National Correct Coding Initiative Reimbursement Policy					
Policy Number	2016RP507A	**Annual Approval Date**	9/27/2016	**Approved By**	Optum Behavioral Reimbursement Committee

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the procedure code or codes that correctly describe the health care services provided to individuals whose behavioral health benefits are administered by Optum, including but not limited to UnitedHealthcare members. This reimbursement policy is also applicable to behavioral health benefit plans administered by OptumHealth Behavioral Solutions of California.

Our behavioral health reimbursement policies may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other procedure coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement. This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to services billed on the UB-04 claim form and to electronic claim submissions (i.e., 837p and 837i) and for claims submitted online through provider portals. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.*

This information is intended to serve only as a general reference resource regarding our reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, Optum may use reasonable discretion in interpreting and applying this policy to behavioral health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for behavioral health care services provided to members. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: member's benefit coverage, provider contracts and/or legislative mandates. Finally, this policy may not be implemented exactly the same way on the different electronic claim processing systems used by Optum due to programming or other constraints; however, Optum strives to minimize these variations.

Optum may modify this reimbursement policy at any time by publishing a new version of the policy on this website. However, the information presented in this policy is accurate and current as of the date of publication.

**CPT® is a registered trademark of the American Medical Association*

Applicability

This reimbursement policy applies to all health care services billed on CMS 1500 forms and to services billed on the UB-04 claim form and to electronic claim submissions (i.e., 837p and 837i) and for claims submitted online through provider portals. This policy applies to all products, all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Policy

Overview

According to the Centers for Medicare and Medicaid Services (CMS), services should be reported with the CPT®/HCPCS codes that most comprehensively describe the services performed. For the purpose of this policy, the Same Individual Physician or Other Health Care Professional is the same individual rendering health care services reporting the same Federal Tax Identification number.

Reimbursement Guidelines

Medicare NCCI edits

Optum uses this policy to administer the "Column One/Column Two" National Correct Coding Initiative (NCCI) edits not otherwise addressed in Optum Behavioral Health reimbursement policies to determine whether CPT and/or HCPCS codes reported together by the Same Individual Physician or Other Health Care Professional for the same member on the same date of service are eligible for separate reimbursement.

When reported with a column one code, Optum will not separately reimburse a column two code unless the codes are appropriately reported with one of the NCCI designated modifiers recognized by Optum under this policy. When modifiers 25, 59, XE, XP, or XU are appended to either the column one or column two code for a procedure or service rendered to the same patient, on the same date of service and by the Same Individual Physician or Other Health Care Professional, and there is an NCCI modifier indicator of "1", Optum will consider both services and/or procedures for reimbursement.

Please refer to the "Modifiers" section of this policy for a complete listing of acceptable modifiers and the description of modifier indicators of "0" and "1".

The edits administered by this policy may be found on the following link:

Medicare National Correct Coding Initiative (NCCI) Edit Files

Medicaid NCCI edits

Consistent with CMS, Optum utilizes the procedure-to-procedure (PTP) edits developed by Medicaid in October of 2012, and will not separately reimburse PTP column two codes unless appropriately reported with one of the NCCI designated modifiers recognized by Optum under this policy. When one of the designated modifiers is appended to either the PTP column one or column two code rendered to the same patient, on the same date of service and by the Same Individual Physician or Other Health Care Professional, and there is an NCCI modifier indicator of "1", Optum will consider both services and/or procedures for reimbursement. Please refer to the "Modifiers" section of this policy for a complete listing of acceptable modifiers.

Medicaid National Correct Coding Initiative (NCCI) Edit Files

Modifiers

Modifiers offer the physician or other healthcare professional a way to identify that a service or procedure has been altered in some way. Under appropriate circumstances, modifiers should be used to identify unusual circumstances, staged or related procedures, distinct procedural services or separate anatomical location(s).

Each CMS NCCI edit has a modifier indicator assigned to it. A modifier indicator of "0" indicates a modifier cannot be used to bypass the edit. A modifier indicator of "1" indicates that an NCCI designated modifier can be used to allow both submitted services or procedures.

Modifiers offer specific information and should be clearly documented in the medical record and used appropriately. Modifiers XE, XP, and XU (referred to collectively as the –X {EPSU} modifiers) define specific subsets of modifier 59. According to the CPT book, modifier 59 should only be used when a more descriptive modifier is not available and therefore the provider should report one of these modifiers or modifier 59, but not both. Please refer to the "Codes" section for a complete listing of modifiers and their descriptions.

Information describing usage of modifier 59 and the -X {EPSU} modifiers can be found on the CMS Medicare NCCI, Medicaid NCCI or CMS MLN Matters websites CMS MLN Matters website:Medicare Learning Network (MLN) Proper Use of Modifier 59.

Optum recognizes the following designated modifiers under this reimbursement policy: 25, 59, XE, XP, and XU.

25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service: It may be necessary to

	indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.
59	Distinct Procedural Code
XE	Separate encounter, a service that Is distinct because it occurred during a separate encounter
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

Questions and Answers	
1	**Q:** When should modifier 59 be used? **A:** Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under certain circumstances.
2	**Q:** When should modifier 25 be used? **A:** Modifier 25 is used when necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable evaluation and management (E/M) service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. It should not be used to report an E/M service that resulted in a decision to perform surgery.
3	**Q:** Can a behavioral health provider bill cpt code 96127 as part of a therapy session and be reimbursed? **A:** No, Optum Behavioral Health will not reimburse a behavioral health provider if they bill cpt code 96127 as part of any therapy session. For example, a provider cannot bill 96127 along with cpt code 90791.
4	**Q:** What is the difference between Medicare NCCI edits and Medicaid NCCI Edits? **A:** CMS administers Medicare NCCI edits on a national level whereas Medicaid NCCI edits are administered at a state level. The Medicaid NCCI program is derived from the Medicare NCCI program with modifications relevant to the Medicaid program. CMS has worked with states to develop specific PTP edits for each state because of differences in state Medicaid programs and laws and regulations. In order to avoid confusion between the two programs, the Medicaid NCCI program uses the term NCCI PTP to identify its NCCI column one/column two edits.

Definition	
Same Individual Physician or Other Health Care Professional	The same individual rendering health care services reporting the same Federal Tax Identification number.

Resources

www.cms.gov

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

CMS National Correct Coding Initiatives website - https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

History / Updates	
May, 2022	Annual Review; No Updates
May, 2021	Annual Review
December, 2020	Added Q&A 3 related to 96127
March, 2020	Annual Review
March, 2019	Annual review, renamed policy to National Correct Coding Initiative, removed the MUE information and created a separate policy (Maximum Frequency Per Day).
April, 2018	Annual review
September, 2016	New