KanCare NPI and Modifier Billing Requirements for CMHC's

This bulletin incorporates previous language from KMAP General Bulletin 14140 and further clarifies additional billing guidelines. Revisions/additions to the initial bulletin have been italicized.

Effective with dates of service on and after November 1, 2014 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 Editing (MUE) 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 appropriate (diagnosis, place of service etc. is the same.) No modifiers are necessary. *If diagnosis, place of service, etc. are not the same, services must be billed on separate detail lines, on the same claim.*

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 a 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 (diagnosis, place of service etc. is the same.)]. No modifiers are necessary. *If diagnosis, place of service, etc. are not the same, services must be billed on separate detail lines, on the same claim.*

Please note that all services performed for the same beneficiary on the same day must be billed on the same claim. This applies to claims billed to HPES as well as to claims billed to the Managed Care Organizations.

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, item 32 (Service Facility Location Information) of the 1500 health insurance claim form may be left blank. This will allow CMHC's to bill those services on the same claim. The CMHC 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 HPES or one of the KanCare Managed Care Organizations.

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 diagnosis, place of service, etc. 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, box 32 may be left blank and the complete address of where each service was rendered must be clearly documented in the beneficiaries' 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 NPI's, 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 NPI's, which identifies them as separate providers.

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 utilized.

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.

Please refer to your Current Procedural Coding (CPT) book 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 at the following CMS website:
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html

For Beneficiaries Not Assigned to an MCO
CMHC's should not identify a rendering provider on claims *for beneficiaries not assigned to an MCO*.