



Medicare Hospital and Chargemaster Version LifePoint Custom

KEY CONCEPTS OUTLINE

Module 3: Medicare Claims and Edit Fundamentals

- I. The UB-04 Form/837 I Electronic Format
 - A. The UB-04/837I format is used by Medicare for “provider” claims.
 1. Handout 5 is a hardcopy UB-04 claim form.
 - B. CMS has instructed providers to obtain code descriptions from the National Uniform Billing Committee (NUBC) or from the local MAC. *<Medicare Claims Processing Manual Transmittal 1973>*
 1. The *Official UB-04 Data Specifications Manual* (NUBC Manual) contains the official code descriptions for fields on the UB-04, as well as the meeting minutes of the NUBC committee, which may be helpful to understand new codes and changes to existing code descriptions.
 - a. The NUBC manual can be obtained by subscribing through the American Hospital Association’s bookstore. Information can be found on the NUBC website at: www.nubc.org.
 - b. The NUBC Manual is released on July 1 of every year, i.e., the 2023 version was released July 1, 2022.
 2. CMS continues to communicate specific code implementation direction via change requests (CRs), i.e., transmittals. *<Medicare Claims Processing Manual Transmittal 1973>*
- II. Key UB-04 Fields Applicable to Hospital Services *<See Selected Pages from Medicare Claims Processing Manual, Chapter 25 § 70>*
 - A. Billing Provider Name, Address and Telephone Number (FL 01)
 1. Identifies the street address or physical location where the service was rendered, including the 9-digit zip code. *<See Workgroup for Electronic Data Interchange (WEDI) Frequently Asked Questions, 5010 837 Billing Provider*

Address, April 28, 2011; see *Medicare Claims Processing Manual*, Chapter 1 § 170.1.1; NUBC August 7-8, 2007, Meeting Minutes, Issue 8, page 962>

- a. The 9-digit zip code reported in this field is used to determine the applicable payment locality where used (e.g., the Medicare Physician Fee Schedule). <*Medicare Claims Processing Manual*, Chapter 1 § 170.1.1>
- b. CMS developed “Systemic Validation Edits for OPPS Providers with Multiple Service Locations” to RTP a claim if the service address does not match an address on the 855A enrollment form submitted by the hospital as reflected in the Provider Enrollment, Chain and Ownership System (PECOS). <*Medicare One Time Notice Transmittal 1704*; NUBC Committee Meeting Minutes, April 4-5, 2017>
 - i. CMS has conducted 3 rounds of testing of the edits and was set to implement them in April 2020, however, they have delayed them indefinitely due to the COVID-19 PHE. <*MLN Matters SE19007*>
 - ii. Services reported with Condition Code A7 (hospital service provided in a mobile facility or portable unit) bypass the service address matching edits. <*Medicare One Time Notification Transmittal 2394*>

2. Services Rendered at More Than One Location:

- a. If any service on the claim was rendered at the main provider address, only the main provider address is reported in UB04 FL01 (paper claim) and the 837I billing provider loop 2010AA (electronic claim). The PBD address is not reported in the 837I service facility address loop 2310E (electronic claim). <*MLN Matters SE18002, SE18023*>
- b. If no services on the claim were rendered at the main provider address, but any service was rendered at another campus address of a multi-campus hospital, the campus address is reported in UB04 FL01 (paper claim) and the 837I service facility address loop 2310E (electronic claim). The PBD address is not reported. <*MLN Matters SE18002, SE18023*>
- c. If all services were provided at one PBD location, the PBD address is reported in UB04 FL01 (paper claim) and the 837I service facility address loop 2310E (electronic claim). <*MLN Matters SE18002, SE18023*>
- d. If services are provided at more than one PBD location, the address of the PBD that provided the first registered encounter reported on the claim is reported in UB04 FL01 (paper claim) and the 837I service facility address loop 2310E (electronic claim). <*MLN Matters SE18002, SE18023*>

B. Bill Type (FL 04)

1. The most common bill types used by hospitals include:
 - a. Inpatient Part A – 011X;
 - b. Inpatient Part B – 012X;
 - c. Outpatient Part B – 013X;
 - d. Non-patient diagnostic laboratory – 014X; and
 - e. Outpatient Critical Access Hospital – 085X.
2. The last digit of the bill type, often represented by the variable X in CMS policies, is filled in with a frequency code, e.g., 1 for “admit through discharge” or 7 for an “adjustment claim”.

C. Statement Covers Period (From-Through) (FL 06)

1. Indicates the dates of service included on the claim, with the “from” date being the earliest date of service on the claim. <MLN Matters Article SE1117>

D. Admission/Start of Care Date (FL 12)

1. Required on inpatient claims to indicate the admission date of the patient.
 - a. The date of inpatient admission is the date of the doctor’s order for inpatient care. <42 C.F.R. 412.3, Medicare Claims Processing Manual, Chapter 3 § 40.2.2 K>
 - i. If the patient dies or is discharged prior to being assigned and/or occupying a room, the patient is nonetheless considered an inpatient on the date of the admission order and the hospital may charge for room and board. <Medicare Claims Processing Manual, Chapter 3 § 40.2.2 K>

Example: A patient is seen in the ED on Monday evening. The physician writes an inpatient admission order at 10:00 p.m. on Monday. The patient remains in the ED until 2:30 a.m. on Tuesday, at which time the patient is transported to an inpatient bed. The date of admission is Monday.

2. The admission date need not match the statement “from” date in FL 6 and may be after the “from” date, if appropriate. <MLN Matters Article SE1117>

E. Patient Discharge Status (FL 17)

1. Indicates the patient status (i.e., discharged, transferred, etc.) as of the “through” date of the billing period.

Tip: CMS published Special Edition MLN Matters Article SE1411 to clarify the use of Patient Discharge Status codes.

F. Condition Codes (FLs 18-28)

1. Used to communicate various types of claim/beneficiary specific information to the MAC (e.g., Condition Code 44 is used to indicate an inpatient admission that was changed to outpatient following a UR determination).

G. Occurrence Codes (FLs 31-34)

1. Used to communicate the occurrence of an event (and the date of the event) to the MAC (e.g., Occurrence Code 32 is used to indicate the date a patient was given an ABN).

H. Occurrence Span Codes (FLs 35-36)

1. Used to communicate the beginning and ending dates for a particular event (e.g., Occurrence Span Code 72 denotes a contiguous outpatient service that precedes an inpatient admission).

I. Value Codes (FLs 39-41)

1. Used to communicate a dollar amount, unit amount or other similar information required for some types of claims (e.g., Value Code 48 is used to indicate the most recent hemoglobin reading to verify coverage of Epoetin).

J. Revenue Codes (FL 42)

1. Indicates the revenue center for each charge included on the bill.
 - a. Used to capture charges by revenue center for cost/charge-based payment purposes and for cost report reconciliation.
2. If CMS has not provided explicit instructions, hospitals should “report their charges under the revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report.” <Medicare Claims Processing Manual, Chapter 4 § 20.5>

- a. A crosswalk of revenue code to cost center mapping is posted on the CMS website.

Link: Revenue Code to Cost Center Crosswalk under Medicare-Related Sites – Hospital

3. Hospitals should choose the most precise revenue code or subcode when applicable rather than the “0” (General) or “9” (Other) categories. <Medicare Claims Processing Manual Transmittal 1599, 1. Revenue Code Reporting>
4. Revenue codes are validated (i.e., checked for effective date, deactivation, etc.) based on the claims processing receipt date rather than the claim from and through date or line-item date of service. <IOCE Specifications, Section 4.3>

K. HCPCS Codes/Rates (FL 44)

1. On inpatient claims, used to report the accommodation rate.
 - a. Blood Clotting Factor Add-on Payment:
 - i. Hospitals do not generally use HCPCS codes for reporting inpatient services, however, to receive the hemophilia blood clotting factor add-on payment the hospital must report Revenue Code 0636 and a HCPCS code with the number of units administered reported in the unit field. <Medicare Claims Processing Manual, Chapter 3 § 20.7.3>
 - ii. The blood clotting factor add-on payment is only available if the patient has a specified hemophilia diagnosis code, listed in the *Medicare Claims Processing Manual*, Chapter 3 § 20.7.3.
2. On outpatient claims, used to report HCPCS codes (i.e., CPT (HCPCS Level I) and HCPCS Level II codes; Handout 6 is a diagram of coding systems for reference.)
 - a. Reporting HCPCS codes is generally required for hospitals paid under the OPPS, where they exist, and should be consistent with the HCPCS long descriptor. <Medicare Claims Processing Manual, Chapter 4 § 20.1>
 - b. Unless specifically indicated, hospitals may report any HCPCS code without regard to the term “physician” in the descriptor. <Medicare Claims Processing Manual, Chapter 4 § 20.2>

Tip: The term “physician” used in HCPCS code descriptors or coding policies applies to hospitals and other practitioners eligible to bill the HCPCS code under applicable Medicare coverage and payment provisions.

- c. If a separate code exists for reporting the technical component of a service, the hospital should report the technical component code for their services. <Medicare Claims Processing Manual, Chapter 4 § 20.2>
- d. If no separate code exists for the technical component of a service, the hospital should report the code that represents that complete procedure. <Medicare Claims Processing Manual, Chapter 4 § 20.2>
- e. Modifiers are two-digit codes, consisting of letters and numbers, that are reported after HCPCS codes to provide more information about the code. <Medicare Claims Processing Manual, Chapter 4 § 20.6>
 - i. Modifiers may bypass code edits, trigger payment modifications or simply be informational.
 - ii. Modifiers should only be appended to HCPCS codes if the clinical circumstances justify the use of the modifier and must be used if the payment or informational conditions for use of the modifier have been met. <NCCI Policy Manual, Chapter 1 (E)>
 - iii. Pricing modifiers should be appended first, followed by descriptive modifiers. <Billing 340B Modifiers under the Hospital Outpatient Prospective Payment System (OPPS), Frequently Asked Questions, Q14>
 - a) If conflicting modifiers are reported together on the same HCPCS code line, edit 102 of the Integrated Outpatient Code Editor (IOCE) will return the claim to the provider. <See IOCE Specifications, Section 6.2, Edit 102 (Supplement)>
 - b) The list of modifier pairs that trigger edit 102 are available in the IOCE Quarterly Data File, Report-Tables folder, “MAP_MODIFIER_CONFLICT” available on the IOCE homepage.
 - iv. MACs are required to accept and process up to five modifiers. <Medicare Claims Processing Manual, Chapter 23 § 20.3>

L. Principal Diagnosis Code (FL 67)

- 1. For inpatient claims, used to report the “principal” diagnosis.
 - a. The principal diagnosis is “the condition established after study to be chiefly responsible for [the] admission.” <Official ICD-10-CM Guidelines for Coding and Reporting, Section II>

2. For outpatient claims, used to report the “first-listed” diagnosis.
 - a. The “principal diagnosis” concept does not apply to outpatient services. <Official ICD-10-CM Guidelines for Coding and Reporting, Section IV(A)>
 - b. The first-listed diagnosis is the “diagnosis, condition, problem, or other reason for [the] encounter/visit shown in the medical record to be chiefly responsible for the services provided.” <Official ICD-10-CM Guidelines for Coding and Reporting, IV (G)>
 - c. If a code identified as an unacceptable principal diagnosis code is reported on an outpatient claim, edit 113 of the IOCE will return the claim to the provider (RTP) unless the code is on the list of outpatient exclusions. <See IOCE Specifications, Section 6.2, Edit 113 (Supplement)>
 - i. The list of unacceptable principal diagnosis codes and outpatient exclusions are available in the IOCE Quarterly Data File, Report-Tables folder, “Data_DX10” available on the IOCE homepage.

M. Other Diagnosis Codes (FLs 67A-Q)

1. Used to report additional diagnosis codes applicable to an encounter/admission.
2. Medicare claims systems accepts 24 additional diagnosis codes in addition to the principal diagnosis. <See IOCE Specifications, Section 3.1.1 (Supplement); Medicare Claims Processing Manual, Chapter 3 § 20.2.1 C>

N. Present on Admission (POA) Indicator (FLs 67, 67A-Q, and 72 supplemental locator)

1. The POA is used to indicate whether a condition was present upon inpatient admission. <Official ICD-10-CM Guidelines for Coding and Reporting, Appendix I Present on Admission Reporting Guidelines, “General Reporting Requirements”>
2. Reporting of the POA indicator is required for inpatient claims submitted by hospitals paid under the Inpatient Prospective Payment System (IPPS) and Maryland Hospitals exempt from IPPS. <Medicare Claims Processing Manual Transmittal 1240; 78 Fed. Reg. 50524-25>
 - a. Critical Access Hospitals, Long Term Care Hospitals, Inpatient Rehabilitation Facilities, Inpatient Psychiatric Facilities, cancer hospitals, and children’s hospitals are exempt from POA reporting requirements. <One Time Notification Transmittal 354>

O. Admitting Diagnosis (FL 69)

1. For inpatient claims, the “condition identified by the physician at the time of the patient’s admission requiring hospitalization” must be reported in this field for all claims subject to review by the Quality Improvement Organization (QIO).
 - a. Although inpatient Part B claims (TOB 012X) are billing for part B payment, NUBC instructions require an admitting diagnosis in FL69 for TOB 012X claims. <NUBC Manual, FL69>

P. Patient’s Reason for Visit (FLs 70a-c)

1. For outpatient claims, the patient’s reason for the visit must be reported for claims with type of bill 013X (hospital outpatient) and 085X (critical access hospital outpatient) if:
 - a. The Priority (Type) of Admission or Visit is 1 (emergency), 2 (urgent), or 5 (trauma); and
 - b. Revenue codes 045X (emergency department), 0516 (urgent care clinic), or 0762 (observation hours) are reported.
2. Although signs and symptoms that are integral or related to the definitive diagnosis are not reported as additional diagnosis codes, they may be reported in FLs70a-c. <MLN Matters Article 3437; Coding Clinic for ICD-9-CM, Third Quarter 2003>

Tip: The patient reason for visit may be reported on any claim type at the discretion of the provider if the information substantiates the medical necessity of the services rendered.

Case Study 1

Facts: A patient presents to the emergency department with chest pain (R07.9). Following testing, including an EKG and cardiac enzymes, the patient is diagnosed with a recurrence of Gastroesophageal Reflux Disease (GERD) (K21.0). What diagnosis or diagnoses codes should be reported on the claim and in what field or fields?

Q. Principal Procedure (FL 74) and Other Procedures (FLs 74A-E)

1. Required only for inpatient claims – used to report ICD-10-PCS procedure codes.
 - a. The principal procedure is “the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication”.
2. Medicare inpatient claims systems process 24 procedures in addition to the principal procedure, for a total of 25. <Medicare Claims Processing Manual, Chapter 3 § 20.2.1>

III. Medicare Claims Flow and Processing Systems for Hospitals

A. Medicare claims flow through 3 primary systems during processing. <MLN Matters Article SE0605>

1. The MAC’s Claims Processing System.
 - a. System resides at the MAC level.
 - i. The MAC generates responses to providers and beneficiaries for submitted claims. <MLN Matters Article SE0605>
2. The “Fiscal Intermediary Shared System” (FISS).
 - a. The FISS processes institutional provider claims passing from the MAC systems. Two other “shared systems” process supplier (professional) and DME claims. <MLN Matters Article SE0605>
 - i. The FISS processes hospital Part A and Part B claims, using the inpatient and outpatient PRICER, the inpatient GROUPER, fee schedules, coding tables, the IOCE and MCE supplied by CMS.
3. The Common Working File (CWF)
 - a. The Common Working File contains beneficiary specific information.
 - i. The CWF serves to verify entitlement to Medicare, deductible status, benefit days, Medicare Secondary Payor issues, and eligibility for frequency limited services. <MLN Matters Article SE0605>

B. How do the Systems Fit Together

1. Handout 7 is a chart mapping the Medicare Claims Processing Systems from *MLN Matters Article SE0605*.

IV. The Integrated Outpatient Code Editor (IOCE)

A. What is the IOCE?

1. The IOCE is software used by the Fiscal Intermediary Shared System (FISS) to edit outpatient claims and assign Ambulatory Payment Classifications (“APCs”). <See *IOCE Specifications*, Section 3 (Supplement)>

B. IOCE Quarterly Data Files

Link: [OCE Specifications under Medicare-Related Sites - Hospital](#)

1. Each quarter, CMS publishes the IOCE Quarterly Data Files, which include:
 - a. An *IOCE Specifications* document containing descriptions of the edits and logic included in the IOCE. The current *IOCE Specifications* are included in the Supplement to these materials.
 - (i) The Summary of Quarterly Release Modifications, included at the beginning of the document, contains a list of changes to the edits and edit documentation for the quarter.
 - b. The Final Summary of Data Changes for each quarter detailing all codes and edits added, deleted, or modified for the quarter.
 - c. A folder titled “Report-Tables” containing Excel files detailing various data elements for the edits applied through the IOCE software (e.g., C-APC ranks, offset values, etc.). Applicable lists from these files are included throughout the materials, with instructions for finding them in the files for the purpose of updating them in subsequent quarters.
 - (i) Note: The excel files have version columns to indicate the timeframes the edits or information apply. The “LO_VERSION” indicates the first applicable quarter and the “HI_VERSION” indicates the last applicable quarter. Version 93 corresponds to the October 2023 quarter.
 - d. A folder titled “Report-Table-Difference” containing Excel files detailing additions, deletions, and modifications to various data elements for the applicable quarter for the edits applied through the IOCE software.

C. Applicability to hospital outpatient claims

1. All hospital outpatient Part B claims are processed through the IOCE, including certain non-OPPS hospitals. <See *IOCE Specifications*, Section 3 (Supplement)>

D. The IOCE edits

1. In general, the edits are driven by the ICD-10-CM diagnosis codes, the HCPCS codes and any modifiers reported on the claim. <See *IOCE Specifications*, Section 3 (Supplement)>

E. Why do hospitals need to know anything about the IOCE?

1. The *IOCE Specifications* sometimes answer billing/coding questions that are not clearly answered anywhere else.

V. National Correct Coding Initiative (“NCCI”) Overview

A. What is the NCCI?

1. The NCCI is a CMS initiative intended “to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.” <*NCCI Policy Manual*, Introduction>
2. The NCCI applies only to Medicare Part B claims – it does not apply to services covered under Medicare Part A.
3. Issues with NCCI Edits should be addressed by email to NCCIPTMUE@cms.hhs.gov.

B. Types of NCCI Edits

1. The NCCI consists of three types of edits: Procedure to Procedure (PTP) edits, Medically Unlikely Edits (MUEs), and Add-on Code Edits. <*NCCI Policy Manual*, Introduction; *Medicare Claims Processing Manual*, Chapter 23 § 20.9>

C. Basis for the NCCI Edits

1. According to the *NCCI Policy Manual*, the NCCI is developed by CMS for the Medicare program and the most important consideration in developing the edits is CMS Policy. CMS also considers the following:
 - a. The *NCCI Policy Manual for Medicare Services*;
 - b. CPT and HCPCS Manual code descriptors;
 - c. Coding conventions defined in the CPT Manual;
 - d. Coding guidelines developed by national societies;
 - e. Analysis of standard medical and surgical practice;

- f. Review of current coding practice; and
- g. Provider billing patterns. <NCCI Policy Manual, Introduction>

D. The NCCI Policy Manual and Edits

1. The NCCI Policy Manual and edits may be downloaded from the NCCI web site. Scroll to the bottom of the page to download a guide entitled “How to Use the Medicare National Correct Coding Initiative (NCCI) Tools”.

Link: National Correct Coding Initiative under Medicare-Related Sites – General

Use the drop down in the center titled “NCCI for Medicare” to get to pages for the following:

- NCCI Policy Manual
- Medically Unlikely Edits and Archive
- Procedure-to-Procedure (PTP) Edits
- Add-on Code Edits
- FAQ Library

VI. Procedure to Procedure (PTP) edits

- A. PTP edits are pairs of CPT or HCPCS Level II codes that are not both separately payable when billed by the same provider for the same beneficiary for the same date of service, unless an appropriate modifier is reported (discussed below). <NCCI Policy Manual, Introduction; Medicare Claims Processing Manual, Chapter 23 § 20.9.1.1 A>

1. When a PTP code pair is reported, without a modifier, the column 1 code processes for payment and the line with the column 2 codes is rejected. <See IOCE Specifications, Section 6.2 (Supplement); Medicare Claims Processing Manual, Chapter 23 § 20.9.1.1 A>

B. Obtaining PTP Edits

1. The hospital specific PTP edits are available in four files posted on the CMS website. The four files contain both the column 1/column 2 edits and the mutually exclusive edits (discussed below). Each file contains roughly one quarter of the NCCI edits and is updated quarterly.

Link: National Correct Coding Initiative under Medicare-Related Sites – General, center drop down, Procedure-to-Procedure (PTP) Edits

C. Composition of PTP Edits

1. “Column 1/Column 2” (formerly known as “comprehensive/component”) edits
 - a. The Column 1/Column 2 edits are generally designed to prevent unbundling – i.e., separate payment for a service that is considered to be a lesser included component of another more comprehensive service provided at the same session. <*NCCI Policy Manual*, Introduction>
2. “Mutually Exclusive” Edits
 - a. The “Mutually Exclusive” edits are designed to prevent separate payment for a service that is “mutually exclusive” of another service provided at the same session. The edits consist of procedures which cannot reasonably be performed together based on the code definition or anatomic considerations. <*NCCI Policy Manual*, Introduction>

Tip: The column 1 code of a mutually exclusive pair is the lower weighted (i.e., lower paying) code. If grouper software indicates a mutually exclusive edit, it is important to recode the case to ensure the correct code is reported, which in many cases is the higher weighted column 2 code.

- b. The *NCCI Policy Manual* provides the following examples of scenarios where two services “cannot reasonably be done at the same session.” <*NCCI Policy Manual*, Chapter 1(P)>
 - (i) The repair of an organ by two different methods. According to the *NCCI Policy Manual*, one repair method must be reported for the repair.
 - (ii) An “initial” service and a “subsequent” service. According to the *NCCI Policy Manual*, it is contradictory for a service to be classified as an initial and a subsequent service at the same time, with the exception of drug administration services.
3. Edit Rationale
 - a. The PTP files provide a rationale for each PTP edit, describing the background for that particular edit. The following are examples of the rationales for PTP edits:
 - (i) Standards of medical/surgical practice,
 - (ii) HCPCS/CPT procedure code definition,
 - (iii) CPT “separate procedure” definition,

- (iv) Misuse of the column two code with the column one code,
- (v) Mutually exclusive procedures,
- (vi) Gender-specific (formerly designation of sex) procedures, and
- (vii) Sequential Procedure.

D. Modifiers Applied to Procedure-to-Procedure Edits

1. In some cases, appending an NCCI modifier to a column 2 code will “override” (i.e., bypass) the NCCI edit and allow payment for both codes. <*NCCI Policy Manual*, Chapter 1; *Medicare Claims Processing Manual*, Chapter 23 § 20.9.1.1 A>
 - a. There is a “modifier” status indicator assigned to each set of PTP code pairs:
 - (i) If the modifier status indicator is “1,” the edit may be overridden by reporting one of the NCCI modifiers on the column 2 code.
 - (a) If the column 2 code is reported without a modifier, edit 40 of the IOCE rejects the line with the column 2 code. <See *IOCE Specifications*, Section 6.2, Edit 40 (Supplement)>
 - (ii) If the modifier status indicator is “0,” the edit will not be affected by reporting a modifier.
 - (a) If the column 2 code is reported with or without a modifier, edit 20 of the IOCE rejects the line with the column 2 code. <See *IOCE Specifications*, Section 6.2, Edit 20 (Supplement)>
 - (iii) If the modifier status indicator is “9,” the edit has been removed from the NCCI and is displayed for historical purposes. <*NCCI Policy Manual*, Chapter 1 (E)>

Case Study 2

Facts: Ms. Percy, a Medicare patient, presented to a hospital-based outpatient clinic for excision of a chalazion or cyst on her left eyelid (CPT code 67800). The physician also performed an incisional biopsy of the eyelid skin (CPT code 67810). The physician documented the biopsy as being an integral component of excision of the cyst.

Applicable PTP edit: Column 1 – 67800 and Column 2 – 67810, with modifier status indicator of 1.

How should these services be reported?

2. NCCI Modifiers

- a. According to CMS, the following modifiers will override an NCCI PTP edit. <See *IOCE Specifications*, Section 4.1 (Supplement); *NCCI Policy Manual*, Chapter 1 (E); *Medicare Claims Processing Manual*, Chapter 23 § 20.9.1.1 A>
 - (i) -E1 through -E4 – eyelids
 - (ii) -FA, F1 through -F9 – fingers
 - (iii) -LC, -LD, -LM and -RC, -RI – arteries
 - (iv) -LT and -RT – left and right sides
 - (v) -TA, T1 through -T9 – toes
 - (vi) -24 – unrelated E/M service during post-op period (identified in the Integrated Outpatient Code Editor but inapplicable to hospital reporting)
 - (vii) -25 – significant, separately identifiable E/M service
 - (viii) -27 – separate and distinct E/M encounter
 - (ix) -57 – decision for surgery (identified in the Integrated Outpatient Code Editor but inapplicable to hospital reporting)
 - (x) -58 – staged or related procedure
 - (xi) -59 – distinct procedural services

- (a) Modifier -59 should only be used if no other more specific modifier is appropriate. <See *MLN Fact Sheet: Proper Use of Modifiers 59 & -X{EPSU}*>
- (b) CMS established the -X{EPSU} modifiers to provide greater reporting specificity in situations where modifier -59 was previously reported and should be used in lieu of modifier -59 whenever possible. <See *MLN Fact Sheet: Proper Use of Modifiers 59 & -X{EPSU}*>
1. -XE: Separate encounter, a service that is distinct because it occurred during a separate encounter
 2. -XS: Separate structure, a service that is distinct because it was performed on a separate organ/structure.
 3. -XP: Separate practitioner, a service that is distinct because it was performed by a different practitioner.
 4. -XU: Unusual, non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.

CMS guidance appears to indicate the X modifiers should be used if the provider is certain they fit the coding scenario, otherwise modifier 59 would be used. While their use isn't required, CMS guidance indicates they should be used when they can be appended with certainty.

- (c) CMS published additional guidance on the use of modifier -59 and the -X{EPSU} modifiers in addition to the guidance found in the *CPT Manual* and *CPT Assistant*. <See *MLN Fact Sheet: Proper Use of Modifiers 59 & -X{EPSU}*; *Medicare Claims Processing Manual*, Chapter 23 § 20.9.1.1>
1. CMS has indicated that modifiers -59 or -XS are typically only used for procedures performed on different anatomic sites not ordinarily performed or encounter on the same day.
 - a. Treatment of contiguous structures in the same organ or anatomic region does not constitute treatment of different anatomic sites.
 2. CMS has indicated that modifiers -59 or -XE are typically only used for procedures performed during different patient encounters on the same day.

- a. Modifiers -59 or -XE should only be used if no other modifier more appropriately describes the relationship of the two procedure codes.
 - b. An encounter is defined as direct personal contact between the patient and a physician or other person authorized to order or furnish services for diagnosis or treatment of the patient. <Medicare Claims Processing Manual, Chapter 2 § 90.6>
 - c. An episode of care begins when a patient arrives at a facility for treatment and terminates when the patient leaves the facility. An episode of care may last more than one calendar day. <National Correct Coding Initiative Policy Manual, Chapter XI, Section J, Subsection 8>
3. CMS has provided three other limited situations in which two services may be reported as separate and distinct because they are separated in time and describe non-overlapping services even if provided during the same encounter. <See MLN Fact Sheet: Proper Use of Modifiers 59 & -X{ESPU}>
- a. Modifiers -59 or -XE can be used when two services described by timed codes are provided during the same encounter and they are performed sequentially (i.e., one service is completed before the subsequent service begins).
 - b. Modifiers -59 or -XU can be used when a diagnostic procedure precedes a surgical or non-surgical therapeutic procedure only if the diagnostic procedure clearly provides the information needed to make a decision to proceed with the therapeutic procedure.
 - c. Modifiers -59 or -XU can be used when a diagnostic procedure occurs subsequent to a completed therapeutic procedure only if the diagnostic procedure is not an otherwise inherent part of the therapeutic procedure.

(xii) -78 – related procedure

(i) -79 – unrelated procedure or service

- (a) Modifiers -78 and -79 also have the payment effect of turning off the multiple procedure reduction under OPPS (discussed in a later module). <IOCE Specifications, Section 5.2.1 (Supplement)>

(ii) -91 – repeat lab test

2. Use of NCCI Modifiers

- a. Modifiers should only be appended to HCPCS/CPT codes if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass an NCCI edit if the clinical circumstances do not justify its use. <NCCI Policy Manual, Chapter 1 (E)>

Case Study 3

Facts: Mr. Henderson, a Medicare patient, was badly injured as a result of a fall at his home. Among other problems, he had a penetrating wound of his left arm and a deep hematoma on his right shoulder. He was rushed to outpatient surgery where the surgeon explored the arm wound (CPT code 20103) and drained the shoulder hematoma (CPT code 23030).

Applicable PTP edit: Column 1 – 23030 and Column 2 – 20103, with modifier status indicator of 1.

How should these services be reported?

VII. Medically Unlikely Edits

- A. The Medically Unlikely Edits (MUEs) represent the maximum number of units reportable for a HCPCS code by the same provider for the same beneficiary for the same date of service, in most circumstances. <NCCI Policy Manual, Chapter 1 (V); Medicare Claims Processing Manual, Chapter 23 § 20.9.3.2>
- B. CMS publishes an MUE file containing the MUE limits for some, but not all HCPCS codes. The file is updated quarterly and there is a separate file for practitioner, facility and DME services. <NCCI Policy Manual, Chapter 1 (V)>

Link: National Correct Coding Initiative under Medicare-Related Sites – General, center drop down, Medically Unlikely Edits

- C. The MUE file contains a column with the rationale for each of the MUEs. The MUEs are based on the following considerations:
 1. Anatomic considerations (e.g., appendectomy);
 2. Code descriptions (e.g., a code with the term “initial” in its title);
 3. Established CMS policy (e.g., bilateral procedures);
 4. Nature of the analyte (e.g., 24-hour urine collection);

5. Nature of the procedure and the amount of time required to perform the procedure (e.g., overnight sleep study);
 6. Nature of the item (e.g., wheelchair);
 7. Clinical judgment based on input from physicians and clinical coders;
 8. Prescribing information based on FDA labeling and off label information; and
 9. Submitted claims data from a 6-month period. <NCCI Policy Manual, Chapter 1(V)>
- D. The MUE file contains an “MUE Adjudication Indicator” (MAI) indicating whether an MUE will be applied by date of service or by claim line. <Medicare Claims Processing Manual, Chapter 23 § 20.9.3.2>
1. MUEs Applied by Claim Line – MAI of 1
 - a. If a claim line with a HCPCS code with an MAI of 1 exceeds the MUE value, the line will be denied. <Medicare One Time Notice Transmittal 1421>
 - b. Medically appropriate units of service in excess of an MUE may be reported on a separate line with an appropriate modifier. Each line is edited against the MUE separately so the units on the separate line will process for payment. <NCCI Policy Manual, Chapter 1 (V)>
 - c. Line-item denials for units in excess of an MUE are appealable denials. <Medicare One Time Notice Transmittal 1421; Medicare Claims Processing Manual, Chapter 23 § 20.9.3.2>
 2. MUEs Applied by DOS – MAI of 2 or 3
 - a. All claim lines on the same date of service with the same HCPCS code with an MAI of 2 or 3, regardless of modifier, will be summed and compared to the MUE value. The claim lines will be denied if the units summed in this way exceed the MUE value. <Medicare One Time Notice Transmittal 1421>
 - (i) Claim lines are summed on the claim being edited and all prior paid claims with the same date of service. <Medicare One Time Notice Transmittal 1421>
 - b. An MAI of 2 indicates that the edit is based on regulation, policy or instruction that is inherent in the code descriptor. <Medicare One Time Notice Transmittal 1421; Medicare Claims Processing Manual, Chapter 23 § 20.9.3.2>

- (i) MACs are bound by MUE values with a MAI of 2 in their determinations and redeterminations. <Medicare One Time Notice Transmittal 1421; Medicare Claims Processing Manual, Chapter 23 § 20.9.3.2>
- c. An MAI of 3 indicates that the edit is based on clinical information, billing patterns, prescribing instructions and other information. <Medicare One Time Notice Transmittal 1421; Medicare Claims Processing Manual, Chapter 23 § 20.9.3.2>
 - (i) If the provider verifies the coding instructions and the units are correctly coded and medical necessary, the provider may submit an appeal. <Medicare One Time Notice Transmittal 1421; Medicare Claims Processing Manual, Chapter 23 § 20.9.3.2>

Case Study 4

Facts: On April 1st the hospital performed a lab test three times for a patient in observation pursuant to a physician's order. The hospital determined all three lab tests were medically necessary. The line item for the lab tests was denied stating it exceeded the maximum number of units for the HCPCS code. After researching further, the hospital identified that the MUE value for the HCPCS code is 2 and the edit has an MAI of 3. Can the hospital use a modifier to rebill the claim and get payment for all three tests?

VIII. Add-on Code Edits

- A. An add-on code describes a service always performed in conjunction with another primary service. An add-on code may not be reported unless the code for the primary service is also reported on the claim. <Medicare Claims Processing Manual Transmittal 2636; Medicare Claims Processing Manual, Chapter 23 § 20.9>
 - 1. Add-on codes are designated with a "+" symbol or the phrases "each additional" or "list separately in addition to the primary procedure" in the CPT Manual. <Medicare Claims Processing Manual Transmittal 2636>
- B. If an add-on code is reported without the required primary procedure code on the same day or the day before, the line with the add-on code will trigger a line item denial. <See IOCE Specifications, Section 4.2 (Supplement)>
 - 1. Exception for Drug Administration Codes

- a. The add-on code edits for drug administration add-on codes are applied by claim. The drug administration add-on codes trigger a line item denial only if the associated primary procedure code is not reported on the same claim, rather than the same day or day before. <See *IOCE Specifications*, Section 4.2 (Supplement)>
 - b. The list of drug administration add-on codes is available in the IOCE Quarterly Data Files, Report-Tables folder, “DATA_HCPCS” file, column DD “ADDON_DRUG_ADMIN”. The current quarterly file is available on the IOCE homepage.
- C. Prior to 2022, CMS published an Excel file containing the add-on code edits and updated the edits in January and on a quarterly basis as necessary. Beginning 2022, CMS only makes the file available as a “fixed-width text file”. <CMS.gov, “Add-on Code Edits” website>

Link: National Correct Coding Initiative under Medicare-Related Sites – General, center drop down, Add-on Code Edits

D. Three Types of Add-on Code Edits

1. Type I add-on codes have a limited number of identifiable primary codes. <*Medicare Claims Processing Manual Transmittal 2636*>
2. Type II add-on codes do not have a list of acceptable primary codes. MACs must develop a list of acceptable primary codes required for reporting and payment of the add-on code. <*Medicare Claims Processing Manual Transmittal 2636*>
3. Type III add-on codes have some, but not all, the acceptable primary codes identified. MACs must develop a list of additional acceptable primary codes for reporting and payment of the add-on code. <*Medicare Claims Processing Manual Transmittal 2636*>

Case Study 5

Facts: Ms. Stewart presented to the hospital outpatient surgical department for neuroplasty to treat carpal tunnel syndrome (CPT code 64721). During the procedure the surgeon performed neurolysis using the operating microscope (CPT code 64727). Microsurgical techniques requiring the use of the operating microscope are described by CPT code 69990.

Applicable PTP edit: Column 1 – 64727 and Column 2 – 69990, with modifier status indicator of 0.

Applicable Add-on Code edit: Add-on code 64727 and Primary codes 64702-64726

How should these services be reported?

IX. Practical NCCI Issues

A. Codes or Units Denied as a Result of the NCCI are Provider Liability

1. CMS takes the position that services denied based on an NCCI edit are denied based on incorrect coding, rather than coverage and therefore the service may not be billed to the beneficiary. <*NCCI Policy Manual*, Introduction; *Medicare Claims Processing Manual*, Chapter 23 § 20.9.3.1 and 20.9.3.2>
 - a. Providers may not issue an ABN and bill the beneficiary for codes or units not paid because of an NCCI edit because non-payment is based on coding rather than medical necessity. <*NCCI Policy Manual*, Introduction; *Medicare Claims Processing Manual*, Chapter 23 § 20.9.3.1 and 20.9.3.2>

B. Do Not Count on the CMS Systems to Serve as Your “Claims Scrubber”

1. In theory, CMS claims processing systems should reject or deny lines or claims that do not conform to NCCI edits, however if the claims system fails and the MAC pays for a service in contradiction to an NCCI edit, the provider may be required to make a repayment.

CASE STUDIES WITH ANALYSIS

Case Study 1

Facts: A patient presents to the emergency department with chest pain (R07.9). Following testing, including an EKG and cardiac enzymes, the patient is diagnosed with a recurrence of Gastroesophageal Reflux Disease (GERD) (K21.0). What diagnosis or diagnoses codes should be reported on the claim and in what field or fields?

Analysis: The GERD (K21.0) should be reported in FL 67 Principal/First Listed Diagnosis Code. The chest pain (R07.9) must also be reported in FL 70 Patient Reason for Visit because this was an emergency visit and a Patient Reason for Visit must be reported on emergency department visits. The chest pain further provides the justification for the cardiac related tests, even though the final diagnosis for the patient was GERD. <Medicare Claims Processing Manual, Chapter 25 § 75.6>

Case Study 2

Facts: Ms. Percy, a Medicare patient, presented to a hospital-based outpatient clinic for excision of a chalazion or cyst on her left eyelid (CPT code 67800). The physician also performed an incisional biopsy of the eyelid skin (CPT code 67810). The physician documented the biopsy as being an integral component of excision of the cyst.

Applicable PTP edit: Column 1 – 67800 and Column 2 – 67810, with modifier status indicator of 1.

How should these services be reported?

Analysis: Only 67800 should be reported. According to the NCCI edit, the biopsy (67810) is bundled into the excision (67800) and should not be reported separately unless it is a distinct procedure (e.g., provided at a different anatomic site). The physician documented the biopsy was an integral component of the excision so it would be inappropriate to report it separately.

Case Study 3

Facts: Mr. Henderson, a Medicare patient, was badly injured as a result of a fall at his home. Among other problems, he had a penetrating wound of his left arm and a deep hematoma on his right shoulder. He was rushed to outpatient surgery where the surgeon explored the arm wound (CPT code 20103) and drained the shoulder hematoma (CPT code 23030).

Applicable PTP edit: Column 1 – 23030 and Column 2 – 20103, with modifier status indicator of 1.

How should these services be reported?

Analysis: Both procedures should be reported, with modifier -59 or -XS appended to 20103 because the procedure involved a separate anatomic site. Failure to report the modifier -59 or -XS on the column 2 code would cause the code to reject, resulting in underpayment.

Case Study 4

Facts: On April 1st the hospital performed a lab test three times for a patient in observation pursuant to a physician's order. The hospital determined all three lab tests were medically necessary. The line item for the lab tests was denied stating it exceeded the maximum number of units for the HCPCS code. After researching further, the hospital identified that the MUE value for the HCPCS code is 2 and the edit has an MAI of 3. Can the hospital use a modifier to rebill the claim and get payment for all three tests?

Analysis: No, the MAI of 3 indicates the edit is applied by date of service. Billing the units in excess of the MUE on a separately line with a modifier will not allow the additional units to be paid. Based on the MAI of 3, the hospital may appeal the denial after confirming the units were coded correctly and were medically necessary.

Case Study 5

Facts: Ms. Stewart presented to the hospital outpatient surgical department for neuroplasty to treat carpal tunnel syndrome (CPT code 64721). During the procedure the surgeon performed neurolysis using the operating microscope (CPT code 64727). Microsurgical techniques requiring the use of the operating microscope are described by CPT code 69990.

Applicable PTP edit: Column 1 – 64727 and Column 2 – 69990, with modifier status indicator of 0.

Applicable Add-on Code edit: Add-on code 64727 and Primary codes 64702-64726

How should these services be reported?

Analysis: The hospital should report 64721 and 64727. The applicable PTP edit will reject 69990 if it is reported with 64727. The provider must report the neuroplasty code 64721 along with the neurolysis 64727. The applicable Add-on code edit requires the primary code for the neuroplasty be reported with the neurolysis or the claim will be returned to the provider.

Billing Requirements for OPPS Providers with Multiple Service Locations

MLN Matters Number: SE18002

Related Change Request (CR) Number: 9613; 9907

Related CR Release Dates: August 5, 2016;
February 5, 2017

Effective Date: January 1, 2017

Related CR Transmittal Numbers:
R1704OTN and R1783OTN

Implementation Date: January 3, 2017 for
CR9613 and July 3, 2017 for CR9907

PROVIDER TYPES AFFECTED

This MLN Matters® Special Edition Article is intended for Outpatient Prospective Payment System (OPPS) providers that have multiple service locations submitting claims to Medicare A/B Medicare Administrative Contractors (MACs).

WHAT YOU NEED TO KNOW

This article conveys enforcement editing requirements for the Medicare Claims Processing Manual, Chapter 1, and Section 170 which describes Payment Bases for Institutional Claims. These requirements are not new requirements. Previously, these requirements were discussed in CRs 9613 and 9907, both of which were effective on January 1, 2017. MLN Matters articles for CRs 9613 and 9907 are available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9613.pdf> and <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9907.pdf>, respectively. Make sure your billing staff is aware of these instructions.

BACKGROUND

Increasingly, hospitals operate off-campus, outpatient, provider-based department of a hospital's facilities. In some cases, these additional locations are in a different payment locality than the main provider. In order for Medicare Physician Fee Schedule (MPFS) and OPSS payments to be accurate, the service facility address of the off-campus, outpatient, provider-based department of a hospital facility is used to determine the locality in these cases.

Additionally, in accordance with Section 1833(t)(21) of the Act, as added by section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74), Non-excepted services provided at an off-

campus, outpatient, provider-based department of a hospital were required to be identified as non-excepted items and services billed on an institutional claim and to be paid under the MPFS and not the OPFS rates.

Claim level information:

Medicare outpatient service providers report the service facility location for off-campus, outpatient, provider-based department of a hospital facilities in the 2310E loop of the 837 institutional claim transaction. Direct Data Entry (DDE) submitters also are required to report the service facility location for off-campus, outpatient, provider-based department of a hospital facilities. Paper submitters report the service facility address information in Form Locator (FL) "01" on the paper claim form. For MPFS services, Medicare systems use this service facility information to determine the applicable payment method or locality whenever it is present.

Additionally, Medicare systems will validate service facility location to ensure services are being provided in a Medicare enrolled location. The validation will be exact matching based on the information submitted on the Form CMS-855A submitted by the provider and entered into the Provider Enrollment, Chain and Ownership System (PECOS). Providers need to ensure that the claims data matches their provider enrollment information.

When all the services rendered on the claim are from the billing provider address, providers are:

- To report the billing provider address only in the billing provider loop and not to report any service facility location.

When all the services rendered on the claim are from one campus of a multi-campus provider that report a billing provider address, providers are:

- To report the campus address where the services were rendered in the service facility location if the service facility address is different from the billing provider address.

When all the services rendered on the claim are from the same off-campus, outpatient, provider-based department of a hospital facilities, providers are:

- To report the off-campus, outpatient, provider-based department service facility address in the service facility provider loop.

When there are services rendered on the claim from multiple locations:

- If any services on the claim were rendered at the billing provider address, providers should report the billing provider address only in the billing provider loop 2010AA and do not report the service facility location in loop 2310E.

- If no services on the claim were rendered at the billing provider address, providers should report the service facility address from the first registered encounter of the “From” date on the claim.

NM1 - SERVICE FACILITY LOCATION NAME – 60 Characters 837I – 25, UB-04**N3 - SERVICE FACILITY LOCATION ADDRESS****N301 – 55 Characters 837I – 25 Characters on the UB-04****N302 – 55 Characters 837I – not on UB-04 paper form****N4 - SERVICE FACILITY LOCATION CITY, STATE, ZIP CODE****N401 City Name – 30 Characters 837I – 12 Characters on the UB-04****N402 State Code – 2 Characters 837I – 2 Characters on the UB-04****N403 Postal Code – 15 Characters 837I – 9 Characters on the UB-04****Line level information:**

In the CY 2015 OPSS Final Rule (79 FR 66910-66914), the Centers for Medicare & Medicaid Services (CMS) created a HCPCS modifier for hospital claims that is to be reported with each claim line with a HCPCS for outpatient hospital items and services furnished in an off-campus provider-based department (PBD) of a hospital. This 2-digit modifier was added to the HCPCS annual file as of January 1, 2015, with the label “PO.” Reporting of this new modifier was voluntary for CY 2015, with reporting required beginning on January 1, 2016.

In accordance with Section 1833(t)(21) of the Act, as added by section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74), CMS established a new modifier “PN” (Non-expected service provided at an off-campus, outpatient, provider-based department of a hospital) to identify and pay non-expected items and services billed on an institutional claim. Effective January 1, 2017, non-expected off-campus provider-based departments of a hospital are required to report this modifier on each claim line with a HCPCS for non-expected items and services. The use of modifier “PN” will trigger a payment rate under the MPFS. CMS expects the PN modifier to be reported with each non-expected line item and service including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services; with reporting required beginning on January 1, 2017.

As a result, effective January 1, 2017, excepted off-campus provider-based departments of a hospital must continue to report existing modifier “PO” (Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments) for all excepted items and services with a HCPCS furnished.

Billing Examples

No.	Service Facility	Billing Provider	Service Facility Address	Modifier Used
1	Billing provider (Main Campus) Only	Yes	N/A	No "PO" or "PN" Modifier required on billing provider services.
2	Billing Provider (Main Campus), Excepted Off-Campus	Yes	N/A	No "PO" or "PN" Modifier required on Main Campus services. Modifier "PO" required on services with a HCPCS from Excepted Off-Campus.
3	Billing Provider (Main Campus), Non-Excepted Off-Campus	Yes	N/A	No "PO" or "PN" Modifier required on Main Campus services. Modifier "PN" required on services with a HCPCS from Non-Excepted Off-Campus.
4	Billing Provider (Main Campus), Campus of Multi-Campus provider*	Yes	N/A	No "PO" or "PN" Modifier required on billing provider services or other Campus services of a Multi-Campus.
5	Campus of Multi-Campus provider*	Yes	Yes Campus Address*	No "PO" or "PN" Modifier required on billing Campus services of a Multi-Campus.
6	Billing Provider (Main Campus), Excepted Off-Campus, Non-Excepted Off-Campus	Yes	N/A	No "PO" or "PN" Modifier required on Billing Provider services. Modifier "PO" required on services with a HCPCS from Excepted Off-Campus. Modifier "PN" required on services with a HCPCS from Non-Excepted Off-Campus.

No.	Service Facility	Billing Provider	Service Facility Address	Modifier Used
7	Billing Provider (Main Campus), Campus of Multi-Campus provider*, Excepted Off-Campus, Non-Excepted Off-Campus	Yes	N/A	No "PO" or "PN" Modifier required on billing provider services or other Campus services of a Multi-Campus. Modifier "PO" required on services with a HCPCS from Excepted Off-Campus. Modifier "PN" required on services with a HCPCS from Non-Excepted Off-Campus.
8	Campus of Multi-Campus provider*, Excepted Off-Campus, Non-Excepted Off-Campus	Yes	Yes Campus Address*	No "PO" or "PN" Modifier required on billing Campus services of a Multi-Campus. Modifier "PO" required on services with a HCPCS from Excepted Off-Campus. Modifier "PN" required on services with a HCPCS from Non-Excepted Off-Campus.
9	Excepted Off-Campus	Yes	Yes	Modifier "PO" required on all services with a HCPCS.
10	Non-Excepted Off-Campus	Yes	Yes	Modifier "PN" required on all services with a HCPCS.
11	Excepted Off-Campus, Non-Excepted Off-Campus	Yes	Yes First Registered Encounter	Modifier "PO" required on services with a HCPCS from Excepted Off-Campus. Modifier "PN" required on services with a HCPCS from Non-Excepted Off-Campus.

No.	Service Facility	Billing Provider	Service Facility Address	Modifier Used
12	Excepted Off-Campus, Excepted Off-Campus	Yes	Yes First Registered Encounter	Modifier "PO" required on all services with a HCPCS.
13	Non-Excepted Off- Campus, Non-Excepted Off- Campus	Yes	Yes First Registered Encounter	Modifier "PN" required on all services with a HCPCS.

* Campus address is different from Billing Provider address; if the Campus address is the same as the Billing Provider address, follow the billing provider instructions.

ADDITIONAL INFORMATION

If you have any questions, please contact your MAC at their toll-free number, which is available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html>.

You may also want to review relevant portions of MLN Matters articles MM9097 and MM9930 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9097.pdf> and <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9930.pdf>, respectively.

DOCUMENT HISTORY

Date of Change	Description
March 15, 2018	Initial article released.

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Proper Use of Modifiers 59 & –X{EPSU}

What's Changed?

- No substantive content updates

This fact sheet educates physicians and other providers on proper use of modifiers 59 and –X{EPSU} and gives information on:

- Definition of modifiers 59, XE, XP, XS, and XU
- Appropriate and inappropriate use of these modifiers
- Examples of appropriate and inappropriate use

The Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define when you shouldn't report certain HCPCS or CPT codes together either in all situations or in most situations. These edits allow the following:

- For NCCI PTP-associated edits that have a Correct Coding Modifier Indicator (CCMI) of "0," never report the codes together by the same provider for the same beneficiary on the same date of service. If you do report the codes together on the same date of service, the Column One code is eligible for payment and Medicare denies the Column Two code.
- For NCCI PTP-associated edits that have a CCMI of "1," you may report the codes together only in defined circumstances by using specific NCCI PTP-associated modifiers.

Refer to the National Correct Coding Initiative Policy Manual for Medicare Services, [Chapter 1](#), for general information about the NCCI program, NCCI PTP-associated edits, CCMI, and NCCI PTP-associated modifiers.

One purpose of NCCI PTP-associated edits is to prevent payment for codes that report overlapping services except where the services are “separate and distinct.” Modifier 59 is an important NCCI PTP-associated modifier that providers often use incorrectly.

This fact sheet will help you use this modifier correctly.

Definition of Modifiers 59, XE, XP, XS, and XU

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 (Evaluation/Management) 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.”

Don't use modifiers 59, -X{EPSU} and other NCCI PTP-associated modifiers to bypass an NCCI PTP edit unless the proper criteria for use of the modifiers are met. Medical documentation must satisfy the required criteria.

Effective January 1, 2015, XE, XS, XP, and XU are valid modifiers. These modifiers give greater reporting specificity in situations where you used modifier 59 previously. Use these modifiers instead of modifier 59 whenever possible. (Only use modifier 59 if no other more specific modifier is appropriate.)

CMS allows the modifiers 59 or -X{ESPU} on Column One or Column Two codes (see the related transmittal at [CR11168](#)).

We define these modifiers as follows:

- XE – “Separate Encounter, a service that is distinct because it occurred during a separate encounter.” Only use XE 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”

Appropriate & Inappropriate Use of These Modifiers

1. Using modifiers 59 or –XS properly for different anatomic sites during the same encounter only when procedures which aren't ordinarily performed or encountered on the same day are performed on:

- Different organs, or
- Different anatomic regions, or
- In limited situations on different, non-contiguous lesions in different anatomic regions of the same organ

Modifiers 59 or –XS are for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that:

- Are performed at different anatomic sites,
- Aren't ordinarily performed or encountered on the same day, and
- Can't be described by one of the more specific anatomic NCCI PTP-associated modifiers – that is, RT, LT, E1-E4, FA, F1-F9, TA, T1-T9, LC, LD, RC, LM, or RI. (See examples 1, 2, and 3 below.)

From an NCCI program perspective, the definition of different anatomic sites includes different organs or, in certain instances, different lesions in the same organ. We created NCCI edits to prevent the inappropriate billing of lesions and sites that aren't considered separate and distinct. The treatment of contiguous structures in the same organ or anatomic region doesn't generally constitute treatment of different anatomic sites. For example:

- Treatment of the nail, nail bed, and adjacent soft tissue distal to and including the skin overlying the distal interphalangeal joint on the same toe or finger constitutes treatment of a single anatomic site. (See example 4 below.)
- Treatment of posterior segment structures in the ipsilateral eye constitutes treatment of a single anatomic site. (See example 5 below.)

2. Only use modifiers 59 or -XE if no other modifier more properly describes the relationship of the 2 procedure codes.

Another common use of modifiers 59 or –XE is for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that are performed during different patient encounters on the same day that can't be described by one of the more specific NCCI PTP-associated modifiers – that is, 24, 25, 27, 57, 58, 78, 79, or 91. (See example 7 below.)

3. Don't use modifiers 59 or –XU just because the code descriptors of the 2 codes are different.

One of the common misuses of modifier 59 relates to the part of the definition of modifier 59 allowing its use to describe a “different procedure or surgery.” The code descriptors of the 2 codes of a code pair edit describe different procedures, even though they may overlap. Don't report the 2 codes together if they're performed at the same anatomic site and same patient encounter, because they aren't considered “separate and distinct.” Don't use modifiers 59 or –XU to bypass a PTP edit based on the 2 codes being “different procedures.” (See example 8 below.)

However, if you perform 2 procedures at separate anatomic sites or at separate patient encounters on the same date of service, you may use modifiers 59 or –X{ES} to show that they're different procedures on that date of service. Also, there may be limited circumstances sometimes identified in the [National Correct Coding Initiative Policy Manual](#) for Medicare services when you may report the 2 codes of an edit pair together with modifiers 59 or –X{ES} when performed at the same patient encounter or at the same anatomic site.

4. Other specific proper uses of modifiers 59 or -X{EU}.

There are 3 other limited situations where you may report 2 services as separate and distinct because they're separated in time and describe non-overlapping services even though they may occur during the same encounter.

- A. **Using modifiers 59 or –XE properly for 2 services described by timed codes provided during the same encounter only when they are performed one after another.** There's an appropriate use for modifier 59 that's applicable only to codes for which the unit of service is a measure of time (two examples are: per 15 minutes or per hour). If you provide 2 timed services in time periods that are separate and distinct and aren't mingled with each other (that is, you complete one service before the next service begins), you may use modifiers 59 or –XE to identify the services. (See example 9 below.)
- B. **Using modifiers 59 or –XU properly for a diagnostic procedure which is performed before a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure.** When you perform a diagnostic procedure before a surgical procedure or non-surgical therapeutic procedure and it's the basis on which you decide to perform the surgical procedure or non-surgical therapeutic procedure, you may consider that diagnostic procedure to be a separate and distinct procedure if it:
 - a. Occurs before the therapeutic procedure and isn't mingled with services the therapeutic intervention requires
 - b. Provides clearly the information needed to decide whether to proceed with the therapeutic procedure; and
 - c. Doesn't constitute a service that would have otherwise been required during the therapeutic intervention (See example 10 below.)

If the diagnostic procedure is an inherent component of the surgical procedure, don't report it separately.

- C. Using modifiers 59 or –XU properly for a diagnostic procedure which occurs after a completed therapeutic procedure only when the diagnostic procedure isn't a common, expected, or necessary follow-up to the therapeutic procedure.** When a diagnostic procedure follows the surgical procedure or non-surgical therapeutic procedure, you may consider that diagnostic procedure to be a separate and distinct procedure if it:
- Occurs after the completion of the therapeutic procedure and isn't mingled with or otherwise mixed with services that the therapeutic intervention requires
 - Doesn't constitute a service that would have otherwise been required during the therapeutic intervention. If the post-procedure diagnostic procedure is an inherent component or otherwise included (or not separately payable) post-procedure service of the surgical procedure or non-surgical therapeutic procedure, don't report it separately.

Use of modifiers 59 or –X{EPSU} doesn't require a different diagnosis for each HCPCS or CPT coded procedure. On the other hand, different diagnoses aren't adequate criteria for use of modifiers 59 or –X{EPSU}. The HCPCS or CPT codes remain bundled unless you perform the procedures at different anatomic sites or separate patient encounters or meet one of the other 3 scenarios described by A, B, or C above.

Examples of Appropriate & Inappropriate Use

Example 1: Column 1 Code/Column 2 Code - 11102/17000

- CPT Code - 11102 - Tangential biopsy of skin (eg, shave, scoop, saucerize, curette); single lesion
- CPT Code - 17000 - Destruction (g, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion

You may report modifiers 59 or -XS with either the Column 1 or Column 2 code if you did the procedures at different anatomic sites on the same side of the body and a specific anatomic modifier isn't applicable. If you did the procedures on different sides of the body, use modifiers RT and LT or another pair of anatomic modifiers. Don't use modifiers 59 or -XS.

The use of modifier 59 or -XS is appropriate for different anatomic sites during the same encounter only when procedures (which aren't ordinarily performed or encountered on the same day) are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.

Example 2: Column 1 Code/Column 2 Code - 47370/76942

- CPT Code - 47370 - Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency
- CPT Code - 76942 - Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

Don't report CPT code 76942 with or without modifiers 59 or –X{EPSU} if the ultrasonic guidance is for needle placement for the laparoscopic liver tumor ablation procedure 47370. Only report 76942 with modifiers 59 or –X{EPSU} if the ultrasonic guidance for needle placement is unrelated to the laparoscopic liver tumor ablation procedure.

Example 3: Column 1 Code/Column 2 Code - 93453/76000

- CPT Code - 93453 - Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed
- CPT Code - 76000 - Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time

Don't report CPT code 76000 with or without modifiers 59 or –X{EPSU} for fluoroscopy in conjunction with a cardiac catheterization procedure. You may report 76000 with modifiers 59 or –X{EPSU} if the fluoroscopy is performed for a procedure unrelated to the cardiac catheterization procedure.

Example 4: Column 1 Code/Column 2 Code - 11055/11720

- CPT Code - 11055 - Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
- CPT Code - 11720 - Debridement of nail(s) by any method(s); 1 to 5

Don't report CPT codes 11720 and 11055 together for services performed on skin distal to and including the skin overlying the distal interphalangeal joint of the same toe. Don't use modifiers 59 or –X{EPSU} if you debride a nail on the same toe on which you pare a hyperkeratotic lesion of the skin on or distal to the distal interphalangeal joint. You may report modifier 59 or –XS with code 11720 if you debride 1 to 5 nails and you pare a hyperkeratotic lesion on a toe other than 1 with a debrided toenail or the hyperkeratotic lesion is proximal to the skin overlying the distal interphalangeal joint of a toe on which you debride a nail.

Example 5: Column 1 Code/Column 2 Code - 67210/67220

- CPT Code - 67210 - Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation
- CPT Code - 67220 - Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions

Don't report CPT code 67220 with or without modifier 59 or –X{EPSU} if you perform both procedures during the same operative session because the retina and choroid are contiguous structures of the same organ.

Example 6: Column 1 Code/Column 2 Code - 29827/29820

- CPT Code - 29827 - Arthroscopy, shoulder, surgical; with rotator cuff repair
- CPT Code - 29820 - Arthroscopy, shoulder, surgical; synovectomy, partial

Don't report CPT code 29820 with or without modifiers 59 or –X{EPSU} if you perform both procedures on the same shoulder during the same operative session. If you perform the procedures on different shoulders, use modifiers RT and LT, not modifiers 59 or –X{EPSU}.

Example 7: Column 1 Code/Column 2 Code - 93015/93040

- CPT Code - 93015 - Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation, and report
- CPT Code - 93040 - Rhythm ECG, 1-3 leads; with interpretation and report

You may report modifiers 59 or –XE if you interpret and report the rhythm ECG at a different encounter than the cardiovascular stress test. If you interpret and report a rhythm ECG during the cardiovascular stress test encounter, don't report 93040 with or without modifier 59. You may report modifiers 59 or –XE when you interpret and report the procedures in different encounters on the same day.

Example 8: Column 1 Code/Column 2 Code - 34833/34820

- CPT code - 34833 - Open iliac artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)
- CPT code - 34820 - Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)

CPT code 34833 is followed by a CPT Manual instruction that states: "(Do not report 34833 in conjunction with 33364, 33953, 33954, 33959, 33962, 33969, 33984, 34820 when performed on the same side)." Although the CPT code descriptors for 34833 and 34820 describe different procedures, don't report them together for the same side. Don't add modifiers 59 or –X{EPSU} to either code to report 2 procedures for the same side of the body. If you performed 2 procedures on different sides of the body, you may report them with modifiers LT and RT as appropriate. However, modifiers 59 or –X{EPSU} are inappropriate if the basis for their use is that the narrative description of the 2 codes is different.

Example 9: Column 1 Code/Column 2 Code - 97140/97750

- CPT Code - 97140 - Manual therapy techniques (for example, mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
- CPT Code - 97750 - Physical performance test or measurement (for example, musculoskeletal, functional capacity), with written report, each 15 minutes

You may report modifier 59 if you perform 2 procedures in distinctly different 15-minute time blocks. For example, you may report modifier 59 if you perform 1 service during the initial 15 minutes of therapy and you perform the other service during the second 15 minutes of therapy. As another example, you may report modifier 59 if you split the therapy time blocks by performing manual therapy for 10 minutes, followed by 15 minutes of physical performance test, followed by another 5 minutes of manual therapy. Don't report CPT code 97550 with modifier 59 if you perform 2 procedures during the same time block. You may report modifier 59 when you perform 2 timed procedures in 2 different blocks of time on the same day.

Example 10: Column 1 Code/Column 2 Code - 37220/75710

- CPT Code - 37220 - Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty
- CPT Code - 75710 - Angiography, extremity, unilateral, radiological supervision, and interpretation

You may report modifier 59 or –XU with CPT code 75710 if you haven't already performed a diagnostic angiography and you base the decision to perform the revascularization on the result of the diagnostic angiography. The CPT Manual defines additional circumstances under which you may report diagnostic angiography with an interventional vascular procedure on the same artery. You may report modifier 59 or –XU for a diagnostic procedure performed before a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure.

Together we can advance health equity and help eliminate health disparities for all minority and underserved groups. Find resources and more from the [CMS Office of Minority Health](#):

- [Health Equity Technical Assistance Program](#)
- [Disparities Impact Statement](#)

Resources

- [National Correct Coding Initiative webpage](#)
- [MLN Article, Modification of the MCS Claims Processing System Logic for Modifier 59, XE, XS, XP, and XU Involving the National Correct Coding Initiative \(NCCI\) Procedure to Procedure \(PTP\) Column One and Column Two Codes](#)
- [National Correct Coding Initiative Policy Manual for Medicare Services](#)

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