healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Non-Covered Codes – Medicare		
Policy Number:	PO-RE-155v1		
Effective Date:	01/01/2025	**Last Approval Date:**	10/20/2025

I. Policy Description

This policy outlines the reimbursement approach for non-covered Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes submitted by providers participating in Healthfirst Medicare Advantage (MA) plans. Healthfirst follows the Centers for Medicare & Medicaid Services (CMS) guidelines, including National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and Medicare coverage status indicators, to determine service coverage and reimbursement eligibility.

The policy supports accurate billing and ensures alignment with Medicare regulations and Healthfirst contractual agreements.

The information below applies to the following lines of business:

- Medicare Advantage
- Medicare HMO and PPO
- Medicaid Advantage Plus/MAP (CompleteCare)

Reimbursement Guidelines

1. Non-Covered Code Identification
   - Codes are non-reimbursable if they are assigned Medicare status indicators denoting exclusion or non-payment, such as:
     - “N” – Non-covered
     - “X” – Statutory exclusion
     - “I” – Invalid for Medicare
     - “M” – Not valid for Medicare
   - These codes are automatically denied regardless of provider type or service location.

2. Bundled and Alternate Code Billing
   - Non-covered codes must not be submitted for separate payment.
   - Instead, providers must:
     - Use an appropriate, approved covered code, or
     - Bundle the service within a related covered procedure when appropriate.

3. No Reimbursement for Unapproved Services
    - Any code marked as “Not Approved”, or lacking validation in CMS official schedules, is automatically excluded from reimbursement.
    - This exclusion applies regardless of claim volume or provider submission frequency.

4. Reimbursement Updates
    - CMS fee schedule updates are regularly monitored by Healthfirst.
    - Healthfirst conducts periodic reviews to ensure its reimbursement policies reflect:
        - Newly released CMS regulations,
        - Revisions to coverage policies, and
        - Current national and local coverage determinations.

5. No Exceptions Without Formal Review
    - Codes with ambiguous or escalated status indicators such as:
        - “I” – Invalid
        - “M” – Not valid for Medicare
        - “R” – Restricted coverage
          are not reimbursed unless and until formally reviewed by Healthfirst.
    - Pending this internal assessment, no payment will be issued for such codes.

6. Correct Coding Initiative (CCI) Compliance
    - Providers must follow CMS National Correct Coding Initiative (NCCI) rules to prevent:
        - Improper unbundling,
        - Mutually exclusive code combinations,
        - Redundant submissions.

Adjudication and Appeal Process

1. Claims submitted by providers that do not adhere to this policy will be denied or rejected. It is the responsibility of the provider to ensure claims are coded accurately.

2. If the line of business (LOB) is not mentioned in this policy, the services are not covered and not eligible for reimbursement.

3. This policy is a provider resource for understanding Healthfirst’s reimbursement guidelines. It does not guarantee coverage or payment. Final reimbursement decisions depend on benefit coverage, state/federal mandates, medical necessity, and provider contract.

4. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17.6, “Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process” in this section.*

For any questions or further clarification regarding this policy, providers are encouraged to reach out to their designated contact within our organization

II. Applicable Codes

Code	Description	Comment

III. Definitions

Term	Meaning

IV. Related Policies

Policy Number	Policy Description
N/A	N/A

Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

Search the Physician Fee Schedule | CMS
MCD Search
NCCI for Medicare | CMS

VI. Revision History

Revision Date	Summary of Changes

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for the services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.