Roadmap to Coding/Reimbursement Tools and Resources

Purpose
In this session, participants will learn the claim submission process at Medica and will review coding and reimbursement methodologies.

Objectives
Upon completion of this session, participants will be able to:

- Find key tools and resources available on medica.com
- Navigate CMS references for sourcing of reimbursement policies

Session Content

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Contact Information

The Provider Service Center is the first point of contact for providers in regards to eligibility inquiries, benefit determination questions and claim status issues.

Press 1 to reach the Provider Service Center, then choose from the following options:

- **Press 1** for automated information on claims, benefits and eligibility
- **Press 2** to speak with a representative regarding a member’s effective date, benefits or claims, then:
  1. to verify effective date or to get an ID number
  2. for benefit information
  3. for hospital and other UB-04 claims
  4. for physician claims and all other claims
  9. mental health and substance abuse
  0. to repeat menu
- **Press 3** for pharmacy and pharmacy-related appeals, then:
  1. for MedImpact or MedCare
  2. for Medco
  3. all other inquiries
- **Press 4** for admissions, referrals, notifications, prior authorization requests, case management, or appeals, then:
  1. for Admissions, Referrals, Notifications,
  2. for Prior Authorizations
  3. for Clinical Appeals
  8. if you know the extension of whom you want to reach
  0. to repeat menu
- **Press 5** to call another extension (The 5-digit extension should be entered and you will be connected)
- **Press 6** for other options, then:
  1. for technical support on medica.com
  2. for the Medica claims address
- **Press 7** for all other inquiries
- **Press 0** to repeat the options
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<td>• Automated Phone Response System</td>
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Claims & Coding Operations Resources

Provider Communications

- *Medica Connections®* Articles and Provider Alerts are located on medica.com at Providers>News You Can Use
- To receive *Medica Connections* and Provider Alerts via email click on subscribe now.

The following documents are located on medica.com at Providers>Reference Tools and Forms>Tools and Forms>Coding Tools and Forms:

Coding Guidelines

- DME Numeric Code List - Coverage Eligibility by Medica Product
- DME Used in the Home Setting - Reimbursement Policy
- Eligible Chiropractic Codes for Commercial and Individual Plans
- Power Mobility Devices and Power Wheelchairs and POVs
  Reimbursement Policy (Refer to DME Numeric Code List above)
- Procedure Codes for Elderly Waivered Home Health Care
- Procedure Codes for Personal Care Assistance Services
- Procedure Codes for PCA Public Health Agencies
- Procedure Codes for Home Health Care Services
- Procedure Codes for Public Health Home Care
- Procedure Codes that Require Up-Front Documentation

The following documents are located on medica.com at Providers>Medical Policies:

- Utilization Management Policies
- Prior Authorization List & Request Forms
- Coverage Policies
- View full Prior Authorization List
Claims and Coding Operations

Code Update Overview
Medica, like all other payers and providers, utilizes standard sets of procedure and diagnosis codes to ensure appropriate reimbursement for health care services covered by the Medica benefit plans. The AMA and CMS are responsible for maintaining and updating CPT codes and HCPCS codes, respectively.

The AMA and CMS publish quarterly updates to the CPT and HCPCS codes. The code updates are effective quarterly as shown below:

- January 1
- April 1
- July 1
- October 1

Other code updates include:
- Revenue Codes - Periodic releases from the National Uniform Billing Committee (NUBC)
- ICD-9-CM - Annual releases become effective on October 1
- DRG - Annual release published in the August Federal Register

The AMA or CMS assigns each code a status that identifies the action being taken with the code: Adding a new code (N), changing an existing code (C), recycling a retired code (T), revising an existing code (R), or deleting an existing code (D).

Information related to new, revised and changed codes can be found in the various CPT, HCPCS, ICD-9-CM and/or other publications available to the coding community.

Helpful websites include:

| Links | 
|-------|---|
| CMS National Physician Fee Schedule | [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html?redirect=/PhysicianFeeSched/PFSRVF/list.asp](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html?redirect=/PhysicianFeeSched/PFSRVF/list.asp) |
| American Medical Association (AMA) | [http://www.ama-assn.org/ama](http://www.ama-assn.org/ama) |

NOTE: Due to Health Insurance Portability and Accountability Act (HIPAA) requirements, Medica no longer allows a 90-day grace period for the implementation of the ICD-9 CPT/HCPCS updates. The HIPAA transaction and code set rule requires the use of national medical code sets that are valid at the time the service is provided.
**Code Update Process**

Claims Operations/Coding takes the lead when the new codes/changes are released and collaborates with various Medica stakeholders, reviewing each code involved and making decisions on how Medica should administer each code. This is done through the “Interdepartmental Code Update” (ICU) process. Once decisions are made, all impacted departments at Medica ensure that systems and processes are updated so that each code is administered and adjudicated as intended.

Areas thoroughly researched and evaluated include:

- Member Benefits
- Provider Reimbursement
- Utilization Management Policies
- Coverage Policies
- Prior Authorization requirements and processes

Once final determinations by the stakeholders are established, the workgroup determines if provider communication is necessary. Provider communication is available on medica.com at Providers>News You Can Use for Connections Articles or Provider Alerts.

**ICD-10**

Medica is preparing for ICD-10 implementation. *Medica Connections* will provide information as it becomes available.
Medical Policies

Utilization Management Policies

Utilization management (UM) policies are documents containing clinical criteria used by Medica staff members for prior authorization, appropriateness of care and coverage determination. The criteria are specific to the clinical characteristics of the population that will benefit from the treatment or technology. The needs of individual patients who may not meet these criteria must be considered and are addressed by the process in the section labeled "Coverage Issues" on the UM policy.

Individual utilization management policies contain the clinical criteria used by Medica staff members for making prior authorization determinations. Access UM policies and learn more about how these polices are developed on medica.com at Providers>Medical Policies >Utilization Management Policies

Prior Authorization

The purpose of prior authorization is to evaluate the appropriateness of a medical service based on coverage criteria and medical necessity. Prior Authorization information is located on medica.com at Providers>Medica Policies>Prior authorization List and Request Forms>then select a prior authorization request form or View full Prior Authorization List for medical services that require prior authorization. Some services have specific forms to help providers in submitting prior authorization requests for review.

Coverage Policies

A coverage policy is a document that is developed to communicate decisions about coverage and benefits for various medical services. Each coverage policy contains a description of the medical service, as well as the coverage determination, product application, coding considerations and requirements for prior authorization.

Coverage policies can be found on medica.com at Providers>Medical Policies> Coverage Policies

Note: In addition to the above policy requirements, some radiology services require notification under the High-Tech Imaging Program. More information can be found on medica.com at Providers>Tools and Forms>Tools and Forms>Claims Tools and Forms.
Claim Submission – Professional & Facility Services

Methods of submitting claims

Minnesota providers are required to submit all claims electronically. Other participating providers may submit claims to Medica by paper or electronically. Go to medica.com at this location for details about submitting claims:
Providers>Reference Tools and Forms> Administrative Manuals >Medica Provider Administrative Manual>Billing and Reimbursement> Electronic Transactions

- Paper claims must be submitted on the CMS-1500 Claim Form—established by the American Medical Association (AMA)—or the invoice accepted by the Minnesota Department of Human Services (MDHS) for professional services and for facility services claims must be submitted on the UB-04 claims form established by the National Uniform Billing Committee (NUBC).
- Electronic claims are accepted through various vendor systems. (Please check with vendors to determine if they have a direct connection with Medica). Go to medica.com at Providers> Reference Tools and Forms>Tools and Forms>Claims Tools and Forms for the following information on Electronic Claims Submission:

  AUC Initiative
  Delta Dental of Minnesota
  Direct Data Entry
  HIPAA 5010 FAQ
  MN E-Connect Registration

Where to submit paper claims

All paper Medica claims go to:
Medica
PO Box 30990
Salt Lake City, UT 84130

Minnesota Provider Requirement

To adhere to the guidelines set by the Minnesota Administrative Uniformity Committee (AUC) and to be consistent with Minnesota law to standardize electronic healthcare transactions, Minnesota providers are required to submit all claims electronically, including professional, institutional, dental and pharmacy claims. For additional information on the AUC, go to medica.com at Providers>Reference Tools and Form>Tools and Forms> Claims Tools and Forms>AUC Initiative or http://www.health.state.mn.us/auc/profguide.htm

Medica electronic payer ID: 94265

Claim Submission Requirements

Each claim submitted to Medica, regardless of submission method, must include information covered in this section.

- Patient’s name, address, sex, date of birth
- Primary member’s name and ID number
- Name, signature, ‘remit to’ address, and phone number of the physician or health care provider performing the service, as described in the participation agreement
- Physician’s or health care provider’s National Provider Identifier (NPI) and federal tax ID number
- Date of service(s), place of service(s) and number of services (units) rendered
- Current CPT-4 and HCPCS procedure codes with modifiers where appropriate
• Current ICD-9-CM (or its successor) diagnostic codes by specific service
code to the highest level of specificity and following the Official ICD-9-
CM/ICD-10-CM Guidelines for Coding and Reporting
• Referring physician’s name and tax ID number (if applicable)
• Charges per service and total charges
• Information about other insurance coverage, including job-related, auto or
accident information, if available.
• Submit one attachment, (i.e. Explanation of Medicare Benefit or primary
carrier’s Explanation of Benefit statement) per member per provider per
form.

All Minnesota providers need to submit attachments following Minnesota
AUC Companion Guide and best practice for submission of attachments.

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<th>Administrative Issues</th>
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<tr>
<td>Administrative Issues</td>
<td>Medica does not cover medications &quot;dispensed&quot; by a physician or clinic (e.g., medications for outpatient or home use). To be eligible for coverage, a prescription must be filled by a participating pharmacy.</td>
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### Miscellaneous Data Entry Information – Professional and Facility Claims

| **Missing or invalid information** | For both physician and facility claims, Medica enters fields as they are submitted. If a field contains invalid information or information is missing, a send-back letter for “the required information” is sent back to the provider. |
| **COB** | If the claim has missing or invalid data elements, claims should not be sent back to the provider if the other insurance has paid on the claim and EOB/EOMB is attached. This applies for both Medicare and any commercial payer. If the other insurance has paid, we are supplementing that other insurance and should be picking up the deductible and coinsurance. |
| **Member Numbers (baby claims)** | Often a claim will be submitted for a newborn before the baby has been entered as a Medica member. In these cases, a letter will be sent to both the member and the provider and the claim will not be returned. |
| **Referring Physician** | A referring physician is required when the following specialty types submit claims.  
  - Pathologist  
  - Radiologist  
  - Anesthesiologist  
  - Therapeutic radiologist  
  - Independent lab  
  - Medical supply firm (DME/Orthotics) |
<p>| <strong>COB/Recovery Field</strong> | On the CMS-1500 claim form if field number 10a (Work related) and 10b (Auto) are marked with a “Y”, the claim will be flagged for COB or recovery. If the claim has attachments of any kind (check copies, EOBs, letters of exhaustion, or any other type of correspondence) that would indicate COB/Recovery, the claim will be flagged for COB or recovery. |
| <strong>Negative and Zero Charges</strong> | If a claim is submitted with a negative charge, it will be returned to the provider. If a claim is submitted with a zero charge, the system will change it to one penny to enable processing of the claim. |
| <strong>Modifiers</strong> | If the modifier is invalid, the provider will receive a send-back letter. |
| <strong>Patient Account # field</strong> | Medica will enter information listed in box 26 of the claim form. If this field is blank and there is a provider copy of the EOMB attached, Medica will enter the information listed in the account number field. If no EOMB is attached, the field will be left blank. |
| <strong>Assignment of Benefits</strong> | Claims submitted by a participating provider always have the benefits assigned to the provider and not the member. Medica does not accept assignment of benefits for claims for service from non-network providers unless the services have been prior-authorized for in-network benefits or it is an emergency although this may vary according to the member’s plan. |
| <strong>Missing Codes</strong> | For all Medica Products that have missing or invalid diagnosis or CPT/HCPCS codes, claims will be entered with 999.99 for a missing or invalid diagnosis code and XXXXX should be entered for a missing or invalid CPT/HCPCS code. A Department of Labor send-back letter will be sent to the provider requesting the additional information. The claim will remain closed in our system until the information is received. |</p>
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<td>If units submitted are more than 999, 999 will be entered in the units field, and in the description field the actual number of units will be entered.</td>
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<tr>
<td>If units are less than one, 1 unit will be entered.</td>
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<tr>
<td>If units are submitted as a decimal (example 1.25), enter a 99 modifier and a 1 in the units field. The description field will open and the processor will enter the correct number of units in the description field.</td>
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Minnesota Administrative Uniformity Committee

What is the AUC?

The Minnesota Administrative Uniformity Committee (AUC) is a voluntary, broad-based group representing Minnesota health care public and private payers, hospitals, health care providers and state agencies, working to standardize, streamline, and simplify health care administrative processes.

It has served since 1992 to develop agreement among payers and providers on standardized administrative processes and acts as a consulting body to various public and private entities.

The AUC meets as a large committee of the whole, as well as through numerous work groups and Technical Advisory Groups (TAGs). Members of each TAG represent particular areas of expertise and divisions of labor with respect to different types of health care administrative transactions and processes.

Current AUC TAGs are:
- Claims Data Definition
- Communications/Membership/Policy
- Eligibility
- Explanation of Benefits/Remittance Advice
- Legislative
- Medical Code
- Two Digit Program Code

What is the purpose of AUC?

To develop agreement among Minnesota payers and providers on standardized administrative processes when implementation of the processes will reduce administrative costs.

The AUC accomplishes this by:
- Participating in the implementation of standards
- Functioning as a consulting resource to national and state administrative simplification efforts
- Researching new issues that may lead to enhanced administrative uniformity
- Creating documentation that reflects recommendations and rules:
  - "Best Practice"
  - MN Uniform Companion Guide

What is the difference between the Minnesota AUC’s Best Practice documents and the Minnesota Uniform Companion Guides?

AUC Best Practices are:
- The consensus recommendations of the AUC to further standardize and harmonize health care administrative transactions.
- Not mandatory and do not have the force of law. While adoption or adherence to the AUC best practices is voluntary, it is strongly encouraged to further reduce health care administrative burdens and costs.

Minnesota Uniform Companion Guides are:
- Rules for the standard data content and format of standard, electronic health care administrative transactions.
- Mandatory and have the force of law.

Version 5010 and D.Ø of the guides are required for use beginning January 1, 2012. The Minnesota Department of Health (MDH) collaborates with the Minnesota AUC in developing the guides.
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<th>What are the benefits of standardizing administrative processes?</th>
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<td>▪ Quicker payment</td>
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<td>▪ More efficient transactions</td>
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<td>▪ Less costly transactions over time</td>
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<th>Who has legislative authority over the Minnesota AUC?</th>
<th>The Minnesota Department of Health (MDH) is statutorily required to consult with the Minnesota AUC, on rules for the data content and format for standard, electronic health care administrative transactions.</th>
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<td>Minnesota Statutes, section 62J.536, requires the Minnesota Commissioner of Health, in consultation with the Minnesota Administrative Uniformity Committee (AUC), to promulgate rules pursuant to section 62J.61 establishing and requiring group purchasers and health care providers to use electronic eligibility, claims, payment/advice, and acknowledgment transactions with a single, uniform companion guide to the implementation guides described under the Code of Federal Regulations, title 45, part 162.</td>
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<th>Additional Resources</th>
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<td>Minnesota Uniform Companion Guides</td>
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<td>62J.536 Uniform Electronic Transactions and Implementation Guide Standards</td>
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<td>Code of Federal Regulations, title 45, part 162</td>
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## Medica Reimbursement Policy Overview

Medica reimbursement policies provide payment methodology guidelines for medical, surgical and associated services submitted.

Reimbursement Policies are developed through a committee process with consideration of the following resources:
- Centers for Medicare and Medicaid (CMS) National Correct Coding Initiative (NCCI)
- National Physician Fee Schedule Relative Value File (NPFS)

## Policy Review Process

Reimbursement policies are reviewed on an annual basis.

Periodic updates can also be performed based on the following:
- Quarterly CPT/HCPCS releases
- Quarterly NPFS file releases
- AUC 5010 Guide

## Policy Location

View Medica policy documents and applicable code lists on medica.com:
- Providers > Reference Tools and Forms > Tools and Forms > Reimbursement / Claims Policies
## Reimbursement Policy Review

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<tr>
<th>Reimbursement Policy</th>
<th>Policy Description</th>
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</table>
| **3-Day Payment Window*              | The Medicare 3-Day Payment Window policy is applicable to Medicare and Minnesota Senior Health Options (MSHO) claims. Per the 3-Day Payment Window policy, a hospital (or an entity wholly owned or operated by the hospital) is required to include in its claim for an inpatient stay, the diagnoses, procedures, and charges for the following services when provided during the 3 days prior to admission to the hospital:  
  • All outpatient diagnostic services  
  • Admission-related non-diagnostic services  
  In addition, when billing for services subject to the 3-Day Payment Window policy, wholly owned/operated entities must identify applicable charges through use of the PD modifier. |
| **Add-On Code**                      | This policy describes reimbursement for physician claims submitted with add-on codes. Add-on codes are reimbursable services when reported in addition to the appropriate primary service or procedure by the same physician or other health care professional.  
  • Add-on codes describe procedures/services that are always performed in addition to the primary procedure/service. |
| **Adverse Health Care Events***      | Facilities are prohibited from billing members for services associated with an Adverse Health Care Event and Medica will not reimburse Facilities for services associated with an Adverse Health Care Event. If an Adverse Health Care Event involving a Medica member occurs, facilities are required to submit an Adverse Health Care Event Identification Form to Medica (see Attachments section). A quality case review will be initiated for all Adverse Health Care Events reported to Medica. |
| **After Hours and Weekend Care**     | This policy describes reimbursement for after hours or weekend care services, codes 99050-99060.  
  • Based on CMS status indicator “B” (Bundled Services) in the NPFS, these codes are not separately reimbursed and are considered to be bundled into the payment for other services provided by the same physician. |
| **Anesthesia**                       | This policy describes reimbursement for anesthesia and pain management services provided by anesthesiology professionals. |
| **Assistant Surgeon**                | This policy describes the procedures eligible for assistant surgeon reimbursement.  
  • Assistant surgeon status indicator “2” in the Centers for Medicare and Medicaid (CMS) National Physician Fee Schedule (NPFS) will be allowed without documentation |
| **Bilateral Procedures**             | Bilateral procedures are services that can be performed on both sides of the body during the same session on the same day by the same provider.  
  • All codes in the NPFS with the "bilateral" status indicators "1" or "3" are considered to be eligible for bilateral services as indicated by the bilateral modifier 50  
  • Status "1" = 150% payment adjustment for bilateral services  
  • Status "3" = 100% payment for each side. Example: Radiology procedures or other diagnostic tests  
  • Submit code with modifier 50 on one line with 1 unit |
| **Bundled Services**                 | Medica’s Bundled Services Policy defines services that are not eligible for separate reimbursement and are considered to be part of another service.  
  • Based on CMS status indicator “B” (Bundled Services) in the NPFS  
  • Example: 99070 Miscellaneous supplies and materials provided in an office setting |
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<tr>
<th>Reimbursement Policy</th>
<th>Policy Description</th>
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| Care Plan Oversight                              | Care Plan Oversight (CPO) is the physician supervision of a patient under the care of a hospice or home health agency.  
• CPO services are denied as ineligible charges because they do not involve direct patient contact. One exception: Under Medicare’s National Coverage Provision, these services are reimbursable for Medicare members. |
| CCI Editing                                      | This policy describes coding relationships through Column One/Column Two code pair edits and Mutually Exclusive code pair edits from CMS’s National Correct Coding Initiative (NCCI).                                           |
| Contrast and Radiopharmaceutical Materials       | This policy addresses reimbursement for high and low osmolar contrast and radiopharmaceutical materials submitted with codes A4641, A4642, A9500-A9700, J1245, Q3001, Q9951, Q9953, Q9954, and Q9956-Q9968 on the CMS-1500 form. |
| Co-Surgeon / Team Surgeon                        | This policy describes procedures eligible for reimbursement when two or more surgeons are required to perform surgery on the same patient during the same operative session.  
• Modifier 62 – Two Surgeons  
  NPFS status indicator “1” or “2” – Co-surgeons permitted and no documentation required  
• Modifier 66 – Surgical Team  
  NPFS status indicator “1” or “2” – Team surgeons permitted; pay by report only |
| Discarded Drugs and Biologicals                  | This policy addresses billing guidelines to report discarded drugs or biologicals when a single use vial/package is opened and the entire dose/quantity is not administered to the patient.                      |
| Discontinued Procedure                           | This policy describes reimbursement for claims appended with modifier 53 (discontinued procedure).  
• Medica’s reimbursement for most services appended with modifier 53 is 60% of the allowable amount for the unmodified procedure |
| From-To Date                                     | This policy describes reimbursement for identical services provided on consecutive days by the same provider and submitted on one line on a CMS-1500 claim form.  
• The “From” and “To” dates are entered in field 24A, DATE(S) OF SERVICE  
• “Days or Units” are entered in field 24G, DAYS OR UNITS, for each applicable service line |
| Global Days                                      | Reimbursement for surgical procedures includes payment for all related preoperative, intraoperative, and postoperative services and supplies that are routine and necessary to perform the procedure.  
• Global periods for surgical procedures are defined in the National Physician Fee Schedule as 0, 10, or 90 days  
• Modifiers may be used as appropriate to indicate services that are not included in the global package |
| Inappropriate Primary Diagnosis                  | The purpose of this new reimbursement policy is to describe and enforce appropriate billing guidelines for reporting certain ICD-9-CM (International Classification of Diseases, 9th Revision, Clinical Modification) codes. This policy would apply correct diagnosis coding guidelines, denying reimbursement when a diagnosis is reported inappropriately. |
| Increased Procedural Services                    | This policy describes reimbursement for codes submitted with modifier 22 and modifier 63.  
Modifier 22 (Increased Procedural Services):  
• Should only be reported with procedure codes that have a global period of 0, 10 or 90 days  
• Codes submitted with this modifier must include medical record documentation  
• If documentation supports submission of modifier 22, an additional 20% of the
<table>
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<tr>
<th>Reimbursement Policy</th>
<th>Policy Description</th>
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| **Modifier 63** | Allowable amount for the unmodified procedure is allowed. Modifier 63 (Procedure Performed on Infant less than 4 kg):  
- No additional reimbursement is allowed for codes submitted with modifier 63.  
Codes exempt from modifier 63 are listed in Appendix F of CPT. |
| **Initial Inpatient Consultations** | CPT codes 99251 – 99255 are used to report physician consultations provided to hospital inpatients.  
- Only one initial consultation per inpatient hospitalization is reimbursed when submitted by the same physician for the same patient.  
- Note: Effective 01/01/2010, CMS no longer recognizes AMA CPT consultation codes for Medicare members. |
| **Injection and Infusion Services** | This policy addresses reimbursement of diagnostic and therapeutic injection services (codes 96372-96379) when reported with Evaluation and Management (E/M) services and/or medications in an office place of service. The policy also addresses the reimbursement of associated supplies such as standard tubing and syringes when reported with injection and infusion services (codes 96360-96549) in an office place of service.  
- If both an E/M service and an injection code are submitted by the same physician or other healthcare professional on the same date of service, only the injection code will be reimbursed unless a significant, separately identifiable E/M service has been performed, as identified by modifier 25. |
| **Laboratory Rebundling** | This policy addresses the processing of lab codes.  
- All of the individual components of a panel must be billed in order for the charges to be bundled under a comprehensive panel code.  
- Only one laboratory handling (code 99000) and one venipuncture (code 36415 or 36416) charge will be reimbursed per date of service, per provider specialty.  
- Codes with a NPFS PC/TC indicator of “3” or “9” are not reimbursable to a reference or non-reference provider in a facility setting. |
| **Maximum Frequency per Day (Units)** | This policy describes reimbursement for services submitted with multiple units for the same CPT or HCPCS code on the same date of service.  
- Unit values are assigned to every CPT and HCPCS code.  
- The unit value establishes the highest number of units automatically allowed for services on a single date of service. |
| **Microsurgery** | This policy describes reimbursement for microsurgical techniques requiring the use of an operating microscope.  
- Microsurgical techniques requiring the use of the operating microscope may be paid separately only when submitted with certain CPT codes. Medica follows CMS guidelines for microsurgery reimbursement. |
| **Moderate Sedation** | Moderate (conscious) sedation is a drug-induced depression of consciousness during which a patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain the patient’s airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Moderate sedation services are divided into two families of codes:  
- Provision of sedation services by the physician who performs the procedure, requiring the presence of an independent trained observer to assist in monitoring the patient (codes 99143-99145)  
- Provision of sedation services by a physician other than the health care provider who performs the procedure (codes 99148-99150)  
- Procedures which include moderate sedation are listed in Appendix G of CPT. |
<table>
<thead>
<tr>
<th>Reimbursement Policy</th>
<th>Policy Description</th>
</tr>
</thead>
</table>
| Multiple Procedure Reduction              | Multiple procedures performed by the same physician on the same date of service during the same operative session will be subject to the multiple procedure reduction policy. When multiple procedures are performed on the same day, reduction in reimbursement for secondary and subsequent procedures will occur.  
  - Based on CMS multiple procedure indicators “1,” “2,” and “3” in the NPFS file to determine which procedures are eligible for multiple procedure reductions  
  - 100% of the allowable amount for the primary/major procedure  
  - 50% of the allowable amount for the secondary procedure and for all subsequent procedures |
| New Patient Visit                         | A new patient is a patient who has not received any professional services, i.e., evaluation and management (E/M) service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years.                                                                                                      |
| Obstetrical                               | This policy describes reimbursement for global and non-global obstetric services. Global obstetric (OB) care includes antepartum care, delivery services, and postpartum care. A physician, group practice or clinic that manages the patient’s care throughout the entire antepartum, delivery and postpartum periods is providing global OB care. |
| One or More Sessions                      | This policy addresses the reimbursement of codes whose code description indicates that the code should be submitted only once during a defined treatment or monitoring period.                                                                                                                        |
| Once in a Lifetime                        | This policy limits the frequency of reimbursement for certain identified procedures to once in the patient’s lifetime. Once in a Lifetime Procedures, by the nature of their description, can be performed only once in a patient’s lifetime.  
  - Example: Code 44950, appendectomy                                                                                                                                  |
| Physicians Billing                        | Physicians should report E/M or Preventive Medicine service CPT codes 99201-99499 in lieu of the nonphysician CPT codes: 96040, 96150-96155, 97802-97804/G270-G0271, and 98960-98962.                                                                                                                                       |
| Nonphysician Health Care Professional Medicine Services |                                                                                                                                                                                                                                                                                                                                                      |
| Physical Medicine & Rehabilitation: PT, OT and Evaluation & Management | This policy addresses reimbursement of evaluation services performed by physical therapy (PT) and occupational therapy (OT) providers.  
  - There are specific codes that describe evaluation services for PT and OT providers: 97001, 97002, 97003 and 97004  
  - E/M codes 99201-99499 are not eligible for reimbursement                                                                                                                |
| Preventive Medicine and Screening         | The Preventive Medicine and Screening policy addresses reimbursement of preventive medicine services when performed with other E/M services, screening and miscellaneous services.                                                                                                               |
| Professional and Technical Components     | Certain procedural codes are a combination of a professional component and a technical component. When the procedures are reported separately, modifiers 26 or TC should be appended to the procedure code.  
  - Procedures with professional and technical components include radiology, laboratory, medicine and a limited number of surgical codes.  
  - Professional and Technical Status Indicator “5” (Incident-To) codes describe services provided by auxiliary personnel. Payment may not be made for these services when they are provided to hospital inpatients or patients in the hospital outpatient department. |
<table>
<thead>
<tr>
<th>Reimbursement Policy</th>
<th>Policy Description</th>
</tr>
</thead>
</table>
| Prolonged Services                              | This policy describes reimbursement of prolonged physician services involving direct (face-to-face) patient contact beyond the usual service in either the inpatient or outpatient setting.  
  • Medica reimburses prolonged physician services in conjunction with certain E/M codes when time is a factor in determining level of service in accordance with CMS and CPT guidelines.  
  • Medica does not provide reimbursement for non face-to-face services.                                                                                                                                                                                                                       |
| Rebundling                                      | This policy provides an overview of how Medica addresses coding relationships through rebundling edits.  
  • According to CMS, medical and surgical procedures should be reported with the CPT/HCPCS codes that most comprehensively describe the services performed.  
  • Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code.  
  • If one of the codes is considered to be mutually exclusive or a component code of the other code, only the most comprehensive code will be reimbursed.  
  • Sources of edits:  
    o CMS National Correct Coding Initiative (CCI) edits;  
    o CMS Policy; and  
    o AMA CPT                                                                                                                                                                                                                                                                             |
| Recalled or Replaced Medical Devices*           | Medica will cover the cost of medically necessary procedures to remove and replace recalled or replaced devices. Medica will not be responsible for the full cost of a replaced device if an inpatient or outpatient facility is receiving a partial or full credit for a device, due to either recall or service during the warranty period.                                                                                     |
| Reduced Services                                | Under certain circumstances a service or procedure is partially reduced or significantly less than usually required to perform the service. The service provided can be identified by procedure code and the addition of modifier 52 (reduced services).  
  • Reimbursement for services submitted with modifier 52 is 75% of the allowable amount for the unmodified procedure  
  • This modifier is not used to report the elective cancellation of a procedure before anesthesia induction, intravenous (IV) conscious sedation, and/or surgical preparation in the operating suite  
  • Modifier 52 should not be used with an E/M service                                                                                                                                                                                                                                       |
| Registered Dietitian and Home Health Specialties Billing E/M Codes | This policy addresses appropriate coding for Registered Dietitians (nonphysician) and home health specialties.  
  • Specific codes define medical nutrition therapy services performed by registered dietitians: CPT 97802-97803, HCPCS G0108-G0109, and G0270  
  • Home health specialties include home health and home infusion providers. Specific codes exist that describe services performed by these providers such as 99500-99600, and 99601-99602  
  • E/M codes 99201-99499 are not eligible for reimbursement                                                                                                                                                                                                                                  |
| Robotic-Assisted Surgery                        | This policy addresses reimbursement of robotic-assisted surgery.  
  • S2900 – Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure)  
  • Not separately reimbursable                                                                                                                                                                                                                                                                 |
| Same Day Same Service                           | This policy addresses the reimbursement of E/M codes when provided with other services on the same date of service for the same patient by the same specialty physician or other health care professional.  
  • Only one E/M service may be reported unless the evaluation and management services are for unrelated problems.                                                                                                                                                                   |
<table>
<thead>
<tr>
<th>Reimbursement Policy</th>
<th>Policy Description</th>
</tr>
</thead>
</table>
| • A problem oriented E/M is allowed on the same day as a preventive medicine E/M (CPT 99381 - 99397).  
• A problem oriented E/M must have modifier 25 appended if submitted on the same date of service as a preventive medicine E/M. |
| Self-Administered Drugs | Self-Administered Drugs are covered as described under a member’s pharmacy benefit, subject to formulary status and applicable utilization management parameters. Self-Administered Drugs are to be obtained through pharmacies and not from healthcare providers.  
• See Medica.com for a comprehensive list of drugs applicable to this policy.  
• The administration fee will be covered as indicated under the member’s medical benefit, when the drug is purchased by the member at a pharmacy and brought to a provider clinic or a facility for administration. |
| Split Surgical Package | This policy addresses reimbursement of a split surgical package. A surgical package consists of preoperative management, surgical care and postoperative management services. A split surgical package occurs when the components of a surgical package are split between 2 or more physicians (not within the same group practice).  
• Example – one physician performs the surgical procedure and another furnishes the preoperative and/or postoperative care, denoted by the use of modifiers 54, 55, and 56 |
| Standby Physician | This policy addresses the reimbursement of physician standby service, and hospital mandated on call service. The following codes apply to this policy:  
• 99360 - Physician standby service, requiring prolonged physician attendance, each 30 minutes  
• 99026 - Hospital mandated on call service; in-hospital, each hour  
• 99027 - Hospital mandated on call service; out-of-hospital, each hour |
| SU Modifier | This policy addresses reimbursement for procedure codes billed with the SU modifier in an office place of service.  
• Modifier SU is defined as procedure performed in physician’s office (to denote use of facility and equipment). It was established by CMS for informational purposes.  
• Use of an office facility and equipment are considered included in the practice expense of the Relative Value Unit (RVU) for a service or procedure. Therefore procedure codes billed with the SU modifier are not eligible for reimbursement. |
| Supply | This policy describes reimbursement for supplies and surgical trays when they are provided on the same day as an evaluation and management (E/M) service or procedure performed in an office place of service. |
| Team Conferences | This policy addresses reimbursement for team conferences, codes 99366-99368.  
• These codes have a Status Indicator of “B” in the NPFS. Consistent with CMS, Medica considers these codes not eligible for reimbursement. |
<p>| Telehealth | Telehealth services, sometimes also referred to as Telemedicine, are medical services delivered other than in person (such as over the phone, or live audiovisual interaction), and do not involve direct, in-person patient contact. |
| Time Span Codes | This policy addresses reimbursement of codes that contain specific time span verbiage in their description in the CPT book. There are a number of codes that, by their description, should only be submitted weekly, monthly, annually, or any specified time period other than daily. |</p>
<table>
<thead>
<tr>
<th>Reimbursement Policy</th>
<th>Policy Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unlisted Procedure Code</td>
<td>The purpose of this policy is to address the appropriate reporting of unlisted CPT and HCPCS codes. Unlisted procedure codes were created to report services for which there is no specific code descriptor available.</td>
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<tr>
<td></td>
<td>• When billing an unlisted code always include a description of the service on the CMS-1500 claim form.</td>
</tr>
<tr>
<td></td>
<td>• Claims for unlisted procedure codes also require submission of documentation such as an operative note or a copy of the report for the diagnostic study or office notes. A cover letter providing a comparative service is beneficial.</td>
</tr>
<tr>
<td></td>
<td>• Claims for unlisted drug codes require the submission of the 11-digit National Drug Code (NDC) in the correct format and location on the claim form.</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>This policy addresses HCPCS codes S9083 (Global fee urgent care centers) and S9088 (Services provided in an urgent care center).</td>
</tr>
<tr>
<td></td>
<td>• These codes represent where the service was performed, and do not describe specific components of services rendered. These codes are considered part of the primary service and are denied.</td>
</tr>
<tr>
<td>Wrong Surgery or Other Invasive Procedures</td>
<td>This policy addresses that Medica will not provide reimbursement for surgical or other invasive procedures that are erroneously performed by a healthcare provider.</td>
</tr>
<tr>
<td></td>
<td>• Erroneous procedures include: A surgical procedure performed on the wrong side or body part; a surgical procedure performed on the wrong person; or the wrong surgical service or other invasive procedure rendered to a patient.</td>
</tr>
</tbody>
</table>

Note: (*) denotes policy applicable to facility/UB-04 only
Facility Reimbursement

Completing the UB-04 Claim Form

For instructions go to Medica.com at Providers>Reference Tools and Forms>Tools and Forms>Claims Tools and Forms> How To Complete - UB-04

Facility Claim Specifics

Medica follows national and state uniform billing guidelines for the submission of UB-04 claim forms, although some fields required by Medicare or other payers may not be necessary for Medica claims.

Enter the accommodation rate for room and board on inpatient claims, or the appropriate CPT®/HCPCS code for the outpatient ancillary service being reported.

Important: Refer to your Medica contract to determine whether a CPT/HCPCS code is required for adjudication of the claim. For example, outpatient surgeries being paid under a grouper or other codes (e.g., labs, therapies) carved out for specific rates.

Special Notes

If revenue codes 450 (Emergency Room) and 456 (Urgent Care) both are billed on the same claim, a send-back form and the claim will be returned to the provider. Only one of these codes should be submitted.

All claims from Home Health Care providers and charges for home health billed by a Public Health provider should be submitted on an UB-04 claim form with the appropriate NPI number.

Effective September 1, 2010, eligible facility claims incurred by eligible Indian Health Services (IHS) Tribal Enrollees will be reimbursed at the American Indian Tribes fee schedule amount based on Medicare-like rates. This is industry standard for payers in the Medica service area.

Providers will be able to identify these members by the designation on their Medica ID card which indicates "IHS Tribal Enrollee." Also, the provider remittance advices (PRAs) or provider explanations of benefits (EOBs) for such claims will indicate "Paid According to IHS Medicare-Like Rates."
National Physician Fee Schedule Relative Value File (NPFS)

National Physician Fee Schedule Relative Value File - A public use file that contains information on services covered by the Medicare Physician Fee Schedule (MPFS). The file contains the associated relative value units (RVUs), a fee schedule status indicator, and various payment policy indicators needed for payment adjustment (e.g., payment of assistant at surgery, team surgery, bilateral surgery).

Relative Value Unit - CMS defines RVU as the assigned unit value of a particular CPT or HCPCS code.

For more than 10,000 physician services, the National Physician Fee Schedule (NPFS) file contains the associated relative value units (RVUs), a fee schedule status indicator, and various payment policy indicators needed for payment adjustment (i.e., payment of assistant at surgery, team surgery, bilateral surgery, etc.).

The files are typically updated quarterly and are named with the effective year and an alpha character.

To locate NPFS files, go to: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html

NPFS Example:
- RVU12A is the file for Relative Value Units (RVU) for the first quarter (A) of 2012 (12)
- RVU12AR is the file for 1st quarter (A), Revised (R) of 2012 (12)

PFS Relative Value Files

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<tr>
<th>Calendar Year</th>
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<tr>
<td>2011</td>
<td>RVU11AR</td>
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<td>2012</td>
<td>RVU12A</td>
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</tr>
<tr>
<td>2012</td>
<td>RVU12C</td>
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</tbody>
</table>

1st quarter (A) Revised (R) 2012 update
1st quarter (A) 2012 update
Details for Calendar Year: 2012

Calendar Year
2012

File Name
RVU12A

Description
Physician Fee Schedule - January 2012 release. This file contains the revisions identified in the Physician Fee Schedule Final Regulation published November 2011.

File Size
3.35MB

NOTE: 'Medicare payment rates under the Medicare Physician Fee Schedule (MPFS) are set according to statutory criteria. The following 2012 MPFS payment rates are reflective of the 2012 Physician Fee Schedule Final Rule that was put on display at the Office of the Federal Register on November 1, 2011, and are based on current law which provides a negative update for 2012. However, the Centers for Medicare & Medicaid Services will quickly work to update MPFS payment rates in the event Congress passes legislation to prevent the negative update from going into effect on January 1, 2012. Please be on the alert for more information about the 2012 physician update as it becomes available.'

Downloads
RVU12A [ZIP, 3.3MB]
Example database file - data elements:
- HCPCS (Procedure Code)
- Mod (Modifier)
- Description of code
- Status Code

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>MOD</th>
<th>DESCRIPTION</th>
<th>STATUS CODE</th>
<th>MEDICARE</th>
<th>WORK</th>
<th>TRANSFORMED FULLY</th>
<th>IMPLEMENTED</th>
<th>FACILITY</th>
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<tr>
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<td>Chest x-ray</td>
<td>A</td>
<td>0.21</td>
<td>0.08</td>
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<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

Example of NPFS Data Elements (continued):
- PCTC - Professional and Technical Component (Indicates whether code has professional and/or technical components)
- Glob Days - Global Days (Provides time frames that apply to each surgical procedure)
- Mult Proc - Multiple Procedure Reduction (Indicates applicable payment adjustment rule for multiple procedures)
- Bilat Surg - Bilateral Surgery (Indicates services subject to payment adjustment)
- Asst Surg - Assistant Surgeon (Indicates services where an assistant at surgery is paid)
- Co Surg - Co-Surgeon (Indicates services for which two surgeons, each in a different specialty, may be paid)
- Team Surg - Team Surgeon (Indicates services for which team surgeons may be paid)
OVERVIEW: CMS National Correct Coding Initiatives Edits (aka CCI Edits)

Location:

National Correct Coding Initiatives Edits

Important notice to all NCCI Users concerning the National Correct Coding Initiative Policy Manual for Medicare Services:

The annual updated version of the National Correct Coding Initiative Policy Manual for Medicare Services will be effective January 1, 2012 rather than October 1, 2011. This manual will be posted on the NCCI website on or around December 1, 2011.

As of April 1, 2012, a revision to Chapter 8 (CPT codes 60000-69999), Section C, Nervous System, Paragraph #15, Pages VIII-74 has been posted on the CMS' NCCI web page.

The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. The CMS annually updates the National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual). The Coding Policy Manual should be utilized by carriers and EDI as a general reference tool that explains the rationale for NCCI edits.

Carriers implemented NCCI edits within their claim processing systems for dates of service on or after January 1, 1996.

A subset of NCCI edits is incorporated into the outpatient code editor (OCE) for OPPE and therapy providers (Skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs), outpatient physical therapy and speech-language pathology providers (OPTs), and home health agencies (HHAs) billing under TOBs 22X, 23X, 76X, 74X, 34X).

The purpose of the NCCI edits is to prevent improper payment when incorrect code combinations are reported. The NCCI contains one table of edits for physicians/practitioners and one table of edits for outpatient hospital services. The Columns One/Column Two Correct Coding Edits table and the Mutually Exclusive Edits table have been combined into one table and include code pairs that should not be reported together for a number of reasons explained in the Coding Policy Manual.

This web page provides information to providers on Medicare's NCCI edits but does not address specific NCCI edits. If the viewer has concerns about specific NCCI edits, he/she may submit comments in writing to:

National Correct Coding Initiative
Correct Coding Solutions LLC
P.O. Box 5007
Carmel, IN 46080-0007

Attention: Niles R. Rosen, M.D., Medical Director and Linda S. Dietz, RHA, CCE, CCP, Coding Specialist
Fax #: 317-571-1745

The NCCI Edits Manual may also be obtained by purchasing the manual, or sections of the manual, from the National Technical Information Service (NTIS) website located in the "Related Links Outside CMS" section below, or by contacting NTIS at 1-800-336-2008 or 703-487-4680.
The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of Part B claims. The coding policies are based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice.

Scroll all the way down to the bottom of the page and click on the link “NCCI Policy Manual for Medicare Services – Effective January 1, 2012” (red arrow):

The NCCI Policy Manual Table of Contents opens up, containing a wealth of correct coding principles and information. The Introduction and Chapter 1 (blue arrows) offer general coding principles. Each chapter covers coding guidelines relevant to that range of codes (example 10000-19999).
CCI edits are of two types: Procedure-to-Procedure (PTP) edits and Medically Unlikely Edits (MUE).

- PTP edits prevent inappropriate payment of services that should not be reported together. Each edit has a column one and column two code. The column one code is considered the more comprehensive service and is eligible for payment, but the column two code is denied as a component unless a clinically appropriate CCI-associated modifier is also reported.

- MUE edits (aka Maximum Frequency per Day or Units) prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for any code is the maximum number of units of service under most circumstances reportable by the same provider for the same beneficiary on the same date of service.

To view the PTP edits, return to the CMS.gov opening page and click on “NCCI Coding Edits” (red arrow):

A similar looking page opens; scroll to the bottom and click on “Physician CCI Edits V18.1 Effective April 1, 2012” (red arrow):
The license agreement page opens; scroll to the bottom and click on “Accept” (red arrow):

The Zip file opens; both files contain identical CCI edits but they are in different formats (txt vs xlsx). Select the format supported by your version of Excel (purple arrow for pre-2007 Excel, aqua arrow for 2007 or 2010 Excel), and click to open the edits.
The PTP edit tables appear as below.

Example: CPT codes 43622, 43810

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</table>

Column F indicators:
0 = Modifier not allowed
1 = Modifier allowed
9 = Not applicable

Which modifier?
59 = 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:
If column E has an expiration date, the bundling edit is no longer valid in CCI but may still be valid with the payer.
♦ To view the MUEs, return to the opening CMS page and click on "Medically Unlikely Edits" (red arrow):

![CMS.gov](image1)

National Correct Coding Initiatives Edits

Medically Unlikely Edits

Quarterly NCCI and MUE Version
Update Changes

NCCI Coding Edits

NCCI Transmittals

Medically Unlikely Edits

Important notice to all NCCI Users concerning the National Correct Coding Initiative Policy Manual for Medicare Services:

The annual updated version of the National Correct Coding Initiative Policy Manual for Medicare Services will be effective January 1, 2012 rather than October 1, 2011. This manual will be posted on the NCCI website on or around December 1, 2011.

As of April 1, 2012, a revision to Chapter II (CPT codes 60000-69999), Section C, Nervous System, Paragraph #15, Pages VIII.7-8 has been posted on the CMS NCCI web page.

The following page opens; scroll to the bottom and click on "Practitioner Services MUE Table" (red arrow):

![CMS.gov](image2)

National Correct Coding Initiatives Edits

Medically Unlikely Edits

Quarterly NCCI and MUE Version
Update Changes

NCCI Coding Edits

NCCI Transmittals

Medically Unlikely Edits

The CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. An MUE for a HCPCS/HCPCS code is the maximum unit of service that a provider should report under most circumstances for a single beneficiary on a single date of service. All HCPCS/HCPCS codes do not have an MUE.

MUE was implemented January 1, 2007, and is utilized to adjudicate claims at Centers, Fiscal Intermediaries, and DME MACs.

This webpage has links to the MUE Frequently Asked Questions and Answers (FAQs), MUE files, and the Publication Announcement Letter which explain major aspects of the MUE program.

Although CMS publishes most MUE values on its website, other MUE values are confidential and are for CMS and CMS Contractors’ use only. The latter group of MUE values should not be released since CMS does not publish them.

If you have concerns about the MUE program other than MUE values for specific codes, contact Valeria Allen (valeria.allen@cms.hhs.gov).

Inquiries about a specific claim should be addressed to the claims processing contractor.

Inquiries about the rationale for an MUE value should be addressed to your claims processing contractor or a national healthcare organization whose members often perform the procedure.

If a national healthcare organization, provider, or other party wants to submit a request for reconsideration of an MUE value, the procedure described in the MUE Frequently Asked Questions (FAQ) should be followed. See the web link below. Such requests should be addressed to:

National Correct Coding Initiative

Contact Coding Solutions, LLC

P.O. Box 927

Carmel, IN 46032-0927

Fax #: 317-571-1745

Downloads

MUE Publication Announcement Letter [PDF, 61 KB]

Related Links

MUE FAQs

Practitioner Services MUE Table - Updated 4/1/12

Facility Outpatient Services MUE Table - Updated 4/1/12

DME Supplier Services MUE Table [Note: This file will include HCPCS D, E, H, K, Y codes at this time and will not include HCPCS codes under DME MAC jurisdictions] - Updated 4/1/12

Page last modified: 04/13/2012 12:43 PM
Help with file formats and signups

A federal government website managed by the Centers for Medicare & Medicaid Services

7550 Security Boulevard, Baltimore, MD 21244

7/19/2013

Roadmap to Coding/Reimbursement Tools and Resources

Page 31 of 33
Click through the license agreement page ("Accept"), and the MUE files appear. Any version of Excel will support the "xlsx" file (red arrow), so click to open it:

The MUE file appears as below. This is CMS's version of Maximum Frequency per Day, or units. Note: Not every code has a published MUE value.
## Provider Resources

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>LOCATION</th>
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<tbody>
<tr>
<td><strong>Medica Resources</strong></td>
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<tr>
<td>Coding Tools and Forms</td>
<td>medica.com at Providers&gt;Reference Tools and Forms&gt;Tools and Forms&gt;Coding Tools and Forms</td>
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<tr>
<td>Medica Product Information</td>
<td>medica.com at Providers&gt;Reference Tools and Forms&gt;Tools and Forms&gt;Product Information</td>
</tr>
<tr>
<td>Medica Provider Service Center</td>
<td>1-800-458-5512 or medica.com at <a href="http://provider.medica.com/default.aspx">http://provider.medica.com/default.aspx</a></td>
</tr>
<tr>
<td>Medica Connections &amp; Provider Alerts</td>
<td>medica.com at Providers&gt;News You Can Use</td>
</tr>
<tr>
<td>Medica Points of Contacts</td>
<td>medica.com at Providers&gt;Contact Medica</td>
</tr>
<tr>
<td>Utilization Management Policies, Prior Authorization List &amp; Request Forms, Coverage Policies, etc.</td>
<td>medica.com at Providers&gt;Medical Policies</td>
</tr>
<tr>
<td>Claims Tools and Forms (mailing addresses, adjustment &amp; resubmission processes, electronic claims submission, referral processes, timely filing and more)</td>
<td>medica.com at Providers&gt;Reference Tools and Forms&gt;Tools and Forms&gt;Claims Tools and Forms</td>
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<tr>
<td><strong>Other Resources</strong></td>
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<tr>
<td>Resources to review Medicare policies</td>
<td>Refer to Medicare NCD/LCD policies:</td>
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<tr>
<td></td>
<td>• MN &amp; WI members medical policies  <a href="http://www.wpsmedicare.com/">http://www.wpsmedicare.com/</a></td>
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<tr>
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<td>• ND &amp; SD members medical claims  <a href="https://www.noridianmedicare.com/">https://www.noridianmedicare.com/</a></td>
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<td>• ND &amp; SD DME Policies  <a href="https://www.noridianmedicare.com/dme/coverage/lcd.html">https://www.noridianmedicare.com/dme/coverage/lcd.html</a></td>
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<tr>
<td>Medicare links and resources</td>
<td>• CMS.gov (Centers for Medicare &amp; Medicaid Services) Medicare Coverage Database – Centers for Medicare &amp; Medicaid Services</td>
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<tr>
<td></td>
<td>• WPS Medicare  Part B Provider Home Page</td>
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<td>• Noridian Administrative Services (NAS)  Active Local Coverage Determinations (LCDs)</td>
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<td>• Medicare.gov  Medicare.gov – the Official U.S. Government Site for Medicare</td>
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<tr>
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<td>• National Government Services (NGS)  Durable Medical Equipment - Home</td>
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<td>Additional resources</td>
<td>Minnesota AUC website</td>
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<td></td>
<td>Minnesota Uniform Companion Guides</td>
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<tr>
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<td>62J.536 Uniform Electronic Transactions and Implementation Guide Standards</td>
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<td>Code of Federal Regulations, title 45, part 162</td>
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