Medicare Hospital Version

KEY CONCEPTS OUTLINE
Module 5: Medicare Edit Systems

I.   The Medicare Code Editor ("MCE")

A.   What is the MCE?

1.   The MCE is software used to edit inpatient claims. The MCE identifies claims that require further review before being processed by the GROUPER. <See *Medicare Claims Processing Manual*, Chapter 3 § 20.2.1.A>

a.   The MCE contains 20 edits. The MCE documentation is included in the materials behind the outline. <See *Medicare Claims Processing Manual*, Chapter 3 § 20.2.1; *Medicare Claims Processing Manual* Transmittal 11059>

b.   CMS publishes a manual titled "Definitions of Medicare Code Edits" containing a description of each coding edit with the corresponding ICD-10-CM and ICD-10-PCS code lists.

> Link: MS-DRG Classifications and Medicare Code Editor (MCE) Definitions under Medicare-Related Sites - Hospital

II. The Integrated Outpatient Code Editor (IOCE)

A.   What is the IOCE?

1.   The IOCE is software used in CMS processing systems to edit outpatient claims and assign Ambulatory Payment Classifications ("APCs"). <See *IOCE Specifications*, Section 3.1 (Supplement)>

B.   IOCE Quarterly Data Files

> Link: OCE Quarterly Files – Specifications and Report Tables 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-Table" 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 94 corresponds to the January 2024 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 3.1 (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 3.1 (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.

III. 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: NCCIPTPMUE@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: NCCI Medicare Manual under Medicare-Related Sites – General; and NCCI Medicare Main Page under Medicare-Related Sites – General

IV. 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, 20.9.3.1>

   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 8.2, Edit 20 and 40 (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: NCCI – Procedure to Procedure Edits under Medicare-Related Sites – General

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 8.2, 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 8.2, 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 1

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?

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2. NCCI Modifiers

a. The following modifiers will override an NCCI PTP edit. <See *IOCE Specifications*, Section 5.1 (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{ESPU}*>

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 6.3.1 (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 2**
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> **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?

V. 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: NCCI – Medically Unlikely Edits under Medicare-Related Sites – General

 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 3

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?

VI. 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 5.2 (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 5.2.1 (Supplement)>

    b. The list of drug administration add-on codes is available in the IOCE Quarterly Data Files, Report-Table 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: NCCI – Add-on Code Edits under Medicare-Related Sites – General

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 4

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 – 64721 and Column 2 – 69990, with modifier status indicator of 0.
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?

VII. 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: 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 2

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 3

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 4

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.

20.2.1 - Medicare Code Editor (MCE)
(Rev.11059; Issued: 10-21-21; Effective: 04-01-22; Implementation: 04-04-22)

A. - General

The MCE edits claims to detect incorrect billing data. In determining the appropriate MS-DRG for a Medicare patient, the age, sex, discharge status, principal diagnosis, secondary diagnosis, and procedures performed must be reported accurately to the Grouper program. The logic of the Grouper software assumes that this information is accurate and the Grouper does not make any attempt to edit the data for accuracy. Only where extreme inconsistencies occur in the patient information will a patient not be assigned to a MS-DRG. Therefore, the MCE is used to improve the quality of information given to Grouper.

The MCE addresses three basic types of edits which will support the MS-DRG assignment:

- **Code Edits -** Examines a *claim* for the correct use of diagnosis and procedure codes. They include basic consistency checks on the interrelationship among a patient's age, sex, and diagnoses and procedures *reported.*

- **Coverage Edits -** Examines the type of patient and procedures performed to determine if the services *are* covered.

- **Clinical Edits -** Examines the clinical consistency of the diagnostic and procedural information on the claim to determine if they are clinically reasonable and, therefore, should be paid.

B. - Implementation Requirements

The A/B MAC (A) processes all inpatient Part A discharge/transfer *claims* for both PPS and non-PPS facilities (including waiver States, long-term care hospitals, and excluded units) through the MCE. It processes claims that have been reviewed by the QIO prior to billing through the MCE only for edit types 1, 2, 3, 4, 7, and 12. It does not process the following kinds of *claims* through the MCE:

- Where no Medicare payment is due (amounts reported by value codes 12, 13, 14, 15, or 16 equal or exceed charges).

- Where no Medicare payment is being made. Where partial payment is made, editing is required.

- Where QIO reviewed prior to billing (condition code C1 or C3). It may process these exceptions through the program and ignore development codes or bypass the program.

The MCE software contains multiple versions. The version of the MCE accessed by the program depends upon the patient discharge date entered on the claim.

C. - Bill System/MCE Interface

The A/B MAC (A) installs the MCE online, if possible, so that prepayment edit requirements identified in subsection C can be directed to hospitals without clerical handling.
The MCE needs the following data elements to analyze the *claim*:

- Age;

- Sex;

- Discharge status;

- Diagnosis (25 maximum - principal diagnosis and up to 24 additional diagnoses);

- Procedures (25 maximum); and

- Discharge date.

The MCE provides the A/B MAC (A) an analysis of "errors" on the *claim* as described in subsection D. The A/B MAC (A) develops its own interface program to provide data to MCE and receive data from it.

The MCE Installation Manual describes the installation and operation of the program, including data base formats and locations.

D. - Processing Requirements

The hospital must follow the procedure described below for each error code. For *claims* returned to the provider, the A/B MAC (A) considers the *claim* improperly completed for control and processing time purposes. (See chapter 1.)

NOTE: The following instructions are based on ICD-9-CM diagnosis and procedure codes, *ICD-10-CM and ICD-10-PCS codes.*

1. Invalid Diagnosis or Procedure Code

The MCE checks each diagnosis code, including the admitting diagnosis, and each procedure code against a table of valid diagnosis and procedure codes. An admitting diagnosis, a *principal* diagnosis, and up to *24* additional diagnoses may be reported. Up to *25* total procedure codes may be reported on an inpatient claim. If the recorded code is not in this table, the code is invalid, and the A/B MAC (A) returns the *claim* to the provider.

For a list of valid diagnosis or procedure codes see the "International Classification of Diseases" revision applicable to the date of the inpatient discharge or other service and the "Addendum/Errata" and new codes furnished by the A/B MAC (A). The hospital must review the medical record and/or face sheet and enter the correct diagnosis/procedure codes before returning the *claim*.

2. External Cause of Injury Code as Principal Diagnosis

External Cause of Injury codes describe the circumstances that caused an injury, not the nature of the injury, and therefore are not recognized by the Grouper program as acceptable principal diagnoses. In ICD-9-CM the external cause of injury diagnosis codes begin with the letter E. In ICD-10-CM the external cause of injury codes begin with the letters V, W, X and Y. For a list of all External cause of injury codes, see *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), and the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)*. The hospital must review the medical record and/or face sheet and enter the correct diagnosis before returning the *claim*.

3. Duplicate of *Principal Diagnosis*

Any secondary diagnosis *reported on the claim* that is the same code as the principal diagnosis reported on the claim is identified as a duplicate of the principal *diagnosis.* This is unacceptable because the secondary diagnosis may cause an erroneous assignment to a higher severity *level* MS-DRG. Hospitals may not repeat a diagnosis code. The A/B MAC (A) will delete the duplicate secondary diagnosis and process the *claim*.

4. Age Conflict

The MCE detects inconsistencies between a patient's age and any diagnosis on the patient's record. Examples are:

- A 5-year-old patient with benign prostatic hypertrophy.

- A 78-year-old *who* delivers *a baby*.

In the above cases, the diagnosis is clinically impossible in a patient of the stated age. Therefore, either the diagnosis or age is presumed to be incorrect. Four age code categories are described below.

- A subset of diagnoses is intended only for *"perinatal/newborn." These are diagnoses that occur during the perinatal or newborn period of age 0.*

- Certain diagnoses are considered reasonable only for children between the ages of 0 and 17. These are "Pediatric" diagnoses.

- Diagnoses identified as "Maternity" are coded only for patients between the ages of 9 and 64.

- A subset of diagnoses is considered valid only for patients over the age of 14. These are "Adult" diagnoses. For "Adult" diagnoses the age range is 15 through 124.

The list of diagnoses that are acceptable for each age category can be located in the most current version of the *Definition of Medicare Code Edits manual which is posted at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software*

Prior versions of the manual can be located at:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS
and select the final rule for the applicable *Fiscal Year (FY)* from the list on the left. Then select the FY*(CCYY)* Final Rule Data Files, and scroll down to the Definition of Medicare Code Edits *link*.

If the A/B MAC (A) edits online, it will return *claims* for a proper diagnosis or correction of age as applicable. If the A/B MAC (A) edits in batch operations after receipt of the admission query response, it uses the age based on CMS records and returns *claims* that fail this edit. The hospital must review the *Electronic Health Record (EHR), paper medical record,* and/or face sheet and enter the proper diagnosis or patient's age before returning the *claim*.

5. Sex Conflict

The MCE detects inconsistencies between a patient's sex and a diagnosis or procedure on the patient's record. Examples are:

- Male patient with cervical cancer (diagnosis).

- Male patient with a hysterectomy (procedure).

In both instances, the indicated diagnosis or the procedure conflicts with the stated sex of the patient. Therefore, either the patient's diagnosis, procedure or sex is incorrect.

The MCE contains listings of male and female related diagnosis and procedure codes and the corresponding English descriptions. The hospital should review the *EHR, paper medical record,* and/or face sheet and enter the proper sex, diagnosis, and procedure before returning the *claim*.

6. Manifestation Code *as* Principal Diagnosis

A manifestation code describes the manifestation of an underlying disease, not the disease itself, and therefore, cannot be a principal diagnosis. The MCE contains listings of diagnosis codes identified as

manifestation codes. The hospital should review the *EHR, paper medical record,* and/or face sheet and enter the proper diagnosis before returning the *claim*.

7. Nonspecific Principal Diagnosis

Effective October 1, 2007 (FY 2008), the non-specific principal diagnosis edit was discontinued and *is only applicable when processing claims* using MCE version 2.0-23.0 only.

8. Questionable Admission

There are some diagnoses which are not usually sufficient justification for admission to an acute care hospital.

The MCE contains a listing of diagnosis codes identified as "Questionable Admission" when used as principal diagnosis.

The A/B MACs (A) may review on a post-payment basis all questionable admission cases. Where the A/B MAC (A) determines the denial rate is sufficiently high to warrant, it may review the claim before payment.

9. Unacceptable Principal Diagnosis

There are selected codes that describe a circumstance which influences an individual's health status but is not a current illness or injury; therefore, they are unacceptable as a principal diagnosis. For example, the diagnosis code for family history of a certain disease would be an unacceptable principal diagnosis since the patient may not have the disease.

In a few cases, there are codes that are acceptable *as a principal diagnosis* if a secondary diagnosis is coded. If no secondary diagnosis is present the message "requires secondary dx" *will be returned by the MCE.* The A/B MAC (A) may review claims with codes *from* the Unacceptable Principal Diagnosis section and a secondary diagnosis. A/B MACs (A) may choose to review as a principal diagnosis if data analysis deems it a priority.

If codes *from the unacceptable principal diagnosis edit code list* are identified without a secondary diagnosis, the A/B MAC (A) returns the claim to the hospital and requests *that the applicable secondary* diagnosis *be entered.* Also, *any claims* containing other "unacceptable principal diagnosis" codes are returned.

The hospital reviews the *EHR, paper medical record,* and/or face sheet and enters the appropriate principal diagnosis that describes the illness or injury before *resubmitting* the *claim*.

10. Nonspecific O.R. Procedures

Effective October 1, 2007 (FY 2008), the non-specific O.R. procedure edit was discontinued and *is only applicable when processing claims* using MCE version 2.0-23.0 only.

11. Noncovered O.R. Procedures

There are some O.R. procedures for which Medicare does not provide payment.
The A/B MAC (A) will return the *claim* requesting that the non-covered procedure and its associated charges be removed from the claim, Type of Bill (TOB) 11X. If the hospital wishes to receive a Medicare denial, etc., the hospital may submit a non-covered claim, TOB 110, with the non-covered procedure/charges. (For more information on billing non-pay claims, see Chapter 1 of this Manual, Section 60.1.4).

12. Open Biopsy Check

Effective October 1, 2010, the open biopsy check edit was discontinued and *is* only *applicable* when processing *claims using* MCE version 2.0 - 26.*0*.

13. Bilateral Procedure

Effective October 1, 2015, the bilateral procedure edit was discontinued and is only used when processing claims using MCE version 2.0-33.0.

14. Invalid Age

If the hospital reports an age over l24, the A/B MAC (A) requests the hospital *confirm* if it made a *claim* preparation error. If the beneficiary's age is *confirmed to be over l24*, the hospital enters 123.

15. Invalid Sex

A patient's sex is sometimes necessary for appropriate MS-DRG *assignment*. The sex code reported must be either 1 (male) or 2 (female).

16. Invalid Discharge Status

A patient's discharge status is sometimes necessary for appropriate MS-DRG *assignment*. Discharge status must be coded according to the Form CMS-1450 *and UB-04* conventions. See Chapter 25.

17. *Limited Coverage*

For certain procedures whose medical complexity and serious nature incur extraordinary associated costs, Medicare limits coverage to a portion of the cost.

18. *Wrong Procedure Performed*

Certain external causes of morbidity codes indicate that the wrong procedure was performed.

19. Procedure inconsistent with length of stay *(LOS)*

The following procedure code should only be coded on claims when the respiratory ventilation is provided for greater than four **consecutive** days during the length of stay.

Effective *with discharges on and after* October 1, 2015, ICD-10-PCS code, 5A1955Z - Respiratory Ventilation, Greater than 96 Consecutive Hours

Prior to this date, discharges on and after October 1, 2012, ICD-9-CM procedure code, 96.72, Continuous invasive mechanical ventilation for 96 consecutive hours or more

20. *Unspecified Code*

Unspecified codes exist for circumstances when documentation in the medical record does not provide the level of detail needed to support reporting a more specific code. However, in the inpatient setting, there should generally be very limited and rare circumstances for which the laterality (right, left, bilateral) of a condition is unable to be documented and reported.

Effective April 1, 2022, the Unspecified Code edit will be triggered for certain unspecified diagnoses codes currently designated as either a Complication or Comorbidity (CC) or Major Complication or Comorbidity (MCC), that include other codes available in that code subcategory that further specify the anatomic site, when entered on the claim. This edit message indicates that a more specific code is available to report. It is

the provider's responsibility to determine if a more specific code from that subcategory is available in the medical record documentation by a clinical provider.

If, upon review, additional information to identify the laterality from the available EHR or paper medical record, or documentation by any other clinical provider is unable to be obtained or there is documentation in the record that the physician is clinically unable to determine the laterality because of the nature of the disease/condition, then the provider must enter that information into the remarks section.

The provider should submit the billing note/remarks that best identifies the primary reason why specificity could not be determined:

Billing Note/Remarks	Definition
UNABLE TO DET LAT 1	*Provider is unable to obtain additional information to specify laterality.*
UNABLE TO DET LAT 2	*Physician is clinically unable to determine laterality.*

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FACT SHEET
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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, CCMIs, and NCCI PTP-associated modifiers.

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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:

a. Occurs after the completion of the therapeutic procedure and isn't mingled with or otherwise mixed with services that the therapeutic intervention requires

b. 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](#)