THIS CA UPDATE HAS BEEN SENT TO THE FOLLOWING:

COUNTIES:

☒ Imperial
☒ Riverside/San Bernardino
☒ Los Angeles
☐ Orange
☒ Sacramento
☒ San Diego

LINES OF BUSINESS:

☐ Molina Medi-Cal Managed Care
☒ Molina Medicare
☐ Molina Marketplace (Covered CA)

PROVIDER TYPES:

☒ **Medical Group/ IPA/MSO**

Primary Care
☒ IPA/MSO
☒ Directs

Specialists
☒ Directs
☒ IPA

☒ **Hospitals**

Ancillary
☒ CBAS
☒ SNF/LTC
☒ DME
☒ Home Health
☐ Other

CA Weekly Code Edits

This is an advisory notification to Molina Healthcare of California (MHC) network providers on recent code edits.

What you need to know:

Medicare National Correct Coding Initiative (NCCI) Add-on Code Edits

An Add-on Code (AOC) is a code that describes a service that is performed in conjunction with the primary service by the same practitioner. The edit uses the Centers for Medicare and Medicaid Services (CMS) and NCCI Add-on file to identify when an AOC is reported and whether the associated primary code has received an edit. AOCs may be identified in three ways:

- The AOC is in the Add-on file as a Type 1, Type 2, or Type 3 AOC (formerly displayed as Type I, Type II, or Type III).
- On the Medicare Physician Fee Schedule Database, an AOC generally has a global surgery period of "ZZZ."
- In the CPT Manual, an AOC is designated by the symbol "+." The code descriptor of an AOC generally includes phrases such as "each additional" or "(List separately in addition to primary procedure)."

For more information on AOC, please refer to the CMS website at: https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare/medicare-ncci-add-code-edits.

Surgical Procedure Anatomical Modifier Required

This edit fires when a bilateral surgical procedure is billed without an anatomical modifier. Bilateral and unilateral procedures require laterality modifiers for appropriate claim processing.

The NCCI program requires that bilateral surgical procedures may be reported using modifier 50 with one unit of service unless the code descriptor defines the procedure as "bilateral." Bilateral procedures may be reported as:

- "2" units of service on 1 claim line
- "1" unit of service and modifier 50 on 1 claim line
- "1" unit of service and modifier RT on 1 claim line plus "1" unit of service and modifier LT on a second claim line

For more information on anatomical modifiers, please refer to Chapter 4 of the Medicare Claims Processing Manual at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf.

Inappropriate Use of Modifier 78

This edit denies claim lines submitted with modifier 78 appended when the place of service reported on the claim line is not an operating or procedure room (POS 19, 21, 22, 23, 24, 25). Modifier 78 requires a return trip (e.g.,

Cath Lab, Interventional Radiology Procedure Room, Endoscopy Room) for a related procedure during a postoperative period.

For more information on modifier 78, please refer to Chapter 12 of the Medicare Claims Processing Manual at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf.

Unspecified Codes

This edit identifies when unspecified diagnosis codes are reported as a principal or secondary diagnosis based on the Medicare Code Editor (MCE). Unspecified codes exist for circumstances when documentation in the medical record does not provide the level of detail needed to support reporting a more specific code. However, in the inpatient setting, there should generally be very limited and rare circumstances for which the laterality (right, left, bilateral) of a condition is unable to be documented and reported.

The Unspecified Code edit will be triggered for certain unspecified diagnoses codes currently designated as either a Complication or Comorbidity (CC) or Major Complication or Comorbidity (MCC), that include other codes available in that code subcategory that further specify the anatomic site when entered on the claim. This edit message indicates that a more specific code is available to report.

For more information on unspecified codes, please refer to the CMS Manual Summary at: https://www.cms.gov/files/document/r11059cp.pdf.

Molina Policy COVID-19 Bypasses:

COVID-19 leniencies are being lifted surrounding POS 02, and COVID-19 modifiers 95, CG, CR, CS, G0, GQ, and GT. Correct coding guidelines will apply.

- Ex.) An in-person procedure was reported with a GT modifier for 'Via interactive audio and video telecommunication systems'.
- Ex.) An in-person procedure was reported in POS 02 'Telehealth Provided Other than in Patient's Home'.

What if you need assistance?

If you have any questions regarding the notification, please contact your Molina Provider Services Representative below:

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