General reminders:


- Edits for CPT, ICD-9, modifier and HCPCS codes deleted by the AMA and/or the Centers for Medicare & Medicaid Services (CMS) will be removed.

- In order to adjudicate claims accurately and in a timely manner, Humana will identify inappropriately coded claims and, when possible, reimburse using the correct code. Humana will do so based only on facts known to Humana, such as the age and gender of the member. For example, if Humana’s records indicate the age of the member does not match the description of the CPT code, the claim will be considered based on the CPT code that properly reflects the member’s age. If a claim is submitted for CPT code 42825 (tonsillectomy, primary or secondary; younger than age 12) and the member is 15 years old, that code will be denied, and CPT code 42826 (tonsillectomy, primary or secondary; age 12 or over) will be added to the claim. When the correct code cannot clearly be identified, the claim will be returned to the physician for correction and resubmission, if applicable.

- Claims that are incomplete, claims with diagnosis codes that are not coded to the highest specificity or claims that have invalid codes may cause the claim to be denied.

- Claim lines submitted with an unlisted or not otherwise classified code must be submitted with a description of services provided; claim lines submitted without a description, with a generic description or with an incomplete description may be denied.

- As noted in the AMA CPT manual, procedure codes that are designated add-on codes are intended to report additional service beyond the related primary code. The add-on code must be reported in conjunction with a related primary code. Therefore, add-on codes will not be reimbursed when the primary code is absent or has been denied for other reasons.

- Humana is continuing to automate its medical coverage policies. Our claim code-editing logic will be updated to include the diagnosis and procedure codes that are covered per our policies. Procedure codes and/or diagnosis codes not allowed per our policies will not be reimbursed. For a complete list of medical coverage policies, please visit Humana.com/provider and choose “Medical and Pharmacy Coverage Policies” under “Resources.”
Humana is committed to remaining consistent with CMS claims processing guidelines. To further that effort, as Medicare payment policies change, Humana continuously updates code-editing logic on all Humana Medicare Advantage (MA) products. Health care providers must follow applicable claims submission guidelines, including local coverage determinations (LCDs) and national coverage determinations (NCDs), to facilitate accurate claims processing.

Per Humana’s provider contract language, claims shall include the physician’s national provider identifier (NPI) and the valid taxonomy code that most accurately describes the health care services reported on the claim. Submitting this information on claims will allow more accurate and timely processing of claims through Humana’s systems.

For California physicians, this notification does not affect any contractual relationship you may have with a contracted independent physician association (IPA) for a Humana MA HMO product. This notification solely pertains to your participation with Humana under your ChoiceCare Network contract.
Claim payment policy and code-editing updates

**Effective June 22, 2015**, the following changes apply to professional claims submitted for Humana commercial fully insured, including health maintenance organization exchange (HMOx) and select self-funded* members, Medicaid and Medicare Advantage (MA) health maintenance organization (HMO), preferred provider organization (PPO) and private fee-for-service (PFFS) members:

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| Evaluation and management (E/M) services      | Immunization administration    | **What is changing?** Immunization administration is not eligible for reimbursement when billed with an E/M code. | • Commercial fully insured products  
• Select self-funded* products                 |
|                                               |                                | **Why is Humana implementing this change?**  
According to the National Correct Coding Initiative (NCCI), immunization administration is not reimbursed when billed with an E/M code. |                                                                        |
| Genetic Testing                               | Diagnosis limitations          | **What is changing?** DJAK2 (Janus kinase 2) gene analysis, p.Val617Phe (V617F) variant, is eligible for reimbursement only when billed with a requisite diagnosis. | • Commercial fully insured products  
• Select self-funded* products                 |
|                                               |                                | **Why is Humana implementing this change?**  
According to multiple local coverage determinations (LCDs) and Humana policy, JAK2 (Janus kinase 2) analysis (CPT code 81270) must be reported with certain myeloproliferative diagnoses in order to meet coverage criteria. |                                                                        |
| Genetic Testing                               | Diagnosis limitations          | **What is changing?** Epidermal growth factor receptor (EGFR) gene analysis, common variants, is eligible for reimbursement only when billed with a diagnosis of malignant neoplasm of | • Commercial fully insured products  
• Select self-funded* products                 |

Claim edits do not supersede the necessity to obtain preauthorization. Preauthorization requirements are still applicable.

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| HCPCS – Drugs & Biologicals    | Bendamustine | **What is changing?** Injection, bendamustine HCl, 1 mg, is limited to 243 units per date of service when billed with a diagnosis of mantle cell lymphoma or Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma.  
**Why is Humana implementing this change?** According to the pharmaceutical compendia, the maximum daily dosage of injection, bendamustine HCl, 1 mg, for an indication of mantle cell lymphoma or Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, is 243 units. | • Commercial fully insured products  
• Select self-funded* products  
• All Medicare Advantage products |
| HCPCS – Drugs & Biologicals    | Bendamustine | **What is changing?** Injection, bendamustine HCl, 1 mg, is limited to 270 units per date of service when billed with a diagnosis of chronic lymphocytic leukemia.  
**Why is Humana implementing this change?** According to the FDA-approved package insert/prescribing information, the maximum daily dosage of injection, bendamustine HCl, 1 mg, for an indication of chronic lymphocytic leukemia, is 270 units. | • Commercial fully insured products  
• Select self-funded* products  
• All Medicare Advantage products |

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| HCPCS – Drugs & Biologicals | Bendamustine | **What is changing?** Injection, bendamustine HCl, 1 mg, is limited to 324 units per date of service when billed with a diagnosis of AIDS-related B-cell lymphoma, Hodgkin's lymphoma or non-Hodgkin's lymphoma (except mantle cell lymphoma).  

**Why is Humana implementing this change?** According to the FDA-approved package insert/prescribing information, the maximum daily dosage of injection, bendamustine HCl, 1 mg, for an indication of AIDS-related B-cell lymphoma, Hodgkin's lymphoma or non-Hodgkin's lymphoma (except mantle cell lymphoma), is 324 units. | • Commercial fully insured products  
 • Select self-funded* products  
 • All Medicare Advantage products |
| HCPCS – Drugs & Biologicals | Bortezomib  | **What is changing?** Injection, bortezomib, 0.1 mg, is limited to 41 units when billed with a diagnosis of mantle cell lymphoma.  

**Why is Humana implementing this change?** According to the FDA-approved package insert/prescribing information, the maximum daily dosage of injection, bortezomib, 0.1 mg, for an indication of mantle cell lymphoma, is 41 units. | • Commercial fully insured products  
 • Select self-funded* products  
 • All Medicare Advantage products |
| HCPCS – Drugs & Biologicals | Bortezomib  | **What is changing?** Injection, bortezomib, 0.1 mg, is reimbursed up to one time every three days when billed by any health care provider.  

**Why is Humana implementing this change?** According to the FDA-approved package insert/prescribing information, injection, bortezomib, 0.1 mg, should not be administered more frequently than once every three days by any health care provider. | • Commercial fully insured products  
 • Select self-funded* products  
 • All Medicare Advantage products |

Claim edits do not supersede the necessity to obtain preauthorization. Preauthorization requirements are still applicable.  

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| HCPCS – Drugs & Biologicals | Eculizumab       | **What is changing?**  
Chemotherapy administration, IV infusion, each additional hour, is limited to 1 unit when billed with injection, eculizumab, 10 mg, and no other drug is delivered by prolonged IV chemotherapy administration and billed for the same date of service.  

**Why is Humana implementing this change?**  
According to the FDA-approved package insert/prescribing information, the intravenous infusion time for injection, eculizumab, 10 mg, is between 35 and 120 minutes, depending on the dose administered. Therefore, codes representing intravenous infusion for each additional hour are limited to one unit. | • Commercial fully insured products  
• Select self-funded* products  
• All Medicare Advantage products |
| HCPCS – Drugs & Biologicals | Golimumab        | **What is changing?**  
Injection, golimumab, 1 mg, for intravenous use, is eligible for reimbursement only when billed with a diagnosis of rheumatoid arthritis.  

**Why is Humana implementing this change?**  
According to the FDA-approved package insert/prescribing information, injection, golimumab, 1 mg, for intravenous use, is used for an indication of rheumatoid arthritis. | • Commercial fully insured products  
• Select self-funded* products  
• All Medicare Advantage products |
| HCPCS – Drugs & Biologicals | Golimumab        | **What is changing?**  
Injection, golimumab, 1 mg, for intravenous use, is reimbursable only once every four weeks when billed by any health care provider.  

**Why is Humana implementing this change?**  
According to the FDA-approved package insert/prescribing information, injection, golimumab, 1 mg, for intravenous use, should not be administered more frequently | • Commercial fully insured products  
• Select self-funded* products  
• All Medicare Advantage products |

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| HCPCS – Drugs & Biologicals | Golimumab                   | **What is changing?**  
Injection, golimumab, 1 mg, for intravenous use, will be reimbursed up to nine times per calendar year when billed by any health care provider.  
**Why is Humana implementing this change?**  
According to the FDA-approved package insert/prescribing information, injection, golimumab, 1 mg, for intravenous use, is administered at weeks 0 and 4, then every eight weeks. Therefore, golimumab for intravenous use should not be administered more frequently than nine times in one calendar year. | • Commercial fully insured products  
• Select self-funded* products  
• All Medicare Advantage products |
| HCPCS – Drugs & Biologicals | Leuprolide Acetate, 1 mg     | **What is changing?**  
Leuprolide acetate, per 1 mg, is not reimbursable for patients under the age of 18 years when billed without a diagnosis of central precocious puberty.  
**Why is Humana implementing this change?**  
According to the FDA-approved package insert/prescribing information, leuprolide acetate, per 1 mg, is only appropriate for an indication of central precocious puberty for patients under the age of 18 years. | • Commercial fully insured products  
• Select self-funded* products |
| HCPCS – Drugs & Biologicals | Pralatrexate                | **What is changing?**  
Injection, pralatrexate, 1 mg, is limited to 81 units per date of service.  
**Why is Humana implementing this change?**  
According to the FDA-approved package insert/prescribing information, the maximum daily dosage of injection, pralatrexate, 1 mg, should not exceed 81 units for any indication. | • Commercial fully insured products  
• Select self-funded* products  
• All Medicare Advantage products |

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<tr>
<td>HCPCS – Drugs &amp; Biologicals</td>
<td>Tocilizumab</td>
<td><strong>What is changing?</strong>&lt;br&gt;Injection, tocilizumab, 1 mg, is eligible for reimbursement only when billed with a diagnosis of rheumatoid arthritis or systemic juvenile idiopathic arthritis.</td>
<td>• All Medicare Advantage products</td>
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<tr>
<td><strong>Why is Humana implementing this change?</strong>&lt;br&gt;According to the FDA-approved package insert/prescribing information, injection, tocilizumab, 1 mg, is used to treat an indication of rheumatoid arthritis or systemic juvenile idiopathic arthritis.</td>
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<td>HCPCS – T Codes</td>
<td>Clinic visit or encounter</td>
<td><strong>What is changing?</strong>&lt;br&gt;Humana plans do not reimburse HCPCS code T1015. HCPCS code T1015 is defined as “clinic visit/encounter, all-inclusive.”</td>
<td>• All Medicare Advantage products</td>
</tr>
<tr>
<td><strong>Why is Humana implementing this change?</strong>&lt;br&gt;This change aligns with CMS guidance per the MPFS, which designates the services as not valid for Medicare purposes.</td>
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<td>HCPCS – T Codes</td>
<td>Personal care services</td>
<td><strong>What is changing?</strong>&lt;br&gt;Humana plans do not reimburse HCPCS code T1019. HCPCS code T1019 is defined as “personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, intermediate care facility for individuals with mental retardation (ICF/MR) or institution for mental disease (IMD), part of the individualized plan of treatment (code may not be used to identify services provided by a home health aide or certified nurse assistant).”</td>
<td>• All Medicare Advantage products</td>
</tr>
<tr>
<td><strong>Why is Humana implementing this change?</strong>&lt;br&gt;This change aligns with CMS guidance per the MPFS, which designates the services as not valid for Medicare purposes.</td>
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<td>HCPCS – T Codes</td>
<td>Respite care services</td>
<td><strong>What is changing?</strong> Humana plans do not reimburse HCPCS code T1005. HCPCS code T1005 is defined as “respite care services, up to 15 minutes.”</td>
<td>• All Medicare Advantage products</td>
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<td><strong>Why is Humana implementing this change?</strong> This service is not reimbursable per Chapter 7 of the Medicare Benefit Policy Manual. Additionally, the Medicare Physician Fee Schedule (MPFS) designates the services as not valid for Medicare purposes.</td>
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<tr>
<td>HCPCS – T Codes</td>
<td>Sign language/oral interpretive services</td>
<td><strong>What is changing?</strong> Humana plans do not reimburse HCPCS code T1013. HCPCS code T1013 is defined as “sign language or oral interpretive services, per 15 minutes.”</td>
<td>• All Medicare Advantage products</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Why is Humana implementing this change?</strong> This change aligns with Centers for Medicare &amp; Medicaid Services (CMS) guidance per the MPFS, which designates the services as not valid for Medicare purposes.</td>
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<tr>
<td>ICD-9 Diagnoses</td>
<td>External cause diagnosis codes</td>
<td><strong>What is changing?</strong> Claims submitted with an ICD-9 external cause diagnosis code (E diagnosis) as the principal or primary diagnosis are not reimbursable.</td>
<td>• Commercial fully insured products&lt;br&gt;• Select self-funded* products&lt;br&gt;• Medicaid&lt;br&gt;• All Medicare Advantage products</td>
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<td><strong>Why is Humana implementing this change?</strong> According to ICD-9 guidelines, E diagnoses are used to classify environmental events, circumstances and conditions as the cause of injury, poisoning and other adverse effects. E-codes are supplemental to the assignment of diagnosis codes and are not to be used as a principal or first-listed diagnosis.</td>
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| Lab/pathology             | Clinical laboratory improvement amendments (CLIA) | **What is changing?**  
Currently Humana may allow a charge during initial adjudication for lab or pathology without a CLIA number billed on the initial claim, or if a practitioner submits a procedure that is above the performing lab’s CLIA certification. Humana will then request a refund from the practitioner after initial adjudication. With this change, Humana will deny the services during initial adjudication if no CLIA number is provided or if a procedure exceeds the performing practitioner’s CLIA certification.  

**Why is Humana implementing this change?**  
This change will improve Humana’s ability to process claims correctly during initial adjudication and reduce the need to request a refund from a practitioner.  

For additional information, practitioners may wish to review the CMS article, [Clinical Laboratory Improvement Amendments (CLIA)](https://www.cms.gov). | • Commercial fully insured products  
• Select self-funded* products  
• All Medicare Advantage products |
| Lab/pathology             | Genetic testing                                     | **What is changing?**  
Humana will not cover genetic testing, MTHFR (5,10-methylenetetrahydrofolate reductase, e.g., hereditary hypercoagulability) gene analysis, common variants (e.g., 677T, 1298C), CPT code 81291.  

**Why is Humana implementing this change?**  
Humana's clinical policy on genetic testing has been updated to indicate that CPT 81291 is considered experimental/investigational and is not a covered service.  

For additional information, refer to the [Humana Medical and Pharmacy Coverage Policy](#) and search by keyword “MTHFR.” | • Commercial fully insured products  
• Select self-funded* products |

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</table>
| Lab/pathology| Genetic testing        | **What is changing?**  
Humana will not cover HCPCS code S3852. HCPCS code S3852 is defined as “genetic testing, DNA analysis for APOE epsilon 4 allele for susceptibility to Alzheimer’s disease.”  

**Why is Humana implementing this change?**  
Humana's clinical policy on genetic testing has been updated to indicate that HCPCS code S3852 is considered experimental/investigational and is not a covered service.  

For additional information, refer to the [Humana Medical and Pharmacy Coverage Policy](#) and search by keyword “S3852.” | • Commercial fully insured products  
• Select self-funded* products |
| Modifiers    | Modifier 53 – Discontinued services | **What is changing?**  
Professional services submitted with modifier 53 are allowed at 29 percent of base allowable amount, subject to any other applicable adjustment.  

**Notes:**  
• Modifier 53 should be used only when the procedure is discontinued after anesthesia is administered.  
• Modifier 53 should not be used when a laparoscopic or endoscopic procedure is converted to an open procedure.  

**Why is Humana implementing this change?**  
Coding with Modifiers, published by the AMA, states when it is appropriate and inappropriate to use modifier 53. This change also aligns with Chapter 12 of the Medicare Claims Processing Manual and Humana’s internal policy. The change recognizes that it is appropriate to reduce payment for services when a procedure was discontinued, meaning that some of the services associated with that | • Commercial fully insured products  
• Select self-funded* products  
• Medicaid products |
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| Modifiers | Modifier 53 – Discontinued services | **What is changing?**  
Professional services submitted with modifier 53 are allowed at 29 percent of base allowable amount, subject to any other applicable adjustment.  

**Notes:**  
- Modifier 53 should be used only when the procedure is discontinued after anesthesia is administered.  
- Modifier 53 should not be used when a laparoscopic or endoscopic procedure is converted to an open procedure.  

**Exception:**  
For a service priced on the basis of MPFS amount, if the MPFS has a specific modifier 53 amount, reimbursement will be based on the MPFS amount, subject to any other applicable adjustment. As of June 22, 2015, the exception applies only to CPT codes 45378, colonoscopy, and 45330, sigmoidoscopy.  

**Why is Humana implementing this change?**  
Coding with Modifiers, published by the AMA, states when it is appropriate and inappropriate to use modifier 53. This change also aligns with Chapter 12 of the Medicare Claims Processing Manual and Humana’s internal policy. The change recognizes that it is appropriate to reduce payment for services when a procedure was discontinued, meaning that some of the services associated with that procedure code were not actually performed.  

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</table>
| **Modifiers** | Modifier 53 – Discontinued services | **What is changing?**  
Humana Florida Medicaid plans allow professional services submitted with modifier 53 at 25 percent of base allowable amount.  

**Notes:**  
- Modifier 53 should be used only when the procedure is discontinued after anesthesia is administered.  
- Modifier 53 should not be used when a laparoscopic or endoscopic procedure is converted to an open procedure.  

**Why is Humana implementing this change?**  
Coding with Modifiers, published by the AMA, states when it is appropriate and inappropriate to use modifier 53. This change also aligns with the practices of the Agency for Health Care Administration (AHCA), the Florida Medicaid agency. | • Florida Medicaid products |
| **Modifiers** | Modifier 53 – Discontinued services | **What is changing?**  
Humana Illinois Medicaid plans do not allow services submitted with modifier 53. Services should be reported only when completed entirely.  

**Why is Humana implementing this change?**  
This change aligns with the practices of the Illinois Department of Healthcare and Family Services, the Illinois Medicaid agency. | • Illinois Medicaid products |
| **Modifiers** | Modifier 53 – Discontinued services | **What is changing?**  
Humana Virginia dual Medicare-Medicaid products allow professional services submitted with modifier 53 based upon the percentage of services completed. An operative report is required in order to make the decision. | • Virginia dual Medicare-Medicaid products |

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<td>Notes:</td>
<td>Modifier 53 should be used only when the procedure is discontinued after anesthesia is administered.</td>
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<td></td>
<td>Modifier 53 should not be used when a laparoscopic or endoscopic procedure is converted to an open procedure.</td>
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<tr>
<td>Why is Humana implementing this change?</td>
<td>Coding with Modifiers, published by the AMA, states when it is appropriate and inappropriate to use modifier 53. This change also aligns with the practices of the Virginia Department of Medical Assistance Services.</td>
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<tr>
<th>Modifiers</th>
<th>Modifiers 24, 25, 55 and 56 – Postoperative period</th>
<th>What is changing?</th>
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<td></td>
<td>Evaluation and management services submitted with modifiers 24, 25, 55 or 56 within the postoperative global period of a previously performed procedure are not reimbursable when the use of the modifier is not supported by information on the claim or in the member history.</td>
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<td></td>
<td>• Modifier 24 – Unrelated evaluation and management (E/M) service by the same physician or other qualified health care professional during the postoperative period.</td>
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<td>• Modifier 25 – Significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the procedure or other service.</td>
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<td>• Modifier 55 – Postoperative management only.</td>
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<td>• Modifier 56 – Preoperative management only.</td>
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<tr>
<td>Why is Humana implementing this change?</td>
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According to AMA CPT, a modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some circumstance, but not changed in its definition or code. The additional work these modifiers represent often warrants additional payment; therefore, when the modifier is not supported by information on the claim or in member history, the service will not be reimbursed.

### Modifiers

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<th>Modifiers 78 and 79 – Same-day usage</th>
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<td><strong>What is changing?</strong></td>
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<tr>
<td>Procedures submitted with modifiers 78 or 79 on the same date of service as another service are not reimbursable when the use of the modifier is not supported by information on the claim or in the member history.</td>
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- **Modifier 78** – Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period.
- **Modifier 79** – Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period.

### Why is Humana implementing this change?
According to the AMA CPT manual, a modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some circumstance, but not changed in its definition or code. The additional work these modifiers represent often warrants additional payment; therefore, when the modifier is not supported by information on the claim or in the member history, the service will not be reimbursed.

### Radiology

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<th>Chest and rib X-ray</th>
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<td><strong>What is changing?</strong></td>
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<td>When CPT code 71010 and CPT code 71100 are billed for the same day, the codes</td>
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Claim edits do not supersede the necessity to obtain preauthorization. Preauthorization requirements are still applicable.

*Note: These and all edits previously published or posted on Humana.com/providers for fully insured commercial Humana members may be applied to self-funded members, when requested by the self-funded group.
<table>
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<tr>
<th>Category</th>
<th>Topic</th>
<th>Policy statement</th>
<th>Impacted products</th>
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|          |       | will be recoded to the comprehensive CPT code or CPT code 71101. | • Select self-funded* products  
• All Medicare Advantage products |
|          |       | • CPT code 71010 is defined as “radiologic examination, chest; single view, frontal.” | |
|          |       | • CPT code 71100 is defined as "radiologic examination, ribs, unilateral; two views.” | |
|          |       | • CPT code 71101 is defined as “radiologic examination, ribs, unilateral; including posteroanterior chest, minimum of three views.” | |
|          |       | **Why is Humana implementing this change?** | |
|          |       | CPT code 71010 is for a chest X-ray, and code 71100 is for rib views. If both views are being performed, the appropriate code to bill is code 71101, which is for the rib and chest views, per AMA’s CPT description. | |

### Radiology

#### Chest X-ray

**What is changing?**

CPT code 71010 is not separately reimbursed when billed with CPT code 71100 or CPT code 71101.

- CPT code 71010 is defined as “radiologic examination, chest; single view, frontal.”
- CPT code 71100 is defined as “radiologic examination, ribs, unilateral; two views.”
- CPT code 71101 is defined as “radiologic examination, ribs, unilateral; including posteroanterior chest, minimum of three views.”

**Why is Humana implementing this change?**

According to NCCI, CPT code 71010 is not reimbursed when billed with CPT codes 71100 or 71101. Humana commercial plans will follow the NCCI editing.

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