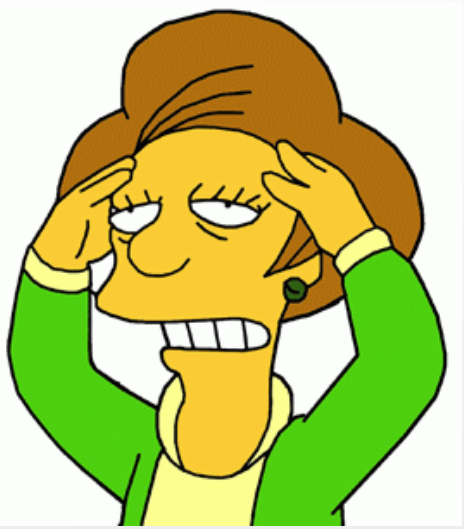
Teamwork: The Cure for the Common Claim Edit



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2019 CTHIMA ANNUAL MEETING

AUGUST 16, 2019

ROCKY HILL, CT

CtHiMA
AHIMA Affiliate
Connecticut Health Information Management Association

Agenda

- The Medicare Outpatient Code Editor (OCE)
- National Correct Coding Initiative
- Medically Unlikely (MUE) Edits
- Procedure to Procedure (PTP) Edits
- Add-on Edit
- NCDs/LCDs
- Modifier Reporting
- TEAMWORK

So Many Edits!

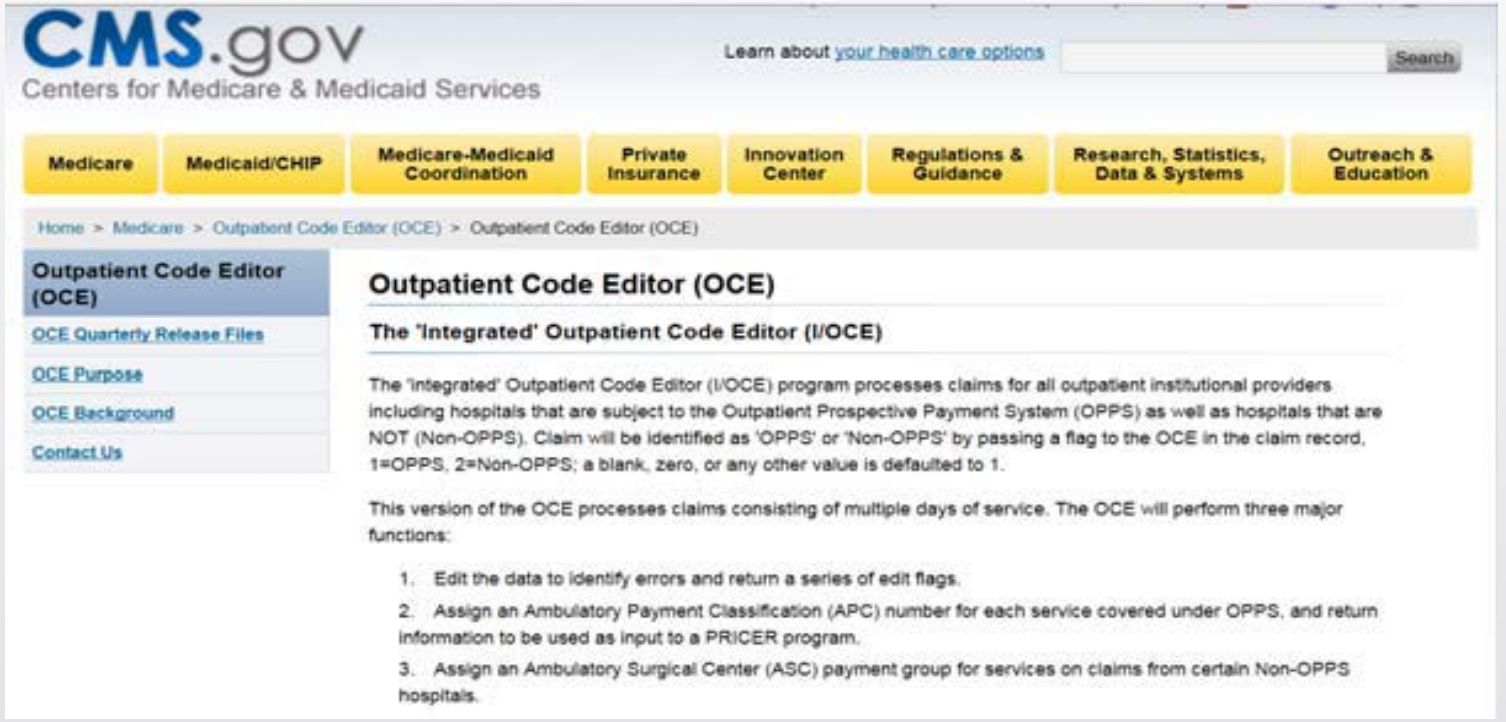
- CMS OCE Editor
- NCCI Edits
- MUEs – Unit Edits
- PTPs – Pairing Edits
- Add-on Edits
- NCD/LCDs – Medical Necessity Edits

The Medicare OCE - Background

- The outpatient code editor was implemented when Medicare implemented APCs
- Updated once a quarter
- Each edit is assigned an edit number, description, and claim or line-item disposition
- 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/

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

OCE Claim Dispositions

Six possible dispositions for claims and claim lines:

1. **RTP** – Return to Provider – whole claim returned to provider. Can resubmit once problems are corrected
2. **Line Item Denial** –Claim is processed for payment with one or more line items are denied payment. The denied line item must be appealed
3. **Line Item Rejection** – provider may correct line items and resubmit claim
4. **Claim Denial** – Whole claim denied, only option for provider is to appeal
5. **Claim Rejection** - provider must rework the claim and resubmit
6. **Claim Suspend** – Claim is not returned to provider or processed for payment - MAC must make a payment determination or request more information from provider

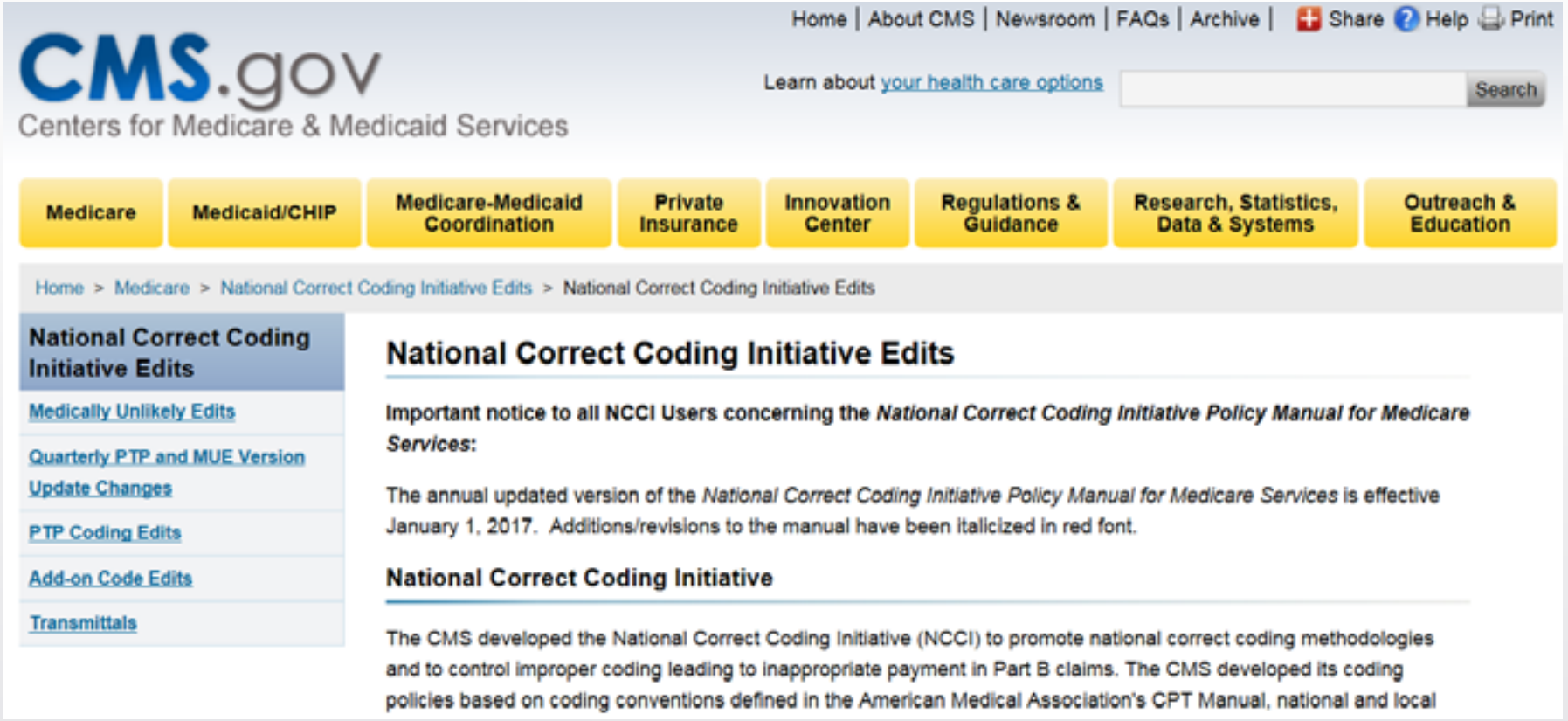
Example – OCE Edit 21

- 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

Example – OCE Edit 21

- The physician sees a 59 year old male in the emergency department for chest pain and possible myocardial infarction.
- The physician orders an EKG.
- The ER visit level (99284) is an APC status indicator V
- The EKG (93005) is a status indicator S
- OCE edit 21 indicates that there is an APC status V reported with an APC status S and will RTP the claim unless it is corrected.
- **SOLUTION: Billing requests HIM coder to review chart. Coder determines that the E/M service 99284 may be billed with modifier -25, applies the modifier, and appropriately bypasses OCE edit 21.**



- NCCI edits are 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

CMS NCCI Policy Manual

- Released annually, downloadable data files and resources
- Excellent reference for common CCI edits

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

Downloads

How to Use The National Correct Coding Initiative (NCCI) Tools [PDF, 1MB]
R1386CP [PDF, 167KB]
MM5824 [PDF, 69KB]
NCCI Policy Manual for Medicare Services - Effective January 1, 2014 [ZIP, 749KB]
NCCI Policy Manual for Medicare Services - Effective January 1, 2015 [ZIP, 1MB]
NCCI Policy Manual for Medicare Services - Effective January 1, 2016 [ZIP, 761KB]
NCCI Policy Manual for Medicare Services - Effective January 1, 2017 [ZIP, 770KB]
Correspondence Language Manual for Medicare Services - Effective April 1, 2015 [PDF, 322KB]
Correspondence Language Manual for Medicare Services – Effective April 1, 2016 [PDF, 195KB]
Chapter 23 - Fee Schedule Administration and Coding Requirements [PDF, 1MB]
Modifier 59 Article: Proper Usage Regarding Distinct Procedural Service – Updated 11/16/16 [PDF, 106KB]

Medicaid NCCI Policy Manual

- Medicaid edits similar to but NOT identical to Medicare edits
- Resources available for download:

https://www.medicaid.gov/medicaid/program-integrity/ncci/reference-documents/index.html

Recent NCCI Manuals

Medicaid NCCI Policy Manual (ZIP 1.19 MB) effective January 1, 2019 revised December 12, 2018

- Revisions were made in Chapter I, Section N (Laboratory Panel) and Chapter X, Section C (Organ or Disease Oriented Panels.)

Medicaid NCCI Technical Guidance Manual (PDF 1.11 MB) revised October 2018

- The Medicaid NCCI Technical Guidance Manual contains information previously published in the Technical Guidance Document and the Edit Design Manual.

Medicaid NCCI Correspondence Language Manual (PDF 395.59 KB) April 2019

Modifier 59 Article (PDF 84.01 KB) revised January 2018

Medically Unlikely Edits – Navigating the MUE Minefield

- Developed in 2007
- Included in the NCCI program
  - Part of the Medicare Outpatient Code Editor (OCE)
- Designed to reduce errors that result from:
  - Clerical entries
  - Incorrect coding on the basis of anatomic considerations
  - HCPCS/CPT® code descriptors

More information about the rationale of MUE is available in the National Correct Coding Initiative Policy Manual for Medicare Services, Chapter 1, Section V (Medically Unlikely Edits).

Medically Unlikely Edits

A MUE is the maximum number of units that can be reported IN MOST CASES on a single claim on a single date of service

- NOT all codes have an MUE
- Medicare – SOME Medicare MUE's are unpublished and are considered "confidential" for CMS and the CMS contractors' use only! (Go figure)
- Medicaid - There are NO confidential/unpublished MUE edits for the Medicaid at this time, they are all published
- When a code is subject to an MUE limit, additional units of service cannot be billed to patient even with an ABN

Not All MUEs Are Created Equal

- MAI - In 2014 a new field – the **MUE Adjudication Indicator** - was added to further explain the MUE edits
- Three MAI's exist:

➢ **MAI 1** – Claim line item edit- Provider should report additional units of service AS SEPARATE LINE ITEMS with modifiers when appropriate

- **6% of the edits**

➢ **MAI 2** – **Absolute** date of service edit with firm limits that cannot be bypassed

- E.g., 94002, vent management initial day, cannot report more than once per day
  - **38% of the edits**

MAI – Adjudication Indicator

- **MAI 3** – Date of service edits
  - **56% of the edits**
  - **This is the most common MUE and IT IS APPEAL-ABLE!**
- "Per day edits based on benchmarks"
- If appealed, contractors may pay unit of service in excess of the MUE <u>if there is adequate documentation of medical necessity and correct reporting of units</u>
- Facilities should have a claims review and appeals process in place when documentation supports billing additional units of service.

Example: Wound care services often hit MUE's due to multiple debridements provided on the same DOS. Good documentation can override the edits and get your claim paid.

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

PTP Edits – Procedure to Procedure Edits

- PTP edits are code pairs developed to prevent reporting incorrect code combinations
- Included in the Medicare OCE editor and the Medicaid Outpatient Pricer
- A PTP edit generates a line item rejection
- Complete list of PTP edits is updated quarterly and is on the CMS website at:

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

For Medicaid PTP edits: https://Data.Medicaid.gov

Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicab	PTP Edit Rationale
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

Column 2 code is included in column 1 code unless unusual circumstance

0 = non modifiable, 1 = modifiable, 9 = not applicable

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

Modifiable PTP Edit

- The PTP edits with a modifier indicator of 1 may be bypassed with a modifier if appropriate

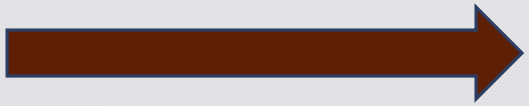
Sally is treated in the wound care clinic for two lesions – one on the left leg, the other on the right leg. The lesion on the left leg is debrided, the other lesion is treated with an unna boot.

Modifiable PTP Edit Example

- The wound care clinic reports the services:

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

- The combination of 29580 and 11042 hits a modifiable PTP 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

Your coders will know that 29580-XS will appropriately bypass this edit and get the claim out the door.

Add-on Edits

- An add-on code describes a service that is always performed in conjunction with a primary, or “parent” service.
- In the CPT Manual an add-on code is designated by the symbol "+“
- An add-on code is eligible for payment only WHEN reported with an appropriate primary procedure performed by the same practitioner
- Claims with add-on codes but no primary service codes will bump against this edit

Example: 29826, decompression of subacromial space, shoulder, cannot be billed without a primary procedure from code range 29806-29825, 29827 or 29828

National Coverage Determinations

- Developed at the national level
- Apply to services across the country
- Published in CMS Coverage Manual
- Changes with advances in medicine or as coverage rules change

National Coverage Determinations

- Over 300 currently
- 23 pertain to specific laboratory tests
- Provider must submit acceptable diagnoses for the treatment and diagnosis of injury/illness
- Medicare will deny payment for a test covered under an NCD or LCD unless the claim contains an approved diagnosis code

Local Coverage Determinations

- **LCD**s (Local Coverage Determinations) are published by Medicare Administrative Contractors and can vary from MAC to MAC
- Services may be lab, imaging, cardiology, PT/OT/ST, etc.
- If an LCD service is billed, a diagnosis code included in the LCD must be on the claim or **Medicare will not pay for the test**
- ***It is against the law for the Hospital to change or add a diagnosis 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]

Coders Should Review All NCD and LCD Edits

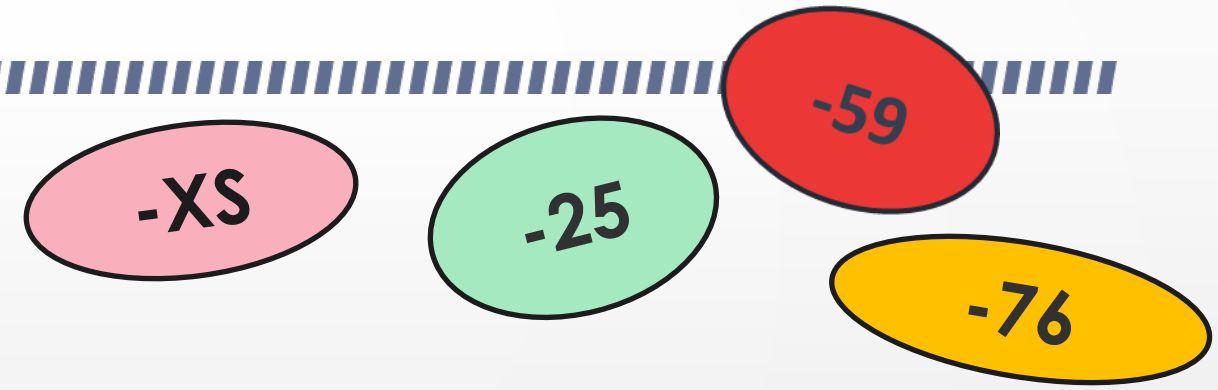
Documentation may be present in the chart to support additional diagnoses to cover the medical necessity for the service:

If the original order needs an amendment, coders can work with the provider to obtain revised orders that comply with CMS's Recordkeeping Principles and meet medical necessity requirements.

Coders can identify when a coded service does not reflect the provider's order and can correct the service code for claim resubmission :

e.g. Provider orders a diagnostic PSA for a patient with BPH; lab incorrectly enters charge for screening PSA.

Modifier Mania



What are Modifiers?

- Two Characters appended to a CPT/HCPCS code that modify the meaning of the service
- Required when a combination of codes generates an edit:
  - ✓ Outpatient Code Edit (OCE) such as a significant procedure with a separately identifiable medical visit
  - ✓ Correct Coding Initiative Edit (NCCI/PTP) such as a combination of two primary/initial infusion codes
  - ✓ Medically Unlikely Edit (MUE)

Modification of the MCS Claims Processing System - 07/01/2019

- PROVIDER TYPE AFFECTED -physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.
- PROVIDER ACTION NEEDED -CR11168 informs MACs about changes to National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) edits which consist of column one and column two codes. Make sure that your billing staffs are aware of these changes
- BACKGROUND -Modifiers 59, XE, XS, XP, and XU are among the NCCI-associated modifiers. The Multi-Carrier System (MCS) currently requires that modifiers 59, XE, XS, XP, or XU be appended to the column two code of a PTP edit to bypass the edit. With the implementation of CR 11168, Medicare will allow modifiers 59, XE, XS, XP, or XU on column one and column two codes to bypass the edit.
- ADDITIONAL INFORMATION - The official instruction, CR11168, issued to your MAC regarding this change is available at

https://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/2019Downloads/R2259OTN.pdf

- MLN

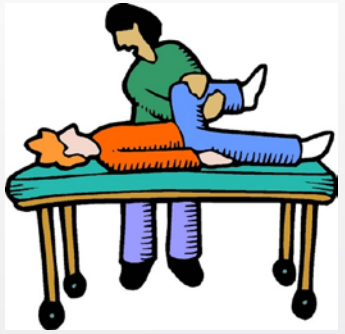
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11168.pdf

Per CMS:

- Modifiers are appended to HCPCS and CPT codes when clinical circumstances justify the use of the modifier.

- Review the medical record to ensure that you have clinical circumstances to justify the modifiers and do not append to HCPCS and CPT codes to simply bypass the NCCI edits.

G-Codes and PT/OT/SLP Modifiers



- Beginning January 1, 2013, Functional Reporting requires therapy practitioners and providers to report non-payable G-codes and modifiers to convey information about the beneficiary's functional status including projected goal status throughout the episode of care.

- For each non-payable G-code reported, a modifier must be used to report the severity level for that functional limitation. Therefore, the beneficiary's current status, projected goal status, and discharge status are reported via the appropriate severity modifiers.

Pharmacy NDC Codes

- National Drug Codes are 11-digit numbers used to identify prescription and OTC drugs distributed commercially in the US.
- Hospitals must report NDCs as well as HCPCs codes when submitting claims with vaccines or other medications.
- Many private payers also require NDCs.
- Each pharmacy should have a list of NDCs for all the drugs in its formulary.
- CMS provides an NDC-HCPCS crosswalk here:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2018ASPFiles.html

So, what is a biller to do with claims errors?

Education, Communication, Collaboration

- Educate PFS staff about the types of edits they will encounter in claims processing
- Identify HIM coders and staff from other service areas (pharmacy, rehab, practices, etc.) as go-to contacts for edit resolution
- Route edits to the appropriate department
- Pull the group together to discuss the claims editing process:
  - Communication tool
  - Turn around time
  - Appeals and denials management
  - Provider education
  - System issues such as order sets, chargemaster errors, etc.
- Meet as often as needed to stay on top of workflow and maintain effective communication


TIME FOR QUESTIONS
12
1
2
3
4

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