EFFECTIVE DATE: 09|01|2015
POLICY LAST UPDATED: 09|02|2015

OVERVIEW

This Policy provides an overview of coding and payment guidelines as they pertain to claims submitted to Blue Cross & Blue Shield of Rhode Island (BCBSRI). These guidelines follow correct coding guidelines published by National and Regional CMS (including DMEMAC), AMA guidelines, knowledge of anatomy, and the standards of medical practice.

PRIOR AUTHORIZATION

Not applicable.

POLICY STATEMENT

BCBSRI clinical editing adheres to the following guidelines:

National Correct Coding Initiative (NCCI)

Blue Cross & Blue Shield of Rhode Island follows the National Correct Coding Initiative (NCCI) for all products for physician and hospital outpatient claims.

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)

The following list of modifiers will be considered exception modifiers and the CCI Edit rules will be applied based on the modifier indicator flag that is in the CMS File: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LC, RC, 25, 27, 58, 59 78, 79 or 91

Physician Fee Schedule

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.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html

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:

- Modifier 80: Assistant surgeon (MD or DO) who assisted on the majority of the case
- Modifier 81: Assistant surgeon (MD or DO) who assisted on less than the majority of the case available
- 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) as a guideline 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.

The indicators on the PFSRVU file are as follows:

- Indicator 0: Assistant surgeon may be paid with documentation to support medical necessity
- Indicator 1: Assistant surgeon may not be paid
- Indicator 2: Assistant surgeon may be paid
- Indicator 9: Not applicable concept (e.g., service is not surgery)

BCBSRI will only pay for an assistant surgeon for those procedures with an indicator 2 (assistant surgeon may be paid). 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. Cosurgeons (Modifier 62)

Cosurgery 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 cosurgeon 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 cosurgeons, two distinct operative notes are required. The operative notes should not overlap because this negates the concept of cosurgery and will drive the use of the appropriate assistant versus cosurgeon modifiers.

Co-Surgeons Payment Rules
We use 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.

The MPFSDB is located at:
http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp
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 cosurgeons will fall into one of two categories: Codes that allow a cosurgeon; Codes that do not allow a cosurgeon. When billing for cosurgeon 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 cosurgeon 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.

Coding for Bilateral Services
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 file for multiple surgical reductions (MSR) rules and the AMA CPT book for modifier 51 exempt codes and for add-on codes. CMS will reimburse the highest surgical procedure at 100%, and each additional separate procedure that is not considered bundled or denied at 50% of the allowable amount. Multiple procedure reductions apply to services rendered by the same physician on the same date of service.

CMS Multiple Procedure Indicators (MULT PROC) are found in the most current CMS National Physician Fee Schedule Relative Value File. The values assigned to CPT codes for reimbursement are:

- **0** No payment adjustment rules for multiple procedures apply.
- **2** Standard payment adjustment rules for multiple procedure apply.
- **3** Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family.
- **4** Special rules for the technical component (TC) of diagnostic imaging procedures apply if procedure is billed with another diagnostic imagining procedure in the same family.
- **9** Concept of multiple surgical reductions does not apply.

AMA CPT Modifier 51 exempt and add-on codes

Codes that are modifier 51 exempt are separately reimbursed without reducing payment if services are appropriately reported together.
Add-on codes are separately reimbursed without reducing payment when appropriately billed with proper primary procedure codes.

6. Split Care Modifier (54, 55, 56)
BCBSRI follows CMS guidelines regarding which procedure codes are valid for use with split care modifiers 54, 55, 64. Reimbursements of modified codes are based on the CMS percentage on the RVU file.

7. Technical Component - TC
Technical Component refers to certain procedures that are a combination of a physician component and a technical component. Using modifier TC identifies the technical component. BCBSRI follows CMS guidelines for correct usage of the TC component. The TC modifier should only be appended to health service codes that that have a 1 in the PC/TC field on the National Relative Value Field file.

BCBSRI recognized modifiers:

Billing Information
Refer to the most updated industry standard coding guidelines for a complete list of modifiers and their usage. In the instances when a modifier is submitted incorrectly with the procedure code, BCBSRI will deny the claim line for incorrect use of modifier.

Note: The absence or presence of a modifier may result in a claim being denied.

Billing Information

Refer to the most updated industry standard coding guidelines for a complete list of modifiers and their usage. In the instances when a modifier is submitted incorrectly with the procedure code, BCBSRI will deny the claim line for incorrect use of modifier.

Multiple Modifiers
BCBSRI accepts the submission of multiple modifiers.

Modifier 24
In order to clarify the correct use of Modifier 24 when visits in the post-operative period combine post-operative care with E/M unrelated to the procedure, the following shall apply:

> The primary reason for the service shall be the unrelated condition. Incidental minor findings or lower levels of medical decision making do not warrant separate E/M reporting. The number and level of E/M in the post-operative period reflects a range of anticipated complexity and number of visits.
>
> When eligible to be reported, the basis of code selection shall not include the key components related to the procedure post-operative E/M.

In the case of planned separate surgeries (e.g., sequential cataract surgery) that are not staged procedures, E/M within the global period related to the second planned surgery is not separately reportable unless there is a significant change in the patient's condition. Confirming plans and verification of information that would be expected to be up to date as part the routine post-operative care, will not be considered a distinct service.

The list below represents the most common modifiers used by BCBSRI and identifies how they are used for claims processing. This is not an all-inclusive list of modifiers.

Modifier	Modifier Description	System Indications	Reimbursement Impact
22	Unusual procedural services	Claims review for additional payment/not state supplied	Claim review required. Exception for BCBSRI: Modifier 22 is also used to differentiate when vaccine is not supplied by the state.
23	Unusual anesthesia	Informational	Informational only.
24	Unrelated evaluation and management service by the same physician during the postoperative period	Payment during a global period	Payment allowed based on percentage of contracted rate.
25	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service	Payment during a global period	Payment allowed based on percentage of contracted rate.
26	Professional component	Percentage of payment	Payment allowed based on percentage of contracted rate.
32	Mandated services	Payment	Payment allowed based on percentage of contracted rate.
47	Anesthesia by surgeon	Informational	Informational
50	Bilateral procedure	Multiple procedure payment	Payment made at 150% of base code fee
51	Multiple procedures	Multiple procedure payment	Primary procedure reimbursed at 100% of

			allowance and subsequent procedures reimbursed at 50% of allowance (other than add-on or 51 exempt codes).
52	Reduced services	Claims review for payment	Payment made at 80%
53	Discontinued services	Payment	Payment is made at 50% of the allowable (effective 10/1/2014)
54	Surgical care only	Percentage of payment	Payment made at % of base code fee as outlined in CMS Physician RVU file.
55	Postoperative care only	Percentage payment	Payment made at % of base code fee as outlined in CMS Physician RVU file.
56	Preoperative care only	Percentage payment	Payment made at % of base code fee as outlined in CMS Physician RVU file.
57	Decision for surgery	Global payment	Payment allowed based on percentage of contracted rate.
58	Staged or related procedure or service by the same physician during the postoperative period	Global percentage payment	Payment allowed based on percentage of contracted rate.
59	Distinct procedural service	Payment	Payment allowed. Modifier is used to identify a distinct procedural service if there is no other modifier that can more accurately describe the distinct nature of the services performed. Please see appropriate HCPCS modifiers.
62	Two surgeons/ Co-surgeons	Claims review for payment	Claim review required. Payment made at 62.5% of base code fee allowance based on CMS.
63	Procedure performed on infants	Informational	Informational only.
66	Surgical team	Claims review payment by report	Claim review required. Manual pricing required based on operative notes.
76	Repeat procedure by the same physician	Global payment	BCBSRI only

			recognizes this modifier with radiology codes. Payment allowed based on percentage of contracted rate. **Modifier 76 not recognized on surgical codes.**
77	Repeat procedure by another physician	Global payment	BCBSRI only recognizes this modifier with radiology codes. Payment allowed based on percentage of contracted rate. **Modifier 77 not recognized on surgical codes.**
78	Unplanned return to the operating room by the same physician following the initial procedure for a related procedure during the postoperative period	Global percentage of payment	Payment allowed based on percentage of contracted rate.
79	Unrelated service or procedure by the same physician during the postoperative period	Global payment	Payment allowed based on percentage of contracted rate.
80	Assistant surgeon	Claim review percentage of payment	Claims review required. Percentage based on contracted rate.
81	Minimum assistant surgeon	Claim review percentage of payment	Claims review required. Percentage based on contracted rate.
82	Assistant surgeon (when qualified resident surgeon not available)	Claim review percentage of payment	Claims review required. Percentage based on contracted rate.
GENETIC TESTING CODE MODIFIERS		Informational	Informational only
HCPCS MODIFIERS			
Ambulance Modifiers			See Ground Ambulance policy.
AA	Anesthesia service performed personally by anesthesiologists	Payment	Payment allowed based on percentage of contracted rate.
AH	Clinical psychologist	Payment	Payment allowed based on percentage of contracted rate.
AJ	Clinical social worker	Payment	Payment allowed based on percentage of contracted rate.
AS	Assistant surgeon for mid-levels	Claim review percentage payment	Claim review required. Percentage based on contracted rate.

			NOTE: BCBSRI does not review AS modifier for medical necessity. When medical necessity review is required for payment by **BlueCHiP for Medicare**, BCBSRI denies additional payment under the provider contract-Provider liability.
E1	Upper left eyelid	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
E2	Lower left eyelid	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
E3	Upper right eyelid	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
E4	Lower right eyelid	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
EP	Early intervention	Payment	Payment allowed based on state reimbursement.
F1	Left hand, second digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
F2	Left hand, third digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
F3	Left hand, fourth digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
F4	Left hand, fifth digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
F5	Right hand, thumb	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
F6	Right hand, second digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
F7	Right hand, third digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
F8	Right hand, fourth digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
F9	Right hand, fifth digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.

FA	Left hand, thumb	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
GA	Waiver of liability statement issued as required by payer policy, individual case	Payment	Indicates claims will deny as member liability for health service.
GC	This service has been performed in part by a resident under the direction of a teaching physician	Payment	Payment allowed based on percentage of contracted rate.
GO	Services delivered under an outpatient occupational therapy plan of care	Payment 4 Effective 1/1/2014	Claim will deny as provider liability if modifier is missing
GP	Services delivered under an outpatient physical therapy plan of care	Payment Effective 1/1/2014	Claim will deny as provider liability if modifier is missing
GU	Waiver of liability statement issued as required by payer policy, routine notice	Payment	Claims will deny as member liability for health service.
GX	Notice of liability issues, voluntary under payer policy	Payment	Claims will deny as member liability for health service.
GY	Item or service is not covered	Payment	Claims will be not covered.
JW	Drug amount discarded/not administered to any patient	Payment	Payment allows for the amount of discarded drug or biological.
KS	Requirements specified in the medical policy have been met	Payment (Eff. 1/1/2015)	Payment allows when medical criteria are met
KX	Requirements specified in the medical policy have been met	Payment (Eff. 1/1/2014)	Payment allows when medical criteria are met
LT	Left	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
NP	Nurse practitioner	Payment	Payment allowed based on percentage of contracted rate.
PA	Physician's assistant	Payment	Payment allows at pre-determined percentages.
Q0	(Q zero) Investigational clinical service provided in a clinical research study that is in an approved clinical research study	Informational	Only BlueCHiP for Medicare members who are participating in National Institutes of Health (NIH)-sponsored clinical trials (per CMS).
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.	Payment	Payment allowed based on percentage of contracted rate.
QS	Monitored anesthesia care services - MAC	Informational	Informational only.

QW	CLIA waived test	Informational	CLIA waived instant drug test kits/screenings performed by participating BCBSRI providers.
QX	CRNA medical direction by physician	Payment	Payment allowed based on percentage of contracted rate.
QY	Medical direction of one CRNA by an anesthesiologist	Payment	Payment allowed based on percentage of contracted rate.
QZ	CRNA service: without medical direction of a physician	Payment	Payment allowed based on percentage of contracted rate.
RA	Replacement of a DME, Orthotic or Prosthetic Item	Informational	Payment allowed based on percentage of contracted rate.
RB	Replacement of a Part of a DME, Orthotic or Prosthetic Item Furnished as Part of a Repair	Informational	Payment allowed based on percentage of contracted rate.
RR	Rental	Payment	Payment allowed based on percentage of contracted rate.
RT	Right	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
T1	Left foot, second digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
T2	Left foot, third digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
T3	Left foot, fourth digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
T4	Left foot, fifth digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
T5	Right foot, great toe	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
T6	Right foot, second digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
T7	Right foot, third digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
T8	Right foot, fourth digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
T9	Right foot, fifth digit	Multiple surgery payment	Payment allowed based on percentage of

			contracted rate.
TA	Left foot, great toe	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
TC	Technical Component	Percentage of payment	Payment allowed based on percentage of contracted rate.
TU	Special payment rate	Prolonged services payment	Claims require review.

Medically Unlikely Edits (MUEs) or Maximum Unit Limits
The Maximum Units of Service value used in our clinical editing is derived from several sources: National and Regional CMS (including DMEMAC), AMA guidelines, knowledge of anatomy, the standards of medical practice, FDA and other nationally recognized drug references, and claims data from provider billing patterns.

Diagnosis Codes
Code 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).

MEDICAL CRITERIA
Not applicable

BACKGROUND
In the development of claim editing rules, BCBSRI, follows correct coding guidelines published by National and Regional CMS (including DMEMAC), AMA guidelines, knowledge of anatomy, the standards of medical practice.

COVERAGE
Not applicable as this policy is a reference document

CODING
See Policy section

RELATED POLICIES
None

PUBLISHED

Provider Update, November 2015
Provider Update, November 2013
Provider Update, May 2013
Provider Update, November 2012
Provider Update, January 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

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