Denial Management: Understanding Outpatient Edits and Applying Modifiers

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Better Healthcare Through Better Business

Agenda

- The Medicare Outpatient Code Editor (OCE)
- National Correct Coding Initiative
- Medically Unlikely (MUE) Edits
- Procedure to Procedure (PTP) Edits
- Add-on Edits
- NY Medicaid Application of these Edits
- Modifier Reporting
- Discussion

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CMS OCE Editor
NCCI Edits
MUEs – Unit edits
PTPs – Pairing edits
Add-on Edits
NCD/LCDs – Necessity edits

The Medicare OCE - Background

- The outpatient code editor was implemented when Medicare implemented APCs
  - Updated once a quarter
  - Edits claims and "groups" the case
  - Indicates the disposition of the claim or the claim-line such as "line-item denial"
  - Includes the NCCI/PTP edits which in turn include the MUE edits

http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html?redirect=/OutpatientCodeEdit/

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Current OCE Edits

- Currently there are 101 edits, some of which are inactive
- The edits listed below are the most recent
- Each edit is assigned an edit number, description and claim or line-item disposition

94	Biosimilar HCPCS reported without biosimilar modifier	17.0 – present	1/1/16 – present	Y*	RTP
95	Partial hospitalization claim span is equal to or more than 4 days with insufficient number of hours of service	17.2 only	7/1/16 – 9/30/16		RTP

Edit #	Description	Versions Effective	Dates Effective	Non-OPPS	Disposition
97	Partial hospitalization services are required to be billed weekly	17.2 only	7/1/16 – 9/30/16		RTP
98	Claim with pass-through device lacks required procedure	17.2 – present	1/1/16 - present		RTP
99	Claim with pass-through or non-pass-through drug or biological lacks OPPS payable procedure	17.3 - present	1/1/16 – present		RTP
100	Claim for HSCT allogeneic transplantation lacks required revenue code line for donor acquisition services	18.0 -	1/1/17 -		RTP

IOCE CMS Specifications – V18.0 24

New 2017

Edit #	Description	Versions Effective	Dates Effective	Non-OPPS	Disposition
101	Item or service with modifier PN not allowed under PFS	18.0 -	1/1/17 -		RTP

OCE Claim Dispositions

- Six possible dispositions for claims and claim lines:
  1. RTP – Return to Provider
  2. Line Item Denial
  3. Line Item Rejection
  4. Claim Denial
  5. Claim Rejection
  6. Claim Suspend

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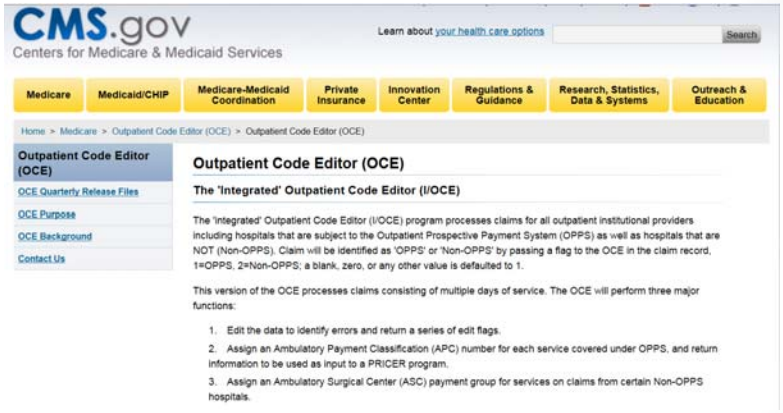
OCE Quarterly Release Specifications



OCE quarterly release specification lists the current edits and provides updated information

https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/Index.html

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OCE Edit Number 21

- Common edit impacting clinic and emergency department claims.
- Indicates that there is an Evaluation and Management (E/M) visit code and a significant procedure (APC status indicator S or T) reported on the same date of service on the same claim.
- Generates a disposition of RTP- return to provider.

OCE Edit No.	Edit	Disposition
21	Medical visit on the same day as a type T or S procedure without modifier 25	RTP

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Example 1 - OCE Edit Number 21

- The physician sees a 59 year old male in the emergency department for chest pain and possible myocardial infarction.
- The physician orders a CPK level and an EKG
  - The ER visit level (99284) is an APC status indictor J2 that maps to an APC SI of V
  - The EKG (93005) is an APC SI Q1 that maps to an APC SI of S
  - OCE edit 21 indicates that there is an APC status V reported with an APC status S

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Example 1 - OCE Edit Number 21

- The claim will be RTP'd (returned to provider)
- Health Information Management (HIM)/Medical Records reviews the documentation and determines that the medical visit (99284) is significant and separately identifiable from the EKG (93005)
- HIM applies a modifier – 25 to the medical visit (99284) and appropriately bypasses OCE edit 21

Service Description	CPT/HCPCS	Add B SI	Add A SI	Modifier	Units	OCE Edit	Rev Code
Assat of CK (CPK)	82550	Q4			2		301
EKG Tracing w/ Min 12 Leads	93005	Q1	S		2		730
Emergency Visit Level IV	99284	J2	V	25	1	21	450

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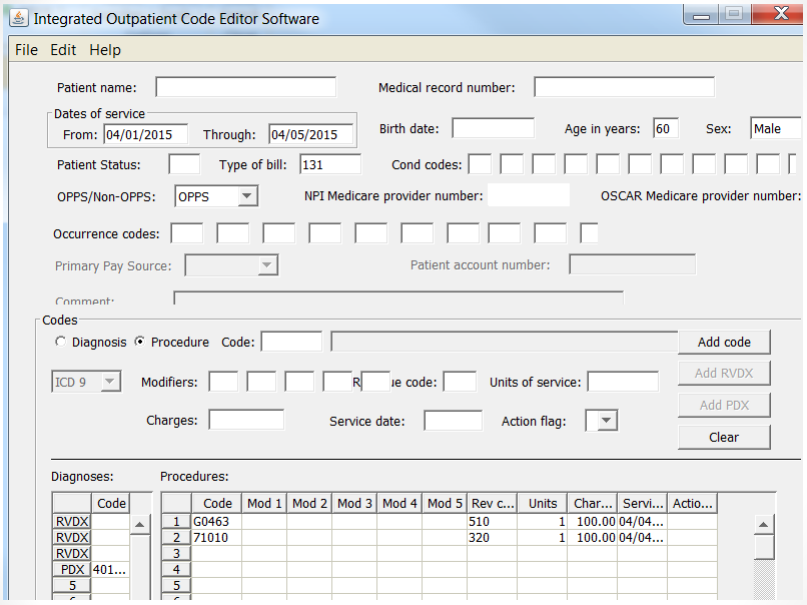
OCE Software/Data File

- CMS has a free OCE editor that can be downloaded once per quarter



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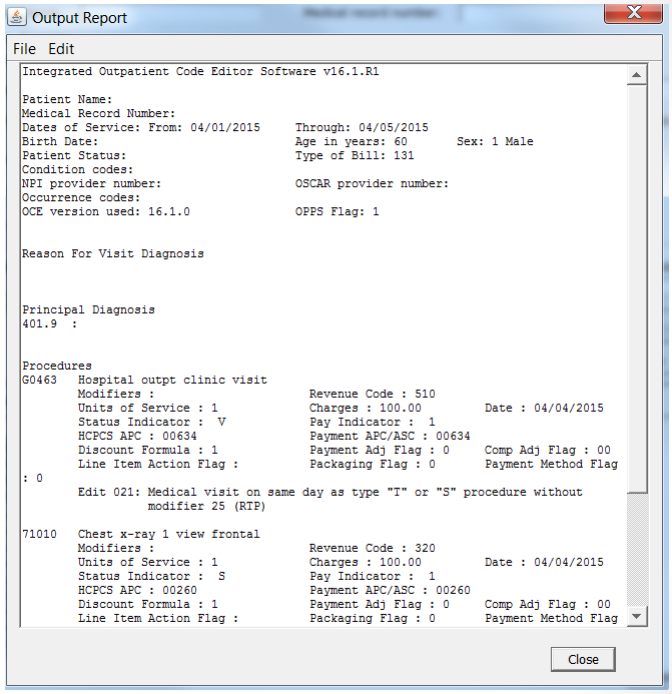

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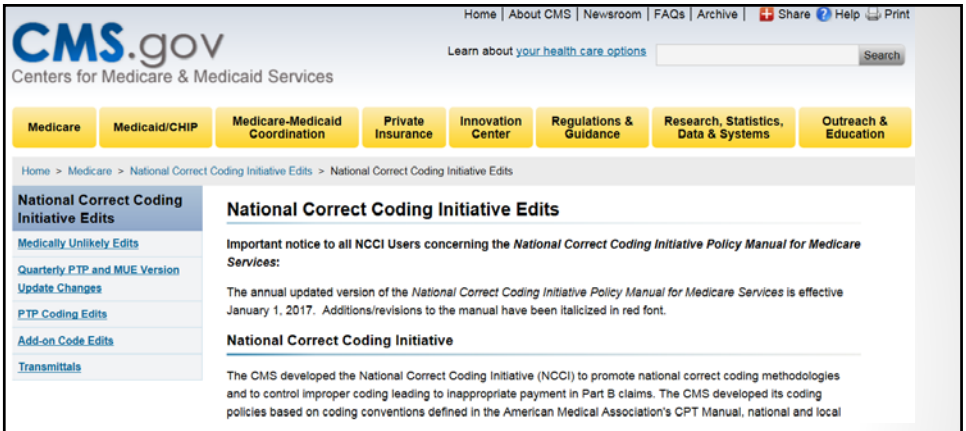

- Incorporated into the Medicare OCE
- Includes three levels of edits
  - Medically Unlikely Edits – Unit edits
  - PTP Coding Edits – Code Pair edits
  - Add-on Code Edits

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CMS NCCI Policy Manual

- Released annually
- Invaluable reference for common CCI edits
- Recommend keeping a current copy on your computer

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

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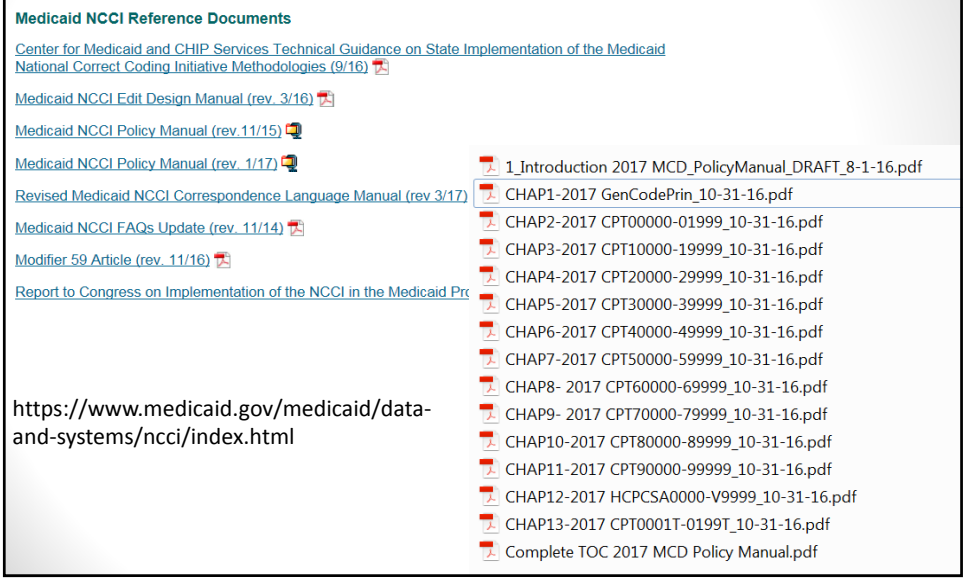
Medicaid NCCI Policy Manual



https://www.medicaid.gov/medicaid/data-and-systems/ncci/index.html

CMS Medically Unlikely Edits (MUEs)

- Developed in 2007
- Included in the NCCI program which are part of the Medicare Outpatient Code Editor (OCE)
- Goal is to reduce the error rate for Medicare claims
- Designed to reduce errors that result from the following:
  - Clerical entries
  - Incorrect coding on the basis of anatomic considerations
  - HCPCS/CPT® code descriptors
- Information about MUE is in Chapter 1, Section V, of the NCCI Policy Manual

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Medically Unlikely Edits

- A MUE is <u>the maximum number of units that a provider should report under most circumstances</u> for a single claim on a single date of service
- All CPT® and HCPCS codes do not have an MUE
- Medicare - All Medicare MUE's are not published
  - Unpublished MUE's are considered "confidential" and are for CMS and the CMS contractors' use only
- Medicaid - There are NO confidential or non-published MUE edits for the Medicaid NCCI Program at this time, they are all published
- Cannot be billed to patient even with an ABN

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Revisions to CMS MUEs

- April 1, 2013
  - Moved some edits to Date of Service edits
  - Added a new data field to the MUE table "MUE Adjudication Indicator" or MAI
- August 2014
  - Made additional changes effective January 2015

Source: Transmittal 1421, CR 8853, Released August 15, 2014

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CMS MUE Adjudication Indicator (MAI)

- MAI of "1" – Adjudicated as a claim line edit (the standard (i.e., original) MUE)
  - UOS (units of service) of each line is compared to the MUE value ***7% of the edits***
- MAI of "2" – Absolute date of service edit
  - UOS are summed for a DOS (date of service)
  - These are "per day edits based on policy"
  - Considered impossible because contrary of statute, regulation or sub-regulatory guidance
    - E.g., 94002, *vent management initial day*
    - Cannot report more than once per day
  - Essentially cannot be over-ridden – FIRM LIMITS **39% of the edits**

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MAI – Adjudication Indicator

- MAI of "3" – Date of service edits
  - Sum all UOS for the code for the same DOS without any modifier
  - "Per day edits based on benchmarks"
  - If appealed, contractors may pay UOS in excess of MUE if there is adequate documentation of medical necessity and correct reporting of units
  - **54% of the edits**

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Modifier - 50

- Claim lines w/ a modifier – 50 have a single unit
- As part of the MUE processing the billed units are doubled before testing against the MUE value

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CMS Medically Unlikely Edits

- The table below is an excerpt of the MUE edits
- For each CPT® and HCPCS code with a published MUE, the maximum expected units, the MAI and the Rationale are listed
- https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html

HCPCS/CPT Code	Description	Outpatient Hospital Services MUE Values	MUE Adjudication Indicator	MUE Rationale
93005	Electrocardiogram tracing	3	1 Line Edit	Clinical: Data
93015	Cardiovascular stress test	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
93016	Cardiovascular stress test	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
93017	Cardiovascular stress test	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
93018	Cardiovascular stress test	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
93024	Cardiac drug stress test	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
93025	Microvolt t-wave assess	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
93040	Rhythm ecg with report	3	1 Line Edit	Clinical: Data
93041	Rhythm ecg tracing	3	1 Line Edit	Clinical: Data
93042	Rhythm ecg report	3	1 Line Edit	Clinical: Data
93050	Art pressure waveform analys	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
93224	Ecg monit/reprt up to 48 hrs	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
93225	Ecg monit/reprt up to 48 hrs	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
93226	Ecg monit/reprt up to 48 hrs	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
93227	Ecg monit/reprt up to 48 hrs	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction

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MAI 1 – Claim Line Edit

- The original MUE that can be reported on a separate claim line and bypassed with a modifier (e.g., 59, 76, 77, 91) when appropriate
- Rationale varies
  - E.g., Nature of Service/Procedure
  - CMS Policy
  - Anatomic Consideration
- Examples

HCPCS/CPT Code	Description	Outpatient Hospital Services MUE Values	MUE Adjudication Indicator	MUE Rationale
76802	Ob us < 14 wks addl fetus	3	1 Line Edit	Nature of Service/Procedure
76810	Ob us >/= 14 wks addl fetus	3	1 Line Edit	Nature of Service/Procedure
76812	Ob us detailed addl fetus	3	1 Line Edit	Nature of Service/Procedure
76814	Ob us nuchal meas add-on	3	1 Line Edit	Nature of Service/Procedure
76881	Us xtr non-vasc complete	2	1 Line Edit	Clinical: CMS Workgroup
76882	Us xtr non-vasc lmtd	2	1 Line Edit	Clinical: CMS Workgroup
76936	Echo guide for artery repair	2	1 Line Edit	Clinical: Data
76965	Echo guidance radiotherapy	2	1 Line Edit	Clinical: Data
77014	Ct scan for therapy guide	2	1 Line Edit	Clinical: Data
80158	Drug assay cyclosporine	3	1 Line Edit	Clinical: Data
81415	Exome sequence analysis	1	1 Line Edit	Nature of Analyte
81416	Exome sequence analysis	2	1 Line Edit	Nature of Analyte
81417	Exome re-evaluation	1	1 Line Edit	Nature of Analyte

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MAI 2 – Date of Service Edit: Policy

- Firm edits, can not be bypassed
- Rationale varies
  - E.g., Code Description/CPT Instruction
  - Nature of the procedure
  - Anatomic Consideration
- Examples

HCPCS/CPT Code	Description	Outpatient Hospital Services MUE Values	MUE Adjudication Indicator	MUE Rationale
75807	Lymph vessel x-ray trunk	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
75952	Endovasc repair abdom aorta	1	2 Date of Service Edit: Policy	Anatomic Consideration
75956	Xray endovasc thor ao repr	1	2 Date of Service Edit: Policy	Anatomic Consideration
75957	Xray endovasc thor ao repr	1	2 Date of Service Edit: Policy	Anatomic Consideration
75959	Xray place dist ext thor ao	1	2 Date of Service Edit: Policy	Anatomic Consideration
76506	Echo exam of head	1	2 Date of Service Edit: Policy	Anatomic Consideration
76510	Ophth us b & quant a	2	2 Date of Service Edit: Policy	Anatomic Consideration
76511	Ophth us quant a only	2	2 Date of Service Edit: Policy	Anatomic Consideration
76512	Ophth us b w/non-quant a	2	2 Date of Service Edit: Policy	Anatomic Consideration
76513	Echo exam of eye water bath	2	2 Date of Service Edit: Policy	Anatomic Consideration
76514	Echo exam of eye thickness	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
76516	Echo exam of eye	1	2 Date of Service Edit: Policy	CMS Policy

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MAI 3 – Date of Service Edit: Clinical

- Firm edits, can be appealed
- Rationale varies
  - E.g., Code Description/CPT Instruction
  - Nature of the procedure
  - Clinical Data
- Examples

HCPCS/CPT Code	Description	Outpatient Hospital Services MUE Values	MUE Adjudication Indicator	MUE Rationale
95971	Analyze neurostim simple	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
95980	Io anal gast n-stim init	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
95981	Io anal gast n-stim subsq	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
95982	Io ga n-stim subsq w/reprog	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
96002	Dynamic surface emg	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
96003	Dynamic fine wire emg	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
96371	Sc ther infusion reset pump	1	3 Date of Service Edit: Clinical	Code Descriptor / CPT Instruction
96374	Ther/proph/diag inj iv push	1	3 Date of Service Edit: Clinical	Code Descriptor / CPT Instruction
96376	Tx/pro/dx inj same drug adon	10	3 Date of Service Edit: Clinical	Clinical: Data
96402	Chemo hormon antineopl sq/im	2	3 Date of Service Edit: Clinical	Clinical: Data
96409	Chemo iv push sngl drug	1	3 Date of Service Edit: Clinical	Code Descriptor / CPT Instruction
96413	Chemo iv infusion 1 hr	1	3 Date of Service Edit: Clinical	Code Descriptor / CPT Instruction
96416	Chemo prolong infuse w/pump	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure

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Medicaid MUEs

https://www.medicaid.gov/medicaid/data-and-systems/ncci/index.html

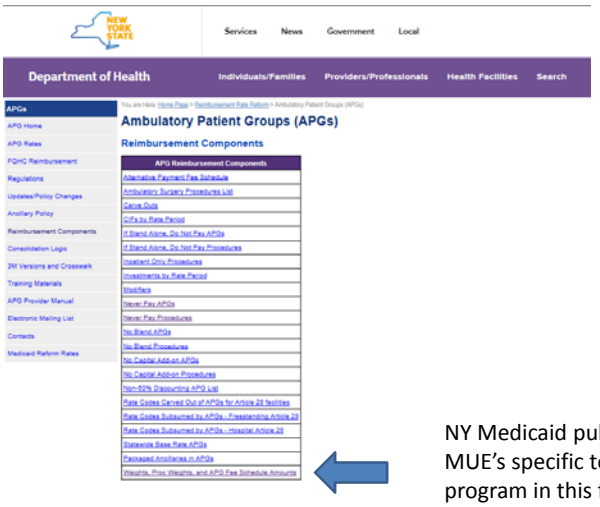
Medicaid NCCI Edit Files

The complete updated Medicaid NCCI edit files are posted here at the beginning of each calendar quarter. These files completely replace the Medicaid NCCI edit files from previous calendar quarters. The presence of a HCPCS / CPT code in a PTP edit or of an MUE value for a HCPCS / CPT code does not necessarily indicate that the code is covered by any state Medicaid program or by all state Medicaid programs. States cannot use the files here for processing and paying Medicaid claims.

The complete Medicaid NCCI edit files for the calendar quarter beginning April 1, 2017 can be accessed by clicking on the links below:

- PTP edits for practitioner and ambulatory surgical center (ASC) services effective 4/1/2017
- PTP edits for outpatient services in hospitals (including emergency department, observation, and hospital laboratory services) effective 4/1/2017
- PTP edits for provider claims for durable medical equipment effective 4/1/2017
- MUEs for practitioner and ASC services effective 4/1/2017
- MUEs for outpatient services in hospitals effective 4/1/2017
- MUEs for provider claims for durable medical equipment effective 4/1/2017

NY Medicaid APG Additional MUEs



NY Medicaid publishes MUE's specific to the APG program in this file

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https://www.health.ny.gov/health_care/medicaid/rates/methodology/history_and_fee_schedule.htm

APG Procedure Based Weights and APG Fee Schedule

- Note that MC and MCD both reimburse fee based services on the lesser of (lesser of fee or charges)
- Each has an MUE

NYS DOH APG Procedure Based Weig

Revised for January 1, 2017 Updates:

Effective Date >				January 1, 2017
HCPCS Code	HCPCS Code Description	APG (ref only)	Px-Based Weight	Units Limit
97161	Pt eval low complex 20 min	271	0.5427	1
97162	Pt eval mod complex 30 min	271	0.7236	1
97163	Pt eval high complex 45 min	271	0.9045	1
97164	Pt re-eval est plan care	271	0.5427	1
97165	Ot eval low complex 30 min	270	0.4885	1
97166	Ot eval mod complex 45 min	270	0.6513	1
97167	Ot eval high complex 60 min	270	0.8141	1
97168	Ot re-eval est plan care	270	0.4885	1

APG Fee Schedule Procedures (o

Revised for January 1, 2017 Updates:

Effective Date >		July 1, 2(		January 1, 2015		July 1, 2015		Jan 1, 2016		Jan 1, 2017	
HCPCS Code	HCPCS Code Description	Reimbursement Amount (per unit)	Max units	Reimbursement Amount (per unit)	Max units	Reimbursement Amount (per unit)	Max units	Reimbursement Amount (per unit)	Max units	Reimbursement Amount (per unit)	Max units
59412	Ante-partum manipulation	$ 35.00	1	$ 35.00	1	$ 35.00	1	$ 35.00	1	$ 35.00	1
61885	Insrt/redo neurostim 1 array	$ 11,794.40	1	$ 11,794.40	1	$ 11,794.40	1	$ 11,794.40	1	$ 11,794.40	1
64568	Inc for vagus n elect impl	$ 19,630.40	1	$ 19,630.40	1	$ 19,630.40	1	$ 19,630.40	1	$ 19,630.40	1
81025	Urine pregnancy test	$ 3.19	1	$ 3.19	1	$ 3.19	1	$ 3.19	1	$ 3.19	1
96372	Ther/proph/diag inj sc/im									$ 13.23	1
J1459	Inj IVIG privigen 500 mg	$ 36.60	1	$ 36.60	1	$ 36.60	1	$ 38.28	456	$ 38.28	456
J1561	Gamunex-C/Gammaked	$ 38.97	1	$ 38.97	1	$ 38.97	1	$ 39.80	456	$ 39.80	456
J1568	Octagam injection	$ 31.57	1	$ 31.57	1	$ 31.57	600	$ 38.66	456	$ 38.66	456
J1569	Gammagard liquid injection	$ 39.17	1	$ 39.17	1	$ 39.17	600	$ 38.78	545	$ 38.78	545
J1572	Flebogamma injection	$ 35.95	1	$ 35.95	1	$ 35.95	1	$ 34.75	137	$ 34.75	137
J1745	Infliximab injection	$ 67.96	70	$ 67.96	70	$ 67.96	70	$ 76.89	114	$ 76.89	114

Example 2 - MUE

- A patient is referred for observation for chest pain, suspected MI
- After four days of tests it is determined that the patient did not have an MI
- An inpatient order was never obtained, the patient is discharged after 84 hours of observation
- 84 units exceeds the G0378 MUE of 72

Service Description	CPT/HCPCS	Modifier	Units	Revenue Code	Covered Charges	Non-Covered Charges
ER Visit, Lvl 5	99285		1	450	$500.00	$0.00
Observation, Per hour	G0378		84	762	$6,300.00	$0.00

G0378	72	Clinical: Medicare Data

Example 2- MUE

If the unit of service on that line exceeds the MUE value, the entire line is denied.

- The entire observation claim line is denied, not just the units exceeding the MUE
- The claim needs to be resubmitted with the non-covered units and charges moved to non-covered

Service Description	CPT/HCPCS	Modifier	Units	Revenue Code	Covered Charges	Non-Covered Charges
ER Visit, Lvl 5	99285		1	450	$500.00	$0.00
Observation, Per hour	G0378		72	762	$5,400.00	$0.00
Observation, Per hour	G0378		12	762	$0.00	$900.00

The PTP Edits – Procedure to Procedure Edits

- Developed to "promote correct coding and to prevent improper payment" when incorrect code combinations are reported.
- Included in the OCE editor for Medicare and in the Outpatient Pricer for Medicaid
- The OCE edits associated with the PTP edits are OCE edit numbers 20 and 40
  - NCCI edits generate a line item rejection

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

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CMS NCCI PTP Edits

- A complete list of the current NCCI PTP edits is available on the CMS web site – Now known as PTP (Procedure to Procedure) Edits
- The lists are updated quarterly

Related Links

Hospital PTP Edits v22.3 effective October 1, 2016 (495,618 records) 0001T/0002T – 29999/C8952
Hospital PTP Edits v22.3 effective October 1, 2016 (375,708 records) 30000/0213T - 49999/49570
Hospital PTP Edits v22.3 effective October 1, 2016 (330,567 records) 50010/0213T - 79999/36000
Hospital PTP Edits v22.3 effective October 1, 2016 (121,873 records) 80003/80002 –R0075/R0070
Practitioner PTP Edits v22.3 effective October 1, 2016 (668,511 records) 0001M/36591 – 29999/G0354
Practitioner PTP Edits v22.3 effective October 1, 2016 (498,018 records) 30000/0213T - 49999/49570
Practitioner PTP Edits v22.3 effective October 1, 2016 (489,682 records) 50010/0213T - 79999/90784
Practitioner PTP Edits v22.3 effective October 1, 2016 (179,162 records) 80003/80002 –R0075/R0070

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html

NCCI Edits Now Impact NY Medicaid APGs

- **Medicaid** National Correct Coding Initiative (NCCI) edits include two types of edits:
  - Procedure-to-Procedure (PTP) edits
  - Medically Unlikely Edits (MUE)
- Medicaid began denying April 1, 2011
  - Modifiers needed to override edits (typically 25 and 59 and their replacement modifiers XS,E,P,U)
- Medicaid and Medicare edits are NOT the same

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Medicaid NCCI PTP Edits

- A complete list of the current Medicaid NCCI edits is available https://www.medicaid.gov/medicaid/data-and-systems/ncci/index.html
- The list is updated quarterly

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NCCI Edits

- NCCI/PTP Edits are code pair edits
- CMS has added a new column with the rationale for the edit
  - Anesthesia service included in the surgical procedure
  - CPT separate procedure definition
  - CPT or CMS manual coding instructions
  - Gender specific procedure
  - HCPCS/CPT procedure code definition
  - Missuse of column 2 code with column 1 code
  - More extensive procedure
  - Mutually Exclusive Procedures
  - Sequential procedures
  - Standards of medical/surgical practice

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CMS NCCI PTP Edits

Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date	Modifier	PTP Edit Rationale
				*=no data	0=not allowed 1=allowed	
					9=not applicab	
50020	49020		19990701	*	1	Mutually exclusive procedures
50020	49405		20140101	*	1	More extensive procedure
50020	49406		20140101	*	1	More extensive procedure
50020	50010		19980401	*	1	Standards of medical / surgical practice
50020	50205		19980401	*	1	More extensive procedure
50020	51701		20071001	*	1	Standards of medical / surgical practice
50020	51702		20071001	*	1	Standards of medical / surgical practice
50020	51703		20071001	*	1	Standards of medical / surgical practice
50020	61650		20160101	20160101	9	Misuse of column two code with column one code

- Code pairs
- Column 2 code is indicated to be included in column code unless unusual circumstance
- 0 = non modifiable, 1 = modifiable, 9 = not applicable

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https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/How-To-Use-NCCI-Tools.pdf

Medicaid NCCI / PTP Edits

- NCCI PTP Edits are **coding pair edits** set up in a similar manner as CMS, though there are some variations in the edits:

Procedure-to-Procedure Edits

The edits in this PTP file are active for dates of service (April 1, 2017 - June 30, 2017). This file should NOT be used by state Medicaid programs as their edit file.

Current Procedural Terminology (CPT) codes, descriptions and other data only are copyright

Column	Columr	Effective Date	Deletion Date	Modifier Indicator 0=not allowed 1= allowed 9= not applicab	PTP Edit Rationale
36430	96360	20101001	20110930	1	Standards of medical / surgical practice
36430	96365	20101001	20110930	1	Standards of medical / surgical practice
36430	96372	20101001	20110930	1	Standards of medical / surgical practice
36430	96374	20101001	20110930	1	Standards of medical / surgical practice
36430	96375	20101001	20110930	1	Standards of medical / surgical practice
36430	96376	20101001	20110930	1	Standards of medical / surgical practice

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Medicaid NCCI / PTP Edits

- There are some Medicaid-specific code pair edits
- For instance, H0049 and H0050 are substance abuse screening and intervention codes for Medicaid
- Generate a Medicaid NCCI edit when billed with an Clinic E/M:

Procedure-to-Procedure Edits

The edits in this PTP file are active for dates of service (April 1, 2017 - June 30, 2017). This file should NOT be used by state Medicaid programs as their edit file.

Column	Column	Effective Date	Deletion Date	Modifier Indicator 0=not allowed 1= allowed 9= not applicab	PTP Edit Rationale
99211	H0050	20110401		1	Standards of medical / surgical practice
99212	H0049	20110401		1	Standards of medical / surgical practice
99212	H0050	20110401		1	Standards of medical / surgical practice
99213	H0049	20110401		1	Standards of medical / surgical practice
99213	H0050	20110401		1	Standards of medical / surgical practice
99214	H0049	20110401		1	Standards of medical / surgical practice
99214	H0050	20110401		1	Standards of medical / surgical practice
99215	H0049	20110401		1	Standards of medical / surgical practice
99215	H0050	20110401		1	Standards of medical / surgical practice

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Example 3 - Modifiable PTP Edit

- The PTP edits with a <u>modifier indicator of 1 may be bypassed with a modifier if appropriate</u>
- Sally is treated in the wound care clinic for two lesions – one on the left leg, the other on the right leg. The lesion on the left leg is debrided, the other lesion is treated with an unna boot.

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Example 3 - Modifiable PTP Edit

- The wound care center reports the services as follows:

Service Description	CPT/HCPCS	Modifier	Units	Revenue Code
Unna Boot	29580	RT	1	761
Debridement, SQ	11042	LT	1	761

- The combination of 11042 and 29580 generates a modifiable NCCI edit:

Column	Column	Effective Date	Deletion Date	Modifier Indicator 0=not allowed 1= allowed 9= not applicab	PTP Edit Rationale
11042	29540	20101001		1	Standards of medical / surgical practice
11042	29550	20101001		1	Standards of medical / surgical practice
11042	29580	20101001		1	Standards of medical / surgical practice
11042	29581	20101001		1	Standards of medical / surgical practice

Example 4-Non-Modifiable PTP Edit

- NCCI edits with a <u>modifier indicator of 0 can never be bypassed with a modifier.</u>
- Parker is sent to the radiology department symptoms of an upper respiratory infection, possible pneumonia. The physician orders a two view chest x-ray, frontal and lateral. The radiology clerk mistakenly charges the chest x-ray twice, once with the CPT® 71015, *chest x-ray stereo, frontal*, and once with the CPT® 71020, *chest x-ray two views, frontal and lateral*.

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Example 4-Non-Modifiable PTP Edit

- The radiology department reports the services as follows:

Service Description	CPT/HCPCS	Modifier	Units	Revenue Code
ER Visit, Lvl 4	99284		1	450
Chest X-ray, 2 view	71020		1	324
Chest X-ray, stereo	71015		1	324

- The combination of 71015 and 71020 generates a non-modifiable NCCI edit. The 71015 must be removed and the claim re-submitted.

71015	71010	20101001		1	More extensive procedure
71015	71020	20101001		0	Mutually exclusive procedures
71015	71023	20101001		1	Mutually exclusive procedures

NCCI – Add-on Edits

- An add-on code is a code that is always performed in conjunction with a primary service
- In most cases Medicare does not reimburse for add-on procedures
- Add-on procedures are often designated with a "+"
- Three types:
  - Type 1 – Add-on code has a limited number of primary codes
  - Type 2 – Add-on code does not have a specific primary code
  - Type 3 – Add-on code has some, but not all, specific primary code

TYPE I - *CPT MANUAL, HCPCS MANUAL,* AND/OR CMS POLICY DEFINES ALL ACCEPTABLE PRIM

ADD-ON CODE	PRIMARY CODE(S)	Effective Date
17314	17313	4/1/2013
17315	17311-17314	4/1/2013
19001	19000	4/1/2013
19082	19081	1/1/2014
19084	19083	1/1/2014
19086	19085	1/1/2014
19126	19125	4/1/2013
19282	19281	1/1/2014
19284	19283	1/1/2014

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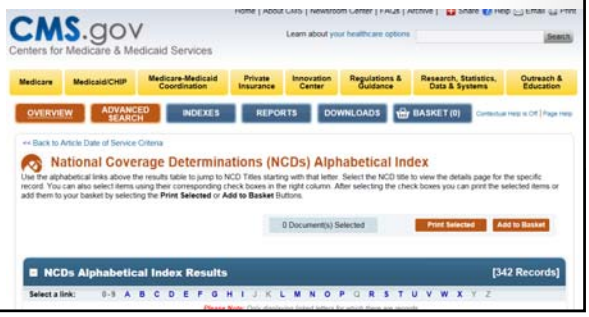
National Coverage Determinations

- Developed at the national level
  - **NCD**s cover the entire country
- May specify services always covered
- May specify services never covered
- Published in CMS Coverage Manual
- Changes with advances in medicine or as coverage rules change



National Coverage Decisions

- Became effective on 11/25/02
- Over 300 currently
- 23 pertain to specific laboratory tests
- Provide acceptable diagnoses required for the treatment and diagnosis of injury or illness
- Medicare will deny payment for a test covered under an NCD or LCD unless the claim contains an approved diagnoses code

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Local Coverage Determinations

- **LCD**s (Local Coverage Determinations) are published by Medicare
- Developed for tests that can be used for screening or diagnosis of disease
  - CPT® codes describe tests and diagnoses codes that determine when coverage is allowed
  - If an LCD test is billed, an diagnoses code included in the LCD must be included on the claim or **Medicare will not pay for the test**
    - ***It is against the law for the Hospital to change or add an diagnoses code submitted by a physician***
    - *The Balanced Budget Act of 1997 made it illegal for physicians to order LCD tests and not supply a diagnosis code with the order* [reason for the test]

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Advance Beneficiary Notices (ABNs)

- Advance Beneficiary Notices (ABNs) allow Hospitals to bill Medicare patients directly for specific tests that are not covered by Medicare

ABNs

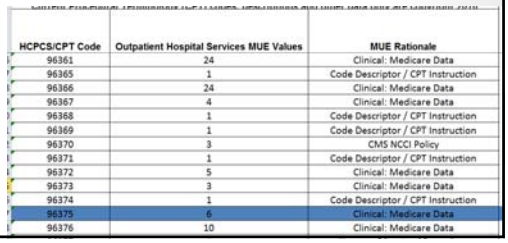
- Cannot bill a Medicare Beneficiary for a test unless the patient is notified in writing that Medicare is not going to pay for the test before the test is provided
  - This notice is called an ABN
- The beneficiary may choose not to have the test performed if they do not want to pay for it
- Hospitals cannot make Medicare beneficiaries sign ABNs
- The ABN must contain the specific name of the test
- The ABN must give a specific reason the Hospital thinks payment for the test will be denied
- The beneficiary should be given a copy of the signed ABN

Guidelines are provided in the CMS Medicare Claims Processing Manual, Chapter 30, Section 50, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf
The latest forms and instructions can be found at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/abn_booklet_icn006266.pdf

Modifier Reporting

What are Modifiers

- Two Characters appended to a CPT® or HCPCS code that modify the meaning of the service
- Required when a combination of codes generates an edit – usually a:
  - Correct Coding Initiative Edit (NCCI/PTP) such as a combination of two primary/initial infusion codes
  - Medically Unlikely Edit (MUE) - such as more than six units of a secondary IVP code 96375 billed to Medicaid



HCPCS/CPT Code	Outpatient Hospital Services MUE Values	MUE Rationale
96361	24	Clinical: Medicare Data
96365	1	Code Descriptor / CPT Instruction
96366	24	Clinical: Medicare Data
96367	4	Clinical: Medicare Data
96368	1	Code Descriptor / CPT Instruction
96369	1	Code Descriptor / CPT Instruction
96370	3	CMS NCCI Policy
96371	1	Code Descriptor / CPT Instruction
96372	5	Clinical: Medicare Data
96373	3	Clinical: Medicare Data
96374	1	Code Descriptor / CPT Instruction
96375	6	Clinical: Medicare Data
96376	10	Clinical: Medicare Data

Modifier 25

- Used when there is a **significant, separately identifiable E/M service** on the same date of service as a significant procedure
- Appended to the E/M code only when the patient requires a separately identifiable E/M service above and beyond the significant procedure

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Modifier – 25 "Picked Apart"

- "**Significant**, **Separately Identifiable** Evaluation and Management Services by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service:
  - It may be necessary to indicate on the day a procedure or service identified by a CPT code was performed, **the patient's condition required** a significant, separately identifiable E/M service **above and beyond the other service** provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed...

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Modifier – 25 "Picked Apart"

…A significant, separately identifiable E/M service is defined or substantiated by **documentation** that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service **may be prompted by the symptom or condition for which the procedure and/or service was provided**. As such, different diagnoses are not required for reporting of the E/M services on the same date. The circumstances may be reported by adding modifier – 25 to the appropriate level of E/M service..."

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Modifier 25

- E.g., Clinic or ED E/M (e.g., 99214, 99285)
- Report an E/M service only if a separately identifiable medical visit has been provided
- Do not report for standard nursing care provided as part of the separate procedure

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When NOT to Report – 25 Modifier

- When there is only an E/M service performed during the office visit (no procedure done)
- When the procedure is so minimal that it is incorporated in the E/M service and does not qualify for a separate CPT®/HCPCS code (e.g., pelvic exam)
- When the patient came in for a scheduled procedure only

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Modifier – 25 Reporting Hints

- Only applied to E/M codes
- Does not require different diagnoses, but, it certainly doesn't hurt
- The modifier is "asking" for payment on both the E/M code and the procedure code
- This is a closely monitored modifier, claims are audited
  - **2005 OIG report found that more than 33% were reported incorrectly, $538 million in improper payments (http://oig.hhs.gov/oei/reports/oei-07-03-00470.pdf)**

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OIG Identified Areas of Concern

Correct Coding Initiative rules further specify that **if the patient evaluation** during a medical visit "**is limited** to whether or not the procedure should be performed, whether comorbidity may impact the procedure, or involves discussion and education with the patient, **[then] an evaluation/management code is not reported separately**."

Source: Chapter 9, NCCI Policy Manual

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OIG Identified Areas of Concern

Appropriate documentation of both the E/M and the procedure must be maintained. **The E/M must clearly describe the E/M elements (History, Exam, MDM).** The documentation must be unambiguous!

- It may help to physically present the documentation as separate notes. This would help to demonstrate that they are separate.
- The E/M should be documented in a similar manner to the way they would document an E/M that was performed without a procedure on the same day.

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CPT Modifier 27 Multiple E&M visits

- Reported when there are multiple Outpatient E/M encounters on the same date of service
  - When a patient receives multiple E/M services by different physicians in multiple OP settings on the same day of service
- Appended to the second visit E/M code

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CPT Modifier 50 Bilateral Procedure

- Used to report bilateral procedures performed during the same operative session
- Should not be used in cases when the code is identified as being bilateral
- Medicare status T's and the APG Grouper/Pricer calculates the payment at 100% for the first procedure and 50% for the second procedure

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Modifier - 59

- ***Distinct Procedural Service*** – Indicates a procedure or service was distinct or independent from others performed on the same day
- Documentation must support:
  - Different session
  - Different procedure/surgery
  - Different site or organ system
  - Separate incision/excision
  - Separate lesion
  - Separate injury

[CPT® book]

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Modifier – 59 "Picked Apart"

- "**Distinct Procedural Service:** Under certain circumstances it may be necessary to indicate that a procedure or service was **distinct or independent** from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures / services, other than E/M, that are **not normally reported together**, but are appropriate under the circumstances. Documentation must support a **different site** or **organ system**, **separate incision/excision**, **separate lesion**, or **separate injury** (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual…"

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Modifier – 59 "Picked Apart"

- "…However, **when another already established modifier is appropriate it should be used rather than modifier 59**. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used…See also page 684, Level II HCPCS/National Modifier Listing"

In other words, modifier – 59 is the modifier of last resort

Source: CPT Professional Edition, 2017

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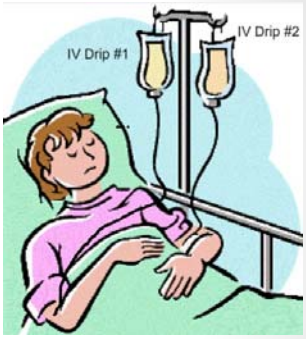
Example 4 - Modifier - 59



- Patient is brought into Emergency Room with a serious infection
- The physician orders two IV infusions in two separate sites with two different antibiotics
- This is reported as 96365x1 and 96365-59x1
- Or 96365x1 and 96365-XUx1

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Modifier – 59 Changes Effective January 2015

- Modifier – 59 is the most widely used modifier
- And, according to CMS, frequently reported inappropriately
- Will over-ride an NCCI and/or MUE edit
  - Modifier – 59 "***often over-rides the edit in the exact circumstances for which CMS created it in the first place. CMS believes that more precise coding options coupled with increased education and selective editing is needed to reduce the errors associated with this overpayment.***"

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Source: MLN Matters Number: MM8863, CR R1422OTN, 8863, Release Date August 15, 2014

Modifier – 59 Changes Effective January 2015

- CMS created four new modifiers that are much more specific
- These can be used in place of modifier – 59
- Modifier – 59 is still available but will be closely watched and should not be used when a new modifier will apply
  - Ultimately modifier – 59 may not be sufficient to bypass certain edits
  - Some edits may be by-passable only with a specific modifier (e.g., XE) but not others

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Source: MLN Matters Number: MM8863, CR R1422OTN, 8863, Release Date August 15, 2014

Modifier – 59 Replacement Modifiers

- **XE Separate Encounter**, A Service That Is Distinct Because It Occurred During A Separate Encounter
- **XS Separate Structure**, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure,
- **XP Separate Practitioner**, A Service That Is Distinct Because It Was Performed By A Different Practitioner, and
- **XU Unusual Non-Overlapping Service**, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service.

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Modifier – 59 Replacement Modifiers

- If possible and if the payer will accept them, it is generally a good policy to utilize the new X modifiers rather than modifier – 59
- They are more specific to the situation warranting a distinct procedure modifier

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CMS Definition of "Encounter"

90.6 - Definition of Encounter (Rev. 1, 10-01-03)

The term "encounter" means a direct personal contact in the hospital between a patient and a physician, or other person who is authorized by State law and, if applicable, by hospital staff bylaws to order or furnish services for diagnosis or treatment of the patient. Direct personal contact does not include telephone contacts between a patient and physician…Patients will be treated as hospital outpatients for purposes of billing for certain diagnostic services that are ordered during or as a result of an encounter that occurred while such patients are in an outpatient status at the hospital…When a patient has follow-up visits with a physician in the hospital following an initial encounter, each subsequent visit to the physician will be treated as a separate encounter for billing.

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Chapter 2, Medicare Claims Processing Manual, Section 90.6

Other Modifiers

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Modifier 26 – Professional Service

- Modifier – 26 is would only be reported on a professional claim (CMS-1500)
- It is reportable only with CPT/HCPCS that are associated with a – 26 modifier on the MPFS (or Epoch OP Resource)
- These are generally radiology services:
  - E.g., 76942 , US guidance
- Or other services like spirometry or fetal non-stress tests
  - 94010, spirometry
  - 59025, fetal non-stress test
- Utilized to indicate the professional interpretation and report services

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Modifier 26 – Professional Service

HCPCS	Mod	Short Description	APC	Add B HCPCS Status Indicator	Add A APC Status Indicator	National APC Rate	50% of the OPPS Payment	Carrier 13282 Locality 99 POS 11	Carrier 13282 Locality 99 POS 19/22
59025		Fetal non-stress test	5411	T	T	152.15	$76.08	46.87	46.87
59025	26	Fetal non-stress test	5411	T	T	152.15	$76.08	29.35	29.35
59025	TC	Fetal non-stress test	5411	T	T	152.15	$76.08	17.53	17.53
76942		Echo guide for biopsy	0	N		0	$0.00	59.18	59.18
76942	26	Echo guide for biopsy	0	N		0	$0.00	33.2	33.2
76942	TC	Echo guide for biopsy	0	N		0	$0.00	25.99	25.99
94010		Breathing capacity test	5721	Q1	S	127.05	$63.53	34.71	34.71
94010	26	Breathing capacity test	5721	Q1	S	127.05	$63.53	8.39	8.39
94010	TC	Breathing capacity test	5721	Q1	S	127.05	$63.53	26.33	26.33

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Modifiers – 76 and - 77

- Modifier – 76: *Repeat procedure or service by same clinician*
- Modifier – 77: *Repeat procedure or service by different clinician*
- Applicable for repeat procedures on the same date of service
- May by-pass an MUE MAI 1 edit when applicable and appropriate
- Guidelines tell us to utilize these modifiers before we utilize modifier - 59

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Modifier - 76

- Repeat EKG in a single day (93005)
  - MUE of 5, MAI of 1
- Repeat 94640, *non-pressurized inhalation treatment for acute airway obstruction*
  - Per CPT, report modifier – 76 when performed more than once per day
  - MUE of 2, MAI of 3
- Two injections of the same drug in a single day
  - 96401 – MUE of 4, MAI of 3
  - E.g., 96401, *chemotherapy (or MAB) SQ/IM injection, non-hormonal,* - 76

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Modifier – 91

- Modifier – 91: *Repeat clinical diagnostic laboratory test*
- Applicable for repeat lab test on the same date of service to obtain subsequent test results, for instance to see whether a patient is getting better or worse due to treatment

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Modifier – 91 Example 5

- Repeat troponin (84484)
  - MUE of 4, MAI of 3
- Repeat EKG in a single day (93005)
  - MUE of 5, MAI of 1
- Physician refers a patient to observation for chest pain, he orders four repeat troponins (84484) and three EKGs (93005) during the stay to R/O MI
- 93005 84484
- 93005 x 2 – 76 84484 x 3 -91

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Modifier – 91 Example 6

- Basic metabolic panel (80048) and electrolyte panel (80051)
- Physician orders a basic metabolic panel (80048). After reviewing the results and treating the patient, he orders a follow-up electrolyte panel (80051)
- 80048
- 80051-91

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Medicare ABN Specific Modifiers

- GA – Waiver of liability statement issued as required by payer
  - Indicates that an ABN is on file
  - Upon denial, Medicare will automatically assign the beneficiary liability
- GX – Waiver of liability issued, voluntary under payer policy
  - Indicates that a voluntary ABN was issued for non-covered services
  - Covered charges will be rejected by Medicare
  - Additional information: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6563.pdf

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Medicare ABN Specific Modifiers

- GY – Notice of liability not issued, not required for a non-covered service
  - Services that are statutorily excluded from Medicare do not require an ABN
  - E.g., shingles vaccine (not covered by Medicare)
- GZ – Service expected to be denied as not reasonable and necessary
  - ABN may have been required but was not obtained
  - This is a claim-line specific modifier

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Other Professional Modifiers of Note

- 51 – *Multiple procedures (other than E/M) by the same provider at the same session*
  - Applied to the secondary code
  - Generally results in a discounted payment for that procedure
  - Appendix E of CPT lists exempt procedures
  - E.g., colonoscopy and upper endoscopy
- 58 - *Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period*
- 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*
- 79 - *Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period*

Modifier Reporting Summary

Correct Reporting of Modifiers

- Modifiers in general are used to bypass a billing edit and allow a particular line-item to be paid
- Should only be applied when the medical record documentation and medical necessity warrant the application of the modifier
- Frequently require a review of the medical record before they can be applied

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Correct Reporting of Modifiers

- The requirement for a modifier, especially if frequent, often indicates a miss-reporting of the service
- That is, a bundled service is being incorrectly “exploded” or miss-charged
- The root cause should be identified and corrected in these cases

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Questions and Discussion

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