New Claim Edits Based on the Diagnosis Billed

Effective March 1, 2024, the anesthesia codes below will be denied when appended with modifier QS (monitored anesthesia care) and billed without an approved diagnosis on the claim. This follows the Centers for Medicare & Medicaid Services Local Coverage Determination (LCD) A57361.

- 00100
- 00124
- 00148
- 00160
- 00164
- 00300
- 00322
- 00400
- 00410
- 00454
- 00520
- 00522
- 00524
- 00530
- 00532
- 00635
- 00640
- 00702
- 00731
- 00732
- 00842
- 00920
- 00921
- 01130
- 01380
- 01420
- 01490
- 01680
- 01730
- 01780
- 01782
- 01820
- 01829
- 01860
- 01916
- 01920
- 01922
- 01930
- 01935
- 01936
- 01937-01942
- 01991
- 01992
- 01999

Lumbar spinal fusion procedure codes 22533, 22558, 22612, 22630, and 22633 will deny when:

- Billed and the only diagnosis on the claim is lumbar stenosis and the patient is 18 years of age or older

These edits affect your HAP Commercial and HAP Medicare Advantage claims.