




Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth



MassHealth
All Provider Bulletin 227
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TO: All Providers Participating in MassHealth
FROM: Julian J. Harris, M.D., Medicaid Director 
RE: **Modifier Coverage and National Correct Coding Initiative (NCCI) Updates**

Background

Modifiers are codes that can be added to service codes to provide additional information about the claim. They can indicate informational or positional (e.g., right or left), processing (e.g., bypass edit), or pricing instructions (e.g., calculate an actual fee). Certain modifiers, such as 25 and 59, allow for payment for two medically necessary, separately identifiable procedures billed together for a member by the same provider for the same date of service.

On April 1, 2011, MassHealth incorporated the methodologies of the National Correct Coding Initiative (NCCI) as required by Section 6507 of the federal Affordable Care Act (Public Laws 111-148 and 111-152). (See *All Provider Bulletin 209* at www.mass.gov/eohhs/docs/masshealth/bull-2011/all-209.pdf.)

Although the Centers for Medicare & Medicaid Services (CMS) NCCI rules permit the use of modifiers to bypass NCCI editing and allow payment in certain cases for two medically necessary, separately identifiable procedures billed for a member on the same date of service, MassHealth has had a longstanding policy against allowing certain modifiers, including NCCI-associated modifiers. After careful review, MassHealth is now expanding the list of allowable modifiers for use with MassHealth-covered service codes, as described in this bulletin.

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Allowable Modifiers

CMS has identified a set of modifiers to facilitate claims-processing for service codes that are not usually separately payable when billed in combination on the same date of service by the same provider, including CMS-designated NCCI code pairs. For dates of service starting July 1, 2012, MassHealth will begin allowing certain modifiers for affected providers, as further described in this bulletin to more accurately define service encounters and avoid claim denials due to certain system edits, including NCCI code pair edits and global surgery edits (see current lists of edit codes below) that don't currently allow payment for two medically necessary, separately identifiable services/procedures.

NCCI Code Pair Edits

- 5096 – NCCI-Conflict with Adjusted Other Service Prev Paid
- 5927 – NCCI-Another Service Prev Paid–Same Claim
- 5928 – NCCI-Another Service Prev Paid–Other Claim
- 5929 – NCCI-Conflict with Other Service Prev Paid

Global Surgery Edits

- 8175 – Service provided on the same day of a global surgical procedure is included in fee amt
- 8176 – Service provided on the day of and during 10-day global surgical procedure included
- 8177 – Service provided day before and during 90-day global surgical procedure included
- 8253 – Visit and surgery not allowed same day/same POS

Allowable Modifiers

These changes will be reflected in updated program regulations, lists of service codes and descriptions, and billing instructions in the coming months for affected providers. Regardless of the publication date of the regulations and other nonregulatory material, the following modifiers will be allowed when used appropriately, effective for claims with dates of service on or after July 1, 2012.

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Allowable Modifiers
(cont.)

Modifier	Description (see CPT code book for full description)
E1–E4	Anatomic areas of the eyelid
F1–F9, FA	Hands and digits
LC, LD, RC	Anatomic areas of the coronary arteries
LT, RT	Left and right sides of the body
T1–T9, TA	Foot and toes
24	Unrelated evaluation and management service by the same physician during a postoperative period
25	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service
27	Multiple outpatient hospital evaluation and management encounters on the same date (facility use only)
57	Decision for surgery
58	Staged or related procedure or service by the same physician during postoperative period
59	Distinct procedural service
78	Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period
79	Unrelated procedure or service by the same physician during the postoperative period

Please refer to the Current Procedural Terminology (CPT) code book for more information on which modifiers can be used with particular code combinations. The *CPT Assistant*, March 2012, Vol. 22(3), pp. 4-7, also contains information about modifiers 25 and 59. Additional and subsequent guidance on these modifiers may also be available.

Affected Providers

All providers that bill for services under the various circumstances in which these modifiers apply, according to the CPT code book, will be able to use the modifiers for claims submission when medically appropriate.

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***Appropriate Use of
Modifiers***

It is important that providers use modifiers only when appropriate. Providers continue to be responsible for ensuring that all services furnished are medically necessary and are billed appropriately. As defined by CMS, modifiers indicate special circumstances that allow providers to bill code pairs that are otherwise denied when billed together. *A modifier must not be appended to a HCPCS/CPT code solely to bypass an edit if the clinical circumstances do not justify its use.* Providers must ensure that documentation in the patient's records is sufficient to support the use of a modifier upon review by MassHealth. Finally, providers should bear in mind that they are obligated to code correctly and refrain from billing inappropriate code combinations even if specific edits do not exist to prevent use of those code combinations.

Providers should consult the CPT code book for additional information about how to appropriately use modifiers. In particular, providers should apply modifiers 25 and 59 only as follows.

Modifier 25: Modifier 25 may be appended to an evaluation and management (E&M) CPT code to indicate that the E&M service is significant and separately identifiable from other procedures/services reported on the same date. The E&M service may be related to the same or different diagnosis as the other procedure(s)/service(s).

Modifier 59: Apply modifier 59 to identify procedures/services that are not normally provided on the same date of service, but are medically necessary under the circumstances. For example, it can be used if two or more procedures are performed at different anatomic sites or different patient encounters. It should be used only if no other modifier more appropriately describes the relationship between the two or more service codes.

Please note that all providers must follow CMS rules when billing with NCCI-associated modifiers and that not all NCCI code pairs allow modifier use. For a more detailed discussion of modifier usage in the context of NCCI, refer to CMS guidelines at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How-To-Use-NCCI-Tools-.pdf>.

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***Determining
Inappropriate Use***

With this policy to expand the list of allowable modifiers, MassHealth plans to review claims submitted with these newly allowable modifiers to determine if they have been submitted using acceptable billing practices. (See 130 CMR 450.307.)

MassHealth will conduct postpayment reviews on a regular basis to assess and evaluate utilization of modifiers 25 and 59. Criteria for this review may include:

- determining whether the E&M service billed with modifier 25 is significant and separately identifiable from the other service/procedure reported on the same day and whether the E&M service exceeds the usual preprocedure, intraprocedure, and postprocedure care inherent in the other service/procedure reported (global allowance);
- determining whether the service billed with modifier 59 is a distinct procedural service from the other services provided on the same date; and
- determining whether the service was clinically appropriate and medically necessary.

MassHealth will also consider whether to conduct prepayment reviews and implement other review and audit strategies.

NCCI Updates

Quarterly NCCI File Updates

CMS updates the procedure-to-procedure code pairs that are subject to NCCI edits and the Medically Unlikely Edits (MUE) service limits on a quarterly basis. Please refer to the following CMS link for current NCCI and MUE information: www.cms.gov/NationalCorrectCodInitEd/.

Requests for MassHealth Review of NCCI/MUE Denials

MassHealth previously described the process for requests for review of NCCI/MUE claims denials in *All Provider Bulletin 209*.

<http://www.mass.gov/eohhs/docs/masshealth/bull-2011/all-209.pdf>

In addition to the four NCCI/MUE edit codes listed in *All Provider Bulletin 209* for which providers can request agency review, providers also can request a review of claims denied due to the following edit code.

5096 – NCCI-Conflict with Adjusted Other Service Prev Paid

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NCCI Updates
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When submitting an NCCI/MUE request for review, providers must include the provider name, provider identification number/service location (PID/SL), and contact information **for the servicing provider** (as well as the billing office) along with the other required information listed in *All Provider Bulletin 209*, found at <http://www.mass.gov/eohhs/docs/masshealth/bull-2011/all-209.pdf>. Including this information will allow the reviewing clinician to communicate directly with the servicing provider, if necessary.

Providers must submit requests for review electronically, unless the provider has received an approved electronic-submission waiver. Every request must be submitted separately with all required supporting documentation (as described in *All Provider Bulletin 209*). These documents must be scanned and included with a direct-data-entry (DDE) claim submission. Providers should use the Attachments tab to upload all applicable documents.

Only “Delay Reason Code 11–(Other)” may be used when submitting an NCCI/MUE request for review. For professional claims, providers must select Delay Reason Code 11 from the drop-down box on the Extended Services tab of the Provider Online Service Center (POSC). For institutional claims, providers must select Delay Reason Code 11 from the drop-down box on the Billing and Service tab.

Claims submitted for NCCI/MUE requests for review will appear in a suspended status on the remittance advice with **Edit 829 (NCCI/Appeal/Special Handle Under Review)** while the request is under review. Providers will receive an approval notice if the request for review is approved after clinical review. Claims subject to approved requests for review will be paid on a subsequent remittance advice, provided that they otherwise comply with claim submission requirements. A final determination notice will be sent if a request is denied.

Questions

If you have any questions about the information in this bulletin, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.
