

## Coding

### Coding Guidelines and Resources

South Country Health Alliance (South Country) uses a claims editing system (CES) in processing claims. The CES incorporates Medicare Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs) policies in claim processing. South Country's CES is continuously updated to remain in compliance with State and Federal regulatory mandates as well as general industry standards. All claims are subject to correct billing and coding standards.

The main function of the CES is to analyze Professional (medical) and Facility (hospital) claims. This means that the system looks at the data on the claim and checks for errors, omissions, and questionable coding relationships. For each claim that is processed, the system thoroughly reviews the entire claim and each line on it for important coding issues such as the following:

- Unbundling
- Rejection of duplicate claims
- Re-bundles/Transfers
- Detection of mutually exclusive services
- New patient visit auditing
- Patient diagnosis correlated with procedure appropriateness
- Validation of procedure modifiers
- Detection of multiple procedure reductions
- Place of service editing
- Surgical assistant appropriateness
- Flagging of maximum frequency per day
- Age appropriateness of procedures and diagnoses
- Sex specific procedures and diagnoses versus patient sex
- Medically Unlikely Edits (Both Medicare and Medicaid)

### National Correct Coding Initiative in Medicaid

The 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. For information about, and edits for, the Medicare NCCI program, see the Centers for Medicare & Medicaid Services (CMS) [National Correct Coding Initiative Edits](#) web page. The Medicaid NCCI program has significant differences from the Medicare NCCI program.

The National Correct Coding Initiative (NCCI) contains the following two types of edits:

1. NCCI procedure-to-procedure (PTP) edits that 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.
2. Medically Unlikely Edits (MUEs) define for each HCPCS/CPT code the maximum units of service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service.

The published MUE will consist of most of the codes with MUE values of 1 – 3. See the CMS [Medically Unlikely Edits](#) and [Medicaid.gov MUE Edits](#) web pages for more information.

## Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs)

### Local Coverage Determination (LCD)

An LCD, as defined in §1869(f)(2)(B) of the Social Security Act (SSA), is a determination by a Medicare Administrative Contractor (MAC) regarding whether or not a particular item or service is covered on a contractor-wide basis in accordance with section 1862(a)(1)(A) of the Act.

### National Coverage Determination (NCD)

NCDs are made through an evidence-based process, with opportunities for public participation. In some cases, CMS' own research is supplemented by an outside technology assessment and/or consultation with the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC). In the absence of a national coverage policy, an item or service may be covered at the discretion of the Medicare contractors based on an LCD.

For more information on LCDs and NCDs, consult the [Medicare Coverage Database](#).

## Modifiers

HCPSC (Levels I and II): include 2-digit alpha, numeric, and alphanumeric modifiers. Use appropriate modifier(s) to identify:

1. A service/procedure altered by a specific circumstance, but not changed in its definition or code;
2. Rental, lease, purchase, repair, or alteration of medical supply; or
3. The origin and destination for medical transportation (1-digit alpha codes).

### Bundling

When the description of the code or the service performed usually includes several procedures, then it would be inappropriate to code for any procedures that are included.

### Unbundling

The CPT Manual defines modifier 59 as follows: "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. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25." CMS established four new HCPSC modifiers (XE, XS, XP, and XU) to provide greater reporting specificity in situations where modifier 59 was previously reported.

Modifiers XE, XS, XP, and XU are effective January 1, 2015. These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be utilized in lieu of modifier 59 whenever possible. (Modifier 59 should only be utilized if no other more specific modifier is appropriate.)

- XE – "Separate encounter, A service that is distinct because it occurred during a separate encounter" This modifier should 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 Package

The global surgical package, also called global surgery, includes all the necessary services normally furnished by a surgeon before, during, and after a procedure.

The following are the three types of global surgical packages:

- 0-Day Post-operative Period (endoscopies and some minor procedures)
  - No pre-operative period
  - No post-operative days
  - Visit on day of procedure is generally not payable as a separate service
- 10-Day Post-operative Period (other minor procedures)
  - No pre-operative period
  - Visit on day of the procedure is generally not payable as a separate service
  - Total global period is 11 days. Count the day of the surgery and the 10 days immediately following the day of the surgery.
- 90-day Post-operative Period (major procedures)
  - One day pre-operative included
  - Day of the procedure is generally not payable as a separate service
  - Total global period is 92 days. Count 1 day before the day of the surgery, the day of surgery, and the 90 days immediately following the day of surgery.

## Billing Modifiers

*For use when services are unrelated to surgical procedure*

- Modifier 24: Unrelated E/M; same physician during postop period
- Modifier 25: Indicates that the E/M service provided on the same day as a surgical procedure was significant and separately identifiable as unrelated to the surgery performed; used for minor surgical procedures with global period of 000 or 010 days
- Modifier 57: Indicates that an E/M code was performed on the same day of surgery for the purpose of deciding whether to perform the surgical procedure; used for major surgical procedures with a global period of 90 days
- Modifier 78: Unplanned return to the operating room during the postoperative period
- Modifier 79: Unrelated; performed by the same physician during the postoperative period

## Other Surgical Modifiers

- Modifier 54: Surgical care only; when one physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number
- Modifier 55: Postoperative management only; when one physician or other health care professional performs the postoperative management and another performs the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number
- Modifier 62: Two surgeons; when two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report their distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedures (including add-on procedures) are performed during the same surgical session, separate codes may also be reported with modifier 62 added.

## General Coding

Providers are required to enter the most specific diagnosis code(s) on claims submitted to South Country. All providers are required to enter the appropriate procedure/service codes on claims identifying covered services. Providers must use applicable codes and follow the most current guidelines from the following manuals:

|                  |                                                                                                                                                             |
|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>ICD-10-CM</b> | International <b>C</b> lassification of <b>D</b> iseases, <b>10</b> <sup>th</sup> Revision, <b>C</b> linical <b>M</b> odification.                          |
| <b>CPT</b>       | Physicians' <b>C</b> urrent <b>P</b> rocedural <b>T</b> erminology (HCPCS Level I)                                                                          |
| <b>HCPCS</b>     | <b>H</b> ealthcare <b>C</b> ommon <b>P</b> rocedural <b>C</b> oding <b>S</b> ystem (HCPCS Level II National Codes)                                          |
| <b>NDC</b>       | <b>N</b> ational <b>D</b> rug <b>C</b> odes. ( <a href="#">review the National Drug Code Directory</a> [click <i>Search National Drug Code Directory</i> ]) |
| <b>NUBC</b>      | <a href="#">National Uniform Billing Committee</a> (for UB-04 reporting)                                                                                    |
| <b>CDT</b>       | <b>C</b> urrent <b>D</b> ental <b>T</b> erminology                                                                                                          |

Providers are not required to purchase all of the manuals listed above. Determine which manuals are appropriate for the services you provide.

## Lab Billing and Panel Codes

When lab codes are billed individually and not as a panel code, as a courtesy, South Country utilizes our claims editing software (CES) to add the panel code to the claim and bundles the rest of the lines rather than denying the services. For example, if a claim is submitted with three separate labs (80053, 85025, and 84443), the claim is processed through our CES and the individual lines are denied and replaced with an add-on line that is the panel code (80050). The charges for all three lines are combined as the charge amount on the new line.

More information can be found in [CMS Manual System Pub 100-04 Medicare Claims Processing, Transmittal 4299](#), or the CPT professional AMA code book within the "Pathology & Laboratory" section (the beginning of the section explains how to bill panel codes).

## Unlisted Codes

Bill unlisted procedure codes only when a specific code is not available to define a service/procedure. When an unlisted code is billed, a detailed description must be included in the charge line description field of the 837 transaction file for the specific unlisted code defining the service/procedure.

The following are some examples of unlisted codes that require descriptions (please note this is not an all-inclusive list):

1. T2029: Specialized medical equipment, not otherwise specified (NOS), waiver
2. A9999: Miscellaneous DME supply or accessory, NOS