Cotiviti Implementation

As a valued member of our provider community, we want to inform you about upcoming claims processing enhancements. We will be adding new edits that address coding situations too complex to auto-adjudicate and accordingly have a human review component. The edits are based on correct coding rules published by national industry sources and administrative bodies to detect potential coding errors and incorrect billing practices.

One issue the new edits addresses is the correct use of modifiers. Modifiers have been defined by the American Medical Association (AMA) and adopted by the Centers for Medicare and Medicaid (CMS) to provide additional information about the services rendered. The National Correct Coding Initiative (NCCI) Policy Manual directs when modifiers should be used. It states, "Modifiers may be appended to HCPSC/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier shall not be appended to a HCPCS/CPT solely to bypass an NCCI PTP edit if the clinical circumstances do not justify its use." **NCCI Policy Manual, January 2019**. The new edits involve reviewing the information on the claim and in the patient's claim history to determine if the modifier has been used correctly. Modifiers 25, 59, XE, XS, XP, and XU are among the most commonly used modifiers. Therefore, the new edits will evaluate the correct use of these and other overriding modifiers. We are providing information about when these modifiers should be used to prevent the incorrect processing of claims.

CPT and the AMA specify that by using a modifier -25, the provider indicates that a "significant, separately identifiable evaluation and management service (was provided) by the same physician on the same day of the procedure or other service". CPT guidelines also state that this significant and separate service must be "above and beyond" the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The AMA Guidelines in "Coding with Modifiers" state that "The E/M service must meet the key components (i.e., history, examination, medical decision making) of that E/M service including medical record documentation. To use modifier 25 correctly, the chosen level of E/M service needs to be supported by adequate documentation for the appropriate level of service, as well as referenced by a diagnosis code. The CPT codes for procedures do include the evaluation services necessary before the performance of the procedure (e.g., assessing the site and condition of the problem area, explaining the procedure, obtaining informed consent). However, when significant and identifiable (i.e., medical decision making and another key component) E/M services are performed, these services are not included in the descriptor for the procedure or service performed."

Modifiers 59, XE, XP, XS, and XU should be used when the physician needs to indicate a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together but are appropriate under the circumstances. This may represent a different session or patient encounter, 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 physician.

When preparing claims for submission, it is important to make sure all appropriate diagnosis codes are assigned to the claim and that modifiers are used only when clinically appropriate based on published guidelines. If you have claims you believe are incorrectly denied due to the incorrect use modifiers, please submit medical records so we can determine the correct payment for those claims. Additional information about when to use modifiers can be found in the CPT manual and in the Provider and NCCI manuals on CMS's website.