Aetna Better Health® of Illinois
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Aetna Better Health® of Illinois
Provider Education: Coding Validation

As a valued member of our provider community, we want to inform you of some upcoming enhancements to claims processing.

Effective 8/1/2022, Aetna will be adding new edits to address coding situations which are too complex for auto-adjudication without a human review. These edits are based on correct coding rules published by national industry sources and administrative bodies. They are designed to detect potential coding errors and incorrect billing practices.

One issue addressed by the new edits is the correct use of modifiers. Modifiers have been defined by the American Medical Association (AMA) and adopted by the Centers for Medicare and Medicaid Services (CMS) to provide additional information regarding the services rendered. The National Correct Coding Initiative (NCCI) Policy Manual also provides directions on modifier use:

Modifiers may be appended to HCPSC/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier shall not be appended to a HCPCS/CPT solely to bypass an NCCI PTP edit if the clinical circumstances do not justify its use (NCCI Policy Manual, January 2021, pg. I-18).

Coding Validation reviews consider the information on the claim, and in the patient's claim history, to determine if the modifier has been used correctly. Modifiers 25, 59, XE, XS, XP and XU comprise many of the overriding modifiers appended to services. Coding Validation edits evaluate the correct use of overriding modifiers. Cotiviti is providing the following information regarding the use of the previously mentioned modifiers to prevent the incorrect processing and payment of claims.

Modifier 25 Guidelines

The AMA published guidelines in the Coding with Modifiers: A Guide to Correct CPT® and HCPCS Level II Modifier Usage 6th ed. instruct providers to append modifier 25 to indicate a "significant, separately identifiable evaluation and management (E/M) service was performed by the same physician or other qualified healthcare professional (QHP) on the same day of a

procedure or other services" (Linker, 2020, chap. 2 pg. 45). CPT guidelines define this significant and separate service as being "above and beyond" the usual preoperative and postoperative care associated with the procedure or service performed. The AMA Coding with Modifiers states:

> The E/M service must meet the key components (i.e., history, examination, medical decision making) of that E/M service including medical record documentation. To use modifier 25 correctly, the chosen level of E/M service needs to be supported by adequate documentation for the appropriate level of service and referenced by a diagnosis code. The CPT codes for procedures do include the evaluation services necessary before the performance of the procedure (e.g., assessing the site and condition of the problem area, explaining the procedure, obtaining informed consent); however, when significant and identifiable (i.e., medical decision making and another key component) E/M services are performed, these services are not included in the descriptor for the procedure or service performed. (Linker, 2020, chap. 2 pg. 45)

Modifier 59, XE, XP, XS, XU Guidelines

The Coding with Modifiers guidelines state modifiers 59, XE, XP, XS, XU should be used when the physician needs to indicate that a procedure or service was distinct or independent from other services performed on the same day:

> CMS established the National Correct Coding Initiative (NCCI) program to ensure the correct coding of services.... NCCI Procedure-to Procedure (PTP) edits prevent inappropriate payment of services that should not be reported together. Each edit has a column one and column two HCPCS/CPT code. If a provider reports the two codes of an edit pair for the same beneficiary on the same date of service, the column two code is denied, and the column one code is eligible for payment. However, if it is clinically appropriate to utilize an NCCI PTP-associated modifier, both the column one and column two codes are eligible for payment. (Linker, 2020, chap. 5 pg. 139)
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> Modifier 59 is used to identify procedures/services that are not normally reported together but are appropriate under certain circumstances. This may represent a different session or patient encounter, 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 physician.
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> When preparing claims for submission, it is important to make sure all appropriate diagnosis codes have been assigned to the claim and that modifiers are used only in accordance with published guidelines. If you have claims that you believe are incorrectly denied due to the incorrect use modifiers, please submit medical records so we can determine the correct payment for those claims. Additional information can be found in the CPT book and NCCI manuals on CMS's website regarding the appropriate use of modifiers.