Payment Policy: CMS Correct Coding Initiative: Unbundling Edits

Reference Number: LA.PP.031
Product Types: All
Last Review Date: 08/2022~~1~~

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
Louisiana Healthcare Connection administers unbundling edits based on the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI). These edits are further 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 related 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.

Louisiana Healthcare Connections 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~~
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index

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

Outpatient Code Editor

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).

Policy Description

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 use 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 under appropriate clinical circumstances, 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.

- *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

Reimbursement

The code editing software analyzes professional and outpatient institutional claims for adherence to correct coding principles. The software's logic contains the CMS NCCI column 1/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.

Documentation Requirements

Below are some examples of required documentation or circumstances 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 and use all applicable anatomical modifiers designating which areas of the body were treated – Modifier -59
- Claim history indicates a separate patient encounter – Modifier -59
- 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
- The provider bills supplies or equipment, on or around the same date, that are unrelated to the procedure performed but would have required an E/M service to determine the patient's need – Modifier -25
- Staged or related procedures performed by the same physician – Modifier -58

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 20~~19~~21, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

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CPT/HCPCS Code	Descriptor
NA	NA

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
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
22	Increased Procedural Services
23	Unusual Anesthesia
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period

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
26	Professional Component
27	Multiple Outpatient Hospital E/M Encounters on the Same Date
32	Mandated Services
33	Preventive Service
47	Anesthesia by Surgeon
50	Bilateral Procedure
51	Multiple Procedures
52	Reduced Services
53	Discontinued Procedure
54	Surgical Care Only
55	Postoperative Management Only
56	Preoperative Management Only
57	Decision for Surgery
58	Staged or Related Procedure or Service by the Same Physician During the Postoperative Period
59	Distinct Procedural Service
62	Two Surgeons
63	Procedure Performed on Infants less than 4 kg
66	Surgical Team
73	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia
74	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia
76	Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional
77	Repeat Procedure or Service by Another Physician or Other Qualified Health Care Professional
78	Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period
79	Unrelated Procedure or Service by the Same Physician During the Postoperative Period
80	Assistant Surgeon
81	Minimum Assistant Surgeon
82	Assistant Surgeon (when qualified resident surgeon not available): The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).
90	Reference (Outside) Laboratory
91	Repeat Clinical Diagnostic Laboratory Test
92	Alternative Laboratory Platform Testing

95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System
96	Habilitative Services
97	Rehabilitative Services
99	Multiple Modifiers
AA	Anesthesia Services Performed Personally by Anesthesiologist
AD	Medical Supervision by a Physician: More than 4 Concurrent Anesthesia Procedures
AR	Physician Provider Services in a Physician Scarcity Area
AS	Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist Services for Assistant at Surgery
QK	Medical direction of two, Three, or four concurrent anesthesia procedures involving qualified individuals.
QS	Monitored anesthesia care service
QW	CLIA Waived Test
QX	CRNA Service : With Medical Direction by a Physician
QY	Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist.
QZ	CRNA Service: Without medical direction by a physician
TC	Technical Component
XE	Separate encounter, a service that is distinct because it occurred during a separate encounter
XP	Separate practitioner, a service that is distinct because it was performed by a different practitioner

ICD-10 Codes	Descriptor
NA	NA

Definitions

1. *HealthCare Common Procedure Coding System* (HCPCS), Level I Modifiers: Also known as CPT modifiers consisting of two numeric digits. These modifiers are in the range of 22-99. The list is updated annually by the AMA.
2. *HealthCare Common Procedure Coding System* (HCPCS), Level II Modifiers: Also known as the HCPCS modifiers and consist of two alpha-numeric characters. These modifiers are in the range of AA-VP. The list is updated annually by the CMS.
3. *Modifier*: Two digit numeric or alpha-numeric descriptor that is used by providers to indicate that a service or procedure has been altered by a specific circumstance, but the procedure code and definition is unchanged.
4. *Modifiers Affecting Payment*: Modifiers which impact how a claim or claim line will be reimbursed.
5. *Patient Encounter:* An interaction between a health care provider and a patient.

6. *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.
7. *CMS NCCI:* Centers for Medicare and Medicaid Services, National Correct Coding Initiative

Related Documents or Resources

1. *Current Procedural Terminology (CPT)*®, 20~~19~~21
2. *HCPCS Level II*, 201
3. ~~*http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*~~ *http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index*

~~3.~~

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 Clinical Validation of Modifier -25*
7. ~~*https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html*~~https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html

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References

~~8.~~**1** *Current Procedural Terminology (CPT®)*, 20~~19~~21

2 ~~*https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html*~~*https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS*

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~~10.~~**3** *HCPCS Level II*, 20~~19~~21

~~11.~~**4** *International Classification of Diseases*, Tenth Revision, Clinical Modification (ICD-10-CM), 20~~19~~21

~~12.~~**5** *ICD-10-CM Official Draft Code Set*, 20~~19~~21

~~13.~~**6** *Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services.*

Revision History

08/15/2020	Converted corporate to local policy.
08/30/2022	Annual Review; Updated dates and links in the reference section from 2019 to 2021 Removed clinical and added payment policy in "Important Reminder" section

Important Reminder

This ~~clinical policy~~payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this ~~clinical policy~~payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this ~~clinical policy~~payment policy. This ~~clinical policy~~payment policy is consistent with standards of medical practice current at the time that this ~~clinical policy~~payment policy was approved.

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POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to an actual signature on paper.

Senior Director of Network Accounts: _____Electronic Signature on File_