Diagnosis Procedure Age Guidelines

Reimbursement Policy ID: RPC.0030.0100

Recent review date: 02/01/2024

Next review date: 12/2025

Keystone First reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. Keystone First may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy addresses age-specific coding edits involving select International Classification of Diseases,10th Revision, Clinical Modification diagnosis codes and procedure codes from the Procedure Code Sets (ICD-10-CM and ICD-10-PCS). It also addresses select codes from the Current Procedural Terminology (CPT) code set and Healthcare Common Procedure Coding System (HCPCS) that have age limitations. Age designations are assigned to codes based on code descriptions or on publications and guidelines from sources such as professional specialty societies, the World Health Organization (WHO), the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA) or the American Hospital Association (AHA) Coding Clinic.

Exceptions

N/A

Reimbursement Guidelines

Keystone First utilizes 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 (e.g., WHO, CMS, AMA). Keystone First will apply age edits when diagnosis and/or procedure codes are reported inappropriately for the patient's age. Diagnosis and procedure age conflicts will be considered billing errors and will not be reimbursed. For example, if the diagnosis code Z00.00 “Encounter for general adult medical examination with abnormal findings” is billed for a 10-year-old child, the claim will not be reimbursed.

Claims submitted with an age-based diagnosis or procedure code that conflicts with the patient’s age will be denied. For example, a claim for five-year-old male patient with a diagnosis code for benign prostatic hypertrophy will be denied because that diagnosis code is applicable only to adult patients aged 15 to124, inclusive. Similarly, a claim for a 78-year-old patient with a cesarean section delivery procedure code will be denied because pregnancy diagnosis/procedure codes are only valid for patients ages 12 to 55. Corrected claims are required for payment.

Definitions

N/A

Edit Sources

I. Current Procedural Terminology.
II. Healthcare Common Procedure Coding System (HCPCS)
III. International Classification, 10th revision, Clinical Modification (ICD-10-CM), https://www.cms.gov/files/document/fy-2024-icd-10-cm-coding-guidelines.pdf
IV. International Classification, 10th revision, Procedure Code System (ICD-10-PCS), https://www.cms.gov/files/document/2024-official-icd-10-pcs-coding-guidelines.pdf.
V. Healthcare Common Procedure Coding System (HCPCS).
VI. Centers for Medicare and Medicaid Services (CMS).
VII. The National Correct Coding Initiative (NCCI)
VIII. Corresponding Keystone First Clinical Policies.
IX. Applicable Keystone First manual reference.
X. Commonwealth of Pennsylvania Medicaid Program guidance.
XI. Commonwealth of Pennsylvania Medicaid Program fee schedule(s).

Attachments

N/A

Associated Policies

N/A

Policy History

06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble

04/2024	Revised preamble
02/2024	Reimbursement Policy Committee Approval
06/2023	Policy Implemented by Keystone First
06/2023	Reimbursement Policy Committee Approval
01/2023	Template revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section