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Health Insurance for New Yorkers

Provider Alert

Introducing Coding Validation from Cotiviti

Effective Sept. 1, 2023, consistent with the recommendations of the Office of Inspector General (OIG) and the Centers for Medicare & Medicaid Services (CMS), Healthfirst will implement **Cotiviti's Coding Validation**, an enhanced program based on nationally sourced guidelines regarding modifier usage. Guidelines for the correct use of modifiers are thoroughly documented in the Current Procedural Terminology (CPT) and Coding with Modifiers manuals (published by the American Medical Association [AMA]), and in the Correct Coding Initiative (CCI) and CMS claims-processing manuals (published by CMS).

Why is this change being made?

In the past, certain modifiers, including but not limited to modifiers 25, 59, 79, and 24, have overridden some unbundling edits and have not always been applied appropriately. After an extensive review of modifier usage, the OIG and CMS have advised the use of prepayment review of modifier usage based on claim details and patient claim history. Modifiers have been defined by the AMA and adopted by CMS to provide additional information regarding the services rendered.

The National Correct Coding Initiative (NCCI) Policy Manual also provides directions on modifier use:

- Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier shall not be appended to a HCPCS/CPT code solely to bypass an NCCI PTP edit if the clinical circumstances do not justify its use (**NCCI Policy Manual**, January 2023, pg. I-12).

Reviews consider 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 comprise many of the overriding modifiers appended to services. Reviews will evaluate the correct use of overriding modifiers.

AMA guidelines published in *Coding with Modifiers: A Guide to Correct CPT® and HCPCS Level II Modifier Usage 6th ed.* instruct providers to append modifier 25 to indicate a "significant, separately identifiable evaluation and management (E/M) service was performed by the same physician or other qualified healthcare professional (QHP) on the same day of a procedure or other services" (Linker, 2020, chap. 2, pg. 45). CPT guidelines define this significant and separate service as being "above and beyond" the usual preoperative and postoperative care associated with the procedure or service performed.

The AMA's *Coding with Modifiers* states:

- 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 and 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 (Linker, 2020, chap. 2, pg. 45).

The *Coding with Modifiers* guidelines state:

- Modifiers 59, XE, XP, XS, and XU should be used when the physician needs to indicate that a procedure or service was distinct or independent from other services performed on the same day.

CMS established the NCCI program to ensure the correct coding of services. NCCI Procedure-to-Procedure (PTP) edits prevent inappropriate payment of services that should not be reported together. Each edit has a column one and column two HCPCS/CPT code. If a provider reports the two codes of an edit pair for the same beneficiary on the same date of service, the column two code is denied, and the column one code is eligible for payment. However, if it is clinically appropriate to utilize an NCCI PTP-associated modifier, both the column one and column two codes are eligible for payment (Linker, 2020, chap. 5, pg. 139).

Modifier 59 is used to identify procedures/services that are not normally reported together but are appropriate under certain 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.

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When preparing claims for submission, it is important to make sure all appropriate diagnosis codes have been assigned to the claim and that modifiers are used only in accordance with published guidelines.

What if claims I submitted are denied due to "incorrect use of modifiers" but I disagree?

Healthfirst is committed to ensuring you receive the correct payment for the services you provide. If you disagree with our decision, you may submit an appeal with supporting medical records and other documentation to the address below within 60 days of your receipt of the EOP:

Healthfirst Correspondence Unit
P.O. Box 958438
Lake Mary, FL 32795-8438

You can find additional information regarding the appropriate use of modifiers in the CPT book and NCCI manuals on CMS' website.

Where can I find the new reimbursement policy?

The library of Healthfirst reimbursement policies is available **here**. Select the filter for "Reimbursement Policy" and check back frequently for updates.

An updated policy will be published and available for review by June 1, 2023.

Please contact your Network Account Manager if you have any questions.