**Applicable To:**
☑ Medicaid - Kentucky

# Claims and Payment Policy: Prepay Code & Modifier Validation (Kentucky)

**Policy Number: CPP-152**

**Original Effective Date: 01/01/2020**
**Revised Date(s): N/A**

## BACKGROUND

In 1996, the Centers for Medicare & Medicaid Services (CMS) began the National Correct Coding Initiative (NCCI) to promote correct coding and to prevent payment of inappropriately coded services. Within the NCCI, CMS defines code pairs that generally should not be billed together for the same patient on the same date of service. otherwise referred to as Procedure to Procedure (PTP), Mutually Exclusive and Global Package rules. These rules define procedures and explain which components are included within each specific procedure code. When billing certain procedures on the same date of service, providers can append modifiers to a service or procedure to indicate a change in circumstance of the service delivery. A modifier is a two character code that indicates a service or a procedure has been altered by some specific circumstance but has not changed in its definition or code.There are several modifiers that can override standard code edits from being applied and this can lead to incorrect coding and reimbursement.

## RATIONALE

Over the last decade, the Department of Health and Human Services (HHS) and the Office of Inspector General (OIG) have performed audits of the usage of some of the modifiers that override edits and found that:

- Modifier 59 (distinct procedural service) was used incorrectly 40% of the time
- Modifier 25 (significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) was used incorrectly 35% of the time

Due to a continued high rate of incorrect usage of modifiers, such as modifier 59 which defines Distinct Procedural Services, the OIG has recommended implementation of prepayment review of modifiers based on information in the patient's claim history. CMS encourages carriers to reexamine provider modifier 25 (Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service) usage and presently includes modifier 25 reviews in their prepayment review strategies.

## POSITION STATEMENT

Due to the significant impact of incorrect coding as demonstrated through recent research and statistical analysis, WellCare has decided to follow the OIG's recommendations for additional prepay claims and record review.

A number of edits, including but not limited to NCCI edits, are embedded within WellCare's claims processing system to identify claims that may be coded inappropriately. The system analyzes each claim and compares it to previous claims for the patient. When a claim line is found that does not adhere to correct coding rules, an edit is assigned to a claim line. Typically, these edits result in a denial or adjustment of a claim line.



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WellCare is implementing additional edits and processes which further ensure coding assignment is accurate.

If a provider does not agree with payment they may appeal the denial. Wellcare will require medical records that substantiate the billing of the code pair and/or modifier as correct.

## APPLICATION

Wellcare has developed algorithm to look for the justification of modifiers that override edits. The support for modifier usage can be found using information from a patient's past claim history and present claim adjudication. This claim review is conducted by registered nurses (RNs) trained as coders who are AAPC or AHIMA certified. These Nurse Coders use their coding acumen to review claims data to determine if additional provider payment is warranted.

Nationally sourced guidelines are utilized to ensure correct usage of modifiers. The guidelines for appropriate use of modifiers are well documented in Current Procedural Terminology (CPT) manuals, Coding with Modifiers, CPT Assistant, CMS's National Correct Coding Initiative (NCCI) Policy Manual, Claims Processing Manual, Benefit Manual, MLN Matters and the Federal Register.

## CODE & MODIFIER VALIDATION

Each of the edits below include the additional review of claim and claim history information.

**Medicaid/Medicare NCCI Modifier Review**

In the Introductory chapter of the NCCI Policy Manuals it states in part "The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding".

The NCCI Policy Manual describes PTP edits as follows "…edits prevent inappropriate payment of services that should not be reported together. Each edit has a column one and column two HCPCS/CPT code. If a provider reports the two codes of an edit pair for the same beneficiary on the same date of service, the column one code is eligible for payment, but the column two code is denied unless a clinically appropriate NCCI-associated modifier is also reported."

Another type of edit is mutually exclusive code pairs. NCCI states "Mutually exclusive procedures cannot reasonably be performed at the same anatomic site or same patient encounter. An example of a mutually exclusive situation is the repair of an organ that can be performed by two different methods. Only one method can be chosen to repair the organ. A second example is a service that can be reported as an "initial" service or a "subsequent" service."

"Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier." The NCCI Policy Manual further states "Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier used."

CMS "pays for an E/M service provided on the day of a procedure with a global fee period if the physician indicates that the service is for a significant, separately identifiable E/M service that is above and beyond the usual pre- and post-operative work of the procedure." Chapter 12, Section 30.6.6.B. When modifier 25 is used documentation needs to satisfy the relevant criteria for the respective E/M service.

Modifier 58 is used to report staged or related procedures done within the post-operative period of another procedure. If the procedure is a complication that does not require return to the O.R. it may not be reimbursable. Documentation needs to indicate that the procedure was planned pre-operatively, at the time of the original procedure, is more extensive than the original procedure, or is a therapeutic follow a diagnostic procedure. Chapter 12, Section 40.2.6. If documentation does not support a staged or related procedure the code will be denied as fragmented billing.

For the purposes of NCCI, modifier 59 should be used "to indicate that two or more procedures are performed at different anatomic sites or at different patient encounters. One function of NCCI PTP edits is to prevent payment for codes that report overlapping services except in those instances where the services are "separate and distinct." Per NCCI Policy Manual, Chapter 2, Section E.1.d., when reviewing claim lines with modifier 59, or one of the X modifiers listed below, WellCare will be looking for documentation that supports "a different session, different procedure or surgery, 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." Chapter 2, Section E.1.d further describes the correct use of the X modifiers:

XE – "Separate encounter, A service that is distinct because it occurred during a separate encounter" This modifier shall only be used to describe separate encounters on the same date of service.

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".

XU – "Unusual Non-Overlapping Service, The use of a service that is distinct because it does not overlap usual components of the main service"

**Global Surgical Procedure Clinical Review**

As defined by the AMA and as implemented by CMS, WellCare follows the surgical (global) package concept which bundles all normal pre, intra and post-operative care into a package. Wellcare will not pay for fragmented billing of services included in the surgical (global) package. These edits identify situations where there is fragmented billing of E/M codes or procedures as indicated by the presence of modifiers 24, 25, 27, 57, 58, 78 or 79 within the global period of another procedure. Separate payment will be allowed when there is sufficient documentation that the visit or procedure is unrelated to the surgical (primary) procedure.

CMS states modifier 24 should be used only when E/M services are "absolutely unrelated to the surgery".

CMS "pays for an E/M service provided on the day of a procedure with a global fee period if the physician indicates that the service is for a significant, separately identifiable E/M service that is above and beyond the usual pre- and post-operative work of the procedure." Chapter 12, Section 30.6.6.B. When modifier 25 is used documentation needs to satisfy the relevant criteria for the respective E/M service".

Modifier 27 is like modifier 25 except it is for use by facilities.

Modifier 57 indicates the E/M service resulted in the decision for surgery performed on the day of or the day before a procedure with a 90-day global period. If the E/M service is part of the standard pre-operation care for the surgical procedure it will not be allowed.

Modifier 58 is used to report staged or related procedures done within the post-operative period of another procedure. If the procedure is a complication that does not require return to the operating room it may not be reimbursable. Documentation needs to indicate the procedure was planned pre-operatively or at the time of the original procedure or is more extensive than the original procedure or is a therapeutic follow a diagnostic procedure. Chapter 12, Section 40.2.6. If documentation does not support a staged or related procedure the code will be denied as fragmented billing.

Modifier 78 indicates a return trip to the OR to handle complications from the original procedure on the same day or within the post-operative period. CMS states additional payment will be allowed to "treat complications of the original surgery". Chapter 12, Section 40.4.C.

Modifier 79 identifies unrelated procedures during the post-operative period of another procedure. If documentation does not support an unrelated procedure it will be denied as fragmented billing.

**Multiple Evaluation and Management**

Both the AMA and CMS have rules regarding the billing multiple E/M services on the same day for the same patient. CMS does "not pay two E/M office visits billed by a physician (or physician of the same specialty from the same group practice) for the same beneficiary on the same day unless the physician documents that the visits were for unrelated problems in the office, off campus-outpatient hospital, or on campus-outpatient hospital setting which could not be provided during the same encounter (e.g., office visit for blood pressure medication evaluation, followed five hours later by a visit for evaluation of leg pain following an accident)." Chapter 12, Section 30.6.7.B. Modifiers 25 and 27 (for outpatient facility claims) are used to identify situations where two E/M services are for the treatment of "significant and

separate" services that are above and beyond the other service provided. During review we will be looking for information that satisfies the relevant criteria for the respective E/M service.

### Unbundled AMA Modifier Review

These edits are code combinations that the parenthetical notes in CPT state should not be billed together. WellCare will use the guidelines defined by CPT for modifiers that override these edits as described in the other Clinical Validation edits.

### Cross Provider Duplicates

This edit identifies situations where two providers have billed the same procedure code for the same patient on the same day of service. In many instances it is appropriate and expected to have the same code billed by more than one provider. However, this situation represents a potential duplication of services or procedures. Analysts, using their acumen of medical processes and procedures will review the information available on the claim and in the claim history to determine if it is likely both procedures were performed or it if is likely it is a coding or billing error. Examples of this coding issue are when an emergency room physician bills for the professional component of an EKG when a cardiologist also bills for the interpretation of the EKG.

### Range Provider Duplicates

This edit is like the Cross Provider Duplicate edit in that it identifies multiple providers billing the on the same day for the same patient, however, in this edit the procedure codes represent different levels of the same service. For example, one provider bills a 99213 and the other bills a 99214. Since only one E/M service is usually allowed per day except when the providers are from different areas of specialty or are treating different conditions, Analysts will use the provider's specialty and if absence other public information to determine if the providers are from different specialties or treating different conditions. More than one provider of the same specialty/subspecialty billing within a level of service for E/M services will be denied.

### Add-on CPT Clinical Validation

This edit identifies add-on codes that are not reimbursable because the primary code(s) have been denied by a clinical validation edit. Some codes in the CPT Manual are identified as "add-on" codes which describe a service that can only be reported in addition to a primary procedure. CMS states that "the reason for these CPT codes is to enable physicians and others to separately identify a service that is performed in certain situations as an additional service." Chapter 12, Section 30.D. When all of the primary procedures for the add-on code are denied the add-on code will also be denied

## CODING & BILLING

All applicable ICD 10 CM, CPT Category I, II and III codes; HCPCS Level II codes.

## MODIFIERS

The following modifiers may be used under appropriate clinical circumstances to bypass an NCCI PTP edits, Mutually Exclusive, AMA Unbundling and Global Package edits:

| Modifier | Type | Description |
|---|---|---|
| E1 | Anatomical | Upper left |
| E2 | Anatomical | Lower left |
| E3 | Anatomical | Upper right |
| E4 | Anatomical | Lower right |
| FA | Anatomical | Left hand thumb |
| F1 | Anatomical | Left hand, second digit |
| F2 | Anatomical | Left hand , third digit |
| F3 | Anatomical | Left hand, fourth digit |
| F4 | Anatomical | Left hand, fifth digit |

| | | |
|---|---|---|
| F5 | Anatomical | Right hand, thumb |
| F6 | Anatomical | Right hand, second digit |
| F7 | Anatomical | Right hand, third digit |
| **F8** | Anatomical | Right hand, fourth digit, |
| **F9** | Anatomical | Right hand, fifth digit |
| TA | Anatomical | Left foot, great toe |
| T1 | Anatomical | Left foot, second digit |
| T2 | Anatomical | Left foot, third digit |
| T3 | Anatomical | Left foot, fourth digit |
| T4 | Anatomical | Left foot, fifth digit |
| T5 | Anatomical | Right foot, great toe |
| T6 | Anatomical | Right foot, second digit |
| T7 | Anatomical | Right foot, third digit |
| T8 | Anatomical | Right foot, fourth digit |
| T9 | Anatomical | Right foot, fifth digit |
| LT | Anatomical | Left side of the body |
| RT | Anatomical | Right side of the body |
| LC | Anatomical | Left circumflex coronary artery |
| LD | Anatomical | Left anterior descending coronary artery |
| RC | Anatomical | Right coronary artery |
| LM | Anatomical | Left main coronary artery |
| RI | Anatomical | Ramus intermedius |
| 24 | Global Package | Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional during a Post-Operative Period |
| 25 | Global Package/Multiple E/M | Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service |
| 27 | Multiple E/M | Multiple Outpatient Hospital Evaluation and Management Encounters on the Same Date |
| 57 | Global Package | Decision for Surgery |
| 58 | Global Package | Staged or Related Procedure or Service by the Same Physician or other Qualified Health Care Professional during the Post-Operative Period |
| 59 | Distinct Procedural Service | Distinct Procedural Service |
| 78 | Global Package | 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 Post-Operative Period. |
| 79 | Global Package | Unrelated Procedure or Service by the Same Physician during the Post-Operative Period |
| XE | Distinct Procedural Service | Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter |
| XS | Distinct Procedural Service | Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure |
| XP | Distinct Procedural Service | Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner |
| XU | Distinct Procedural Service | Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service |
| 91 | Other | Repeat Clinical Diagnostic Laboratory Test |

## DEFINITIONS

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|---|---|
| **Anatomical Modifier** | Anatomical modifiers designate the area or part of the body on which the procedure is performed on different sites during the same session. |
| **Evaluation and Management Coding** | Evaluation and management coding (commonly known as E/M coding or E&M coding**)** is a medical coding process in support of medical billing**.** Practicing health care providers in the United States must use E/M coding to be reimbursed by Medicare, Medicaid programs, or private insurance for patient encounters. |
| **Modifiers** | A modifier is a two character code that indicates a service or a procedure has been altered by some specific circumstance but has not changed in its definition or code. |
| **Mutually Exclusive Procedures** | NCCI mutually exclusive procedures cannot reasonably be performed at the same anatomic site or same patient encounter. |
| **NCCI** | The Center for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) promotes national correct coding methodologies and reduces improper coding which may result in inappropriate payments of Medicare Part B claims and Medicaid claims. |
| **Procedure to Procedure (PTP)** | NCCI procedure-to-procedure (PTP) edits define pairs of Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported |

## REFERENCES

1. American Medical Association including the following publications: Current Procedural Terminology (CPT®), Principles of CPT Coding, Coding With Modifiers, CPT Assistant.
2. Centers for Medicare and Medicaid Services (CMS) including: National Correct Coding Initiative (NCCI) edit files, NCCI Policy Manual, MLN Matters, Transmittals.
3. Centers for Medicare and Medicaid Services (CMS) publications including but not limited to: Claims Processing Manual, Benefit Policy Manual, MLN Matters, Federal Register, NPFS files and support manuals and other publications.
4. Individual state Medicaid regulations, manuals & fee schedules.

## IMPORTANT INFORMATION ABOUT THIS DOCUMENT

Claims and Payment Policies (CPPs) are policies regarding claims or claim line processing and/or reimbursement related to the administration of health plan benefits. They are not recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for diagnosing, treating, and making clinical recommendations to the member. CPPs are subject to, but not limited to, the following:

- State and federal laws and regulations;
- Policies and procedures promulgated by the Centers for Medicare and Medicaid Services, including National Coverage Determinations and Local Coverage Determinations;
- The health plan's contract with Medicare and/or a state's Medicaid agency, as applicable;
- Other CPPs and clinical policies as applicable including, but not limited to, *Pre-Payment and Post-Payment Review*.
- The provisions of the contract between the provider and the health plan; and

- The terms of a member's particular benefit plan, including those terms outlined in the member's Evidence of Coverage, Certificate of Coverage, and other policy documents.

In the event of a conflict between a CPP and a member's policy documents, the terms of a member's benefit plan will always supersede the CPP.
The use of this policy is neither a guarantee of payment, nor a prediction of how a specific claim will be adjudicated. Any coding information is for informational purposes only. No inference should be made regarding coverage or provider reimbursement as a result of the inclusion, or omission, in a CPP of a CPT, HCPCS, or ICD-10 code. Always consult the member's benefits that are in place at time of service to determine coverage or non-coverage. Claims processing is subject to a number of factors, including the member's eligibility and benefit coverage on the date of service, coordination of benefits, referral/authorization requirements, utilization management protocols, and the health plan's policies. Services must be medically necessary in order to be covered.
References to other sources and links provided are for general informational purposes only, and were accurate at the time of publication. CPPs are reviewed annually but may change at any time and without notice, including the lines of business for which they apply. CPPs are available at www.wellcare.com. Select the "Provider" tab, then "Tools" and then "Payment Guidelines".

## RULES, PRICING & PAYMENT COMMITTEE HISTORY AND REVISIONS

| Date | Action |
|---|---|
| MM/DD/YYYY | • Approved by RGC |