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Upcoming Code Edits

Effective Date 10/26/25

Beginning October 26,2025, we'll implement the following new coding guidelines for:

- **Repeat Lab Procedures (Facilities)**
- **Modifier 26/TC**
- **Primary Diagnosis Code Only**

Repeat Lab Procedures-Facilities – Modifier 91

Claims that include lab procedures with modifier 91, used to indicate a repeat test, will be reviewed against claim history. If no original procedure for the same date of service is found, the claim line will be denied. This edit follows official guidance from the Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA) regarding proper use of modifier 91 and procedure repeatability.

Modifier 26/TC Billing Edit

Claims submitted with both modifiers 26 and TC for the same procedure, same date, and same provider will be denied ensuring correct billing. Use the appropriate global procedure code when the same provider delivers both professional and technical components on the same date of service.
This edit ensures accurate component billing for procedures performed on the same date by the same provider.

Primary Diagnosis Code Only Edit

Claim submissions containing Primary Diagnosis Only (PDO) code in a secondary diagnosis field will result in claim denial.
Certain diagnosis codes in the ICD-10-CM manual are designated for use exclusively in the first-listed (primary) diagnosis position on claims. These primary-only codes reflect the principal reason for the patient encounter and must be appropriately positioned to meet coding standards. We'll edit the claim line if a primary-only diagnosis code is billed in a position other than the first-listed or primary position.
Please follow the ICD-10-CM guidelines when submitting claims to avoid claims being denied.