/CPT codes are reported on a claim without the pneumonia drug administration code. Please refer to Medicare Claims Processing Manual, chapter 18, section 10.	8/8/2019	Medicare	Professional
Return Edit	umMPNf	Per Medicare guidelines, the associated administration code for vaccine procedure code <1>, is invalid. Please update administration code as appropriate.	(umMPNf) Medicare Pneumonia Vaccine Without Admin Code Smart Edit (umMPNf) will apply when the Pneumonia vaccine drugs HCPCS/CPT codes are reported on a claim without the pneumonia drug administration code. Please refer to Medicare Claims Processing Manual, chapter 18, section 10.	8/8/2019	Medicare	Institutional
Return Edit	umMSP	Per NCD 210.2, diagnosis is not listed for procedure code . Update code(s) as applicable for services rendered.	(umMSP) Custom Medicare Screening, pelvic The mMSP identifies a claim line that contains HCPCS code G0101 reported without a diagnosis code indicated by Medicare for Medicare Screening Pelvic exam. Please refer to NCD 210.2: Screening PAP Smears and Pelvic Examinations for early detection of Cervical or Vaginal Cancer.	9/26/2019	Medicare	Professional
Return Edit	uMUDC	Procedure code <1> has been submitted for <diagnosis code 2>, which could be an unproven or off-label use of this drug per FDA guidelines. Please evaluate and update as applicable.	(uMUDC) Medicare Unproven Drug An off-label/unlabeled use of a drug is defined as a use for a non-FDA approved indication, that is, one that is not listed on the drug's official label/prescribing information. An indication is defined as a diagnosis, illness, injury, syndrome, condition, or other clinical parameter for which a drug may be given. Off-label use is further defined as giving the drug in a way that deviates significantly from the labeled prescribing information for a particular indication. Please refer to the following Policy Guideline on UHCprovider.com for further information: Coverage of Drugs and Biologicals for Label and Off-Label Uses	11/21/2019	Medicare	Professional
Return Edit	uMUDCf	Procedure code <1> could be an unproven or off-label use of this drug per FDA guidelines for the diagnosis codes submitted on this claim. Please evaluate and update as applicable.	(uMUDCf) Medicare Unproven Drug Charges An off-label/unlabeled use of a drug is defined as a use for a non-FDA approved indication, that is, one that is not listed on the drug's official label/prescribing information. An indication is defined as a diagnosis, illness, injury, syndrome, condition, or other clinical parameter for which a drug may be given. Off-label use is further defined as giving the drug in a way that deviates significantly from the labeled prescribing information for a particular indication. Please refer to the following Policy Guideline on UHCprovider.com for further information: Coverage of Drugs and Biologicals for Label and Off-Label Uses.	1/30/2020	Medicare	Institutional
Return Edit	uMVA	The diagnosis code submitted <1> appears to be related to a motor vehicle accident. Claim is missing an auto accident indicator. Update the accident indicator and accident date if applicable.	(uMVA) Auto Accident Services related to a motor vehicle accident where benefits may be payable under another plan should indicated on the claim by the accident indicator field. Please refer to the claim submission requirements section of the administrative guide on UHCProvider.com	7/25/2019	Commercial	Professional

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Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	uNDC	Missing National Drug Code (NDC). Procedure <1> must be billed with valid NDC data.	(uNDC) Missing National Drug Code NDC numbers are the industry-standard identifier for drugs and provide full transparency to the medication administered. The NDC number identifies the manufacturer, drug name, dosage, strength, package size and quantity. A NDC number is required for the following CPT/HCPCS codes: J3490 Unclassified drugs J3590 Unclassified biologics J7199 Hemophilia clotting factor, not otherwise classified J7599 Immunosuppressive drug, not otherwise classified J8499 Prescription drug, oral, non-chemotherapeutic, not otherwise specified J9999 Not otherwise classified, antineoplastic drug A9699 Radiopharmaceutical, therapeutic, not otherwise classified 90749 Unlisted vaccine/toxoid If one of the above CPT/HCPCS codes is billed and the NDC is blank, the uNDC edit will be triggered. Please refer to the National Drug Code Requirement Reimbursement Policy for Medicare Advantage Plans on UHCProvider.com for further information.	8/16/2018	Medicare	Professional
Informational Edit	uNPPR	INFORMATIONAL Referring UnitedHealthcare members to out-of-network labs without the member's written prior consent may result in certain penalties.	(uNPPR) Non Par Physician Referral UHC requires providers to refer members to contracted providers when available. Please refer to the UHC Administrative Guide for more information about referrals.	1/30/2020	Commercial	Professional
Informational Edit	uPANC	INFORMATIONAL - effective on or after 1/01/2020, <procedure code 1> will require prior authorization. Please see page 18 of the November Network Bulletin at UHCprovider.com for effective date per state.	(uPANC) Prior Auth Change Notice by Code Effective 1/1/20, United Healthcare is expanding the list of codes that require prior authorization for Site of Service surgical procedures. This SmartEdit fires when one of those codes is submitted on a claim line.	11/14/2019	Commercial	Professional
Informational Edit	uPANCf	INFORMATIONAL - effective on or after 1/01/2020, <procedure code 1> will require prior authorization. Please see page 18 of the November Network Bulletin at UHCprovider.com for effective date per state.	(uPANCf) Prior Auth Change Notice by Code Effective 1/1/20, United Healthcare is expanding the list of codes that require prior authorization for Site of Service surgical procedures.	11/14/2019	Commercial	Institutional
Informational Edit	uPANP	INFORMATIONAL - effective 12/01/2019, additional surgical codes will require prior authorization. Please see Outpatient Surgical Procedures - Site of Service Utilization Review Guideline at UHCprovider.com.	(uPANP) Prior Auth Change Notice by Provider Effective 12/1, United Healthcare is expanding the list of codes that require prior authorization for Site of Service surgical procedures. This SmartEdit fires when one of those codes is submitted on a claim line.	11/14/2019	Commercial	Professional
Informational Edit	uPANPf	INFORMATIONAL - effective 12/01/2019, additional surgical codes will require prior authorization. Please see Outpatient Surgical Procedures - Site of Service Utilization Review Guideline at UHCprovider.com.	(uPANPf) Prior Auth Change Notice by Provider Effective 12/1, United Healthcare is expanding the list of codes that require prior authorization for Site of Service surgical procedures.	11/14/2019	Commercial	Institutional

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As Returned on the 277CA Clearinghouse Rejection Report

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Return Edit	uPCN	Payer Claim Control Number is invalid and is required because the Claim Frequency Type Code (CLM05-3) is 7 or 8. Reference your Provider Remittance Advice for the Payer Claim Control Number (Claim ID).	(uPCN) Invalid Payer Control Number In accordance with HIPAA guidelines, claims require an accurate "Original Payer Claim Control Number" when submitting a corrected claim (bill type xx7/xx8). A "replacement' encounter should be sent to UnitedHealthcare when an element of data on the encounter was either not previously reported or when there is an element of data that needs to be corrected. A replacement encounter should contain a claim frequency code of [7] in Loop 2300 CLM05-3 segment. A "void" encounter should be sent to UnitedHealthcare when the previously submitted encounter should be eliminated. A void encounter must match the original encounter with the exception of the claim frequency type code and the payer assigned claim number. A void encounter should not contain "negative" values within the encounter. It should contain a claim frequency code of [8] in Loop 2300 CLM05-3 segment. The replacement or void encounter is required to be submitted with the "Original Reference Number" (Payer Claim Control Number) in Loop 2300 REF segment. REF01 must be [F8] and REF 02 must be the "Original Reference Number". If the required information in Loop 2300 REF01 and REF02 is not submitted, the encounter will reject back to the submitter. Please refer to the EDI Companion Guides on UHCprovider.com for further information.	1/31/2019	Medicaid	Professional
Return Edit	uPMN	The diagnosis <1> may not support the procedure code <2>. A more appropriate procedure code may be available for the diagnosis. Update code(s) as applicable for services rendered.	(uPMN) Psoriasis Treatment: The 96920-96922 family of CPT codes is used specifically and exclusively for reporting laser treatment of psoriasis. Although the code descriptor for this code family reads "Laser treatment for inflammatory skin disease (psoriasis)," the intent of these codes is that they are to be used only for psoriasis treatment. Source of edit is the AMA CPT code description.	3/21/2019	Medicare Medicaid Commercial	Professional
Return Edit	uPOS	Procedure code <1> is not typically performed by a provider in Place of service <2>.	(uPOS) Place of Service The place of service (uPOS) flag identifies claim lines where the submitted place of service (POS) is not typical with the submitted CPT/HCPCS procedure. This edit flags CPT or HCPCS codes (excluding unlisted codes) when the submitted POS falls outside of the list of sourced POS for the current CPT or HCPCS code. Both the Current CPT Professional Edition and the HCPCS Level II Expert provide a list of POS codes and a description of the most common locations where these codes would take place. The flag message states, "Procedure Code <_____> is not typically performed by a physician at Place of service <_____>." In summary, the POS flag identifies claim lines where the POS designated is not on the list of commonly associated POS for the CPT or HCPCS procedure code submitted. Please refer to the Procedure to Place of Service Reimbursement Policy on UHCprovider.com for further information.	8/16/2018	Medicare	Professional
Informational Edit	uPTC	INFORMATIONAL Beginning February 1, 2020 procedure <1> submitted with modifier TC will not be eligible for reimbursement to health care professionals as it is considered included in the payment to the facility.	(uPTC) Pro Tech Exception Removal Effective with dates of process on or after February 1, 2020, in alignment with the Centers for Medicare and Medicaid (CMS), reimbursement for the technical component of CPT codes 92585, 92587 and 92588, when reported in a facility place of service (POS), will be denied. Currently the policy includes an exception to bypass denial of the technical component for these services, allowing reimbursement when reported in a facility POS. Payment for the technical component of these services is considered included in the payment to the facility and therefore not reimbursable on a CMS 1500 claim form.	12/19/2019	Medicaid Commercial	Professional

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As Returned on the 277CA Clearinghouse Rejection Report

Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	uREVRf	Claim line revenue code <1> requires submission of a HCPCS or CPT code. Update code(s) as applicable for services rendered.	(uREVRf) Rev 471 Needs a HCPC The UHC Provider claims billing guide clearly lists this revenue code as requiring a procedure code. Bill types to be excluded: • Home Health (33X) • Religious Non Medical Healthcare (43X) • Rural Health Care Clinic (71X) • Hospital based Clinic (72X) • Free standing Clinic (73X) • Federally Qualified Health Center Clinic (77X) Please refer to the UnitedHealthcare Administrative Guide found on UHCprovider.com	9/5/2019	Medicaid	Institutional
Return Edit	uRFVRf	A patient reason for visit diagnosis code is required. Update code(s) as applicable for services rendered.	(uRFVRf) Missing Patient Reason Code - Emergency Missing Patient Reason for Visit code. Please refer to the EDC Analyzer and NUBC manual as well as the Emergency Department Facility Evaluation and Management Coding Policy on UHCprovider.com	8/29/2019	Commercial	Institutional
Return Edit	uRVT	<Procedure code 1> submitted is not appropriate when submitted with place of service <2>. There are other respiratory viral codes that are available for use in a non-facility place of service.	(uRVT) Medicaid Respiratory Viral Panel Testing Please refer to the Respiratory Viral Panel Testing policy for Community and State located at uhcprovider.com.	9/26/2019	Medicaid	Professional
Informational Edit	uRVTI	INFORMATION - <1> may not be appropriate when submitted with place of service <2>. There are other respiratory viral testing codes that are available for use in a non-facility place of service.	(uRVTI) Commercial Respiratory Viral Panel Testing Per IDSA and CDC guidelines, procedure codes 87631, 87632 and 87633 may not be appropriate in a physician office setting. Please visit idsociety.org or cdc.gov for more information. Please refer to the following: Infectious Disease Society of America (IDSA) Centers for Disease Control and Prevention (CDC)	10/10/2019	Commercial	Professional
Return Edit	uSPPf	Diagnosis code <1> may not meet medical coding guidelines for MS DRG <2>. Please review and update the principal diagnosis and/or MS DRG if applicable	(uSPPf) Simple Pneumonia and Pleurisy CMS considers Coding Clinic published by The American Hospital Association, to be the official coding guidelines. Hospitals should follow the Coding Clinic Guidelines to ensure ICD 10 CM coding and DRG assignment accuracy. Coding Tips Pneumonia and Pneumonitis Bacterial pneumonia should be assigned based on the physician documentation. If the physician has not specified the type of pneumonia (i.e. bacterial) then code for Pneumonia, unspecified is assigned. Always document tobacco use and tobacco smoke exposure, and chemical or environmental exposures. DRG Levels Medicare Severity Diagnosis Related Group (MS-DRG) codes are often divided into three levels of severity for each primary DRG. DRG 193, 194, and 195 – Simple Pneumonia and Pleurisy DRG 193 - Simple Pneumonia & Pleurisy with MCC DRG 194 – Simple Pneumonia & Pleurisy with CC DRG 195 – Simple Pneumonia & Pleurisy w/o CC/MCC Please refer to ICD10 coding guidelines and AHA Coding Clinic guidelines.	11/7/2019 1/30/2020	Commercial Medicare	Institutional

UnitedHealthcare Smart Edits

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As Returned on the 277CA Clearinghouse Rejection Report

Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	uST	Per the ICD-10-CM, procedure 92507 requires a supporting diagnosis code. Update code(s) as applicable for speech language pathology services rendered.	(uST) Procedure code 92597 requires supporting diagnosis Procedure code 92507 denotes treatment of speech, language, voice, communication, and/or auditory processing disorder; individual. A speech/language/hearing diagnosis code must be submitted with it to support the procedure. Additional guidelines can be found at https://www.asha.org/practice/reimbursement/coding/icd-10-cm-coding-faqs-for-audiologists-and-slps/.	6/6/2019	Medicaid	Professional
Return Edit	uSTCA	Per the ICD-10-CM, F80.4 requires a supporting diagnosis code. Update code(s) as applicable for services rendered.	(uSTCA) Code Also F80.4 'Code Also' codes are appropriately paired with a second ICD-10 code to further specify the type of diagnosis. F80.4 (speech and language delay due to hearing loss) must be accompanied by a second ICD-10 code describing the type of hearing loss (H90.-, H91. - series). Additional guidelines can be found at https://www.asha.org/practice/reimbursement/coding/icd-10-cm-coding-faqs-for-audiologists-and-slps/.	6/6/2019	Medicaid	Professional
Return Edit	uSTCAf	Per the ICD-10-CM, F80.4 requires a supporting diagnosis code. Update code(s) as applicable for services rendered.	(uSTCAf) Speech-Language and Swallowing Disorders DX Code The "Code Also" rule designates that two ICD-10 codes are required to fully describe a condition. 'Code Also' codes are appropriately paired with a second ICD-10 code to further specify the type of diagnosis. For Example, F80.4 (speech and language delay due to hearing loss) must be accompanied by a second ICD-10 code describing the type of hearing loss (H90.-, H91. - series) For additional information please refer to ICD-10 guidelines	8/15/2019	Medicaid	Institutional
Return Edit	uSTf	Per the ICD-10-CM, procedure 92507 requires a supporting diagnosis code. Update code(s) as applicable for speech language pathology services rendered.	(uSTf) Speech Therapy 92507 The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis. Every claim submitted should include an ICD-10 code that corresponds to the reason for the visit documented in the medical record. There should be agreement between the ICD-10 code and CPT code included on the claim. For additional information please refer to ICD-10 guidelines	8/15/2019	Medicaid	Institutional
Return Edit	uSTR	Per the ICD-10-CM, submitted diagnosis <Diagnosis code 1> requires an additional diagnosis code that supports the underlying medical condition(s). Update code(s) as applicable.	If one of these codes is present on a charge line without an additional Speech Language Pathology code, UHC C&S wants to catch the claim in ACE. Additional guidelines can be found at https://www.asha.org/practice/reimbursement/coding/icd-10-cm-coding-faqs-for-audiologists-and-slps/.	6/6/2019	Medicaid	Professional
Return Edit	uSTRf	Per the ICD-10-CM, submitted diagnosis <Diagnosis code 1> requires an additional diagnosis code that supports the underlying medical condition(s). Update code(s) as applicable.	(uSTRf) R-Series Code (Speech Therapy) Generally, audiologists and SLPs should use the ICD-10-CM diagnosis code for the speech, language, swallowing, vestibular, and/or hearing disorder that they are evaluating or treating (i.e., primary or treating diagnosis) as their first-listed diagnosis. The second-listed diagnosis—sometimes referred to as the secondary or medical diagnosis—is the medical diagnosis that is causing or contributing to the speech, language, swallowing, vestibular, and/or hearing disorder. For additional information please refer to ICD-10 guidelines	8/15/2019	Medicaid	Institutional
Return Edit	uTOBf	Per CMS and NUBC, Type of Bill 14x is required for non patient laboratory specimens. Outpatient services should be billed on Type of Bill 85x for CAH and 13x for all other hospitals.	(uTOBf) Bill Type 14X The National Uniform Billing Committee (NUBC) has redefined the Type of Bill 14X to be limited in use for non-patient laboratory specimens. For more information go to - CMS.gov > Regulations & Guidance > Guidance > Transmittals > Downloads > R795CP.pdf	8/8/2019	Medicaid	Institutional

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Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	uTOBf	Bill Type 034x is not valid for home health care revenue codes without a plan of care. Please update revenue code or bill type as appropriate.	(uTOBf)Bill Type 34X Home health agencies may submit claims for certain medical and other health services when there is no home health plan of care under a type of bill 34X versus a 32X type of bill (home health services under a plan of care). For additional information please refer to the Home Health Services and Home Health Visits Coverage Summary found on UHCprovider.com	8/15/2019	Medicare	Institutional
Return Edit	uTOBf	Per CMS and NUBC, Type of Bill 14x is required for non patient laboratory specimens. Outpatient services should be billed on Type of Bill 85x for CAH and 13x for all other hospitals.	(uTOBf) Bill Type 14X Providers are billing outpatient non-laboratory services such as radiology and electrocardiograms on a 14X Type of Bill rather than 13X or 85x Type of Bill. CMS and the National Uniform Billing Committee have very clear guidance that the 14X Type of Bill can only be used to bill for non-patient lab specimens and cannot be used for non-laboratory services. Non-patient lab specimens are indicated by Revenue Codes 0300-0319. Critical Access Hospitals should use bill type 85x All non-CAH facilities should use bill type 13x If a claim is received with Bill Type 14x, and one of the non-patient lab specimen revenue codes is present, we want to fire an edit that the type of bill is incorrect. For additional information, please visit https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019-Transmittals.html	7/11/2019	Commercial Medicare	Professional
Return Edit	UUD	Procedure <1> unbundles to procedure <2> on the current or a previously submitted claim. Update code(s) as applicable for service rendered.	(UUD) Unbundle Procedure, Deny UnitedHealthcare Community Plan uses this policy to determine whether CPT and/or HCPCS codes reported together by the Same Individual Physician or Health Care Professional for the same member on the same date of service are eligible for separate reimbursement. UnitedHealthcare Community Plan will not reimburse services determined to be Incidental, Mutually Exclusive, Transferred, or Unbundled to a more comprehensive service unless the codes are reported with an appropriate modifier. Please refer to the Rebundling Policy, Professional (4/8/2019) on UHCProvider.com for additional information.	7/25/2019	Medicaid	Professional
Return Edit	uTXT	1) A billing provider taxonomy code, valid with Texas provider registration, is required to be submitted on the claim. 2) A rendering provider taxonomy code, valid with Texas provider registration, is required to be submitted on the claim when other rendering provider information is included.	(uTXT) Missing Texas Taxonomy Codes Missing Texas Taxonomy Codes: Starting Jan. 1, 2018, your claims for Medicaid members in UnitedHealthcare Community Plan STAR, STAR Kids and STAR+PLUS programs will need to include the correct taxonomy codes. We realize you may have seen earlier communications with other implementation dates, but this is the final and correct start date. The taxonomy codes on the claim need to match the care provider's Texas Medicaid enrollment for: • The rendering care provider. This includes the attending physician for institutional claims. • The billing care provider, which is the practice or group submitting the claim. All billing providers are required to submit their Texas Medicaid attested taxonomy on all claims. Claims submitted without the correct taxonomy code and National Provider Identifier (NPI) will be denied. Please refer to the Taxonomy Code Requirements Reimbursement Policy on UHCprovider.com for further information.	10/4/2018	Medicaid (Texas Only)	Professional

UnitedHealthcare Smart Edits

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As Returned on the 277CA Clearinghouse Rejection Report

Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	uUNS	The ICD-10-CM code reported defines an unspecified or Not Otherwise Specified (NOS) ICD-10-CM diagnosis code. Review documentation to verify whether or not a more specific ICD-10-CM diagnosis code is appropriate.	(uUNS) Candidiasis Unspecified Diagnosis Physicians billing with Unspecified Codes for Candidiasis. Dx code: B37.9 is an unspecified code for Candidiasis. Candidiasis codes are classified by site and /or manifestation and coding should be done to the highest level of specificity per the AHA Coding Clinic Guidelines. Candidiasis is a yeast infection caused by the Candida species, usually C. albicans but also C. tropicalis and C. parapsilosis. C. albicans is found on mucosal tissues in the mouth and genital regions in about half the population and typically does not cause infection. Infection is present only when overgrowth occurs in the mouth or genital region or when the yeast is found in sites other than the mouth and genital areas. In healthy individuals this may be a result of medications, such as antibiotics, changing the natural environment of these areas. Most Candida infections are simple cases of diaper rash or vulvovaginal infection. However, Candida is also an opportunistic illness and significant systemic infection is seen among the immunosuppressed, including individuals receiving chemotherapy and those with acquired immune deficiency syndrome (AIDS). Candidiasis codes are classified by site and/or manifestation. Based on AHA Coding Clinic Guidelines as defined by ICD-10_CM. Consult the current ICD-10-CM coding manual for details regarding diagnosis code B37.9.	5/2/2019	Medicare Medicaid Commercial	Professional
Return Edit	UUS	Procedure <1> is included with procedure <2> on the current or a previously submitted claim. Under appropriate circumstances, a designated modifier may be required to identify distinct services.	(UUS) Unbundle Procedure, Secondary UnitedHealthcare Community Plan uses this policy to determine whether CPT and/or HCPCS codes reported together by the Same Individual Physician or Health Care Professional for the same member on the same date of service are eligible for separate reimbursement. UnitedHealthcare Community Plan will not reimburse services determined to be Incidental, Mutually Exclusive, Transferred, or Unbundled to a more comprehensive service unless the codes are reported with an appropriate modifier. UnitedHealthcare Community Plan sources its Rebundling edits to methodologies used and recognized by third party authorities. Those methodologies can be Definitive or Interpretive. A Definitive source is one that is based on very specific instructions from the given source. An Interpreted source is one that is based on an interpretation of instructions from the identified source (please see the Definitions section below for further explanations of these sources). The sources used to determine if a Rebundling edit is appropriate are as follows: • Current Procedural Terminology book (CPT) from the American Medical Association (AMA); • CMS National Correct Coding Initiative (CCI) edits; • CMS Policy; and Specialty Societies (e.g., American Academy of Orthopaedic Surgeons (AAOS), American Congress of Obstetricians and Gynecologists (ACOG), American College of Cardiology (ACC), and Society of Cardiovascular Interventional Radiology (SCIR)). Please refer to the Rebundling Policy on UHCProvider.com for further information.	5/30/2019	Medicaid	Professional
Return Edit	uUST	Diagnosis Code <1> is a nonspecific or Not Otherwise Specified code and must be billed with a speech language pathology diagnosis. Please adjust if applicable and resubmit.	(uUST) Diagnosis codes must have speech pathology additional diagnosis UHC follows ICD-10-CM guidelines for correct coding. Supplemented by American Speech-Language-Hearing Association (ASHA) documentation and as defined by ICD-10, diagnosis code F80.89 is not specific and F80.9 is Not Otherwise Specified. This edit is specific to diagnosis codes F80.89 (Other developmental disorders of speech and language) and F80.9 (Developmental disorder of speech and language, unspecified). Additional guidelines can be found at https://www.asha.org/practice/reimbursement/coding/icd-10-cm-coding-faqs-for-audiologists-and-slps/	6/6/2019	Medicaid	Professional

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Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	uUSTf	<Diagnosis Code 1> is a nonspecific or Not Otherwise Specified code and must be billed with a speech language pathology diagnosis. Please adjust if applicable and resubmit.	(uUSTf) Speech Therapy Unspecified/Not Otherwise Specified F80x UHC follows ICD-10-CM guidelines for correct coding. Supplemented by ASHA documentation and as defined by ICD-10, diagnosis code F80.89 is not specific and F80.9 is Not Otherwise Specified. If one of these codes is present on a charge line without an additional Speech Language Pathology code, UHC C&S wants to catch the claim in ACE. For additional information please refer to ICD-10 guidelines	8/15/2019	Medicaid	Institutional
Return Edit	VAGDG	The age of the patient does not align with the CDC's Advisory Committee on Immunization Practices (ACIP) recommendation for procedure code <1>.	(VAG) Vaccine Age Gender Restrict Eff 20140801 Nov15 The standard UnitedHealthcare Certificate of Coverage covers preventive health services, including immunizations, administered in a physician office. Some immunizations are excluded, e.g., immunizations that are required for travel, employment, education, insurance, marriage, adoption, military service, or other administrative reasons. An immunization that does not fall under one of the exclusions in the Certificate of Coverage is considered covered after both of the following conditions are satisfied: 1. US Food and Drug Administration (FDA) approval; and 2. ACIP definitive (e.g., should, shall, is) recommendation rather than a permissive ("may") recommendation published in the Morbidity & Mortality Weekly Report (MMWR) of the Centers for Disease Control and Prevention (CDC). Implementation of covered vaccines will typically occur within 60 days after publication in the MMWR. Please see the Preventive Care Services Coverage Determination Guideline for further information. Please refer to Vaccines Commercial Medical & Drug Policies on UHCProvider.com for further information.	3/7/2019	Commercial	Professional
Return Edit	VAGDZ	The age of the patient does not align with the CDC's Advisory Committee on Immunization Practices (ACIP) recommendation for procedure code <1>.	(VAG) Vaccine Age Gender Restrict Eff 20140801 Nov15 The standard UnitedHealthcare Certificate of Coverage covers preventive health services, including immunizations, administered in a physician office. Some immunizations are excluded, e.g., immunizations that are required for travel, employment, education, insurance, marriage, adoption, military service, or other administrative reasons. An immunization that does not fall under one of the exclusions in the Certificate of Coverage is considered covered after both of the following conditions are satisfied: 1. US Food and Drug Administration (FDA) approval; and 2. ACIP definitive (e.g., should, shall, is) recommendation rather than a permissive ("may") recommendation published in the Morbidity & Mortality Weekly Report (MMWR) of the Centers for Disease Control and Prevention (CDC). Implementation of covered vaccines will typically occur within 60 days after publication in the MMWR. Please see the Preventive Care Services Coverage Determination Guideline for further information. Please refer to Vaccines Commercial Medical & Drug Policies on UHCProvider.com for further information.	3/7/2019	Commercial	Professional
Return Edit	VDTDX	Procedure <1> not submitted with a diagnosis from the Vitamin D Testing Diagnosis list. Update code(s) as applicable for services rendered.	(VDTDX) Vitamin D Diagnosis Denial UnitedHealthcare Community Plan will allow four Vitamin D tests per year , when submitted with an appropriate ICD-10 diagnosis code plus the codes UnitedHealthcare has added to that list in any position. Vitamin D tests that do not include a diagnosis from the Vitamin D Testing diagnosis list will be denied. Please refer to the Vitamin D Testing Reimbursement Policy at UHCProvider.com	7/18/2019	Medicaid	Professional

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Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit	VFCIM	Modifier <1> is not appropriate for members aged 19 or over. Update modifier as applicable for services rendered.	(VFCIM) Denies VFC modifier for overage patient Through this policy, UnitedHealthcare Community Plan will ensure compliance with the federally mandated Vaccines For Children program, while reducing inappropriate payments where providers have access to free vaccines for children enrolled in Medicaid, and also meet all State specific requirements. This policy applies to members under age 19 only (age 18 + 364 days). Please refer to the Vaccines for Children Policy, Professional Reimbursement Policy on UHCprovider.com for further information.	2/21/2019	Medicaid	Professional
Return Edit	VFCMM	The required modifier for this VFC service is missing. Refer to your State Fee for Service Medicaid Plan for further details for modifier requirements of each State.	(VFCMM) Vaccine Modifier Missing Vaccines for Children Policy addresses VFC serum codes not submitted with the required modifier. This policy describes the reimbursement methodology for CPT and HCPCS codes based on the CMS NPFS Relative Value File, Professional Component (PC)/Technical Component (TC) Indicators. NPFS PC/TC Indicator Description 0 Physician Service Codes 1 Diagnostic Tests 2 Professional Component Only Codes 3 Technical Component Only Codes 4 Global Test Only Codes 5 Incident To Codes 6 Laboratory Physician Interpretation Codes 8 Physician interpretation codes 9 Not Applicable Relative to these services, this policy also addresses information pertaining to Duplicate or Repeat Services, modifier usage, submissions based on place of service (POS) and the Professional Component with an Evaluation and Management service. Unless otherwise specified, for the purposes of this policy, Same Individual Physician or Other Qualified Health Care Professional, is defined as the same individual rendering health care services reporting the same Federal Tax Identification number. Please refer to the Vaccines for Children Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	10/4/2018	Medicaid	Professional
Return Edit	VFCSD	Procedure code <1> is a vaccine serum code and is not appropriate without the corresponding vaccine administration code. Update codes as applicable for services rendered.	(VFCSD) Admin with no NON VFC Denial The Vaccines for Children (VFC) program was established in 1993 to serve children defined as "federally vaccine eligible" under section 1928(b)(2), which includes both "uninsured" and "Medicaid eligible" children. American Indian, Alaskan Native children and children whose insurance does not cover immunizations are also eligible for VFC. States will continue to receive federal funding for reduced-price vaccines under this program. All children from birth through 18 years of age (18 years + 364 days) who are covered by Medicaid are considered VFC eligible because of their Medicaid status. The Advisory Committee on Immunization Practices (ACIP) is a federal advisory committee whose role is to provide advice and guidance to the Secretary and the Assistant Secretary for Health and Human Services, and the Director, Centers for Disease Control and Prevention (CDC), regarding the most appropriate selection of vaccines and related agents for control of vaccine-preventable diseases in the civilian population of the United States. Immunization programs that receive VFC funds are required to implement ACIP-recommended vaccines for which there are VFC resolutions and for which federal contracts have been established to purchase these vaccines. Please refer to the Vaccines for Children Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	2/13/2019	Medicaid	Professional

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Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Return Edit - is sent when the claim in question is likely to result in a denial, reduce potential medical record requests, or reduce potential future overpayment requests if it continues into UnitedHealthcare's claims processing system. This edit is found at the line level of the claim Informational Edit - message notifies you of key information in the claim submission process or about upcoming events that require your attention. Informational Edits are found at the line level of the claim and DO NOT impact the specific claim. Informational Banner - is exhibited on all claims receiving smart edits. The intent of the banner is to provide resources for further information on smart edits and the associated policies at a claim level.						