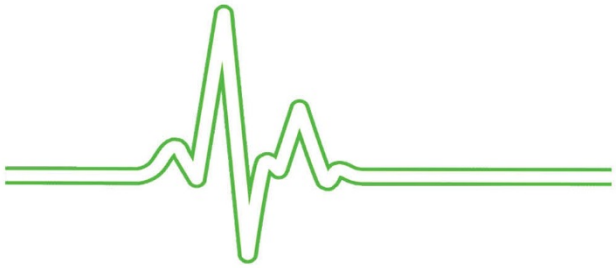
Soundpath HEALTH

Provider Pulse



Provider News & Information

Claims Process Code Updates Spring 2018

Spring 2018: Claims Process Code Updates

In accordance with the Centers for Medicare and Medicaid Services (CMS), Soundpath Health, would like to remind providers and their billing staff about the following correct billing practices to ensure proper claims payment.

Modifier 50

This modifier is used to report services done on both the left and right side during a procedure. When billed correctly, the payment for services rendered will be 150% of the CMS Allowable.

In order to ensure proper payment providers must only bill with 1 unit when using modifier 50. Starting in April, Soundpath Health will be denying lines that are billed more than 1 unit on lines with modifier 50.

Also, when the CPT code description has the terms "bilateral" or "unilateral or bilateral" modifier 50 is not required and should not be billed because the payment already takes into account for the work done bilaterally.

For example:

> CPT 27331 has a bilateral indicator of a 1, which means bilateral surgery rules apply. If the 50 modifier is appended to the CPT with 1 unit billed, Medicare will allow 150%.
>
> If billed with 2 units, it states the procedure was completed 4 times and will be denied as unprocessable.
>
> If two of the same services were performed bilaterally, the services should be billed on two separate lines with 1 unit apiece, the 50 modifier and the appropriate repeat modifier on one of the lines.

This same rationale also applies to billing Cerumen Impaction (CPT 69210) services. Providers should only bill with 1 unit when the service is performed bilaterally.

For more information on what services are eligible for bilateral payments, please refer to the RVU fee schedule "Bilat Surg" column.

> 0 = 150% payment adjustment for bilateral procedures does not apply.
> 1 = 150% payment adjustment for bilateral procedures applies.
> 2 = 150% payment adjustment for bilateral procedures does not apply.
> 3 = 150% payment adjustment for bilateral procedures does not apply.
> 9 = Does not apply.

CMS. (2017, October 13). *Chapter 12 - Physicians/Nonphysician Practitioners*. Retrieved from CMS: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

CMS. (2018). *PFS Relative Value Files*. Retrieved from CMS: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html

Noridian Healthcare Services. (2017, November 10). *Bilateral Surgery*. Retrieved from Noridian Healthcare Services: https://med.noridianmedicare.com/web/jfb/specialties/surgery/bilateral-surgery

Modifier 25

This modifier is used to report separately identifiable Evaluation and Management (E/M) services by the same physician or other qualified healthcare professional on the same day of the procedure or other service. Documentation should include the key components of an E/M service to support the additional work needed to perform the E/M service with modifier 25.

Both CMS and Noridian Healthcare Solutions have provided some examples of correct usage of Modifier 25.

Some examples they have provided as correct usage of Modifier 25 with an E/M service are as follows:

- When the patient's condition required a significant, separately identifiable E/M service above and beyond other services provided or beyond usual pre-operative and post-operative care associated with the procedure that was performed.
- Indicate that an E/M service was provided on the same day as another procedure that would normally bundle under National Correct Coding Initiative (NCCI). In this situation, this modifier signifies that the E/M service was performed for a reason unrelated to other procedures.
- New patient CPT codes when chemotherapy or non-chemotherapy infusions are performed on the same day.

Some examples they have provided as incorrect usage of Modifier 25 with an E/M service are as follows:

- New patient CPT codes except in the example above. New patient CPT codes are excluded from the global surgical package.
- Used when the procedure or service has no global fee period.
- When the documentation does not support a separately identifiable E/M service.

For additional examples and further clarifications please refer to the links listed below.

CMS. (2012, November 12). *Payment for Evaluation and Management Services Provided During Global*. Retrieved from CMS: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm5025.pdf

CMS. (2017, October 13). *Chapter 12 - Physicians/Nonphysician Practitioners*. Retrieved from CMS: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

Noridian Healthcare Services. (2017, November 06). *Modifier 25*. Retrieved from Noridian Healthcare Services: https://med.noridianmedicare.com/web/jfb/topics/modifiers/25

Professional Claims (CMS 1500 & EDI) and Admission Date Requirement on Certain Place of Services (POS)

Starting in April, Soundpath Health will be returning claims to providers when a provider bills an inpatient E/M service with an inpatient POS such as 21 or 61 where the admit date is not present on the claim. (Please note, additional POS's may be added

This change is affecting all providers billing on a CMS 1500 and in the 837-P 5010 complaint format. Per the 5010 implementation guidelines, the admit date is required on all inpatient claims with E/M services

Soundpath Health is implementing this change due to Risk Adjustment and Encounter data protocols.

If you have any questions or concerns about this new payment policy please contact your local provider relations representative.

Non-Covered Laboratory Services

Soundpath Health has identified laboratory claims billed with CPT codes 80320 through 80377 that are non-covered by CMS. These codes have been inappropriately paid and will be reprocessed in the next few weeks.

Per CMS there other covered CPT codes for drug testing services. Please educate your staff to make them aware of these changes and to instruct them to start billing with the appropriate CMS covered drug testing CPT codes.

If you have any questions or concerns about this new payment policy please contact your local provider relations representative.

CMS. (2018, March 29). *MLN Matters - Proper Coding for Specimen Validity Testing Billed in Combination with Drug Testing.* Retrieved from CMS: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18001.pdf

Anesthesia Electronic Claims (837-P Format)

We would like to remind all Anesthesia providers and their billing staff regarding the proper format to bill their time units on electronic (837-P) claims.

In order to report the total minutes a procedure took, the 837-P format segment SV103, must contain the MJ qualifier. Using this required qualifier will ensure proper payment for the services rendered, as well as accurate encounter data reporting to CMS.

Anesthesia P1 – P6 Modifiers

Starting in April, Soundpath Health will not be paying additional monies for anesthesia services billed with modifiers P1 – P6. This change is being done in accordance with CMS guidelines. All claims that received this additional money will be reprocessed in the next few weeks.

If you have any questions or concerns about this new payment policy please contact your local provider relations representative.

Noridian Healthcare Solutions. (2017, November). *Anesthesia Services.* Retrieved from Noridian Healthcare Solutions: https://med.noridianmedicare.com/documents/10542/2840524/Anesthesia+Services+Presentation/139f1cb5-254a-4828-9b23-0e85824d6f18

Noridian Healthcare Solutions. (2018, February 19). *Modifiers.* Retrieved from Noridian Healthcare Solutions: https://med.noridianmedicare.com/web/jfb/topics/modifiers#anesthesia

ASC Facility Claims and Modifier PT Usage

Please ensure that claims submitted for members who presented for a screening procedure at an ASC facility, contain modifier PT. When modifier PT is billed with the surgical CPT code on the facility claim, the member will not be assessed a copay.

We encourage our members to obtain the necessary screening services and in return, we want to ensure that they are not inappropriately assessed a copay for a screening procedure.

Timely Filing Reminder

All claims submitted to the plan must be submitted within 365 days of the date of service.

For the time allowance to reprocess a claim, please refer to your provider contract with us.

Corrected Claim Submissions

As a reminder, all corrected claims should be sent either electronically or hard copy to the addresses listed below. Soundpath Health prefers providers to submit their corrected claims electronically if able to do so.

Also, for faster assistance with either the electronic or paper corrected claims submission, please reference our claim number that you are requesting to be corrected.

Please note: If sending electronic corrected claims, please ensure the frequency code of your claims is a "7".

Claims Mailing Address	**Soundpath Health** PO Box 853924 Richardson, TX 75085-3924
EMDEON ID	**SPH:** 42172 **SPH/PSW:** 91171

Inpatient Claims – Discharge Status and Occurrence Code 55

Starting in April, Soundpath Health will be returning claims to providers when their claim is missing the required occurrence code when the FL-17 field on the UB04 or element CL103 (837-I) contains one of the following status codes: 20, 40, 41, or 42.

Per CMS guidelines providers are required to bill occurrence code 55 when the patient status code is 20, 40, 41, or 42. This requirement is for all institutional claims.

This change is needed to ensure accurate claims processing and for reporting encounter data to CMS.

CMS. (2012, April 27). *New Occurrence Code to Report Date of Death - CR7792*. Retrieved from CMS: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1079OTN.pdf

CMS. (2012, May 31). *New Occurrence Code to Report Date of Death - MM7792*. Retrieved from CMS: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7792.pdf

Same Day Transfers and Condition Code 40

All institutional providers are required by CMS to use condition code 40 when the patient status is one of the following codes: 02, 03, 05, 50, 51, 61, 62, 63, 65, 66, or 70.

Per Noridian Healthcare Solutions a local Medicare Administrative Contractor (MAC), "A same day transfer occurs when a [patient] is admitted to your facility, but later, on the same day [is] transferred to another hospital or another distinct part of the hospital."

Starting in April, Soundpath Health will begin to return claims to providers when condition code 40 is missing and one of the above patient status codes were used.

If you have any questions about this requirement, please contact your local provider relations representative.

CMS. (2017, August 08). *Chapter 3 - Inpatient Hospital Billing*. Retrieved from CMS: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf

Noridian Healthcare Solutions. (2017, Aug 10). *Same Day Transfers*. Retrieved from Nordian Healthcare Solutions: https://med.noridianmedicare.com/web/jfa/provider-types/acute-ipps-hospital/same-day-transfers

Patient Reason for Visit Diagnosis Codes

All institutional providers billing for outpatient services with types of bills 13x and 85x and with Revenue Codes 045x, 0516, or 0762 are required to bill with a patient reason for visit diagnosis code.

In accordance with CMS regulations, Soundpath Health over the next few months, will return claims to providers when institutional providers do not report the patient reason for visit diagnosis code when the above type of bills and one of the revenue codes are present on a claim.

If you have any questions about this requirement, please contact your local provider relations representative.

CMS. (2015, July 1). *Clarification on Patient's Reason for Visit Necessary to Capture HIPAA Compliant Fields - CR9450*. Retrieved from CMS: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R3435CP.pdf

CMS. (2017, February 03). *Chapter 25 - Completing and Processing the Form CMS-1450 Data Set*. Retrieved from CMS: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c25.pdf

CMS. (2017, August 08). *Chapter 3 - Inpatient Hospital Billing*. Retrieved from CMS: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf

Manifestation Codes as Principal Diagnosis Codes on UB04.

Per the ICD-10-CM coding guidelines:

> For such conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first, if applicable, followed by the manifestation. Whenever such a combination exists, there is a "use additional code" note at the etiology code and a "code first" note at the manifestation code.
>
> There are manifestation codes that do not have "in diseases classified elsewhere" in the title. For such codes, there is a "use additional code" note at the etiology code and a "code first" note at the manifestation code, and the rules for sequencing apply.

Soundpath Health has been noticing providers billing manifestation codes without the underlying codes. One example that is commonly seen is with diabetic diagnosis codes starting with E08. Per ICD-10-CM guidelines and the instruction found under E08, the guidelines state to "code first the underlying condition. Soundpath Health has also noticed the manifestation codes being billed as a principal diagnosis without the underlying condition. Per CMS manifestation codes cannot be listed as a principal diagnosis code.

Therefore starting in April, Soundpath Health will begin to reject outpatient facility claims when billed with the manifestation diagnosis code as the principal diagnosis code. Please correct your billings and resubmit the claim.

Soundpath Health also recommends that all providers adhere to the ICD-10-CM guidelines even if the manifestation code is not a principal diagnosis code. Soundpath Health expects for the underlying condition to be present when the manifestation diagnosis code is billed.

For more information where to obtain the listing, please review the links below.

CMS; AHIMA, American Hospital Association. (2017, October 1). *ICD-10-CM Official Guidelines for Coding and Reporting.* Retrieved from ICD-10: https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2018-ICD-10-CM-Coding-Guidelines.pdf

Noridian Healthcare Solutions. (2017, December). *Outpatient Code Editors and Addendums.* Retrieved from Noridian Healthcare Solutions: https://med.noridianmedicare.com/documents/10538/2760408/Inpatient+and+Outpatient+Code+Editors+and+Addendums+A+and+B/dce95d49-137f-4671-be2a-920f6423dda0

Hospice Claims Billing and Medicare Advantage

As a reminder, if one of our members has elected Hospice coverage, then all medical claims, related to the member's hospice condition, must be sent to the local Medicare Administrative Contractor (MAC).

All other medical claims that are unrelated to the member's hospice condition, can be billed to Soundpath Health. Please remember to use the proper Hospice modifiers when billing your claims.

Per each MAC:

Append Hospice modifier if appropriate

Modifier GV - Attending physician is not employed or paid under an agreement by patient's Hospice provider

Modifier GW - Condition not related to patient's terminal condition

If you have any questions about where to submit your claim, please contact your local provider relations representative.

CMS. (2015, December). *Home Health & Hospice MAC Areas*. Retrieved from CMS: https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/Home-Health-and-Hospice-Area-Map-Dec-2015.pdf

CMS. (2017, September 26). *Chapter 11 - Processing Hospice Claims*. Retrieved from CMS: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf

Noridian Healthcare Solutions. (2017, November 13). *Patient Enrolled in Hospice*. Retrieved from Noridian Healthcare Solutions: https://med.noridianmedicare.com/web/jfb/topics/claim-submission/reason-code-guidance/patient-enrolled-in-hospice

CERIS – Institutional Outlier Claim Review

Effective mid first quarter 2018, Soundpath Health has instituted a new claims review procedure to ensure claims accuracy. The new procedure entails reviewing all inpatient facility claims received on a paper UB04 or an electronic 837-I format that incur an outlier amount.

Claims that incur an Outlier amount are based on the charge amount and above the threshold per diagnosis-related group (DRG). Soundpath Health has contracted with CorVel Healthcare Corporation's ("CorVel") CERIS division, to review hospital's itemized billing statements as well as any supporting medical documentation.

The review provided by CERIS identifies errors, duplicate charges, and non-separately payable routine services and supplies, including equipment. Only the itemized bill is needed, as this review does not include medical necessity, and the review does not affect the DRG portion of the payment.

In order to receive timely payment on claims, please provide any requested itemized billings within the time limits stated in the request. Payments could be reduced or delayed if this information is not provided.

CERIS Review Program FAQ's

1. **Who is CERIS?**
    a. *CERIS is an independent facility claim review service*
2. **Why is CERIS reviewing facility provider's itemized bills?**
    a. *Soundpath Health has a fiduciary duty to review all claims for accuracy. The review provided by CERIS identifies errors, duplicate charges, and non-separately payable routine services and supplies, including equipment. Only the itemized bill is needed, as this review does not include medical necessity.*
3. **Are all DRG claims reviewable by CERIS?**
    a. *No only inpatient claims that reach an Outlier status.*
4. **Is CERIS reducing the DRG payment?**
    a. *No. The DRG is not affected by the Itemized Bill Review. Charges billed in error are removed and the claim is priced with the new allowable.*
5. **What should occur if a hospital appeals CERIS' review?**
    a. *Appeals, received in writing, should be forwarded to the **CERIS' Customer Service Department.** CERIS will review the original outcome ensuring the recommendations are correct and provide a complete appeal response to the client and/or hospital.*
6. **What should occur if I have questions related to the CERIS review?**
    a. *You can contact **CERIS' customer service at 800-546-2570** or send an email to the team at CustomerService@CERIS.com.*
7. **What should occur if the provider has any questions related to the CERIS review?**
    a. *Providers can be directed to contact **CERIS customer service at 800-546-2570.***

Obesity and ICD-10-CM Code Assignment

Obesity is a chronic disease; patient and practitioner must understand that a successful treatment requires a lifelong effort. Obesity means having too much body fat. It increases the risk of diabetes, heart disease, stroke, arthritis, and some cancers. In 2009-2010, the prevalence of obesity among American men and women was nearly 36 percent. If you are obese, losing even 5-10 percent of your weight can delay or prevent some of these diseases. Obesity is a substantial public health crisis in the United States, and internationally, with the prevalence increasing rapidly in numerous industrialized nations.

Documentation Guidance: Documentation is the key to coding overweight and obesity. Documentation should include:

Severity — Overweight, Obese, or Morbid obesity

Contributing factors — Excessive calories or drug-induced

Association — Pregnancy

Symptoms/Findings/Manifestations — BMI or Alveolar hypoventilation

Supporting documentation may include: Diet discussed, Exercise encouraged, Gastric bypass surgery consult, Diet medication, Dietician referral and/or counseling, Weight loss program (i.e. gym membership), Food log, and Physiatrist referral.

ICD-10-CM code choices

E66.01 Morbid (severe) obesity due to excess calories

E66.09 Other obesity due to excess calories

E66.1 Drug-induced obesity (note: This code contains an instructional note to use an additional code for the adverse effect, if applicable to identify the drug (T36-T50) with fifth or sixth character 5).

E66.2 Morbid (severe) obesity with alveolar hypoventilation

E66.3 Overweight

E66.8 Other obesity

E66.9 Obesity, unspecified

Category E66 contains two instructional notes:

1. Code first obesity complicating pregnancy, childbirth, and puerperium, if applicable (O99.21)
2. Use an additional code to identify body mass index (BMI) if known (Z68).

Body mass index (BMI) is a measure of body fat based on height and weight that applies to adult men and women. BMI can provide sound clinical information on a person's nutritional status. Obesity is diagnosed when an individual's body mass index (BMI) is 30 or higher. The National Institutes of Health (NHLBI Obesity Education Initiative) recommended the following classifications for BMI, adopted by the Expert Panel on the Identification, Evaluation, and Treatment of Overweight and Obesity in adults and endorsed by leading organizations of health professionals:

Classification	BMI
Underweight	<18.5 kg/m2
Normal weight	18.5–24.9 kg/m2
Overweight	25–29.9 kg/m2
Obesity (Class 1)	30–34.9 kg/m2
Obesity (Class 2)	35–39.9 kg/m2
Extreme obesity (Class 3)	≥40 kg/m2

BMI (adult 21 years of age or older)

Z68.1 BMI 19 or less, adult

Z68.20-Z68.24 BMI 20.0-24.9 Normal

Z68.25-Z68.29 BMI 25.0-29.9 Overweight

Z68.30-Z68.39 BMI 30.0-39.9 Obesity

Z68.41 BMI 40.0-44.9, adult

Z68.42 BMI 45.0-49.9, adult

Z68.43 BMI 50-59.9, adult

Z68.44 BMI 60.0-69.9, adult

Z68.45 BMI 70 or greater, adult

Coding Examples:

Example 1: The patient is a 44-year-old woman who has gained over 50 pounds in the last 10 years. She is seen today because she would like medical treatment to help her lose weight. The physician examines the patient and suggests that she try to lose weight through diet and exercise before he prescribes her medication. The physician diagnosed the patient with obesity.

Based on this documentation the patient is diagnosed with obesity; however, there is no documentation of the cause, or of her BMI. **Because of the lack of detail, the correct code is E66.9 *Obesity, unspecified*.**

Example 2: A 53-year-old female is seen for obesity. She has a 10-year history of type 2 diabetes mellitus. She complains of fatigue, difficulty losing weight, and no motivation. She denies polyuria, polydipsia, polyphagia, blurred vision, or vaginal infections. She states she has gained an enormous amount of weight since being placed on insulin 6 years ago. She eats in excess of 2000 calories a day. She eats only 3 meals a day but eats a lot of snacks through the day. On exam, her height is 5'1" and her weight is 265lb, BMI is 50.1. Her blood pressure is 120/80 mmHg. The remainder of her physical exam is unremarkable.

Assessment: Morbid obesity, Type 2 diabetes mellitus

Based on this documentation, the patient is diagnosed with morbid obesity due to excess calories, which would be coded E66.01 *Morbid (severe) obesity due to excess calories*. The patient has a body mass index of 50.1, which would be coded Z68.43 *Body mass index (BMI) 50-59.9, adult*. The patient also has Type 2 diabetes without complication (E11.9 *Type 2 diabetes mellitus without complications*), with long-term, current use of insulin (Z79.4 *Long-term (current) use of insulin*). **Because of the documentation detail, the correct codes are E66.01, Z68.43, E11.9, Z79.4**