OKLAHOMA Health Care Authority | Serving Oklahomans through SoonerCare

CLAIM PROCESSING UPDATES

Do you have to get the PA with the modifier 59 if you already know a patient is having a CPT combo that will require the 59?

The PA system will ignore the modifier 59 since it does not require it.

Are there some edits on some of the codes that are requiring modifier 25 that are not active yet? I have noticed a code or two on the bypass list that are not requiring the modifier.

Some items may not be fully implemented at this time. The NCCI edits will go into full effect on January 1, 2022.

What providers does this affect?

Currently this is for our medical, behavioral health, and DME providers billing on a HCFA 1500 claim form. Many behavioral health codes are included on the modifiers 25 and 59 bypass lists so the modifiers must be included to pay appropriately.

What if the procedure is prior-authorized but changes after the procedure is completed? Does this have a retro window?

This would fall under the prior authorization rules for OHCA. Providers would need to follow the steps for Amending a Prior Authorization. For more information, please visit our Medical Authorization page: https://oklahoma.gov/ohca/providers/medical-authorization-unit.html.

In the past OHCA has not required modifier 25 when an injection was performed, and both the E&M and injection were paid. Will this change with the addition of the new NCCI edit compliance?

Yes, there will be a modifier 25 required on the E&M code for injections. It is on the bypass list, so it does not require documentation to be attached.

When billing for professional inpatient services, such as 99234 and 90935/90945, what would be an example of documentation that would warrant and validate the 25 modifier?

For outpatient or office visits, it needs to show what service was provided above and beyond what is included in the procedure codes. It needs to show that an E&M service was provided in addition to what is normally provided.

Where can I find the bypass list?

It is on the OHCA NCCI webpage: https://oklahoma.gov/ohca/providers/national-correct-coding-initiative.html.

Regarding modifiers 25 & 59, is there a DOS range in which documentation is needed when it falls within the bypass code list? For instance, is this only from when this list first came out in October, with October DOS to current, or does this go back to January 2021 DOS as well?

The effective date for codes currently on the modifier 25 bypass list is Oct. 1, 2020. The effective date for codes currently on the modifier 59 bypass list is Dec. 1, 2020. Services billed with modifier 25 or 59 performed prior to these effective dates would need to have documentation attached for review.

With behavioral health, they use modifiers to denote completely different services. For example, both individual and group counseling are billed under the H0004. Are you saying if the H0004 is billed during the same day, the second one will require the *25? Also, if we bill 99213 with the H0004, do we use the 25 and 59?*

Modifier 25 is for E&M visits only. If it was done twice in one day, then two units would be used. If it is done during different sessions, then a 59 modifier would be required. If 99213 is billed, the 25 modifier is required; if H0004 is billed, the 59 modifier is required.

Will this affect any behavioral health claims submitted for CCBHC reporting or will this only apply to fee-for-service claims?

It will generally only apply to fee-for-service claims.

If we batch bill our claims directly on OHCA's portal, does OHCA have the capability to receive these note attachments for these modifiers?

Yes, OHCA is capable of receiving the needed attachments. If claims are being sent in through EDI, then you would need to use the appropriate cover sheet for the attachments.

Is the 59 modifier going to apply to therapy if the patient has a session with two different providers on the same day? (Example: one speech session, one OT session, different therapists, on the same day.)

No, it would not pertain to different providers.

Will this affect anyone who is not utilizing the 1500 or ub04 forms? Also, will this change affect anyone sending 837?

The current changes affect professional claims, which are typically billed on the 1500.

Is OHCA going to require therapy (ie. speech/OT/PT) to bill the 59 modifier and upload notes if speech is performed in the same day of PT and OT?

Only if the services are billed by the same provider. If the services are billed by different providers, it would not be required.

So, my understanding is we have to submit documentation for every claim when we use a modifier 25?

If the code is not on the modifier 25 bypass list, then documentation needs to be attached. The list can be found at https://oklahoma.gov/content/dam/ok/en/okhca/docs/providers/ncci/Modifier%2025%20Review.pdf.

What should be done for claims that that have already been billed with a 25 modifier and paid but no records were attached?

This change will be fully implemented on Jan. 1, 2022. If a claim was billed previous to this and paid, then nothing needs to be done.

Will this affect when an OT performs developmental testing and occupational therapy evaluation on the same day and with the same provider?

Yes, this will be affected. The system will look at an occupational therapy evaluation as a full evaluation, so if developmental testing is done, a 59 modifier and documentation will be needed.

Can behavioral health providers provide individual therapy, family therapy and/or group therapy in the same day by either the same or different provider, and if so, do we need to use a specific modifier?

Yes, these services can be done in the same day. A 59 modifier would be needed. More information can be found in the NCCI manual at https://www.cms.gov/medicare/national-correct-coding-initiative-edits/ncci-policy-manual-medicare.

If an OT bills 96112 and 97166, will we need to use 59 modifier on code 96112 and submit documentation? Does this apply to secondary claims?

Modifier 59 indicates that a procedure is separate and distinct from another procedure on the same date of service. Typically, this modifier is applied to a procedure code that is not ordinarily paid separately from the first procedure but should be paid per the specifics of the situation. It is allowable to place modifier 59 on either code in the edit pair. Documentation would need to be submitted in this instance of using a modifier 59 with code pair 96112 and 97166. *As far as Medicaid being secondary, the provider needs to follow the rules for the primary insurance.*