Medical Coverage Policy

Coding and Payment Guidelines

☐ **Device/Equipment**   ☐ **Drug** ☐ **Medical**   ☐ **Surgery**   ☐ **Test**   ☒ **Other**

Effective Date:	11/15/2011	Policy Last Updated:	8/21/2012

☐ **Prospective review is recommended/required. Please check the member agreement for preauthorization guidelines.**

☒ **Prospective review is not required.**

The effective date of this policy relates specifically to the date BCBSRI created the documentation to reflect the reimbursement processes that are already in place and does not indicate a change in the payment process.

Description:

National Correct Coding Initiative (NCCI)

Blue Cross and Blue Shield of RI follow the Centers for Medicare and Medicaid Services (CMS) NCCI for all products for physician and hospital outpatient claims. More information on NCCI edits are available online from the National Correct Coding Initiative Policy Manual on the CMS website at http://www.cms.hhs.gov/NationalCorrectCodInitEd/

NCCI are edits based upon code pairs. The edits are in place to prevent codes that should not be reported together from being reported. Usually one of the two members of the pair is a service already included in the other procedure and not reported separately when correctly coding. In some cases, the services are mutually exclusive, i.e., the procedures would not be performed concurrently for clinical reasons.

NCCI edits are of two types:
1) There are "0" indicator edits, which are never correctly reported together;
2) There are "1" indicator edits, which may be overridden by a modifier (typically modifier 59 or a digit modifier).

It is the reporting clinician's responsibility to be sure the modifier is correctly used.

BCBSRI follows CMS Physician Fee Schedule (PFS) Relative Value Units (RVU) for details relating to
1) Global period
2) Assistant Surgeon
3) Two Surgeons (Co-Surgery)
4) Bilateral Surgery, and
5) Multiple Procedure Reductions status

The Medicare Physician Fee Schedule Relative Value Unit files can be found on the CMS Physician Fee Schedule website (currently labeled PPRRVUxx.xlsx) at http://www.cms.hhs.gov/PhysicianFeeSched/

1. **Global Period:**

   All procedures on the Medicare Physician Fee Schedule are assigned a Global period of 000, 010, or 090 days. If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. BCBSRI follows the surgical global period as designated by CMS on the Relative Value Units (RVU) files.

2. **Assistant Surgeon (Modifiers 80, 81, AS)**

   When there is an assistant surgeon, the surgeon of record is listed as the primary surgeon. The surgeon of record is responsible for identifying the presence of the assistant surgeon and the work performed. In this situation, the assistant surgeon does not dictate an operative note. An MD, DO, PA, NP, CNS or RFNA serving as the assistant surgeon will report the CPT codes for those procedures.

   The primary surgeon would report the procedures without a modifier and at their full fee. The assistant would append the appropriate assistant modifiers and at a reduced fee. The following modifiers should be used:
   - o Modifier 80: Assistant surgeon (MD or DO) who assisted on the majority of the case
   - o Modifier 81: Assistant surgeon (MD or DO) who assisted on less than the majority of the case available
   - o AS Modifier: Medicare modifier for a PA, NP, CNS or RFNA who is an assistant at surgery

   Assistant Surgeon Payment Rules

   We use the CMS table on the Medicare Physician Fee Schedule (PFS) to determine if we will pay for an assistant surgeon. These are not medical necessity determinations and are not reviewed for medical necessity if appealed. The payment determination is a contractual payment policy.

   Surgical procedures billed for an assistant surgeon will fall into one of two categories: Codes that allow an assistant surgeon and codes that do not allow an assist. When billing for assistant surgery services BCBSRI follows PFSRVU files using terms which are not reimbursed for Medicare's "sometimes" or "never" categories. Participating physicians may not require members to pay an assistant fee even if the members accept responsibility to do so, as this is charging outside of the approved amount.

3. **Co surgeons (Modifier 62)**

   Co surgery means that two surgeons, typically each in a different specialty, are performing distinct separate parts of the same procedure. This most frequently occurs when one surgeon performs the approach and the other surgeon performs the definitive procedure. For both surgeons to receive appropriate reimbursement, they must not be assisting each other, but performing distinct and separate parts of the same procedure.

If surgeons of different specialties are each performing a different procedure with specific CPT codes, neither co-surgery nor multiple surgery rules apply, even if performed through the same incision.

In certain instances, co-surgeons may be of the same specialty. In such cases, for services with a "1" or "2" indicator, Medicare Part B may pay for co-surgeons where the documentation justifies the medical necessity for two surgeons without regard to the two specialty requirement.

The co surgeon modifier 62 should be appended to only one primary procedure code and its associated add-on codes. If the second surgeon continues to assist on the case, he or she becomes the assistant surgeon; modifier 81 or 82 should be used in this case.

When two surgeons are reporting services as co surgeons, two distinct operative notes are required. The operative notes should not overlap because this negates the concept of co surgery and will drive the use of the appropriate assistant versus co surgeon modifiers.

Co-Surgeons Payment Rules

BCBSRI uses Medicare payment policy indicators on the Medicare Physician Fee Schedule Database (MPFSDB) to determine if co-surgeon services are reasonable and necessary for a specific HCPCS/CPT code.

These are not medical necessity determinations and are not reviewed for medical necessity if appealed. The payment determination is a contractual payment policy.
The MPFSDB is located at
http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp

Surgical procedures billed for co surgeons will fall into one of two categories: Codes that allow a co surgeon; Codes that do not allow a co surgeon. When billing for co surgeon services, please use the same codes in CMS's "always" category. BCBSRI does not reimburse for Medicare's "sometimes" or "never" categories. Participating physicians may not require members to pay a co surgeon fee even if the members accept responsibility to do so, as this is charging outside of the approved amount.

4. Bilateral Surgery

BCBSRI has adopted CMS payment policies with respect to bilateral services. In limited cases, the implementation of the CMS bilateral payment policy and edits will result in payment reductions that are not a result of enforcing correct coding. For example, CPT® may allow use of a bilateral modifier, yet the payment policy may be to allow the same payment whether for one or both sides. In other cases, edits will enforce correct coding. For example, some CPT codes have "unilateral or bilateral" in the descriptor making it clear the service is inherently bilateral.

Bilateral Surgery Payment Rules

The Medicare Physician Fee Schedule Relative Value Unit (RVU) file (currently labeled PPRRVUxx.xlsx) has a column labeled "Bilat Surg." In the column are indicator numbers 0,

1, 2, 3, or 9. Even though the indicator is labeled "surgery," a designation is made for every service. The indicators have the following effects and rationales:

0: The modifiers 50, -RT, and -LT do not apply. The code represents a single side and/or both sides. Payment for one or both sides is the lower of the total charges or 100 percent of the allowance for a single side.

1: This designation indicates that the second side is treated as a multiple procedure and is accordingly reduced whether a modifier or two units of service are reported. BCBSRI does not typically unit price surgical services subject to multiple procedure reduction. Therefore, use modifiers. Payment is at 150 percent for -50 or combined -RT and –LT.

2: The service is bilateral by description. (In most cases application of modifiers or units is incorrect coding as the descriptor is explicitly bilateral.) Use of 50, -RT, -LT, or 2 units is not applicable. Payment is the lower of the charge or 100 percent of the service allowance.

3: This indicator does not occur on any surgeries. It is seen mostly in imaging of limbs and some eye codes. For procedures with status 3, we ask that you report each side as a single line using -RT/-LT. Payment is based on 100 percent for each side or the total charge if lower.

9: The concept of "bilateral" does not apply as this is used for items such as drug codes where bilateral is nonsensical.

BCBSRI claims filed with bilateral services using the -50 modifier should be filed on one line. Bilateral claims filed using the RT and LT should be filed on two separate lines.

5. Multiple Procedure Reduction Payment Rules:

BCBSRI follows the CMS Relative Value Units files and will reimburse the highest surgical procedure at 100%, and each additional separate procedure that is not considered bundled or denied at 50%. Multiple procedure reductions apply to services rendered by the same physician on the same date of service.

There are select codes that will not be reduced based on RVU rules. These are "add-on" codes and other special exception codes, as defined by CMS. Add-on codes are not subject to the multiple procedures reduction rules.

Medically Unlikely Edits (MUEs) or Maximum Unit Limits

BCBSRI follows the CMS MUEs developed to reduce the paid claims error rate for Part B claims. An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single member on a single date of service. Not all HCPCS/CPT codes have an MUE. MUE list can be found at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html

Bundled CPT and HCPCS II Codes

BCBSRI follows CMS for codes that are "bundled" and considered not separately reimbursed for physicians and other professional providers. These are covered services for which there is no

payment. Generally, they are part of another service or services concurrently performed or performed in the past or to be performed. In some cases the designation is applied to a code because another code exists to describe the service and we ask that the alternative code be the one used. (For example, if there are G codes and CPT codes for essentially the same service, we typically use the CPT code.)

Diagnosis Codes

Coding to the highest degree of specificity

Providers who must select ICD-9-CM (ICD-10) diagnosis codes should use codes that provide the highest degree of accuracy and completeness, or the greatest specificity. For example, an ICD-9-CM carried to the 5th digit when applicable. The Centers for Medicare and Medicaid Services (CMS) require all Medicare practitioners to use ICD-9-CM (ICD-10) diagnosis codes with the highest specificity as requested by the Health Insurance Portability and Accountability Act (HIPAA).

Related Topics:
Modifier Payment Policy
Multiple Procedure Payment Reduction (MPPR) Certain Diagnostic Imaging Procedures

Publications:
Provider Update, January 2012
Provider Update, November 2012

References:
CMS National Correct Coding Initiatives Edits
https://www.cms.gov/NationalCorrectCodInitEd/

CMS Physician Fee Schedule
https://www.cms.gov/PhysicianFeeSched/

How to use the National Correct Coding Initiative (NCCI) Tools
https://www.cms.gov/MLNProducts/downloads/How-To-Use-NCCI-Tools.pdf