Smart Edits guide

Please use this document to find specific Smart Edits information by using Ctrl + F.

Smart Edits definitions

Rejection: Occurs when a claim requires immediate attention. If you don't take action to correct the claim, it won't enter our claims processing system.

Return: Occurs when a claim in question is likely to result in a denial, reduce potential medical record requests or reduce potential future overpayment requests. This edit is found at the line level of the claim.

Informational: Notifies you of key information in the claims process or about upcoming events that require your attention.This edit is found at the line level of the claim and doesn't require any specific follow-up.

Documentation: Notifies you when a submitted claim requires additional information. Please submit documentation in the UnitedHealthcare Provider Portal using TrackIt.

Policies

If the Smart Edit description refers to a reimbursement policy, coverage summary or policy guideline, please visit our Policies and Protocols for Healthcare Providers and select the applicable plan name.

Questions?

If you have questions, visit our **Smart Edits** or **EDI Contacts** pages.

New monthly smart edits

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**sMOD**	Modifier <1> is not typical for procedure code <2>. Update codes as applicable.	Medicaid Invalid 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 Procedure to Modifier Policy, Professional - Reimbursement Policy - UnitedHealthcare Community Plan at UHCprovider.com.	4/3/2025	Individual & Famly Plan	Professional

Smart edits

Edit type	Smart edit	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.	Mutually Exclusive/NCCI Code 2 of a Pair 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 4/25/2024	Commercial UHOne	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
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.	Diagnosis Not Typical for Patient 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 review the Age to Diagnosis Code & Procedure Code Policy, Professional on UnitedHealthcare Community Plans.	3/7/2019	Medicaid	Professional
Return Edit	**ACUALL**	Procedure <1> with a maximum acupuncture face-to-face time unit of <2> has been exceeded by <3>. Update code(s) as applicable.	Acupuncture Maximum Frequency Per Day In accordance with the code descriptions and/or the Centers for Medicare and Medicaid Services (CMS) guidelines and National Correct Coding Initiative (NCCI) established Medically Unlikely Edits (MUE) values, the maximum units of Acupuncture services allowed per date of service. UHC follows 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. Please review Acupuncture Policy, Professional Commercial Reimbursement Policy at UHCprovider.com	9/28/2023	Commercial	Professional
Return Edit	**ADOCC**	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.	Add On Codes Critical care codes are time-based Evaluation and Management (E/M) services. CPT code 99291 is reported for the first 30-74 minutes of care; Add-on code +99292 is reported for each additional 30 minutes. UnitedHealthcare Community Plan will reimburse for critical care add-on services (code +99292) when certain conditions are met. Please review the Add-On Codes Reimbursement Policy on UHCprovider.com.	9/26/2024	Individual & Family Plan 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.	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 review the Add-On Codes Reimbursement Policy on UHCprovider.com.	10/4/2018 7/11/2019	Medicaid Commercial	Professional
Return Edit	**ADOHB**	Procedure <1> is a behavioral health add-on code and is not separately reimbursable. Update code(s) as applicable.	Add On Behav Health Not Sep Reimburseable 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 Standalone codes are not reimbursable services in accordance with Current Procedural Terminology (CPT®) and the Centers for Medicare and Medicaid Services (CMS) guidelines. Please review the Add-On Codes Reimbursement Policy on UHCprovider.com.	9/28/2023	Commercial	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**AGPDN**	Procedure code <1> is not typical for the age of this patient. The typical age range for this procedure is <3>.	Age to Procedure UnitedHealthcare will consider reimbursement for an age-based CPT or HCPCS code when the patient's age is within the age designation assigned to the code. Procedure codes reported inappropriately will be considered billing errors and will not be considered for reimbursement. Providers may resubmit using the appropriate age-based code. Please review Age-based Codes Policy, Professional on UHCprovider.com	10/26/2023 10/24/2024 3/21/2025	Commercial Individual & Family Plan Level Funded Oxford	Professional
Return Edit	**AHC**	Procedure <1> is not reimbursable in place of service <2>. Update code(s) as applicable.	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. review After Hours policy for when after hours or weekend care codes are considered for separate reimbursement. Please review the After Hours and Weekend Care reimbursement policy at UHCprovider.com.	11/14/2018 9/28/2023	Medicaid Commercial	Professional
Return Edit	**AHCAD**	Procedure <1> is not a separately reimbursable service.	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. review After Hours policy for when after hours or weekend care codes are considered for separate reimbursement. Please review the After Hours and Weekend Care Policy on UHCprovider.com.	5/26/2022	Commercial	Professional
Return Edit	**AHCDN**	An after hours procedure code <1> has already been billed for date of service <2> and provider <3> on this or a previously submitted claim. Update code(s) as applicable.	AHC Code Same Day, Same Provider 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. review After Hours policy for when after hours or weekend care codes are considered for separate reimbursement. Please review the After Hours and Weekend Care Policy, Professional on UHCprovider.com.	5/26/2022	Commercial	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.	AHC Code Same Day, Same Provider 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 review the After Hours and Weekend Care reimbursement policy at UHCprovider.com.	6/13/2019 5/26/2022	Medicaid Commercial	Professional
Return Edit	**AHCSD**	Procedure <1> is not appropriate when submitted in <2> Place of Service for the state of <3>. Update code(s) as applicable for services rendered.	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 review the After Hours and Weekend Care Policy, Professional on UnitedHealthcare Community Plans on UHCprovider.com.	3/7/2019	Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**AMBMD**	Ambulance Procedure <1> has been denied because of a missing or invalid ambulance modifier. Update code(s) as applicable.	Ambulance Modifier For ambulance transportation claims, UnitedHealthcare has adopted the Centers for Medicare and Medicaid Services (CMS) guidelines that require an Ambulance Supplier to report an origin and destination modifier for each trip provided. Please review Ambulance Policy, Professional Commercial Reimbursement Policy at UHCprovider.com	8/29/2024	Commercial	Professional
Return Edit	**AMRDN**	Procedure code <1> may need to be submitted with an anatomical modifier. The most specific modifier to represent the anatomical site should be reported. Update code(s) as applicable.	Anatomical Modifier Requirement According to the Centers for Medicare and Medicaid Services (CMS), a modifier is a two-character code that is added, when appropriate, to the end of a procedure or service to clarify the services being billed. Modifiers add more information, such as the anatomical site, to the code. In addition, they help to eliminate the appearance of duplicate billing and unbundling. Modifiers are used to increase accuracy in reimbursement, coding consistency, editing, and to capture payment data. Please review Anatomical Modifier Requirement Policy, Professional - Reimbursement Policy at UHCprovider.com	1/30/2025	Commercial Level Funded Oxford	Professional
Return Edit	**AMRMR**	Procedure code <1> may need to be submitted with an anatomical modifier. The most specific modifier to represent the anatomical site should be reported. Update code(s) as applicable.	Anatomical Modifier Requirement According to the Centers for Medicare and Medicaid Services (CMS), a modifier is a two-character code that is added, when appropriate, to the end of a procedure or service to clarify the services being billed. Modifiers add more information, such as the anatomical site, to the code. In addition, they help to eliminate the appearance of duplicate billing and unbundling. Modifiers are used to increase accuracy in reimbursement, coding consistency, editing, and to capture payment data. Please review Anatomical Modifier Requirement Policy, Professional - Reimbursement Policy at UHCprovider.com	1/30/2025	Commercial Individual & Family Plan Level Funded Oxford	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.	Anesthesia 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 review the Anesthesia Policy, Professional on UnitedHealthcare Community Plans on UHCprovider.com.	3/28/2019	Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
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.	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." review UnitedHealthcare Community Plan's "Add-on Policy" for further details on reimbursement of CPT code 01953. Please review the Anesthesia Policy, Professional on UnitedHealthcare Community Plans on UHCprovider.com.	5/30/2019	Medicaid	Professional
Return Edit	**ANSMU**	Procedure <1> is not submitted with an appropriate modifier. Please update as applicable.	Anesthesia Required Modifier 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. Please review the Anesthesia reimbursement policy on UHCprovider.com.	10/28/2021	Medicaid	Professional
Return Edit	**ANSNM**	Procedure <1> is included in procedure <2> on this or a previously submitted claim. Update code(s) as applicable.	Anesthesia Non Eligible Modifier When duplicate (same) anesthesia codes are reported by the same or different physician or other qualified health care professional for the same patient on the same date of service, UnitedHealthcare will only reimburse the first submission of that code. However, anesthesia administration services can be rendered simultaneously by an MD and a CRNA during the same operative session, each receiving 50% of the Allowed Amount (as indicated in the Modifier Table above) by reporting modifiers QK or QY and QX. In the event an anesthesia administration service is provided during a different operative session on the same day as a previous operative session, UnitedHealthcare will reimburse one additional anesthesia administration appended with modifier 59, 76, 77, 78, 79 or XE. Please review the Anesthesia reimbursement policy on UHCprovider.com.	9/28/2023	Commercial	Professional
Return Edit	**ANSQC**	Procedure code <1> is inappropriate when submitted without an anesthesia service. Update code(s) as applicable for services rendered.	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 review the Anesthesia Policy, Professional at UHCprovider.com.	5/9/2019	Commercial	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**ASUDM**	Procedure <1> is missing the appropriate modifier for assistant surgeon. Update code(s) as applicable.	Assistant Surgeon The Assistant-at-Surgery Eligible List is developed based on the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule Relative Value File (NPFS) payment policy indicators. All codes in the NPFS with the payment code indicator "2" for "Assistant-at-Surgery" are considered by UnitedHealthcare to be reimbursable for Assistant-at-Surgery services, as indicated by an assistant surgeon modifier (80, 81, 82, or AS). The procedure code summitted is not on the Assistant -at-Surgery Eligible List. Please refer to Assist-at Surgery Services Policy, Professional on www.UHCprovider.com.	11/30/2023	Commercial	Professional
Return Edit	**ASUNE**	Proc <1> is not eligible for assistant surgeon. Please update code(s) as applicable.	Assistant Surgeon Not Eligible The Assistant-at-Surgery Eligible List is developed based on the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule Relative Value File (NPFS) payment policy indicators. All codes in the NPFS with the payment code indicator "2" for "Assistant-at-Surgery" are considered by UnitedHealthcare to be reimbursable for Assistant-at-Surgery services, as indicated by an assistant surgeon modifier (80, 81, 82, or AS). The procedure code summitted is not on the Assistant -at-Surgery Eligible List. Please review the Assistant Surgeon Policy on UHCprovider.com.	2/25/2021 9/26/2024	Commercial Individual & Family Plan Medicaid	Professional
Return Edit	**BBCAD**	Procedure <1> is considered inclusive to other services reported. Update code(s) if applicable.	B Bundle Codes Consistent with CMS, UnitedHealthcare will not separately reimburse for specific Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes assigned a status code “B” on the NPFS Relative Value File indicating a bundled procedure. B Bundle Codes are not reimbursable services regardless of whether they are billed alone or in conjunction with other services. Please review the B Bundle Codes Policy on UHCprovider.com.	4/29/2021 2/24/2022 3/31/2022 11/17/2022	Individual & Family Plan Medicaid All Savers Commercial	Professional
Return Edit	**BCC**	Per LCD or NCD guidelines, procedure code <1> has not met the associated Code-to-Code relationship criteria. Please review and update the claim as applicable.	Part B Code to Code Missing or Invalid The NCD/LCD policy has a code to code relationship defined and the claim does not have all the procedure codes required or the procedure codes submitted do not match to the policy requirements. Please review the NCD/LCD policy for service(s) billed on www.cms.gov.	7/28/2022	Medicare	Professional
Return Edit	**BIL**	Procedure <1> is not appropriate when billed with a bilateral modifier. Update code(s) or modifier as applicable for services rendered.	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. Please review the Bilateral Procedures Reimbursement Policy on UHCprovider.com.	1/31/2019 2/21/2019	Commercial Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
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.	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 review the Bilateral Procedure Policy, Professional on UnitedHealthcare Community Plans on UHCprovider.com.	3/28/2019	Medicaid	Professional
Return Edit	**BILNE**	Procedure <1> is not appropriate when billed with a bilateral modifier. Update code(s) as applicable.	Bilateral Procedures 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. Please refer to Bilateral Procedure Policy, Professional on www.UHCprovider.com.	11/30/2023	Medicaid	Professional
Return Edit	**c00002PD**	Procedure Code <1> is not reimbursable when billed in POS <2>. Update codes(s) as applicable for services rendered.	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 review the Procedure to Place of Service Policy on UHCprovider.com.	11/14/2019	Medicaid	Professional
Return Edit	**c00002SD**	Procedure Code <1> is not reimbursable when billed in POS <2>. Update code(s) as applicable for services rendered.	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 review the Procedure to Place of Service Policy on UHCprovider.com.	8/29/2024	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.	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 review the Procedure to Place of Service Policy, Professional on UnitedHealthcare Community Plans on UHCprovider.com.	5/2/2019	Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**C01DN**	Diagnosis <1> is not appropriate with procedure <2> per the Clinical Diagnostic Lab Policy for Carcinoembryonic Antigen.	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 review the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com.	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.	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 review the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com.	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.	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 review the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com.	11/14/2018	Medicaid	Professional
Return Edit	**C04DN**	Diagnosis <1> is not appropriate with procedure <2> per the Clinical Diagnostic Lab Policy for Prostate Specific Antigen.	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 review the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com.	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.	Urine Cultrue, 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 review the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com.	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.	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 review the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com for further information.	11/14/0218	Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**C07DN**	Diagnosis <1> is not appropriate with current line procedure code <2> per the Clinical Diagnostic Lab Policy for Thyroid Testing.	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 review the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com.	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.	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 review the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com.	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.	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 review the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com.	11/14/2018	Medicaid	Professional
Return Edit	**C10DN**	Diagnosis <1> is not appropriate with procedure <2> per the Clinical Diagnostic Lab Policy for Prothrombin Time (PT) Testing.	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 review the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com.	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.	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 review the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com.	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.	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 review the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com.	11/14/2018	Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
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.	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 review the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com.	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.	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 review the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com.	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.	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 review the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com.	11/14/2018	Medicaid	Professional
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	Invalid Procedure Diagnosis - Glycated Hemoglobin/Glycated 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 review the Clinical Diagnostic Lab Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com.	10/4/2018	Medicaid	Professional
Return Edit	**CABO**	Per NCD Guidelines, the modifier code(s) for procedure code <1> should be reviewed. Please update the code(s) as applicable.	Custom Abortion 1 Abortions are not covered Medicare procedures except: If the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician place the woman in danger of death unless an abortion is performed. An appropriate modifier must be submitted with procedure code. Please review the UnitedHealthcare Medicare Advantage Policy, Abortion (NCD 140.1) on UHCprovider.com.	4/28/2022	Medicare	Professional
Return Edit	**CADD**	The diagnosis code(s) on the claim line may not be appropriate for procedure code <1>. Please review and update as applicable.	Custom Insertion of Anterior Segment Aqueous Drainage Device Glaucoma is a disease of the eye associated with increased intraocular pressure. Glaucoma surgical aqueous drainage devices will be considered medically reasonable and necessary when approved by the FDA and used within accordance of the FDA-approved/cleared indications. The diagnosis code(s) listed should support the use of an aqueous drainage device. Please review the Anterior Segment Aqueous Drainage Device policy on UHCprovider.com.	5/26/2022	Medicare	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**CAEM2**	The diagnosis code(s) on claim line do not meet medical necessity for procedure code <1>. Update code(s) as applicable.	Long Term EEG and Ambulatory EEG Monitoring The CAEM2 edit is returned when an Ambulatory EEG Monitoring procedure code is submitted without supporting diagnosis codes that meet CMS billing guidelines. Please refer to Medicare Ambulatory EEG Monitoring Policy at UHCprovider.com.	1/30/2025	Medicare	Professional
Return Edit	**CAFB2**	The diagnosis code(s) on the claim line may not be appropriate for CPT code <1>. Please review and update as applicable.	Custom Air Fluidized Beds An air-fluidized bed uses warm air under pressure to set small ceramic beads in motion which simulate the movement of fluid. There are numerous CMS manual requirements, reasonable and necessary (R&N) requirements, benefit category, and other statutory and regulatory requirements that must be met. Coverage is limited to bed-ridden or chair-bound patients with stage III or stage IV pressure ulcers that without the use of an air-fluidized bed would be institutionalized. Please review the Air-Fluidized Bed policy on www.UHCprovider.com.	7/28/2022	Medicare	Professional
Return Edit	**CAG**	Procedure code is not typical for a patient whose age is <1> years. Please update code(s) as applicable.	Procedure Code Not Typical for Age The code submitted is invalid due to the age of the member at time of service. This edit applies when procedure codes are reported for the inappropriate patient's age. Please review ICD-10 Guidelines	4/28/2022	Medicare	Professional
Return Edit	**CALD**	The diagnosis code(s) on the claim line may not be appropriate for CPT code <1>. Please review and update as applicable.	Custom Arthroscopic Lavage and Debridement for the Osteoarthritic Knee Rule Arthroscopy is a surgical procedure that allows the direct visualization of the interior joint space. Osteoarthritis is a chronic and painful joint disease caused by degeneration. The CALD edit will apply when the submitted diagnosis code does not follow Medicare Guidelines for Arthroscopic Lavage and Arthroscopic Debridement. Please review the Arthroscopic Lavage and Arthroscopic Debridement for the Osteoarthritic Knee policy on www.UHCprovider.com	7/28/2022	Medicare	Professional
Return Edit	**CAPE**	The diagnosis code(s) on the claim line may not be appropriate for CPT code <1>. Please review and update as applicable.	Custom Capsule Endoscopy Rule Wireless capsule endoscopy (WCE) requires that the patient ingest a small capsule containing a disposable light source, miniature color video camera, battery, antenna and a data transmitter. Patients should receive services using FDA approved devices. The service should be performed by physicians trained in endoscopy or in an independent diagnostic testing facility under the general supervision of a physician trained in endoscopy procedures. The CAPE edit will apply when the submitted diagnosis code does not follow the guidelines for WCE. Please review the Capsule Endoscopy policy on www.UHCprovider.com	7/28/2022	Medicare	Professional
Return Edit	**CBIP**	Procedure code <1> is not available for purchase. Please review and update as applicable.	Custom Biphasic Positive Airway Pressure (BIPAP) The Centers for Medicare & Medicaid Services (CMS) determines that Continuous Positive Airway Pressure (CPAP) therapy when used in adult patients with OSA is considered reasonable and necessary in specific situations. The use of CPAP is covered when used in adult patients with obstructive sleep apnea (OSA). Coverage of CPAP is initially limited to a 12-week period to identify beneficiaries diagnosed with OSA as subsequently described who benefit from CPAP. Please review the Continuous Positive Airway Pressure (CPAP) Therapy for Obstructive Sleep Apnea (OSA) policy on UHCprovider.com.	5/26/2022	Medicare	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**CBIPD**	Per NCD guidelines, the primary diagnosis code <1> on the claim line does not support CPT code <2>.	CBIP Custom Biphasic Positive Airway Pressure (BIPAP) The Centers for Medicare & Medicaid Services (CMS) determines that Continuous Positive Airway Pressure (CPAP) therapy when used in adult patients with obstructive sleep apnea is considered reasonable and necessary in specific situations. The CBIPD edit will apply when the submitted diagnosis code does not follow Medicare Guidelines for CPAP Therapy. Please review the Continuous Positive Airway Pressure (CPAP) Therapy for Obstructive Sleep Apnea (OSA) policy on www.UHCprovider.com.	7/28/2022	Medicare	Professional
Return Edit	**CBSC4**	Procedure code <1> is missing appropriate modifier.	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 review the CMS RUL Limits available at CMS Code of Federal Regulations.	1/17/2019	Medicare	Professional
Return Edit	**CCAP**	Procedure code <1> has been submitted without an appropriate primary procedure code. Please update code(s) as applicable.	Custom COVID Additional Payment Allowed U0005 is an add-on code that must be submitted with another high-throughput COVID test code, which at this time is U0003 and/or U0004. UnitedHealthcare is requiring that all of the charges be submitted on the same claim.	12/2/2021	Medicare	Professional
Return Edit	**CCHF**	The diagnosis code(s) on the claim line may not be appropriate for CPT code <1>. Please review and update as applicable.	Custom Cardiac Rehabilitation Programs for Chronic Heart Failure Cardiac rehabilitation (CR) programs are defined as physician supervised programs that furnish physician prescribed exercise, cardiac risk factor modification, including education, counseling, and behavioral intervention; psychosocial assessment, outcomes assessment, and other items/services. The diagnosis code associated with the procedure should support its performance. Please review the Cardiac Rehabilitation Programs for Chronic Heart Failure Policy onwww.UHCprovider.com.	11/17/2022	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.	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 review the "Modifiers" section of this policy for a complete listing of acceptable modifiers. Please review the CCI Editing Policy, Professional available on UHCprovider.com.	5/9/2019	Commercial	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**CCIMD**	Procedure <1> is included with procedure <2> on the current or previously submitted claim.	Medicaid CCI Unbundled 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 review the "Modifiers" section of this policy for a complete listing of acceptable modifiers and the description of modifier indicators of "0" and "1". Please review the CCI Editing Policy, Professional and Facility Reimbursement Policy on UHCprovider.com.	5/2/2019	Medicaid	Professional
Return Edit	**CCIUN**	Procedure code <1> is included with procedure code <2> on the current or previously submitted claim. Under appropriate circumstances, a designated modifier may be required to identify distinct services.	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 review the "Modifiers" section of this policy for a complete listing of acceptable modifiers and the description of modifier indicators of "0" and "1". Please review the CCI Editing Policy, Professional Reimbursement Policy – UnitedHealthcare Commercial Plans on UHCprovider.com.	4/25/2019 2/24/2022	Commercial All Savers	Professional
Return Edit	**CCYT**	The diagnosis code(s) on the claim line may not be appropriate for CPT code <1>. Please review and update as applicable.	Custom Cytogenetic Studies Cytogenetic studies is used to describe the microscopic examination of the physical appearance of human chromosomes. The CCYT edit will apply when the submitted diagnosis code does not follow Medicare Guidelines. Please review the Cytogenetic Studies policy on www.UHCprovider.com for acceptable diagnosis codes.	1/26/2023	Medicare	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**CDB2**	Per NCD 160.24, procedure code <1> has not met the associated code to code criteria. Please review and update as applicable.	NCD 160-24 Deep Brain Stimulation DME For patients who become unresponsive to pharmacological treatments and/or have intolerable drug side effects, Deep Brain Stimulation (DBS) may be helpful; DBS requires the stereotactic placement of an indwelling electrode in the brain. Please review the Deep Brain Stimulation for Essential Tremor and Parkinson's Disease (NCD 160.24) policy on www.UHCprovider.com for information regarding procedure and/or diagnosis codes.	2/23/2023	Medicare	Professional
Return Edit	**CDEX3**	Per LCD guidelines, procedure code <1> is missing required modifier(s). Update code(s) as applicable.	Custom Continuous Glucose Monitors Use of an appropriate modifier for the submitted procedure code, indicates that the supplier ensured coverage criteria for continuous glucose monitoring has been met. Please refer to medicare-coverage-database search and enter the procedure code and choose the active LCD policy for your Medicare Administrative Contractor (MAC) at cms.gov.	11/21/2024	Medicare	Professional
Return Edit	**CDL**	Procedure code <1> is no longer active. Please review and update as applicable.	Deleted Procedure Code CMS maintain and annually updates a list of Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) Codes. The AMA develops and manages CPT codes on a rigorous and transparent process which ensures codes are issued and updated regularly to reflect current clinical practice and innovation in medicine. Please refer the current applicable code list.	3/30/2023 9/5/2024	Medicare All Savers Commercial Dual Enrollment Individual & Family Plan Level Funded Medicaid Oxford	Professional
Return Edit	**CDME**	Procedure code <1> may not be valid for Medicare plans without the use of an appropriate modifier. Please review and update as applicable.	Non-Covered DME Equipment categories have been determined by CMS to be covered under the DME benefit. When UnitedHealthcare receives a claim for an item of equipment which does not appear to fall logically into any of the CMS equipment categories, UnitedHealthcare has the authority and responsibility for deciding whether those items are covered under the DME benefit. These decisions must be made by UnitedHealthcare based on the advice of its medical consultants, considering: The Medicare Claims Processing Manual, Chapter 20, "Durable Medical Equipment, Prosthetics and Orthotics, and Supplies (DMEPOS)." Please review the Durable Medical Equipment Reference List policy on www.UHCprovider.com.	2/23/2023	Medicare	Professional
Return Edit	**CDNT1**	Procedure code <1> with primary diagnosis code <2> is dental in nature and may not be covered under the medical plan. Please review and update as applicable.	Dental Services 1 Dental services are excluded from coverage in connection with the care, treatment, removal, filling, or replacement of teeth, or structures directly supporting the teeth. There is an exception for inpatient hospital services in connection with such dental procedures when hospitalization is required. Please review the Dental Services policy on www.UHCprovider.com.	2/23/2023	Medicare	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**CDXM**	The procedure code is missing the required modifiers. Please review and update as applicable.	Custom Therapeutic Continuous Glucose Monitors The general term Continuous Glucose Monitor (CGM) refers to both therapeutic/non-adjunctive and non-therapeutic/adjunctive CGMs. CGM codes require modifiers to detail the service provided. Use modifier KX if the beneficiary is insulin treated or use modifier KS if the beneficiary is non-insulin treated. The KX modifier must not be used for a beneficiary who is not treated with insulin administrations. The CG modifier must be added to the claim line only if all of the CGM coverage criteria in the Glucose Monitor Local Coverage Determination are met. Please review the Continuous Glucose Monitors Policy Guideline on www.UHCprovider.com.	11/17/2022	Medicare	Professional
Return Edit	**CION**	Procedure code <1> may not be appropriate for place of service <2>. Please review and update as applicable.	Custom Intraoperative Neuromonitoring Per the American Medical Association, Intraoperative Neuromonitoring (IONM) is the use of electrophysiological methods to monitor the functional integrity of certain neural structures during surgery. IONM codes are reported based upon the time spent monitoring only and not the number of baseline tests performed or parameters monitored. The American Academy of Neurology states IONM services should be performed in Place of Service (POS) 19, 21, 22 or 24. Please review the Intraoperative Neuromonitoring Policy on www.UHCprovider.com.	3/30/2023	Medicare	Professional
Return Edit	**CJEV**	The diagnosis code(s) on the claim line may not be appropriate for J9043. Please review and update as applicable.	Custom Jevtana Jevtana® is a microtubule inhibitor indicated in combination with prednisone for treatment of patients with metastatic castration-resistant prostate cancer previously treated with a docetaxel-containing treatment regimen. Coverage for medication is based on the patient's condition, the appropriateness of the dose and route of administration, based on the clinical condition and the standard of medical practice regarding the effectiveness of the drug for the diagnosis and condition. Please review the Jevtana® (Cabazitaxel) Policy on UHCprovider.com.	5/26/2022	Medicare	Professional
Return Edit	**CLLP**	The submitted modifier for <1> may not be appropriate. Please review and update as applicable.	Custom Lower Limb Prosthesis The right (RT) and/or left (LT) modifiers must be used with prosthesis codes. In addition, when submitting a prosthetic claim, the billed code for knee, foot, ankle and hip components must be submitted with modifiers K0-K4, indicating the expected beneficiary functional level. This expectation of functional ability information must be clearly documented and retained in the prosthetist's records. The simple entry of a K modifier in those records is not sufficient. There must be information about the beneficiary's history and current condition which supports the designation of the functional level by the prosthetist. Please review the Lower Limb Prostheses policy on www.UHCprovider.com	8/25/2022	Medicare	Professional
Return Edit	**CMGT**	The diagnosis code(s) on the claim line may not be appropriate for procedure code <1>. Please update code(s) as applicable.	Custom Molecular Pathology Molecular Diagnostics Genetic Testing The CMGT Edit will apply when the submitted diagnosis code does not follow Medicare Guidelines for Molecular Pathology Molecular Diagnostics Genetic Testing. Please review the Molecular Pathology/Molecular Diagnostics/Genetic Testing policy on UHCprovider.com for acceptable diagnosis codes.	12/2/2021	Medicare	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uCMJW1**	Procedure code <1> requires JZ or JW modifier. This claim has been rejected and will not be processed.	Discarded Drug Modifier Missing or Innappropriate JW modifiers must be appended to the HCPCS to indicate the drug amount discarded. However, the JZ modifier should be used to attest that no amount of drug was discarded. JZ modifier should only be used for claims that bill for single-dose container drugs. Note: This Smart edit was originally CMJW1, with a production effective date of 8/29/2024. Please review the Discarded Drug and Biologicals Policy on UHCprovider.com.	3/27/2025	Medicare	Professional
Return Edit	**uCMJW2**	The JZ or JW modifier submitted is inappropriate. This claim has been rejected and will not be processed.	Discarded Drug Discard Modifier Missing or Innapropriate The CMJW2 Smart Edit is returned when a JW or JZ modifier is submitted inappropriately. A single-dose container drug is administered the use of a JW or JZ modifier is required. JW Modifiers are required to indicate the drug amount discarded and must be appended to the HCPCS. The JZ modifier is used to attest that no amount of drug was discarded. Note: This Smart edit was originally CMJW1, with a production effective date of 8/29/2024. Please review the Medicare Advantage Discarded Drug and Biologicals Reimbursement Policy on UHCprovider.com	3/27/2025	Medicare	Professional
Return Edit	**CmSBE**	Add-on procedure code 99292 has been submitted without an appropriate primary procedure. Please review and update as applicable.	Custom Medicare w/o Primary Procedure Exceptions Add-on codes are reimbursable services when reported in addition to the appropriate primary service.Medicare has specific language around critical care services and add on requirements for procedures 99291/99292.	5/25/2023	Medicare	Professional
Return Edit	**CNCC**	Procedure code <1> is not covered by Medicare.	Custom Non-Covered Codes Non-covered policies included are: Cavernous Nerves Electrical Stimulation with Penile Plethysmography (NCD 20.14) Orthopedic Procedures, Devices and Products Medicare Advantage Coverage Summary Sterilization (NCD 230.0) Transportation Services Medicare Advantage Policy Guideline Please review the policy appropriate to the services billed for additional information.	5/27/2021	Medicare	Professional
Return Edit	**COPT**	The diagnosis code(s) on the claim line may not be appropriate for CPT code <1>. Please review and update as applicable.	Orthoptic Pleoptic Training Orthoptists evaluate and measure eye deviations, manage amblyopia treatment and treat small intermittent symptomatic eye deviations. The profession of orthoptics includes the evaluation and treatment of disorders of the visual system, particularly involving binocular vision and eye movement. The COPT edit will apply when the submitted diagnosis code does not follow Medicare Guidelines. Please review the UHG Medical Policy: Visual Information Processing Evaluation and Orthoptic and Vision Therapy policy on www.UHCprovider.com for acceptable diagnosis codes.	1/26/2023	Medicare	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**COST1**	The diagnosis code may not be appropriate for procedure code <1>. Please update the claim as applicable.	Custom Osteopathic Manipulations Osteopathic manipulative treatment (OMT) is a treatment employed, primarily by osteopathic physicians, to facilitate a patient's recovery from somatic dysfunction. The diagnosis of somatic dysfunction is made by determining the presence of one or more findings, known as T.A.R.T. (Tenderness, Asymmetry, Restriction of Motion and Tissue Abnormality). Documentation of examination findings of somatic dysfunction should describe pathology in the areas of the skeletal, arthrodial, and myofascial structures as well as related vascular, lymphatic and neuro elements. Please review the Osteopathic Manipulations (OMT) policy on www.UHCprovider.com	3/30/2023	Medicare	Professional
Return Edit	**CPCI**	The diagnosis code(s) on the claim line may not be appropriate for procedure code <1>. Please update code(s) as applicable.	Custom Percutaneous Coronary Interventions The CPCI Edit will apply when the submitted diagnosis code does not follow Medicare Guidelines for Percutaneous Coronary Interventions. Please review the Percutaneous Coronary Interventions policy on UHCprovider.com for acceptable diagnosis codes.	12/2/2021	Medicare	Professional
Return Edit	**CPETD**	The diagnosis code may not be appropriate for procedure code <1>. Please update the claim as applicable.	Custom PET Scan Positron Emission Tomography (PET) is a minimally invasive diagnostic imaging procedure. The CPETD edit will apply when the submitted diagnosis code does not follow Medicare Guidelines for a Positron Emission Tomography (PET) Scan. Please review the Positron Emission Tomography (PET) Scan policy on www.UHCprovider.com for additional coding information.	3/30/2023	Medicare	Professional
Return Edit	**CPKX1**	Per LCD guidelines, an appropriate modifier is missing for procedure code <1>. Please review and update the claim as applicable.	Custom DME KX Modifier Use of the KX modifier indicates that the supplier has ensured coverage criteria for the Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) billed is met and that documentation does exist to support the item. Documentation must be available upon request. Please review information go to https://www.cms.gov/medicare-coverage-database/search.aspx, enter the procedure code and choose the active LCD policy for your Medicare Administrative Contractor (MAC).	3/30/2023	Medicare	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.	Care Oversight Plan Care Plan Oversight (CPO) Services review 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. Please review the Care Plan Oversight Policy Reimbursement policy and the Community Plan Care Plan Oversight Policy on UHCprovider.com.	3/14/2019	Commercial	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**CPPC1**	Procedure code <1> is not appropriate for the place of service billed. Please update code as applicable.	Custom Procedure to POS Code UnitedHealthcare Medicare Advantage will reimburse CPT and HCPCS codes when reported with an appropriate place of service (POS). UnitedHealthcare Medicare Advantage aligns with The Centers for Medicare & Medicaid Services (CMS) POS Code set, which are two-digit codes submitted on the CMS 1500 Health Insurance Claim Form or its electronic equivalent to indicate the setting in which a service was provided. Please review the Procedure and Place of Service Policy, Professional.	6/24/2021	Medicare	Professional
Return Edit	**CPT**	Procedure Code <1> is invalid. Please review and update as applicable. Procedure Code is missing. Please review and update as applicable. Procedure Code <1> is disabled. Please review and update as applicable.	Invalid Procedure Code CMS maintain and annually updates a list of Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) Codes. The AMA develops and manages CPT codes on a rigorous and transparent process which ensures codes are issued and updated regularly to reflect current clinical practice and innovation in medicine. Please refer to the Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) Code list.	9/26/2019 9/26/2024	Commercial Medicare Oxford	Professional
Return Edit	**CPTC7**	Per Medicare guidelines, procedure code <1> describes a diagnostic procedure that is not eligible for separate reimbursement in place of service <2>. Please update claim as applicable.	Custom Professional and Technical Component Reimbursement of the Professional Component, the Technical Component, and the Global Service for codes assigned a PC/TC Indicator subject to the PC/TC concept according to the NPFS are based upon physician and other qualified health care professional specialty and CMS POS code set. The edits administered by this policy may be found on the following link using the appropriate year and quarter referencing the “PCTC IND” column. Please review the Professional/Technical Component, Professional - Reimbursement Policy on UHCprovider.com.	12/2/2021	Medicare	Professional
Return Edit	**CRSC**	The diagnosis code(s) is not appropriate on the current line to support procedure code <2>. Please review and update as applicable.	Custom Rectal Spacers The anterior wall of the rectum is considered a major dose-limiting factor in radiation therapy of prostate cancer. Physical separation is proposed to allow reduced toxicity and treatment intensification. The diagnosis code submitted should support various materials or devices placed between the prostate and anterior wall of the rectum for use in men receiving radiation therapy for prostate cancer. Please review the Prostate Rectal Spacers policy onwww.UHCprovider.com	8/25/2022	Medicare	Professional
Return Edit	**CSLB3**	Diagnosis code(s) <1> on claim line are for screening purposes only. Please update code(s) as applicable.	Screening Lab Per Clinical Diagnostic Laboratory Services policy, 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 review these policies on UHCprovider.com: Molecular Pathology/Molecular Diagnostics/Genetic Testing Molecular Diagnostic Infectious Disease Testing Obsolete or Unreliable Diagnostic Tests Biomarkers in Cardiovascular Risk Assessment Genetic Testing for LYNCH Syndrome Tier 2 Molecular Pathology Procedures	11/18/2021	Medicare	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
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.	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 review the Consultation Services Policy on UHCprovider.com.	1/30/2020	Commercial	Professional
Return Edit	**CSU2**	Procedure code <1> submitted with modifier 62 is not appropriate because this procedure is not eligible for co-surgeon. Update code(s) as applicable for services rendered.	Co-Surgeon 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 review the Co-Surgeon & Team Surgeon Policy, Professional on UHCprovider.com.	4/4/2019 5/2/2019	Commercial Medicaid	Professional
Rejection Edit	**CSX**	REJECT - Procedure code <1> is not typically performed for a patient whose gender is <2>. This claim is rejected and will not be processed.	Procedure Not Typical with Patient Gender Per ICD-10-CM coding guidelines this claim line is billing a procedure code that isn't appropriate for the patient's gender. Certain procedures are defined with patient gender (sex) requirements. Please see Medicare's MLN Matters® article MM6638 for additional information for use of the KX modifier for gender-specific billing if applicable. Please review UnitedHealthcare Medicare Advantage Procedure to Modifier Policy, Professional on UHCprovider.com	11/18/2021 Changed to a rejection edit on 9/28/2023	Medicare	Professional
Rejection Edit	**CTPM**	REJECT - Procedure code <1> is not billed with an appropriate modifier. This claim is rejected and will not be processed.	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.	3/14/2019 11/30/2023 Changed to a rejection edit	Medicare	Professional
Return Edit	**CVEDN**	Procedure <1> is not eligible for separate reimbursement when billed with COVID vaccine administration <2>. Update code(s) as applicable.	COVID Vaccine E/M Code Per United Healthcare COVID-19 Provider Billing Guidance: For in-network health care professionals, we will reimburse COVID-19 vaccine administration when billed with the appropriate codes through the end of the public health emergency. If a health care professional bills visit codes on the same date of service as a COVID-19 vaccine code claim for the same patient, UnitedHealthcare will deny the vaccine code. Please review our COVID-19 billing guide: https://www.UHCprovider.com/content/dam/provider/docs/public/resources/news/2020/covid19/UHC-COVID-19-Provider-Billing-Guidance.pdf	10/28/2021	Commercial	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**CZOL**	CPT Code <1> exceeds the number of occurrences allowed within the time period. History Claim(s) (2). Please update as applicable.	Zoledronic Acid Zoledronic acid is a bisphosphonic acid, which is an inhibitor of osteoclastic bone resorption. Zoledronic acid is currently available under the brand names Zometa and Reclast. If there is another claim line in the member's history with the same procedure code, the same primary diagnosis code, no secondary diagnosis code, and the history claim line was within 364 days of the current claim line then the CZOL flag will apply. Please review the Zoledronic Acid policy on www.UHCprovider.com.	1/26/2023	Medicare	Professional
Return Edit	**DDBDN**	Procedure code < 1 > billed with JW modifier is not covered when NDC number indicates multiple dose vial. Please update code(s) as applicable.	Discarded Drug Invalid Dose The JW modifier is only permitted to be used to identify discarded amounts from a single vial or single package drug or biological. It is inappropriate to append JW modifier to a multi-dose vial (MDV). Please review the Discarded Drugs and Biologicals Policy on www.UHCprovider.com.	11/17/2022	Commercial	Professional
Return Edit	**DDBHD**	Procedure code < 1 > with JW modifier is not covered when there is not a separate claim line with the same HCPCS or CPT code and NDC number without JW modifier. Please update code(s) as applicable.	Discarded Drug Invalid Dose The JW modifier is only permitted to be used to identify discarded amounts from a single vial or single package drug or biological. It is inappropriate to append JW modifier to a multi-dose vial (MDV). CMS guidelines state to report the drug amount administered on one line, and on a separate line report the amount of drug not administered (discarded) with modifier JW appended to the associated CPT/HCPCS code Please review the Discarded Drugs and Biologicals Policy on www.UHCprovider.com.	11/17/2022	Commercial	Professional
Return Edit	**DMEAD**	The current line adjusted procedure <1> is a DME code that does not require a rental or purchase modifier and may not be separately reimbursable. Please update code(s) as applicable.	DME Denial Durable Medical Equipment, Prosthetics/Orthotics & Supplies are categorized into payment classes. Some Durable Medical Equipment (DME) items are eligible for rental as well as for purchase. Claims must specify whether equipment is rented or purchased. For purchased equipment, the claim must also indicate whether equipment is new or used. The codes must be reported with the appropriate rental or purchase modifier in order to be considered for reimbursement. Some DME items are eligible for rental only. The codes representing these items must be reported with the appropriate rental modifier in order to be considered for reimbursement. Please review the Durable Medical Equipment, Orthotics and Prosthetics Policy, Professional Policy on www.UHCprovider.com.	11/17/2022	Commercial	Professional
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.	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 review the Durable Medical Equipment, Orthotics and Prosthetics Policy, Professional Reimbursement Policy on UHCprovider.com.	3/28/2019	Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
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.	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 review the Durable Medical Equipment, Orthotics and Prosthetics Policy, Professional Reimbursement Policy on UHCprovider.com.	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.	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 review the Durable Medical Equipment, Orthotics and Prosthetics Policy, Professional Reimbursement Policy on UHCprovider.com.	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.	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 review the Durable Medical Equipment, Orthotics and Prosthetics Policy, Professional-Reimbursement Policy UnitedHealthcare Commercial Plans on UHCprovider.com.	5/30/2019	Commercial	Professional
Return Edit	**DMEHD**	DME procedure code <1> is not appropriate for home use in place of service <2>. Please update code(s) as applicable.	Implantable DME Place of service Implantable DME Place of Service - Specific Durable Medical Equipment items or implantable devices are not suitable for dispensing or using in the home setting and are therefore not reimbursed with a home place of service. Please refer to the Coverage Limitations and Exclusions section of the Durable Medical Equipment, Orthotics, Medical Supplies and Repairs/Replacements Policy on UHCprovider.com for further information.	12/19/2024	Commercial	Professional
Return Edit	**DMEIP**	Procedure <1> is included with Procedure <2> on this or a previously submitted claim. Update code as applicable.	Durable Medical Equipment CMS guidelines indicate when DME items are purchased or rented; there are certain supplies that are included in the initial purchase or during the rental period. Please review the Durable Medical Equipment, Orthotics and Prosthetics Policy, Professional-Reimbursement Policy UnitedHealthcare Commercial Plans on UHCprovider.com.	6/30/2022	Commercial	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**DMEMD**	Procedure <1> is a DME, orthotics, or prosthetics code billed with modifier RT and LT on the same line. Modifier RT and LT should be reported on separate lines. Update code as applicable for services rendered.	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. Please review the Durable Medical Equipment, Orthotics and Prosthetics Policy reimbursement policy at UHCprovider.com.	3/28/2019 4/4/2019	Medicaid Commercial	Professional
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.	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 review the Durable Medical Equipment, Orthotics and Prosthetics Policy, Professional Reimbursement Policy on UHCprovider.com.	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.	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 review 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.	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 review Durable Medical Equipment, Orthotics and Prosthetics Policy, Professional Reimbursement Policy – UnitedHealthcare Commercial Plans on UHCprovider.com.	4/4/2019	Commercial	Professional
Return Edit	**DXIDN**	Diagnosis Code <1> is an incomplete diagnosis. Please update to a complete diagnosis code.	Incomplete Diagnosis Code Commercial Incomplete Diagnosis Code Commercial Incomplete Diagnosis Code billed, additional digits may be required. Please review ICD-10 Guidelines and update diagnosis code(s)	2/21/2019 3/28/2019 7/25/2024	Commercial Medicaid Individual & Family Plan	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**EDCf**	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	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 9/20/2018 7/28/2023	Commercial Medicaid Medicare Individual & Family Plan Level Funded Oxford	Facility
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.	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 review the Procedure to Place of Service Policy, Professional (2/10/2019) Reimbursement Policy on UHCprovider.com.	3/7/2019	Medicaid	Professional
Documentation Edit	**FTADN**	Medical Records may be required and can be uploaded to the UHC Provider Portal at secure.uhcprovider.com. For more information on this edit, go to uhcprovider.com/smartedits.	Fetal Aneuploidy 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) when maternal age or oocyte age of 35 years or older at delivery. Medical records may be required if maternal age is 34 years or younger. Please review the Cell-Free Fetal DNA Testing Medical Policy on UHCprovider.com.	1/28/2021	Medicaid	Professional
Return Edit	**FTADX**	Diagnosis <1> is not appropriate when submitted with procedure code <2>. Update code(s) as applicable for services rendered.	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 review Fetal Aneuploidy Testing Using Cell-Free Fetal Nucleic Acids in Maternal Blood Commercial Medical & Drug Policies on UHCprovider.com.	4/4/2019	Commercial	Professional
Return Edit	**GAMDN**	Procedure code <1> is subject to coverage and medical necessity guidelines. Please ensure procedure code and modifier combination reflects services rendered.	Ground Ambulance Transportation The modifier combination represents non-covered non-emergency ground ambulance transport. Non-emergent ambulance transportation is appropriate with documentation that the member’s condition is such that other means of transportation could endanger the member’s health, and ambulance transportation is medically required. Please refer to the Ambulance Services Medical Policy on UHCprovider.com	4/25/2024	Commercial	Professional

Edit type	Smart edit	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.	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. Please review the Global Days Policy, Professional Reimbursement Policy on UHCprovider.com.	4/25/2019 5/30/2019	Commercial Medicaid	Professional
Return Edit	**HBODN**	Proc <1> is not allowed without an HBO Therapy diagnosis code. Please update code(s) as applicable.	Hyperbaric Oxygen Therapy Diagnosis Hyperbaric Oxygen Therapy (HBOT) is an intervention in which an individual breathes near 100% oxygen intermittently while inside a hyperbaric chamber that is pressurized to greater than sea level pressure. This edit will apply when the submitted diagnosis code does not follow the guidelines for HBOT. Please review Hyperbaric Oxygen Therapy and Topical Oxygen Therapy Policy at www.UHCprovider.com	6/29/2023	Commercial	Professional
Return Edit	**HRSNM**	Procedure code <1> requires a modifier to distinguish if the service is habilitative or rehabilitative. Please update claim as applicable.	Habilitative and Rehabilitative Services Billed Without the Correct Modifier Claims for Habilitative, and Rehabilitative Services should be reported using the appropriate Modifiers. Habilitative services help a person learn, keep, or improve skills and functioning for daily living. While rehabilitative services are necessary after an illness or injury to help a person restore, keep, or improve skills and functioning for daily living. The same CPT/HCPC codes may be utilized for both habilitative and rehabilitative services, modifiers 96 and 97 were developed to help differentiate which service being billed. Please refer to the Habilitative & Rehabilitative Services Policy, Professional & Facility for UnitedHealthcare Commercial or Community and State Plans for further information.	3/27/2025	Individual & Family Plan	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.	ICD10 Filters Denial for Injection 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 review the Injections into Tendon Sheath, Ligament, Ganglion Cyst, Carpal and Tarsal Tunnel Policy Reimbursement Policy on UHCprovider.com.	1/31/2019	Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**I05DN**	Procedure <1> for Viral Hepatitis Serology Testing is not appropriate with the primary diagnosis submitted. If applicable, update your submission.	ICD10 Filters Denial for Viral Hepatitis 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 review the Viral Hepatitis Serology Testing Policy, Professional Reimbursement Policy on UHCprovider.com.	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.	ICD10 Filters Denial for Audiological Testing 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 review the Audiologic Vestibular Function Testing Policy Reimbursement Policy on UHCprovider.com.	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.	ICD10 Filters Denial for RAST 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 symptom. 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 review the Radioallergosorbent (RAST) Type Tests Policy Reimbursement Policy on UHCprovider.com.	1/31/2019	Medicaid	Professional
Return Edit	**IAG**	Diagnosis code(s) <1> is not appropriate for a patient whose age is <2> years. Please update code as applicable.	Diagnosis Not Typical for Patient Age Per IDC-10-CM coding guidelines this claim line is billing a diagnosis code that isn't appropriate for the patient's gender age. Please review ICD-10 Guidelines	6/13/2019	Medicare	Professional
Informational Edit	**IDCD**	Per ICD-10-CM Excludes1 guideline, these diagnoses cannot be reported together except when unrelated - <Diag code pairs listed>.	ICD-10 CM Excludes 1 code pairs 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 review ICD-10 Guidelines	1/25/2024 3/27/2025	Commercial Dual Enrollment Individual and Family Plan Level Funded Medicaid Medicare Oxford Surest	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**IDCDf**	Per ICD-10-CM Excludes1 guideline, diagnose codes <1> identify two conditions that cannot be reported together except when they are unrelated. Please update code(s) as applicable.	ICD-10 CM Excludes 1 code pairs 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 review ICD-10 Guidelines	1/25/2024	Commercial Dual Enrollment Individual and Family Plan Level Funded Medicaid Medicare Oxford	Facility
Return Edit	**IDX**	Additional digits are required to provide specificity for diagnosis code <1>. Please update the diagnosis code(s) as applicable.	Non-Specific Diagnosis Code The IDX edit identifies claims that contain a diagnosis code requiring a 4th or 5th digit for appropriate specificity. Please review the following resources: American Medical Association, Current Procedural Terminology (CPT®) Professional Edition and associated publications and services Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets	10/28/2021	Medicare	Professional
Rejection Edit	**IMC**	REJECT - Modifier [1] and modifier [2] are inappropriate for submission on the same claim line.	Inappropriate Modifier Combination The IMC flag identifies CPT and/or HCPCS modifier combinations that are inappropriate when submitted together on the same claim line. Please review the Procedure to Modifier Reimbursement Policy on www.UHCprovider.com.	5/25/2023	Medicare	Professional
Return Edit	**IMO**	The modifier code(s) [1] are invalid. Please review and update as applicable	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 review the Procedure to Modifier Reimbursement Policy – UnitedHealthcare Medicare Advantage onwww.UHCprovider.com	8/25/2022	Medicare	Professional
Informational Banner	**INFO**	For additional information regarding this edit refer to our Smart Edits Guide at UHCProvider.com/SmartEdits.	Informational Banner The Informational banner is exhibited on all claims receiving smart edits. The intent of the INFO banner is to provide resources for further information on smart edits and the associated policies.	1/31/2019	All	All
Return Edit	**INMDN**	Procedure code <1> is not appropriate for place of service <2>. Please update code(s) as applicable.	Intraoperative Neuromonitoring Inoperative Neural Monitoring - According to The Centers for Medicare and Medicaid Services (CMS), Intraoperative neurophysiology testing (HCPCS/CPT codes 95940 and G0453) should not be reported by the physician performing an operative or anesthesia procedure since it is included in the global package. The American Academy of Neurology states IONM services should be performed in Place of Service (POS) 19, 21, 22 or 24. Please review the Intraoperative Neuromonitoring Policy UnitedHealthcare Commercial Plans on UHCprovider.com.	8/31/2023	Commercial	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**IPDDN**	REJECT - Diagnosis code <1> is an inappropriate primary diagnosis code. Claim has been rejected and will not be processed.	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 Diagnosis Code Requirement Policy, Professional and Facility - Reimbursement Policy - UnitedHealthcare Commercial and Individual Exchange at UHCprovider.com.	10/4/2018 2/24/2022 12/19/2024	Commercial All Savers Level Funded Oxford	Professional
Rejection Edit	**IPDf**	REJECT – Diagnosis code <1> is an inappropriate principal diagnosis code. This claim has been rejected and will not be processed.	Inappropriate Primary Diagnosis Inappropriate Principal Diagnosis Codes Policy states appropriate principal 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 principal. Please refer to the Inappropriate Principal Diagnosis Codes Reimbursement Policy – UnitedHealthcare Commercial Plans on UHCprovider.com.	12/19/2024	Commercial Level Funded Oxford	Facility
Return Edit	**ISPDN**	Incontinence group 2 procedure <1> should be submitted with a qualifying incontinence group 1 procedure. Update code(s) as applicable.	Incontinence Supply HCPC 2 Deny Claims for incontinence supplies must contain more than one ICD-10 diagnosis code. An ICD-10 diagnosis code from the Incontinence Supplies ICD-10 Diagnosis Codes List and an ICD-10 diagnosis code reflecting the condition causing the incontinence must both be present on the claim. If one or more of the ICD-10 diagnoses on the Incontinence Supplies ICD-10 Diagnosis Codes List are the ONLY diagnosis code(s) on the claim all incontinence supplies will be denied. Please review Incontinence Supplies Policy, Professional UnitedHealthcare Community Plans on UHCprovider.com	9/28/2023	Medicaid	Professional
Return Edit	**ISPDX**	A valid incontinence diagnosis and condition causing the incontinence must be listed on the claim. Diagnosis is inconsistent with procedure code <1>. Update code(s) as applicable.	Incontinence Supply Diagnosis inconsistent with procedure denial Claims for incontinence supplies must contain more than one ICD-10 diagnosis code. An ICD-10 diagnosis code from the Incontinence Supplies ICD-10 Diagnosis Codes List and an ICD-10 diagnosis code reflecting the condition causing the incontinence must both be present on the claim. If one or more of the ICD-10 diagnoses on the Incontinence Supplies ICD-10 Diagnosis Codes List are the ONLY diagnosis code(s) on the claim all incontinence supplies will be denied. Please review Incontinence Supplies Policy, Professional UnitedHealthcare Community Plans on UHCprovider.com	9/28/2023	Medicaid	Professional
Return Edit	**ISPMX**	Procedure code <1> should be submitted with a valid incontinence diagnosis in addition to the submitted diagnoses. Update code(s) as applicable.	Incontinence Supply Multiple Diagnoses inconsistent with procedure denial Claims for incontinence supplies must contain more than one ICD-10 diagnosis code. An ICD-10 diagnosis code from the Incontinence Supplies ICD-10 Diagnosis Codes List and an ICD-10 diagnosis code reflecting the condition causing the incontinence must both be present on the claim. If one or more of the ICD-10 diagnoses on the Incontinence Supplies ICD-10 Diagnosis Codes List are the ONLY diagnosis code(s) on the claim all incontinence supplies will be denied. Please review Incontinence Supplies Policy, Professional UnitedHealthcare Community Plans on UHCprovider.com	9/28/2023	Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**ISX**	REJECT - Diagnosis code(s) <1> is not typical for the gender of the patient. This claim has been rejected and will not be processed.	Diagnosis Not Typical for Gender Diagnosis Per ICD-10-CM coding guidelines this claim line is billing a diagnosis code that isn't typical for the patient's gender. Please review Medicare's MLN Matters® article MM6638 for additional information for use of the KX modifier for gender-specific diagnosis billing if applicable.is Not Typical For Gender	6/24/2021 Changed to a Rejection Edit - 6/29/2023	Medicare	Professional
Return Edit	**LABAD**	Procedure code <1> is incorrect. Drug Assay services may be reported with a more appropriate HCPCS code. Update code as applicable.	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 review the Laboratory Services reimbursement policy at UHCprovider.com.	11/14/2018	Commercial	Professional
Return Edit	**LABDM**	Procedure <1> is a LAB code that is not eligible when billed with an inappropriate modifier by anon Laboratory Center. Update claim as applicable.	Non-Lab Modifier A modifier that is not typical for the procedure code was submitted.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 Procedure to Modifier Policy, Professional at uhcprovider.com.	9/26/2024	Medicaid	Professional
Return Edit	**LABDU**	This procedure <1> has been previously submitted by this or another provider. Update code(s) as applicable for services rendered.	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 review the Laboratory Services Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com.	5/9/2019 5/30/2019	Commercial Medicaid	Professional
Return Edit	**LABEM**	Procedure <1> is included in the EM procedure <2> on this or a previously submitted claim. Update code(s) as applicable.	Lab Venipuncture included in E/M UnitedHealthcare Individual & Family Plan and Community Plan considers CPT code 36416 an integral part of an E&M service when performed on the same date of service by the same provider. When CPT code 36416 is submitted with an E&M service, only the E&M service will be considered for reimbursement. No modifier overrides will exempt CPT code 36416 from bundling into an E&M service. Please review the Laboratory Service Policy on UHCprovider.com.	8/26/2021 2/24/2022	Individual and Family Plan Medicaid	Professional
Return Edit	**LABHANE**	Procedure <1> is not an eligible service. Update code(s) as applicable.	Lab Handling Not Eligible Service Laboratory handling and conveyance CPT codes 99000 and 99001 and HCPCS code H0048 are included in the overall management of a patient and are not separately reimbursed. Please review the Laboratory Services Policy on UHCprovider.com	4/29/2021 8/26/2021 2/24/2022	Individual and Family Plan Commercial Medicaid; All Savers	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**LABMD**	Procedure <1> should not be billed with a modifier. Update code(s) as applicable.	Laboratory Services - Panel - OH 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 Procedure to Modifier Policy, Professional at uhcprovider.com.	9/26/2024	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.	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 review the Laboratory Services Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com.	5/30/2019	Medicaid	Professional
Return Edit	**LABRS**	Proc <1> is not eligible when billed by this provider specialty. Update claim as applicable.	Lab Non-Eligible Specialty CPT codes 80503 – 80506 and 88321 – 88325 are reimbursable services only to Reference Laboratories and to providers whose primary specialty is pathology or dermatology. UnitedHealthcare considers clinical and surgical pathology consultation codes as included in an Evaluation and Management (E/M) service provided for the same patient on the same date of service. If billed with an E/M service, codes 80503 – 80506 and/or 88321 - 88325 are not separately reimbursable. Please refer to Laboratory Services Policy, Professional at uhcprovider.com.	9/26/2024	Medicaid	Professional
Return Edit	**LABRV**	Proc <1> is not a reimbursable service. Please update code as applicable.	Laboratory Respiratory Viral Consistent with CMS Local Coverage Determinations, UnitedHealthcare does not consider multiplexPolymerase Chain Reaction (PCR) respiratory viral panels of 6 or more pathogens eligible for reimbursement, and codes 0115U, 0202U, 0223U, 0225U, 87632 and 87633 will be denied. Please review Laboratory Services Policy, Professional on UHCprovider.com.	4/27/2023	Commercial	Professional
Return Edit	**LABUN**	Procedure <1> is included in procedure code <2>. A comprehensive laboratory panel code is more appropriate. Please review and update code(s) as applicable.	Laboratory Panel Bundling Individual laboratory codes, which together make up a laboratory Panel Code, will be denied. The provider will be required to submit the more comprehensive laboratory Panel Code Please review the Laboratory Services Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com	10/4/2018 2/25/2021 7/25/2024	Medicaid Individual & Family Plan Commercial	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
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.	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 review the Laboratory Services Policy on UHCprovider.com.	11/7/2019	Commercial Medicaid	Professional
Rejection Edit	**LBI**	REJECT - Per LCD or NCD guidelines, procedure code <1> has not met the associated Diagnosis Code relationship criteria for CMS ID(s) <2>.	LCD Part B Missing or Invalid Diagnosis The LBI edit is returned when a procedure code is submitted without supporting diagnosis codes that meet LCD/NCD guidelines. Please refer to MCD Search (cms.gov) and search on the policy id(s) referenced in the edit message.	12/28/2023	Medicare	Professional
Return Edit	**mAM**	Per CMS guidelines, HCPCS Code <1> is identified as an ambulance code and requires an ambulance modifier appended. Please update as applicable.	Medicare Ambulance Origin and Destination Modifiers Ambulance services are covered if they are furnished to a beneficiary whose medical condition is such that use of any other means of transportation is contraindicated. The beneficiary's condition at the time of the transport is the determining factor in whether medical necessity is met. 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. Please review the Transportation Services policy on www.UHCprovider.com.	8/16/2018	Medicare	Professional
Rejection Edit	**mANM**	REJECT - Per Medicare guidelines, anesthesia code <1>-<2> on claim line ID <3> requires an appropriate modifier. This claim has been rejected and will not be processed.	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 determinedby the use of these modifiers. For more information, please review the Anesthesia Services Reimbursement Policy at UHCprovider.com.	10/4/2018 Changed to a Rejection Edit - 6/29/2023	Medicare	Professional
Rejection Edit	**mAS**	REJECT - Procedure code <1> is not appropriate when billed by an assistant surgeon. This claim has been rejected and will not be processed.	No Payments For Assistant Surgeon All codes in the NPFS with the status code indicator "1" for "Assistant Surgeons" are considered by UnitedHealthcare Medicare Advantage to not be reimbursable for Assistant Surgeon services, as indicated by an Assistant Surgeon or surgical assistant modifier (80, 81, 82, or AS), and will not be allowed for payment. For more information, please review the Assistant at Surgery Policy for Medicare Advantage at UHCprovider.com.	8/16/2018 Changed to Rejection Edit - 6/29/2023	Medicare	Professional
Return Edit	**mBC**	Per CMS guidelines, payment for procedure code <1> may be bundled into another service. Please update code(s) as applicable.	Bundled Code Consistent with CMS, UnitedHealthcare will not separately reimburse for specific CPT/HCPCS codes assigned a status code “B” on the NPFS Relative Value File indicating a bundled procedure. B Bundle Codes are not reimbursable services regardless of whether they are billed alone or in conjunction with other services. Please review Section 20.3 of the Medicare Claims Processing Manual (cms.gov).	11/18/2021	Medicare	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**mCO**	Procedure code <1> is not appropriate when billed by a co surgeon. Please update code as applicable.	Co-Surgeon Not Permitted 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 review 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.	Maximum Frequency Per Day 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. Please review the Maximum Frequency Per Day Policy, Professional on UHCprovider.com.	5/9/2019 10/27/2022	Commercial Medicaid	Professional
Rejection Edit	**mFL**	REJECT - Per Medicare guidelines, a diagnosis code(s), which meets medical necessity for procedure code <1>, is missing or invalid. This claim has been rejected and will not be processed.	Influenza Vaccine As per the CMS policy for Medicare part -B vaccines Influenza, Pneumococcal, Hepatitis -B vaccination codes, the claim should contain their respective Vaccine administration codes along with diagnosis code ,i.e G0008-G00010 with Z23. Please refer to Vaccine Administration article at www.cms.gov.	8/31/2023 11/30/2023 Changed to a rejection edit	Medicare	Professional
Return Edit	**mGT**	Per Medicare guidelines, modifier <1> is inappropriately appended to procedure code <2>. Please review and update code(s) as applicable.	Modifier 26 or TC applied inappropriately - Global Service This edit identifies claim lines that contain codes that have the modifier 26 or TC appended inappropriately. The concept of professional and technical component splits (PC/TC) does not apply since global test only codes identified by the indicator of “4” in the PC/TC column of the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) cannot be split into professional and technical components under CMS rules. Modifier 26 and TC cannot be used with these codes. Please refer to the Professional/Technical Component, Professional - Reimbursement Policy at UHCprovider.com, UnitedHealthcare Medicare Advantage.	6/13/2019	Medicare	Professional
Rejection Edit	**mHB**	REJECT - Per Medicare guidelines, a diagnosis code(s), which meets medical necessity for procedure code <1>, is missing or invalid. This claim has been rejected and will not be processed.	Hepatitis B Vaccine As per the CMS policy for Medicare part -B vaccines Influenza, Pneumococcal, Hepatitis -B vaccination codes, the claim should contain their respective Vaccine administration codes along with diagnosis code ,i.e G0008-G00010 with Z23. Please review Vaccine Administration article at www.cms.gov.	8/31/2023 3/28/2024 Changed to a rejection edit	Medicare	Professional
Rejection Edit	**mHBf**	REJECT - Per Medicare guidelines, a diagnosis code(s), which meets medical necessity for procedure code <1>, is missing or invalid. This claim has been rejected and will not be processed.	Hepatitis B Vaccine As per the CMS policy for Medicare part -B vaccines Influenza, Pneumococcal, Hepatitis -B vaccination codes, the claim should contain their respective Vaccine administration codes along with diagnosis code ,i.e G0008-G00010 with Z23. Please refer to Vaccine Administration article at www.cms.gov.	8/31/2023 3/28/2024 Changed to a rejection edit	Medicare	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**mIC**	Use of the modifier 26 or TC is not appropriate for procedure code <1>. This service is covered incident to a physician's service. Please review and update as applicable	Medicare Incident to Codes Incident to a physician's professional services means the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness. As a condition for United Healthcare Medicare Advantage payment all "incident to" services and supplies must be furnished in accordance with applicable state law and the individual furnishing "incident to" services must meet any applicable state requirements to provide such services. For additional information, please review the Incident to Services Policy, Professional on UHCprovider.com	5/26/2022	Medicare	Professional
Rejection Edit	**mIM**	REJECT - Modifier <1> is not appropriate for procedure code per Medicare guidelines. This claim has been rejected and will not be processed.	Medicare 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. For additional information, please review these policies on UHCprovider.com: Procedure to Modifier Policy, Professional – Reimbursement Policy – Medicare Advantage Co-Surgeon/ Team Surgeon Policy, Professional – Reimbursement Policy – Medicare Advantage Increased Procedural Services Policy, Professional – Reimbursement Policy – Medicare Advantage Multiple Procedure Payment Reduction (MPPR) for Medical and Surgical Services Policy, Professional – Reimbursement Policy – Medicare Advantage Plans Professional/ Technical Component Policy, Professional – Reimbursement Policy – Medicare Advantage	11/18/2021	Medicare	Professional
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.	Invalid Procedure Diagnosis Coverage for Renflexis (infliximab-abda), Remicade® (infliximab) is the preferred infliximab product. Coverage will be provided for Remicade® contingent on the coverage criteria in the Diagnosis-Specific Criteria section. Please review Infliximab (Remicade®, Inflectra™, Renflexis™) Commercial Medical & Drug Policies on UHCprovider.com.	2/21/2019	Commercial	Professional
Return Edit	**mMUR**	HCPCS code R0075 was billed without the required modifier. Please review and update as applicable.	Medicare Portable X-Ray Modifier Required for Multiple Patients Effective with dates of service on or after February 1, 2021, procedure code R0075 should be billed with the applicable modifier consistent with the CMS requirement that modifiers (UN, UP, UQ, UR, and US) are required to be reported with HCPCS code R0075 when billing Medicare carriers for portable x-rays. The five modifiers are used to report the number of patients served during a single trip that the portable x-ray supplier makes to a particular location. For more information, please review the Procedure to Modifier Policy, Professional on UHCprovider.com.	5/26/2022	Medicare	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**mNP**	Procedure Code <1> does not typically require performance by a physician in Place of Service <2> per Medicare Guidelines. Update code(s) as applicable.	Medicare Non-Physician Service(s) According to CMS, "Incident To Codes" are reportable by providers for services performed in physicians' office. They cannot be reported for services provided in a facility setting (place of service) such as hospital inpatient, outpatient, or emergency departments. Modifiers 26 and TC cannot be used with these codes and payment may not be made by carriers for these services. Please review Medicare NCCI 2023 Coding Policy Manual – Chapter 11 at cms.gov.	8/29/2024	Medicare	Professional
Return Edit	**mNV**	Procedure Code <1> is not valid for Medicare plans. Please review and update as applicable.	Medicare Non-Covered Codes All codes published on the NPFS Relative Value File are assigned a status code. Status code I represents "Invalid" codes. Medicare uses another code for reporting of, and payment for, these services. Please review the Medicare Physician Fee Schedule Status Indicator Policy, Professional on www.UHCprovider.com.	11/17/2022	Medicare	Professional
Return Edit	**MOD**	Modifier <1> is inappropriate for Procedure Code <2>.	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. Please review the Procedure to Modifier reimbursement policy at UHCprovider.com.	11/15/2018	Commercial	Professional
Return Edit	**MODAT**	Procedure code <1> should be submitted with the required modifier. Update code(s) as applicable.	Always Therapy Modifiers Effective with dates of service on or after July 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). Please review the Modifier Reference Policy, Professional on UHCprovider.com.	9/10/2020	Commercial Medicaid	Professional
Return Edit	**MODRM**	Procedure <1> requires a modifier. Update code(s) as applicable.	Procedure to Modifier A modifier is typically required for the procedure code submitted.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 Procedure to Modifier Policy, Professional at uhcprovider.com.	9/26/2024	Medicaid	Professional
Return Edit	**MODSD**	Modifier is not valid with procedure code. Update code(s) as applicable for services rendered.	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 review 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

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**MOHDI**	Procedure <1> is included in Mohs HxProc <2> on this or a previously submitted claim. Update code(s) as applicable.	Mohs Pathology Included Denial The AMA indicates that pathology examination of the specimen is an inclusive component of Mohs and should not be separately reported by the Mohs surgeon. If a separate pathology code is submitted for the same date of service as Mohs by the same provider and records do not indicate the pathology was related to a biopsy or excision performed distinctly separate from the Mohs tumor site, the pathology code will be denied as included in the Mohs surgery. Please refer to Mohs Micrographic Surgery Policy, Professional at www.UHCprovider.com	12/28/2023	Commercial	Professional
Rejection Edit	**mPC**	REJECT - Procedure code <1> submitted with modifier 26 or TC is for the part of the diagnostic test performed by the physician and is not appropriate for separate reimbursement.	Professional Component Only 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 review the Professional/Technical Component, Professional - Reimbursement Policy - UnitedHealthcare Medicare Advantage.	6/13/2019 Changed to a rejection edit on 9/28/2023	Medicare	Professional
Rejection Edit	**mPI**	REJECT - Per Medicare guidelines, Procedure Code describes a physician interpretation for this service and is inappropriate in Place of Service.	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. 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 review Professional/Technical Component, Professional-Reimbursement Police - UnitedHealthcare Medicare Advantage at www.UHCprovider.com.	5/25/2023	Medicare	Professional
Return Edit	**mPS**	Procedure code <1> may not be reimbursable when submitted with modifier 26 or TC. Please update codes as applicable.	Medicare Physician Services 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 review the Professional/Technical Component Reimbursement Policy on UHCprovider.com.	7/25/2019	Medicare	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**MSUDN**	Procedure code <1> is not appropriate with modifier SU. Update code(s) as applicable for services rendered.	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 review the Modifier SU Policy, Professional Reimbursement Policy on UHCprovider.com.	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. Please review and update code(s) as applicable.	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. Please review the Professional/Technical Component reimbursement policy at UHCprovider.com.	7/18/2019	Medicare	Professional
Return Edit	**mTS**	Procedure code <1> is not appropriate because this procedure is not eligible for team surgery. Update code(s) as applicable for services rendered.	Team Surgeon 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 review the Co-Surgeon / Team Surgeon Policy, Professional Reimbursement Policy on UHCprovider.com.	11/18/2021	Medicare	Professional
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.	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 review the Medically Unlikely Edits (MUE) Policy, Professional and Facility Reimbursement Policy Community Plan on UHCprovider.com.	5/30/2019	Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**mUN**	REJECT - Per Medicare CCI Guidelines, procedure code <1> has an unbundle relationship with procedure code <2>on line ID <3>.	Medicare CCI Bundle According to the CMS, medical and surgical procedures should be reported with the CPT or HCPCS codes that most comprehensively describe the services performed. Unbundling occurs when multiple procedure codes are submitted for a group of procedures that are described by a single comprehensive code. Under appropriate circumstances, modifiers should be used to identify unusual circumstances, staged or related procedures, distinct procedural services, or separate anatomical location(s). Use of modifiers only applies when they are used according to correct coding guidelines. Please review the Rebundling and NCCI Edits Professional Policy onwww.UHCprovider.com	5/25/2023	Medicare	Professional
Return Edit	**NAGDN**	Procedure code is not typical for patients age. Update claim as applicable.	Age to Diagnosis Code & Procedure Code Policy UnitedHealthcare will consider reimbursement for an age-based CPT or HCPCS code when the patient's age is within the age designation assigned to the code. Procedure codes reported inappropriately will be considered billing errors and will not be considered for reimbursement. Providers may resubmit using the appropriate age-based code. Please review the Age to Diagnosis Code & Procedure Code Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com.	10/4/2018	Medicaid	Professional
Return Edit	**NCCNN**	Procedure code <1> is not a covered service.	AC National Non-Covered Code Denial UnitedHealthcare Community Plan considers any CPT and HCPCS codes that are not on a state Medicaid fee schedule as not covered for that state's Medicaid market unless there are benefit &/or contractual agreements with negotiated rates. Please review Non-Covered and Covered Codes Policy, Professional	2/24/2022	Medicaid	Professional
Return Edit	**NCCSD**	The following code <1> is not a covered service.	Non-Covered Codes UnitedHealthcare Community Plan considers any CPT and HCPCS codes that are not on a state Medicaid fee schedule as not covered for that state's Medicaid market unless there are benefit &/or contractual agreements with negotiated rates. Please review the Non-Covered and Covered Codes Policy, Professional on UHCprovider.com.	3/26/2020	Medicaid	Professional
Return Edit	**NCODN**	Procedure <1> is not appropriate. Update code(s) as applicable.	Non-Covered Code Services that do not meet the definition of a Covered Health Service are excluded. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following: • Provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, mental illness, substance abuse, or their symptoms. • Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below. • Not provided for the convenience of the Covered Person, Physician, facility or any other person. • Described in this Certificate of Coverage under Section 1: Covered Health Services and in the Schedule of Benefits. • Not otherwise excluded in this Certificate of Coverage under Section 2: Exclusions and Limitations. Please refer to Non-Covered HCPCS Codes Reimbursement Policy at public.providerexpress.com	11/21/2024	Commercial	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
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.	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 review 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.	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 review the National Drug Code Requirement Reimbursement Policy on UHCprovider.com for further information.	10/4/2018	Commercial	Professional
Return Edit	**NDCLC**	Procedure code 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.	National Drug Code Listed Closure 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 review the National Drug Code Requirement reimbursement policy at UHCprovider.com for further information.	6/27/2024	Commercial Level Funded Oxford	Professional
Return Edit	**NDCLD**	Procedure code 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.	National Drug Code Listed Invalid 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 review the National Drug Code Requirement reimbursement policy at UHCprovider.com for further information.	6/27/2024	Commercial Level Funded Oxford	Professional
Return Edit	**NDCUC**	Submission of an unlisted code 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.	National Drug Code Unlisted Closure 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 review the National Drug Code Requirement reimbursement policy at UHCprovider.com for further information.	6/27/2024	Commercial Level Funded Oxford	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
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.	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 review the National Drug Code Requirement reimbursement policy at UHCprovider.com for further information.	11/14/2018 6/27/2024	Commercial Level Funded Oxford	Professional
Return Edit	**NHCDN**	Procedure code <1> is intended for use by nonphysician health care professionals only. Please update code as applicable.	Nonphysicians Health Codes In accordance with correct coding guidelines, UnitedHealthcare will not reimburse nonphysician health care professional service codes listed when reported by a Physician, because these codes are intended for use by nonphysician health care professionals. Please refer to the Nonphysician Health Care Codes Policy, Professional policy on UHCprovider.com.	6/27/2024	Commercial	Professional
Return Edit	**NIRDN**	Procedure <1> is either a Status M or Status Q code and is not appropriate when reported by healthcare professionals. Update code(s) as applicable for services rendered.	Codes Not for Reportable by Health Care Professionals Consistent with CMS and in accordance with correct coding, UnitedHealthcare Community Plan will deny codes that have the CMS NPFS Relative Value File designation of status M or status Q reported on a CMS-1500 form as these are designated "for reporting purposes only. Please review the Services and Modifiers Not Reimbursable to Health Care Professionals Policy, Professional – UnitedHealthcare Community Plan on UHCprovider.com.	3/31/2022	Medicaid	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.	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 review 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.	Inappropriate Procedure and Modifier Combination Modifiers 27, 73, 74 and 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. Modifiers SE, HV, HZ, SL, HW, QJ, H9, HX, TR, HU & HY represent services that are funded by a county, state or federal agency and therefore additional reimbursement for such services would not be appropriate. Please review the Services and Modifiers Not Reimbursable to Healthcare Professionals, Professional Reimbursement Policy Commercial Plans located on UHCprovider.com.	5/30/2019	Commercial	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**NPT**	This patient received care by same specialty provider <1> on date of service <2> and is within three years of procedure code <3> on current line. An established patient E/M code should be used.	New Patient Visit According to the Centers for Medicare and Medicaid Services (CMS), a New Patient is a patient who has not received any professional services, i.e., E&M service or other face-to-face service (e.g., surgical procedure) from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years. Therefore, UnitedHealthcare will reimburse a New Patient E/M code only when the elements of that definition have been met. Please review New Patient Visit Policy, Professional Commercial Reimbursement Policy at UHCprovider.com	9/28/2023 3/28/2024	Commercial UHOne	Professional
Return Edit	**NPT1D**	This patient received care by the same provider group as this provider within the last three years. New patient code <2> may not be appropriate. Update claim as applicable.	New Patient Code for Established Patient According to the Centers for Medicare and Medicaid Services (CMS), a New Patient is a patient who has not received any professional services, i.e., E&M service or other face-to-face service (e.g., surgical procedure) from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years. Please review the New Patient Visit Policy, Professional Policy, Commercial Plan on UHCprovider.com.	7/29/2021	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.	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 review the Obstetrical Policy, Professional on UHCprovider.com.	1/31/2019 5/9/2019	Medicaid Commercial	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.	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 procedure (CPT codes 76801-76817 and 76820-76828) only if the E/M service has modifier 25 appended to the E/M code. Please review the Obstetrical Policy, Professional Reimbursement Policy Commercial Plans on UHCprovider.com.	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.	Included in Facility Payment 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 review the Contrast and Radiopharmaceutical Materials Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com.	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.	Contrastor 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 review the Contrast and Radiopharmaceutical Materials Policy on UHCprovider.com.	11/7/2019	Commercial	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
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.	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 review the Diabetic and Other Orthopedic Shoes, Professional Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com.	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.	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. Please review the Diabetic and Other Orthopedic Shoes, Professional Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com.	4/25/2019	Medicaid	Professional
Documentation Edit	**ORTDM**	Medical Records for HCPCS L3000 may be required and can be uploaded to the improved UHC Provider Portal at secure.uhcprovider.com. For more information on this edit, go to uhcprovider.com/smartedits.	Orthotics UnitedHealthcare Community Plan will reimburse HCPCS code L3000 only when accompanied by a written prescription from the provider ordering the orthotic, unless the ordering provider is also the supplier. When the ordering provider is also the supplier, office visit notes are required. Please review the Orthotics Reimbursement Policy on UHCprovider.com.	10/29/2020	Medicaid	Professional
Return Edit	**P03DN**	Procedure code <1> is inconsistent with rendering provider specialty. Update as applicable.	OT PT Therapy Consistent with coding guidelines of the Centers for Medicare and Medicaid Services (CMS), UnitedHealthcare Community Plan will not reimburse Physical and Occupational Therapists or Physical and Occupational Therapy Assistants for CPT evaluation and management codes 99091, 99202-99499 or HCPCS code G2252. Please review Physical Medicine & Rehabilitation: PT, OT and Evaluation & Management Policy, Professional on UHCprovider.com	3/30/2023	Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
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.	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 review the Physical Medicine & Rehabilitation Maximum Combined Frequency Per Day Policy on UHCprovider.com for further information	11/14/2019 8/26/2021 9/28/2023	Commercial Individual and Family Plan Medicaid	Professional
Return Edit	**PAPDN**	Procedure code <1> is not appropriate in <2> Place of service. Please update as applicable.	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 8/29/2024	Commercial Level Funded Oxford	Professional
Return Edit	**PDXDN**	Diagnosis is not appropriate with procedure code <1>. Update code(s) as applicable.	Invalid Procedure to Diagnosis Combo This edit is based on identifying correct coding between HCPCS ® and ICD -10.	9/28/2023	Medicaid	Professional
Rejection Edit	**POS**	REJECT - Procedure code <1> is not typically performed by a provider in Place of service <2>. This claim has been rejected and will not be processed.	Place of Service The place of service 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 the most common locations where these codes of would take place. Please review the Procedure to Place of Service Reimbursement Policy on UHCprovider.com for further information.	12/2-/2021 Changed to a rejection edit 9/28/2023	Medicare	Professional
Return Edit	**POSDN**	Procedure <1> is not reimbursable in POS <2>. Update code(s) as applicable.	Procedure to POS MD & NC Specific 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 Place of Service (POS) in their descriptions when assigning the applicable places of service. 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. Please review the Procedure to Place of Service Reimbursement Policy- United Healthcare Community Plan on UHCprovider.com for further information.	3/28/2024	Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**POXDN**	Oximeter procedure code <1> requires a rental or purchase modifier. Please update code(s) as applicable.	Oximeter Modifier 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 modifierin order to be considered for reimbursement. Please refer to the Coverage Limitations and Exclusions section of the Durable Medical Equipment, Orthotics, Medical Supplies and Repairs/Replacements Policy on UHCprovider.com.	11/21/2024	Commercial	Professional
Return Edit	**PPSCD**	Procedure <1> billed on mmddyyyy is not appropriate in <2> Place Of Service for the State of <3>.	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 review 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**	Preventive procedure code <1> and E/M procedure code <1> may be submitted on same date of service when the other E/M code represents significant, separately identifiable service and submitted with appropriate modifier.	Preventative 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 review the Preventative Medicine and Screening Reimbursement Policy on UHCprovider.com for further information.	10/4/2018	Commercial	Professional
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.	Preventative 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 review the Preventative Medicine and Screening Reimbursement Policy on UHCprovider.com for further information.	7/18/2019	Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**PRMSC**	"Preventive procedure code <1> and E/M procedure code <1> may be submitted on same date of service when the other E/M code represents significant, separately identifiable service and submitted with appropriate modifier. "	Preventative Medicine Screening Code Preventive Medicine Services [Current Procedural Terminology (CPT®) codes 99381-99387, 99391-99397, Healthcare Common Procedure Coding System (HCPCS) code G0402] are comprehensive in nature, reflect an age and gender appropriate history and examination, and include counseling, anticipatory guidance, and risk factor reduction interventions, usually separate from disease-related diagnoses. Occasionally, an abnormality is encountered or a pre-existing problem is addressed during the preventive visit, and significant elements of related Evaluation and Management (E/M) services are provided during the same visit. When this occurs, UnitedHealthcare Value & Balance Exchange 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. Please review the Preventive Medicine and Screening Policy on UHCprovider.com	8/26/2021	Individual & Family Plan	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.	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 review the Professional/Technical Component reimbursement policy at UHCprovider.com for further information.	5/2/2019	Medicaid	Professional
Return Edit	**PTCDM**	Procedure code <1> is not an appropriate code for services provided. Report the Status A (active) code that best describes the services provided.	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 review the Professional/Technical Component reimbursement policy at UHCprovider.com for further information.	11/14/2018	Commercial	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
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.	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 review the Professional/Technical Component Policy, Professional - Reimbursement Policy UnitedHealthcare Plans on UHCprovider.com.	5/30/2019	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.	Non ProTech Lab Code Denial 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 review the Professional/Technical Component reimbursement policy for the appropriate line of business at UHCprovider.com.	5/2/2019 3/25/2021 2/24/2022 3/27/2025	Medicaid Individual and Family Plan All Savers Oxford Level Funded Surest	Professional
Return Edit	**PTCHD**	Procedure <1> is not appropriate in a facility setting. Update code(s) as applicable for services rendered.	ProTech Deny Hospital Services 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 review the Professional/Technical Component Policy, Professional Reimbursement policy UnitedHealthcare on UHCprovider.com.	5/30/2019	Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**PTCIH**	Procedure <1> is not reimbursable to a physician or health care professional with a place of service other than inpatient hospital. Update code(s) as applicable.	Professional Technical Component Policy Inpatient Hospital The CMS NPFS guidelines advise that payment should not be recognized for PC/TC Indicator 8 codes, which are defined as physician interpretation codes, furnished to patients in the outpatient or non-hospital setting (POS other than 21). In alignment with CMS, UnitedHealthcare will not reimburse PC/TC Indicator 8 (CPT code 85060) when reported by a physician or other qualified health care professional with a CMS POS code other than inpatient hospital (POS 21). Please review the Professional/Technical Component Policy, Professional Reimbursement policy UnitedHealthcare on UHCprovider.com.	6/30/2022	Commercial	Professional
Return Edit	**PTCIM**	Modifier 26 or TC is not appropriate for procedure code <1>. Update code(s) as applicable for services rendered.	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 review the Professional/Technical Component Reimbursement Policy, Professional on UHCprovider.com.	4/25/2019 5/30/2019 5/30/2024 5/30/2024	Commercial Medicaid Level Funded Oxford	Professional
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.	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 review the Professional/Technical Component Policy, Reimbursement Policy UnitedHealthcare Commercial Plans on UHCprovider.com for further information.	5/30/2019	Commercial	Professional
Return Edit	**PTCMD**	Procedure <1> submitted with modifier TC is not appropriate when reported in a facility setting. Update code(s) as applicable.	ProTech TC Facility POS 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 Techincal Component according to CMS PC/TC indicators, UnitedHealthcare will reimburse the interpreting physician or other QHP onlt the Professional Component as the facility is reimbursed for the Techincal Component of the service. Please refer to the Professional/Technical Component Policy, Professional on UHCprovider.com	4/25/2024	Commercial	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**PTPDN**	Proc [<1>] submitted in POS [<2>] is not reimbursable. Update codes as applicable.	Pro and POS Denial Facility-based Behavioral Health Program Professional Fees may be reimbursed if considered an integral part of the program services such as individual or group therapy, family therapy, and/or crisis intervention. Non-integral services in facility-based programs are not reimbursed. Please review the Facility-Based Behavioral Health Program Professional Fees Reimbursement Policy at UHCprovider.com	8/31/2023	Commercial	Professional
Return Edit	**RASIN**	Procedure <1> is not a separately reimbursable service. Under appropriate circumstances, a designated modifier may be required to identify distinct services. Update code(s) as applicable.	Robotic Assisted Surgery According to the Centers for Medicare and Medicaid Services (CMS), medical and surgical procedures should be reported with the Current Procedural Terminology (CPT®)/HCPCS codes that most comprehensively describe the services performed. UnitedHealthcare considers S2900, (Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure)) to be a technique integral to the primary surgical procedure and not a separately reimbursed service. When a surgical procedure is performed using code S2900, reimbursement will be considered included as part of the primary surgical procedure. Please review the Robotic Assisted Surgery Policy, Professional - Reimbursement Policy UnitedHealthcare Commercial Plans on UHCprovider.com.	6/30/2022	Commercial	Professional
Rejection Edit	RCPDN	REJECT - Procedure <1> is not an appropriate code for services rendered. Report the status A (active) code that best describes the services provided. This claim has been rejected and will not be processed.	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. Please review the Replacement Codes reimbursement policy at UHCprovider.com.	11/14/2018 2/24/2022 9/26/2024	Commercial All Savers Level Funded Oxford	Professional
Documentation Edit	**RDCDD**	Medical Records may be required and can be uploaded to the UHC Provider Portal at secure.uhcprovider.com. For more information on this edit, go to uhcprovider.com/smartedits.	Code Review This procedure code is used to describe a service or procedure that requires manual review. Medical records can be updated to the Provider Portal at https://secure.uhcprovider.com.	1/28/2021	Medicaid	Professional
Documentation Edit	**RDCRD**	Medical Records may be required and can be uploaded to the UHC Provider Portal at secure.uhcprovider.com. For more information on this edit, go to uhcprovider.com/smartedits.	Refer Code Review This procedure code is used to describe a service or procedure that requires manual review. Medical records can be uploaded to the UnitedHealthcare Provider Portal at https://secure.uhcprovider.com.	1/28/2021	Medicaid	Professional
Informational Banner	**REJINFO**	INFORMATIONAL This claim has been rejected and will not be processed. See UHCprovider.com/SmartEdits. Repaired claims should be sent with the original frequency code, not a replacement or voided indicator of 7 or 8.	Rejection Banner This edit will trigger in conjunction with all of our rejection edits to provide additional information on how to repair the claim.	8/27/2020	Medicare Medicaid Commercial	Professional

Edit type	Smart edit	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.	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. Please review the Sodium Hyaluronate Medical Policy on UHCprovider.com.	3/14/2019 5/2/2019	Medicaid Commercial	Professional
Return Edit	**S03DN**	Diagnosis <1> is not appropriate with procedure code <2>.	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 review the High Frequency Chest Wall Compression Devices Medical Policy on UHCprovider.com	11/15/2018	Commercial	Professional
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.	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 review the Light and Laser Therapy for Cutaneous Lesions and Pilonidal Disease reimbursement policy at UHCprovider.com.	11/15/2018 3/14/2019	Commercial Medicaid	Professional
Return Edit	**S16DN**	Procedure code <2> submitted with diagnosis <1> is an excluded service on most benefit plans.	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

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**S20DN**	Diagnosis <1> is not appropriate when submitted with procedure code <2> for Sodium Hyaluronate. Update code(s) as applicable for services rendered.	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 review Sodium Hyaluronate Commercial Medical & Drug Policies on UHCprovider.com.	3/14/2019 4/4/2019	Medicaid Commercial	Professional
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.	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 review the Light and Laser Therapy for Cutaneous Lesions and Pilonidal Disease Policy on UHCprovider.com.	11/15/2018 3/14/2019	Commercial Medicaid	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.	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 review Somatostatin Analogs Commercial Medical & Drug Policies on UHCprovider.com for further information.	3/14/2019	Commercial Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
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.	Service to Diagnosis - Transforaminal Epidural Injection 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 review the Epidural Steroid and Facet Joint Injections for Spinal Pain - UnitedHealthcare Commercial Medical Policy on UHCprovider.com for further information.	5/30/2019 10/27/2022	Commercial Medicaid	Professional
Return Edit	**S25DN**	Diagnosis <1> is not appropriate with procedure code <2>.	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 review 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.	Invalid Procedure Diagnosis - 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 review Orencia® (Abatacept) Injection for Intravenous Infusion Commercial Medical & Drug Policies on UHCprovider.com.	3/14/2019	Commercial	Professional
Return Edit	**S31DN**	Diagnosis <1> is not appropriate with procedure code <2>.	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 review the Hepatitis Screening Policy on UHCprovider.com for further information.	10/4/2018	Commercial	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**S32DN**	Diagnosis <1> is not appropriate with procedure code <2> when submitted for <3>.	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 review 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.	Invalid Procedure Diagnosis 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 review Stelara® (Ustekinumab) Commercial Medical & Drug Policies on UHCprovider.com for further information.	3/14/2019	Commercial	Professional
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.	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 review Benlysta® (Belimumab) Commercial Medical & Drug Policies on UHCprovider.com for further information.	3/7/2019 10/27/2022	Commercial Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
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.	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 review Actemra® (Tocilizumab) Injection for Intravenous Infusion Medical & Drug Policies on UHCprovider.com.	2/21/2019	Commercial	Professional
Return Edit	**S43DN**	Procedure code <1> for Vascular Endothelial Growth Factor may require a Diagnosis code that was not found on this claim. Update code(s) as applicable.	Invalid Procedure Diagnosis Age 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 review the Vascular Endothelial Growth Factor Inhibitors reimbursement policy at UHCprovider.com.	11/15/2018 3/7/2019	Commercial 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.	Service to Diagnosis Ocular Screening 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 review 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>.	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 review the Occipital, Neuralgia and Cervicogenic, Cluster and Migraine 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.	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 review Simponi Aria® (Golimumab) Injection for Intravenous Infusion Medical & Drug Policies on UHCprovider.com.	3/14/2019	Commercial	Professional

Edit type	Smart edit	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.	Invalid Procedure Diagnosis 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 review Entyvio® (Vedolizumab) Commercial Medical & Drug Policies on UHCprovider.com.	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.	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 review Xolair® (Omalizumab) Commercial Medical & Drug Policies on UHCprovider.com for further information.	3/14/2019	Commercial	Professional

Edit type	Smart edit	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.	Invalid Procedure Diagnosis 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 review 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.	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 review 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>	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 finger stick 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. Please review the Continuous Glucose Monitoring and Insulin Delivery of Managing Diabetes on UHCprovider.com	11/15/2018	Commercial	Professional
Documentation Edit	**S58DN**	Medical Records may be required and can be uploaded to the UHC Provider Portal at secure.uhcprovider.com. For more information on this edit, go to uhcprovider.com/smartedits.	Continuous Glucose Monitoring The procedure code and/or diagnosis code may not be appropriate for continuous glucose monitoring and may require review of medical records. Medical records can be updated to LINK. Please review the Continuous Glucose Monitoring and Insulin Delivery of Managing Diabetes on UHCprovider.com	2/25/2021	Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**S63DN**	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.	Service to Diagnosis - Fecal Calprotectin Fecal measurement of calprotectin is proven and medically necessary for establishing the diagnosis or for management of the following: Crohn's Disease, Ulcerative Colitis. Due to insufficient evidence of efficacy, fecal measurement of calprotectin is unproven and not medically necessary for establishing the diagnosis or for management of any other condition. This edit fires when a diagnosis not related to Crohn's Disease or Ulcerative Colitis is not submitted on claim. Please review the Fecal Calprotectin Medical Policy on UHCprovider.com for additional information.	4/25/2024	Commercial	Professional
Return Edit	**S64DN**	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.	Service to Diagnosis - Testosterone Pellet (Testopel®) Injectable testosterone and Testopel (testosterone pellets) are proven for replacement therapy in conditions associated with a deficiency or absence of endogenous testosterone, including primary hypogonadism (congenital or acquired) and hypogonadotropic hypogonadism (congenital or acquired). This edit fires when a covered diagnosis is not submitted. Please see Testosterone Replacement or Supplementation Therapy medical policy on UHCprovider.com for additional information.	4/25/2024	Commercial	Professional
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.	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 review the Standby Services Policy on UnitedHealthcare Community Plans on UHCprovider.com.	4/4/2019	Medicaid	Professional
Documentation Edit	**SFCCL**	Medical records may be required for procedure <1> and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information on this edit, go to UHCprovider.com/smartedits.	Surgical Flap Codes Flap repair is considered reconstructive and medically necessary in certain circumstances. Please review UHC policies for required clinical information. Medical records can be uploaded to the UHC Provider Portal at secure.UHCprovider.com.	4/27/2023	Commercial	Professional
Return Edit	**sMOD**	Modifier <1> is not typical for procedure code <2>. Update codes as applicable.	Medicaid Invalid 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 Procedure to Modifier Policy, Professional - Reimbursement Policy - UnitedHealthcare Community Plan at UHCprovider.com.	4/3/2025	Individual & Famly Plan	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**SMSMD**	Sclerotherapy code <1> may require anatomical modifier. Please update code(s) as applicable.	Sclerotherapy Anatomical Modifier Per UHC policy, the appropriate site modifier must be appended with the sclerotherapy procedure code to indicate if the service was performed unilaterally or bilaterally. Please review the Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins policy at UHCprovider.com.	11/21/2024	Commercial	Professional
Return Edit	**SSVDN**	Procedure code <1> with split services modifier FS is not allowed in POS <3>. Update code(s) as applicable.	Split Visit Place of Service According to CMS, a split (or shared) visit is an evaluation and management (E/M) visit in the Facility Setting that is performed in part by both a physician and a Nonphysician Practitioner (NPP) who are in the same group, in accordance with applicable law and regulations such that the service could be billed by either the physician or NPP if furnished independently by only one of them. Payment is made to the practitioner who performs the substantive portion of the visit. Office or other outpatient evaluation and management services are not eligible to be billed as a split (or shared) service in an office setting – place of service 11. Please review Service Incident to a Supervising Health Care Provider and Split or Shared Services Policy at UHCprovider.com	3/27/2025	Commercial Individual & Family Plan Level Funded Oxford	Professional
Return Edit	**SUPDS**	Procedure <1> may not be separately reimburseable unless billed in conjunction with correct procedure code(s) on same claim and date of service. Please update code(s) as applicable.	Implantable Tissue Markers CMS clarifies that implantable tissue markers (HCPCS code A4648) and implantable radiation dosimeters (HCPCS code A4650) are separately billable and payable when used in conjunction with CPT codes 19499, 32553, 49411 or 55876 on a claim for physician services. Consistent with CMS, UnitedHealthcare will allow separate reimbursement for HCPCS codes A4648 and A4650 when billed on the same date of service with either CPT codes 19499, 32553, 49411 or 55876. If A4648 and A4650 are reported in a facility setting or without CPT codes 19499, 32553, 49411, or 55876 they are not separately reimbursable. Please refer to the Supply Policy, Professional at UHCprovider.com	3/20/2025	Commercial Individual & Family Plan Medicaid	Professional
Return Edit	**sUN**	Per Medicaid CCI Guidelines, procedure <1> has an unbundle relationship with procedure <2>. Update code(s) as applicable.	Rebundling Policy 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.	6/27/2024	Medicaid	Professional
Return Edit	**SUPDC**	Procedure <1> billed in facility place of service [<2>] is not reimbursable. Update code(s) as applicable.	DME Supplies in Facility POS Consistent with CMS, UnitedHealthcare will not allow separate reimbursement for specific HCPCS supplies, DME, orthotics, prosthetics, biologicals, and drugs when submitted on a CMS-1500 claim form by any physician or other qualified health care professional in the following facility POS: 19, 21, 22, 23, and 24. The UnitedHealthcare Supply Facility J-Code Denial Code list and Supply DME Codes in a Facility Setting contains the codes that are not separately reimbursable in a facility place of service. Facility place of service is considered POS 19, 21, 22, 23, and 24. Please review the Supply Policy on UHCprovider.com.	8/29/2024	Commercial	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**SUPDD**	Procedure <1> is not appropriate in Place of service <2>. Update code(s) as applicable for services rendered.	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 review 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.	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 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 review the Supply Policy, Professional on UHCprovider.com.	1/31/2019 7/25/2024	Commercial Individual & Family Plan Medicaid	Professional
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.	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 non-facility place of service. Please review 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.	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 non-facility 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 Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**SUPFP**	Procedure <1> is considered inclusive to other services reported. Update code(s) as applicable.	Supply Codes Submitted in Facility Place of Service Certain HCPCS supply codes are not separately reimbursable as the cost of supplies is incorporated into the Evaluation and Management (E/M) service or procedure code. 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 non-facility place of service by a physician or other qualified health care professional. Please review the Supply Policy, Professional – UnitedHealthcare Community Plan on UHCprovider.com.	5/30/2019	Commercial Medicaid	Professional
Return Edit	**SUPIN**	Procedure <1> is considered inclusive to other services reported. Update code(s) as applicable.	Supply Service Included in Primary Procedure Certain HCPCS supply codes are not separately reimbursable as the cost of supplies is incorporated into the Evaluation and Management (E/M) service or procedure code. 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 non-facility place of service by a physician or other qualified health care professional. Please review the Supply Policy, Professional – UnitedHealthcare Community Plan on UHCprovider.com.	3/31/2022 6/30/2022	Medicaid Commercial	Professional
Return Edit	**SUPNC**	Procedure code <1> is not appropriate because it is non-specific. Update code(s) as applicable for services rendered.	Non-Specific CPT Code 99070 - Supplies 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 review the Supply Policy, Professional - Reimbursement Policy on UHCprovider.com.	3/7/2019	Medicaid	Professional
Return Edit	**TCH**	Proc <1> is not an appropriate telehealth code. Update code(s) as applicable.	Telephone Charges UnitedHealthcare will consider for reimbursement Telehealth services when they are rendered via audio and video and reported with either place of service POS 02 or 10. Please review the Telehealth/ Virtual Health Policy on UHCprovider.com.	10/27/2022	Medicaid	Professional
Return Edit	**TCHAD**	Audio only modifier 93 is not appropriate for procedure code <1>. Please update code or modifier(s) as applicable.	Telemedicine Audio Only Modifier UnitedHealthcare aligns with the AMA and will only consider reimbursement for services reporting real-time, interactive audio-only Telehealth, when appended with modifier 93, and reported with POS 02 or 10. See the Telehealth Audio-Only Eligible Services Code List in the Attachments section. Please refer to the Audio-Only Telehealth/Virtual Policy, Professional at UHCprovider.com	2/27/2025	Commercial Level Funded Oxford	Professional
Return Edit	**TCHAP**	Procedure <1> is not allowed in POS <2> with an Audio Only modifier. Please update as applicable.	Telemedicine Audio Only POS UnitedHealthcare aligns with the AMA and will consider for reimbursement the services included in Appendix T of the CPT code set, which are appropriate for reporting real-time, interactive audio-only Telehealth, when appended with modifier 93, and reported with POS 02 or 10. See the Telehealth Audio-Only Eligible Services Code List in the Attachments section. CPT codes reported with modifier 93 that are not included in Appendix T of the CPT code set will not be eligible for reimbursement.	8/29/2024	Commercial Level Funded Oxford	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**TCHBB**	Procedure <1> submitted with a telehealth modifier but without an appropriate place of service. Update code(s) as applicable.	Telehealth Invalid POS with MOD Optum will consider reimbursement for telemental health services when they are rendered via audio and video and submitted with place of service POS 02 or 10. Modifiers 93, 95, FQ, GQ, GT are not required to identify Telehealth services but are accepted as informational if reported on claims with eligible Telehealth services and POS 02 or 10. Please review: the Optum Telemental Health Services Reimbursement Policy at: https://public.providerexpress.com/content/dam/ope-provexpr/us/pdfs/clinResourcesMain/guidelines/reimbPolicies/CommTeleHealthReimbus.pdf	5/30/2024	Commercial	Professional
Return Edit	**TCHBM**	Procedure <1> is not appropriate with a telehealth modifier. Update code(s) as applicable.	Telehealth Modifier Optum will not reimburse for telehealth services if a modifier is only presented on the claim without billing the appropriate POS 02 or 10. Please review: the Optum Telemental Health Services Reimbursement Policy at: https://public.providerexpress.com/content/dam/ope-provexpr/us/pdfs/clinResourcesMain/guidelines/reimbPolicies/CommTeleHealthReimbus.pdf	5/30/2024	Commercial	Professional
Return Edit	**TCHBP**	Procedure <1> is not appropriate in a telehealth place of service. Update code(s) as applicable.	Telehealth POS Invalid POS with MOD Optum will consider reimbursement telemental health services when they are rendered via audio and video and place of service POS 02 or 10. Please review: the Optum Telemental Health Services Reimbursement Policy at: https://public.providerexpress.com/content/dam/ope-provexpr/us/pdfs/clinResourcesMain/guidelines/reimbPolicies/CommTeleHealthReimbus.pdf	5/30/2024	Commercial	Professional
Return Edit	**TCHDP**	Procedure <1> is not an appropriate telehealth code. Update code(s) as applicable.	Not Telemedicine Procedure UnitedHealthcare will consider for reimbursement the Telehealth services when they are rendered via audio and video and reported with either place of service POS 02 or 10. See the Telehealth Eligible Services Code List in the Attachments Section of the Telemedicine Policy. Please review the Telehealth and Telemedicine Policy on UHCprovider.com.	10/13/2022	Commercial	Professional
Return Edit	**TCHEM**	Procedure <1> is not appropriate with a telehealth modifier. Update code(s) as applicable.	Telehealth Modifier Communication Technology-Based Services (CTBS) and Remote Physiologic Monitoring (RPM) services are never rendered in-person and therefore should not be reported with POS 02 or 10 and/or a Telehealth modifier (95, GT, GQ or G0). Please review the Telehealth and Telemedicine Policy on UHCprovider.com.	10/13/2022	Commercial	Professional
Return Edit	**TCHHA**	Procedure <1> submitted without an appropriate modifier. Update code(s) as applicable.	Telemedicine Modifier Hawaii UnitedHealthcare Community Plan will consider for reimbursement Telehealth services which are recognized by The Centers for Medicare and Medicaid Services (CMS) and appended with modifiers GQ or GT, or G0 (numeric zero, not alpha O) for Telehealth services related to acute stroke, as well as services recognized by the American Medical Association (AMA) included in Appendix P of CPT and appended with modifier 95. Please review the TeleHealth/Virtual Health Professional Policy on www.UHCprovider.com.	11/17/2022	Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**TCHHB**	Procedure <1> for telehealth submitted without an appropriate place of service. Update code(s) as applicable.	Telemedicine Hawaii POS Denial UnitedHealthcare Community Plan follows CMS guidelines which do not allow reimbursement for Telehealth/virtual health transmission, per minute, professional services bill separately reported with Healthcare Common procedure Coding System (HCPCS) code T1014. They are non-reimbursable codes according to the CMS Physician Fee Schedule (PFS) and are considered included in services. Please review the TeleHealth/Virtual Health Professional Policy on www.UHCprovider.com.	11/17/2022	Medicaid	Professional
Return Edit	**TCHHC**	Procedure <1> submitted without an appropriate modifier. Update code(s) as applicable.	Telemedicine Hawaii no MOD UnitedHealthcare Community Plan requires one of the Telehealth-associated modifiers (GQ, GT, G0 or 95) to be reported when performing a service via Telehealth to indicate the type of technology used and to identify the service as Telehealth/virtual visits. Please review the TeleHealth/Virtual Health Professional Policy on www.UHCprovider.com.	11/17/2022	Medicaid	Professional
Return Edit	**TCHHD**	Procedure <1> submitted without an appropriate place of service. Update code(s) as applicable.	Telemedicine Hawaii Place of Service Denial UnitedHealthcare Community Plan requires one of the Telehealth-associated modifiers (GQ, GT, G0 or 95) to be reported when performing a service via Telehealth to indicate the type of technology used and to identify the service as Telehealth/virtual visits. Please review the TeleHealth/Virtual Health Professional Policy on www.UHCprovider.com.	11/17/2022	Medicaid	Professional
Return Edit	**TCHHE**	Proc <1> submitted without an appropriate modifier and place of service is not reimbursable. Update code(s) as applicable.	Telemedicine Hawaii Procedure code for POS and Modifier UnitedHealthcare Community Plan requires one of the Telehealth-associated modifiers (GQ, GT, G0 or 95) to be reported when performing a service via Telehealth to indicate the type of technology used and to identify the service as Telehealth/virtual visits. Please review the TeleHealth/Virtual Health Professional Policy on www.UHCprovider.com.	11/17/2022	Medicaid	Professional
Return Edit	**TCHKC**	Procedure <1> for telehealth submitted without an appropriate place of service. Update code(s) as applicable.	AC Telemedicine Denial UnitedHealthcare Community Plan follows CMS guidelines which do not allow reimbursement for Telehealth/virtual health transmission, per minute, professional services bill separately reported with Healthcare Common procedure Coding System (HCPCS) code T1014. They are non-reimbursable codes according to the CMS Physician Fee Schedule (PFS) and are considered included in services.	3/30/2023	Medicaid	Professional
Rejection Edit	**TCHMP**	REJECT - Telehealth charges should be reported with place of service 02 or 10. Telehealth modifiers are considered informational only. This claim has been rejected and will not be processed.	Telehealth Place of Service Beginning 01/01/21, providers should report place of service 02 or 10 for telehealth services. The telehealth modifiers (95, GT, GQ or G0 [zero]) will no longer be required. Please review the Telehealth and Telemedicine Policy on UHCprovider.com.	1/7/2021 2/24/2022 8/29/2024	Commercial Oxford All Savers Level Funded	Professional
Return Edit	**TCHPD**	Procedure <1> is not appropriate with telehealth place of service. Update code(s) as applicable.	Telehealth Place of Service UnitedHealthcare will consider for reimbursement Telehealth services when they are rendered via audio and video and reported with either place of service POS 02 or 10. Please review the Telehealth/ Virtual Health Policy, Professional on UHCprovider.com.	10/13/2022	Commercial	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**THIEM**	INFORMATIONAL - 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.	E/M Code included in Therapeutic Injection Code 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 review the Injection and Infusion Services Policy, Professional-Reimbursement Policy UnitedHealthcare Community Plan for further information.	5/9/2019 6/1/2023	Commercial Individual & Family Plan 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.	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 review the T Status Codes Policy, Professional - Reimbursement Policy UnitedHealthcare Community Plan.	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.	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 review the Co-Surgeon / Team Surgeon Policy, Professional Reimbursement Policy on UHCprovider.com.	3/14/2019	Commercial	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**u340Bf**	Facility is active in the 340B program and billed a Status K drug code J2505 without JG modifier. Update claim or attest; without action 340B discount applies. Attestation details at UHCprovider.com/SmartEdit	340B Drug Pricing This facility has been identified as participating in the 340B Drug Pricing program and has billed a Status K drug code. Drugs obtained via the 340B program require an appropriate modifier. Drugs identified as 340B eligible will be paid at the appropriate discounted rate. If the impacted drug(s) were not obtained via the 340B program, this can be indicated by providing an attestation statement within the 'Service Line Remarks' field on the UB claim form, ensuring to point the remarks to the corresponding Status K drug line. Attestation statement should also include why the drug was not obtained via 340B program. Acceptable attestations must include: 1. Specific Drug code (if multiple drug codes billed) 2. Reason why drug was not obtained via 340B program, in accordance with CMS guidance 3. The verbiage "attest" UnitedHealthcare retains its rights to monitor compliance and may request additional supporting information related to the claim and services reported. For more CMS information, please check out the CMS-1736 Fact Sheet, CMS Medicare Fee-for-Service (FFS) Program Frequently Asked Questions, and the CMS Medicare Hospital Outpatient PPS Addendum A and Addendum B Updates. For information on UHCprovider.com, please refer to the 340B Medicare Advantage Drug Pricing Program – UnitedHealthcare Medicare Advantage Plans and "Use required 340B modifiers for accurate payment" Network News article.	7/22/2021	Medicare	Facility
Return Edit	**uAAPUZIP**	The pickup point zip code is missing for procedure code <1>. Please review and update as applicable.	Air Ambulance Pick-up Zip Code Ambulance transportation from one point to another requires a pickup point zip code accompany the billed services. CMS provides a national breakout of the geographic area definitions (rural, urban, and super rural) by zip code. Please review the Ambulance Fee Schedule and Zip Code files at cms.gov.	9/26/2024	Commercial	Professional
Return Edit	**uAAPUZIPf**	The pickup point zip code is missing for procedure code <1>. Please review and update as applicable.	Air Ambulance Pick-up Zip Code Ambulance transportation from one point to another requires a pickup point zip code accompany the billed services. CMS provides a national breakout of the geographic area definitions (rural, urban, and super rural) by zip code. Please review the Ambulance Fee Schedule and Zip Code files at cms.gov.	9/26/2024	Commercial	Facility
Return Edit	**UADODN**	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.	Add on Outpatient Facility Add-on codes are reimbursable services when reported in addition to the appropriate primary service by the same outpatient hospital 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 Outpatient Hospital Add-ons Codes Policy on www.UHCprovider.com.	11/17/2022	Commercial	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**UAMBDM**	Ambulance procedure code submitted with invalid or missing required ambulance modifier. Update code(s) as applicable.	Ambulance Modifier Outpatient Facility Institutional-based providers must report modifier QM with the HCPCS code to describe ambulances services provided under arrangement by the provider of services or QN to describe ambulance services provided directly. Please refer to the Hospital Based Ambulance Policy on www.UHCprovider.com.	11/17/2022	Commercial	Facility
Return Edit	**UAMBDN**	Ambulance service HCPCS code requires an ambulance mileage HCPCS code. Update code(s) as applicable.	Ambulance Service Mileage HCPCS Code Outpatient Facility The ambulance service and mileage must be reported with the appropriate HCPCS code, modifier, and revenue code 0540 or 0545 when appropriate. The ambulance service and mileage are reported on separate lines with the same date of service and on the same claim. The ambulance service should be reported with one unit. The number of units reported for mileage should reflect the loaded number of miles being billed. Please refer to the Hospital Based Ambulance Policy on www.UHCprovider.com.	11/17/2022	Commercial	Facility
Return Edit	**UAMBMA**	Ambulance procedure code submitted with invalid or missing required ambulance modifier. Update code(s) as applicable.	Ambulance Required Modifiers Amb Service For ambulance transportation claims, UnitedHealthcare has adopted the Centers for Medicare and Medicaid Services (CMS) guidelines that require institutional-based providers and suppliers to report an origin and destination modifier for each trip provided. Please refer to the Hospital Based Ambulance Policy, Facility on UHCprovider.com.	3/30/2023	Commercial	Facility
Return Edit	**uAMBMf**	Procedure code <1> should be reported with a two-digit ambulance modifier. Update code(s) as applicable.	Outpatient Hospital Based Ambulance For ambulance transportation claims, UnitedHealthcare has adopted the Centers for Medicare and Medicaid Services (CMS) guidelines that require institutional-based providers and suppliers to report an origin and destination modifier for each trip provided. Please refer to the Outpatient Hospital Based Ambulance Policy, Facility on UHCprovider.com.	2/25/2021	Commercial	Facility
Return Edit	**uAMBMR**	Ambulance mileage code <1> requires an appropriate modifier comprised of origin and destination of journey. Update modifier(s) as applicable.	Ambulance Mileage Modifier For ambulance service claims, providers and suppliers must report an origin and destination modifier for each ambulance trip provided. 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. Ambulance mileage (A0425, A0435, A4036, A0888) require origin and destination modifier. Please refer to Ambulance Services Medical Policy at UHCprovider.com	11/21/2024	Commercial	Facility
Return Edit	**uAMBO**	Modifier <1> indicates the beneficiary was not onboard the ambulance during the time of service. Please review the modifier and update claim as applicable.	Ambulance Ground Transport to the Scene No payment may be made for the transport of ambulance staff or other personnel when the beneficiary is not on board the ambulance (e.g., an ambulance transport to pick up a specialty care unit from one hospital to provide services to a beneficiary at another hospital). This policy applies to both ground and air ambulance transports. Please review the Ambulance Services Policy on UHCprovider.com	4/28/2022	Medicare	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uAMBOIP**	This ambulance service date occurred during an inpatient stay and may not be separately reimbursable. Please review and update as applicable.	Ambulance Service While Inpatient Hospital bundling rules exclude payment to independent suppliers of ambulance services for beneficiaries in a hospital inpatient stay when the ambulance service date falls within the admission and discharge dates on a hospital inpatient bill. An exception is when the ambulance service date falls within the occurrence span code 74 from and through dates plus one day. In this case, the ambulance may be separately payable. Please review the Medicare Claims Processing Manual on www.cms.gov.	4/27/2023	Medicare	Professional
Return Edit	**uAMBRC**	Ambulance HCPCS code <1> requires an appropriate revenue code. Update code(s) as applicable.	Ambulance Revenue Code The ambulance service and mileage must be reported with the appropriate HCPCS code, modifier, and revenue code 0540 or 0545 when appropriate. Please review the Hospital Based Ambulance Policy on UHCprovider.com for further information.	7/25/2024	Commercial	Facility
Return Edit	**uAMMZIP**	The pickup point zip code is missing for procedure code <1>. Please review and update as applicable.	Ambulance Pick up Zip Missing Ambulance transportation from one point to another requires a pickup point zip code accompany the billed services. CMS provides a national breakout of the geographic area definitions (rural, urban, and super rural) by zip code. Please refer to the Ambulance Services policy on www.uhcprovider.com for additional information.	7/30/2022	Medicare	Professional
Return Edit	**uAMSP**	Procedure code <1> may need to be submitted with an anatomic modifier. The most specific modifier to represent the anatomical site should be reported. Update code(s) as applicable.	Anatomic Modifiers Surgical Procedure When certain surgical procedures are performed on a different digit or limb it is appropriate that these services be reported using a site-specific modifier. Please refer to: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104C23.pdf	2/17/2022 10/24/2024	Commercial Oxford Medicare Medicaid Individual & Family Plan Level Funded UHCOne	Professional
Return Edit	**uANSDM**	Procedure code <1> requires an anesthesia modifier identifying whether the procedure was personally performed, medically directed or medically supervised. Update modifier(s) as applicable.	Anesthesia Modifier Required All services reported for anesthesia management services must be submitted with the appropriate modifiers. These modifiers identify monitored anesthesia and whether a procedure was personally performed, medically directed, or medically supervised. Please refer to the Required Anesthesia Modifiers section of Anesthesia Policy, Professional on UHCprovider.com.	11/30/2023	Commercial	Professional
Informational Edit	**uASIPf**	INFORMATIONAL- Claim data does not support the use of CPT code 96375 as no new drug was billed.	Additional Sequential Intravenous Push of a New Drug Injection code for additional IV push of a new drug billed without the presence of a new drug on the claim. The administration of the same drug does not support billing of an injection for a new drug.	11/19/2020	Medicare Medicaid Commercial Oxford	Facility
Return Edit	**uASUNE**	Procedure <1> is not eligible for assistant surgeon. Please update code(s) as applicable.	Assistant Surgeon Not Eligible The Assistant-at-Surgery Eligible List is developed based on the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule Relative Value File (NPFS) payment policy indicators. All codes in the NPFS with the payment code indicator "2" for "Assistant-at-Surgery" are considered by UnitedHealthcare to be reimbursable for Assistant-at-Surgery services, as indicated by an assistant surgeon modifier (80, 81, 82, or AS). The procedure code summitted is not on the Assistant -at-Surgery Eligible List. Please review the Assistant at Surgery reimbursement policy on UHCprovider.com	10/28/2021	Oxford	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Documentation Edit	**uATC250K**	Medical Records and itemized bill may be required and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information on this edit, go to UHCprovider.com/smartedits.	Billed Charges over $250K Claims submitted with billed charges exceeding $250,000.00 may require medical records and itemized bill for payment. The itemization of charges should include dates and detailed descriptions for each individual charge. Please refer to the Provider Administrative Guide on UHCprovider.com.	11/18/2021	Commercial	Professional
Documentation Edit	**uATC250Kf**	Medical Records and itemized bill may be required and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information on this edit, go to UHCprovider.com/smartedits.	Attachment for Billed Charges over $250K Claims submitted with billed charges exceeding $250,000.00 may require medical records and itemized bill for payment. The itemization of charges should include dates and detailed descriptions for each individual charge. For more information, please refer to the Provider Administrative Guide on UHCprovider.com.	11/18/2021	Commercial	Facility
Documentation Edit	**uATCAA**	Medical Records may be required and can be uploaded to the claims Link tool at https://healthid.optum.com. For more information on this edit, go to UHCprovider.com/smartedits.	Air Ambulance Medical Records Air Ambulance and Non-Emergency Transport (Ground or Air) Medical notes documenting all of the following: Date of service, Ordering physician's name and phone number (if request is made to Air Ambulance provider), Physician order and documentation by explaining the reason for Air Ambulance transport, Any additional equipment or personnel needed for transport, Member's diagnosis and chief complaint, Members current condition (clinical summary) including: Co-morbidities, Current functional limitations, Description of members inpatient (IP) stay and progress if applicable, Where member is traveling from (facility name & contact name/phone number), Where member is traveling to (facility name & contact name/phone number), Mileage (one-way) for transport including air mileage and land mileage for transport. Please review the Commercial Ambulance Policy on UHCprovider.com.	12/17/2020	Commercial	Professional
Documentation Edit	**uATCABL**	Medical Records must be submitted and can be uploaded to the UHC Provider Portal at secure.uhcprovider.com. For more information on this edit, go to uhcprovider.com/smartedits.	Advanced Biomedical Labs This procedure code is used to describe a service or procedure that requires manual review. Medical records can be updated to the Provider Portal at https://secure.uhcprovider.com. Please refer to the Provider Administrative Guide on UHCprovider.com	11/2/2023	All Savers Commercial Dual Enrollment Individual and Family Plan Level Funded Medicaid Medicare Oxford	Professional
Documentation Edit	**uATCCGT**	Member approaching therapy visit max. Treatment plan may be required and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information on this edit, go to UHCprovider.com/smartedits.	Cognitive Therapy Visit Limit Treatment notes may be required for cognitive therapy visits exceeding the plan maximum visit limit. This member is approaching their annual visit limit. Documentation may be uploaded to the provider portal. For more information, please review the Provider Administrative Guide on UHCprovider.com.	10/27/2022	Commercial	Professional
Documentation Edit	**uATCCME**	A child medical evaluation form may be needed for services rendered. It can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information on this edit, go to UHCprovider.com/smartedits.	North Carolina Child Medical Evaluation A Child Medical Evaluation (CME) is a medical evaluation in which the service is provided by a qualified physician, nurse practitioner or physician assistant. The purpose of the CME is to assist with determining the most appropriate medical diagnoses and treatment plan due to concerns for child maltreatment. Providers can submit claims for an office consultation provided during a CME to a patient using CPT code 99499. Providers must submit all required documentation which verifies that components of the service have been met. Please review the Child Medical Evaluation at NC Medicaid Division of Health Benefits - https://medicaid.ncdhhs.gov/providers/forms/child-medical-evaluation?msclkid=37439892aaad11ec9d1d8e91635f3354	4/21/2022	Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Documentation Edit	**uATCCMEf**	A child medical evaluation form may be needed for services rendered. It can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information on this edit, go to UHCprovider.com/smartedits.	NC Child Medical Evaluation A Child Medical Evaluation (CME) is a medical evaluation in which the service is provided by a qualified physician, nurse practitioner or physician assistant. The purpose of the CME is to assist with determining the most appropriate medical diagnoses and treatment plan due to concerns for child maltreatment. Providers can submit claims for an office consultation provided during a CME to a patient using CPT code 99499. Providers must submit all required documentation which verifies that components of the service have been met. Please refer to the Child Medical Evaluation at NC Medicaid Division of Health Benefits - https://medicaid.ncdhhs.gov/providers/forms/child-medical-evaluation?msclkid=37439892aaad11ec9d1d8e91635f3354	4/21/2022	Medicaid	Facility
Documentation Edit	**uATCCTST**	Medical records may be required for E/M code <1> and can be uploaded to the claims Link tool at healthid.optum.com. For more information on this edit, go to UHCprovider.com/smartedits.	E/M Code with COVID Test May Require Medical Records Claims submitted for COVID testing reimbursement that have a Level 3, 4, or 5 Evaluation and Management code without supporting diagnosis codes may require medical records for payment.	7/29/2021	Commercial	Professional
Documentation Edit	**uATCCTSTf**	Medical records may be required for E/M code <1> and can be uploaded to the claims Link tool at healthid.optum.com. For more information on this edit, go to UHCprovider.com/smartedits.	E/M Code with COVID Test May Require Medical Records Claims submitted for COVID testing reimbursement that have a Level 3 Evaluation and Management code without supporting diagnosis codes may require medical records for payment. Please refer to Emergency Department Facility Evaluation and Management Codin Policy on UHCprovider.com.	7/22/2021	Commercial	Facility
Documentation Edit	**uATCDIFBf**	Medical Records may be required and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information on this edit, go to UHCprovider.com/smartedits.	Diabetes Injury The diagnoses codes submitted are used to describe a condition that requires manual review. Submit sufficient documentation to support the reported ICD-10-CM diagnoses. Medical records can be updated to the Provider Portal at https://secure.UHCprovider.com. Please refer to the ICD-10-CM Guidelines; UnitedHealthcare Care Provider Administrative guide at UHCprovider.com.	7/27/2023	Commercial	Facility
Documentation Edit	**uATCDME1K**	Medical Records may be required for DME procedure code < 1 > and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information, go to UHCprovider.com/smartedits.	DME charges $1,000 or Greater Per the description of billed procedure code and the dollar amount billed, additional documentation may be required. For example, make and model, trade name, medical history and physical, doctor's order of DME, description of services and supplies etc. Medical records can be uploaded to the UHC Provider Portal at secure.UHCprovider.com.	3/30/2023	Commercial	Professional
Documentation Edit	**uATCDMER**	Medical Records may be required for procedure code <1> and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information, go to UHCprovider.com/smartedits.	DME Procedure Codes Requiring Additional Information Per the description of billed procedure code, additional documentation may be required. Medical records can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. Please review Durable Medical Equipment, Orthotics, Medical Supplies and Repairs Coverage Determination Guide at UHCprovider.com.	1/26/2023	Commercial	Professional
Documentation Edit	**uATCDMERf**	Medical Records may be required for procedure code <1> and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information, go to UHCprovider.com/smartedits.	DME Procedure Codes Requiring Additional Information Per the description of billed procedure code, additional documentation may be required. Medical records can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. Please refer to Durable Medical Equipment, Orthotics, Medical Supplies and Repairs Coverage Determination Guide at UHCprovider.com..	1/26/2023	Commercial	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Documentation Edit	**uATCDSCf**	Medical Records may be required and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information on this edit, go to UHCprovider.com/smartedits.	Diabetes Skin Complications Medical Records may be required and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information on this edit, go to UHCprovider.com/smartedits.	7/27/2023	Commercial	Facility
Documentation Edit	**uATCEN**	Medical Records may be required for procedure code <1> and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information, go to UHCprovider.com/smartedits.	Enteral Nutrition Benefits for prescription or over-the-counter enteral nutrition formula may be available when a Physician issues a prescription or written order stating the formula or product is medically necessary for the therapeutic treatment of a condition requiring specialized nutrients and specifying the quantity and the duration of the prescription or order. Per the description of enteral nutrition procedure code, additional documentation may be required to determine coverage. Medical records can be uploaded to the UHC Provider Portal at secure.UHCprovider.com.	12/15/2022	Commercial	Professional
Documentation Edit	**uATCHEP**	Medical records may be required and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information on this edit, go to UHCprovider.com/smartedits.	Hepatitis Screening Documentation Medical records may be required and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information on this edit, go to UHCprovider.com/smartedits.	2/23/2023	Commercial	Professional
Documentation Edit	**uATCmD1**	Medical Records may be required for procedure code <1> with modifier <2> and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information, go to UHCprovider.com/smartedits.	Assistant at Surgery Attachments The uATCmD1 edit utilizes the Centers for Medicare and Medicaid Services' (CMS) Medicare Physician's Fee Schedule (MPFS) 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 '0' in the assistant surgeon column of the MPFS that are submitted with modifier 80, 81, 82, or AS appended. Please review the Medicare Co-Surgeon/ Team Surgeon Reimbursement Policy on UHCprovider.com.	9/30/2021	Medicare	Professional
Documentation Edit	**uATCmD2**	Medical Records may be required for procedure code <1> with modifier <2> and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information, go to UHCprovider.com/smartedits.	Co-Surgeon Procedure Attachments The uATCmD2 edit utilizes the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine eligibility of a CPT® code for the co-surgeon modifier 62. This edit will fire on all claim lines containing codes that have an indicator of "1" in the co-surgeon column of the NPFS that are submitted with modifier 62 appended. Please review the Medicare Co-Surgeon/ Team Surgeon Reimbursement Policy on UHCprovider.com.	9/30/2021	Medicare	Professional
Documentation Edit	**uATCMR**	Medical records may be required and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information on this edit, go to UHCprovider.com/smartedits.	Medical Record Requests This claim describes a service or procedure that requires manual review. Medical records can be uploaded to the UHC Provider Portal. For more information, please review the Provider Administrative Guide on UHCprovider.com.	7/28/2022	Commercial	Professional
Documentation Edit	**uATCmTF**	Valid proof of timely filing may be required and can be uploaded to the UHC Provider Portal at provider.linkhealth.com. For more information on this edit, go to UHCprovider.com/smartedits.	Proof of Timely Filing Required Valid proof of timely filing may be required and can be uploaded to the Provider Portal at https://secure.UHCprovider.com. Please review the link below- https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2010-Transmittals-Items/CMS1237936 MM7080 contains the information about timely filing.	8/26/2021	Medicare	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Documentation Edit	**uATCmTFf**	Valid proof of timely filing may be required and can be uploaded to the UHC Provider Portal at provider.linkhealth.com. For more information on this edit, go to UHCprovider.com/smartedits.	Proof of Timely Filing Required Valid proof of timely filing may be required and can be uploaded to the Provider Portal at https://secure.UHCprovider.com. Please refer to the link below- https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2010-Transmittals-Items/CMS1237936 MM7080 contains the information about timely filing.	8/26/2021	Medicare	Facility
Documentation Edit	**uATCNCHC**	A hysterectomy consent form may be needed for services rendered and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information on this edit, go to UHCprovider.com/smartedits.	North Carolina Hysterectomy Consent Form Required Providers should ensure that a valid hysterectomy consent form has been completed prior to rendering a hysterectomy procedure. The sterilization consent form is a federally mandated document. The consent form can be uploaded to the UnitedHealthcare Provider Portal at https://secure.UHCprovider.com. Please review Family Planning Services (for North Carolina Only) on UHCprovider.com.	11/17/2022	Medicaid	Professional
Documentation Edit	**uATCNCHCf**	A hysterectomy consent form may be needed for services rendered and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information on this edit, go to UHCprovider.com/smartedits.	North Carolina Hysterectomy Consent Form Required Providers should ensure that a valid hysterectomy consent form has been completed prior to rendering a hysterectomy procedure. The sterilization consent form is a federally mandated document. The consent form can be uploaded to the UnitedHealthcare Provider Portal at https://secure.UHCprovider.com. Please review Family Planning Services (for North Carolina Only) on UHCprovider.com.	11/17/2022	Medicaid	Facility
Documentation Edit	**uATCNCSC**	A sterilization consent form may be needed for services rendered and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information on this edit, go to UHCprovider.com/smartedits.	NC Sterilization Consent Form Providers should ensure that a valid sterilization consent form has been completed prior to rendering a sterilization procedure. The sterilization consent form is a federally mandated document. The consent form can be uploaded to the UnitedHealthcare Provider Portal at https://secure.UHCprovider.com. Please review UnitedHealthcare Community Plan Coverage Determination Guideline for Family Planning Services (for North Carolina Only).	3/31/2022	Medicaid	Professional
Documentation Edit	**uATCNCSCf**	A sterilization consent form may be needed for services rendered and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information on this edit, go to UHCprovider.com/smartedits.	NC Sterilization Consent Form Providers should ensure that a valid sterilization consent form has been completed prior to rendering a sterilization procedure. The sterilization consent form is a federally mandated document. The consent form can be uploaded to the UnitedHealthcare Provider Portal at https://secure.UHCprovider.com. Please refer to UnitedHealthcare Community Plan Coverage Determination Guideline for Family Planning Services (for North Carolina Only).	3/31/2022	Medicaid	Facility
Documentation Edit	**uATCNEER**	Non-emergent primary diagnosis code <1> may require Emergency Room medical records which can be uploaded to the UHC Provider Portal at secure.UHCprovider.com.	Non-Emergent DX This CPT code is billed with a non-emergent primary diagnosis code and may need Emergency Room medical records for manual review. Emergency Room records can be uploaded to the UnitedHealthcare Provider Portal athttps://secure.UHCprovider.com	8/31/2023	Commercial	Professional
Documentation Edit	**uATCNEERf**	Non-emergent primary diagnosis code <1> may require Emergency Room medical records which can be uploaded to the UHC Provider Portal at secure.UHCprovider.com.	Non-Emergent DX This CPT code is billed with a non-emergent primary diagnosis code and may need Emergency Room medical records for manual review. Emergency Room records can be uploaded to the UnitedHealthcare Provider Portal athttps://secure.UHCprovider.com	8/31/2023	Commercial	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Documentation Edit	**uATCPCD**	Medical Records may be required for procedure code <1> and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information, go to UHCprovider.com/smartedits.	Pneumatic Compression Device Pneumatic compression devices are proven and medically necessary in certain circumstances for the treatment of lymphedema or chronic venous insufficiency with edema and non-healing lower extremity ulcers. Medical records may be required. Please review Pneumatic Compression Devices Policy https://www.UHCprovider.com/content/dam/provider/docs/public/policies/comm-medical-drug/pneumatic-compression-devices.pdf	2/23/2023	Commercial	Professional
Documentation Edit	**uATCPT**	Member approaching PT visit max. Treatment plan may be required and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information on this edit, go to UHCprovider.com/smartedits.	Physical Therapy Visit Limit Treatment notes may be required for physical therapy visits exceeding the plan maximum visit limit. This member is approaching their annual visit limit. Documentation may be uploaded to the provider portal. Please review the Provider Administrative Guide on UHCprovider.com.	10/27/2022	Commercial	Professional
Documentation Edit	**uATCSHC**	An ASH consent form is required on procedure code <1> and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information on this edit, go to UHCprovider.com/smartedits.	ASH Form Requirement Abortions, Sterilization, and Hysterectomy (ASH) procedures require an ASH form to be submitted with the claim in order to be paid. The form can be found at secure.UHCprovider.com. https://www.uhcprovider.com/en/resource-library/news/2023/tn-medicaid-ash-claim-billing-requirements.html	5/25/2023	Medicaid	Professional
Documentation Edit	**uATCST**	Member approaching therapy visit max. Treatment plan may be required and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information on this edit, go to UHCprovider.com/smartedits.	Speech Therapy Visit Limit Treatment notes may be required for speech therapy visits exceeding the plan maximum visit limit. This member is approaching their annual visit limit. Documentation may be uploaded to the provider portal. For more information, please review the Provider Administrative Guide on UHCprovider.com.	10/27/2022	Commercial	Professional
Documentation Edit	**uATCUCD**	Unlisted code <1> may require medical records which can be uploaded to the UnitedHealthcare Provider Portal at secure.uhcprovider.com. For more information, go to uhcprovider.com/smartedits.	Unlisted Code Attachment The procedure code submitted is an unlisted procedure that requires manual review, but documentation was not received. Medical records can be uploaded to the UnitedHealthcare Provider Portal using TrackIt. Please refer to the Administrative Guide on www.uhcprovider.com.	11/30/2023	Commercial	Professional
Documentation Edit	**uATCUD**	Procedure J3490 may require an invoice to be submitted. This can be uploaded to the UHC Provider Portal at https://secure.UHCprovider.com. For more information on this edit, go to UHCprovider.com/smartedits.	Claims Billed with an Invoice for an Unclassified Drug Code Claims submitted with procedure code J3490 for unlisted drugs may require an invoice for payment. This can be uploaded to the UHC Provider Portal at https://secure.UHCprovider.com.	6/30/2022	Medicare	Professional
Documentation Edit	**uATCTRD**	A referral for this therapy service may be required and can be uploaded to the UHC Provider Portal at secure.uhcprovider.com. For more information on this edit, go to uhcprovider.com/smartedits.	Therapy Referral Documentation A referral is required for Physical Therapy, Occupational Therapy and Speech Therapy. The referral can be submitted through the Provider Portal. https://www.uhcprovider.com/content/dam/provider/docs/public/health-plans/mid-atlantic/MIDATL-Referral-Protocol.pdf	2/29/2024	Commercial Level Funded Oxford	Professional
Documentation Edit	**uATCTRDf**	A referral for this therapy service may be required and can be uploaded to the UHC Provider Portal at secure.uhcprovider.com. For more information on this edit, go to uhcprovider.com/smartedits.	Therapy Referral Documentation A referral is required for Physical Therapy, Occupational Therapy and Speech Therapy. The referral can be submitted through the Provider Portal. https://www.uhcprovider.com/content/dam/provider/docs/public/health-plans/mid-atlantic/MIDATL-Referral-Protocol.pdf	2/29/2024	Commercial Level Funded Oxford	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Documentation Edit	**uATCUOT**	Occupational Therapy treatment plan may be required and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information on this edit, go to UHCprovider.com/smartedits.	Unlimited Occupational Therapy Notes Treatment notes may be required for occupational therapy visits exceeding 30 visits. This member is approaching 30 annual visits for occupational therapy. Documentation may be uploaded to the provider portal. Please review the Provider Administrative Guide on UHCprovider.com.	6/29/2023	Commercial	Professional
Documentation Edit	**uATCUPN**	Medical records may be needed to support unlisted code <1>. Records can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information, go to UHCprovider.com/smartedits.	Unlisted Procedure Nervous System An unlisted code may be submitted for a procedure or service that does not have a valid, more descriptive CPT or HCPCS code assigned. Documentation is required for all unlisted codes submitted for reimbursement. Documentation is to include but is not limited to:• A clear description of the nature, extent, and need for the procedure or service • Whether the procedure was performed independent from other services provided, or if it was performed at the same surgical site or through the same surgical opening • Any extenuating circumstances which may have complicated the service or procedure • Time, effort, and equipment necessary to provide the service • The number of times the service was provided When submitting supporting documentation, designate the portion of the report that identifies the test or procedure associated with the unlisted procedure code. Required information must be legible and clearly market. Please review the UnitedHealthcare Administrative Guide on www.UHCprovider.com.	3/30/2023	Medicare	Professional
Documentation Edit	**uATCUPNf**	Medical records may be needed to support unlisted code <1>. Records can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information, go to UHCprovider.com/smartedits.	Unlisted Procedure Nervous System An unlisted code may be submitted for a procedure or service that does not have a valid, more descriptive CPT or HCPCS code assigned. Documentation is required for all unlisted codes submitted for reimbursement. Documentation is to include but is not limited to:• A clear description of the nature, extent, and need for the procedure or service • Whether the procedure was performed independent from other services provided, or if it was performed at the same surgical site or through the same surgical opening • Any extenuating circumstances which may have complicated the service or procedure • Time, effort, and equipment necessary to provide the service • The number of times the service was provided When submitting supporting documentation, designate the portion of the report that identifies the test or procedure associated with the unlisted procedure code. Required information must be legible and clearly market. Please review the UnitedHealthcare Administrative Guide on www.UHCprovider.com.	3/30/2023	Medicare	Facility
Documentation Edit	**uATCUPT**	Physical Therapy treatment plan may be required and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information on this edit, go to UHCprovider.com/smartedits.	Unlimited Physical Therapy Notes Treatment notes may be required for physical therapy visits exceeding 30 visits. This member is approaching 30 annual visits for physical therapy. Documentation may be uploaded to the provider portal. Please review the Provider Administrative Guide on UHCprovider.com.	6/29/2023	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 UHCProvider.com/MPP. For My Practice Profile help, please call 866-842-3278, option 1, 7 am – 9 pm CST M-F.	Provider Attestation Due Provider informational message to renew CMS attestation through the My Practice Profile application on UHCProvider.com/MPP.	6/6/2019	Medicaid Commercial Medicare	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**uAWRHO**	REJECT - Oxford Health Plans no longer provides administrative services (claims and appeals processing, etc.) for this plan. Please contact the member for additional information.	Avenue World Holding Oxford Health Plans no longer provides administrative services (claims and appeals processing, etc.) for this plan. Please contact the member for additional information.	8/31/2023	Oxford	Professional
Rejection Edit	**uAWRHOf**	REJECT - Oxford Health Plans no longer provides administrative services (claims and appeals processing, etc.) for this plan. Please contact the member for additional information.	Avenue World Holding Oxford Health Plans no longer provides administrative services (claims and appeals processing, etc.) for this plan. Please contact the member for additional information.	8/31/2023	Oxford	Facility
Informational Edit	**uBACf**	INFORMATIONAL - R78.81 should not be reported as principal diagnosis if a definitive diagnosis has been documented.	Bacteremia Diagnosis Bacteremia cannot be reported as principal diagnosis when a definitive diagnosis has been documented. Bacteremia should not be reported in the principal position when the documentation states it was a “contaminant”. Medical records may be submitted for review to determine the proper principal diagnosis or resequencing or removing the diagnosis of bacteremia. Please refer to ICD-10 guidelines.	4/28/2022	Commercial Medicare Oxford Level Funded Individual & Family Plan	Facility
Return Edit	**uBACI**	CLM 08 assignment of benefits indicator submitted with N indicating payment should be made to the member. Update to Y if payment should be made to the provider.	Benefits Assignment Certification Indicator CLM08 is assignment of benefits indicator. A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N' value indicates benefits have not been assigned to the provider. Please verify that "N" was submitted correctly for this claim. For more information, please review the Provider Administrative Guide on UHCprovider.com.	10/27/2022	Oxford Level-Funded	Professional
Informational Edit	**uBACICH**	INFORMATIONAL - The assignment of benefits indicator was submitted with an N, indicating payment be made to the member. Please verify the amount paid for procedure <1> is entered on the claim.	Benefits Assignment Certification Indicator Chiropractic Non-assigned is the method of reimbursement a physician/supplier has when choosing to not accept assignment of benefits. Under this method, a non-participating provider is the only provider that can file a claim as non-assigned. When the provider does not accept assignment, the payment will be made directly to the beneficiary.	3/30/2023	Medicare	Professional
Return Edit	**uBACIf**	CLM 08 assignment of benefits indicator submitted with N indicating payment should be made to the member. Update to Y if payment should be made to the provider.	Benefit Assignment Indicator CLM08 is assignment of benefits indicator. A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N' value indicates benefits have not been assigned to the provider. Please verify that "N" was submitted correctly for this claim. For more information, please refer to the Provider Administrative Guide on UHCprovider.com.	10/27/2022	Oxford Level-Funded	Facility
Rejection Edit	**uBAM**	REJECT – FDA EU authorization for Bamlanivimab has been revoked when administered alone effective 4/16/21. This claim has been rejected and will not be processed.	Bamlanivimab Antibody Therapy EUA Revoked Based on its ongoing analysis of emerging scientific data, specifically the sustained increase of SARS-CoV-2 viral variants that are resistant to bamlanivimab alone resulting in the increased risk for treatment failure, the FDA has determined that the known and potential benefits of bamlanivimab, when administered alone, no longer outweigh the known and potential risks for its authorized use. Therefore, the agency determined that the criteria for issuance of an authorization are no longer met and has revoked the EUA. United Healthcare is following these guidelines and will not reimburse code M0239 when billed as the only monoclonal antibody therapy on the claim. Please review Coronavirus (COVID-19) Update: FDA Revokes Emergency Use Authorization for Monoclonal Antibody Bamlanivimab on www.fda.gov.	5/27/2021	Medicaid Commercial Oxford	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**uBAMf**	REJECT – FDA EU authorization for Bamlanivimab has been revoked when administered alone effective 4/16/21. This claim has been rejected and will not be processed.	Bamlamivimab EUA Revoked Based on its ongoing analysis of emerging scientific data, specifically the sustained increase of SARS-CoV-2 viral variants that are resistant to bamlanivimab alone resulting in the increased risk for treatment failure, the FDA has determined that the known and potential benefits of bamlanivimab, when administered alone, no longer outweigh the known and potential risks for its authorized use. Therefore, the agency determined that the criteria for issuance of an authorization are no longer met and has revoked the EUA. United Healthcare is following these guidelines and will not reimburse code M0239 when billed as the only monoclonal antibody therapy on the claim. Please refer to Coronavirus (COVID-19) Update: FDA Revokes Emergency Use Authorization for Monoclonal Antibody Bamlanivimab on www.fda.gov.	5/27/2021	Medicaid Commercial Oxford	Facility
Rejection Edit	**uBICCL**	REJECT-CLIA ID <1> does not meet the certification level for procedure code <1>. Please update as applicable.	Invalid CLIA Cert Level (Billing Provider) The lab certification level must 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. Please review our Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com.	4/29/2021 6/30/2022 1/25/2024	Commercial Medicaid Oxford Level Funded All Savers UHOne	Professional
Informational Edit	**uBMDTR**	INFORMATIONAL - A BMD test is recommended for this patient. Bone mineral density studies are covered when Medicare coverage criteria are met. Reference Bone Mineral Density Studies NCD 150.3.	Bone Mineral Density Test Reminder Women at risk for osteoporosis should be prescribed a bone density screening every two years. Please review Bone Density Studies/Bone Mass Measurements – Medicare Advantage Coverage Summary and Bone (Mineral) Density Studies (NCD 150.3) – Medicare Advantage Policy Guideline on UHCprovider.com.	3/31/2022	Medicare	Professional
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.	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 review Medicare National Correct Coding Initiative (NCCI) Edits on cms.gov.	1/30/2020	Medicare	Professional
Return Edit	**uBPPB**	Procedure code 88305 is not appropriate when billed with procedure code <1> for prostate needle biopsy specimen assessment. Please update codes as applicable.	Incorrect Billing of 88305 In alignment with CMS, UnitedHealthcare requires surgical pathology for prostate needle biopsy specimens (including gross and microscopic examination) to be reported with HCPCS code G0416, rather than 88305. Code G0416 represents 1 unit of service regardless of the number of specimens examined. Code 88305 will not be reimbursed for prostate needle biopsy surgical pathology. Please review the Laboratory Services Policy at UHCprovider.com.	3/25/2021 7/25/2024	Commercial Individual & Family Plan	Professional
Informational Edit	**uBRPPB**	INFORMATIONAL - The purchase of a personal-use electric breast pump (E0603) is limited to one pump per birth. This member has received this service within the previous 9 months.	One Breast Pump Per Birth Per the Preventive Care Services Coverage Determination Guidelines, the purchase of a personal-use electric breast pump (HCPCS code E0603) is limited to one pump per birth. In the case of a birth resulting in multiple infants, only one breast pump is covered.	3/30/2023	All Savers Commercial Level Funded Oxford	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**uCARDf**	INFORMATIONAL - Please ensure documentation supports the use of principal diagnosis code <1>.	Cardiac and Shock Providers should report the appropriate ICD-10 diagnosis code that describes the patient's condition and should consult with ICD 10 code book. DRG Levels Medicare Severity Diagnosis Related Group (MS-DRG) codes are often divided into three levels of severity for each primary DRG. For additional information please refer to ICD-10 guidelines	2/27/2020 4/30/2020 Changed from Return Edit to Informational Edit 7/9/2020	Commercial Medicare	Facility
Return Edit	**uCBDS**	Per NCD 150.3, diagnosis <1> is not listed for procedure code <2>. Update codes(s) as applicable for services rendered.	Custom Bone Mineral Density Study This edit is based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available atwww.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD. 835 READS: These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: review the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Please review National Coverage Determination (NCD) for Bone (Mineral) Density Studies (150.3) found on cms.gov.	5/28/2020	Medicare	Professional
Return Edit	**uCBSL4**	Per NCD guidelines, CMS ID 40.2 procedure code <1> requires a valid modifier. Update code(s) as applicable for services rendered.	Custom Blood Strips Diabetic supply requires an appropriate modifier for submitted procedure code. When both modifiers KS and KX are submitted, the combination of both modifiers for the procedure is not appropriate billing. Please review Home Blood Glucose Monitors (NCD 40.2) policy found on UHCprovider.com.	5/28/2020	Medicare	Professional
Return Edit	**uCCIDN**	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.	Facility CCI No Modifier Allowed - Different Claim The edit identifies whether CPT and/or HCPCS codes reported together by the outpatient hospital 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. Please refer to Outpatient Hospital CCI Editing Policy, Facility on UHCprovider.com	3/30/2023	Commercial	Facility
Return Edit	**UCCIMD**	Procedure <1> is included with procedure <2>. Under appropriate circumstances, a designated modifier may be required to identify distinct services. Update code(s) as applicable.	Facility CCI Modifier 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 the Outpatient Hospital CCI Editing policy. When modifiers 59, XE, XP, XS, or XU are appended to either the column one or column two code for a procedure or service rendered to the same patient, on the same date of service, 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 “0” and “1”. Please refer to the Outpatient Hospital CCI Editing Policy, Facility Reimbursement Policy – UnitedHealthcare Commercial Plan on UHCprovider.com.	7/28/2022	Commercial	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uCCIPS**	Provider state <1> submitted on the claim does not match the state registered with CLIA <2>. Please update claim as applicable.	CLIA Invalid Provider State CLIA Certificate Identification number and their associated state 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. Please review the Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com for further information.	12/15/2022 3/28/2024	All Savers Commercial Level Funded Oxford UHOne	Professional
Return Edit	**uCCIPZ**	Provider ZIP Code <1> submitted on the claim does not match ZIP code registered with CLIA <2>. Please update claim as applicable.	CLIA Invalid Provider Zip CLIA Certificate Identification number and their associated zip 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. Please review the Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com for further information.	12/15/2022 3/28/2024	All Savers Commercial Level Funded Oxford UHOne	Professional
Rejection Edit	**uCCTERM**	REJECT - CLIA ID <1> submitted on the claim is not valid for date of service <2> based on QIES database. This claim has been rejected and will not be processed.	CLIA Termed 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 CMS1500) or its electronic equivalent. Any claim that contains an invalid or expired ID or does not contain the CLIA ID and/or the complete servicing provider demographic information will be considered incomplete and rejected or denied. Submitting the correct loop, segment, and associate line level qualifier on the claim is important to ensure the CLIA certification identification number is submitted appropriately. Please review the Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com for further information.	9/28/2023 3/27/2025	All Savers Commercial Level Funded Oxford Surest	Professional
Return Edit	**UCCTO2**	Diagnosis <1> is not listed for procedure code <2>. Update code(s) as applicable for services rendered.	Custom Corneal Topography CR v2 According to Medicare billing and coding guidelines, Corneal topography is a covered service when medically reasonable and necessary only if the results will assist in defining further treatment. Please review the Corneal Topography policy on UHCprovider.com.	2/27/2020	Medicare	Professional
Rejection Edit	**uCCVAXP**	REJECT – COVID-19 vaccine product code <1> submitted without an appropriate admin code. Please update claim as applicable. This claim has been rejected and will not be processed.	COVID Vaccine Product Code Without Admin This United Healthcare Community and State plan requires that if a COVID-19 vaccine product code is submitted, its corresponding administration code must also be submitted.	1/7/2021	Medicaid	Professional
Rejection Edit	**uCCVAXPf**	REJECT – COVID-19 vaccine product code <1> submitted without an appropriate admin code. Please update claim as applicable. This claim has been rejected and will not be processed.	Medicaid COVID-19 Vaccine Product Code This United Healthcare Community and State plan requires that if a COVID-19 vaccine product code is submitted, its corresponding administration code must also be submitted.	1/7/2021	Medicaid	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uCDME**	Procedure code <1> is not covered by Medicare.	Custom DME Non-Covered Charges Per CMS guidelines, some durable medical equipment is not covered for payment. Please review 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
Informational Edit	**uCGMPA**	INFORMATIONAL - Procedure code <1> prior authorization. Please ensure the advance notification has been submitted to support services billed.	Prior Authorization for Continuous Glucose Monitors Beginning September 1, 2024, UnitedHealthcare Medicare Advantage Plans including Medicare and Medicaid Dual Special Needs Plans (D-SNPs) will require prior authorization for personal long-term continuous glucose monitors (CGMs) for members with any diagnosis other than Type 1 diabetes. When the durable medical equipment (DME) vendor receives a physician order for a CGM, the DME provider must obtain prior authorization for both the device and the supplies. The prior authorization will be effective for a consecutive 12-month period. Please review the CMS Continuous Glucose Monitors Policy, plan requirements Advance Notification guidelines, and the July 1, 2024, Network News article on www.UHCprovider.com.	9/19/2024	Medicare	Professional
Informational Edit	**uCGMPAD**	INFORMATIONAL - Procedure code <1> prior authorization. Please ensure the advance notification has been submitted to support services billed.	Prior Authorization for Continuous Glucose Monitors Beginning September 1, 2024, UnitedHealthcare Medicare Advantage Plans including Medicare and Medicaid Dual Special Needs Plans (D-SNPs) will require prior authorization for personal long-term continuous glucose monitors (CGMs) for members with any diagnosis other than Type 1 diabetes. When the durable medical equipment (DME) vendor receives a physician order for a CGM, the DME provider must obtain prior authorization for both the device and the supplies. The prior authorization will be effective for a consecutive 12-month period. Please review the CMS Continuous Glucose Monitors Policy, plan requirements Advance Notification guidelines, and the July 1, 2024, Network News article on www.UHCprovider.com.	9/19/2024	Dual Enrollment	Professional
Informational Edit	**uCHD**	INFORMATIONAL: Congenital Heart Diagnosis code <1> was reported for the pregnant mother on this claim. Please confirm this code is related to the condition of the mother.	Congenital Heart Disease Please review the diagnosis codes billed on this claim. The echocardiography findings billed (Codes Q20-Q28) were for the fetus and not the mother. Please review the ICD-10-CM code book for more information.	7/30/2020	Medicaid Commercial	Professional
Informational Edit	**uCHHI**	INFORMATIONAL - Effective 7/1/24, professional home health claims for dates of service submitted while a member is inpatient will not be reimbursed.	Home Health Intake Home health services must be provided in the home. Services should not be billed while the patient is in an inpatient facility. Please review the Home Health Services Professional policy on UHCprovider.com.	6/13/2024	Commercial	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**uCHMOD**	INFORMATIONAL – Procedure code <1> may be missing the modifier to indicate acute treatment.	Chiropractic Services Missing Modifier Medicare coverage of chiropractic service is specifically limited to treatment by means of manual manipulation of the spine to correct a subluxation (that is, by use of the hands). For Medicare purposes, a chiropractor must place an AT modifier on a claim when providing active/corrective treatment to treat acute or chronic subluxation. Modifier AT must only be used when the chiropractic manipulation is "reasonable and necessary" as defined by national policy and the LCDs. Modifier AT must not be used when maintenance therapy has been performed. Please review the Chiropractic Services policy onwww.UHCprovider.com.	5/25/2023	Dual Enrollment Medicare	Professional
Return Edit	**uCINAf**	NDC <1> should be reported with number of tablets or pills and not the number of units. Please update the claim as applicable	ESRD Facilities: Bill Correctly for Cinacalcet Oral Drug Beginning January 1, 2021, the Cinacalcet oral drug is eligible for consideration as an ESRD outlier service: The ESRD facility should report any drug or biological furnished on the ESRD claim with the line-item date of service and the quantity of the drug or biological furnished at the time of the visit. When submitting the drug, it should be reported with the number of tablets or pills, not the number of units (for example, milligrams). For additional information, please review these at cms.gov: 2021-09-23-MLNC MLN Matters Article MM12011 Medicare Benefit Policy Manual, Chapter 11, Section 20.3.C MLN Matters Article MM12011 Related CR 12011 ESRD Outliers ESRD PPS Outlier Services Acute Kidney Injury and ESRD Facilities	10/27/2022 5/25/2023	Dual Enrollment Medicare	Facility
Return Edit	**uCIPDf**	Per CMS guidelines, Other Diagnosis <1> should not be sent as principal diagnosis when U071 is present on admission. Please update claim as applicable.	Inpatient COVID-19 Principal Diagnosis Per ICD-10-CM Official Guidelines, beginning on page 28, when COVID-19 meets the definition of principal diagnosis, diagnosis code U07.1, should be sequenced first, followed by the appropriate codes for associated manifestations, except when another guideline requires that certain codes be sequenced first, such as obstetrics, sepsis, or transplant complications. Please refer to our COVID-19 billing guide on UHCprovider.com Please refer to ICD-10-CM Guidelines for Coding and Reporting on www.cdc.gov	12/16/2021	Medicare	Facility
Return Edit	**uCMGT4**	Procedure code <1> is not covered by Medicare.	Custom Molelcular Pathology Molecular Diagnostics Genetic Testing The CMGT4 Edit will apply when submitted CPT code does not follow Medicare Guidelines for Molecular Pathology Molecular Diagnostics Genetic Testing. Please review the policy for acceptable CPT codes. Please review the Molecular Pathology/ Molecular Diagnostics/ Genetic Testing Policy on UHCprovider.com	8/27/2020	Medicare	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uCMGT7**	Procedure code <1> for Molecular Diagnostic Infectious Disease Testing is not appropriate with the primary diagnosis code <2>. Update codes as applicable for services rendered.	Molecular Diagnostics Genetic Testing Per CMS Guidelines for Molecular Pathology/Molecular Diagnostics/Genetic Testing, there are certain diagnosis codes that are never covered when given as the primary reason for a test when submitted with CPT codes: 87480, 87510, 87660 and 87661. Please review the Molecular Pathology/Molecular Diagnostics/Genetic Testing policy for approved ICD-10 diagnosis codes.	3/25/2021	Medicare	Professional
Informational Edit	**uCMM**	INFORMATIONAL - Beginning 04/01/23, Procedure <1> must be submittedwith appropriate prior authorization for implantable hemodynamic monitor.	CardioMEMS Management Effective April 1, 2023, we will require prior authorization for CardioMEM HF System (CPT codes 33289 and C2624). Please review C&S Prior Authorization Grid for Providers www.UHCprovider.com/en/resource-library/news/2023/cardiomems-system-coverage-update.html	3/16/2023	Medicaid	Professional
Informational Edit	**uCMME**	INFORMATIONAL - Procedure code <1> requires prior authorization. Please ensure the authorization request has been submitted to support services billed.	CardioMEMS Management Prior authorization for CardioMEMS™ HF System (CPT® codes 33289 and C2624) is required. The CardioMEMS HF System is unproven and not medically necessary due to insufficient evidence of safety and/or efficacy. Please review Omnibus Codes – Community Plan Medical Policy and UHCprovider.com.	9/28/2023	Commercial	Professional
Informational Edit	**uCMMEf**	INFORMATIONAL - Procedure code <1> requires prior authorization. Please ensure the authorization request has been submitted to support services billed.	CardioMEMS Management Prior authorization for CardioMEMS™ HF System (CPT® codes 33289 and C2624) is required. The CardioMEMS HF System is unproven and not medically necessary due to insufficient evidence of safety and/or efficacy. Please refer to Omnibus Codes – Community Plan Medical Policy and UHCprovider.com.	9/28/2023	Commercial	Facility
Informational Edit	**uCMMf**	INFORMATIONAL - Beginning 04/01/23, Procedure <1> must be submittedwith appropriate prior authorization for implantable hemodynamic monitor.	CardioMEMS Management Effective April 1, 2023, we will require prior authorization for CardioMEM HF System (CPT codes 33289 and C2624). Please refer to C&S Prior Authorization Grid for Providers www.UHCprovider.com/en/resource-library/news/2023/cardiomems-system-coverage-update.html	3/16/2023	Medicaid	Facility
Informational Edit	**uCMZCODE**	INFORMATIONAL - CPT <1> is recommended to be submitted with a DEX Z-Code. Please visit dexzcodes.com for more information.	Missing Z Code UnitedHealthcare recommends that providers submit the appropriate DEX Z-Code for this molecular diagnostic test. The assigned Z-Code can be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com).	5/25/2023	Commercial Level Funded Oxford	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**uCMZCODEf**	INFORMATIONAL - CPT <1> is recommended to be submitted with a DEX Z-Code. Please visit dexzcodes.com for more information.	Missing Z Code UnitedHealthcare recommends that providers submit the appropriate DEX Z-Code for this molecular diagnostic test. The assigned Z-Code can be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com).	5/25/2023	Commercial Level Funded Oxford	Facility
Return Edit	**uCNB3**	Procedure code <1> is not covered by Medicare.	Nebulizers Certain Nebulizer CPT codes are not covered by Medicare. Please review the Nebulizer Policy found on UHCprovider.com for further information.	10/3/2019	Medicare	Professional
Rejection Edit	**uCOPI**	REJECT - This patient has primary insurance coverage with another carrier. Please resubmit as electronic secondary once adjudicated by the primary payor.	Commercial Other Primary Insurance No OI Name No OI Date This member has a commercial plan and primary health insurance with another carrier. Our records indicate the other insurance carrier is primary. This claim can be resubmitted as electronic secondary once adjudicated by the primary payor. Find specific information about secondary claims submissions, such as coordination of benefits (COB) electronic claim requirements and EDI specifications, on uhcprovider.com/ediclaimtips > Secondary/COB or Tertiary Claims. Please refer to the Administrative Guide at UHCprovider.com.	10/24/2024	Commercial	Professional
Rejection Edit	**uCOPIf**	REJECT - This patient has primary insurance coverage with another carrier. Please resubmit as electronic secondary once adjudicated by the primary payor.	Commercial Other Primary Insurance No OI Name No OI Date This member has a commercial plan and primary health insurance with another carrier. Our records indicate the other insurance carrier is primary. This claim can be resubmitted as electronic secondary once adjudicated by the primary payor. Find specific information about secondary claims submissions, such as coordination of benefits (COB) electronic claim requirements and EDI specifications, on uhcprovider.com/ediclaimtips > Secondary/COB or Tertiary Claims. Please refer to the Administrative Guide at UHCprovider.com.	10/24/2024	Commercial	Facility
Rejection Edit	**uCOPID**	REJECT - This patient has primary insurance coverage with another carrier with effective date <Prisec Effective Date (UDF38) >. Please resubmit as electronic secondary once adjudicated by the primary payor.	Commercial Other Primary Insurance with OI Date This member has a commercial plan and primary health insurance with another carrier. Our records indicate the other insurance carrier is primary. This claim can be resubmitted as electronic secondary once adjudicated by the primary payor. Find specific information about secondary claims submissions, such as coordination of benefits (COB) electronic claim requirements and EDI specifications, on uhcprovider.com/ediclaimtips > Secondary/COB or Tertiary Claims. Please refer to the Administrative Guide at UHCprovider.com.	10/24/2024	Commercial	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**uCOPIDf**	REJECT - This patient has primary insurance coverage with another carrier with effective date <Prisec Effective Date (UDF38) >. Please resubmit as electronic secondary once adjudicated by the primary payor.	Commercial Other Primary Insurance with OI Date This member has a commercial plan and primary health insurance with another carrier. Our records indicate the other insurance carrier is primary. This claim can be resubmitted as electronic secondary once adjudicated by the primary payor. Find specific information about secondary claims submissions, such as coordination of benefits (COB) electronic claim requirements and EDI specifications, on uhcprovider.com/ediclaimtips > Secondary/COB or Tertiary Claims. Please refer to the Administrative Guide at UHCprovider.com.	10/24/2024	Commercial	Facility
Rejection Edit	**uCOPIND**	REJECT - This patient has primary insurance coverage effective <Effective Date (UDF38) >. Please resubmit as electronic secondary once adjudicated by the primary payor.	Commercial Other Primary Insurance with OI Name and OI Date This member has a commercial plan and primary health insurance with another carrier. Our records indicate the other insurance carrier is primary. This claim can be resubmitted as electronic secondary once adjudicated by the primary payor. Find specific information about secondary claims submissions, such as coordination of benefits (COB) electronic claim requirements and EDI specifications, on uhcprovider.com/ediclaimtips > Secondary/COB or Tertiary Claims. Please refer to the Administrative Guide at UHCprovider.com.	10/24/2024	Commercial	Professional
Rejection Edit	**uCOPINDf**	REJECT - This patient has primary insurance coverage effective <Effective Date (UDF38) >. Please resubmit as electronic secondary once adjudicated by the primary payor.	Commercial Other Primary Insurance with OI Name and OI Date This member has a commercial plan and primary health insurance with another carrier. Our records indicate the other insurance carrier is primary. This claim can be resubmitted as electronic secondary once adjudicated by the primary payor. Find specific information about secondary claims submissions, such as coordination of benefits (COB) electronic claim requirements and EDI specifications, on uhcprovider.com/ediclaimtips > Secondary/COB or Tertiary Claims. Please refer to the Administrative Guide at UHCprovider.com.	10/24/2024	Commercial	Facility
Rejection Edit	**uCOVAT2**	REJECT – The maximum frequency for COVID antibody testing was reached for this member and this date of service.	COVID-19 Antibody Test Max Daily Frequency 2 Units Maximum Frequency Per Day (MFD) values apply whether a physician or other qualified health care professional submits one CPT or HCPCS code with multiple units on a single claim line or multiple claim lines with one or more unit(s) on each line. This edit message is returned on procedures that have a maximum daily frequency of 2 for the same date of service, same member, regardless of billing or servicing provider. Please review the Maximum Frequency Per Day Policy on UHCprovider.com	10/29/2020	Medicaid	Professional
Rejection Edit	**uCOVAT2f**	REJECT – The maximum frequency for COVID antibody testing was reached for this member and this date of service.	COVID Antibody Maximum Frequency per Day - 2 allowed Maximum Frequency Per Day (MFD) values apply whether a physician or other qualified health care professional submits one CPT or HCPCS code with multiple units on a single claim line or multiple claim lines with one or more unit(s) on each line. This edit message is returned on procedures that have a maximum daily frequency of 2 for the same date of service, same member, regardless of billing or servicing provider.	10/29/2020	Medicare Medicaid Commercial Oxford	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**uCOVAT3**	REJECT – The maximum frequency for COVID antibody testing was reached for this member and this date of service.	COVID-19 Antibody Text Max Frequency 3 Units Maximum Frequency Per Day (MFD) values apply whether a physician or other qualified health care professional submits one CPT or HCPCS code with multiple units on a single claim line or multiple claim lines with one or more unit(s) on each line. This edit message is returned on procedures that have a maximum daily frequency of 3 for the same date of service, same member, regardless of billing or servicing provider. Please review the Maximum Frequency Per Day Policy on UHCprovider.com	10/29/2020	Medicaid	Professional
Rejection Edit	**uCOVAT3f**	REJECT – The maximum frequency for COVID antibody testing was reached for this member and this date of service.	COVID Antibody Maximum Frequency per Day - 3 allowed Maximum Frequency Per Day (MFD) values apply whether a physician or other qualified health care professional submits one CPT or HCPCS code with multiple units on a single claim line or multiple claim lines with one or more unit(s) on each line. This edit message is returned on procedures that have a maximum daily frequency of 3 for the same date of service, same member, regardless of billing or servicing provider.	10/29/2020	Medicare Medicaid Commercial Oxford	Facility
Rejection Edit	**uCOVDX**	REJECT - ICD-10 U072 is for international reporting only and should not be used to indicate a medical COVID-19 diagnosis. Please correct or remove and resubmit.	COVID DX Not Appropriate ICD-10 code U07.2 has not been implemented for use in the United States. In response to the national emergency that was declared concerning the COVID-19 outbreak, a new diagnosis code, U07.1, COVID-19, has been implemented, effective April 1, 2020. The new code, U07.1, where appropriate, for discharges on or after April 1, 2020. Please review the updated MLN Matters Article for additional Medicare Fee-For-Service information.	11/19/2020	Medicare Medicaid Commercial Oxford	Professional
Rejection Edit	**uCOVDXf**	REJECT - ICD-10 U072 is for international reporting only and should not be used to indicate a medical COVID-19 diagnosis. Please correct or remove and resubmit.	Inappropriate COVID Diagnosis ICD-10 code U07.2 has not been implemented for use in the United States. In response to the national emergency that was declared concerning the COVID-19 outbreak, a new diagnosis code, U07.1, COVID-19, has been implemented, effective April 1, 2020. The new code, U07.1, where appropriate, for discharges on or after April 1, 2020. Please refer to the updated MLN Matters Article for additional Medicare Fee-For-Service information.	11/19/2020	Medicare Medicaid Commercial Oxford	Facility
Return Edit	**uCOVTSTNCf**	COVID-19 testing for this billing scenario is not reimbursable.	COVID Test Not Covered Per COVID-19 Testing, Treatment, Coding, and Reimbursement guidelines, United Healthcare covers medically appropriate COVID-19 testing during the national public health emergency period when ordered by a physician or appropriately licensed healthcare professional for the purposes of the diagnosis or treatment of an individual member. United Healthcare health benefits plans generally do not cover testing for surveillance or public health purposes.	6/10/2021	Commercial	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**uCRADUL**	INFORMATIONAL – Effective 2/1/25 CPT <1> has a maximum number of units of <2> within a 90-day episode of care. For more information, refer to the 11/1/24 Network News Bulletin for the Radiation Therapy Policy.	Radiation Therapy Unit Limits Effective for dates of service on or after February 1, 2025, UnitedHealthcare will implement the new Radiation Therapy-Dosimetry, Simulation/Devices and Management Policy, Professional and Facility. Specific radiation therapy dosimetry, simulation and management services, identified with select CPT ® codes, will have unit limitations during a 90-day episode of care. Units billed in excess of the limits will not be considered for reimbursement. Please review UHC Commercial Plan Reimbursement Policy Update Bulletin November 2024.	1/2/2025	Commercial Individual & Family Plan Level Funded Oxford	Professional
Informational Edit	**uCRADULf**	INFORMATIONAL – Effective 2/1/25 CPT <1> has a maximum number of units of <2> within a 90-day episode of care. For more information, refer to the 11/1/24 Network News Bulletin for the Radiation Therapy Policy.	Radiation Therapy Unit Limits Effective for dates of service on or after February 1, 2025, UnitedHealthcare will implement the new Radiation Therapy-Dosimetry, Simulation/Devices and Management Policy, Professional and Facility. Specific radiation therapy dosimetry, simulation and management services, identified with select CPT ® codes, will have unit limitations during a 90-day episode of care. Units billed in excess of the limits will not be considered for reimbursement. Please review UHC Commercial Plan Reimbursement Policy Update Bulletin November 2024.	1/2/2025	Commercial Individual & Family Plan Level Funded Oxford	Facility
Rejection Edit	**uCSBICCL**	REJECT - CLIA ID <1> does not meet the certification level for procedure code <1>. Claim has been rejected and will not be processed.	CLIA Certification Level The lab certification level must 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. If the code is under waiver a modifier will be required. Please review our Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com.	5/11/2023 5/30/2024	Medicaid Dual Enrollment	Professional
Rejection Edit	**uCSCIPS**	REJECT - Provider state <1> submitted on the claim does not match the state registered with CLIA <2>. Claim has been rejected and will not be processed.	CLIA Invalid Provider State CLIA Certificate Identification number and their associated state 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. Please review the Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com for further information.	12/15/2022 5/30/2024	Individual & Family Plan Medicaid Dual Enrollment	Professional
Rejection Edit	**uCSCIPZ**	REJECT - Provider ZIP Code <1> submitted on the claim does not match the ZIP code registered with CLIA <2>. This claim has been rejected and will not be processed.	CLIA Invalid Provider Zip CLIA Certificate Identification number and their associated zip 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. Please review the Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com for further information.	12/15/2022 5/30/2024	Individual & Family Plan Medicaid Dual Enrollment	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**uCSCTERM**	REJECT - CLIA ID <1> submitted on the claim is not valid for date of service <2> based on QIES database.	CLIA Termed 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 CMS1500) or its electronic equivalent. Any claim that contains an invalid or expired ID or does not contain the CLIA ID and/or the complete servicing provider demographic information will be considered incomplete and rejected or denied. Submitting the correct loop, segment, and associate line level qualifier on the claim is important to ensure the CLIA certification identification number is submitted appropriately. Please review Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com	9/28/2023 5/30/2024	Individual & Family Plan Medicaid Dual Enrollment	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.	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. Please review the Urgent Care Policy-Reimbursement Policy for UnitedHealthcare Commercial Plans for further information.	3/7/2019	Commercial	Professional
Return Edit	**uCSFR**	Procedure code <1> is considered an inpatient, nonphysician service and must be furnished and billed through the hospital. Please refer to the Medicare Claims processing manual chapter 3, section 10.4.	Services Included in Facility Reimbursement Policy CMS follows a Prospective Payment System (PPS) where Medicare payment is based on a predetermined, fixed amount payable to a facility for inpatient or outpatient services. With these payment systems, all costs associated with nonphysician services are deemed included in the payment to the facility and not considered separately reimbursable when reported on a CMS-1500 claim form by a physician or other qualified health care professional. Please review the Services Included In Facility Reimbursement Policy on UHCprovider.com.	8/26/2021	Medicare	Professional
Informational Edit	**uCSHHI**	INFORMATIONAL - Effective 7/1/24, professional home health claims for dates of service submitted while a member is inpatient will not be reimbursed.	Home Health Intake Home health services must be provided in the home. Services should not be billed while the patient is in an inpatient facility. Please review the Home Health Services Professional policy on UHCprovider.com.	6/13/2024	Medicaid	Professional
Rejection Edit	**uCSIBC**	REJECT - Billing CLIA ID submitted on the claim is not valid based on QIES and CDC database, and will not be forwarded for adjudication. Please resubmit claim with a valid CLIA ID.	Invalid Billing CLIA 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 CMS1500) 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. Please review the Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com for further information.	5/11/2023 5/30/2024	Medicaid Dual Enrollment	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uCSIDCDIDMf**	Per the ICD-10-CM Excludes1 guideline, diagnosis codes <1> identify two conditions that cannot be reported together except when they are unrelated. Please update code(s) as applicable.	ICD-10 CM Excludes 1 code pairs 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 review ICD-10 CM Coding Guidelines	6/27/2024	Medicare	Facility
Return Edit	**uCSIDCDIPf**	Per the ICD-10-CM Excludes1 guideline, diagnosis codes <1> identify two conditions that cannot be reported together except when they are unrelated. Please update code(s) as applicable.	ICD-10 CM Excludes 1 code pairs 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 review ICD-10 CM Coding Guidelines	6/27/2024	Medicaid	Facility
Informational Edit	**uCSISACCI**	INFORMATIONAL - Effective 2/1/25, procedure code <1> and <2> are inappropriate for the same date of service for the same shoulder per NCCI or CCI guidelines. See the 11/1/24 Network News Bulletin.	Ipsilateral Shoulder Arthroscopy In accordance with the CMS National Correct Coding Initiative (NCCI) CPT codes 29805-29828 Procedure to Procedure (PTP) edit, code pairs consisting of two codes describing two shoulder arthroscopy procedures performed on the same shoulder will not be considered for separate reimbursement regardless if the code is appended with an NCCI PTP associated modifier. This includes the use of modifier 59. Please review NCCI for Medicaid at CMS.gov.	1/9/2025	Medicaid	Professional
Informational Edit	**uCSISACCIf**	INFORMATIONAL - Effective 2/1/25, procedure code <1> and <2> are inappropriate for the same date of service for the same shoulder per NCCI or CCI guidelines. See the 11/1/24 Network News Bulletin.	Ipsilateral Shoulder Arthroscopy In accordance with the CMS National Correct Coding Initiative (NCCI) CPT codes 29805-29828 Procedure to Procedure (PTP) edit, code pairs consisting of two codes describing two shoulder arthroscopy procedures performed on the same shoulder will not be considered for separate reimbursement regardless if the code is appended with an NCCI PTP associated modifier. This includes the use of modifier 59. Please review NCCI for Medicaid at CMS.gov.	1/9/2025	Medicaid	Facility
Rejection Edit	**uCSISC**	REJECT - Servicing CLIA ID submitted on the claim is not valid based on QIES and CDC database, and will not be forwarded for adjudication. Please resubmit claim with a valid CLIA ID.	Invalid Servicing CLIA 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 CMS1500) 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. Please review the Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com for further information.	5/11/2023 5/30/2024	Medicaid Dual Enrollment	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**uCSMCID**	REJECT - CLIA ID was not submitted on the claim and will not be forwarded for adjudication. Please resubmit claim with a valid CLIA ID.	Missing CLIA 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 CMS1500) 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. Please review the Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com for further information.	5/11/2023 5/30/2024	Medicaid Dual Enrollment	Professional
Informational Edit	**uCSMTSD**	INFORMATIONAL- CPT codes <1> constitute a panel, not distinct services, unless indicated with the appropriate modifier.	Multiple Tests, Same date of service UnitedHealthcare will require providers to submit the appropriate DEX Z-Code for molecular diagnostic test services for the services to be considered for reimbursement. This policy will apply to both facility and professional claims. The assigned Z-Code should be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com). After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. Please review the Molecular Pathology Policy, Community Plan at UHCprovider.com	2/6/2025	Medicaid	Professional
Informational Edit	**uCSMTSDf**	INFORMATIONAL- CPT codes <1> constitute a panel, not distinct services, unless indicated with the appropriate modifier.	Multiple Tests, Same date of service UnitedHealthcare will require providers to submit the appropriate DEX Z-Code for molecular diagnostic test services for the services to be considered for reimbursement. This policy will apply to both facility and professional claims. The assigned Z-Code should be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com). After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. Please review the Molecular Pathology Policy, Community Plan at UHCprovider.com	2/6/2025	Medicaid	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**uCSMZCODE**	INFORMATIONAL - Starting 02/01/25, CPT <1> will require a valid DEX Z-Code in the line level 2400 loop, SV101-7 on electronic claims. Please visit dexzcodes.com for more information.	Medicaid Missing Z-Code UnitedHealthcare recommends that providers submit the appropriate DEX Z-Code for this molecular diagnostic test. The assigned Z-Code can be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. Please refer to DEX Diagnostics Exchange Test Registration for additional information on test registration at dexzcodes.com.	12/5/2024	Medicaid	Professional
Informational Edit	**uCSMZCODEf**	INFORMATIONAL - Starting 02/01/25, CPT <1> will require a valid DEX Z-Code in the line level 2400 loop, SV101-7 on electronic claims. Please visit dexzcodes.com for more information.	Medicaid Missing Z-Code UnitedHealthcare recommends that providers submit the appropriate DEX Z-Code for this molecular diagnostic test. The assigned Z-Code can be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. Please refer to DEX Diagnostics Exchange Test Registration for additional information on test registration at dexzcodes.com.	12/5/2024	Medicaid	Facility
Informational Edit	**uCSRADUL**	INFORMATIONAL – Effective 2/1/25 CPT <1> has a maximum number of units of <2> within a 90-day episode of care. For more information, refer to the 11/1/24 Network News Bulletin for the Radiation Therapy Policy.	Radiation Therapy Unit Limits Effective for dates of service on or after February 1, 2025, UnitedHealthcare will implement the new Radiation Therapy-Dosimetry, Simulation/Devices and Management Policy, Professional and Facility. Specific radiation therapy dosimetry, simulation and management services, identified with select CPT ® codes, will have unit limitations during a 90-day episode of care. Units billed in excess of the limits will not be considered for reimbursement. Please review UHC Community Plan Reimbursement Policy Update Bulletin November 2024.	1/2/2025	Medicaid	Professional
Informational Edit	**uCSRADULf**	INFORMATIONAL – Effective 2/1/25 CPT <1> has a maximum number of units of <2> within a 90-day episode of care. For more information, refer to the 11/1/24 Network News Bulletin for the Radiation Therapy Policy.	Radiation Therapy Unit Limits Effective for dates of service on or after February 1, 2025, UnitedHealthcare will implement the new Radiation Therapy-Dosimetry, Simulation/Devices and Management Policy, Professional and Facility. Specific radiation therapy dosimetry, simulation and management services, identified with select CPT ® codes, will have unit limitations during a 90-day episode of care. Units billed in excess of the limits will not be considered for reimbursement. Please review UHC Community Plan Reimbursement Policy Update Bulletin November 2024.	1/2/2025	Medicaid	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Documentation Edit	**uCSRIDR**	Diagnostic Radiology Interpretation Report may be required and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information, go to UHCprovider.com/smartedits.	Interpretive Radiology UnitedHealthcare considers the interpretation (modifier 26) of a radiology service assigned a PC/TC Indicator 1 to be included in the Evaluation and Management (E/M) service when performed by the Same Individual Physician or Other QHP on the same date of service for the same patient as these services usually are not distinct from the E/M service when both are provided on the same day. American College of Radiology (ACR) guidelines suggest that physicians and other QHP who believe the Professional Component (modifier 26) for a PC/TC Indicator 1 radiology code is reimbursable in addition to the E/M service on the same day must include medical records. Please review the Professional/Technial Component Policy at UHCprovider.com	9/12/2024	Medicaid	Professional
Informational Edit	**uCSRTNEC**	INFORMATIONAL – CPT <1> begins a new 90-day therapeutic radiology treatment planning episode of care. For more information, refer to the 11/1/24 Network News Bulletin regarding the new Radiation Therapy Policy.	Radiation Therapy Episode of Care Effective for dates of service on or after February 1, 2025, UnitedHealthcare will implement the new Radiation Therapy-Dosimetry, Simulation/Devices and Management Policy, Professional and Facility. Specific radiation therapy dosimetry, simulation and management services, identified with select CPT ® codes, will have unit limitations during a 90-day episode of care. Units billed in excess of the limits will not be considered for reimbursement. Please review UHC Community Plan Reimbursement Policy Update Bulletin November 2024.	1/2/2025	Medicaid	Professional
Informational Edit	**uCSRTNECf**	INFORMATIONAL – CPT <1> begins a new 90-day therapeutic radiology treatment planning episode of care. For more information, refer to the 11/1/24 Network News Bulletin regarding the new Radiation Therapy Policy.	Radiation Therapy Episode of Care Effective for dates of service on or after February 1, 2025, UnitedHealthcare will implement the new Radiation Therapy-Dosimetry, Simulation/Devices and Management Policy, Professional and Facility. Specific radiation therapy dosimetry, simulation and management services, identified with select CPT ® codes, will have unit limitations during a 90-day episode of care. Units billed in excess of the limits will not be considered for reimbursement. Please review UHC Community Plan Reimbursement Policy Update Bulletin November 2024.	1/2/2025	Medicaid	Facility
Rejection Edit	**uCSSICCL**	REJECT - CLIA ID <1> does not meet the certification level for procedure code <2>. This claim has been rejected and will not be processed.	CLIA Certification Level The lab certification level must 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. If the code is under waiver a modifier will be required. Please review our Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com.	5/11/2023 5/30/2024	Medicaid Dual Enrollment	Professional
Return Edit	**uCSTAC1f**	In alignment with CMS, trauma centers billing for trauma activation should include revenue code <1> with HCPCS G0390 on same claim line, and CPT 99291 on the same date of service, when documentation supports.	Trauma Activation Code UHC aligns with coding requirements set by CMS for Trauma Activation. Hospitals that provide less than 30 minutes of critical care when trauma activation occurs under the circumstances described by the NUBC guidelines that would permit reporting a charge under revenue code 68x, may report a charge under 68x, but they may not report HCPCS code G0390. In this case, payment for the trauma response is packaged into payment for the other services provided to the patient in the encounter, including the visit that is reported.	11/30/2023	Medicaid	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**UCSTD**	Procedure code <1> is not reimbursable. Update code(s) as applicable for services rendered.	Not Separately Reimbursable 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 review the Urgent Care Policy on UHCprovider.com for further information.	11/14/2019 12/19/2024	Commercial UHOne	Professional
Informational Edit	**uCSTZCODE**	INFORMATIONAL - Starting 02/01/25, CPT <1> will require a valid DEX Z-Code in the line level 2400 loop, SV101-7 on electronic claims. Please visit dexzcodes.com for more information.	Medicaid Value Not Z-Code UnitedHealthcare recommends that providers submit the appropriate DEX Z-Code for this molecular diagnostic test. The assigned Z-Code can be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. Please refer to DEX Diagnostics Exchange Test Registration for additional information on test registration at dexzcodes.com.	12/5/2024	Medicaid	Professional
Informational Edit	**uCSTZCODEf**	INFORMATIONAL - Starting 02/01/25, CPT <1> will require a valid DEX Z-Code in the line level 2400 loop, SV101-7 on electronic claims. Please visit dexzcodes.com for more information.	Medicaid Value Not Z-Code UnitedHealthcare recommends that providers submit the appropriate DEX Z-Code for this molecular diagnostic test. The assigned Z-Code can be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. Please refer to DEX Diagnostics Exchange Test Registration for additional information on test registration at dexzcodes.com.	12/5/2024	Medicaid	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**uCSZCDCPT**	INFORMATIONAL - CPT <1> is recommended to be submitted with a DEX Z-Code. Please visit dexzcodes.com for more information.	Invalid Z-Code for CPT UnitedHealthcare will require providers to submit the appropriate DEX Z-Code for molecular diagnostic test services for the services to be considered for reimbursement. This policy will apply to both facility and professional claims. The assigned Z-Code should be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com). After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. Please review the Molecular Pathology Policy, Community Plan at UHCprovider.com	2/6/2025	Medicaid	Professional
Informational Edit	**uCSZCDCPTf**	INFORMATIONAL - CPT <1> is recommended to be submitted with a DEX Z-Code. Please visit dexzcodes.com for more information.	Invalid Z-Code for CPT UnitedHealthcare will require providers to submit the appropriate DEX Z-Code for molecular diagnostic test services for the services to be considered for reimbursement. This policy will apply to both facility and professional claims. The assigned Z-Code should be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com). After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. Please review the Molecular Pathology Policy, Community Plan at UHCprovider.com	2/6/2025	Medicaid	Facility
Informational Edit	**uCSZCDMPL**	INFORMATIONAL - CPT <1> is recommended to be submitted with a DEX Z-Code. Please visit dexzcodes.com for more information.	Multiple Z-Codes Submitted on Claim Line UnitedHealthcare will require providers to submit the appropriate DEX Z-Code for molecular diagnostic test services for the services to be considered for reimbursement. This policy will apply to both facility and professional claims. The assigned Z-Code should be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com). After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. Please review the Molecular Pathology Policy, Community Plan at UHCprovider.com	2/6/2025	Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**uCSZCDMPLf**	INFORMATIONAL - CPT <1> is recommended to be submitted with a DEX Z-Code. Please visit dexzcodes.com for more information.	Multiple Z-Codes Submitted on Claim Line UnitedHealthcare will require providers to submit the appropriate DEX Z-Code for molecular diagnostic test services for the services to be considered for reimbursement. This policy will apply to both facility and professional claims. The assigned Z-Code should be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com). After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. Please review the Molecular Pathology Policy, Community Plan at UHCprovider.com	2/6/2025	Medicaid	Facility
Informational Edit	**uCSZCDPSC**	INFORMATIONAL - CPT <1> is recommended to be submitted with a DEX Z-Code. Please visit dexzcodes.com for more information.	Z-Code Procedure More than Once Same DOS Same Claim UnitedHealthcare will require providers to submit the appropriate DEX Z-Code for molecular diagnostic test services for the services to be considered for reimbursement. This policy will apply to both facility and professional claims. The assigned Z-Code should be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com). After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. Please review the Molecular Pathology Policy, Community Plan at UHCprovider.com	2/6/2025	Medicaid	Professional
Informational Edit	**uCSZCDPSCf**	INFORMATIONAL - CPT <1> is recommended to be submitted with a DEX Z-Code. Please visit dexzcodes.com for more information.	Z-Code Procedure More than Once Same DOS Same Claim UnitedHealthcare will require providers to submit the appropriate DEX Z-Code for molecular diagnostic test services for the services to be considered for reimbursement. This policy will apply to both facility and professional claims. The assigned Z-Code should be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com). After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. Please review the Molecular Pathology Policy, Community Plan at UHCprovider.com	2/6/2025	Medicaid	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**uCSZCDU**	INFORMATIONAL- Molecular diagnostic procedure code <1> should not be submitted with more than one unit.	Z-Code Multiple Units UnitedHealthcare will require providers to submit the appropriate DEX Z-Code for molecular diagnostic test services for the services to be considered for reimbursement. This policy will apply to both facility and professional claims. The assigned Z-Code should be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com). After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. Please review the Molecular Pathology Policy, Community Plan at UHCprovider.com	2/6/2025	Medicaid	Professional
Informational Edit	**uCSZCDUf**	INFORMATIONAL- Molecular diagnostic procedure code <1> should not be submitted with more than one unit.	Z-Code Multiple Units UnitedHealthcare will require providers to submit the appropriate DEX Z-Code for molecular diagnostic test services for the services to be considered for reimbursement. This policy will apply to both facility and professional claims. The assigned Z-Code should be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com). After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. Please review the Molecular Pathology Policy, Community Plan at UHCprovider.com	2/6/2025	Medicaid	Facility
Rejection Edit	**uCTBS**	REJECT - Communication Based Tech Service <1> must be sent without place of service 02 or telehealth modifiers. This claim has been rejected and will not be processed.	Communication Technology Based Services Telehealth Communication Technology-Based Services are codes always delivered electronically and never with an in-person visit. Beginning 01/01/21 telehealth identifiers such as modifiers (95, GT, GQ or G0 [zero]) and place of service 02 will not be required for CTBS. Please review the Telehealth and Telemedicine Policy on UHCprovider.com.	1/14/2021 Changed to Rejection Edit on: 4/15/2021	Commercial Oxford	Professional
Return Edit	**uCTSC1**	Submitted units exceed the Time Span code policy for procedure code <1>. Please review and update codes as applicable.	Custom Tine Span Codes CPT or HCPCS Level II code that specifies a time period for which it should be reported (e.g., weekly, monthly), once during that time period. The time period is based on sourcing from the AMA or CMS. Please review the Medicare Advantage Time Span Code Policy on UHCprovider.com.	11/19/2020	Medicare	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**uCTZCODE**	INFORMATIONAL - CPT <1> is recommended to be submitted with a DEX Z-Code. Please visit dexzcodes.com for more information.	Value not Z Code UnitedHealthcare recommends that providers submit the appropriate DEX Z-Code for this molecular diagnostic test. The assigned Z-Code can be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com).	5/25/2023	Commercial Level Funded Oxford	Professional
Informational Edit	**uCTZCODEf**	INFORMATIONAL - CPT <1> is recommended to be submitted with a DEX Z-Code. Please visit dexzcodes.com for more information.	Value not Z Code UnitedHealthcare recommends that providers submit the appropriate DEX Z-Code for this molecular diagnostic test. The assigned Z-Code can be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com).	5/25/2023	Commercial Level Funded Oxford	Facility
Return Edit	**uCVENIP**	Procedure Code 36410 requires a supporting diagnosis on the same claim line. Please update as applicable.	Venipuncture for Specimen Collection Submit CPT code 36410 only for venipunctures necessitating physician skill when performed by a physician on veins of the neck, (e.g., external or internal jugular), or from deep (central) veins of the thorax (e.g., subclavian) or groin (e.g., femoral); and for venipuncture of superficial extremity veins when the skill of a qualified individual properly trained in venipuncture techniques (e.g., nurse, phlebotomist, medical technician) has been clearly demonstrated, according to the terms of this policy, to be insufficient ICD-10-CM I87.8, I99.8 or R68.89 must be submitted on all claims for CPT 36410. Please review cms.gov - Article - Billing and Coding: Venipuncture Necessitating Physician's Skill for Specimen Collection – Supplemental Instructions Article (A52470)	9/28/2023	Commercial	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uCVENIPf**	Procedure Code 36410 requires a supporting diagnosis on the same claim line. Please update as applicable.	Venipuncture for Specimen Collection Submit CPT code 36410 only for venipunctures necessitating physician skill when performed by a physician on veins of the neck, (e.g., external or internal jugular), or from deep (central) veins of the thorax (e.g., subclavian) or groin (e.g., femoral); and for venipuncture of superficial extremity veins when the skill of a qualified individual properly trained in venipuncture techniques (e.g., nurse, phlebotomist, medical technician) has been clearly demonstrated, according to the terms of this policy, to be insufficient ICD-10-CM I87.8, I99.8 or R68.89 must be submitted on all claims for CPT 36410. Please refer to cms.gov - Article - Billing and Coding: Venipuncture Necessitating Physician's Skill for Specimen Collection – Supplemental Instructions Article (A52470)	9/28/2023	Commercial	Facility
Informational Edit	**uCZCDCPT**	INFORMATIONAL - CPT <1> is recommended to be submitted with a DEX Z-Code. Please visit dexzcodes.com for more information.	Invalid Z Code for CPT UnitedHealthcare recommends that providers submit the appropriate DEX Z-Code for this molecular diagnostic test. The assigned Z-Code can be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a valid Z-Code. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com). After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system.	5/25/2023	Commercial Level Funded Oxford	Professional
Informational Edit	**uCZCDCPTf**	INFORMATIONAL - CPT <1> is recommended to be submitted with a DEX Z-Code. Please visit dexzcodes.com for more information.	Invalid Z Code for CPT UnitedHealthcare recommends that providers submit the appropriate DEX Z-Code for this molecular diagnostic test. The assigned Z-Code can be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a valid Z-Code. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com). After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system.	5/25/2023	Commercial Level Funded Oxford	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**uCZCDMPL**	INFORMATIONAL - CPT <1> is recommended to be submitted with a DEX Z-Code. Please visit dexzcodes.com for more information.	Multiple Z Codes submitted on claim UnitedHealthcare recommends that providers submit the appropriate DEX Z-Code for this molecular diagnostic test. The assigned Z-Code can be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a valid Z-Code. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com). After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment.	5/26/2023	Commercial Level Funded Oxford	Professional
Informational Edit	**uCZCDMPLf**	INFORMATIONAL - CPT <1> is recommended to be submitted with a DEX Z-Code. Please visit dexzcodes.com for more information.	Multiple Z Codes submitted on claim UnitedHealthcare recommends that providers submit the appropriate DEX Z-Code for this molecular diagnostic test. The assigned Z-Code can be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a valid Z-Code. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com). After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment.	5/26/2023	Commercial Level Funded Oxford	Faclity
Informational Edit	**uCZCDPSC**	INFORMATIONAL - Molecular diagnostic procedure code <1> should not be submitted more than once per date of service.	Z code more than once same proc, same claim UnitedHealthcare recommends that providers submit the appropriate DEX Z-Code for this molecular diagnostic test. The assigned Z-Code can be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com). After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment.	5/26/2023	Commercial Level Funded Oxford	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**uCZCDPSCf**	INFORMATIONAL - Molecular diagnostic procedure code <1> should not be submitted more than once per date of service.	Z code more than once same proc, same claim UnitedHealthcare recommends that providers submit the appropriate DEX Z-Code for this molecular diagnostic test. The assigned Z-Code can be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com). After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment.	5/26/2023	Commercial Level Funded Oxford	Facility
Informational Edit	**uCZCDU**	INFORMATIONAL- Molecular diagnostic procedure code <1> should not be submitted with more than one unit.	Z Code CPT Units UnitedHealthcare recommends that providers submit the appropriate DEX Z-Code for this molecular diagnostic test. The assigned Z-Code can be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com). After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment.	5/25/2023	Commercial Level Funded Oxford	Professional
Informational Edit	**uCZCDUf**	INFORMATIONAL- Molecular diagnostic procedure code <1> should not be submitted with more than one unit.	Z Code CPT Units UnitedHealthcare recommends that providers submit the appropriate DEX Z-Code for this molecular diagnostic test. The assigned Z-Code can be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com). After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment.	5/25/2023	Commercial Level Funded Oxford	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uDBTf**	CPT Code <1> was not submitted with the required diagnosis code. Please review and update the claim as applicable	Digital Breast Tomosynthesis A screening mammography is a radiologic procedure furnished to a woman without signs or symptoms of breast disease, for the purpose of early detection of breast cancer, and includes a physician's interpretation of the results of the procedure. A screening mammography has limitations as it must be, at a minimum a two-view exposure of each breast. Digital breast tomosynthesis (DBT) uses a series of two-dimensional images to build a three-dimensional image of the breast. HCPCS code 77063, Screening digital breast tomosynthesis, bilateral (list separately in addition to code for primary procedure), must be billed in conjunction with the screening mammography and must contain the required diagnosis codes. Please review the Preventive Health Services and Procedures policy on www.UHCprovider.com.	11/17/2022	Medicare	Facility
Rejection Edit	**uDCMT**	REJECT - A billing provider taxonomy code, valid with District of Columbia provider registration, is required to be submitted on the claim. This claim has been rejected and will not be processed.	DC Missing Taxonomy The United Healthcare Community Plan for the District of Columbia requires all healthcare professionals who serve members in the District of Columbia to include their registered taxonomy code on claim submissions. Please review 2024 Care Provider Manual Physician, Care Provider, Facility and Ancillary District of Columbia Dual Choice at UHCprovider.com	10/24/2024	Medicaid	Professional
Rejection Edit	**uDCMTf**	REJECT - A billing provider taxonomy code, valid with District of Columbia provider registration, is required to be submitted on the claim. This claim has been rejected and will not be processed.	DC Missing Taxonomy The United Healthcare Community Plan for the District of Columbia requires all healthcare professionals who serve members in the District of Columbia to include their registered taxonomy code on claim submissions. Please review 2024 Care Provider Manual Physician, Care Provider, Facility and Ancillary District of Columbia Dual Choice at UHCprovider.com	10/24/2024	Medicaid	Facility
Rejection Edit	**uDCP1**	This claim appears to be a duplicate of previously submitted claim ID <1> received for processing on <2 ACE analysis date>. This claim has been rejected and will not be processed.	Definite Duplicate within 24 Hours ACE will reject exact match duplicate claims submitted with 24 hours of the original claim. Please review the UHC Administrative Guide.	2/25/2021 9/28/2023 4/25/2024	Commercial Oxford Individual and Family Plan Medicaid Medicare UHOne UMR	Professional
Rejection Edit	**uDCP1IPf**	This claim appears to be a duplicate of previously submitted claim ID <1> received for processing on <2 ACE analysis date>. This claim has been rejected and will not be processed.	Exact Duplicate Claim UHC will reject exact match duplicate claims submitted with 24 hours of the original claim. Please refer to the Administrative Guide on www.UHCprovider.com.	11/30/2023 4/25/2024	All Savers Commercial Dual Enrollment Individual & Family Plan Level Funded Medicaid Medicare Oxford UMR	Facility
Rejection Edit	**uDCP1OPf**	This claim appears to be a duplicate of previously submitted claim ID <1> received for processing on <2 ACE analysis date>. This claim has been rejected and will not be processed.	Exact Duplicate Claim UHC will reject exact match duplicate claims submitted with 24 hours of the original claim. Please refer to the Administrative Guide on www.UHCprovider.com.	11/30/2023 8/2/2024	All Savers Commercial Dual Enrollment Individual & Family Plan Level Funded Medicaid Medicare Oxford UMR	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**uDCP3**	This claim appears to be a duplicate of previously submitted claim ID <1> received for processing on <2 ACE analysis date>. This claim has been rejected and will not be processed.	Expanded Exact Match Duplicate Claim ACE will reject exact match duplicate claims when an original claim has already been processed. If this is a corrected or replacement claim, the submission should represent a complete replacement of the previous claim. Please be sure to resubmit using the claim frequency code or bill type that indicates a replacement of the original submission. Please refer to the Provider Administrative Guide on UHCprovider.com.	2/27/2025	Commercial Individual & Family Plan Medicare	Professional
Rejection Edit	**uDCPIPf**	This claim appears to be a duplicate of previously submitted claim ID <1> received for processing on <2 ACE analysis date>. This claim has been rejected and will not be processed.	Exact Duplicate Claim This claim appears to be a duplicate of previously submitted claim ID <1> received for processing on <2 ACE analysis date>. This claim has been rejected and will not be processed.	6/27/2024	Commercial	Facility
Return Edit	**uDDMOD2**	Single dose drug NDC <1> should be submitted with JW or JZ modifier. Update code(s) as applicable.	Discarded Drug Modifier Effective September 1, 2024, UnitedHealthcare will align with the Centers for Medicare and Medicaid (CMS) requirement for reporting the JZ modifier for a claim to be considered for reimbursement. In accordance with CMS Medicare Claims Processing Manual Chapter 17 (Section 40) providers and suppliers are required to report the JZ modifier to attest that no amount of drug or biological from a single-dose container or a single-use package was unused or discarded. The use of the JW modifier will continue to be required when submitting claims for any waste from a single-dose container or single-use package. Starting from July 1, 2023, Medicare required modifier JZ on all claim lines for single-dose containers where there are no discarded amounts. Claim lines that do not report the modifiers on dates of service (DOS) on or after Oct. 1, 2023,will be denied. Please review the Discarded Drug and Biologicals Policy on UHCprovider.com.	8/29/2024	Medicaid	Professional
Return Edit	**uDDMOD2f**	Single dose drug NDC <1> should be submitted with JW or JZ modifier. Update code(s) as applicable.	Discarded Drug Modifier Effective September 1, 2024, UnitedHealthcare will align with the Centers for Medicare and Medicaid (CMS) requirement for reporting the JZ modifier for a claim to be considered for reimbursement. In accordance with CMS Medicare Claims Processing Manual Chapter 17 (Section 40) providers and suppliers are required to report the JZ modifier to attest that no amount of drug or biological from a single-dose container or a single-use package was unused or discarded. The use of the JW modifier will continue to be required when submitting claims for any waste from a single-dose container or single-use package. Starting from July 1, 2023, Medicare required modifier JZ on all claim lines for single-dose containers where there are no discarded amounts. Claim lines that do not report the modifiers on dates of service (DOS) on or after Oct. 1, 2023,will be denied. Please review the Discarded Drug and Biologicals Policy on UHCprovider.com.	8/29/2024	Medicaid	Facility
Return Edit	**uDEVOPf**	Device dependent procedure code <1> requires that a valid device dependent HCPCS is submitted on the same day and on the same claim. Please update code(s) as applicable.	Device Dependent When a device-dependent procedure code is submitted on an OPP Outpatient facility claim, it requires the appropriate device code to be submitted on the same claim and same date of service unless the procedure was terminated, indicated in the submission of certain skin substitute application procedures require the appropriate skin substitute product be submitted on the same day. These procedures and products are divided into two lists based on high or low cost. Please refer to Device, Implant, and Skin Substitute Policy, Facility on UHCprovider.com	10/26/2023	Individual and Family Plan Medicaid	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**UDISDP**	A device-dependent procedure <1> may require that a device HCPCS code be submitted on the same day. Update code(s) as applicable.	Device Implant and Skin Sub Device Dep Proc without Dev Code Denial When the use of a device or implant is necessary in the performance of certain procedures, the device or implant must be submitted with the same date of service and on the same claim as the procedure. A device or implant dependent procedure will be denied if reported without an applicable device or implant on the same claim and date of service. A submission of the procedure code without a device or implant would only be considered for reimbursement when the service was discontinued prior to the placement of the device or implant and appended with an appropriate modifier indicating it was a discontinued procedure. Please refer to Device, Implant, and Skin Substitute Policy, Facility on UHCprovider.com	1/26/2023	Commercial	Facility
Return Edit	**UDISFD**	This claim does not have the appropriate Device Implant Revenue Code and HCPCS combination. Please review and update as applicable.	Device Implant and Skin Sub FDA Denial 20210101 When a revenue code representing implants is submitted, a HCPCS code which meets the FDA definition of an implant must be reported for outpatient services. If a HCPCS code is not submitted or if the HCPCS code submitted does not match the FDA definition of an implant, the outpatient service will be denied. Please refer to Device, Implant, and Skin Substitute Policy, Facility on UHCprovider.com	8/25/2022	Commercial	Facility
Return Edit	**uDISHOPf**	A skin substitute product may require that a skin substitute procedure is submitted on the same day and on the same claim. This claim is missing a code for the product or the procedure. Please update code(s) as applicable.	Skin Substitute Skin substitute application or replacement procedures identified in the OCE as high cost will be denied when a skin substitute product identified as high cost on the OCE is not submitted for the same date of service and on the same claim. Please refer to Device, Implant, and Skin Substitute Policy, Facility on UHCprovider.com	10/26/2023	Individual and Family Plan Medicaid	Facility
Return Edit	**UDISHS**	A skin substitute high product proc <1> may require that a skin substitute high procedure proc code be submitted on the same day. Update code(s) as applicable.	Device Implant and Skin Sub Skin Sub High Prod Code without Skin Sub High Proc When a skin substitute application or replacement procedure is reported, the associated skin substitute product must be submitted on the same claim and for the same date of service. Skin substitutes are assigned two categories specific to low cost and high cost. Skin substitute application or replacement procedures identified in the OCE as high cost will be denied when a skin substitute product identified as high cost on the OCE is not submitted for the same date of service and on the same claim. Please refer to Device, Implant, and Skin Substitute Policy, Facility on UHCprovider.com	1/26/2023	Commercial	Facility
Return Edit	**UDISIM**	An implant device <1> may require that an implant device procedure code be submitted on the same day. Update code(s) as applicable.	Device Implant and Skin Sub Skin Sub High Prod Code without Skin Sub High Proc When the use of a device or implant is necessary in the performance of certain procedures, the device or implant must be submitted with the same date of service and on the same claim as the procedure. A device or implant dependent procedure will be denied if reported without an applicable device or implant on the same claim and date of service. A submission of the procedure code without a device or implant would only be considered for reimbursement when the service was discontinued prior to the placement of the device or implant and appended with an appropriate modifier indicating it was a discontinued procedure. Please refer to Device, Implant, and Skin Substitute Policy, Facility on UHCprovider.com	1/26/2023	Commercial	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uDISLOPf**	A skin substitute product may require that a skin substitute procedure is submitted on the same day and on the same claim. This claim is missing a code for the product or the procedure. Please update code(s) as applicable.	Low Procedure Skin Substitute Skin substitute application or replacement procedures identified in the OCE as high cost will be denied when a skin substitute product identified as high cost on the OCE is not submitted for the same date of service and on the same claim. Please refer to Device, Implant, and Skin Substitute Policy, Facility on UHCprovider.com	10/26/2023	Individual and Family Plan Medicaid	Facility
Return Edit	**uDMEMOD**	Procedure code <1> requires a modifier to indicate DME rental or purchase. Please review and update the claim as applicable.	DME Required Modifier Durable Medical Equipment, Prosthetics/Orthotics & Supplies are categorized into payment classes. Some Durable Medical Equipment (DME) items are eligible for rental as well as for purchase. Claims must specify whether equipment is rented or purchased. For purchased equipment, the claim must also indicate whether equipment is new or used. The codes must be reported with the appropriate rental or purchase modifier in order to be considered for reimbursement. Some DME items are eligible for rental only. The codes representing these items must be reported with the appropriate rental modifier in order to be considered for reimbursement. Please review the Durable Medical Equipment, Orthotics and Prosthetics Policy, Professional on UHCprovider.com	12/15/2022	Medicare	Professional
Return Edit	**uDPND**	Per NCD Policy 70.2.1, procedure code <1> requires a supporting diagnosis code. Please correct code(s) as applicable.	Diabetic Peripheral Neuropathy Required Diagnosis Codes According to the Medicare Advantage Diabetic Peripheral Neuropathy guidelines, this edit will allow diabetic sensory neuropathy with LOPS procedure(s) when submitted with a diagnosis code found on the allowed diagnosis code list. Please review the Diabetic Peripheral Neuropathy Policy Guideline on UHCprovider.	10/29/2020	Medicare	Professional
Return Edit	**uDPNP**	Per NCD 70.2.1, an initial physician visit or follow-up physician visit must be supplied for same date of service when procedure code G0247 is submitted. Update code(s) as applicable for services rendered.	Diabetic Peripheral Neuropathy Required Diagnosis Codes According to the Medicare Advantage Diabetic Peripheral Neuropathy guidelines, when a foot care service is submitted it must be accompanied with either the initial physician visit or a follow-up physician visit for the same date of service. Please review the Diabetic Peripheral Neuropathy Policy Guideline on UHCprovider.	10/29/2020	Medicare	Professional
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.	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 Medicaid Medicare	Professional
Informational Edit	**uDSC**	INFORMATIONAL - Review diagnosis code <1> for accuracy. Causal relationship between skin condition Not Elsewhere Classified <2> and diabetes must be supported in medical file.	Diabetes with Skin Complications When reporting diabetes mellitus with skin complications Not Elsewhere Classified, the WITH guideline does not apply and documentation must support a causal relationship between the diabetes and the NEC skin condition by MD. No supporting documentation is required to be submitted with this claim. For additional information please review ICD-10 Official guidelines Section 1.A.15.	9/28/2023	Commercial Dual Enrollment Individual and Family Plan Level Funded Medicaid Medicare Oxford	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**uDSSI**	INFORMATIONAL - Proc <1> is subject to the coverage criteria in the UHC MA Medical Policy Skin Substitutes Grafts/Cellular and Tissue-Based Products. Failure to demonstrate medical necessity may result in denial.	Skin Substitute Medical Necessity Skin substitutes provided to MA members in jurisdictions with LCDs will be reviewed for medical necessity using applicable LCD guidance. For use cases not addressed by LCDs, coverage determination will be made by UnitedHealthcare policy, Skin Substitutes Grafts/Cellular and Tissue-Based Products (Injections and/or Applications). Please refer to UHC Medical Policy Skin Substitutes Grafts/Cellular and Tissue-Based Products (Injections and/or Applications) at UHCprovider.com	6/27/2024	Medicare Dual Enrollment	Professional
Informational Edit	**uDSSIf**	INFORMATIONAL - Proc <1> is subject to the coverage criteria in the UHC MA Medical Policy Skin Substitutes Grafts/Cellular and Tissue-Based Products. Failure to demonstrate medical necessity may result in denial.	Skin Substitute Medical Necessity Skin substitutes provided to MA members in jurisdictions with LCDs will be reviewed for medical necessity using applicable LCD guidance. For use cases not addressed by LCDs, coverage determination will be made by UnitedHealthcare policy, Skin Substitutes Grafts/Cellular and Tissue-Based Products (Injections and/or Applications). Please refer to UHC Medical Policy Skin Substitutes Grafts/Cellular and Tissue-Based Products (Injections and/or Applications) at UHCprovider.com	6/27/2024	Medicare Dual Enrollment	Facility
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.	Employment Accident Indicator 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 review the claim submission requirements section of the administrative guide on UHCprovider.com	7/25/2019 5/28/2020 12/19/2024	Commercial Oxford UHOne	Professional
Informational Edit	**uECVAXAf**	INFORMATIONAL - COVID-19 vaccination product code <1> should not be submitted for reimbursement. Only vaccination administration codes should be submitted.	Commercial COVID-19 Vaccine Admin Code COVID-19 vaccine administration codes should not be submitted with a vaccine product code. For future billing, please do not send the product code when billing for vaccine administration. https://www.cms.gov/medicare/covid-19/medicare-billing-covid-19-vaccine-shot-administration	1/7/2021	Commercial	Facility
Rejection Edit	**uECVAXPf**	REJECT - COVID-19 vaccine products are not currently reimbursable. Please remove charge and resubmit claim with an appropriate admin code if applicable. This claim has been rejected and will not be processed.	Commercial COVID-19 Vaccine Product Code Per CMS, vaccine product codes should not be included on a claim while vaccines are distributed free of charge. Only the administration code should be billed. This Smart Edit is returned when a COVID-19 vaccine product has been submitted without a COVID-19 vaccine administration code. Please remove the product code and resubmit the claim with the vaccine-specific administration code if applicable. For more information, please refer to the Medicare Billing for COVID-19 Vaccine Shot Administration on www.cms.gov.	1/7/2021	Commercial Oxford Individual & Family Plan	Facility
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.	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 review the Rebundling Policy, Professional on UHCprovider.com for additional information.	7/25/2019 7/29/2021 8/26/2021	Medicaid Commercial Individual and Family Plan	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational	**uEMLR**	INFORMATIONAL - Please review to determine if procedure code <1> is appropriate based on current CMS billing guidelines for E/M codes. Please ensure documentation supports the E/M code billed.	Level 4/5 E/M Codes CMS changed Physician E&M coding guidelines for Level 4 and 5 E/M codes (99202-99205 and 99212-99215). Coding is now based on the level of medical decision making (MDM) or total time spent on the patient encounter. MDM consists of number and complexity of problems addressed, amount/complexity of data reviewed and analyzed, and risk of complications and/or morbidity/mortality of patient management. Two of those three must be met or exceeded. This edit addresses claims submitted with level 4 and 5 codes and seeks to have the provider review medical decision making and total time spent to determine if a code of a lower level is more appropriate. Documentation should be available if requested.	9/28/2023 2/29/2024	Commercial UHOne	Professional
Return Edit	**uEMLRC**	Procedure code <1> may not be appropriate based on current CMS billing guidelines for E/M codes. If documentation does not support the E/M level submitted, please resubmit with the appropriate E/M level.	Level 4/5 E/M Codes CMS changed Physician E&M coding guidelines for Level 4 and 5 E/M codes (99202-99205 and 99212-99215). Coding is now based on the level of medical decision making (MDM) or total time spent on the patient encounter. MDM consists of number and complexity of problems addressed, amount/complexity of data reviewed and analyzed, and risk of complications and/or morbidity/mortality of patient management. Two of those three must be met or exceeded. This edit addresses claims submitted with level 4 and 5 codes and seeks to have the provider review medical decision making and total time spent to determine if a code of a lower level is more appropriate. Documentation should be available if requested.	9/28/2023	Commercial	Professional
Informational Edit	**uEYMOD**	INFORMATIONAL - CPT code 67028 is missing the modifier indicating the site of service.	Eylea Injection Modifier Per UHC policy, the appropriate site modifier must be appended with the procedure code for intravitreal injection of a pharmacologic agent when billed with the Aflibercept drug code to indicate if the service was performed unilaterally or bilaterally. Please review the Eylea (Aflibercept) Medicare Advantage Policy Guideline on UHCprovider.com	11/18/2021	Medicare	Professional
Informational Edit	**uEYMODf**	INFORMATIONAL - CPT code 67028 is missing the modifier indicating the site of service.	Eylea Injection Modifier Per UHC policy, the appropriate site modifier must be appended with the procedure code for intravitreal injection of a pharmacologic agent when billed with the Aflibercept drug code to indicate if the service was performed unilaterally or bilaterally. Please refer to the Eylea (Aflibercept) Medicare Advantage Policy Guideline on UHCprovider.com.	11/18/2021	Medicare	Facility
Return Edit	**uFACBTDf**	An inpatient stay has been billed for this member. Additional services should be included in that inpatient stay. Please update as applicable.	Facility Between Dates When a physician orders that a patient receive observation care, the patient's status is that of an outpatient. The purpose of observation is to determine the need for further treatment or for inpatient admission. Thus, a patient receiving observation services may improve and be released or be admitted as an inpatient. Most additional services are not separately billable and should be included in the inpatient stay. Please review See the Hospital Services (Outpatient, Observation, and Inpatient) UnitedHealthcare Medicare Advantage Summary Coverage Summary at uhcprovider.com.	9/26/2024	Medicare	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uFSLDf**	Per Medicare Clinical Diagnostic Laboratory Service policy, diagnosis <1> appears to be for screening purposes and is inappropriate with procedure code <2>. Update code(s) as applicable for services rendered.	Facility Screening Lab Per Clinical Diagnostic Laboratory Services policy, 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 Laboratory Services policy for further details.	9/30/2021	Medicare	Facility
Return Edit	**UFTDDN**	Claim line service date is missing or does not fall within the claims statement dates. Update claim as applicable.	From - To Dates In accordance with Centers for Medicare and Medicaid Services (CMS) and National Uniform Billing Committee (NUBC), a valid date of service must be reported on each claim line, as it represents the date the outpatient service was provided. There must be a single line-item date of service reported for every revenue code, procedure code or drug code on all outpatient claims. In addition, each service date (MMDDYY) must fall within the from and to date of service on the outpatient facility claim. Please review the Outpatient From-to Date Policy, Facility at uhcprovider.com.	9/26/2024	Commercial	Facility
Return Edit	**uG0438M**	Procedure code G0438 is for an initial wellness visit and was previously billed on date of service <1>. Please update as applicable.	G0438 Once in a Lifetime Wellness Visit Procedure code G0438 is for an initial wellness after the member is enrolled in Medicare services and can only be used once in a member's lifetime. Billing this code more than once may result in overpayment recovery actions. Please review the New Patient Visit Policy, Professional reimbursement policy for the appropriate line of business at UHCprovider.com	3/31/2022	Medicare	Professional
Return Edit	**uG0439**	Message 1: CPT code G0439 is limited to once per calendar year. This procedure code was previously billed for DOS <1>. Please update claim as applicable. Message2: CPT code G0439 was previously billed and is limited to once per calendar year. Please update claim as applicable.	Annual Wellness Visit Limit Exceeded An annual wellness visit can occur once every calendar year (visits do not need to be 12 months apart). The annual wellness visit is a yearly appointment with a Medicare beneficiary's PCP to create or update a PPPS. This plan may help prevent illness based on current health and risk factors. An annual wellness visit is not a physical exam. For additional information, please see the 2022 Medicare Advantage preventive screening guidelines on UHCprovider.com	8/25/2022	Medicare	Professional
Return Edit	**uG0439f**	Message 1: CPT code G0439 is limited to once per calendar year. This procedure code was previously billed for DOS <1>. Please update claim as applicable. Message2: CPT code G0439 was previously billed and is limited to once per calendar year. Please update claim as applicable.	Annual Wellness Visit Limit Exceeded An annual wellness visit can occur once every calendar year (visits do not need to be 12 months apart). The annual wellness visit is a yearly appointment with a Medicare beneficiary's PCP to create or update a PPPS. This plan may help prevent illness based on current health and risk factors. An annual wellness visit is not a physical exam. For additional information, please see the 2022 Medicare Advantage preventive screening guidelines on UHCprovider.com	8/25/2022	Medicare	Facility
Rejection Edit	**uGECCA**	REJECT - When procedure code <1> is billed by provider <2> it is part of GE Convenience Care Advantage and is eligible through the Optum Rx benefit. Claim has been rejected and will not be processed.	General Electric Convenience Care Advantage Service is part of the General Electric Convenience Care Advantage and is eligible through the Optum Rx benefit. Please call Optum Rx at 800-509-9891 if you have any questions.	11/30/2023	Commercial	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uGENES1**	CPT codes <1> constitute a panel, not distinct services, unless indicated with the appropriate modifier. Please review and update the claim as applicable.	Testing of Multiple Genes A panel of genes is a distinct procedural service from a series of individual genes. Genes assayed on the same date of service are considered to be assayed in parallel if the result of 1 assay does not affect the decision to complete the assay on another gene, and the 2 genes are being tested for the same indication. Genes assayed on the same date of service are considered to be assayed serially when there is a reflexive decision component where the results of the analysis of 1 or more genes determines whether the results of additional analyses are reasonable and necessary. In general, 2 or more codes describing a genetic test billed on the same beneficiary on the same date may constitute a panel, and if so, the service must be billed as a single procedural service. When 2 or more codes are submitted for the same beneficiary on the same date of service, the claims processing system will reject every code submitted after the first service. However, if a lab runs more than 1 distinct procedural service on a single date of service, then the lab must use the 59 modifier with each additional service billed as an attestation that it is a distinct procedural service. Please review the Billing and Coding: MolDX: Testing of Multiple Genes article on www.cms.gov.	8/26/2021 2/27/2025	Medicare Dual Enrollment	Professional
Return Edit	**uGENES1f**	CPT codes <1> constitute a panel, not distinct services, unless indicated with the appropriate modifier. Please review and update the claim as applicable.	Testing of Multiple Genes A panel of genes is a distinct procedural service from a series of individual genes. Genes assayed on the same date of service are considered to be assayed in parallel if the result of 1 assay does not affect the decision to complete the assay on another gene, and the 2 genes are being tested for the same indication. Genes assayed on the same date of service are considered to be assayed serially when there is a reflexive decision component where the results of the analysis of 1 or more genes determines whether the results of additional analyses are reasonable and necessary. In general, 2 or more codes describing a genetic test billed on the same beneficiary on the same date may constitute a panel, and if so, the service must be billed as a single procedural service. When 2 or more codes are submitted for the same beneficiary on the same date of service, the claims processing system will reject every code submitted after the first service. However, if a lab runs more than 1 distinct procedural service on a single date of service, then the lab must use the 59 modifier with each additional service billed as an attestation that it is a distinct procedural service. Please refer to the Billing and Coding: MolDX: Testing of Multiple Genes article on www.cms.gov.	12/15/2022 2/27/2025	Medicare Dual Enrollment	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uGENES2**	CPT codes <1> constitute a panel, not distinct services, unless indicated with the appropriate modifier. Please review and update the claim as applicable.	Non-Molecular Diagnostics States: Testing of Multiple Genes A panel of genes is a distinct procedural service from a series of individual genes. Genes assayed on the same date of service are considered to be assayed in parallel if the result of 1 assay does not affect the decision to complete the assay on another gene, and the 2 genes are being tested for the same indication. Genes assayed on the same date of service are considered to be assayed serially when there is a reflexive decision component where the results of the analysis of 1 or more genes determines whether the results of additional analyses are reasonable and necessary. In general, 2 or more codes describing a genetic test billed on the same beneficiary on the same date may constitute a panel, and if so, the service must be billed as a single procedural service. When 2 or more codes are submitted for the same beneficiary on the same date of service, the claims processing system will reject every code submitted after the first service. However, if a lab runs more than 1 distinct procedural service on a single date of service, then the lab must use the 59 modifier with each additional service billed as an attestation that it is a distinct procedural service. Please review the Billing and Coding: MolDX: Testing of Multiple Genes article on www.cms.gov.	12/15/2022 2/27/2025	Medicare Dual Enrollment	Professional
Return Edit	**uGENES2f**	CPT codes <1> constitute a panel, not distinct services, unless indicated with the appropriate modifier. Please review and update the claim as applicable.	Non-Molecular Diagnostics States: Testing of Multiple Genes A panel of genes is a distinct procedural service from a series of individual genes. Genes assayed on the same date of service are considered to be assayed in parallel if the result of 1 assay does not affect the decision to complete the assay on another gene, and the 2 genes are being tested for the same indication. Genes assayed on the same date of service are considered to be assayed serially when there is a reflexive decision component where the results of the analysis of 1 or more genes determines whether the results of additional analyses are reasonable and necessary. Ingeneral, 2 or more codes describing a genetic test billed on the same beneficiary on the same date may constitute a panel, and if so, the service must be billed as a single procedural service. When 2 or more codes are submitted for the same beneficiary on the same date of service, the claims processing system will reject every code submitted after the first service. However, if a lab runs more than 1 distinct procedural service on a single date of service, then the lab must use the 59 modifier with each additional service billed as an attestation that it is a distinct procedural service. Please refer to the Billing and Coding: MolDX: Testing of Multiple Genes article on www.cms.gov.	12/15/2022 2/27/2025	Medicare Dual Enrollment	Facility
Return Edit	**uGHCf**	Per NCD 190.21, procedure code <1> does not have a supporting diagnosis code listed. Update codes(s) as applicable for services rendered.	Glycated Hemoglobin Codes The management of diabetes mellitus requires regular determinations of blood glucose levels. Glycated hemoglobin/protein levels are used to assess long-term glucose control in diabetes. This edit is to help determine a "normal test value" in establishing the patient's hypoglycemic state in those conditions. Please refer to the CMS Medicare National Coverage Determinations (NCD) Coding Policy Manual and Change Report (ICD-10-CM) for further details. Please refer to Glycated Hemoglobin/ Glycated Protein 190.21 publication on www.cms.gov.	10/22/2020	Medicare	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**uGMNPI**	REJECT - Provider NPI 5417171175 is not valid. Per CMS, physicians must be enrolled with a valid NPI. This claim has been rejected and will not be processed.	Genetic and Molecular Testing Invalid NPI HIPAA, federal Medicare regulations, and Medicaid agencies require health care professionals to obtain and use a standardized NPI. To avoid payment delays or denials, you must submit a valid billing NPI, rendering NPI and relevant taxonomy code(s) on all claims and encounters. In addition, we encourage you to submit the referring health care provider's NPI. You are required to use an NPI as identification on electronic transactions as outlined in the instructions for HIPAA electronic transaction X12N Implementation Guides. Please refer Chapter 10 on the UnitedHealthcare Administrative Guide on UHCprovider.com for the location of the NPI on electronic claims.	1/27/2020	Commercial Oxford Level Funded Medicare Medicaid Individual and Family Plan Dual Enrollment	Professional
Return Edit	**UH1ADODN**	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.	Add On Codes - Procedure is Not Separately Reimbursable 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 Standalone codes are not reimbursable services in accordance with Current Procedural Terminology (CPT®) and the Centers for Medicare and Medicaid Services (CMS) guidelines. Please review the Add-on Codes Policy Professional on UHCprovider.com.	8/29/2024	UHOne	Professional
Informational Edit	**UH1ANSQC**	Procedure code <1> is inappropriate when submitted without an anesthesia service. Update code(s) as applicable for services rendered.	Anesthesia Qualifying Circumstances 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.	9/26/2024	UHOne	Professional
Return Edit	**UH1BIL**	Procedure <1> is not appropriate when billed with a bilateral modifier. Update code(s) or modifier as applicable for services rendered.	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. Please refer to the Bilateral Procedures Reimbursement Policy on UHCprovider.com.	9/26/2024	UHOne	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**UH1CCIDD**	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.	NCCI Medicaid DME Edits 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 CCI Editing Policy, Professional at UHCprovider.com	2/27/2025	UHOne	Professional
Return Edit	**UH1CCIUN**	Procedure code <1> is included with procedure code <2> on the current or previously submitted claim. Under appropriate circumstances, a designated modifier may be required to identify distinct services.	CCI Unbundling 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 on UHCprovider.com.	4/25/2024	UHOne	Professional
Return Edit	**UH1CSPDN**	Consultation Services Proc <1> is not reimbursable based on the Consultation Services Policy. Update codes as applicable.	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 review the Consultation Services Policy, Professional on UHCprovider.com.	8/29/2024	UHOne	Professional
Return Edit	**UH1DMEMD**	Procedure <1> is a DME, orthotics, or prosthetics code billed with modifier RT and LT on the same line. Modifier RT and LT should be reported on separate lines. Update code as applicable for services rendered.	DME Multiple Frequency 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 tp the Durable Medical Equipment, Orthoticsand Prosthetics Reimbursement Policy at UHCprovider.com	1/30/2025	UHOne	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**UH1DMEMR**	Procedure code <1> is a DME code that requires a rental or purchase modifier. Update code(s) as applicable.	DME - Rental or Purchase Modifier Required 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.	9/26/2024	UHOne	Professional
Return Edit	**UH1GDPIN**	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.	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. Please refer to the Global Days, Professional Reimbursement Policy at UHCprovider.com.	1/30/2025	UHOne	Professional
Rejection Edit	**UH1IPDDN**	REJECT - Diagnosis code <1> is an inappropriate primary diagnosis code. Claim has been rejected and will not be processed.	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 Diagnosis Code Requirement Policy, Professional and Facility - Reimbursement Policy - UnitedHealthcare Commercial and Individual Exchange at UHCprovider.com.	5/30/2024	UHOne	Professional
Return Edit	**UH1LABAD**	Procedure code <1> is incorrect. Drug Assay services may be reported with a more appropriate HCPCS code. Update code as applicable.	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 review the Laboratory Services reimbursement policy at UHCprovider.com.	12/19/2024	UHOne	Professional
Return Edit	**UH1LABDU**	This procedure <1> has been previously submitted by this or another provider. Update code(s) as applicable for services rendered.	Duplicate Lab Procedure code 88305 is not appropriate when billed with procedure code <1> for prostate needle biopsy specimen assessment. Please update codes as applicable. Please refer to the Laboratory Services Policy, Professional on UHCprovider.com.	7/25/2024	UHOne	Professional
Return Edit	**UH1LABHANE**	Procedure <1> is considered inclusive to other services reported. Update code(s) as applicable.	Lab Handling Not Eligible Service Laboratory handling and conveyance CPT codes 99000 and 99001 and HCPCS code H0048 are included in the overall management of a patient and are not separately reimbursed. Please review the Laboratory Services Policy on UHCprovider.com	5/30/2024	UHOne	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**UH1LABVDU**	This procedure <1> has been previously submitted by this or another provider. Update code(s) as applicable for services rendered.	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 review the Laboratory Services Policy on UHCprovider.com.	2/27/2025	UHOne	Professional
Return Edit	**UH1MFDUALL**	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.	Maximum Daily Frequency 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. Please refer to https://public.providerexpress.com/content/dam/ope-provexpr/us/pdfs/clinResourcesMain/guidelines/reimbPolicies/rpMaxFreqDay.pdf	9/26/2024	UHOne	Professional
Return Edit	**UH1MOD**	Modifier <1> is inappropriate for Procedure Code <2>. Please update code(s) as applicable.	Modifier Not Appropriate 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. Please refer to the Procedure to Modifier reimbursement policy at UHCprovider.com.	9/26/2024	UHOne	Professional
Return Edit	**UH1MODAT**	Procedure code <1> should be submitted with the required modifier. Update code(s) as applicable.	Always Therapy Modifiers Effective with dates of service on or after July 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). Please refer to Modifer Reference Policy, Professional at uhcprovider.com	6/27/2024	UHOne	Professional
Return Edit	**UH1NIRDN**	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.	Status E and X Codes Reported by Health Care Professional 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 Health Care Professionals Reibmursement Policy, Commercial at UHCprovider.com.	2/27/2025	UHOne	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**UH1NIRMD**	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.	Inappropriate Procedure and Modifier Combination Modifiers 27, 73, 74 and 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. Modifiers SE, HV, HZ, SL, HW, QJ, H9, HX, TR, HU & HY represent services that are funded by a county, state or federal agency and therefore additional reimbursement for such services would not be appropriate. Please review the Services and Modifiers Not Reimbursable to Healthcare Professionals, Professional Reimbursement Policy Commercial Plans located on UHCprovider.com.	12/19/2024	UHOne	Professional
Return Edit	**UH1NPTID**	This patient received care by the same provider group as this provider within the last three years. New patient code <1> may not be appropriate. Update claim as applicable.	New Patient Code for Established Patient According to the Centers for Medicare and Medicaid Services (CMS), a New Patient is a patient who has not received any professional services, i.e., E&M service or other face-to-face service (e.g., surgical procedure) from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years. Therefore, UnitedHealthcare will reimburse a New Patient E/M code only when the elements of that definition have been met. Please review the New Patient Visit Policy, Professional at UHCprovider.com.	1/30/2025	UHOne	Professional
Return Edit	**UH1OBGUA**	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.	OBGYN Services - 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 review the Obstetrical Policy, Professional on UHCprovider.com.	12/19/2024	UHOne	Professional
Return Edit	**UH1OBGUS**	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.	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 procedure (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 at UHCprovider.com	2/27/2025	UHOne	Professional
Return Edit	**UH1OCMIP**	Contrast or Radiopharmaceutical Material code <1> must be billed with an eligible imaging or therapeutic procedure. Update code(s) as applicable for services rendered.	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 review Contrast and Radiopharmaceutical Materials Policy, Professional at UHCprovider.com.	10/24/2024	UHOne	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**UH1P04UALL**	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.	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 review the Physical Medicine & Rehabilitation Maximum Combined Frequency Per Day Policy on UHCprovider.com for further information	5/30/2024	UHOne	Professional
Return Edit	**UH1PAPDN**	Procedure code <1> is not appropriate in <2> Place of service. Please update as applicable.	UHG Proc and Place of Service 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.	10/24/2024	UHOne	Professional
Return Edit	**UH1PTCDM**	Procedure <1> is not reimbursable when appended with modifier 76 or 77. Update code(s) as applicable.	Pro Tech Invalid Modifier According to the AMA and CMS, it is inappropriate to use modifier 76 or 77 to indicate repeat laboratory services. Modifiers XE, XP, XS, XU, or 91 should be used to indicate repeat or distinct laboratory services when reported by the Same Group Physician or Other Qualified Health Care Professional. Separate consideration for reimbursement will not be given to laboratory codes reported with modifier 76 or 77. Please review to the Professional/Technical Component Policy, Professional at UHCprovider.com.	10/24/2024	UHOne	Professional
Return Edit	**UH1PTCDU**	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.	Professional/Technical Duplicate Charges Submitted 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 review to the Professional/Technical Component Policy, Professional at UHCprovider.com.	10/24/2024	UHOne	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**UH1PTCHD**	Procedure <1> is not appropriate in a facility setting. Update code(s) as applicable for services rendered.	Professional/Technical Reported in Hospital Place of 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 review to the Professional/Technical Component Policy, Professional at UHCprovider.com.	10/24/2024	UHOne	Professional
Return Edit	**UH1PTCPP**	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.	Professional/Technical 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.	10/24/2024	UHOne	Professional
Return Edit	**UH1PRMIN**	Preventive procedure code <1> and E/M procedure code <1> may be submitted on same date of service when the other E/M code represents significant, separately identifiable service and submitted with appropriate modifier.	Preventive Medicine, 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.	6/27/2024	UHOne	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**UH1PTCFD**	Procedure <1> was performed in a facility setting <2>. The payment for this charge is included in the payment to the facility.	Non ProTech Lab Code Denial 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 reimbursement policy for the appropriate line of business at UHCprovider.com.	3/28/2024	UHOne	Professional
Return Edit	**UH1PTCIM**	Modifier 26 or TC is not appropriate for procedure code <1>. Update code(s) as applicable.	ProTech Incorrect Modifier CPTor 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.	6/27/2024	UHOne	Professional
Rejection Edit	**UH1RCPDN**	REJECT - Procedure <1> is not an appropriate code for services rendered. Report the status A (active) code that best describes the services provided.	Replacement Codes 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. Please review the UnitedHealthcare Replacement Codes Policy, Professional Commercial Reimbursement Policy at UHCprovider.com.	9/28/2023	UHOne	Professional
Return Edit	**UH1SUPFJ**	Procedure <1> is not appropriate in a facility place of service <2>. Update code(s) as applicable for services rendered.	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 non-facility 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	2/27/2025	UHOne	Professional
Rejection Edit	**UH1TCHMP**	REJECT – Telehealth charges should be reported with appropriate place of service. Telehealth modifiers are considered informational only. This claim has been rejected and will not be processed.	Telehealth Place of Service UnitedHealthcare will consider for reimbursement the following Telehealth services when they are rendered via audio and video and reported with either place of service POS 02 or 10. Please review the Telehealth and Telemedicine Policy on UHCprovider.com.	9/28/2023	UHOne	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**UH1UCSDN**	Procedure code <1> is not appropriate because it does not describe the specific services performed. Update code(s) as applicable for services rendered.	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. Please review the Urgent Care Policy-Reimbursement Policy for UnitedHealthcare Commercial Plans for further information.	12/19/2024	UHOne	Professional
Return Edit	**UH1UED**	<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.	Coding Relationship Error Edit determines 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 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 on UHCprovider.com.	7/25/2024	UHOne	Professional
Return Edit	**uHBOTDX2**	Please verify the submitted diagnosis codes for procedure code <1>. Review the Commercial Hyperbaric Oxygen Therapy policy at UHCprovider.com.	Hyperbaric Oxygen Therapy with Proven DX in History Hyperbaric Oxygen Therapy (HBOT) is an intervention in which an individual breathes near 100% oxygen intermittently while inside a hyperbaric chamber that is pressurized to greater than sea level pressure. This edit will apply when the submitted diagnosis code does not follow the guidelines for HBOT. Please review the Hyperbaric Oxygen Therapy and Topical Oxygen Therapy policy on www.UHCprovider.com.	1/5/2023 2/2/2023	All Savers Level Funded Oxford Individual & Family Plan	Professional
Return Edit	**uHBOTDX2f**	Please verify the submitted diagnosis codes for procedure code <1>. Review the Commercial Hyperbaric Oxygen Therapy policy at UHCprovider.com.	Hyperbaric Oxygen Therapy with Proven DX in History Hyperbaric Oxygen Therapy (HBOT) is an intervention in which an individual breathes near 100% oxygen intermittently while inside a hyperbaric chamber that is pressurized to greater than sea level pressure. This edit will apply when the submitted diagnosis code does not follow the guidelines for HBOT. Please review the Hyperbaric Oxygen Therapy and Topical Oxygen Therapy policy on www.UHCprovider.com.	1/5/2023 2/2/2023	All Savers Commercial Level Funded Oxford Individual & Family Plan	Facility
Return Edit	**uHBP1**	Blood pressure level code(s) are required to support wellness visit <1>. Please review claim and include or update code(s) as applicable.	Hypertension Without BP Results 99211 Blood pressure level code(s) are required to support Hypertension Please review the UnitedHealthcare PATH reference guide on UHCprovider.com for further information.	4/30/2020	Medicare	Professional
Return Edit	**uHCVf**	Procedure code <1> should not be billed with bill type 013(x) and Revenue Code 510. Please update code(s) as applicable.	Hospital Clinic Visits Clinic Visits Effective January 1, 2014, CMS will recognize HCPCS code G0463 (Hospital outpatient clinic visit for assessment and management of a patient) for payment under the OPPS for outpatient hospital clinic visits. CPT codes 99201-99205 and 99211-99215 are no longer valid. Please refer to the Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity (NCD 100.1) Policy on UHCprovider.com.	10/29/2020	Medicare	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uHDVf**	According to CMS/NUBC Discharge Status description, coverage may not be covered for this discharge status when Admit Date and Discharge Date are the same. Please update code(s) as appropriate.	Institutional Hospice Validation According to CMS, once a member elects Hospice coverage, original Medicare coverage is primary for all hospice-related services. Please refer to Medicare Managed Care Manual, Chapter 4 Section 10.2.2	2/27/2020	Medicare	Facility
Return Edit	**uHHI**	Date of service <1> for home health procedure code <2> falls within an inpatient stay claim id <3> for this member. Update claim as applicable.	Home Health while Inpatient Home health services must be provided in the home in lieu of Skilled Care in another setting (including but not limited to a nursing facility, acute inpatient rehabilitation, or a hospital). Services should not be billed while the patient is in an inpatient facility. Please review UnitedHealthcare Community Plan Coverage Determination Guideline, Home Health Care, on UHCprovider.com.	4/28/2022	Medicaid	Professional
Return Edit	**uHIPPSf**	Revenue code <1> requires a valid HIPPS Code. Please update as applicable.	Skilled Nursing Rev Codes CMS regulations require Skilled Nursing revenue codes to be billed with a valid HIPPS Code for Medicare. Please refer to CMS.gov for a list of valid HIPPS codes. Please refer to HIPPS Codes on www.cms.gov for additional information.	4/28/2022	Medicare	Facility
Return Edit	**uHRMOD1**	Procedure code <1> requires a modifier to distinguish if the service is habilitative or rehabilitative. Please update claim as applicable.	Habilitative and Rehabilitative Services Billed without the Correct Modifier This policy describes how claims for Habilitative, and Rehabilitative Services should be reported using the appropriate Modifiers. Habilitative services help a person learn, keep, or improve skills and functioning for daily living. While rehabilitative services are necessary after an illness or injury to help a person restore, keep, or improve skills and functioning for daily living. The same CPT/HCPC codes may be utilized for both habilitative and rehabilitative services, modifiers 96 and 97 were developed to help differentiate which service being billed. Please review Habilitative & Rehabilitative Services Policy, Professional & Facility at UHCprovider.com	2/17/2022	Individual & Family Plan	Professional
Return Edit	**uHRMOD1f**	Procedure code <1> requires a modifier to distinguish if the service is habilitative or rehabilitative. Please update claim as applicable.	Habilitative and Rehabilitative Services Billed without the Correct Modifier This policy describes how claims for Habilitative, and Rehabilitative Services should be reported using the appropriate Modifiers. Habilitative services help a person learn, keep, or improve skills and functioning for daily living. While rehabilitative services are necessary after an illness or injury to help a person restore, keep, or improve skills and functioning for daily living. The same CPT/HCPC codes may be utilized for both habilitative and rehabilitative services, modifiers 96 and 97 were developed to help differentiate which service being billed. Please refer to Habilitative & Rehabilitative Services Policy, Professional & Facility at UHCprovider.com	2/17/2022	Individual & Family Plan	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uHRMOD2**	Procedure code <1> requires a modifier to distinguish if the service is habilitative or rehabilitative. Please update claim as applicable.	Habilitative and Rehabilitative Services Billed without the Correct Modifier This policy describes how claims for Habilitative, and Rehabilitative Services should be reported using the appropriate Modifiers. Habilitative services help a person learn, keep, or improve skills and functioning for daily living. While rehabilitative services are necessary after an illness or injury to help a person restore, keep, or improve skills and functioning for daily living. The same CPT/HCPC codes may be utilized for both habilitative and rehabilitative services, modifiers 96 and 97 were developed to help differentiate which service being billed. Please review Habilitative & Rehabilitative Services Policy, Professional & Facility at UHCprovider.com	2/17/2022	Individual & Family Plan	Professional
Return Edit	**uHRMOD2f**	Procedure code <1> requires a modifier to distinguish if the service is habilitative or rehabilitative. Please update claim as applicable.	Habilitative and Rehabilitative Services Billed without the Correct Modifier This policy describes how claims for Habilitative, and Rehabilitative Services should be reported using the appropriate Modifiers. Habilitative services help a person learn, keep, or improve skills and functioning for daily living. While rehabilitative services are necessary after an illness or injury to help a person restore, keep, or improve skills and functioning for daily living. The same CPT/HCPC codes may be utilized for both habilitative and rehabilitative services, modifiers 96 and 97 were developed to help differentiate which service being billed. Please refer to Habilitative & Rehabilitative Services Policy, Professional & Facility at UHCprovider.com	2/17/2022	Individual & Family Plan	Facility
Return Edit	**uHRMODTX**	Procedure code <1> requires a modifier to distinguish if the service is habilitative and rehabilitative. Please update claim as applicable.	Habilitative and Rehabilitative Services Billed without the Correct Modifier This policy describes how claims for Habilitative, and Rehabilitative Services should be reported using the appropriate Modifiers. Habilitative services help a person learn, keep, or improve skills and functioning for daily living. While rehabilitative services are necessary after an illness or injury to help a person restore, keep, or improve skills and functioning for daily living. The same CPT/HCPC codes may be utilized for both habilitative and rehabilitative services, modifiers 96 and 97 were developed to help differentiate which service being billed. Please review Habilitative & Rehabilitative Services Policy, Professional & Facility at UHCprovider.com	2/17/2022	Individual & Family Plan	Professional
Return Edit	**uHRMODTXf**	Procedure code <1> requires a modifier to distinguish if the service is habilitative and rehabilitative. Please update claim as applicable.	Habilitative and Rehabilitative Services Billed without the Correct Modifier This policy describes how claims for Habilitative, and Rehabilitative Services should be reported using the appropriate Modifiers. Habilitative services help a person learn, keep, or improve skills and functioning for daily living. While rehabilitative services are necessary after an illness or injury to help a person restore, keep, or improve skills and functioning for daily living. The same CPT/HCPC codes may be utilized for both habilitative and rehabilitative services, modifiers 96 and 97 were developed to help differentiate which service being billed. Please refer to Habilitative & Rehabilitative Services Policy, Professional & Facility at UHCprovider.com	2/17/2022	Individual & Family Plan	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**uHRMODVA**	INFORMATIONAL - When billing habilitative or rehabilitative manipulative chiropractic services, please note modifier 96 or 97 should be appended to the billed service.	Habilitative and Rehabilitative Services Billed without the Correct Modifier This policy describes how claims for Habilitative, and Rehabilitative Services should be reported using the appropriate Modifiers. Habilitative services help a person learn, keep, or improve skills and functioning for daily living. While rehabilitative services are necessary after an illness or injury to help a person restore, keep, or improve skills and functioning for daily living. The same CPT/HCPC codes may be utilized for both habilitative and rehabilitative services, modifiers 96 and 97 were developed to help differentiate which service being billed. Please review Habilitative & Rehabilitative Services Policy, Professional & Facility at UHCprovider.com	2/17/2022	Individual & Family Plan	Professional
Informational Edit	**uHRMODVAf**	INFORMATIONAL - When billing habilitative or rehabilitative manipulative chiropractic services, please note modifier 96 or 97 should be appended to the billed service.	Habilitative and Rehabilitative Services Billed without the Correct Modifier This policy describes how claims for Habilitative, and Rehabilitative Services should be reported using the appropriate Modifiers. Habilitative services help a person learn, keep, or improve skills and functioning for daily living. While rehabilitative services are necessary after an illness or injury to help a person restore, keep, or improve skills and functioning for daily living. The same CPT/HCPC codes may be utilized for both habilitative and rehabilitative services, modifiers 96 and 97 were developed to help differentiate which service being billed. Please refer to Habilitative & Rehabilitative Services Policy, Professional & Facility at UHCprovider.com	2/17/2022	Individual & Family Plan	Facility
Return Edit	**uHVPOS**	POS <1> is not appropriate for procedure code <2>. Please update as applicable.	Home Visits with Incorrect Place of Service Home visit services may only be billed in the patient residence. For more information, please see: https://www.cms.gov/files/document/mm13004-home-or-residence-services-billing-instructions.pdf	11/17/2022	Medicare	Professional
Return Edit	**uHVSPOS**	POS <1> is not appropriate for procedure code <2>. Please update as applicable.	Home Visit Services POS Home visit services may only be billed in the patient residence. Please refer to: https://www.cms.gov/files/document/mm13004-home-or-residence-services-billing-instructions.pdf	12/28/2023	Medicare	Professional
Informational Edit	**uHYDSRVf**	INFORMATIONAL- Time-based procedure code < 1 > requires documentation on file of start/stop times. A minimum of 31 minutes is required toreport and hydration is not reported as a concurrent infusion service.	Hydration Start Stop Time The hydration code billed is time-based, therefore start/stop times must be documented in the medical records when billing for these services. A minimum of 31 minutes is required before submitting code for reimbursement. Hydration is not reported for purpose of KVO (keep vein open) or as a concurrent infusion service. Please refer to the ICD-10-CM Guidelines; UnitedHealthcare Care Provider Administrative guide at UHCprovider.com.	7/27/2023	Commercial Individual & Family Plan Level Funded Oxford	Facility
Rejection Edit	**uIBC**	REJECT - Billing CLIA ID submitted on the claim is not valid based on QIES and CDC database, and will not be forwarded for adjudication. Please resubmit claim with a valid CLIA ID.	Invalid Billing CLIA ID 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. Please review the Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com for further information.	1/17/2019 4/11/2019 4/20/2020 7/29/2021 6/30/2022 8/29/2024	Medicaid Commercial Oxford Individual & Family Plan All Savers UHOne	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uIBFD**	Procedure code <1> was submitted with a future date of service, which per Medicare guidelines is not allowed. Please update codes as applicable.	Invalid Billing - Future Date Span Codes CR 2363 (Transmittal B-03-004) states that glucose test strips and supplies can be billed for up to 3 months of supplies at a time. Beginning April 1, 2002, claims for test strips and supplies must be submitted with the appropriate "start" and "end" dates. The "start" and "end" dates for each claim can span across 3 months. For more information, please review the Change Request 2363 on www.cms.gov.	11/19/2020	Medicare	Professional
Return Edit	**uICTPI**	Trigger point procedure code <1> submitted without required therapeutic agent. Update code(s) as applicable.	Trigger Point Injections Trigger point injection CPT codes 20550-20553 require a therapeutic agent (J-codes). Trigger point procedures billed without the therapeutic agent are considered dry needling. Dry needling procedures are needle insertions without injections CPT codes 20560 and 20561. Please also note that J-codes may require the addition of NDC codes, quantity, and units of measure. Please review CPT®) Professional 4th Edition 2022: Trigger Points Code Section (20526-20561). And the National Drug Code (NDC) policy, Professional and Facility.	3/30/2023	Commercial Medicaid	Professional
Return Edit	**UIDCDN**	Per the ICD-10-CM Excludes1 guideline, diagnosis code <1> with <2> identify two conditions that cannot be reported together except when they are unrelated. Please update code(s) as applicable.	ICD-10 CM Excludes 1 code pairs The Inappropriate Diagnosis Combination - Definitive edit identifies ICD-10-CM diagnosis codes that are mutually exclusive and cannot be reported together. The ICD-10-CM guidelines identify specific codes in the Excludes1 notes. These relationships are considered ICD-10-CM definitive in the KnowledgeBase. 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 review ICD-10 CM Coding Guidelines	6/27/2024	Commercial	Professional
Return Edit	**uIDEVOPf**	Device dependent procedure code <1> requires that a valid device dependent HCPCS is submitted on the same day and on the same claim. Please update code(s) as applicable.	Device Dependent When a device-dependent procedure code is submitted on an OPP Outpatient facility claim, it requires the appropriate device code to be submitted on the same claim and same date of service unless the procedure was terminated, indicated in the submission of certain skin substitute application procedures require the appropriate skin substitute product be submitted on the same day. These procedures and products are divided into two lists based on high or low cost. Please review Device Implant and Skin and Skin Substitute Policy, Facility at UHCprovider.com	9/26/2024	Individual & Family Plan	Facility
Informational Edit	**uIHHI**	INFORMATIONAL - Effective 7/1/24, professional home health claims for dates of service submitted while a member is inpatient will not be reimbursed.	Home Health Intake Home health services must be provided in the home. Services should not be billed while the patient is in an inpatient facility. Please review the Home Health Services Professional policy on UHCprovider.com.	6/13/2024	Individual & Family Plan	Professional
Return Edit	**uIKETA**	Diagnosis code <1> may not be appropriate with procedure code <2>. Please update as applicable.	Inappropriate Ketamine Use Ketamine injections are investigational and considered not proven or medically necessary and may not be covered for psychiatric disorders, chronic pain, and/or migraines. Please review the Ketalar (Ketamine) and Spravato (Esketamine) Medical benefit drug policy. Please review Ketalar and Spravato Medical Benefit Drug Policy at UHCprovider.com	3/27/2025	Commercial Oxford Level Funded	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uIKETAf**	Diagnosis code <1> may not be appropriate with procedure code <2>. Please update as applicable.	Inappropriate Ketamine Use Ketamine injections are investigational and considered not proven or medically necessary and may not be covered for psychiatric disorders, chronic pain, and/or migraines. Please review the Ketalar (Ketamine) and Spravato (Esketamine) Medical benefit drug policy. Please review Ketalar and Spravato Medical Benefit Drug Policy at UHCprovider.com	3/27/2025	Commercial Oxford Level Funded	Facility
Informational Edit	**uIMZCODE**	INFORMATIONAL - Starting 02/01/25, CPT <1> will require a valid DEX Z-Code in the line level 2400 loop, SV101-7 on electronic claims. Please visit dexzcodes.com for more information.	Missing Z-Code UnitedHealthcare recommends that providers submit the appropriate DEX Z-Code for this molecular diagnostic test. The assigned Z-Code can be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. Please refer to DEX Diagnostics Exchange Test Registration for additional information on test registration at dexzcodes.com.	12/5/2024	Individual & Family Plan	Professional
Informational Edit	**uIMZCODEf**	INFORMATIONAL - Starting 02/01/25, CPT <1> will require a valid DEX Z-Code in the line level 2400 loop, SV101-7 on electronic claims. Please visit dexzcodes.com for more information.	Missing Z-Code UnitedHealthcare recommends that providers submit the appropriate DEX Z-Code for this molecular diagnostic test. The assigned Z-Code can be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. Please refer to DEX Diagnostics Exchange Test Registration for additional information on test registration at dexzcodes.com.	12/5/2024	Individual & Family Plan	Facility
Informational Edit	**uINFSRVf**	INFORMATIONAL - Time-based procedure code < 1 > requires documentation on file of start/stop times. A minimum of 16 minutes is required to report an infusion service.	Infusion Start Stop Time The infusion code billed is time-based, therefore start/stop times must be documented in the medical records when billing for these services. A minimum of 16 minutes is required before submitting code for reimbursement. Please refer to the ICD-10-CM Guidelines; UnitedHealthcare Care Provider Administrative guide at UHCprovider.com.	7/27/2023	All Savers Commercial Individual & Family Plan Level Funded Oxford	Facility
Return Edit	**uIONM**	Procedure code <1> is not appropriate for place of service <2>. Update code as applicable.	Inoperative Neural Monitoring According to The Centers for Medicare and Medicaid Services (CMS), Intraoperative neurophysiology testing (HCPCS/CPT codes 95940 and G0453) should not be reported by the physician performing an operative or anesthesia procedure since it is included in the global package. The American Academy of Neurology states IONM services should be performed in Place of Service (POS) 19, 21, 22 or 24. Please review the Intraoperative Neuromonitoring Policy, Professional on UHCprovider.com.	7/29/2021 1/30/2025	Commercial Oxford UHOne	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uIPA**	Procedure Code <1> is not typical for a patient whose age is <2>. Update code(s) as applicable.	Invalid Procedure Age The code submitted is invalid due to the age of the member at time of service. This edit applies when diagnosis &/or procedure codes are reported for the inappropriate patient's age. Diagnosis &/or procedure codes reported inappropriately will be considered billing errors and will not be reimbursed.	3/25/2021	Oxford	Professional
Informational Edit	**uIPAPGPT**	INFORMATIONAL – Effective 1/1/2025, UHC will discontinue coverage for multi-gene panel pharmacogenetic code <1>. Prior authorizations are no longer required and should not be requested.	Commercial Prior Auth/Unproven Pharmacogenetic Panel Testing Effective 1/1/25, UnitedHealthcare will no longer cover multi-panel genetic tests and providers will no longer be required to submit prior authorization requests for affected procedure codes. The following procedure codes will be removed from existing prior authorization/advance notification requirements and claims for these codes will be denied as unproven and not medically necessary: 0029U, 0173U, 0175U, 0345U, 0411U, 0419U, 0423U, 0460U, 0476U, 0477U, 81418. Please see 1/1/25 Network Bulletin.	12/5/2024	Individual & Family Plan	Professional
Rejection Edit	**uIPDf**	REJECT – Diagnosis code <1> is an inappropriate principal diagnosis code. This claim has been rejected and will not be processed.	Inappropriate Primary Diagnosis Inappropriate Principal Diagnosis Codes Policy states appropriate principal 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 principal. Please refer to the Diagnosis Code Requirement Policy, Professional and Facility - Reimbursement Policy - UnitedHealthcare Commercial and Individual Exchange at UHCprovider.com	5/27/2021 1/25/2024 12/19/2024	Oxford UHOne Level Funded Commercial	Facility
Rejection Edit	**uIPDKSf**	REJECT - Diagnosis code <1> is an inappropriate principal diagnosis code. This claim has been rejected and will not be processed.	Inappropriate Principal Diagnosis - Kansas The new Facility Outpatient Hospital Inappropriate Primary Diagnosis policy will follow the official ICD-10-CM guidelines for coding and reporting as required by HIPAA. The first listed diagnosis code should follow the coding conventions of ICD-10-CM. Please refer to the Diagnosis Code Requirement Policy, Professional and Facility - Reimbursement Policy - UnitedHealthcare Commercial and Individual Exchange at UHCprovider.com.	5/27/2021	Medicaid	Facility
Rejection Edit	**uIPDRIf**	REJECT - Diagnosis code <1> is an inappropriate principal diagnosis code. This claim has been rejected and will not be processed.	Inappropriate Principal Diagnosis - Rhode Island The new Facility Outpatient Hospital Inappropriate Primary Diagnosis policy will follow the official ICD-10-CM guidelines for coding and reporting as required by HIPAA. The first listed diagnosis code should follow the coding conventions of ICD-10-CM. Please refer to Diagnosis Code Requirement Policy, Professional and Facility - Reimbursement Policy - UnitedHealthcare Commercial and Individual Exchange at UHCprovider.com.	5/27/2021	Medicaid	Facility
Rejection Edit	**uIPDWD**	REJECT – Diagnosis code is an inappropriate principal diagnosis code. This claim has been rejected and will not be processed.	Inappropriate Primary Diagnosis UnitedHealthcare follows the Official International Classifications of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) guidelines, which is published on the Centers for Medicare and Medicaid (CMS) website. ICD -10 -CM specifies when a diagnosis code should never be listed as the primary diagnosis code on an outpatient claim. Please refer to Diagnosis Code Requirement Policy, Professional and Facility - Reimbursement Policy - UnitedHealthcare Commercial and Individual Exchange at UHCprovider.com.	6/29/2023	Commercial	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uIPOSP**	Code <1> billed with place of service <2> was previously submitted by this provider for this date of service on outpatient claim ID <3>. Review place of service and update as applicable.	Invalid POS - Physician This claim describes a service or procedure that requires manual review. Medical records can be uploaded to the UHC Provider Portal. Please review the Provider Administrative Guide on UHCprovider.com.	7/28/2022	Commercial	Professional
Return Edit	**uIPZIP**	ZIP Code 24407 is an invalid ZIP Code. Update code as applicable.	Invalid Providers Zip An invalid ZIP code was submitted.	2/29/2024	All Savers Commercial Dual Enrollment Individual & Family Plan Level Funded Medicaid Medicare Oxford UHOne UMR	Professional
Documentation Edit	**uIRIDR**	Diagnostic Radiology Interpretation Report may be required and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information, go to UHCprovider.com/smartedits.	Interpretive Radiology UnitedHealthcare considers the interpretation (modifier 26) of a radiology service assigned a PC/TC Indicator 1 to be included in the Evaluation and Management (E/M) service when performed by the Same Individual Physician or Other QHP on the same date of service for the same patient as these services usually are not distinct from the E/M service when both are provided on the same day. American College of Radiology (ACR) guidelines suggest that physicians and other QHP who believe the Professional Component (modifier 26) for a PC/TC Indicator 1 radiology code is reimbursable in addition to the E/M service on the same day must include medical records. Please review the Professional/Technial Component Policy at UHCprovider.com	9/12/2024	Individual & Family Plan	Professional
Informational Edit	**uIRLf**	INFORMATIONAL – Our records indicate that an updated Interim Rate Letter from Original Medicare or your MAC needs to be faxed to United HealthCare Reimbursement at 866-943-9811. Disregard if already sent.	Interim Rate Letter Notification For facilities not paid under Prospective Payment System (PPS) methodology, UnitedHealthcare MedicareDirect must have an interim rate letter on file for any date(s) of service for which services were rendered to a member. Fax letters and updates to Reimbursement Services at 866-943-9811. Interim rate reviews are conducted by either Original Medicare or the Medicare Administrative Contractor (MAC) depending on a provider's location.	2/25/2021	Medicare	Facility
Informational Edit	**uISACCI**	INFORMATIONAL - Effective 2/1/25, procedure code <1> and <2> are inappropriate for the same date of service for the same shoulder per NCCI or CCI guidelines. See the 11/1/24 Network News Bulletin.	Ipsilateral Shoulder Arthroscopy In accordance with the CMS National Correct Coding Initiative (NCCI) CPT codes 29805-29828 Procedure to Procedure (PTP) edit, code pairs consisting of two codes describing two shoulder arthroscopy procedures performed on the same shoulder will not be considered for separate reimbursement regardless if the code is appended with an NCCI PTP associated modifier. This includes the use of modifier 59. Please review Rebundling and NCCI Edits Policy Professional at uhcProvider.com.	1/9/2025	Commerical Individual & Family Plan Medicare	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**uISACCIf**	INFORMATIONAL - Effective 2/1/25, procedure code <1> and <2> are inappropriate for the same date of service for the same shoulder per NCCI or CCI guidelines. See the 11/1/24 Network News Bulletin.	Ipsilateral Shoulder Arthroscopy In accordance with the CMS National Correct Coding Initiative (NCCI) CPT codes 29805-29828 Procedure to Procedure (PTP) edit, code pairs consisting of two codes describing two shoulder arthroscopy procedures performed on the same shoulder will not be considered for separate reimbursement regardless if the code is appended with an NCCI PTP associated modifier. This includes the use of modifier 59. Please review Rebundling and NCCI Edits Policy, Facility at uhcProvider.com.	1/9/2025	Commerical Individual & Family Plan Medicare	Facility
Rejection Edit	**uISC**	REJECT - Servicing CLIA ID submitted on the claim is not valid based on QIES and CDC database, and will not be forwarded for adjudication. Please resubmit claim with a valid CLIA ID.	Invalid Servicing CLIA ID 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. Please review the Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com for further information.	1/17/2019 4/11/2019 4/30/2020 7/29/2021 6/30/2022	Medicaid Commercial Oxford Individual & Family Plan All Savers	Professional
Informational Edit	**uITZCODE**	INFORMATIONAL - Starting 02/01/25, CPT <1> will require a valid DEX Z-Code in the line level 2400 loop, SV101-7 on electronic claims. Please visit dexzcodes.com for more information.	Value Not Z-Code UnitedHealthcare recommends that providers submit the appropriate DEX Z-Code for this molecular diagnostic test. The assigned Z-Code can be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. Please refer to DEX Diagnostics Exchange Test Registration for additional information on test registration at dexzcodes.com.	12/5/2024	Individual & Family Plan	Professional
Informational Edit	**uITZCODEf**	INFORMATIONAL - Starting 02/01/25, CPT <1> will require a valid DEX Z-Code in the line level 2400 loop, SV101-7 on electronic claims. Please visit dexzcodes.com for more information.	Value Not Z-Code UnitedHealthcare recommends that providers submit the appropriate DEX Z-Code for this molecular diagnostic test. The assigned Z-Code can be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. Please refer to DEX Diagnostics Exchange Test Registration for additional information on test registration at dexzcodes.com.	12/5/2024	Individual & Family Plan	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**ulUDSf**	Number of bed units do not match the time span billed. Please update as applicable.	Invalid Units for Date Span The number of units submitted is not equal to the date span starting from beginning Date of service to the ending date of service. Please refer to the administrative guide on www.UHCprovider.com.	11/30/2023	Medicaid	Facility
Rejection Edit	**ulUPDf**	REJECT – Diagnosis code <1> is an unacceptable principal diagnosis code. This claim has been rejected and will not be processed.	Inappropriate Principal Diagnosis - Inpatient UnitedHealthcare follows the Official International Classifications of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) guidelines, which is published on the Centers for Medicare and Medicaid (CMS) website. ICD-10-CM specifies when it is unacceptable to list a diagnosis as the primary diagnosis code on an inpatient claim and proper sequencing of diagnosis codes. UnitedHealthcare may deny claims when a code on the Unacceptable Principal ICD-10-CM Diagnosis List is submitted as a principal diagnosis in box 67 on a UB-04 claim form or its electronical equivalent. UnitedHealthcare will also deny claims when a code on the Principal Diagnosis Requiring Secondary Diagnosis List is submitted as a principal diagnosis in box 67 without the appropriate secondary diagnosis. Please refer to Diagnosis Code Requirement Policy, Professional and Facility - Reimbursement Policy - UnitedHealthcare Commercial and Individual Exchange at UHCprovider.com.	9/30/2021	Commercial Oxford Level Funded	Facility
Informational Edit	**ulZCDCPT**	INFORMATIONAL - CPT <1> is recommended to be submitted with a DEX Z-Code. Please visit dexzcodes.com for more information.	Invalid Z Code for CPT UnitedHealthcare recommends that providers submit the appropriate DEX Z-Code for this molecular diagnostic test. The assigned Z-Code can be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a valid Z-Code. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com). After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. Please review the Molecular Pathology Policy, Commercial at UHCprovider.com	2/6/2025	Individual & Family Plan	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**uIZCDCPTf**	INFORMATIONAL - CPT <1> is recommended to be submitted with a DEX Z-Code. Please visit dexzcodes.com for more information.	Invalid Z Code for CPT UnitedHealthcare recommends that providers submit the appropriate DEX Z-Code for this molecular diagnostic test. The assigned Z-Code can be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a valid Z-Code. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com). After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. Please review the Molecular Pathology Policy, Commercial at UHCprovider.com	2/6/2025	Individual & Family Plan	Facility
Informational Edit	**uIZCDU**	INFORMATIONAL- Molecular diagnostic procedure code <1> should not be submitted with more than one unit.	Z-Code Multiple Units UnitedHealthcare will require providers to submit the appropriate DEX Z-Code for molecular diagnostic test services for the services to be considered for reimbursement. This policy will apply to both facility and professional claims. The assigned Z-Code should be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com). After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. Please review the Molecular Pathology Policy, Commercial at UHCprovider.com	2/6/2025	Individual & Family Plan	Professional
Informational Edit	**uIZCDUf**	INFORMATIONAL- Molecular diagnostic procedure code <1> should not be submitted with more than one unit.	Z-Code Multiple Units UnitedHealthcare will require providers to submit the appropriate DEX Z-Code for molecular diagnostic test services for the services to be considered for reimbursement. This policy will apply to both facility and professional claims. The assigned Z-Code should be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com). After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. Please review the Molecular Pathology Policy, Commercial at UHCprovider.com	2/6/2025	Individual & Family Plan	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uJVBRN**	Appropriate diagnosis must be billed when reporting bronchitis in juvenile patient. Please update code(s) as applicable.	Juvenile Bronchitis UnitedHealthcare follows the Official International Classifications of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) guidelines. ICD-10-CM specifies a list of valid diagnosis codes available to report bronchitis in member under 15 years of age. Please review coding alert at https://www.aapc.com/codes/coding-newsletters/my-icd-10-coding-alert/reader-question-look-to-patient-age-anatomy-for-accurate-bronchitis-coding-159485-article	1/26/2023	Commercial	Professional
Return Edit	**uJVBRN2**	Appropriate diagnosis must be billed when reporting bronchitis in juvenile patient. Please update code(s) as applicable.	Juvenile Bronchitis UnitedHealthcare follows the Official International Classifications of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) guidelines. ICD-10-CM specifies a list of valid diagnosis codes available to report bronchitis in member under 15 years of age. For additional information, please review coding alert at https://www.aapc.com/codes/coding-newsletters/my-icd-10-coding-alert/reader-question-look-to-patient-age-anatomy-for-accurate-bronchitis-coding-159485-article	9/28/2023	Commercial	Professional
Return Edit	**uJVBRNf**	Appropriate diagnosis must be billed when reporting bronchitis in juvenile patient. Please update code(s) as applicable.	Juvenile Bronchitis UnitedHealthcare follows the Official International Classifications of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) guidelines. ICD-10-CM specifies a list of valid diagnosis codes available to report bronchitis in member under 15 years of age. Please refer to coding alert at https://www.aapc.com/codes/coding-newsletters/my-icd-10-coding-alert/reader-question-look-to-patient-age-anatomy-for-accurate-bronchitis-coding-159485-article	1/26/2023	Commercial	Facility
Return Edit	**uLAU**	Diagnosis code <1> does not support procedure code 76700. Additional diagnosis codes may be submitted if applicable.	Abdominal Ultrasound A limited abdominal ultrasound should only address a single quadrant, or a single diagnostic problem. Diagnoses indicating more than one quadrant or organ may be inappropriate for a limited abdominal ultrasound. Please review the Ultrasound Diagnostic Procedure Policy Guideline on UHCprovider.com.	10/22/2020	Medicaid Commercial Medicare Oxford Level Funded	Professional
Return Edit	**um040CCOf**	Procedure code <1> is considered to be a component of comprehensive code <2> on the same service date, where the use of a modifier is not appropriate. Please review and update as applicable.	Mutually Exclusive Mutually exclusive procedures refer to two or more procedures that are usually not performed on the same patient on the same date of service. They are defined by the National Correct Coding Initiative (NCCI) as an incorrect code combination. Please refer to The National Correct Coding Initiative (NCCI) https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci	4/6/2023	Medicare	Facility
Return Edit	**umAT**	Therapy procedure <1> must be billed with the required modifier GP, GN, or GO. Update code(s) as applicable.	Always Therapy Effective with dates of service on or after July 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). Please review our Physical, Occupational, and Speech Therapy Including Cognitive/Neuropsychological Rehabilitation for New Jersey Small Group Members Policy on UHCprovider.com.	7/28/2022	Oxford Level Funded	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**umAT2**	REJECT - Therapy procedure <1> must be billed with the required modifier GP, GN, or GO. Update code(s) as applicable.	Always Therapy Effective with dates of service on or after July 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). For additional information, please review the Physical, Occupational, and Speech Therapy Including Cognitive/Neuropsychological Rehabilitation for New Jersey Small Group Members policy on UHCprovider.com.	10/27/2022	Commercial	Professional
Rejection Edit	**umBICCL**	REJECT- CLIA ID <1> does not meet the certification level for procedure code <1>. Please update as applicable.	Invalid CLIA Cert Level (Billing Provider) The lab certification level must 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. Please review our Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com.	4/29/2021	Medicare	Professional
Rejection Edit	**uMCID**	REJECT - CLIA ID was not submitted on the claim and will not be forwarded for adjudication. Please resubmit claim with a valid CLIA ID.	Missing CLIA ID 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. Please review the Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com for further information.	1/17/2019 4/11/2019 4/30/2019 7/29/2021 6/30/2022 1/25/2024 3/27/2025	 Medicaid Commercial Oxford Individual & Family Plan Level Funded All Savers UHOne Surest	Professional
Rejection Edit	**umCIPS**	REJECT - Provider state <1> submitted on the claim does not match the state registered with CLIA <2>. This claim has been rejected and will not be processed.	CLIA Invalid Provider State CLIA Certificate Identification number and their associated state 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. Please review the Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com for further information.	12/15/2022	Medicare	Professional
Rejection Edit	**umCIPZ**	REJECT - Provider ZIP Code <1> submitted on the claim does not match the ZIP code registered with CLIA <2>. This claim has been rejected and will not be processed.	CLIA Invalid Provider Zip CLIA Certificate Identification number and their associated zip 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. Please review the Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com for further information.	12/15/2022	Medicare	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**umCTERM**	REJECT - CLIA ID <1> submitted on the claim is not valid for date of service <2> based on QIES database.	CLIA Termed 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 CMS1500) or its electronic equivalent. Any claim that contains an invalid or expired ID or does not contain the CLIA ID and/or the complete servicing provider demographic information will be considered incomplete and rejected or denied. Submitting the correct loop, segment, and associate line level qualifier on the claim is important to ensure the CLIA certification identification number is submitted appropriately. Please review the Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com for further information.	9/28/2023	Medicare	Professional
Rejection Edit	**umCVAXA**	REJECT - COVID-19 vaccine administration code <1> should be billed to Original Medicare. This claim has been rejected and will not be processed.	COVID Vaccine Admin Code COVID-19 vaccine administration charges should be submitted as primary to Original Medicare. Please submit to the appropriate Medicare Administrative Contractor. For more information, please review Medicare Billing for COVID-19 Vaccine Shot Administration on www.cms.gov	1/7/2021	Medicare	Professional
Rejection Edit	**umCVAXAf**	REJECT - COVID-19 vaccine administration code <1> should be billed to Original Medicare. This claim has been rejected and will not be processed.	Medicare COVID-19 Vaccine Admin Code COVID-19 vaccine administration charges should be submitted as primary to Original Medicare. Please submit to the appropriate Medicare Administrative Contractor. For more information, please refer to Medicare Billing for COVID-19 Vaccine Shot Administration on www.cms.gov	1/7/2021	Medicare	Facility
Informational Edit	**umDDMOD**	INFORMATIONAL - Single dose drug <1> billed with NDC <2> should be submitted with JW or JZ modifier.	Discarded Drug Modifier Effective January 1, 2017, the JW modifier must be used to report discarded amounts of a single-dose container drug in order to obtain payment for a discarded amount of drug from single dose or single use packaging. No later than July 1, 2023, the JZ modifier is required to attest that there were no discarded amounts and no JW modifier amount is reported. For more information, please see: https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/jw-modifier-faqs.pdf	11/9/2023	Medicare	Professional
Return Edit	**uMDRGT1**	Procedure code <1> has a maximum frequency of once per lifetime. Procedure code <1> was also submitted on a claim on date or dates of service <2>. Please update the code or modifier as applicable.	Molecular Diagnostics Repeat Germline Test with Same Provider Unit of Service (UOS) for any one specific germline DNA or RNA-based test is limited to one per lifetime. Germline testing, including using gene panels that contain some genetic content that has already been tested in the same Medicare beneficiary may be considered reasonable and necessary provided that there is established clinical utility present in the remaining, non-duplicative genetic components of the test. Please review the UnitedHealthcare Medicare Advantage Policy on Molecular Pathology/ Molecular Diagnostics/ Genetic Testing on UHCprovider.com.	3/31/2022	Medicare	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**uMDRGT2**	INFORMATIONAL - Procedure code <1> has previously been billed by another provider on date or dates of service <2> for this member.	Molecular Diagnostics Repeat Germline Test with Different Provider Unit of Service (UOS) for any one specific germline DNA or RNA-based test is limited to one per lifetime. Germline testing, including using gene panels that contain some genetic content that has already been tested in the same Medicare beneficiary may be considered reasonable and necessary when billed by a different provider, provided there is established clinical utility present in the remaining, non-duplicative genetic components of the test. Please review the UnitedHealthcare Medicare Advantage Policy on Molecular Pathology/ Molecular Diagnostics/ Genetic Testing on UHCprovider.com.	3/31/2022	Medicare	Professional
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>.	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. 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 review the Professional/Technical Component Reimbursement Policy on UHCprovider.com for further information.	8/16/2018	Medicare	Professional
Return Edit	**uMFD1f**	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.	Outpatient Maximum Frequency 1 The MFD values apply whether a hospital submits one CPT or HCPCS code with multiple units on a single claim line or multiple claim lines with one or more unit(s) on each line. Services provided are reimbursable services up to and including the MFD value for an individual CPT or HCPCS code. There may be situations where a facility 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. For more information please refer to the Outpatient Hospital Maximum Frequency per Day Policy, Facility.	6/24/2021	Commercial Oxford	Facility
Return Edit	**uMFD2f**	INFORMATIONAL - Procedure <1> with an allowed daily frequency of <2> has been exceeded by <3>.	Outpatient Maximum Frequency 2 This edit applies whether an outpatient hospital submits one CPT or HCPCS code with multiple units on a single claim line or multiple claim lines with one or more unit(s) on each line. It is common coding practice for some CPT and HCPCS codes to be submitted with multiple units. This edit applies to MAI 2 codes. For more information please refer to the Outpatient Hospital Maximum Frequency per Day Policy, Facility.	6/24/2021 1/25/2024	Commercial Oxford UHOne	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**umGELIGT**	REJECT - Employer group no longer provides administrative services for this plan. Please go to uhcprovider.com/smartedits for information regarding reconsideration requests.	Inactive Employer Group REJECT - Employer group no longer provides administrative services for this plan. Please go to uhcprovider.com/smartedits for information regarding reconsideration requests.	2/29/2024	Medicare	Professional
Rejection Edit	**umGELIGTf**	REJECT - Employer group no longer provides administrative services for this plan. Please go to uhcprovider.com/smartedits for information regarding reconsideration requests.	Inactive Employer Group REJECT - Employer group no longer provides administrative services for this plan. Please go to uhcprovider.com/smartedits for information regarding reconsideration requests.	2/29/2024	Medicare	Facility
Informational Edit	**umHHI**	INFORMATIONAL - Effective 10/1/24, professional and facility home health claims for dates of service submitted while a member is inpatient will not be reimbursed.	Medicare Home Health Services During Inpatient Stay Home health services must be provided in the home. Services should not be billed while the patient is in an inpatient facility. Please refer to the Home Health Services Professional policy for Medicare on UHCprovider.com.	9/12/2024	Medicare	Professional
Return Edit	**uMHRHCf**	Revenue Code <1> is inappropriate when reported with mental health service procedure code <2> for Rural Health Clinics. Please review and update code(s) as applicable.	Mental health Services reported RHC Per MLN Matters: MM9269 page 4 and Medicare Claims Processing Manual Chapter 9, section 50 page 10, qualifying mental health services are billed using review code 0900. MLN Matters: MM9269 page 4 and Medicare Claims processing manual chapter 9, section 50 page 10.	1/28/2021	Medicare	Facility
Rejection Edit	**umIBC**	REJECT - Billing CLIA ID submitted on the claim is not valid based on QIES and CDC database, and will not be forwarded for adjudication. Please resubmit claim with a valid CLIA ID.	Invalid Billing CLIA ID 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. Please review the Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com for further information.	11/5/2020	Medicare	Professional
Return Edit	**umIDCDIPf**	Per the ICD-10-CM Excludes1 guideline, diagnosis codes <1> identify two conditions that cannot be reported together except when they are unrelated. Please update code(s) as applicable.	ICD-10 CM Excludes 1 code pairs 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 review ICD-10 CM Coding Guidelines	6/27/2024	Medicare	Facility
Return Edit	**umIDCDIDMf**	Per the ICD-10-CM Excludes1 guideline, diagnosis codes <1> identify two conditions that cannot be reported together except when they are unrelated. Please update code(s) as applicable.	ICD-10 CM Excludes 1 code pairs 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 review ICD-10 CM Coding Guidelines	6/27/2024	Medicare	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uMIMOD**	Procedure code <1> is not appropriate when submitted with modifier 26. Update code(s) or modifier as applicable.	Inappropriate Modifier CPT or HCPCS codes are not considered eligible for reimbursement when submitted with modifier 26.	9/26/2024 4/3/2025	Medicaid Dual Enrollment	Professional
Return Edit	**uMINDC**	NDC code <NDC code 1> is not valid for procedure code <procedure code 2.> Please update and resubmit.	Medicaid Invalid Required NDC A valid NDC number for the drug administered will be required on all HCPCS/CPT drug codes. If the NDC information is missing, invalid or incomplete the claim may be denied. Please review the National Drug Code Policy Requirement Policy on UHCprovider.com for further information.	2/27/2020	Medicaid	Professional
Return Edit	**umINDC**	NDC code <NDC code 1> is not valid for procedure code <procedure code 2.> Please update with an active NDC code that is valid for the procedure code and resubmit.	Medicare Invalid NDC 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 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. Please review the National Drug Code (NDC) policy, Professional and Facility on UHCprovider.com	1/27/2020	Medicare	Professional
Return Edit	**umIPLAB11**	Procedure code <1> is an arranged service that can only be billed by the hospital. Please review and update as applicable.	Inpatient Hospital Part B Lab Place of Service 11 UnitedHealthcare uses the codes indicated in the CMS Place of Service (POS) Codes for Professional Claims Database to determine if laboratory services are reimbursable. Only one laboratory provider will be reimbursed when multiple individuals report Duplicate Laboratory Services. When the hospital obtains laboratory tests for outpatients under arrangements with clinical laboratories or other hospital laboratories, only the hospital can bill for the arranged services. If the clinical laboratory test is subject to the laboratory fee schedule, carriers pay only the person or entity that performed or supervised the performance of the test. Please review the Laboratory Services Policy, Professional on UHCprovider.com.	2/23/2023	Medicare	Professional
Return Edit	**umIPLAB81**	Procedure code <1> is an arranged service that can only be billed by the hospital. Please review and update as applicable.	Inpatient Hospital Part B Lab Place of Service 81 UnitedHealthcare uses the codes indicated in the CMS Place of Service (POS) Codes for Professional Claims Database to determine if laboratory services are reimbursable. Only one laboratory provider will be reimbursed when multiple individuals report Duplicate Laboratory Services. When the hospital obtains laboratory tests for outpatients under arrangements with clinical laboratories or other hospital laboratories, only the hospital can bill for the arranged services. If the clinical laboratory test is subject to the laboratory fee schedule, carriers pay only the person or entity that performed or supervised the performance of the test. Please review the Laboratory Services Policy, Professional on UHCprovider.com.	2/23/2023	Medicare	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**uMIRM**	INFORMATIONAL - Effective 10/1/23, in alignment with CMS guidelines, UHC will require procedure code <1> be submitted with JL or JK modifier.	Monthly Insulin Required Modifiers Starting October 1, 2023, in alignment with CMS, UHC will require claims for monthly supplies of insulin with "from date of service" in July and later be billed with a JL modifier for 3-month supply of insulin or modifier JK or a 1-month supply of insulin. For additional information please review Medicare Part B Insulin New Limits on Patient Monthly Coinsurance at cms.gov. MLN Matters 4443820	9/28/2023	Medicare Dual Enrollment	Professional
Rejection Edit	**umISC**	REJECT - Servicing CLIA ID submitted on the claim is not valid based on QIES and CDC database, and will not be forwarded for adjudication. Please resubmit claim with a valid CLIA ID.	Invalid Servicing CLIA ID 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. Please review the Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com for further information.	11/5/2020	Medicare	Professional
Rejection Edit	**uMIT2f**	REJECT - I21.A1 is an inappropriate principal diagnosis and will not be forwarded for claim adjudication. Please resubmit claim with a valid underlying cause coded first.	Myocardial Infarction Type 2 Reporting According to Medicare ICD-10-CM Official Coding Guidelines it states- "Type 2 Myocardial Infarction is assigned to I21.A1 with the underlying cause coded first " Please refer to ICD-10-CM Official Guidelines for Coding and Reporting found on www.cms.gov.	11/19/2020	Medicare	Facility
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.	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 Medicare Claims Processing Manual: Chapter 4, Part B Hospital, Section 290.2.2	1/30/2020	Medicare	Facility
Rejection Edit	**umMAC**	REJECT - COVID-19 monoclonal antibody code <1> should be billed to Original Medicare. This claim has been rejected and will not be processed.	Monoclonal Antibody Codes For Medicare health plans, the CMS Medicare Administrative Contractor will reimburse claims for Medicare beneficiaries with no cost share (copayment, coinsurance or deductible) through 2021. Charges for monoclonal antibody infusions or injects should be submitted to Original Medicare and not a United Healthcare Medicare Advantage plan. Please review the COVID-19 Temporary Provisions Date Guide on UHCprovider.com for more information.	1/21/2021 3/17/2022	Medicare Dual Enrollment	Professional
Rejection Edit	**umMACf**	REJECT - COVID-19 monoclonal antibody code <1> should be billed to Original Medicare. This claim has been rejected and will not be processed.	Medicare Monoclonal Antibody Codes For Medicare health plans, the CMS Medicare Administrative Contractor will reimburse claims for Medicare beneficiaries with no cost share (copayment, coinsurance or deductible) through 2021. Charges for monoclonal antibody infusions or injects should be submitted to Original Medicare and not a United Healthcare Medicare Advantage plan. Please refer to the COVID-19 Temporary Provisions Date Guide on UHCprovider.com for more information.	1/21/2021 3/17/2022	Medicare Dual Enrollment	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**umMCID**	REJECT - CLIA ID was not submitted on the claim and will not be forwarded for adjudication. Please resubmit claim with a valid CLIA ID.	Missing CLIA ID 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. Please review the Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com for further information.	11/5/2020	Medicare	Professional
Rejection Edit	**umMFL**	REJECT - Per Medicare guidelines, the associated administration code for vaccine procedure code <1> is missing or invalid. This claim has been rejected and will not be processed.	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 11/30/2023 Changed to a Rejection Edit	Medicare	Professional
Rejection Edit	**umMFLf**	REJECT - Per Medicare guidelines, the associated administration code for vaccine procedure code <1> is missing or invalid. This claim has been rejected and will not be processed.	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 11/30/2023 Changed to a Rejection Edit	Medicare	Facility
Return Edit	**uMMNDC**	<1> requires an NDC code. Please resubmit with updated NDC code. NDC code submission also requires quantity and units of measure.	Medicaid Missing Required NDC A valid NDC number for the drug administered will be required on all HCPCS/CPT drug codes. If the NDC information is missing, invalid or incomplete the claim may be denied. Please review the National Drug Code Policy Requirement Policy on UHCprovider.com for further information.	2/27/2020	Medicaid	Professional
Return Edit	**umMPN**	Per Medicare guidelines, the associated administration code for vaccine procedure code <1> is invalid. Please update administration code as appropriate.	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 review 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.	Pneumonia Vaccine Invalid Admin Code - 90471 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	Facility
Return Edit	**umMSP**	Per NCD 210.2, diagnosis is not listed for procedure code. Update code(s) as applicable for services rendered.	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 review NCD 210.2: Screening PAP Smears and Pelvic Examinations for early detection of Cervical or Vaginal Cancer.	9/26/2019	Medicare	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uMNDCMR**	Procedure Code <1> requires an NDC code. Please resubmit with updated NDC code. NDC code submission also requires quantity and units of measure.	Medicare Missing NDC The NDC is a unique numeric identifier assigned to medications listed under Section 510 of the United States Federal Food, Drug and Cosmetic Act. Please review the National Drug Code (NDC) Requirement Reimbursement Policy for more information. Please review the National Drug Code Requirement Policy on UHCprovider.com	3/25/2021	Medicare	Professional
Return Edit	**umNOABTf**	The Notice of Admission type of bill <1> is invalid. Please review and update as applicable.	Notice of Admission Invalid Bill Type Per CMS guidelines, as of January 1, 2022, requests for anticipated payment (RAP), bill type 322, should no longer be submitted. Effective January 1, 2022, a one-time Notice of Admission (NOA) is required. The NOA should be submitted with type of bill 32A. Please refer to the Replacing Home Health Requests for Anticipated Payment (RAPs) with a Notice of Admission (NOA) – Manual Instructions on www.cms.gov.	11/30/2023	Medicare	Facility
Return Edit	**umNPD**	Diagnosis code <1> is an inappropriate primary diagnosis code. Please update claim as applicable.	Not Primary Diagnosis 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 billed in the primary position 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 Diagnosis Code Requirement Policy, Professional and Facility - Reimbursement Policy - UnitedHealthcare Commercial and Individual Exchange at UHCprovider.com.	11/30/2023 Changed to a Return Edit 1/25/2024	Medicare	Professional
Return Edit	**umNV**	Medicare considers procedure code <1> as not appropriate. Status Code 1 is not appropriate when reported by health care professionals. Update code(s) as applicable for services rendered.	Not Covered Medicare Services The procedure code submitted is a procedure that Medicare considers “Not valid for Medicare purposes” - Medicare uses another code for reporting of, and payment for, these services. Please review the Medicare Physician Fee Schedule Status Indicator Policy, Professional located on UHCprovider.com for further information.	10/22/2020	Medicare	Professional
Informational Edit	**uPAPGPT**	INFORMATIONAL – Effective 1/1/2025, UHC will discontinue coverage for multi-gene panel pharmacogenetic code <1>. Prior authorizations are no longer required and should not be requested.	Commercial Prior Auth/Unproven Pharmacogenetic Panel Testing Effective 1/1/25, UnitedHealthcare will no longer cover multi-panel genetic tests and providers will no longer be required to submit prior authorization requests for affected procedure codes. The following procedure codes will be removed from existing prior authorization/advance notification requirements and claims for these codes will be denied as unproven and not medically necessary: 0029U, 0173U, 0175U, 0345U, 0411U, 0419U, 0423U, 0460U, 0476U, 0477U, 81418. Please see 11/1/25 Network Bulletin.	12/5/2024	Cmmercial Level Funded Oxford	Professional
Return Edit	**uMOD53f**	Modifier 53 is used to indicate discontinuation of physician services and is not approved for use for outpatient hospital or ASC. Update code(s) as applicable.	Modifier 53 Modifier 53 is used to indicate discontinuation of physician services and is not approved for use for outpatient hospital services. Another modifier may be more appropriate. For additional information, please review the Medicare Claims Processing Manual, Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS) on www.cms.gov.	7/29/2021 10/13/2022	Medicare Commercial Oxford Level-Funded	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
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.	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 review the Anesthesia Policy on UHCprovider.com for further information.	12/15/2019	Oxford	Professional
Return Edit	**umORDNA**	Ordering Physician NPI <1> is ineligible to order service <2(procedure code)> for Medicare. Please contact the Ordering Physician to update their NPI information in CMS.gov.	Ordering Physician NPI Submitted Not Authorized CMS regulations require physicians or other eligible professionals to be enrolled or validly opted-out for the Medicare Program to order or refer items and services for Medicare beneficiaries. The submitted CPT code requires a valid NPI submitted in either the Ordering Provider NPI found in 2420E/NM109 or Line Level Referring Provider NPI found in 2420F/NM109 or Claim Level Referring Provider NPI found in 2310A/NM109.	7/29/2021	Medicare	Professional
Rejection Edit	**umORM**	REJECT - Ordering and/or Referring physician NPI is not found for service code <1>. Per CMS, physicians must be enrolled with a valid NPI. Please verify physician record and resubmit the claim with a valid NPI.	Ordering and Referring Physician Missing NPI CMS regulations require physicians or other eligible professionals to be enrolled or validly opted-out for the Medicare Program to order or refer items and services for Medicare beneficiaries. The submitted CPT code requires a valid NPI submitted in either the Ordering Provider NPI found in 2420E/NM109 or Line Level Referring Provider NPI found in 2420F/NM109 or Claim Level Referring Provider NPI found in 2310A/NM109. For additional information please refer to: Physicians and non-physician practitioners who opt out of Medicare and/or elect to order and certify services to Medicare beneficiaries is available at https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/SE1311.pdf on the U.S. Dept. of Health and Human Services website or Medicare Benefit Policy Manual Chapter 15, section 40. (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.PDF) For the complete list of providers who can order/refer beneficiary services for HHAs please visit: https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/order-and-referring/data For information on UHCprovider.com, https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medadv-reimbursement/rpub/UHC-MEDADV-RPUB-AUG-2023.pdf	7/29/2021	Medicare	Professional
Return Edit	**umPCN**	Payer Claim Control Number is invalid and is required because the Claim Frequency Type Code (CLM05-3) is 7 or 8. Reference the Provider Remittance Advice for Payer Claim Control Number (Claim ID).	Invalid Payer Control Number In accordance with HIPAA guidelines, providers are required to submit an accurate "Original Payer Claim Control Number" when submitting a corrected claim (bill type xx7/xx8).	3/31/2022	Medicare	Professional
Informational Edit	**umRADUL**	INFORMATIONAL – Effective 2/1/25 CPT <1> has a maximum number of units of <2> within a 90-day episode of care. For more information, refer to the 11/1/24 Network News Bulletin for the Radiation Therapy Policy.	Radiation Therapy Unit Limits Effective for dates of service on or after February 1, 2025, UnitedHealthcare will implement the new Radiation Therapy-Dosimetry, Simulation/Devices and Management Policy, Professional and Facility. Specific radiation therapy dosimetry, simulation and management services, identified with select CPT ® codes, will have unit limitations during a 90-day episode of care. Units billed in excess of the limits will not be considered for reimbursement. Please review UHC Medicare Advantage Plan Reimbursement Policy Update Bulletin November 2024.	1/2/2025	Medicare	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**umRADULf**	INFORMATIONAL – Effective 2/1/25 CPT <1> has a maximum number of units of <2> within a 90-day episode of care. For more information, refer to the 11/1/24 Network News Bulletin for the Radiation Therapy Policy.	Radiation Therapy Unit Limits Effective for dates of service on or after February 1, 2025, UnitedHealthcare will implement the new Radiation Therapy-Dosimetry, Simulation/Devices and Management Policy, Professional and Facility. Specific radiation therapy dosimetry, simulation and management services, identified with select CPT ® codes, will have unit limitations during a 90-day episode of care. Units billed in excess of the limits will not be considered for reimbursement. Please review UHC Medicare Advantage Plan Reimbursement Policy Update Bulletin November 2024.	1/2/2025	Medicare	Facility
Documentation Edit	**umRIDR**	Diagnostic Radiology Interpretation Report may be required and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information, go to UHCprovider.com/smartedits.	Interpretive Radiology UnitedHealthcare considers the interpretation (modifier 26) of a radiology service assigned a PC/TC Indicator 1 to be included in the Evaluation and Management (E/M) service when performed by the Same Individual Physician or Other QHP on the same date of service for the same patient as these services usually are not distinct from the E/M service when both are provided on the same day. American College of Radiology (ACR) guidelines suggest that physicians and other QHP who believe the Professional Component (modifier 26) for a PC/TC Indicator 1 radiology code is reimbursable in addition to the E/M service on the same day must include medical records. Please review the Professional/Technial Component Policy at UHCprovider.com	9/12/2024	Medicare	Professional
Rejection Edit	**uPVIN**	REJECT - The billing NPI, Taxonomy, Zip, or Zip +4 submitted was not registered with the State of Indiana for this DOS. This claim is rejected and will not be processed.	Provider Validation - Indiana The State of Indiana requires providers to register with the State in order to receive payment for services to members of the State of Indiana Medicaid programs. The provider submitted on this claim was not registered with the State of Indiana at the time services were performed.	5/2/2024	Medicaid	Professional
Rejection Edit	**uPVINf**	REJECT - The billing NPI, Taxonomy, Zip, or Zip +4 submitted was not registered with the State of Indiana for this DOS. This claim is rejected and will not be processed.	Provider Validation - Indiana The State of Indiana requires providers to register with the State in order to receive payment for services to members of the State of Indiana Medicaid programs. The provider submitted on this claim was not registered with the State of Indiana at the time services were performed.	5/2/2024	Medicaid	Facility
Informational Edit	**UMR250K**	INFORMATIONAL – Medical records and an itemized bill may be required, and can be uploaded at provider.umr.com.	Billed Charges over $250K Claims submitted with billed charges exceeding $250,000.00may require medical records and itemized bill for payment. The itemization of charges should include dates and detailed descriptions for each individual charge. Please refer to the Provider Administrative Guide on UHCprovider.com.	10/3/2024	UMR	Professional
Informational Edit	**UMR250Kf**	INFORMATIONAL – Medical records and an itemized bill may be required, and can be uploaded at provider.umr.com.	Billed Charges over $250K Claims submitted with billed charges exceeding $250,000.00may require medical records and itemized bill for payment. The itemization of charges should include dates and detailed descriptions for each individual charge. Please refer to the Provider Administrative Guide on UHCprovider.com.	10/3/2024	UMR	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**UMRAHCDN**	REJECT - An after hours procedure code <1> has already been billed for date of service <2> and provider <3> on this or a previously submitted claim. Update code(s) as applicable.	AHC Code Same Day, Same Provider 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 After Hours and Weekend Care Policy, Professional at UHCprovider.com	11/30/2023	UMR	Professional
Informational Edit	**UMRANSQC**	INFORMATIONAL - Procedure code <1> is inappropriate when submitted without an anesthesia service. Update code(s) as applicable for services rendered.	Anesthesia Qualifying Circumstance 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 review the Anesthesia Policy, Professional at UHCprovider.com.	4/27/2023	UMR	Professional
Informational Edit	**UMRASUNE**	INFORMATIONAL - Proc <1> is not eligible for assistant surgeon. Please update code(s) as applicable.	Assistant Surgeon Not Eligible Assistant Surgeon not eligible The Assistant-at-Surgery Eligible List is developed based on the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule Relative Value File (NPFS) payment policy indicators. All codes in the NPFS with the payment code indicator "2" for "Assistant-at-Surgery" are considered by UnitedHealthcare to be reimbursable for Assistant-at-Surgery services, as indicated by an assistant surgeon modifier (80, 81, 82, or AS). The procedure code summitted is not on the Assistant -at-Surgery Eligible List. Please review the Assistant Surgeon Policy on UHCprovider.com Please review the Assistant Surgeon Policy on UHCprovider.com.	4/27/2023	UMR	Professional
Informational Edit	**UMRCARDf**	INFORMATIONAL - Please ensure documentation supports the use of principal diagnosis code <1>.	Comprehensive Avoidance - Cardiac & Shock Providers should report the appropriate ICD-10 diagnosis code that describes the patient's condition and should consult with ICD 10 code book. DRG Levels Medicare Severity Diagnosis Related Group (MS-DRG) codes are often divided into three levels of severity for each primary DRG. Please review ICD-10 Guidelines.	12/19/2024	UMR	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**UMRCCIUN**	INFORMATIONAL - Procedure code <1> is included with procedure code <2> on the current or previously submitted claim. Under appropriate circumstances, a designated modifier may be required to identify distinct services.	CCI Unbundling 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 review the "Modifiers" section of this policy for a complete listing of acceptable modifiers and the description of modifier indicators of "0" and "1". Please review the CCI Editing Policy, Professional Reimbursement Policy – UnitedHealthcare Commercial Plans on UHCprovider.com.	4/27/2023	UMR	Professional
Informational Edit	**UMRCMME**	INFORMATIONAL - Procedure code <1> requires prior authorization. Please ensure the authorization request has been submitted to support services billed.	CardioMEMS Management Prior authorization for CardioMEMS™ HF System (CPT® codes 33289 and C2624) is required. The CardioMEMS HF System is unproven and not medically necessary due to insufficient evidence of safety and/or efficacy. Please review Omnibus Codes – Community Plan Medical Policy and UHCprovider.com.	5/2/2024	UMR	Professional
Informational Edit	**UMRCPO**	INFORMATIONAL - 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.	Care Plan Oversight Care Plan Oversight (CPO) Services review 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. Please review the Care Plan Oversight Policy Reimbursement policy and the Community Plan Care Plan Oversight Policy on UHCprovider.com.	4/27/2023	UMR	Professional
Informational Edit	**UMRCSPDN**	INFORMATIONAL - Consultation Services Procedure <1> is not reimbursable based on the Consultation Services Policy. Update to an appropriate evaluation and management procedure code.	Consultation No Longer Covered 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 review the Consultation Services Policy on UHCprovider.com.	4/27/2023	UMR	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**UMRCSU2**	INFORMATIONAL - Procedure code <1> submitted with modifier 62 is not appropriate because this procedure is not eligible for co-surgeon. Update code(s) as applicable for services rendered.	Co-Surgeon Not 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 review the Co-Surgeon & Team Surgeon Policy, Professional on UHCprovider.com. Please review the Co-Surgeon & Team Surgeon Policy, Professional on UHCprovider.com.	4/27/2023	UMR	Professional
Informational Edit	**UMRCVEDN**	INFORMATIONAL - Procedure <1> is not eligible for separate reimbursement when billed with COVID vaccine administration <2>. Update code(s) as applicable.	COVID Vaccine EM Code Evaluation and Management code may not be eligible for reimbursement when billed with a COVID vaccine administration code, when appropriate modifiers are not appended. Please review our COVID-19 billing guide on UHCprovider.com	2/23/2023	UMR	Professional
Rejection Edit	**UMRCVENIP**	REJECT - Procedure Code 36410 requires a supporting diagnosis on the same claim line. This claim has been rejected and will not be processed.	Venipuncture for Specimen Collection Submit CPT code 36410 only for venipunctures necessitating physician skill when performed by a physician on veins of the neck, (e.g., external or internal jugular), or from deep (central) veins of the thorax (e.g., subclavian) or groin (e.g., femoral); and for venipuncture of superficial extremity veins when the skill of a qualified individual properly trained in venipuncture techniques (e.g., nurse, phlebotomist, medical technician) has been clearly demonstrated, according to the terms of this policy, to be insufficient ICD-10-CM I87.8, I99.8 or R68.89 must be submitted on all claims for CPT 36410. Please review the Laboratory Services policy on www.UHCprovider.com	10/3/2024	UMR	Professional
Rejection Edit	**UMRCVENIPf**	REJECT - Procedure Code 36410 requires a supporting diagnosis on the same claim line. This claim has been rejected and will not be processed.	Venipuncture for Specimen Collection Submit CPT code 36410 only for venipunctures necessitating physician skill when performed by a physician on veins of the neck, (e.g., external or internal jugular), or from deep (central) veins of the thorax (e.g., subclavian) or groin (e.g., femoral); and for venipuncture of superficial extremity veins when the skill of a qualified individual properly trained in venipuncture techniques (e.g., nurse, phlebotomist, medical technician) has been clearly demonstrated, according to the terms of this policy, to be insufficient ICD-10-CM I87.8, I99.8 or R68.89 must be submitted on all claims for CPT 36410. Please review the Laboratory Services policy on www.UHCprovider.com.	12/12/2024	UMR	Professional
Informational Edit	**UMRDMEAD**	INFORMATIONAL - The current line adjusted procedure <1> is a DME code that does not require a rental or purchase modifier and is not separately reimbursable.	DME Denial Durable Medical Equipment, Prosthetics/Orthotics & Supplies are categorized into payment classes. Some Durable Medical Equipment (DME) items are eligible for rental as well as for purchase. Claims must specify whether equipment is rented or purchased. For purchased equipment, the claim must also indicate whether equipment is new or used. The codes must be reported with the appropriate rental or purchase modifier in order to be considered for reimbursement. Some DME items are eligible for rental only. The codes representing these items must be reported with the appropriate rental modifier in order to be considered for reimbursement. Please review the Durable Medical Equipment, Orthotics and Prosthetics Policy, Professional Policy on www.UHCprovider.com.	12/19/2024	UMR	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**UMRDMEIP**	INFORMATIONAL - The current line Proc <1> is not separately reimbursable from HxProc <2> found on Claim ID- Ext/Int Line ID <3>.	Durable Medical Equipment CMS guidelines indicate when DME items are purchased or rented; there are certain supplies that are included in the initial purchase or during the rental period. Please review the Durable Medical Equipment, Orthotics and Prosthetics Policy, Professional Policy onwww.UHCprovider.com.	12/19/2024	UMR	Professional
Informational Edit	**UMRDSC**	INFORMATIONAL - Review diagnosis code <1> for accuracy. Causal relationship between skin condition Not Elsewhere Classified <2> and diabetes must be supported in medical file.	Diabetes with Skin Complications When reporting diabetes mellitus with skin complications Not Elsewhere Classified, the WITH guideline does not apply and documentation must support a causal relationship between the diabetes and the NEC skin condition by MD. Please review ICD-10 Official guidelines Section 1.A.15. No supporting documentation is required to be submitted with this claim. Please review ICD-10 Official guidelines Section 1.A.15.	5/2/2024	UMR	Professional
Rejection Edit	**UMRDXIDN**	REJECT - Diagnosis Code <1> is an incomplete diagnosis. Please update to a complete diagnosis code.	Incomplete Diagnosis Code ICD 10 Diagnosis code. Submitted claim missing completed appropriate ICD-10 diagnosis code. Please review International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) on www.cdc.gov.	4/27/2023	UMR	Professional
Return Edit	**umREFNA**	Referring Physician NPI <1> is ineligible to order or refer service <2> for Medicare. Please contact the Referring Physician to update their NPI information in CMS.gov.	Referring Physician NPI Submitted Not Authorized CMS regulations require physicians or other eligible professionals to be enrolled or validly opted-out for the Medicare Program to order or refer items and services for Medicare beneficiaries. The submitted CPT code requires a valid NPI submitted in either the Ordering Provider NPI found in 2420E/NM109 or Line Level Referring Provider NPI found in 2420F/NM109 or Claim Level Referring Provider NPI found in 2310A/NM109.	7/29/2021	Medicare	Professional
Informational Edit	**UMREMLR**	INFORMATIONAL - Please review to determine if procedure code <1> is appropriate based on current CMS billing guidelines for E/M codes. Please ensure documentation supports the E/M code billed.	Level 4/5 E/M Codes CMS changed Physician E&M coding guidelines for Level 4 and 5 E/M codes (99202-99205 and 99212-99215). Coding is now based on the level of medical decision making (MDM) or total time spent on the patient encounter. MDM consists of number and complexity of problems addressed, amount/complexity of data reviewed and analyzed, and risk of complications and/or morbidity/mortality of patient management. Two of those three must be met or exceeded. This edit addresses claims submitted with level 4 and 5 codes and seeks to have the provider review medical decision making and total time spent to determine if a code of a lower level is more appropriate. Documentation should be available if requested.	5/2/2024	UMR	Professional
Informational Edit	**UMREMLRC**	INFORMATIONAL - Procedure code <1> may not be appropriate based on current CMS billing guidelines for E/M codes. If documentation does not support the E/M level submitted, please resubmit with appropriate code.	Level 4/5 E/M Codes CMS changed Physician E&M coding guidelines for Level 4 and 5 E/M codes (99202-99205 and 99212-99215). Coding is now based on the level of medical decision making (MDM) or total time spent on the patient encounter. MDM consists of number and complexity of problems addressed, amount/complexity of data reviewed and analyzed, and risk of complications and/or morbidity/mortality of patient management. Two of those three must be met or exceeded. This edit addresses claims submitted with level 4 and 5 codes and seeks to have the provider review medical decision making and total time spent to determine if a code of a lower level is more appropriate. Documentation should be available if requested.	12/19/2024	UMR	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**UMRIPDDN**	REJECT - Diagnosis code <1> is an inappropriate primary diagnosis code.	Inappropriate Primary Diagnosis 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 Diagnosis Code Requirement Policy, Professional and Facility - Reimbursement Policy - UnitedHealthcare Commercial and Individual Exchange at UHCprovider.com.	4/27/2023	UMR	Professional
Rejection Edit	**UMRJVBRN2**	REJECT - Appropriate diagnosis must be billed when reporting bronchitis in juvenile patient. This claim has been rejected and will not be processed.	Bronchitis DX for Juvenile Patient UnitedHealthcare follows the Official International Classifications of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) guidelines. ICD-10-CM specifies a list of valid diagnosis codes available to report bronchitis in member under 15 years of age.References:- 2021/2022 ICD-10-CM Index > 'Bronchitis' (icd10data.com): https://www.icd10data.com/ICD10CM/Index/B/Bronchitis 2022 ICD-10-CM Diagnosis Code J40: Bronchitis, not specified as acute or chronic (icd10data.com): https://www.icd10data.com/ICD10CM/Codes/J00-J99/J40-J47/J40-/J40 Look to Patient Age, Anatomy for Accurate Bronchitis Coding : Reader Question - Codify by AAPC: https://www.aapc.com/codes/coding-newsletters/my-icd-10-coding-alert/reader-question-look-to-patient-age-anatomy-for-accurate-bronchitis-coding-159485-article	5/2/2024	UMR	Professional
Informational Edit	**UMRLABAD**	INFORMATIONAL - Procedure code <1> is incorrect. Drug Assay services may be reported with a more appropriate HCPCS code.	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 review the Laboratory Services reimbursement policy at UHCprovider.com.	4/27/2023	UMR	Professional
Informational Edit	**UMRLABRV**	INFORMATIONAL - Procedure [1] may not be a reimbursable service.	Laboratory Respiratory Viral Consistent with CMS Local Coverage Determinations, UnitedHealthcare does not consider multiplex Polymerase Chain Reaction (PCR) respiratory viral panels of 6 or more pathogens eligible for reimbursement, and codes 0115U, 0202U, 0223U, 0225U, 87632 and 87633 will be denied. Please review Laboratory Services Policy, Professional on UHCprovider.com.	12/19/2024	UMR	Professional
Informational Edit	**UMRLABVDU**	INFORMATIONAL - 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.	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 review the Laboratory Services Policy on UHCprovider.com.	4/27/2023	UMR	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**UMRMOD**	INFORMATIONAL - Modifier <1> is inappropriate for Procedure Code <2>.	Modifier Not Appropriate 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. Please review the Procedure to Modifier reimbursement policy at UHCprovider.com.	4/27/2023	UMR	Professional
Rejection Edit	**UMRNDCCL**	REJECT - 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.	NDC Closure 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 review the National Drug Code Requirement Reimbursement Policy on UHCprovider.com for further information.	4/27/2023	UMR	Professional
Rejection Edit	**UMRNDCDN**	REJECT - 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.	NDC Denial The UnitedHealthcare National Drug Code (NDC) reimbursement policy requires that claims submitted for reimbursement for drugrelated 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 review the National Drug Code Requirement Reimbursement Policy on UHCprovider.com for further information.	4/27/2023	UMR	Professional
Rejection Edit	**UMRNDCUD**	REJECT - 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.	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 review the National Drug Code Requirement reimbursement policy at UHCprovider.com for further information.	4/27/2023	UMR	Professional
Informational Edit	**UMRNIRDN**	INFORMATIONAL - 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.	Status E and X Codes Reported by Health Care Professional 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 review the Services and Modifiers Not Reimbursable to Healthcare Professionals, Professional Reimbursement Policy Commercial Plans located on UHCprovider.com for further information. Please review the Services and Modifiers Not Reimbursable to Healthcare Professionals, Professional Reimbursement Policy Commercial Plans located on UHCprovider.com for further information.	4/27/2023	UMR	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**UMRNIRMD**	INFORMATIONAL - 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.	Inappropriate Procedure and Modifier Combination Modifiers 27, 73, 74 and 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. Modifiers SE, HV, HZ, SL, HW, QJ, H9, HX, TR, HU & HY represent services that are funded by a county, state or federal agency and therefore additional reimbursement for such services would not be appropriate. Please review the Services and Modifiers Not Reimbursable to Healthcare Professionals, Professional Reimbursement Policy Commercial Plans located on UHCprovider.com.	4/27/2023	UMR	Professional
Informational Edit	**UMROBGUA**	INFORMATIONAL - 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.	OBGYN Services - 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 review the Obstetrical Policy, Professional on UHCprovider.com.	4/27/2023	UMR	Professional
Informational Edit	**UMROBGUS**	INFORMATIONAL - 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.	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 procedure (CPT codes 76801-76817 and 76820-76828). Please review the Obstetrical Policy, Professional Reimbursement Policy Commercial Plans on UHCprovider.com.	4/27/2023	UMR	Professional
Informational Edit	**UMROMPCf**	INFORMATIONAL - Revenue code <1> should be submitted with a HCPCS or CPT code.	Outpatient Missing Procedure Code For Outpatient Covered Services, appropriate CPT/HCPCS codes, as described by the National Uniform Billing Committee and CPT/HCPCS code guidelines, must be submitted on the Institutional Claim in order to be eligible for reimbursement. Please refer to United Healthcare Admin Guide (Chapter 9 page 58/59) for additional information.	12/19/2024	UMR	Facility
Informational Edit	**UMRP04UALL**	INFORMATIONAL - 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.	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 multispecialty 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 review the Physical Medicine & Rehabilitation Maximum Combined Frequency Per Day Policy on UHCprovider.com for further information.	4/27/2023	UMR	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**UMRPAPDN**	INFORMATIONAL - Procedure code <1> is not appropriate in <2> Place of service.	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 review the Procedure and Place of Service reimbursement policy at UHCprovider.com for further information	4/27/2023	UMR	Professional
Informational Edit	**UMRPTCIH**	INFORMATIONAL - Procedure <1> is not reimbursable to a physician or health care professional with a place of service other than inpatient hospital. Update code(s) as applicable.	Professional Technical Component Policy Inpatient Hospital The CMS NPFS guidelines advise that payment should not be recognized for PC/TC Indicator 8 codes, which are defined as physician interpretation codes, furnished to patients in the outpatient or non-hospital setting (POS other than 21). In alignment with CMS, UnitedHealthcare will not reimburse PC/TC Indicator 8 (CPT code 85060) when reported by a physician or other qualified health care professional with a CMS POS code other than inpatient hospital (POS 21). Please refer to Professional/Technical Component Policy, Professional at UHCprovider.com	11/30/2023	UMR	Professional
Informational Edit	**UMRPTCIM**	INFORMATIONAL - Modifier 26 or TC is not appropriate for procedure code <1>. Update code(s) as applicable for services rendered.	ProTech Modifier Denials 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 review the Professional/Technical Component Reimbursement Policy, Professional on UHCprovider.com.	4/27/2023	UMR	Professional
Rejection Edit	**UMRRASIN**	REJECT - Procedure <1> is not a separately reimbursable service. Under appropriate circumstances, a designated modifier may be required to identify distinct services. Update code(s) as applicable.	Robotic Assisted Surgery According to the Centers for Medicare and Medicaid Services (CMS), medical and surgical procedures should be reported with the Current Procedural Terminology (CPT®)/HCPCS codes that most comprehensively describe the services performed. UnitedHealthcare considers S2900, (Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure)) to be a technique integral to the primary surgical procedure and not a separately reimbursed service. When a surgical procedure is performed using code S2900, reimbursement will be considered included as part of the primary surgical procedure. Please refer to Robotic Assisted Surgery Policy, Professional at UHCprovider.com	11/30/2023	UMR	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**UMRRCPDN**	INFORMATIONAL - Procedure <1> is not an appropriate code for services rendered. Report the status A (active) code that best describes the services provided.	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. Please review the Replacement Codes reimbursement policy at UHCprovider.com.	4/27/2023	UMR	Professional
Rejection Edit	**UMRSUPDN**	REJECT - Procedure <1> is not appropriate for casting and splint supplies. A temporary Q procedure code may be more appropriate for casting and splint supplies.	Supply Service is Not Reimbursable 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 review the Supply Policy, Professional on UHCprovider.com.	4/27/2023	UMR	Professional
Informational Edit	**UMRSUPFJ**	INFORMATIONAL - Procedure <1> is not appropriate in a facility place of service <2>. Update code(s) as applicable for services rendered.	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 non-facility 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	4/27/2023	UMR	Professional
Rejection Edit	**UMRTCHDP**	REJECT - Procedure <1> is not an appropriate telehealth code. Update code(s) as applicable.	Not Telemedicine Procedure UnitedHealthcare will consider for reimbursement the Telehealth services when they are rendered via audio and video and reported with either place of service POS 02 or 10. See the Telehealth Eligible Services Code List in the Attachments section of the Telemedicine Policy. Please refer to Telehealth/Virtual Health Policy at UHCprovider.com	11/30/2023	UMR	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**UMRTCHEM**	REJECT - Procedure <1> is not appropriate with a telehealth modifier. Update code(s) as applicable.	Telehealth Modifier Communication Technology-Based Services (CTBS) and Remote Physiologic Monitoring (RPM) services are never rendered in-person and therefore should not be reported with POS 02 or 10 and/or a Telehealth modifier (95, GT, GQ or G0). Please refer to Telehealth/Virtual Health Policy at UHCprovider.com	11/30/2023	UMR	Professional
Rejection Edit	**UMRTCHPD**	REJECT - Procedure <1> is not appropriate with telehealth place of service. Update code(s) as applicable.	Telehealth Place of Service UnitedHealthcare will consider for reimbursement Telehealth services when they are rendered via audio and video and reported with either place of service POS 02 or 10. Please refer to Telehealth/Virtual Health Policy at UHCprovider.com	11/30/2023	UMR	Professional
Informational Edit	**UMRTHIEM**	INFORMATIONAL - 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.	E/M Code included in Therapeutic Injection Code 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 review the Injection and Infusion Services Policy, Professional-Reimbursement Policy UnitedHealthcare Community Plan for further information.	4/27/2023	UMR	Professional
Informational Edit	**umRTNEC**	INFORMATIONAL – CPT <1> begins a new 90-day therapeutic radiology treatment planning episode of care. For more information, refer to the 11/1/24 Network News Bulletin regarding the new Radiation Therapy Policy.	Radiation Therapy Episode of Care Effective for dates of service on or after February 1, 2025, UnitedHealthcare will implement the new Radiation Therapy-Dosimetry, Simulation/Devices and Management Policy, Professional and Facility. Specific radiation therapy dosimetry, simulation and management services, identified with select CPT ® codes, will have unit limitations during a 90-day episode of care. Units billed in excess of the limits will not be considered for reimbursement. Please review UHC Medicare Advantage Plan Reimbursement Policy Update Bulletin November 2024.	1/2/2025	Medicare	Professional
Informational Edit	**umRTNECf**	INFORMATIONAL – CPT <1> begins a new 90-day therapeutic radiology treatment planning episode of care. For more information, refer to the 11/1/24 Network News Bulletin regarding the new Radiation Therapy Policy.	Radiation Therapy Episode of Care Effective for dates of service on or after February 1, 2025, UnitedHealthcare will implement the new Radiation Therapy-Dosimetry, Simulation/Devices and Management Policy, Professional and Facility. Specific radiation therapy dosimetry, simulation and management services, identified with select CPT ® codes, will have unit limitations during a 90-day episode of care. Units billed in excess of the limits will not be considered for reimbursement. Please review UHC Medicare Advantage Plan Reimbursement Policy Update Bulletin November 2024.	1/2/2025	Medicare	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**UMRTSU2**	INFORMATIONAL - 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.	Team Surgeon Not Eligible for Payment 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 review the Co-Surgeon / Team Surgeon Policy, Professional Reimbursement Policy on UHCprovider.com. Please review the Co-Surgeon / Team Surgeon Policy, Professional Reimbursement Policy on UHCprovider.com.	4/27/2023	UMR	Professional
Informational Edit	**UMRUCSDN**	INFORMATIONAL - Procedure code <1> is not appropriate because it does not describe the specific services performed. Update code(s) as applicable for services rendered.	Urgent Care Services Deny 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. Please review the Urgent Care Policy-Reimbursement Policy for UnitedHealthcare Commercial Plans for further information.	4/27/2023	UMR	Professional
Informational Edit	**UMRUCSTD**	INFORMATIONAL - Procedure code <1> is not reimbursable. Update code(s) as applicable for services rendered.	Not Separately Reimbursable 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 review the Urgent Care Policy on UHCprovider.com for further information.	4/27/2023	UMR	Professional
Rejection Edit	**UMRTOBf**	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.	Bill Type 14X 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. Please refer to CMS.gov > Regulations & Guidance > Guidance > Transmittals > Downloads > R795CP.pdf	8/31/2023	UMR	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**UMRVAGDG**	INFORMATIONAL - The age of the patient does not align with the CDC's Advisory Committee on Immunization Practices (ACIP) recommendation for procedure code <1>.	Proc not Proven for Age of Patient 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 review Vaccines Commercial Medical & Drug Policies on UHCprovider.com for further information.	4/27/2023	UMR	Professional
Informational Edit	**UMRVAGDZ**	INFORMATIONAL - The age of the patient does not align with the CDC's Advisory Committee on Immunization Practices (ACIP) recommendation for procedure code <1>.	Proc not Proven for Age of Patient 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 review Vaccines Commercial Medical & Drug Policies on UHCprovider.com for further information.	4/27/2023	UMR	Professional
Rejection Edit	**umSICCL**	REJECT- CLIA ID <1> does not meet the certification level for procedure code <1>. Please update as applicable.	Invalid CLIA Cert Level (Servicing Provider) The lab certification level must 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. Please review our Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com.	4/29/2021	Medicare	Professional
Return Edit	**umTELEBH**	Per CMS, modifier GT is not valid on professional claims for telehealth services. Please update code(s) as applicable.	Telemental Behavioral Health Effective January 1, 2018, the requirement to use modifier GT on professional claims for telehealth services has been eliminated. Providers are no longer required to use the GT modifier (via interactive audio and video telecommunications systems) on professional claims for telehealth services.Use of the telehealth Place of Service (POS) Code 02 certifies that the service meets the telehealth requirements. Please review MLN Matters MM10152 at cms.gov. https://www.cms.gov/regulations-and-guidance/guidance/transmittals/2017downloads/r3929cp.pdf	2/29/2024	Medicare	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**uMTSD**	INFORMATIONAL- CPT codes <1> constitute a panel, not distinct services, unless indicated with the appropriate modifier.	Multiple Tests Same DOS UnitedHealthcare recommends that providers submit the appropriate DEX Z-Code for this molecular diagnostic test. The assigned Z-Code can be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com). After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. Please review Billing and Coding: Testing of Multiple Genes - https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=57503	7/27/2023	Commercial Level Funded Oxford	Professional
Informational Edit	**uMTSDf**	INFORMATIONAL- CPT codes <1> constitute a panel, not distinct services, unless indicated with the appropriate modifier.	Multiple Tests Same DOS UnitedHealthcare recommends that providers submit the appropriate DEX Z-Code for this molecular diagnostic test. The assigned Z-Code can be submitted in the 2400 loop (line level), SV101-7 for professional claims or 2400 loop (line level), SV202-7 for facility claims. This message is returned when that loop and segment does not contain a Z-Code. For further guidance on test registration, refer to DEX – DEX Diagnostics Exchange Test Registration (dexzcodes.com). After DEX assigns a Z-Code to a provider for a specific test, the DEX team will review the test application and will assign a CPT code to the test. Receiving a Z-Code for a test will occur within approximately 2 weeks from adding your test into the DEX system. CPT code assignment can take up to 60 days after Z-Code assignment. Please review Billing and Coding: Testing of Multiple Genes - https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=57503	7/27/2023	Commercial Level Funded Oxford	Facility
Rejection Edit	**umU0005**	REJECT – Add-on HCPCS code U0005 reported without a high-throughput COVID-19 test code on the same claim. Please repair and resubmit. This claim is rejected and will not be processed.	U0005 Add on Without Test Code U0005 is an add-on code that must be submitted with another high-throughput COVID test code, which at this time is U0003 and/or U0004. UnitedHealthcare is requiring that all of the charges be submitted on the same claim. Please review Medicare Billing for COVID-19 Vaccine Shot Administration on www.cms.gov.	2/4/2021	Medicare	Professional
Rejection Edit	**umU0005f**	REJECT – Add-on HCPCS code U0005 reported without a high-throughput COVID-19 test code on the same claim. Please repair and resubmit. This claim is rejected and will not be processed.	U0005 Add On Without Test Code U0005 is an add-on code that must be submitted with another high-throughput COVID test code, which at this time is U0003 and/or U0004. UnitedHealthcare is requiring that all of the charges be submitted on the same claim. Please refer to Medicare Billing for COVID-19 Vaccine Shot Administration on www.cms.gov.	2/11/2021	Medicare	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**umUCD**	REJECT - Procedure code <1> is unlisted and the required detailed description is missing. This claim has been rejected and will not be processed.	Medicare Unlisted Code Description Unlisted procedure codes require a detailed description in addition to the applicable HCPCS/CPT code. Refer to the 837 Implementation Guide and the UHC Provider Administrative Guide for additional information. Please refer to Provider Administrative Guide on UHCprovider.com.	7/25/2024	Medicare	Professional
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.	Motor Vehicle Accident Indicator 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 review the claim submission requirements section of the administrative guide on UHCprovider.com.	7/25/2019 5/28/2020 9/29/2022	Commercial Oxford Level Funded	Professional
Return Edit	**umVAXDRP**	The Rendering Provider is not listed. Please update and resubmit, as applicable.	Rendering Provider for Part D The member's plan is responsible for verifying and reporting a valid prescriber ID. The claim requires a individual provider be submitted, not a group. Therefore, if an active and valid prescriber ID for the individual rendering provider is not included on the Part D claim, either the drug plan sponsor, or the pharmacy if in accordance with the contractual terms of the network pharmacy agreement, must follow up retrospectively to acquire a valid ID. Please review the Prescription Drug Benefit Manual on www.cms.gov.	5/23/2023	Medicare	Professional
Rejection Edit	**uMZCODE**	REJECT - Molecular diagnostic test <1> requires a Z-Code identifier in the line level 2400 loop, SV101-7 on electronic claims. This claim has been rejected and will not be processed.	Molecular DX - Missing Z Code United Healthcare Medicare Advantage will require providers to submit the appropriate DEX Z-code for molecular diagnostic test services. This policy will apply to both facility and professional claims. The Medicare-assigned Z-code should be submitted in the 2400 loop (line level), SV101-7. This message is returned when that loop and segment are blank. Please refer to the Molecular Pathology Policy, Professional and Facility on UHCprovider.com.	3/4/2021 2/27/2025 Changed to Rejection Edit on: 9/30/2021	Medicare Dual Enrollment	Professional
Rejection Edit	**uMZCODEf**	REJECT - Molecular diagnostic test <1> requires a Z-Code identifier in the line level 2400 loop, SV202-7 on electronic claims. This claim has been rejected and will not be processed.	Missing MolDx Z-Code United Healthcare Medicare Advantage will require providers to submit the appropriate DEX Z-code for molecular diagnostic test services. This policy will apply to both facility and professional claims. The Medicare-assigned Z-code should be submitted in the 2400 loop (line level), SV202-7. This message is returned when that loop and segment are blank. Please refer to the Molecular Pathology Policy, Professional and Facility on UHCprovider.com.	3/4/2021 2/27/2025 Changed to Rejection Edit on: 9/30/2021	Medicare Dual Enrollment	Facility
Return Edit	**uNCLAB**	Diagnosis code <1> is an inappropriate primary diagnosis code per the Medicare Clinical Diagnostic Lab Policy.	Invalid Primary Diagnosis - Lab Laboratory claims are being submitted with the incorrect primary diagnosis code = Z0000. Please review the Clinical Diagnostic Laboratory Services on UHCprovider.com.	10/29/2020	Medicare	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**uNCMT**	REJECT - A billing provider taxonomy code, valid with North Carolina provider registration, is required to be submitted on the claim. This claim has been rejected and will not be processed. REJECT - A rendering provider taxonomy code, valid with North Carolina provider registration, is required to be submitted on the claim when other rendering provider information is included.	North Carolina Missing Taxonomy Billing The UnitedHealthcare Community Plan for North Carolina requires all healthcare professionals who serve members in North Carolina to include their registered taxonomy code on claim submissions. Please refer to the Provider Manual for North Carolina on UHCprovider.com.	12/12/2024	Medicaid	Professional
Rejection Edit	**uNCMTf**	REJECT - A billing provider taxonomy code, valid with North Carolina provider registration, is required to be submitted on the claim. This claim has been rejected and will not be processed. REJECT - A rendering provider taxonomy code, valid with North Carolina provider registration, is required to be submitted on the claim when other rendering provider information is included.	North Carolina Missing Taxonomy Billing The UnitedHealthcare Community Plan for North Carolina requires all healthcare professionals who serve members in North Carolina to include their registered taxonomy code on claim submissions. Please refer to the Provider Manual for North Carolina on UHCprovider.com.	12/12/2024	Medicaid	Facility
Return Edit	**uNCT**	The National Clinical Trial number <1> billed on claim is invalid. This 8 digit number should not include NCT or CT. Please review and update code(s) as applicable.	Incorrect National Clinical Trial Number Format According to The Centers for Medicare & Medicaid Services (CMS), The National clinical trial (NCT) number cannot start with "NCT" or "CT". Electronic professional clinical trial claims must include an 8-digit National Clinical Trial Number (NCT). Professional electronic claims that do not contain the complete National Clinical Trial Number, will be considered incomplete and rejected or denied. Please refer to the Medicare Claims Processing Manual Chapter 32 – Section 68.1 – Billing Requirements for Providers Billing for Routine Care Items and Services in Category A IDE Studies for additional information, and Chapter 32 – Section 69 – Qualifying Clinical Trials. Please refer to MLN Matters Article MM8401 at cms.gov.	12/19/2024	Medicare	Professional
Return Edit	**uNCTf**	The National Clinical Trial number <1> billed on claim is invalid. This 8 digit number should not include NCT or CT. Please review and update code(s) as applicable.	Incorrect National Clinical Trial Number Format According to The Centers for Medicare & Medicaid Services (CMS), The National clinical trial (NCT) number cannot start with "NCT" or "CT". Electronic professional clinical trial claims must include an 8-digit National Clinical Trial Number (NCT). Professional electronic claims that do not contain the complete National Clinical Trial Number, will be considered incomplete and rejected or denied. Please refer to the Medicare Claims Processing Manual Chapter 32 – Section 68.1 – Billing Requirements for Providers Billing for Routine Care Items and Services in Category A IDE Studies for additional information, and Chapter 32 – Section 69 – Qualifying Clinical Trials. Please refer to MLN Matters Article MM8401 at cms.gov.	12/19/2024	Medicare	Facility
Documentation Edit	**UNLDN**	Medical Records may be required and can be uploaded to the UHC Provider Portal at secure.uhcprovider.com. For more information on this edit, go to uhcprovider.com/smartedits.	Unlisted Procedure Code The procedure code submitted is an unlisted procedure that requires manual review, but documentation was not received. Medical records can be uploaded to the UnitedHealthcare Provider Portal using TrackIt. Please refer to the Unlisted Services Policy on UHCprovider.com. Please review the Unlisted Services Policy on UHCprovider.com.	2/25/2021	Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**uNMZCODE**	REJECT - Molecular diagnostic test <1> requires a Z-Code identifier in the line level 2400 loop, SV101-7 on electronic claims. This claim has been rejected and will not be processed.	Non-Molecular Diagnostics States Missing Required Z-Code United Healthcare Medicare Advantage will require providers to submit the appropriate DEX Z-code for molecular diagnostic test services. This policy will apply to both facility and professional claims. The Medicare-assigned Z-code should be submitted in the 2400 loop (line level), SV202-7. This message is returned when that loop and segment does not contain a Z-code. Please review the UnitedHealthcare Medicare Advantage Reimbursement Policy Update Bulletin (January 2022) on UHCprovider.com	1/13/2022 2/27/2025 Changed to Rejection Edit on 4/7/2022	Medicare Dual Enrollment	Professional
Rejection Edit	**uNMZCODEf**	REJECT - Molecular diagnostic test <1> requires a Z-Code identifier in the line level 2400 loop, SV202-7 on electronic claims. This claim has been rejected and will not be processed.	Non Molecular Diagnostics States Missing Required Z-Code United Healthcare Medicare Advantage will require providers to submit the appropriate DEX Z-code for molecular diagnostic test services. This policy will apply to both facility and professional claims. The Medicare-assigned Z-code should be submitted in the 2400 loop (line level), SV202-7. This message is returned when that loop and segment does not contain a Z-code. Please refer to the UnitedHealthcare Medicare Advantage Reimbursement Policy Update Bulletin (January 2022) on UHCprovider.com	2/17/2022 2/27/2025 Changed to Rejection Edit on 4/7/2022	Medicare Dual Enrollment	Facility
Rejection Edit	**uNTZCODE**	REJECT – Molecular diagnostic test <1> requires a valid DEX Z-Code in the 2400 loop, SV101-7. <procedure description 2> is not a valid Z-Code. This claim has been rejected and will not be processed.	Non-Molecular Diagnostics States Value Not Z-Code Wave United Healthcare Medicare Advantage will require providers to submit the appropriate DEX Z-code for molecular diagnostic test services. This policy will apply to both facility and professional claims. The Medicare-assigned Z-code should be submitted in the 2400 loop (line level), SV101-7. This message is returned when that loop and segment data does not contain a 5 alpha-numeric value that starts with a "Z." Please refer to the Molecular Pathology Policy, Professional and Facility on UHCprovider.com.	1/13/2022 2/27/2025 Changed to Rejection Edit on 4/7/2022	Medicare Dual Enrollment	Professional
Rejection Edit	**uNTZCODEf**	REJECT – Molecular diagnostic test <1> requires a valid DEX Z-Code in the 2400 loop, SV202-7. <procedure description 2> is not a valid Z-Code. This claim has been rejected and will not be processed.	Non Molecular Diagnostics States Value Not Z-Code This edit follows the Palmetto GBA MAC's requirements that for listed molecular diagnostic tests, labs must register with Palmetto to be assigned a certification number, called a Z-code. This is a 5-character, alpha-numeric code that always starts with a "Z." This edit is informational to begin targeted messaging to providers, and will be updated as a Reject once the downstream SAM edit denial is in place. Once Optum contracts with Palmetto for the provider/z-code table, additional validation edits will be built. Please refer to the Molecular Pathology Policy, Professional and Facility on UHCprovider.com.	2/17/2022 2/27/2025 Changed to Rejection Edit on 4/7/2022	Medicare Dual Enrollment	Facility
Rejection Edit	**uNZCDCPT**	REJECT - Z Code <1> is not valid for CPT code <2>. This claim has been rejected and will not be processed.	Non Mol-DX Invalid Z-Code for CPT United Healthcare Medicare Advantage will require providers to submit the appropriate DEX Z-code for molecular diagnostic test services. This policy will apply to both facility and professional claims. The Medicare-assigned Z-code should be submitted in the 2400 loop (line level), SV101-7. This message is returned when that loop and segment have data submitted, but the listed Z-code is invalid for the corresponding procedure code. Please review the Molecular Pathology Policy, Professional and Facility on UHCprovider.com.	4/14/2022 2/27/2025	Medicare Dual Enrollment	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**uNZCDCPTf**	REJECT - Z Code <1> is not valid for CPT code <2>. This claim has been rejected and will not be processed.	Non Mol-DX Invalid Z-Code for CPT United Healthcare Medicare Advantage will require providers to submit the appropriate DEX Z-code for molecular diagnostic test services. This policy will apply to both facility and professional claims. The Medicare-assigned Z-code should be submitted in the 2400 loop (line level), SV202-7. This message is returned when that loop and segment are blank. Please refer to the Molecular Pathology Policy, Professional and Facility on UHCprovider.com.	4/14/2022 2/27/2025	Medicare Dual Enrollment	Facility
Rejection Edit	**uNZCDMPL**	REJECT - Molecular Diagnostic code <1> requires a single Z-Code be submitted. This claim has been rejected and will not be processed.	Non Mol-DX Multiple Z-Codes Submitted on Claim Line United Healthcare Medicare Advantage will require providers to submit the appropriate DEX Z-code for molecular diagnostic test services. This policy will apply to both facility and professional claims. The Medicare-assigned Z-code should be submitted in the 2400 loop (line level), SV101-7. This message is returned when that loop and segment have multiple DEX Z-codes submitted on a claim line. Please review the Molecular Pathology Policy, Professional and Facility on UHCprovider.com.	4/14/2022 2/27/2025	Medicare Dual Enrollment	Professional
Rejection Edit	**uNZCDMPLf**	REJECT - Molecular Diagnostic code <1> requires a single Z-Code be submitted. This claim has been rejected and will not be processed.	Non Mol-DX Multiple Z-Codes Submitted on Claim Line United Healthcare Medicare Advantage will require providers to submit the appropriate DEX Z-code for molecular diagnostic test services. This policy will apply to both facility and professional claims. The Medicare-assigned Z-code should be submitted in the 2400 loop (line level), SV202-7. This message is returned when that loop and segment have multiple DEX Z-codes submitted on a claim line. Please refer to the Molecular Pathology Policy, Professional and Facility on UHCprovider.com.	4/14/2022 2/27/2025	Medicare Dual Enrollment	Facility
Rejection Edit	**uNZCDPSC**	REJECT - DEX procedure code <1> has been submitted more than once on this claim. This claim has been rejected and will not be processed.	Non Mol-DX Z-Code Procedure More than Once Same DOS Same Claim United Healthcare Medicare Advantage will require providers to submit the appropriate DEX Z-code for molecular diagnostic test services. This policy will apply to both facility and professional claims. The Medicare-assigned Z-code should be submitted in the 2400 loop (line level), SV101-7. This message is returned when that loop and segment have the same DEX Z-code submitted for multiple claim lines on the same date of service. Please review the Molecular Pathology Policy, Professional and Facility on UHCprovider.com.	4/14/2022 2/27/2025	Medicare Dual Enrollment	Professional
Rejection Edit	**uNZCDPSCf**	REJECT - DEX procedure code <1> has been submitted more than once on this claim. This claim has been rejected and will not be processed.	Non Mol-DX Z-Code Procedure More than Once Same DOS Same Claim United Healthcare Medicare Advantage will require providers to submit the appropriate DEX Z-code for molecular diagnostic test services. This policy will apply to both facility and professional claims. The Medicare-assigned Z-code should be submitted in the 2400 loop (line level), SV202-7. This message is returned when that loop and segment have the same DEX Z-code submitted for multiple claim lines on the same date of service. Please refer to the Molecular Pathology Policy, Professional and Facility on UHCprovider.com.	4/14/2022 2/27/2025	Medicare Dual Enrollment	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uNPLDN**	This non-patient facility laboratory service <1> is not eligible for reimbursement. Update code(s) as applicable.	Non Patient Lab Service Hospitals acting as a reference laboratory or conducting diagnostic testing for non-patients cannot bill for such non-patient diagnostic laboratory tests under that hospital's Facility Participation Agreement. Hospitals wishing to participate in a UnitedHealthcare commercial network as a reference laboratory may apply with UnitedHealthcare to be credentialed and contracted as a reference laboratory. Please review Hospital Reference Lab Protocol at UHCprovider.com.	8/29/2024	Commercial	Facility
Return Edit	**uOBGUA**	Urinalysis Procedure <1> is not allowed as a separate charge when billed with OBGYN diagnosis of <2>. Update code(s) as applicable for services rendered.	OBGYN Services - 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. Oxford follows ACOG coding guidelines and considers an E/M service to be separately reimbursed in addition to an OB ultrasound procedure (CPT codes 76801-76817 and 76820-76828) only if the E/M service has modifier 25 appended to the E/M code. Please review the Obstetrical Policy, Professional on UHCprovider.com for further information.	9/24/2020	Oxford	Professional
Return Edit	**uOBPD3**	Revenue Code <2> is not appropriate for Transfusion code <1>. Please update code(s) as applicable.	Transfusion Revenue Code Transfusion services, CPT codes 36430–36460 should be reported with revenue code 0391. A single transfusion code is submitted once per service regardless of the number of units of blood or blood product transfused. In addition, the applicable code for the blood or blood product should be submitted on the same claim. Please review Outpatient Hospital Blood and Blood Products Policy, Facility at UHCprovider.com.	10/24/2024	Commercial	Facility
Return Edit	**uOBPD4**	Transfusion code <1> and Rev code 0391 require a Blood and Blood Products code on the same claim. Please update code(s) as applicable.	Transfusion Services and Blood Product Transfusion services, CPT codes 36430–36460 should be reported with revenue code 0391. A single transfusion code is submitted once per service regardless of the number of units of blood or blood product transfused. In addition, the applicable code for the blood or blood product should be submitted on the same claim. Please review Outpatient Hospital Blood and Blood Products Policy, Facility at UHCprovider.com.	10/24/2024	Commercial	Facility
Return Edit	**uOBPD7**	Revenue Code <2> is not appropriate for Split Unit of Blood or Blood Product code <1>. Please update code(s) as applicable.	Split Unit of Blood or Blood Product A split unit of blood or blood product is where portions are given to different patients or the same patient at different times. HCPCS code P9011 for the split unit of blood must be submitted with the appropriate revenue code (0383, 0384, or 0389) that identifies the blood or blood product transfused. Please review Outpatient Hospital Blood and Blood Products Policy, Facility at UHCprovider.com.	10/24/2024	Commercial	Facility
Return Edit	**uOBSAD**	Observation HCPCS code <1> is not appropriate when submitted without an Observation Additional Services HCPCS code. Update code(s) as applicable.	Outpatient Hospital Observation Additional Services Not Billed Observation services code G0378 should only be reported when one of the following services was also provided on the same date of service or the day before the date reported for observation. Emergency Department visit (99281-99285, G0380-G0384), or Clinic visit (HCPCS code G0463), or Critical care (CPT code 99291), or Direct referral for observation care reported with HCPCS code G0379 which must be reported on the same date of service as the date reported for observation. Please refer to the Outpatient Hospital Observation Policy, Facility policy on UHCprovider.com.	6/27/2024	Commercial	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uOBSCCf**	HCPCS code G0378 must be submitted on the same date of service as direct admission of a patient for hospital observation care code G0379. Update code(s) as applicable.	Observation Care Code Hospital outpatient observation services are reported with the Centers for Medicare and Medicaid Services (CMS) HCPCS codes G0378 and G0379. CMS publishes guidelines for use of these codes to allow for consistent coding and billing by facilities reporting observation services. Direct admission of a patient for hospital observation care code G0379 is not reimbursable if not submitted on the same date of service as G0378. Please refer to the Outpatient Hospital Observation Policy on UHCprovider.com	2/25/2021	Commercial Oxford	Facility
Return Edit	**uOBSDA**	Direct Admission for Observation Care HCPCS code <1> is not appropriate when submitted without an Observation HCPCS code. Update code(s) as applicable.	Outpatient Hospital Observation Direct Admit Without Observation Facilities should report HCPCS code G0379 when observation services are the result of a direct referral/admission for observation care without an associated emergency room visit, hospital outpatient clinic visit or critical care service on the day of initiation of observation services. Facilities should only report HCPCS code G0379 when a patient is referred directly to observation care after being seen by a physician in the community. Direct admission of a patient for hospital observation care code G0379 is not reimbursable if not submitted on the same date of service as G0378. Please refer to the Outpatient Hospital Observation Policy, Facility policy on UHCprovider.com.	6/27/2024	Commercial	Facility
Return Edit	**uOBSDN**	Observation revenue code <1> is not appropriate when submitted without a HCPCS code. Update code(s) as applicable.	Outpatient Hospital Observation Procedure Code Not Billed Observation revenue code <1> is not appropriate when submitted without a HCPCS code. Update code(s) as applicable. Please refer to the Outpatient Hospital Observation Policy, Facility policy on UHCprovider.com.	6/27/2024	Commercial	Facility
Return Edit	**uOBSDP**	Observation HCPCS code <1> is not separately reimbursable from Observation HCPCS code <2> on the current or previously submitted claim. Update code(s) as applicable.	Outpatient Hospital Observation Duplicate Observation HCPCS code <1> is not separately reimbursable from Observation HCPCS code <2> on the current or previously submitted claim. Update code(s) as applicable. Please refer to the Outpatient Hospital Observation Policy, Facility policy on UHCprovider.com.	6/27/2024	Commercial	Facility
Return Edit	**uOBSDS**	Direct Admission for Observation HCPCS code <1> on the current claim line is not separately reimbursable when billed with a Status T or V Indicator code <2>. Update codes as applicable.	Outpatient Hospital Observation Direct Admit with Status Indicator Direct Admission for Observation HCPCS code <1> on the current claim line is not separately reimbursable when billed with a Status T or V Indicator code <2>. Update codes as applicable. Please refer to the Outpatient Hospital Observation Policy, Facility policy on UHCprovider.com.	6/27/2024	Commercial	Facility
Return Edit	**uOBSDSUf**	Observation hours <1> exceed the statement from and through date span. Update claim as applicable.	Observation Hours Date Span to Units Descrepancy The number of units submitted is not equal to the date span starting from beginning Date of service to the ending date of service. Please refer to the UnitedHealthcare Commercial Outpatient Hospital Observation Policy, Facility on UHCprovider.com	3/31/2022	Commercial Oxford Level Funded	Facility
Return Edit	**uOBSf**	Please verify the procedure code and units billed. Procedure code <1> is only payable with a quantity of one. If billing for time-based code, please submit appropriate code(s).	Observation Care Facility billing revenue codes 710, 719 - 721, 729, 760 - 762 or 769 with and E&M code for Observation care with a quantity greater than one. The E&M codes can only be paid with a quantity of 1. Time based services should be submitted with the appropriate code.	7/30/2020 9/29/2022	Oxford Level Funded	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uOBSHR**	Observation HCPCS code <1> is billed with less than the appropriate number of hours [8] to be eligible for reimbursement. Update code(s) as applicable.	Outpatient Hospital Observation Hours Billed Observation service code G0378 will only be considered for reimbursement when the observation period meets or exceeds 8 hours. Please refer to the Outpatient Hospital Observation Policy, Facility policy on UHCprovider.com.	6/27/2024	Commercial	Facility
Return Edit	**uOBSMAXf**	Observation services in excess of 48 hours are not appropriate. Update claim as applicable.	UHC ACE Outpatient Exceed 48 hours Observation care is defined as a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to the emergency department and who then require treatment or monitoring before a decision is made concerning their admission or discharge. Observation stay is an alternative to an inpatient admission that allows reasonable and necessary time to evaluate and render medically necessary services to a member whose diagnosis and treatment are not expected to exceed 24 hours but may extend to 48 hours, but no longer than 48 hours without a discharge or admission. There will be no reimbursement for observation services in excess of 48 hours. For more information, please refer to the Facility Observation Services Policy.	7/29/2021	Medicaid	Facility
Return Edit	**uOBSPC**	Observation revenue code <1> is not eligible for reimbursement when submitted without an Observation HCPCS code. Update code(s) as applicable.	Outpatient Hospital Observation Procedure Code Observation services must be reported by facilities utilizing the following guidelines: Observation services are submitted with type of bill 13X, 78X, or 85X, Report HCPCS code G0378 (hospital observation service, per hour) under the appropriate revenue code (0762) with units that represent the hours in observation care (rounded to the nearest hour). Please refer to the Outpatient Hospital Observation Policy, Facility policy on UHCprovider.com.	6/27/2024	Commercial	Facility
Return Edit	**uOBSPCf**	Revenue code 0762 submitted without an hourly or referral observation procedure code. Update code(s) as applicable.	Observation Procedure Code Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Hospital outpatient observation services are reported with the Centers for Medicare and Medicaid Services (CMS) HCPCS codes G0378 and G0379. CMS publishes guidelines for use of these codes to allow for consistent coding and billing by facilities reporting observation services. Please refer to the Outpatient Hospital Observation Policy on UHCprovider.com	2/25/2021 9/29/2022	Commercial Oxford Level Funded	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uOBSREVf**	Observation service <1 HCPCS> should be submitted with observation revenue code 0762. Update code(s) as applicable.	Observation Revenue Code Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Hospital outpatient observation services are reported with the Centers for Medicare and Medicaid Services (CMS) HCPCS codes G0378 and G0379. CMS publishes guidelines for use of these codes to allow for consistent coding and billing by facilities reporting observation services. Please refer to the Outpatient Hospital Observation Policy on UHCprovider.com	2/25/2021	Commercial Oxford	Facility
Return Edit	**uOBSRV**	Observation HCPCS code <1> is not eligible for reimbursement when submitted without an Observation revenue code. Update code(s) as applicable.	Outpatient Hospital Observation with Status Indicator Observation services must be reported by facilities utilizing the following guidelines: Observation services are submitted with type of bill 13X, 78X, or 85X, Report HCPCS code G0378 (hospital observation service, per hour) under the appropriate revenue code (0762) with units that represent the hours in observation care (rounded to the nearest hour).When reporting services for the direct admission for observation G0379, report with Revenue code 0762. Please refer to the Outpatient Hospital Observation Policy, Facility policy on UHCprovider.com.	6/27/2024	Commercial	Facility
Return Edit	**uOBSSI**	Observation HCPCS code <1> is not separately reimbursable when billed with a Status J1 or T Indicator HCPCS code <2>. Update code(s) as applicable.	Outpatient Hospital Observation with Status Indicator HCPCS code G0378 will not be reimbursed when reported in addition to procedure codes that are assigned a status indicator of J1 or T under the CMS Integrated Outpatient Code Editor (IOCE). Please refer to the Outpatient Hospital Observation Policy, Facility policy on UHCprovider.com.	6/27/2024	Commercial	Facility
Return Edit	**uOBUSRO**	Procedure <123> is the fourth or more ultrasound for this pregnancy. Ultrasounds greater than three require a high-risk pregnancy diagnosis. Claim does not contain a covered diagnosis in the appropriate position.	OB Maternity Ultrasound Report Only As of June 1, 2022, a new obstetrical ultrasound medical policy for UnitedHealthcare commercial members is in place. Up to 3 prenatal ultrasounds per pregnancy, for CPT® codes 76801, 76802, 76805, 76810, 76811, 76812, 76815, 76816 and 76817, will be considered proven and medically necessary. Four or more ultrasounds will be considered proven and medically necessary for high-risk pregnancies, as described in the policy, when the treating provider will make therapeutic determinations based upon the results. This policy applies to professional claims billed on a Health Care Finance Administration (HCFA) form with place of service 11 and 22. This policy doesn't apply to: Prenatal ultrasounds rendered in an emergency room, Outpatient observation care, Inpatient hospital setting. Please review the Obstetrical Policy, Professional on UHCprovider.com for further information.	6/30/2022	Commercial	Professional
Rejection Edit	**uOHNMID**	REJECT – Member group id <1> is not affiliated with Ohio Medicaid electronic payer id 88337. This claim has been rejected and will not be processed.	OH NextGen Wrong Payor ID for Member Effective February 1, 2023, ODM will launch the Next Generation of Ohio Medicaid Managed Care program, which includes a new Electronic Data Interchange (EDI) for Medicaid claims. Submissions should now be directed to electronic payer id 88337. This Smart Edit rejects claims when the member group is not Ohio Medicaid Managed Care and the EDI payer id is 88337. Please review https://managedcare.medicaid.ohio.gov/managed-care.	1/26/2023	Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**uOHNMIDf**	REJECT – Member group id <1> is not affiliated with Ohio Medicaid electronic payer id 88337. This claim has been rejected and will not be processed.	OH NextGen Wrong Payor ID for Member Effective February 1, 2023, ODM will launch the Next Generation of Ohio Medicaid Managed Care program, which includes a new Electronic Data Interchange (EDI) for Medicaid claims. Submissions should now be directed to electronic payer id 88337. This Smart Edit rejects claims when the member group is not Ohio Medicaid Managed Care and the EDI payer id is 88337. Please refer to https://managedcare.medicaid.ohio.gov/managed-care.	1/26/2023	Medicaid	Facility
Rejection Edit	**uOHNPID**	REJECT –Ohio Medicaid requires claims for UnitedHealthcare Community Plan members be submitted to electronic payer id 88337. This claim has been rejected and will not be processed.	OH NextGen Wrong Payor ID Effective February 1, 2023, ODM will launch the Next Generation of Ohio Medicaid Managed Care program, which includes a new Electronic Data Interchange (EDI) for Medicaid claims. Submissions should now be directed to electronic payer id 88337. This Smart Edit rejects claims when the member group is Ohio Medicaid Managed Care and the EDI payer id is not 88337. Please review https://managedcare.medicaid.ohio.gov/managed-care.	1/26/2023	All Savers Commercial Dual Enrollment Individual & Family Plan Level Funded Medicaid Medicare Oxford UMR	Professional
Rejection Edit	**uOHNPIDf**	REJECT –Ohio Medicaid requires claims for UnitedHealthcare Community Plan members be submitted to electronic payer id 88337. This claim has been rejected and will not be processed.	OH NextGen Wrong Payor ID Effective February 1, 2023, ODM will launch the Next Generation of Ohio Medicaid Managed Care program, which includes a new Electronic Data Interchange (EDI) for Medicaid claims. Submissions should now be directed to electronic payer id 88337. This Smart Edit rejects claims when the member group is Ohio Medicaid Managed Care and the EDI payer id is not 88337. Please refer to: https://managedcare.medicaid.ohio.gov/managed-care.	1/26/2023	All Savers Commercial Dual Enrollment Individual & Family Plan Level Funded Medicaid Medicare Oxford UMR	Facility
Rejection Edit	**uOPIC**	REJECT - This patient has primary insurance coverage with another carrier. Please resubmit as electronic secondary once adjudicated by the primary payor.	Other Primary Insurance Community and State No OI Name No OI Date This member has primary health insurance with another carrier. Our records indicate the other insurance carrier is primary. This claim can be resubmitted as electronic secondary once adjudicated by the primary payor. Find specific information about secondary claims submissions, such as coordination of benefits (COB) electronic claim requirements and EDI specifications, on UHCprovider.com/ediclaimtips > Secondary/COB or Tertiary Claims. Please review the UnitedHealthcare Provider Administrative Guide at UHCprovider.com.	8/29/2024	Medicaid	Professional
Rejection Edit	**uOPICD**	REJECT - This patient has primary insurance coverage with another carrier with effective date <Effective Date (UDF26) >. Please resubmit as electronic secondary once adjudicated by the primary payor.	Other Primary Insurance with OI Date - Community and State This member has primary health insurance with another carrier. Our records indicate the other insurance carrier is primary. This claim can be resubmitted as electronic secondary once adjudicated by the primary payor. Find specific information about secondary claims submissions, such as coordination of benefits (COB) electronic claim requirements and EDI specifications, on UHCprovider.com/ediclaimtips > Secondary/COB or Tertiary Claims. Please review the UnitedHealthcare Provider Administrative Guide at UHCprovider.com.	8/29/2024	Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**uOPICND**	REJECT - This patient has primary insurance coverage with < Other Insurance Name (UDF23, first 20 characters only) >, effective <Effective Date (UDF26) >. Please resubmit as electronic secondary once adjudicated by the primary payor.	Other Primary Insurance with OI Name and OI Date - Community and State This member has primary health insurance with another carrier. Our records indicate the other insurance carrier is primary. This claim can be resubmitted as electronic secondary once adjudicated by the primary payor. Find specific information about secondary claims submissions, such as coordination of benefits (COB) electronic claim requirements and EDI specifications, on UHCprovider.com/ediclaimtips > Secondary/COB or Tertiary Claims. Please review the UnitedHealthcare Provider Administrative Guide at UHCprovider.com.	8/29/2024	Medicaid	Professional
Return Edit	**uOIDSf**	Valid date of service is required for each claim line and must fall within the from and to date on the claim. The date of service for code <1> does not meet requirements. Update claim as applicable.	Outpatient Invalid Date of Service In accordance with Centers for Medicare and Medicaid Services (CMS) and National Uniform Billing Committee (NUBC), a valid date of service must be reported on each line. Service Date (MMDDYY) must fall within the from-to-date if service on the outpatient facility claims and it represents the date the outpatient service was provided. There must be a single-line item date of service (LIDOS) reported for every revenue code, procedure codes or drug codes on all outpatient bills. This includes where the "from" and "through: dates are equal. Please review the Outpatient From-to-date Policy at UHCprovider.com	9/22/2024	Level Funded Oxford	Facility
Rejection Edit	**uOIPDf**	REJECT - Diagnosis code <1> is an inappropriate principal diagnosis code. This claim has been rejected and will not be processed.	Inappropriate Principal Diagnosis The new Facility Outpatient Hospital Inappropriate Primary Diagnosis policy will follow the official ICD-10-CM guidelines for coding and reporting as required by HIPAA. The first listed diagnosis code should follow the coding conventions of ICD-10-CM. Please refer to the Diagnosis Code Requirement Policy, Professional and Facility - Reimbursement Policy - UnitedHealthcare Commercial and Individual Exchange at UHCprovider.com	5/27/2021	Medicaid	Facility
Return Edit	**uOMCRD**	Ordering physician NPI is not found for service code <1>. Per CMS, physicians must be enrolled with a valid NPI. Please verify physician record and resubmit the claim with a valid NPI.	Ordering Physician NPI Required but Missing for Capped Rental DME CMS regulations require physicians or other eligible professionals to be enrolled or validly opted-out for the Medicare Program to order or refer items and services for Medicare beneficiaries. The submitted CPT code requires a valid NPI submitted in either the Ordering Provider NPI found in 2420E/NM109 or Line Level Referring Provider NPI found in 2420F/NM109 or Claim Level Referring Provider NPI found in 2310A/NM109. Please review the Medicare Benefit Policy Manual on www.cms.gov.	5/26/2022	Medicare	Professional
Return Edit	**uOMFSD**	Ordering physician NPI is not found for service code <1>. Per CMS, physicians must be enrolled with a valid NPI. Please verify physician record and resubmit the claim with a valid NPI.	Ordering Physician NPI Required but Missing for Frequent Servicing DME CMS regulations require physicians or other eligible professionals to be enrolled or validly opted-out for the Medicare Program to order or refer items and services for Medicare beneficiaries. The submitted CPT code requires a valid NPI submitted in either the Ordering Provider NPI found in 2420E/NM109 or Line Level Referring Provider NPI found in 2420F/NM109 or Claim Level Referring Provider NPI found in 2310A/NM109. Please review the Medicare Benefit Policy Manual on www.cms.gov.	5/26/2022	Medicare	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uOMOD**	Modifier <1> is inappropriate for Procedure Code <2>. Update code(s) as applicable.	Invalid 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. Please review the Procedure to Modifier reimbursement policy at UHCprovider.com.	7/29/2021	Oxford	Professional
Return Edit	**uOMODME**	Ordering physician NPI is not found for service code <1>. Per CMS, physicians must be enrolled with a valid NPI. Please verify physician record and resubmit the claim with a valid NPI.	Ordering Physician NPI Required but Missing for Oxygen DME CMS regulations require physicians or other eligible professionals to be enrolled or validly opted-out for the Medicare Program to order or refer items and services for Medicare beneficiaries. The submitted CPT code requires a valid NPI submitted in either the Ordering Provider NPI found in 2420E/NM109 or Line Level Referring Provider NPI found in 2420F/NM109 or Claim Level Referring Provider NPI found in 2310A/NM109. Please review the Medicare Benefit Policy Manual on www.cms.gov.	5/26/2022	Medicare	Professional
Informational Edit	**uOMPCf**	INFORMATIONAL - Revenue code <1> should be submitted with a HCPCS or CPT code.	Outpatient Missing Procedure Code For Outpatient Covered Services, appropriate CPT/HCPCS codes, as described by the National Uniform Billing Committee and CPT/HCPCS code guidelines, must be submitted on the Institutional Claim in order to be eligible for reimbursement. Please refer to Provider Administrative Guide on UHCprovider.com.	2/25/2021 11/30/2023	Commercial Oxford UHOne	Facility
Return Edit	**uOMRPD**	Ordering physician NPI is not found for service code <1>. Per CMS, physicians must be enrolled with a valid NPI. Please verify physician record and resubmit the claim with a valid NPI.	Ordering Physician NPI Required but Missing for Inexpensive and Routinely Purchased DME CMS regulations require physicians or other eligible professionals to be enrolled or validly opted-out for the Medicare Program to order or refer items and services for Medicare beneficiaries. The submitted CPT code requires a valid NPI submitted in either the Ordering Provider NPI found in 2420E/NM109 or Line Level Referring Provider NPI found in 2420F/NM109 or Claim Level Referring Provider NPI found in 2310A/NM109. Please review the Medicare Benefit Policy Manual on www.cms.gov.	5/26/2022	Medicare	Professional
Return Edit	**uOMVNP**	Trauma Response revenue code is not separately reimbursable when submitted without a Trauma Activation code. Please update code(s) as applicable.	Trauma Activation Code Trauma Activation will be considered for reimbursement only when the criteria for revenue code 068x, HCPCS code G0390, and critical care code 99291 are met and are reported on the same date of service. Please refer to Outpatient Medical Visits and Trauma Activation Policy, Facility on UHCprovider.com	7/25/2024	Commercial	Facility
Return Edit	**uOMVTA**	Trauma Response procedure code <1> is not separately reimbursable when submitted without a critical care procedure code. Please update code(s) as applicable.	Trauma - Critical Care Procedure Code Trauma Activation will be considered for reimbursement only when the criteria for revenue code 068x, HCPCS code G0390, and critical care code 99291 are met and are reported on the same date of service. Trauma activation code G0390 submitted with revenue code 68X (068X) will not be considered for separate reimbursement if it is not performed on the same date of service as critical care service 99291. Please refer to Outpatient Medical Visits and Trauma Activation Policy, Facility on UHCprovider.com	7/25/2024	Commercial	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uOMVTR**	Trauma Response procedure code <1> is not submitted with an appropriate Trauma Response revenue code. Please update code(s) as applicable.	Trauma - Revenue Code Trauma Activation will be considered for reimbursement only when the criteria for revenue code 068x, HCPCS code G0390, and critical care code 99291 are met and are reported on the same date of service. Trauma activation code G0390 submitted with revenue code 68X (068X) will not be considered for separate reimbursement if it is not performed on the same date of service as critical care service 99291. Please refer to Outpatient Medical Visits and Trauma Activation Policy, Facility on UHCprovider.com	7/25/2024	Commercial	Facility
Informational Edit	**uOMWF**	INFORMATIONAL – Procedure code <1> for fracture could be related to Osteoporosis. Coordination of Care with patient's PCP is recommended for follow up including a possible Bone Mineral Density Test.	Osteoporosis Management for Women with Fracture Osteoporosis affects bone density, increasing the risk of fractures. Osteoporotic fractures can lead to complications or death. It is important for the primary care physician of a female patient between the ages of 65 and 85 who have been treated for fracture to be aware of the services rendered, in order that a determination for further testing and treatment be made. Please review the Bone (Mineral) Density Studies (NCD150.3) Policy on UHCprovider.com.	8/27/2020	Medicare	Professional
Informational Edit	**uONPRN**	INFORMATIONAL - Provider billing registration for Tax ID <1> must be confirmed/completed. Please go to UHCprovider.com/outofnetwork to submit the required information.	Out of Network Provider - EPV All out of network providers need to have their billing provider tax id (TIN) registered and verified. Go to www.UHCprovider.com/outofnetwork to complete your digital registration. Be sure to have a pdf version of the billing provider's W-9 tax form and documentation to prove the primary practice location address. Please review www.UHCprovider.com/outofnetwork to complete digital registration.	7/27/2023	All Savers Commercial Dual Enrollment Individual &Family Plan Level Funded Medicaid Medicare Oxford UMR	Professional
Informational Edit	**uONPRNf**	INFORMATIONAL - Provider billing registration for Tax ID <1> must be confirmed/completed. Please go to UHCprovider.com/outofnetwork to submit the required information.	Out of Network Provider - EPV All out of network providers need to have their billing provider tax id (TIN) registered and verified. Go to www.UHCprovider.com/outofnetwork to complete your digital registration. Be sure to have a pdf version of the billing provider's W-9 tax form and documentation to prove the primary practice location address. Please refer to www.UHCprovider.com/outofnetwork to complete digital registration.	7/27/2023	All Savers Commercial Dual Enrollment Individual &Family Plan Level Funded Medicaid Medicare Oxford UMR	Facility
Rejection Edit	**uOPI1**	REJECT - This patient has primary insurance coverage with another carrier. Please resubmit as electronic secondary once adjudicated by the primary payor.	Other Primary Insurance No OI Name No OI Date This member has a commercial plan and primary health insurance with another carrier. Our records indicate the other insurance carrier is primary. This claim can be resubmitted as electronic secondary once adjudicated by the primary payor. Find specific information about secondary claims submissions, such as coordination of benefits (COB) electronic claim requirements and EDI specifications, on uhcprovider.com/ediclaimtips > Secondary/COB or Tertiary Claims. Please review the UnitedHealthcare Provider Administrative Guide https://www.UHCprovider.com/content/dam/provider/docs/public/admin-guides/2023-UHC-Administrative-Guide.pdf	1/25/2024	Level Funded Oxford	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**uOPI1f**	REJECT - This patient has primary insurance coverage with another carrier. Please resubmit as electronic secondary once adjudicated by the primary payor.	Other Primary Insurance No OI Name No OI Date This member has a commercial plan and primary health insurance with another carrier. Our records indicate the other insurance carrier is primary. This claim can be resubmitted as electronic secondary once adjudicated by the primary payor. Find specific information about secondary claims submissions, such as coordination of benefits (COB) electronic claim requirements and EDI specifications, on uhcprovider.com/ediclaimtips > Secondary/COB or Tertiary Claims. Please review the UnitedHealthcare Provider Administrative Guide https://www.UHCprovider.com/content/dam/provider/docs/public/admin-guides/2023-UHC-Administrative-Guide.pdf	1/25/2024	Level Funded Oxford	Facility
Rejection Edit	**uOPID1**	REJECT - This patient has primary insurance coverage with another carrier with effective date <Effective Date (UDF26) >. Please resubmit as electronic secondary once adjudicated by the primary payor.	Other Primary Insurance with OI Date This member has a commercial plan and primary health insurance with another carrier. Our records indicate the other insurance carrier is primary. This claim can be resubmitted as electronic secondary once adjudicated by the primary payor. Find specific information about secondary claims submissions, such as coordination of benefits (COB) electronic claim requirements and EDI specifications, on uhcprovider.com/ediclaimtips > Secondary/COB or Tertiary Claims. Please review the UnitedHealthcare Provider Administrative Guide https://www.UHCprovider.com/content/dam/provider/docs/public/admin-guides/2023-UHC-Administrative-Guide.pdf	1/25/2024	Level Funded Oxford	Professional
Rejection Edit	**uOPID1f**	REJECT - This patient has primary insurance coverage with another carrier with effective date <Effective Date (UDF26) >. Please resubmit as electronic secondary once adjudicated by the primary payor.	Other Primary Insurance with OI Date This member has a commercial plan and primary health insurance with another carrier. Our records indicate the other insurance carrier is primary. This claim can be resubmitted as electronic secondary once adjudicated by the primary payor. Find specific information about secondary claims submissions, such as coordination of benefits (COB) electronic claim requirements and EDI specifications, on uhcprovider.com/ediclaimtips > Secondary/COB or Tertiary Claims. Please review the UnitedHealthcare Provider Administrative Guide https://www.UHCprovider.com/content/dam/provider/docs/public/admin-guides/2023-UHC-Administrative-Guide.pdf	1/25/2024	Level Funded Oxford	Facility
Rejection Edit	**uOPIND1**	REJECT - This patient has primary insurance coverage, effective <Effective Date (UDF26) >. Please resubmit as electronic secondary once adjudicated by the primary payor.	Other Primary Insurance with OI Name and OI Date This member has a commercial plan and primary health insurance with another carrier. Our records indicate the other insurance carrier is primary. This claim can be resubmitted as electronic secondary once adjudicated by the primary payor. Find specific information about secondary claims submissions, such as coordination of benefits (COB) electronic claim requirements and EDI specifications, on uhcprovider.com/ediclaimtips > Secondary/COB or Tertiary Claims. Please review the UnitedHealthcare Provider Administrative Guide https://www.UHCprovider.com/content/dam/provider/docs/public/admin-guides/2023-UHC-Administrative-Guide.pdf	1/25/2024	Level Funded Oxford	Professional
Rejection Edit	**uOPIND1f**	REJECT - This patient has primary insurance coverage, effective <Effective Date (UDF26) >. Please resubmit as electronic secondary once adjudicated by the primary payor.	Other Primary Insurance with OI Name and OI Date This member has a commercial plan and primary health insurance with another carrier. Our records indicate the other insurance carrier is primary. This claim can be resubmitted as electronic secondary once adjudicated by the primary payor. Find specific information about secondary claims submissions, such as coordination of benefits (COB) electronic claim requirements and EDI specifications, on uhcprovider.com/ediclaimtips > Secondary/COB or Tertiary Claims. Please review the UnitedHealthcare Provider Administrative Guide https://www.UHCprovider.com/content/dam/provider/docs/public/admin-guides/2023-UHC-Administrative-Guide.pdf	1/25/2024	Level Funded Oxford	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uOPINf**	The date of service of this outpatient service falls with an inpatient confinement for this member. Update claim as applicable.	Outpatient during Inpatient confinement Out-Patient claim dates are falling within date span of inpatient confinement. Services performed in an inpatient setting should not be submitted separately as outpatient services.	9/30/2021	Medicare	Facility
Informational Edit	**uOPTCPA**	INFORMATIONAL - Effective 9/1/2024, procedure code <1> may require prior authorization. Please ensure the advance notification has been submitted to support services billed.	Outpatient Therapies and Chiropractic Services Prior Authorization Outpatient Therapies and Chiropractic Services may require prior authorization starting September 1, 2024. Advance notification is the first step in UnitedHealthcare's process to determine coverage for a member. Certain services require advance notification to determine if they are medically necessary and covered by the member's plan. Please refer to plan requirements Advance Notification and Clinical Submission Requirements or the August 1 Network News article on uhcprovider.com. If you have any questions, for chat options and contact information, vist UHCprovider.com/contactus.	8/8/2024	Medicare	Professional
Informational Edit	**uOPTCPAf**	INFORMATIONAL - Effective 9/1/2024, procedure code <1> may require prior authorization. Please ensure the advance notification has been submitted to support services billed.	Outpatient Therapies and Chiropractic Services Prior Authorization Outpatient Therapies and Chiropractic Services may require prior authorization starting September 1, 2024. Advance notification is the first step in UnitedHealthcare's process to determine coverage for a member. Certain services require advance notification to determine if they are medically necessary and covered by the member's plan. Please refer to plan requirements Advance Notification and Clinical Submission Requirements or the August 1 Network News article on uhcprovider.com. If you have any questions, for chat options and contact information, vist UHCprovider.com/contactus.	8/8/2024	Medicare	Facility
Return Edit	**uOSADf**	HCPCS code <1> is for a Part B Self-Administered Drug and needs to be submitted to Medicare Part D drug plan per member's coverage. Please update as applicable.	Outpatient Self-Administered Drugs Outpatient Self-Administered Drugs (SADs) should be submitted to the Part D prescription drug plan per the member's coverage. Please refer to Medicare Advantage Coverage Summary for MedicationsOutpatient Part B at UHCprovider.com.	12/19/2024	Medicare	Facility
Informational Edit	**uPASST**	INFORMATIONAL - As of 1/1/2025, all patients 7 years of age or older will require a prior authorization for Speech Therapy for this employer group.	Shell Speech Therapy Effective 1/1/2025, all members of the Shell Group Policy 182232 are required to obtain a prior authorization for speech therapy for all members over the age of 7. Please refer to UHC Commercial Advance Notification PA Requirements at www.UHCprovider.com.	2/27/2025	Commercial	Professional
Return Edit	**uPCIMOD**	Percutaneous coronary intervention code <1> requires an anatomical modifier. The most specific modifier to represent the site should be reported. Please review and update as applicable.	Percutaneous Coronary Intervention Anatomical Modifier Beginning 08/01/2023 when percutaneous coronary intervention codes are submitted, they must be appended with the appropriate modifiers. Please review Anatomical Modifier Requirement Policy, Professional - Reimbursement Policy - UnitedHealthcare Commercial Plans	8/3/2023	Commercial Individual & Family Plan Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
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).	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. Please review the EDI Companion Guides on UHCprovider.com for further information.	1/31/2019	Medicaid	Professional
Return Edit	**uPCS**	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.	Pilonidal Cyst or Sinus I&D and excision codes without Pilonidal Cyst or Sinus Diagnosis Providers are submitting claims for pilonidal cyst or sinus I&D, excision and reporting diagnosis codes that indicate another condition where another CPT would be more appropriate or no condition appropriate for an I&D or excision CPT. Correct Coding. AMA CPT Manual: 10080 Incision and drainage of pilonidal cyst; simple 10081 Incision and drainage of pilonidal cyst; complicated 11770 Excision of pilonidal cyst or sinus; simple 11771 Excision of pilonidal cyst or sinus; extensive 11772 Excision of pilonidal cyst or sinus; complicated	4/30/2020	Medicaid Medicare Commercial	Professional
Rejection Edit	**uPDWDf**	REJECT - Diagnosis code <1> is an unacceptable principal diagnosis code. This claim has been rejected and will not be processed.	Inpt Unacceptable Principal Dx Inappropriate Principal Diagnosis Codes Policy states appropriate principal 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 principal. Please refer to the Inappropriate Principal Diagnosis Codes Reimbursement Policy – UnitedHealthcare Commercial Plans on UHCprovider.com.	12/19/2024	Commercial Level Funded Oxford	Facility
Informational Edit	**uPIDCO**	INFORMATIONAL- Charges for DOS prior to 1/1/2023 should be billed to Payer ID SX141. Charges for DOS on or after 1/1/2023 should be billed to Payer ID 87726.	Colorado Payer ID Change State of Colorado/Rocky Mountain Health Plan is changing their payer ID from SX141 to 87726 for Professional claims effective January 1, 2023. This edit will fire an informational message advising the submitter that charges wholly occurring for dates of service prior to January 1, 2023, should be submitted using the previous payer ID SX141.	12/15/2022	Dual Enrollment Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**uPIDCO2**	INFORMATIONAL- Separate claims should be used for stays/treatment spanning 2022-23. Use Payer ID SX141 for 2022 and earlier DOS. Use Payer ID 87726 for DOS on or after 1/1/2023.	Colorado Payer ID Change - Split Bill State of Colorado/Rocky Mountain Health Plan is changing their payer ID from SX141 to 87726 for Professional claims effective January 1, 2023. This edit will fire an informational message advising the submitter that charges wholly occurring for dates of service prior to January 1, 2023, should be submitted using the previous payer ID SX141.	12/15/2022	Dual Enrollment Medicaid	Professional
Informational Edit	**uPIDCO2f**	INFORMATIONAL- Separate claims should be used for stays/treatment spanning 2022-23. Use Payer ID SX141 for 2022 and earlier DOS. Use Payer ID 87726 for DOS on or after 1/1/2023.	Colorado Payer ID Change - Split Bill State of Colorado/Rocky Mountain Health Plan is changing their payer ID from SX141 to 87726 for Professional claims effective January 1, 2023. This edit will fire an informational message advising the submitter that charges wholly occurring for dates of service prior to January 1, 2023, should be submitted using the previous payer ID SX141.	12/15/2022	Dual Enrollment Medicaid	Facility
Informational Edit	**uPIDCOf**	INFORMATIONAL- Charges for DOS prior to 1/1/2023 should be billed to Payer ID SX141. Charges for DOS on or after 1/1/2023 should be billed to Payer ID 87726.	Colorado Payer ID Change State of Colorado/Rocky Mountain Health Plan is changing their payer ID from SX141 to 87726 for Professional claims effective January 1, 2023. This edit will fire an informational message advising the submitter that charges wholly occurring for dates of service prior to January 1, 2023, should be submitted using the previous payer ID SX141.	12/15/2022	Dual Enrollment Medicaid	Facility
Return Edit	**uPILDCTf**	Procedure <1> requires an appropriate modifier and condition code designating the service as clinical trial to be eligible for reimbursement. Please review and update codes as applicable.	Percutaneous Image-guided Lumbar Decompression Clinical Trial CMS has determined that PILD will be covered by Medicare when provided in a clinical study. CMS requires that clinical trial information is included in order to cover the procedure. Please refer to Medicare Coverage Database - Percutaneous Image-Guided Lumbar Decompression for Lumbar Spinal Stenosis at cms.gov.	8/29/2024	Medicare	Facility
Rejection Edit	**uPLS**	REJECT - Oxford Health Plans no longer provides administrative services (claims and appeals processing, etc.) for this plan. Please contact the member for additional information.	Oxford Group Expiration Oxford Health Plans no longer provides administrative services (claims and appeals processing, etc.) for this plan. Please contact the member for additional information.	1/5/2023	Oxford	Professional
Rejection Edit	**uPLSf**	REJECT - Oxford Health Plans no longer provides administrative services (claims and appeals processing, etc.) for this plan. Please contact the member for additional information.	Oxford Group Expiration Oxford Health Plans no longer provides administrative services (claims and appeals processing, etc.) for this plan. Please contact the member for additional information.	1/5/2023	Oxford	Facility
Rejection Edit	**uPLSI**	REJECT – Oxford Health no longer provides administrative services for this plan. Please go to UHCprovider.com/smartedits for information regarding reconsideration requests.	Oxford Group Expiration Oxford Health Plans no longer provides administrative services (claims and appeals processing, etc.) for this plan. Please go to www.UHCprovider.com for more information if reconsideration is to be requested. If member is not part of the Oxford Group, please verify payer id and group policy number before resubmitting.	1/19/2023	Oxford	Professional
Rejection Edit	**uPLSIf**	REJECT – Oxford Health no longer provides administrative services for this plan. Please go to UHCprovider.com/smartedits for information regarding reconsideration requests.	Oxford Group Expiration Oxford Health Plans no longer provides administrative services (claims and appeals processing, etc.) for this plan. Please go to www.UHCprovider.com for more information if reconsideration is to be requested. If member is not part of the Oxford Group, please verify payer id and group policy number before resubmitting.	1/19/2023	Oxford	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**uPLSTF**	REJECT - The deadline to file a claim for this service has passed and therefore no payment is being made. You should refer to the Administrative Guide for more information on claim submission policies.	Oxford Group Timely Filing The deadline to file a claim for this service has passed and therefore no payment is being made. You should review the Administrative Guide for more information on claim submission policies. You may not bill the member for this service. If member is not part of the Oxford Group, please verify payer id and group policy number before resubmitting.	2/23/2023	Oxford	Professional
Rejection Edit	**uPLSTFf**	REJECT - The deadline to file a claim for this service has passed and therefore no payment is being made. You should refer to the Administrative Guide for more information on claim submission policies.	Oxford Group Timely Filing The deadline to file a claim for this service has passed and therefore no payment is being made. You should refer to the Administrative Guide for more information on claim submission policies. You may not bill the member for this service. If member is not part of the Oxford Group, please verify payer id and group policy number before resubmitting.	2/23/2023	Oxford	Facility
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.	Psoriasis Procedure Code to Diagnosis 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
Informational Edit	**uPOADEf**	INFORMATIONAL - Per ICD-10 Guidelines, the diagnosis code <1> is exempt from reporting an indicator other than U or 1. Please review ICD-10 Guidelines for more information.	Present on Admission Indicator In accordance with ICD-10 Guidelines, certain diagnosis codes are exempt from Present on Admission (POA) reporting with a yes or no indicator. Instructions on how to report the appropriate POA indicator are included in CMS ICD-10 CM guidelines.	2/27/2025	Commercial	Facility
Return Edit	**uPOS99**	Place of service 99 is not appropriate for this provider for this service. Update code(s) as applicable.	POS 99 UnitedHealthcare will reimburse CPT and HCPCS codes when reported with an appropriate place of service (POS). UnitedHealthcare aligns with The Centers for Medicare & Medicaid Services (CMS) POS Code set, which are two-digit codes submitted on the CMS 1500 Health Insurance Claim Form or its electronic equivalent to indicate the setting in which a service was provided. Please refer to the Procedure and Place of Service Professional Reimbursement Policy on UHCprovider.com.	4/25/2024	Commercial	Professional
Return Edit	**uPOSWI**	Code <1> billed with place of service <2> overlaps an inpatient stay. Review place of service and update as applicable.	Place of Service While Inpatient UnitedHealthcare uses the codes indicated in the CMS Place of Service (POS) Codes for Professional Claims Database to determine if laboratory services are reimbursable. Only one laboratory provider will be reimbursed when multiple individuals report Duplicate Laboratory Services. When the hospital obtains laboratory tests for inpatients under arrangements with clinical laboratories or other hospital laboratories, only the hospital can bill for the arranged services. If the clinical laboratory test is subject to the laboratory fee schedule, carriers pay only the person or entity that performed or supervised the performance of the test. Please review Laboratory Services Policy, Professional https://www.UHCprovider.com/content/dam/provider/docs/public/policies/comm-reimbursement/COMM-Laboratory-Services-Policy.pdf	12/15/2022	All Savers Commercial Level Funded Oxford	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uPRATf**	An inpatient stay has been billed for this member. Pre-admission testing rendered within 3 days should be included in that inpatient stay. Please update as applicable.	Pre-Admission Testing Pre-admission testing is usually contracted to be included as part of the global reimbursement for the inpatient stay or outpatient surgical procedure, when performed within 3 calendar days of the following event. Please refer to CMS Medicare Claims Processing Manual 100-04 Ch. 3 Sec. 40.3 at cms.gov.	8/29/2024	Medicaid	Facility
Informational Edit	**uPRVPROB**	INFORMATIONAL- Problem orientated evaluation management code < 1 > is billed for the same date of service as a Preventive Medicine Service code. It is recommended that both codes be reported on the same claim form.	Problem Oriented PRVC Code Preventive Medicine Services [Current Procedural Terminology (CPT®) codes 99381-99387, 99391-99397, Healthcare Common Procedure Coding System (HCPCS) code G0402] are comprehensive in nature. Occasionally, an abnormality is encountered, or a pre-existing problem is addressed during the preventive visit, and significant elements of related Evaluation and Management (E/M) services are provided during the same visit. When this occurs, 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. For more information, please review the Preventative Medicine and Screening Policy at www.UHCprovider.com.	6/29/2023	Commercial	Professional
Return Edit	**uPTCDM**	Procedure <1> is not reimbursable when appended with modifier 76 or 77. Update code(s) as applicable.	Pro tech Invalid Modifier According to the AMA and CMS, it is inappropriate to use modifier 76 or 77 to indicate repeat laboratory services. Modifiers XE, XP, XS, XU, or 91 should be used to indicate repeat or distinct laboratory services when reported by the Same Group Physician or Other Qualified Health Care Professional. Separate consideration for reimbursement will not be given to laboratory codes reported with modifier 76 or 77. Please review the Professional/Technical Component Reimbursement Policy on UHCprovider.com	10/28/2021	Oxford	Professional
Return Edit	**uPTCHD**	Procedure <1> is not appropriate in a facility setting. Update code(s) as applicable for services rendered.	Pro Tech Deny Hospital Services 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).	7/30/2020	Oxford	Professional
Return Edit	**uPTCIM**	Modifier 26 or TC is not appropriate for procedure code . Update code(s) as applicable for services rendered.	Pro Tech Invalid 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 review the Professional/Technical Component Reimbursement Policy on UHCprovider.com	10/28/2021	Oxford	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uR023f**	Per Medicare guidelines, revenue code <023> requires an appropriate HIPPS assessment code effective 1.1.2020.	Revenue Code 023 Requires HIPPS Code As of 1.1.2020 CMS has released a new code set for Home Health claims, all claims from Home Health Agencies (HHAs) received by Medicare Advantage services must contain a valid Health Insurance Prospective Payment System (HIPPS) code. For a Home Health claim the HIPPS code should be derived from the state-of-care assessment. Please refer to HIPPS Codes on www.cms.gov for additional information.	10/22/2020	Medicare	Facility
Return Edit	**uRCT**	Modifier Q1 indicates a routine clinical trial. The National Clinical Trial ID was not sent in loop 2300, REF02 with a P4 qualifier in REF01. Original Medicare COB data is also missing. Please update as applicable.	Routine Clinical Trial In order to adjudicate Clinical Trial claims, the Medicare EOB and/or clinical trail number is required. Please review NCD 310.1 Routine Costs in Clinical Trials and Medicare Managed Care Manual Chapter 4 section 10.7. for additional information.	11/18/2021	Medicare	Professional
Return Edit	**uRCTf**	Modifier Q1 indicates a routine clinical trial. The National Clinical Trial ID was not sent in loop 2300, REF02 with a P4 qualifier in REF01. Original Medicare COB data is also missing. Please update as applicable.	Routine Clinical Trial In order to adjudicate Clinical Trial claims, the Medicare EOB and/or clinical trail number is required. Please refer to NCD 310.1 Routine Costs in Clinical Trials and Medicare Managed Care Manual Chapter 4 section 10.7. for additional information.	11/18/2021	Medicare	Facility
Informational Edit	**uRDMTF**	INFORMATIONAL - Member was readmitted to same hospital within 30 days of a previous discharge. Please review Inpatient Readmission Review Policy at UHCprovider.com to ensure reimbursement guidelines have been met.	Readmission within 30 Days UnitedHealthcare will align with the Centers for Medicare and Medicaid Services (CMS) criteria by utilizing the CMS guidelines to evaluate Same Day Readmissions, Planned Readmissions and Leave of Absence. Medical records may be requested to ensure the reimbursement guidelines have been followed. The medical record review process is consistent with CMS guidelines. A planned readmission/leave of absence within 30 days of the initial admission must be combined with the initial admission and reported on the same UB-04 claim form with occurrence span code 74, reporting the dates the leave began and ended. Please refer to the UHC Inpatient Readmission Review Policy at UHCprovider.com.	6/29/2023	Commercial	Facility
Informational Edit	**uRDSf**	INFORMATIONAL - Review Respiratory Distress Syndrome P22.0 diagnosis for accuracy. Medical record must reflect Respiratory Distress Syndrome when RDS is coded.	Respiratory Distress Syndrome P22.0 (Respiratory distress syndrome of newborn) is a specific diagnosis, please ensure the medical records support this diagnosis and not only respiratory distress that may be caused by other factors. Please refer to ICD-10 Guidelines	10/26/2023	Commercial	Facility
Informational Edit	**uREFS**	INFORMATIONAL - Procedure code 92015 for determination of refractive state may not be covered by the benefit plan.	Refractive State Procedure code 92015 (Determination of refractive state) is typically not covered by the medical plan. Please review Provider Administrative Guide on UHCprovider.com.	2/23/2023	Commercial	Professional
Informational Edit	**uREVMDf**	INFORMATIONAL - Revenue code <1> should be submitted with a HCPCS code associated with NDC Code <2>.	Rev Code with NDC and no HCPC Per NUBC, UB-04 claims must be billed with both a revenue code and a CPT or HCPCS code. A revenue code must be assigned for each line item. If multiple CPT or HCPCS are necessary to reflect multiple, distinct, or independent visits with the same revenue code, repeat the revenue code as required. Absence of a CPT or HCPCs code for revenue code may affect claim payment or result in a claim denial. Please refer to Provider Administrative Guide on UHCprovider.com.	5/28/2020 1/25/2024	Commercial UHOne	Facility

Edit type	Smart edit	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.	Rev Code Requires HCPCS Per NUBC, UB-04 claims must be billed with both a revenue code and a CPT or HCPCS code. A revenue code must be assigned for each line item. If multiple CPT or HCPCS are necessary to reflect multiple, distinct, or independent visits with the same revenue code, repeat the revenue code as required. Absence of a CPT or HCPCs code for revenue code may affect claim payment or result in a claim denial. Please refer to the UnitedHealthcare Administrative Guide found on UHCprovider.com	9/5/2019	Medicaid	Facility
Return Edit	**uRFVRf**	A patient reason for visit diagnosis code is required. Update code(s) as applicable for services rendered.	Missing Patient Reason Code - Emergency 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	Facility
Documentation Edit	**uRIDR**	Diagnostic Radiology Interpretation Report may be required and can be uploaded to the UHC Provider Portal at secure.UHCprovider.com. For more information, go to UHCprovider.com/smartedits.	Interpretive Radiology UnitedHealthcare considers the interpretation (modifier 26) of a radiology service assigned a PC/TC Indicator 1 to be included in the Evaluation and Management (E/M) service when performed by the Same Individual Physician or Other QHP on the same date of service for the same patient as these services usually are not distinct from the E/M service when both are provided on the same day. American College of Radiology (ACR) guidelines suggest that physicians and other QHP who believe the Professional Component (modifier 26) for a PC/TC Indicator 1 radiology code is reimbursable in addition to the E/M service on the same day must include medical records. Please review the Professional/Technial Component Policy at UHCprovider.com	9/12/2024	Commercial	Professional
Informational Edit	**uRTNEC**	INFORMATIONAL – CPT <1> begins a new 90-day therapeutic radiology treatment planning episode of care. For more information, refer to the 11/1/24 Network News Bulletin regarding the new Radiation Therapy Policy.	Radiation Therapy Episode of Care Effective for dates of service on or after February 1, 2025, UnitedHealthcare will implement the new Radiation Therapy-Dosimetry, Simulation/Devices and Management Policy, Professional and Facility. Specific radiation therapy dosimetry, simulation and management services, identified with select CPT ® codes, will have unit limitations during a 90-day episode of care. Units billed in excess of the limits will not be considered for reimbursement. Please review UHC Commercial Plan Reimbursement Policy Update Bulletin November 2024.	1/2/2025	Commercial Individual & Family Plan Level Funded Oxford	Professional
Informational Edit	**uRTNECf**	INFORMATIONAL – CPT <1> begins a new 90-day therapeutic radiology treatment planning episode of care. For more information, refer to the 11/1/24 Network News Bulletin regarding the new Radiation Therapy Policy.	Radiation Therapy Episode of Care Effective for dates of service on or after February 1, 2025, UnitedHealthcare will implement the new Radiation Therapy-Dosimetry, Simulation/Devices and Management Policy, Professional and Facility. Specific radiation therapy dosimetry, simulation and management services, identified with select CPT ® codes, will have unit limitations during a 90-day episode of care. Units billed in excess of the limits will not be considered for reimbursement. Please review UHC Commercial Plan Reimbursement Policy Update Bulletin November 2024.	1/2/2025	Commercial Individual & Family Plan Level Funded Oxford	Facility
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.	Medicaid Respiratory Viral Panel Testing Please review the Respiratory Viral Panel Testing policy for Community and State located at UHCprovider.com.	9/26/2019	Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**URVTDN**	Respiratory viral panel of 6 or more pathogens may not be appropriate. Please update code(s) as applicable.	Respiratory Viral Panel Consistent with CMS Local Coverage Determinations, UnitedHealthcare does not consider multiplex Polymerase Chain Reaction (PCR) respiratory viral panels of 6 or more pathogens eligible for reimbursement, and CPT codes 0115U, 0202U, 0223U, 0225U, 87632, and 87633 will be denied. Please review Laboratory Services Policy, Professional on UHCprovider.com.	4/27/2023	Commercial	Facility
Return Edit	**uS24DNf**	Procedure code <1> has been submitted without any proven diagnosis codes. Update code(s) as applicable.	Invalid Procedure to Diagnosis for Epidural Steroid Injections Correct diagnosis codes must be billed with correct procedure codes in order to receive reimbursement. Correct diagnosis codes must be billed with correct procedure codes in order to receive reimbursement. The Epidural Steroid and Facet Injections for Spinal Pain 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 Commercial Medical Policy on UHCprovider.com.	12/17/2020	Commercial	Facility
Return Edit	**uS25DNf**	Procedure code <1> has been submitted without any proven diagnosis codes. Update code(s) as applicable.	Invalid Procedure Diagnosis Facet Injection Correct diagnosis codes must be billed with correct procedure codes in order to receive reimbursement. Correct diagnosis codes must be billed with correct procedure codes in order to receive reimbursement. The Epidural Steroid and Facet Injections for Spinal Pain 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 Commercial Medical Policy on UHCprovider.com.	12/17/2020	Commercial	Facility
Rejection Edit	**uSCVAX**	REJECT - COVID-19 vaccine code <1> should be submitted directly to the state of <member state> and not to this health plan. This claim has been rejected and will not be processed.	State-Specific Medicaid COVID-19 Vaccine Requirements COVID-19 vaccine product and administration codes should be billed directly to the state for this plan, and not to United Healthcare. If there are other billable charges on the claim, please remove the vaccine service lines and resubmit. Please review Medicare Billing for COVID-19 Vaccine Shot Administration on www.cms.gov.	1/7/2021	Medicaid	Professional
Rejection Edit	**uSCVAXf**	REJECT - COVID-19 vaccine code <1> should be submitted directly to the state of <member state> and not to this health plan. This claim has been rejected and will not be processed.	Medicaid COVID-19 Vaccine Product Code Bill to State COVID-19 vaccine product and administration codes should be billed directly to the state for this plan, and not to United Healthcare. If there are other billable charges on the claim, please remove the vaccine service lines and resubmit. Please refer to Medicare Billing for COVID-19 Vaccine Shot Administration on www.cms.gov.	1/7/2021	Medicaid	Facility
Rejection Edit	**uSICCL**	REJECT- CLIA ID <1> does not meet the certification level for procedure code <1>. Please update as applicable.	Invalid CLIA Cert Level (Servicing Provider) The lab certification level must 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. Please review our Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy on UHCprovider.com.	4/29/2021 1/25/2024	Commercial Medicaid Oxford UHOne	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**uSJURO**	REJECT - Oxford Health Plans no longer provides administrative services (claims and appeals processing, etc.) for this plan. Please contact the member for additional information.	St. John's University Termed Oxford Health Plans no longer provides administration services (claims and appeals processing, etc.) for this plan. Please contact the member for additional information.	6/27/2024	Commercial Level Funded Oxford	Professional
Rejection Edit	**uSJUROf**	REJECT - Oxford Health Plans no longer provides administrative services (claims and appeals processing, etc.) for this plan. Please contact the member for additional information.	St. John's University Termed Oxford Health Plans no longer provides administration services (claims and appeals processing, etc.) for this plan. Please contact the member for additional information.	6/27/2024	Commercial Level Funded Oxford	Facility
Return Edit	**uSLNS**	Service Facility Location Name was not submitted. Update with applicable information.	Service Facility Location Name Not Submitted The No Surprises Act (NSA) prohibits surprise medical bills in certain claim scenarios and is designed to hold consumers harmless from reimbursement disputes between a health insurer or group health plan and out-of-network providers. For compliance with the CAA Surprise bill program, UnitedHealthcare requires the facility name populated in box 32 for certain eligible emergent and inadvertent services. Please review Ending Surprise Medical Bills on www.cms.gov.	9/29/2022 10/13/2022	Commercial Oxford Level-Funded All Savers	Professional
Return Edit	**uSNFCB**	Procedure <1> was provided during an inpatient SNF stay and may be included in SNF consolidated billing. Please review the code and update as applicable.	Skilled Nursing Facility - Consolidated Billing For any Part A or Part B service that is subject to SNF consolidated billing, the SNF must either furnish the service directly with its own resources or obtain the service from an outside entity (such as a supplier) under an arrangement. Under such an arrangement, the SNF must reimburse the outside entity for those Medicare-covered services that are subject to consolidated billing. SNFs are no longer able to unbundle services to an outside supplier that can then submit a separate bill. Please refer to Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing of the Medicare Claims Processing Manual.	1/25/2024	Medicare	Professional
Return Edit	**uSNFCBf**	Procedure <1> was provided during an inpatient SNF stay and may be included in SNF consolidated billing. Please review the code and update as applicable.	Skilled Nursing Facility - Consolidated Billing For any Part A or Part B service that is subject to SNF consolidated billing, the SNF must either furnish the service directly with its own resources or obtain the service from an outside entity (such as a supplier) under an arrangement. Under such an arrangement, the SNF must reimburse the outside entity for those Medicare-covered services that are subject to consolidated billing. SNFs are no longer able to unbundle services to an outside supplier that can then submit a separate bill. Please refer to Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing of the Medicare Claims Processing Manual.	1/25/2024	Medicare	Facility
Return Edit	**uSNFLOS1f**	Per Medicare guidelines, number of bed units <1> must align with the date span and leave of absence days submitted. Please update as applicable.	SNF Length of Stay w/LOA No Status 30 Skilled Nursing Inpatient (Bill Type 2xx) claims need to have bed charge units that match the number of days spanned on the claim. This calculation includes the claim-level Statement From and Through date range, and the number of days accounted for with either Occurrence Code 74 or Revenue Code 018x (Leave of Absence). Patient status code 30 (still a patient or expected to return) is not present. Please refer to the Medicare Claims Processing Manual, Chapter 3 for Inpatient Hospital Billing when reporting the number of units for inpatient services. Please refer to the Medicare Claims Processing Manual, chapter 3.	10/28/2021	Medicare	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uSNFLOS2f**	Per Medicare guidelines, number of bed units <1> must align with the date span and leave of absence days submitted. Please update as applicable.	SNF Length of Stay w/LOA Status 30 Skilled Nursing Inpatient (Bill Type 2xx) claims need to have bed charge units that match the number of days spanned on the claim. This calculation includes the claim-level Statement From and Through date range, an Admit Date that is before the Statement From date, and the number of days accounted for with Occurrence Code 74 or Revenue Code 018x (Leave of Absence). Patient status code 30 (still a patient or expected to return) is present. Please refer to the Medicare Claims Processing Manual, Chapter 3 for Inpatient Hospital Billing when reporting the number of units for inpatient services. Please refer to the Medicare Claims Processing Manual, chapter 3.	10/28/2021	Medicare	Facility
Return Edit	**uSNFLOS3f**	Per Medicare guidelines, number of bed units <1> must align with the date span submitted. Please update as applicable.	SNF Length of Stay w/o LOA No Status 30 Skilled Nursing Inpatient (Bill Type 2xx) claims need to have bed charge units that match the number of days spanned on the claim. This calculation includes the claim-level Statement From and Through date range, an Admit Date that is before the Statement From date, and the number of days accounted for with Occurrence Code 74 or Revenue Code 018x (Leave of Absence). Patient status code 30 (still a patient or expected to return) is present. Please refer to the Medicare Claims Processing Manual, Chapter 3 for Inpatient Hospital Billing when reporting the number of units for inpatient services. Please refer to the Medicare Claims Processing Manual, chapter 3.	10/28/2021	Medicare	Facility
Return Edit	**uSNFLOS4f**	Per Medicare guidelines, number of bed units <1> must align with the date span submitted. Please update as applicable.	SNF Length of Stay w/o LOA Status 30 Skilled Nursing Inpatient (Bill Type 2xx) claims need to have bed charge units that match the number of days spanned on the claim. This calculation includes the claim-level Statement From and Through date range, an Admit Date that is before the Statement From date, and the number of days accounted for with Occurrence Code 74 or Revenue Code 018x (Leave of Absence). Patient status code 30 (still a patient or expected to return) is present. Please refer to the Medicare Claims Processing Manual, Chapter 3 for Inpatient Hospital Billing when reporting the number of units for inpatient services. Please refer to the Medicare Claims Processing Manual, chapter 3.	10/28/2021	Medicare	Facility
Return Edit	**uSOERR**	CPT code E1390 should only be billed once per month and has been previously submitted for date of service <1>. Please update claim as applicable.	Stationary Oxygen Equipment - Rental Payment for stationary and portable contents is included in the fee schedule allowance for stationary equipment. No payment can be made for oxygen contents in a month in which payment is made for stationary equipment. A maximum of 3 months of oxygen contents may be delivered at any one time. There is no difference in payment for oxygen contents for beneficiaries receiving more than 4 LPM or less than 1 LPM. No more than 1 unit of service (UOS) for stationary contents and/or 1 UOS for portable contents per month are billable. Please review Oxygen and Oxygen Equipment Policy at https://www.cms.gov/medicare-coverage-database	4/28/2022	Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
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	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	Facility
Informational Edit	**uSPSD**	INFORMATIONAL - Unspecified sign or symptom diagnosis code <1> is not an appropriate primary diagnosis code with surgical pathology code <2>. A more specific diagnosis should be submitted.	Surgical Pathology Codes for signs and symptoms may be reported in addition to related definitive diagnosis when the sign or symptom is not routinely associated with that diagnosis, such as the various signs and symptoms associated with complex syndromes. The definitive diagnosis code should be sequenced before the symptom code. FY2020 ICD-10-CM Guidelines (cdc.gov) Role of the Surgical Pathologist in the Diagnosis and Management of the Cancer Patient - Holland-Frei Cancer Medicine - NCBI Bookshelf (nih.gov)	2/24/2022 12/19/2024	Commercial Oxford Medicare Medicaid Individual and Family Plan Level Funded UHOne	Professional
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.	Procedure code 92507 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 ICD-10-CM Coding FAQs for Audiologists and SLPs on www.asha.org.	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.	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 ICD-10-CM Coding FAQs for Audiologists and SLPs on www.asha.org.	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.	Speech-Language and Swallowing Disorders DX Code 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 ICD-10-CM Coding FAQs for Audiologists and SLPs on www.asha.org.	8/15/2019	Medicaid	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
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.	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	Facility
Return Edit	**uSUPDN**	Procedure <1> is not appropriate for casting and splint supplies. A temporary Q procedure code may be more appropriate for casting and splint supplies.	Supply Service is Not Reimburseable 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 non facility Places of service. Please review the Supply Policy, Professional on UHCprovider.com.	3/31/2022	Oxford	Professional
Return Edit	**uTAC1f**	In alignment with CMS, trauma centers billing for trauma activation should include revenue code <1> with HCPCS G0390 on same claim line, and CPT 99291 on the same date of service, when documentation supports.	Trauma Activation Code Consistent with the Center for Medicare and Medicaid Services (CMS), trauma center billing for trauma activation should include revenue code 068X with HCPCS code G0390 on the same claim line, and CPT code 99291 on the same date of service when appropriate. Trauma Activation will be considered for reimbursement only when the criteria for revenue code 068x, HCPCS code G0390, and critical care code 99291 are met and are reported on the same date of service. When revenue code 068X is not submitted with HCPCS code G0390 and CPT code 99291 is not submitted on the same date of service, it is considered part of a packaged service. Please refer to Outpatient Medical Visits and Trauma Activation Policy, Facility at UHCprovider.com Please refer to Outpatient Medical Visits Policy at UHCprovider.com	5/25/2023 7/18/2024	Commercial Level Funded Oxford UHOne	Facility
Return Edit	**uTCMTS**	CPT code <1> is considered inclusive to a procedure submitted on date of service <1>. Please review and update as applicable.	Transitional Care Management Time Span When related Time Span Codes which share a common portion of a code description are both reported during the same time span period by the Same Group Physician and/or Other Health Care Professional for the same patient, the code with the most comprehensive description is the reimbursable service. The other code is considered inclusive and is not a separately reimbursable service. Please review UnitedHealthcare Medicare Advantage Time Span Codes Policy, Professional, on UHCprovider.com	4/28/2022	Medicare	Professional
Rejection Edit	**uTELE**	REJECT - Telehealth charges should be reported with place of service 02 or 10. Telehealth modifiers are considered informational only. This claim has been rejected and will not be processed.	Telehealth Place of Service Beginning 01/01/21, providers should report place of service 02 or 10 for telehealth services. The telehealth modifiers (95, GT, GQ or G0 [zero]) will no longer be required. Please refer to the Telehealth and Telemedicine Policy on UHCprovider.com.	4/15/2021	Level Funded Oxford	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uTELEM**	Procedure code <1> may not be appropriate based on current CMS billing guidelines for E/M codes. If documentation does not support the E/M level submitted, please resubmit with the appropriate E/M level.	Telehealth E/M A patient visit performed through telehealth should be documented to the same level as an in-person visit, reflecting exactly what was done during the visit. The provider should also document that the visit was done through audio-video telecommunications. As stated in the UnitedHealthcare Care Provider Administrative Guide for Commercial and Medicare Advantage, we have the right to assess health care provider records to determine the accuracy of CPT coding. For requirements related to Medical Records, please review the Provider Admin Guide Chapter 12: Medical records standards and requirements. You can find more information regarding UnitedHealthcare's Telehealth policy by visiting UHCprovider.com>resources>Telehealth>reimbursement policy. Please review UnitedHealthcare's Evaluation and Management policy, please visit UHCprovider.com>Resources>Health plans, polices, protocols and guides>commercial>reimbursement policies for commercial plans>Evaluation and Management E/M	5/4/2023 5/30/2024	Commercial Level Funded Oxford UHOne	Professional
Informational Edit	**uTELSOS**	INFORMATIONAL – Telehealth distant site provider claim was submitted with POS 10 for this date of service. Code Q3014 originating site service is inappropriate when member distant site was submitted with POS 10.	Telehealth Site of Service The Originating Site is where the member is housed with a Telepresenter during a Telehealth encounter. UnitedHealthcare recognizes the CMS-designated Originating Sites considered eligible for furnishing Telehealth services to a patient located in an Originating Site. The Originating Site may submit a claim for the services of the Telepresenter with code Q3014. Note: Telehealth POS codes 02 and 10 do not apply to Originating Site facilities reporting code Q3014 and POS codes 02 and 10 should not be reported by an Originating Site facility if code Q3014 is reported. For POS where code Q3014 is reported, report the valid POS code reflecting the location of the patient. Please refer to Telehealth/Virtual Health Policy on UHCprovider.com	4/25/2024	Commercial Individual & Family Plan Level Funded Medicaid Oxford	Professional
Return Edit	**uTELTOBf**	Facility claim (UB-04) submission of originating site services reported with code Q3014 is accepted on facility bill types 12X, 13X, 22X, 23X, 71X, 72X, 73X, 76X, 77X or 85X. Update claim as applicable.	Facility Telehealth For facility claim (UB-04) submission of originating site services reported with HCPCS code Q3014, it is accepted on facility bill types 12X, 13X, 22X, 23X, 71X, 72X, 73X, 76X, 77X or 85X. Please refer to the Telehealth Policy on UHCprovider.com.	2/29/2024	Commercial	Facility
Informational Edit	**uTENSAP**	INFORMATIONAL - CPT code <1> has exceeded the lifetime benefit of two months for TENS rental.	TENS Maximum Frequency Transcutaneous Electrical Nerve Stimulation (TENS) is covered for acute post-operative pain. TENS may be covered whether used as an alternative to drugs, or as an adjunct to the use of drugs, in the treatment of acute pain resulting from surgery. TENS devices, whether disposable or durable, may be used in furnishing this service. When used for the purpose of treating acute post-operative pain, TENS devices are considered supplies. Coverage is limited to 30 days (one month's rental) from the day of surgery. It is expected that TENS, when used for acute post-operative pain, will be necessary for relatively short periods of time, usually 30 days or less. In cases when TENS is used for longer periods, ascertain whether TENS is no longer being used for acute pain but rather for chronic pain, in which case the TENS device may be covered as durable medical equipment. Please review Transcutaneous Electrical Nerve Stimulation (TENS)https://www.UHCprovider.com/content/dam/provider/docs/public/policies/medadv-guidelines/t/transcutaneous-electrical-nerve-stimulation-tens.pdf	12/15/2022	Medicare	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**uTIFDf**	REJECT – Statement Through Date <1> is after claim submission date. The statement date should not include any future dates. This claim has been rejected and will not be processed.	Texas Inpatient Future Statement Through Date Per United Healthcare, for inpatient stay claims, the claim-level Statement From and Through Date range should not include a future date. This date span should cover dates of service in which services have been rendered. Please refer to Provider Administrative Guide on UHCprovider.com.	5/30/2024	Medicaid	Facility
Return Edit	**uTHIEMT**	Evaluation/Management service <1> is typically included in the therapeutic or diagnostic admin procedure 96372 with J1071. Update code(s) if services do not support the use of modifier 25.	Evaluation & Management with Low Testosterone Injection E/M services provided in a non-facility setting are considered an inherent component for providing an Injection service. 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. If the E/M service does not meet the requirement for a significant separately identifiable service, then Modifier 25 should not be reported. Please review Evaluation and Management (E/M) Professional policy and Injection and Infusion Services Professional policy found on UHCprovider.com for further information.	3/27/2020 12/19/2024	Commercial UHOne	Professional
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.	Bill Type 14x Invalid 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	Facility
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.	Bill Type 14x Invalid 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	7/11/2019 8/8/2019	Commercial Medicaid	Facility
Rejection Edit	**uTRMTIN**	REJECT - Per CMS, this billing provider is a termed provider. This claim has been rejected and will not be processed.	CMS Termination of TIN This provider has received a Terminations and CLIA Revocation, Suspensions and Limitations notice per CMS. Please refer to cms.gov for additional information.	3/27/2025	Dual Enrollment Medicaid	Professional
Rejection Edit	**uTTIBF**	REJECT- The Facility Taxonomy Code <1> is invalid for type of bill <2>. This claim has been rejected and will not be processed.	TX Taxonomy Invalid Bill Type Bill Type 11X is used for inpatient hospitals and per CMS, facilities must be accredited as a hospital to utilize this type of bill. For additional information on type of bill descriptions, please refer to tmhp.com > Medicaid Provider Manual > Texas Medicaid Provider Procedures Manual (Section 6.6.3 UB-04 CMS 1450 Instruction Table). For additional information on type of bill descriptions, please refer to tmhp.com > Medicaid Provider Manual > Texas Medicaid Provider Procedures Manual (Section 6.6.3 UB-04 CMS 1450 Instruction Table).	5/30/2024	Medicaid	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uTXAS**	The submitted diagnosis code(s) is not appropriate for procedure code < 1 > . Update code(s) as applicable for service(s) rendered.	TX Autism TX STAR KIDS applies to children and young adults under the age of 21 with disabilities. TX STAR PLUS applies to adults who have disabilities or are age 64 or older. TX STAR applies to low income children, pregnant women and families. TX STAR, TX STAR PLUS, and STAR KIDS require behavior treatment procedure codes 97151,97153,97154,97155,97156,97158, and 99366 to be billed with a ICD-10 code of F84.O. For additional information please see the Provider Manual for Texas Children's Health Insurance Program (CHIP), State of Texas Access Reform (STAR), STAR+PLUS, STAR Kids on UHC Provider.com.	10/27/2022	Medicaid	Professional
Rejection Edit	**uTXT**	REJECT- A billing provider taxonomy code, valid with Texas provider registration, is required to be submitted on the claim. REJECT - 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.	Missing Texas Taxonomy Codes The Texas Health and Human Services Commission requires all health care professionals who serve UnitedHealthcare Community Plan members in Texas to include provider taxonomy codes for billing and rendering providers. In addition, when appropriate, supervising, ordering and prescribing provider taxonomy codes must be included for claims to be considered. Please review the Taxonomy Code Requirements Reimbursement Policy on UHCprovider.com for further information.	4/29/2021	Medicaid	Professional
Rejection Edit	**uTXTf**	REJECT- A billing provider taxonomy code, valid with Texas provider registration, is required to be submitted on the claim. REJECT - A attending provider taxonomy code, valid with Texas provider registration, is required to be submitted on the claim when other rendering provider information is included.	Missing Texas Taxonomy Codes Facility The Texas Health and Human Services Commission requires all health care professionals who serve UnitedHealthcare Community Plan members in Texas to include provider taxonomy codes for billing and rendering providers. In addition, when appropriate, supervising, ordering and prescribing provider taxonomy codes must be included for claims to be considered. Please review the Taxonomy Code Requirements Reimbursement Policy on UHCprovider.com for further information.	5/27/2021 Changed to Rejection Edit on 3/27/2025	Medicaid	Facility
Rejection Edit	**uTZCODE**	REJECT – Molecular diagnostic test <1> requires a valid DEX Z-Code in the 2400 loop, SV101-7. <procedure description 2> is not a valid Z-Code. This claim has been rejected and will not be processed.	Molecular DX - Invalid Z Code United Healthcare Medicare Advantage will require providers to submit the appropriate DEX Z-code for molecular diagnostic test services. This policy will apply to both facility and professional claims. The Medicare-assigned Z-code should be submitted in the 2400 loop (line level), SV101-7. This message is returned when that loop and segment data does not contain a 5 alpha-numeric value that starts with a "Z." Please review the Molecular Pathology Policy, Professional and Facility on UHCprovider.com.	3/4/2021 2/27/2025 Changed to Rejection Edit on: 9/30/2021	Medicare Dual Enrollment	Professional
Rejection Edit	**uTZCODEf**	REJECT – Molecular diagnostic test <1> requires a valid DEX Z-Code in the 2400 loop, SV202-7. <procedure description 2> is not a valid Z-Code. This claim has been rejected and will not be processed.	Molecular DX - Invalid Z Code United Healthcare Medicare Advantage will require providers to submit the appropriate DEX Z-code for molecular diagnostic test services. This policy will apply to both facility and professional claims. The Medicare-assigned Z-code should be submitted in the 2400 loop (line level), SV202-7. This message is returned when that loop and segment data does not contain a 5 alpha-numeric value that starts with a "Z." Please refer to the Molecular Pathology Policy, Professional and Facility on UHCprovider.com.	3/4/2021 2/27/2025 Changed to Rejection Edit on: 9/30/2021	Medicare Dual Enrollment	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**uU0005**	REJECT – Add-on HCPCS code U0005 reported without a high-throughput COVID-19 test code on the same claim. Please repair and resubmit. This claim is rejected and will not be processed.	U0005 Add On Without Test Code U0005 is an add-on code that must be submitted with another high-throughput COVID test code, which at this time is U0003 and/or U0004. UnitedHealthcare is requiring that all of the charges be submitted on the same claim. Please refer to Medicare Billing for COVID-19 Vaccine Shot Administration on www.cms.gov.	2/4/2021 11/30/2023	Commercial Oxford Medicaid UHOne	Professional
Rejection Edit	**uU0005f**	REJECT – Add-on HCPCS code U0005 reported without a high-throughput COVID-19 test code on the same claim. Please repair and resubmit. This claim is rejected and will not be processed.	U0005 Add On Without Test Code U0005 is an add-on code that must be submitted with another high-throughput COVID test code, which at this time is U0003 and/or U0004. UnitedHealthcare is requiring that all the charges be submitted on the same claim. Please refer to Medicare Billing for COVID-19 Vaccine Shot Administration on www.cms.gov.	2/4/2021 11/30/2023	Commercial Oxford Medicaid UHOne	Facility
Rejection Edit	**uU0005Sf**	REJECT – Add-on HCPCS code U0005 reported without a high-throughput COVID-19 test code on the same claim. Please repair and resubmit. This claim is rejected and will not be processed.	U0005 Add On Without Test Code U0005 is an add-on code that must be submitted with another high-throughput COVID test code, which at this time is U0003 and/or U0004. UnitedHealthcare is requiring that all of the charges be submitted on the same claim. Please refer to Medicare Billing for COVID-19 Vaccine Shot Administration on www.cms.gov.	7/22/2021	Medicaid	Facility
Rejection Edit	**uUCD**	REJECT - Procedure code <1> is unlisted and the required detailed description is missing. This claim has been rejected and will not be processed.	Unlisted Code Description Unlisted procedure codes require a detailed description in loop 2400, SV101 - 7 in addition to the applicable HCPCS/CPT code. Refer to the 837 Implementation Guide and the UHC Provider Administrative Guide for additional information. Please refer to the Administrative Guide on www.UHCprovider.com.	11/30/2023 3/28/2024 Changed to rejection edit	Commercial	Professional
Rejection Edit	**uUCVAX**	REJECT - Vaccine code <1> has not been federally approved as of this date of service. This claim has been rejected and will not be processed.	Unapproved COVID Vaccine COVID-19 vaccines that have not been approved for use in the United States by the FDA or have not been approved for reimbursement by CMS are not eligible for reimbursement. If there are other billable charges on the claim, the unapproved vaccine charges should be removed, and the claim resubmitted for processing.	3/11/2021 7/2/2021 8/26/2021	Medicare Medicaid Commercial Individual and Family Plan Oxford Dual Enrollment All Savers	Professional
Rejection Edit	**uUCVAXf**	REJECT - Vaccine code <1> has not been federally approved as of this date of service. This claim has been rejected and will not be processed.	Unapproved COVID-19 Vaccine COVID-19 vaccines that have not been approved for use in the United States by the FDA or have not been approved for reimbursement by CMS are not eligible for reimbursement. If there are other billable charges on the claim, the unapproved vaccine charges should be removed, and the claim resubmitted for processing.	3/11/2021 7/2/2021 8/26/2021 12/16/2021	Medicare Medicaid Commercial Individual and Family Plan Oxford Dual Enrollment All Savers Level Funded	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
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.	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 review the Rebundling Policy, Professional on UHCprovider.com.	7/25/2019	Medicaid	Professional
Return Edit	**uUIGEN**	Patient gender <1> may be inappropriate for procedure code <2> without the use of an appropriate modifier. Please review and update as applicable.	Presence or Absence of Urinary Incontinence Gender Certain procedures are defined with patient gender (sex) requirements. In specific cases, the KX modifier, which is defined as "Requirements specified in the medical policy have been met", can be used to identify services that are gender specific (i.e., services that are considered female or male only) for effected beneficiaries. Use of the KX modifier will alert the carrier that the physician/practitioner is performing a service on a patient for whom gender specific editing may apply, and that the service should be allowed to continue with normal processing. Please review the Physician Quality Reporting Initiative CMS policy at https://www.cms.gov/files/document/2010pqrimadesimplefs032310fpdf.	9/28/2023	Medicare	Professional
Return Edit	**uUMSIR**	Medical Student Taxonomy 390200000X is not reimbursable unless performed under specific guidelines and appended with modifier GC or GE, as appropriate. Please update as applicable.	Unlicensed Medical Student, Intern or Resident Services provided by a medical student, intern, or resident, are identified through the Health Care Provider Taxonomy Code 390200000X reported on the claim in Box 24J (servicing provider). Services performed by medical students and interns who do not fall within the scope of the CMS definition of "resident" are not reimbursable; in order to be reimbursed, a teaching physician must re-perform the services and can then bill for those services under their own NPI. If modifiers GC or GE are appended to the services provided by a resident, they will not be denied. These modifiers indicate services were rendered in part by a resident under the direction of a teaching physician, or they were performed by a resident without the presence of a teaching physician under the primary care exception, respectively. Claims for services rendered by an unlicensed resident that do not include modifier GC or GE are not reimbursable. For more information, please review the Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services on www.cms.gov.	12/2/2021 2/29/2024 7/25/2024	Medicaid Medicare Commercial Oxford Level-Funded Individual & Family Plan UHOne	Professional

Edit type	Smart edit	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.	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	Commercial Medicaid Medicare	Professional
Rejection Edit	**uUNSUB**	REJECT - This claim from this billing provider has been rejected and will not be processed for FWAE purposes.	Unapproved Submitter This claim from this billing provider has been rejected and will not be processed. For chat options and contact information, visit UHCprovider.com/contactus.	10/3/2024	Commercial Level Funded Oxford	Professional
Rejection Edit	**uUNSUBf**	REJECT - This claim from this billing provider has been rejected and will not be processed for FWAE purposes.	Unapproved Submitter This claim from this billing provider has been rejected and will not be processed. For chat options and contact information, visit UHCprovider.com/contactus.	10/3/2024	Commercial Level Funded Oxford	Facility
Rejection Edit	**uUPDf**	REJECT - Per CMS ICD-10-CM Guideline, Section II, diagnosis code <1> is not eligible as a primary diagnosis. Refer to MCE for diagnosis codes that are considered acceptable as a principal diagnosis code.	Unacceptable Principal Diagnosis Inpatient Facility Per the MCE (Medicare Code Editor) there are selected diagnosis codes that are considered unacceptable as principal diagnosis codes. In accordance with CMS guidelines, UnitedHealthcare Medicare Advantage will apply diagnosis coding guidelines that identify codes that should never be billed as a principal diagnosis but should always be coded as a secondary or subsequent diagnosis code to ensure appropriate assignment of Inpatient DRG (Diagnostic Related Group) Payment. Please refer to Section II of the 2021 CMS coding guidelines.	2/25/2021	Medicare	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
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.	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 review the Rebundling Policy on UHCprovider.com for further information.	5/30/2019	Medicaid	Professional
Informational Edit	**uUSP**	INFORMATIONAL - Diagnosis code <1> billed does not meet coverage criteria per the Medicare Advantage Urological Supplies Policy Guideline.	Urological Supplies Policy According to the Medicare Advantage Urological Supplies Policy Guidelines, urinary catheters and external urinary collection devices are covered to drain or collect urine for a beneficiary who has permanent urinary incontinence or permanent urinary retention. The use of a urological supply for the treatment of chronic urinary tract infection or other bladder condition in the absence of permanent urinary incontinence or retention is non-covered.	9/24/2020	Medicare	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.	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 ICD-10-CM Coding FAQs for Audiologists and SLPs on www.asha.org.	6/6/2019	Medicaid	Professional
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.	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	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uVAPf**	CPT Code <1> is not supported by the diagnosis code(s) listed. Please review and update as applicable.	Vertebral Augmentation Procedures Percutaneous vertebral augmentation (PVA) is a minimally invasive procedure for the treatment of compression fractures of the vertebral body. PVA is covered for Osteoporotic Vertebral Compression Fracture (VCF) in patients when specific criteria has been met. The diagnosis code(s) must best describe the patient's condition for which the service was performed. Please review the Vertebral Augmentation Procedure (VAP)/Percutaneous Vertebroplasty policy on UHCprovider.com.	1/26/2023	Medicare	Facility
Return Edit	**uVAXDRP**	The Rendering Provider is not listed. Please update and resubmit, as applicable.	Rendering Provider for Part D The member's plan is responsible for verifying and reporting a valid prescriber ID. The claim requires a individual provider be submitted, not a group. Therefore, if an active and valid prescriber ID for the individual rendering provider is not included on the Part D claim, either the drug plan sponsor, or the pharmacy if in accordance with the contractual terms of the network pharmacy agreement, must follow up retrospectively to acquire a valid ID. For additional information, please see the Prescription Drug Benefit Manual on www.cms.gov.	5/25/2023	Dual Enrollment	Professional
Return Edit	**uVAXPD**	Administration code <1> does not support vaccination code <2>. Please update the claim as applicable.	Part D Vaccine Administration Immunizations are generally excluded from coverage under Medicare unless they are directly related to the treatment of an injury or direct exposure to a disease or condition, such as anti-rabies treatment or tetanus antitoxin or booster vaccine. There are specific instances when the vaccination and its administration are eligible for payment. Please review the Vaccination (Immunization) policy on www.UHCprovider.com.	11/17/2022	Medicare	Professional
Return Edit	**uVAXPDf**	Administration code <1> does not support vaccination code <2>. Please update the claim as applicable.	Part D Vaccine Administration Immunizations are generally excluded from coverage under Medicare unless they are directly related to the treatment of an injury or direct exposure to a disease or condition, such as anti-rabies treatment or tetanus antitoxin or booster vaccine. There are specific instances when the vaccination and its administration are eligible for payment. Please refer to the Vaccination (Immunization) policy on www.UHCprovider.com.	11/17/2022	Medicare	Facility
Return Edit	**uVECf**	Procedure Code <1> has a maximum frequency of one unit per episode of care. Please review and update the claim as applicable.	Venipuncture per Episode of Care Per CMS, multiple venipunctures during the same episode of care, to draw blood specimen(s), may only be billed as a single procedure with units of service equal to 1 (one), regardless of the number of attempts or veins entered. An episode of care begins when a patient arrives at a facility for treatment and terminates when the patient leaves the facility. The venipuncture may be billed by the hospital as an outpatient charge. Physicians may not generally bill for routine venipuncture in a hospital site of service. Please refer to Laboratory Services Policy, Professional https://www.UHCprovider.com/content/dam/provider/docs/public/policies/medadv-reimbursement/MEDADV-Laboratory-Services-Policy.pdf	12/15/2022	Medicare	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**uVENIP**	Procedure code 36410 requires a supporting diagnosis on the same claim line. Please update as applicable.	Venipuncture for Specimen Collection Submit CPT code 36410 only for venipunctures necessitating physician skill when performed by a physician on veins of the neck, (e.g., external or internal jugular), or from deep (central) veins of the thorax (e.g., subclavian) or groin (e.g., femoral); and for venipuncture of superficial extremity veins when the skill of a qualified individual properly trained in venipuncture techniques (e.g., nurse, phlebotomist, medical technician) has been clearly demonstrated, according to the terms of this policy, to be insufficient ICD-10-CM I87.8, I99.8 or R68.89 must be submitted on all claims for CPT 36410. For more information, please see: https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52470&Contr	10/26/2023	Medicaid Medicare	Professional
Return Edit	**uVENIPf**	Procedure code 36410 requires a supporting diagnosis on the same claim line. Please update as applicable.	Venipuncture for Specimen Collection Submit CPT code 36410 only for venipunctures necessitating physician skill when performed by a physician on veins of the neck, (e.g., external or internal jugular), or from deep (central) veins of the thorax (e.g., subclavian) or groin (e.g., femoral); and for venipuncture of superficial extremity veins when the skill of a qualified individual properly trained in venipuncture techniques (e.g., nurse, phlebotomist, medical technician) has been clearly demonstrated, according to the terms of this policy, to be insufficient ICD-10-CM I87.8, I99.8 or R68.89 must be submitted on all claims for CPT 36410. For more information, please see: https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52470&Contr	10/26/2023	Medicaid Medicare	Facility
Return Edit	**uVENT**	Modifier is missing or invalid for procedure code <1>. Please update as applicable.	Ventilator Services Billed without the Correct Modifier Frequently Serviced Items Billed without the Correct Modifier: CMS Coding Guidelines indicate that a frequently serviced item can't be billed and/or reimbursed as a purchased item. An appropriate rental modifier needs to be billed. For more information please review the Durable Medical Equipment, Orthotics and Prosthetics Policy, Professional on UHCprovider.com	11/18/2021	Medicare	Professional
Rejection Edit	**uWCIWD**	REJECT - Employment Accident Indicator submitted without diagnosis code related to work injury. Please review employment accident indicator for accuracy and update claim as applicable or provide Workers' Comp EOB.	Workers Comp Indicator without Diagnosis An accident where benefits may be payable under another plan such as Workers' Compensation was indicated on the claim by the accident indicator field. The diagnosis codes submitted do not appear to be related to a work injury. The employment accident indicator may have been selected in error. The denial EOB from Workman's Comp may be submitted if the EM accident indicator is correct. For more information, please review the claim submission requirements section of the administrative guide on UHCprovider.com.	8/25/2022 9/29/2022	Commercial Oxford Level Funded	Professional
Rejection Edit	**uWCVAXP**	REJECT – COVID-19 vaccine admin code <1> submitted without an appropriate vaccine product code. Please update claim as applicable. This claim has been rejected and will not be processed.	Other States Medicaid COVID-19 Vaccine Requirements COVID-19 vaccine product and administration codes should be billed together for Michigan, Louisiana, Ohio, and Massachusetts. Claims billing with only the admin fee should be rejected and the vaccine code should be added to the claim at resubmission.	1/7/2021	Medicaid	Professional
Rejection Edit	**uWCVAXPf**	REJECT – COVID-19 vaccine admin code <1> submitted without an appropriate vaccine product code. Please update claim as applicable. This claim has been rejected and will not be processed.	Washington State COVID-19 Vaccine Product Code COVID-19 vaccine product and administration codes should be billed together for Michigan, Louisiana, Ohio, and Massachusetts. Claims billing with only the admin fee should be rejected and the vaccine code should be added to the claim at resubmission.	1/7/2021	Medicaid	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Informational Edit	**uWIMIRf**	INFORMATIONAL- Effective April 1 2024, Forward Health Wisconsin plan requires personal care agencies to bill the provider Medicaid ID on all claims.	Wisconsin Medicaid ID Required Effective April 1, 2024, personal care service claims to UnitedHealthcare must include the Medicaid ID if exempt from National Provider Identifier (NPI) number requirements. Please refer to Community Plan Wisconsin bulletins and newsletters at UHCprovider.com.	11/21/2024	Medicaid	Facility
Return Edit	**uWNBf**	Newborn charges for well babies are considered under the mother's claim and should not be submitted separately under the newborn.	Well Newborn Charges Included in Mother's Claim Diagnosis Codes Z38.00: (single live born infant delivered vaginally) and Z38.01 (single live born infant delivered by cesarean) should be included in the mother's inpatient hospital charges.	10/22/2020	Commercial	Facility
Rejection Edit	**uZCDCPT**	REJECT - Z Code <1> is not valid for CPT code <2>. This claim has been rejected and will not be processed.	Invalid Z Code for CPT United Healthcare Medicare Advantage will require providers to submit the appropriate DEX Z-code for molecular diagnostic test services. This policy will apply to both facility and professional claims. The Medicare-assigned Z-code should be submitted in the 2400 loop (line level), SV101-7. This message is returned when that loop and segment have data submitted, but the listed Z-code is invalid for the corresponding procedure code. Please review the Molecular Pathology Policy, Professional and Facility on UHCprovider.com	1/20/2022 2/27/2025	Medicare Dual Enrollment	Professional
Rejection Edit	**uZCDCPTf**	REJECT - Z Code <1> is not valid for CPT code <2>. This claim has been rejected and will not be processed.	Invalid Z-Code for CPT United Healthcare Medicare Advantage will require providers to submit the appropriate DEX Z-code for molecular diagnostic test services. This policy will apply to both facility and professional claims. The Medicare-assigned Z-code should be submitted in the 2400 loop (line level), SV101-7. This message is returned when that loop and segment have data submitted, but the listed Z-code is invalid for the corresponding procedure code. Please refer to the Molecular Pathology Policy, Professional and Facility on UHCprovider.com	1/20/2022 2/27/2025	Medicare Dual Enrollment	Facility
Rejection Edit	**uZCDMPL**	REJECT - Molecular Diagnostic code <1> requires a single Z-Code be submitted. This claim has been rejected and will not be processed.	Multiple Z-Codes Submitted on Claim Line United Healthcare Medicare Advantage will require providers to submit the appropriate DEX Z-code for molecular diagnostic test services. This policy will apply to both facility and professional claims. The Medicare-assigned Z-code should be submitted in the 2400 loop (line level), SV202-7. This message is returned when that loop and segment have multiple DEX Z-codes submitted on a claim line. Please review the Molecular Pathology Policy, Professional and Facility on UHCprovider.com	1/20/2022 2/27/2025	Medicare Dual Enrollment	Professional
Rejection Edit	**uZCDMPLf**	REJECT - Molecular Diagnostic code <1> requires a single Z-Code be submitted. This claim has been rejected and will not be processed.	Multiple Z-Codes Submitted on Claim Line United Healthcare Medicare Advantage will require providers to submit the appropriate DEX Z-code for molecular diagnostic test services. This policy will apply to both facility and professional claims. The Medicare-assigned Z-code should be submitted in the 2400 loop (line level), SV202-7. This message is returned when that loop and segment have multiple DEX Z-codes submitted on a claim line. Please refer to the Molecular Pathology Policy, Professional and Facility on UHCprovider.com	1/20/2022 2/27/2025	Medicare Dual Enrollment	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Rejection Edit	**uZCDNV**	REJECT - Z-Code <1> not found on DEX Master Edit File. Molecular Diagnostic CPT code <2> requires a valid Z-Code to be submitted. This claim has been rejected and will not be processed.	Z-Code is Not Valid United Healthcare Medicare Advantage will require providers to submit the appropriate DEX Z-code for molecular diagnostic test services. This policy will apply to both facility and professional claims. The Medicare-assigned Z-code should be submitted in the 2400 loop (line level), SV101-7. This message is returned when that loop and segment have data submitted, but the listed Z-code is invalid. Please review the Molecular Pathology Policy, Professional and Facility on UHCprovider.com	1/20/2022 2/27/2025	Medicare Dual Enrollment	Professional
Rejection Edit	**uZCDNVf**	REJECT - Z-Code <1> not found on DEX Master Edit File. Molecular Diagnostic CPT code <2> requires a valid Z-Code to be submitted. This claim has been rejected and will not be processed.	Z-Code is Not Valid United Healthcare Medicare Advantage will require providers to submit the appropriate DEX Z-code for molecular diagnostic test services. This policy will apply to both facility and professional claims. The Medicare-assigned Z-code should be submitted in the 2400 loop (line level), SV101-7. This message is returned when that loop and segment have data submitted, but the listed Z-code is invalid. Please refer to the Molecular Pathology Policy, Professional and Facility on UHCprovider.com	1/20/2022 2/27/2025	Medicare Dual Enrollment	Facility
Rejection Edit	**uZCDPSC**	REJECT - DEX procedure code <1> has been submitted more than once on this claim. This claim has been rejected and will not be processed.	Z-Code Procedure More than Once Same DOS Same Claim United Healthcare Medicare Advantage will require providers to submit the appropriate DEX Z-code for molecular diagnostic test services. This policy will apply to both facility and professional claims. The Medicare-assigned Z-code should be submitted in the 2400 loop (line level), SV101-7. This message is returned when that loop and segment have the same DEX Z-code submitted for multiple claim lines on the same date of service. Please review the Molecular Pathology Policy, Professional and Facility on UHCprovider.com	1/20/2022 2/27/2025	Medicare Dual Enrollment	Professional
Rejection Edit	**uZCDPSCf**	REJECT - DEX procedure code <1> has been submitted more than once on this claim. This claim has been rejected and will not be processed.	Z-Code Procedure More than Once Same DOS Same Claim United Healthcare Medicare Advantage will require providers to submit the appropriate DEX Z-code for molecular diagnostic test services. This policy will apply to both facility and professional claims. The Medicare-assigned Z-code should be submitted in the 2400 loop (line level), SV101-7. This message is returned when that loop and segment have the same DEX Z-code submitted for multiple claim lines on the same date of service. Please refer to the Molecular Pathology Policy, Professional and Facility on UHCprovider.com	1/20/2022 2/27/2025	Medicare Dual Enrollment	Facility

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
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>.	Vaccine Age Gender Restriction 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 review Vaccines Commercial Medical & Drug Policies on UHCprovider.com for further information.	3/7/2019	Commercial	Professional
Return Edit	**VAGDN**	Procedure <1> is not proven for the age of this patient. Update code as applicable.	Procedure Not Proven for Age 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 refer to the Preventive Care Services Coverage Determination Guideline at UHCprovider.com for further information.	8/29/2024	Commercial	Facility
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>.	Vaccine Age Gender Restriction 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 review Vaccines Commercial Medical & Drug Policies on UHCprovider.com for further information.	3/7/2019	Commercial	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
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.	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 review the Vitamin D Testing Reimbursement Policy at UHCprovider.com	7/18/2019	Medicaid	Professional
Return Edit	**VFCALL**	Procedure code <1> with maximum administration units of <2> has been exceeded by <3>. Update code as applicable.	Deny All Admin Units on Line The vaccine code(s) and administration code(s) may be submitted on separate claims, but the claims must be for the same date of service by the same provider and the number of units for each must match. Excessive units of either code(s) will be denied. Please review Vaccines for Children Policy, Professional https://www.UHCprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan-reimbursement/UHCCP-Vaccines-for-Children-Policy-R7109.pdf	12/15/2022	Medicaid	Professional
Return Edit	**VFCCD**	Procedure code [<1>] is not appropriate when billing vaccines for children. Update code as applicable.	Admin with VFC Serum Denial As part of the Patient Protection and Affordable Care Act (PPACA) regulations the Centers for Medicare & Medicaid Services (CMS) require Medicaid programs to reimburse for VFC services on administration codes 90460, 90471, 90472, 90473, and/or 90474 rather than the serum/toxoid code. Per the PPACA legislation, CPT code 90461 is NOT reimbursable for VFC services. Some States have determined to pay all of these administration codes (except 90461), some only 90460. Any variations from this are listed under the State Exceptions portion of the Vaccines for Children policy. Please review Vaccines for Children Policy, Professional https://www.UHCprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan-reimbursement/UHCCP-Vaccines-for-Children-Policy-R7109.pdf	12/15/2022	Medicaid	Professional
Return Edit	**VFCIM**	Modifier <1> is not appropriate for members aged 19 or over. Update modifier as applicable for services rendered.	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 review the Vaccines for Children Policy, Professional Reimbursement Policy on UHCprovider.com for further information.	2/21/2019	Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
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.	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. 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 review the Vaccines for Children Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com.	10/4/2018	Medicaid	Professional
Return Edit	**VFCSC**	Proc [<1>] is not an appropriate vaccine administration code. Update code as applicable.	Admin to Serum Component Admin Denial The vaccine code(s) and administration code(s) may be submitted on separate claims, but the claims must be for the same date of service by the same provider and the number of units for each must match. Excessive units of either code(s) will be denied. Please review Vaccines for Children Policy, Professional https://www.UHCprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan-reimbursement/UHCCP-Vaccines-for-Children-Policy-R7109.pdf	12/15/2022	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.	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 review the Vaccines for Children Reimbursement Policy – UnitedHealthcare Community Plans on UHCprovider.com.	2/13/2019	Medicaid	Professional

Edit type	Smart edit	Message	Description	Effective date	Market	Claim type
Return Edit	**VFCVD**	Serum code is not appropriate for vaccines for children. Update code(s) as applicable.	Serum Code Denial As part of the Patient Protection and Affordable Care Act (PPACA) regulations the Centers for Medicare & Medicaid Services (CMS) require Medicaid programs to reimburse for VFC services on administration codes 90460, 90471, 90472, 90473, and/or 90474 rather than the serum/toxoid code. Per the PPACA legislation, CPT code 90461 is NOT reimbursable for VFC services. Some States have determined to pay all of these administration codes (except 90461), some only 90460. Any variations from this are listed under the State Exceptions portion of the Vaccines for Children policy. Please review Vaccines for Children Policy, Professional https://www.UHCprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan-reimbursement/UHCCP-Vaccines-for-Children-Policy-R7109.pdf	12/15/2022	Medicaid	Professional