CENTENE Corporation

Payment Policy: CMS Correct Coding Initiative Unbundling Edits

Reference Number: CC.PP.031
Product Types: ALL
Last Review Date: 12/01/2022

Coding Implications
Revision Log

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

Policy Overview

The health plan applies unbundling edits based on the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI). These are defined as procedure-to-procedure (PTP) code pair edits.

CMS developed the NCCI to promote correct coding principles and facilitate correct reimbursement for services performed on patients. 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 code is reimbursable. Therefore, providers should not report multiple CPT codes when a single, more comprehensive code represents all services performed.

CMS organizes PTP codes into column 1 and column 2 pairs. Column 2 represents the code that should not have been billed. The column 1 code is the more comprehensive code. Code pairs may also be mutually exclusive, which are two procedures that could not have been performed during the same patient encounter because of anatomic, temporal or gender considerations.

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, 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 policy manual and NCCI edit tables are updated on an annual basis and are publicly accessible on the CMS website.

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 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 NCCI PTP 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 NCCI PTP tables and references these tables to determine when multiple procedure codes were billed instead of a single, more comprehensive code. When this occurs, the less comprehensive code is denied.

Prepayment Clinical Review of Appropriate Use of Modifier
The health plan conducts prepayment clinical validation of all PTP edit combinations billed with a valid NCCI modifier. The clinical review team performs claim validation to determine if the modifier is clinically appropriate for the coding scenario.

Documentation Requirements
Below are 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 all applicable diagnoses 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 service 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 2022, 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.

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.

Related Documents or Resources

1. CC.PP.014 Distinct Procedural Service: Modifier 59
2. CC.PP.020 Distinct Procedural Modifiers: XE, XS, XP and XU
3. CC.PP.013 Clinical Validation of Modifier -25

References

1. *Current Procedural Terminology (CPT®)*, 2022
2. https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS
3. *HCPCS Level II*, 2022
4. *International Classification of Diseases*, (ICD-10-CM), 2022
5. *ICD-10-CM Official Draft Code Set*, 2022
6. *Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services.*
7. http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index
8. https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html

Revision History	
01/01/2013	Initial Policy Draft
09/09/2016	Added Suggested resources
04/01/2019	Conducted review, converted to new template, verified codes, updated policy
11/01/2019	Annual Review completed
11/01/2020	Annual Review completed
11/30/2021	Annual review completed; links updated
12/01/2022	Annual review completed; code tables removed as this information can be found within the listed references

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.

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