## PAYMENT POLICY

# CMS CORRECT CODING INITIATIVE: UNBUNDLING EDITS

| POLICY NUMBER: | CC.PP.031 | ORIGINAL EFFECTIVE DATE: | 01/01/2013 |
|---|---|---|---|
| PRODUCT TYPE(S): | ALL | REVISION EFFECTIVE DATE: | NOT APPLICABLE |

**IMPORTANT REMINDER**

This policy is current at the time of publication. Centene Corporation retains the right to change or amend this policy at any time.

While this policy provides guidance regarding reimbursement, it is not intended to address every reimbursement situation. In instances that are not specifically addressed by this policy, or addressed by another policy or contract, Centene Corporation retains the right to use reasonable discretion in interpreting this policy and applying it (or not applying it) to the reimbursement of services provided to all or certain members. The provider is responsible for the accuracy of all claims.

This policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this policy or any information contained herein are strictly prohibited.

This policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2014, American Medical Association. All rights reserved. CPT® codes and CPT® descriptions are from current 2016 manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Providers and members are bound by the foregoing terms and conditions, in addition to the Site Use Agreement for Health Plans associated with Centene Corporation.

**Note:** For Medicaid members, when state Medicaid coverage provisions are controlling and conflict with the coverage provisions in this policy, state Medicaid coverage provisions take precedence. In such instance, please refer to the state Medicaid manual for any coverage provisions pertaining to this policy.

### Policy Overview

The health plan administers unbundling edits based on the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI). These edits are further

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defined as procedure-to-procedure (PTP) code pair edits. The health plan administers these edits for professional and outpatient facility claims.

CMS developed the NCCI to promote national correct coding principles and facilitate correct provider reimbursement for medical services performed on patients. The NCCI edit reimbursement methodologies dictate that when two relatable procedure codes are billed for the same member, by the same provider and on the same date of service, only the most comprehensive of those codes is reimbursable. Therefore, physicians should not report multiple CPT codes when a single, more comprehensive code represents all services performed.

The Health Plan administers automated prepayment claims edits to incorrectly billed code pairs.

CMS organizes the code pairs into column 1/column 2 edits. The column 2 code represents the code that should not have been billed. The column 1 code is the more comprehensive code. This file also contains mutually exclusive code pairs. Mutually exclusive procedures are two procedures that could not have been performed during the same patient encounter because of anatomic, temporal or gender considerations.

The CMS NCCI edit reimbursement methodologies are based on correct coding principles established by the American Medical Association (AMA) CPT manual, national and local policies, public-domain specialty society groups, current medical practice and etc.

The CMS publishes a reference document, the *NCCI Policy Manual for Medicare Services* to offer insight into the reimbursement policies used to develop the edits.

The CMS NCCI edit tables are updated on an annual basis and loaded on the CMS website listed below:

**http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html**

## Application

PTP edits apply to both professional and outpatient facility claims on a prepayment basis.

***Outpatient Code Editor***

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PTP edits for outpatient institutional providers subject to the Outpatient Prospective Payment System (OPPS) and hospitals that are non-OPP are housed within the Outpatient Code Editor (OCE).

## Modifier Use

Specific modifiers may be used to indicate that a clinical circumstance made reporting of the two codes appropriate. The use of these modifiers is validated by the clinical review team on a prepayment basis to ensure clinical appropriateness and adherence to correct coding principles. The patient's clinical situation must support use of the modifier. Providers should not modifiers solely to bypass edits.

Each NCCI PTP edit is assigned a specific modifier indicator. Based on the indicator assigned, the provider 1) may not use a modifier to override the edits, 2) a modifier may be used, or 3) the edit has been deleted and the modifier is no longer appropriate

### *Modifier Indicators*

| CMS NCCI Modifier Indicators | Description |
|---|---|
| **0** | Modifiers may not be used to override edits for the particular code pair scenario |
| **1** | Modifier may be used (with appropriate clinical documentation) to override the edit |
| **9** | Procedure-to-procedure code edit has been deleted and modifier is no longer appropriate for use |

Clinically appropriate modifiers for use with the NCCI column 1/column 2 edits are listed below. When the modifier(s) is necessary, apply to the column 2 code.

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- ***Anatomical Modifiers***
  E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI
- ***Global Surgery Modifiers***
  -24, -25,-57, -58, -78, -79.
- ***Additional Modifiers***
  -27, -59, -91, -XE, -XS, -XP, -XU

## Claims Reimbursement Edit

The code editing software analyzes professional and outpatient institutional claims for adherence to correct coding principles. The software's logic contains the CMS NCCI column1/column 2 tables and will reference these tables to determine when multiple procedure codes were billed instead of a single, more comprehensive code. When this occurs, these services will be denied.

The Health Plan will deny all claims billed with an NCCI procedure-to-procedure procedure code combination.

## Prepayment Clinical Review of Appropriate Use of Modifier

The health plan will conduct ***prepayment clinical validation*** of all PTP edit combinations billed with a valid NCCI modifier. The health plan's clinical review team will conduct a clinical ***claims*** review to determine if the modifier is clinically appropriate for the coding scenario.

## Claim Documentation Requirements

Below are some examples of required documentation for use of certain modifiers:

- The diagnosis codes on the claim indicate multiple conditions or sites were treated or are likely to be treated – Modifier -59
- Claim history for the patient indicates that diagnostic testing was performed on multiple body sites or areas which would result in procedures being performed on multiple body areas and sites. To avoid incorrect denials providers should assign to the claim all applicable diagnosis and procedure codes use all applicable anatomical modifiers designating which areas of the body were treated – Modifier 59
- Claim history indicates a separate patient encounter – Modifier 59

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- If the E/M service is the first time the provider has seen the patient or evaluated a major condition. – Modifier -25
- A diagnosis on the claim indicates that a separate medical condition was treated in addition to the procedure that was performed – Modifier -25
- The patient's condition is worsening as evidenced by diagnostic procedures being performed on or around the date of services. – Modifier - 25
- If a provider bills supplies or equipment, on our around the same date, that are unrelated to the procedure performed but would have required an E/M services to determine the patient's need. . – Modifier - 25
- Staged or related procedures performed by the same physician – Modifier 58

## Coding and Modifier Information

| CPT/HCPCS/ICD Code | Descriptor |
|---|---|
| [Insert code] | [Insert descriptor] |

| Modifier | Descriptor |
|---|---|
| E1 | Upper Left, Eyelid |
| E4 | Lower right eyelid |
| FA | Left hand, thumb |
| F1 | Left Hand, Second Digit |
| F2 | Left Hand, Third Digit |
| F3 | Left Hand, Fourth Digit |
| F4 | Left Hand, Fifth Digit |
| F5 | Right Hand, Thumb |
| F6 | Right Hand, 2nd Digit |
| F7 | Right Hand, 3rd Digit |
| F8 | Right Hand, 4th Digit |
| F9 | Right Hand, 5th Digit |
| TA | Left Foot, Great Toe |
| T1 | Left Foot, 2nd Digit |
| T2 | Left Foot 3rd Digit |

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|---|---|
| T3 | Left Foot, 4th Digit |
| T4 | Left Foot, 5th Digit |
| T5 | Right Foot, Great Toe |
| T6 | Right Foot, 2nd Digit |
| T7 | Right Foot, 3rd Digit |
| T8 | Right Foot, 4th Digit |
| T9 | Right Foot, 5th Digit |
| LT | Left Side |
| RT | Right Side |
| LC | Left Circumflex Coronary Artery |
| LD | Left Anterior Descending Coronary Artery |
| RC | Right Coronary Artery |
| LM | Left Main Coronary Artery |
| RI | Ramus Intermediary Coronary Artery |
| 24 | Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period: The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service. |
| 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: It may be necessary to indicate that 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 |
| 57 | Decision for Surgery: An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service. |

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| 58 | Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period: It may be necessary to indicate that the performance of a procedure or service during the postoperative period was (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure |
| 59 | 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 services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support 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. 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 |
| 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: It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.) |

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| 79 | Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period: The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure |
| 27 | Multiple Outpatient Hospital E/M Encounters on the Same Date: For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (eg, hospital emergency department, clinic). Note: This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient evaluation and management services provided by the same physician on the same date and performed in multiple outpatient setting(s) (eg, hospital emergency department, clinic), see Evaluation and Management, Emergency Department, or Preventive Medicine Services codes |
| 91 | Repeat Clinical Diagnostic Laboratory Test: In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. Note: This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used |

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| | for laboratory test(s) performed more than once on the same day on the same patient |
| 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 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 |

**Definitions**

1. **Patient Encounter** – An interaction between a health care provider and a patient.
2. **Prepayment Clinical Validation** – Claims reviewed by a registered nurse who is also a Certified Professional Coder. Claims are reviewed post claims adjudication, but prior to payment
3. **CMS NCCI –** Centers for Medicare and Medicaid Services, National Correct Coding Initiative

## Related Documents or Resources

1. *Current Procedural Terminology (CPT)*®, 2016
2. *HCPCS Level II*, 2016
3. *http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*
4. *CC.PP.014: Distinct Procedural Service: Modifier 59*
5. *CC.PP.020: Distinct Procedural Modifiers: XE, XS, XP and XU*
6. *CC.PP.013: E/M Related Modifiers: Modifier 25*
7. *http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html*

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| REVISION HISTORY | |
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| 09/09/2016 | Added suggested resource |