KanCare NPI and Modifier Billing Requirements for CMHCs

Effective with dates of service on and after April 29, 2016, for Community Mental Health Center (CMHC) KanCare claims billed by a professional level staff member who is able to obtain a National Provider Identifier (NPI), the NPI should be submitted on these claims to avoid inappropriate denials. When the rendering provider is an "atypical provider" who is not required to obtain an NPI, the CMHC will also be the performing provider.

Modifier 59 can no longer be used inappropriately. As an example, use of modifier 59 will no longer bypass Medically Unlikely Edits (MUEs) for evaluation and management (E&M) codes 99201 through 99499. Modifiers 76 and 77 are not valid with the E&M procedure codes. E&M services must be billed using the appropriate rendering provider if more than one service is performed per day.

When a procedure is repeated by the same practitioner on the same day subsequent to the original service and the number of services exceeds the MUE limits, modifier 76 must be attached to the repeat procedure and it must be billed on the same claim. If the number of services does not exceed MUE limits, all services may be billed on the same detail line with the total units of service when (rolled into one claim line when appropriate). No modifiers are necessary.

If the services do exceed MUE limits, services must be billed on separate detail lines. For those CMHCs who do not have the capability to bill multiple detail lines on one claim, the services must be billed on a paper claim with separate detail lines.

When a procedure is repeated by a different practitioner on the same day subsequent to the original service, modifier 77 must be attached to the repeat procedure. If repeat services are billed by an atypical provider who does not have an NPI and the number of services does not exceed MUE limits, the services may be billed on the same detail line of the claim with the total units of service (rolled into one claim line when appropriate). No modifiers are necessary. ***Effective immediately, when the same service is provided in different locations on the same day, those services may be billed on the same detail line with only one of the locations indicated on the claim form. The CMHC must clearly document in their records the name, address, city, state and zip code of the location where each service was rendered.***

Note: All services performed for the same beneficiary on the same day must be billed on the same claim. This applies to claims billed to KMAP as well as to claims billed to the Managed Care Organizations (MCOs).

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Effective immediately, in situations where a CMHC provides multiple services to the same beneficiary on the same day but in different place of service settings, ***only one facility location needs to be noted in item 32 (Service Facility Location Information) of the 1500 health insurance claim form, or item 32 may be left blank.*** This will allow CMHCs to bill those services on the same claim. The CMHCs must clearly document in their records the name, address, city, state, and ZIP code of the location where each service was rendered. These records must be kept on file and available if requested by KMAP or one of the KanCare MCOs.

Billing examples

Attendant Care (T1019) performed by more than one atypical attendant care worker per day.

• The service lines billed by both atypical practitioners should be rolled into one service line when appropriate (diagnosis, place of service, etc. are the same) and billed with the total number of units, because the units do not exceed MUE limitations. No modifier is necessary.

• If diagnoses are not the same, the services must be billed on separate detail lines with modifier 76 appended to the repeat procedure and the services must be billed on the same claim. In the cases where the place of service is not the same, only one location need be recorded in Box 32 or it may be left blank. The complete address of where each service was rendered must be clearly documented in the beneficiary's record.

Office visit (99211) and Psychotherapy (90837) performed on the same day by either the same or two different practitioners (with an individual NPI).

• 99211 and 90837 can be billed on different claims. **OR**
• 99211 and 90837 can be billed on the same claim.

A modifier is not necessary in this example for MUE, NCCI, or duplicate editing purposes.
Office visit (99211) performed by two different typical practitioners on the same day.

• The first visit can be billed on one claim with no modifier. **AND**
• The second visit can be billed on a second claim. No modifier is necessary since these providers bill their individual NPIs, which identifies them as separate providers. **OR**
• They both may be billed on the same claim. No modifier is necessary since these providers bill their individual NPIs, which identifies them as separate providers.

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Office visit (99211) performed twice by the same practitioner on the same day. These services must be billed using the appropriate NPI, however this service will not bypass MUE editing when billed on the same detail line. To avoid MUE denials, these services should be reported on separate detail lines on the same claim. Modifier 25 or 59 may be appropriate in these situations and, if so, should be appended to the repeat service. Modifiers 76 and 77 are not valid with E&M services.

Group psychotherapy (90853) performed by two different practitioners or twice by the same practitioner on the same day. This service has a MUE limit of 1 per day.

• Both services must be billed on the same claim.
• The repeat service should be billed with modifier 76 or 77, whichever is appropriate. Modifiers 25 and 59 are not valid with this procedure code.

Helpful hints

Although claims will not be denied simply for lack of a rendering NPI, it is in the best interest of the CMHC to submit the rendering provider NPI whenever possible to avoid inappropriate MUE, NCCI, or duplicate editing based on supporting documentation for services. Lack of the rendering provider NPI causes a claim to be more susceptible to these denials when the appropriate modifier is not used.

CMHCs should register all rendering providers who have an NPI with each MCO if billing the rendering provider on the KanCare claim to avoid provider-related denials.

Refer to your Current Procedural Coding (CPT®) codebook for a complete description and usage of modifiers noted within this bulletin.

If procedure codes are different and only performed once per date of service, MUE edits and duplicate edits do not apply. These services may be billed on the same or different claims and modifiers are not necessary.

Modifier 59 will no longer override MUE edits, so it is imperative that these billing guidelines are followed to ensure appropriate claim reimbursement.

A listing of all MUE edit limits are posted on the CMS website.

For beneficiaries not assigned to an MCO

CMHCs should not identify a rendering provider on claims for beneficiaries not assigned to an MCO.