CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12961	**Date: November 14, 2024**
	Change Request 13854

SUBJECT: Updates to the Publication 100-04 Claims Processing Manual in the Internet Only Manual (IOM) to Remove Obsolete Language Related to Medicare Fee-for-Service (FFS) Systems Claims Edits

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to revise Chapters 3, 4, 12, and 32 of the Publication 100-04, Claims Processing Manual in the Internet Only Manual (IOM) to remove obsolete language with respect to Medicare FFS systems claim edits.

EFFECTIVE DATE: October 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 17, 2024

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/20.2.1/Medicare Code Editor (MCE)
R	3/20.2.2/DRG GROUPER Program
R	4/Table of Contents
D	4/40.3/Non-OPPS OCE (Rejected Items and Processing Requirements) Prior to July 1, 2007
R	12/30/Correct Coding Policy
R	32/240/Table of Contents
D	32/240/Special Instructions for Certain Claims with a Gender/Procedure Conflict

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in

your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 12961	Date: November 14, 2024	Change Request: 13854

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II. GENERAL INFORMATION

A. Background: The Publication 100-04 Claims Processing Manual in the IOM is being revised to remove obsolete language regarding the Medicare FFS systems claim edits. Chapter 3 is being revised to remove language related to edits in the Medicare Code Editor (MCE) that were inactivated on October 1, 2024. Chapter 4 is being revised to remove language related to the non-Outpatient Prospective Payment System (OPPS) Medicare Outpatient Code Editor (OCE), which was terminated in 2008. Chapter 12 is being revised to remove obsolete language regarding the National Correct Coding Initiative (NCCI) edits.

In addition, the National Uniform Billing Committee (NUBC) maintains national instructions for the code sets that are billed on the claim form. Chapter 32 is being revised to remove obsolete and Medicare-specific language regarding coding and billing.

B. Policy: The Medicare Administrative Contractors (MACs) shall be aware of the changes to Medicare FFS systems claim edits that were implemented on October 1, 2024. These updates are published in Chapters 3, 4, 12, and 32 of the Publication 100-04 Claims Processing Manual in the IOM.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13854.1	The Medicare Administrative Contractors (MACs) shall be aware of the updates to the Medicare FFS systems claims edits that became effective on October 1, 2024. These updates are published in Chapters 3, 4, 12, and 32 of the Publication 100-04	X	X		X					

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	Claims Processing Manual in the IOM.									

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information:N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

20.2.1 - Medicare Code Editor (MCE)

(Rev. 12961; Issued:11-14-24; Effective; 10-01-24; Implementation: 12-17-24)

A. - General

The MCE edits claims to detect incorrect billing data. In determining the appropriate MS-DRG for a Medicare patient, the age, sex, discharge status, principal diagnosis, secondary diagnosis, and procedures performed must be reported accurately to the Grouper program. The logic of the Grouper software assumes that this information is accurate and the Grouper does not make any attempt to edit the data for accuracy. Only where extreme inconsistencies occur in the patient information will a patient not be assigned to a MS-DRG. Therefore, the MCE is used to improve the quality of information given to Grouper.

The MCE addresses three basic types of edits which will support the MS-DRG assignment:

- **Code Edits -** Examines a claim for the correct use of diagnosis and procedure codes. They include basic consistency checks on the interrelationship among a patient's age, sex, and diagnoses and procedures reported.

- **Coverage Edits -** Examines the type of patient and procedures performed to determine if the services are covered.

- **Clinical Edits -** Examines the clinical consistency of the diagnostic and procedural information on the claim to determine if they are clinically reasonable and, therefore, should be paid.

B. - Implementation Requirements

The A/B MAC (A) processes all inpatient Part A discharge/transfer claims for both PPS and non-PPS facilities (including waiver States, long-term care hospitals, and excluded units) through the MCE. It processes claims that have been reviewed by the QIO prior to billing through the MCE only for edit types 1, 2, 3, 4, 7, and 12. It does not process the following kinds of claims through the MCE:

- Where no Medicare payment is due (amounts reported by value codes 12, 13, 14, 15, or 16 equal or exceed charges).

- Where no Medicare payment is being made. Where partial payment is made, editing is required.

- Where QIO reviewed prior to billing (condition code C1 or C3). It may process these exceptions through the program and ignore development codes or bypass the program.

The MCE software contains multiple versions. The version of the MCE accessed by the program depends upon the patient discharge date entered on the claim.

C. - Bill System/MCE Interface

The A/B MAC (A) installs the MCE online, if possible, so that prepayment edit requirements identified in subsection C can be directed to hospitals without clerical handling.
The MCE needs the following data elements to analyze the claim:

- Age;

- Sex;

- Discharge status;
- Diagnosis (25 maximum - principal diagnosis and up to 24 additional diagnoses);
- Procedures (25 maximum); and
- Discharge date.

The MCE provides the A/B MAC (A) an analysis of "errors" on the claim as described in subsection D. The A/B MAC (A) develops its own interface program to provide data to MCE and receive data from it.

The MCE Installation Manual describes the installation and operation of the program, including data base formats and locations.

D. - Processing Requirements

The hospital must follow the procedure described below for each error code. For claims returned to the provider, the A/B MAC (A) considers the claim improperly completed for control and processing time purposes. (See chapter 1.)

NOTE: The following instructions are based on ICD-9-CM diagnosis and procedure codes, ICD-10-CM and ICD-10-PCS codes.

1. Invalid Diagnosis or Procedure Code

The MCE checks each diagnosis code, including the admitting diagnosis, and each procedure code against a table of valid diagnosis and procedure codes. An admitting diagnosis, a principal diagnosis, and up to 24 additional diagnoses may be reported. Up to 25 total procedure codes may be reported on an inpatient claim. If the recorded code is not in this table, the code is invalid, and the A/B MAC (A) returns the claim to the provider.

For a list of valid diagnosis or procedure codes see the "International Classification of Diseases" revision applicable to the date of the inpatient discharge or other service and the "Addendum/Errata" and new codes furnished by the A/B MAC (A). The hospital must review the medical record and/or face sheet and enter the correct diagnosis/procedure codes before returning the claim.

2. External Cause of Injury Code as Principal Diagnosis

External Cause of Injury codes describe the circumstances that caused an injury, not the nature of the injury, and therefore are not recognized by the Grouper program as acceptable principal diagnoses. In ICD-9-CM the external cause of injury diagnosis codes begin with the letter E. In ICD-10-CM the external cause of injury codes begin with the letters V, W, X and Y. For a list of all External cause of injury codes, see International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), and the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). The hospital must review the medical record and/or face sheet and enter the correct diagnosis before returning the claim.

3. Duplicate of Principal Diagnosis

Any secondary diagnosis reported on the claim that is the same code as the principal diagnosis reported on the claim is identified as a duplicate of the principal diagnosis. This is unacceptable because the secondary

diagnosis may cause an erroneous assignment to a higher severity level MS-DRG. Hospitals may not repeat a diagnosis code. The A/B MAC (A) will delete the duplicate secondary diagnosis and process the claim.

4. Age Conflict

The MCE detects inconsistencies between a patient's age and any diagnosis on the patient's record. Examples are:

- A 5-year-old patient with benign prostatic hypertrophy.
- A 78-year-old who delivers a baby.

In the above cases, the diagnosis is clinically impossible in a patient of the stated age. Therefore, either the diagnosis or age is presumed to be incorrect. Four age code categories are described below.

- A subset of diagnoses is intended only for "perinatal/newborn." These are diagnoses that occur during the perinatal or newborn period of age 0.
- Certain diagnoses are considered reasonable only for children between the ages of 0 and 17. These are "Pediatric" diagnoses.
- Diagnoses identified as "Maternity" are coded only for patients between the ages of 9 and 64.
- A subset of diagnoses is considered valid only for patients over the age of 14. These are "Adult" diagnoses. For "Adult" diagnoses the age range is 15 through 124.

The list of diagnoses that are acceptable for each age category can be located in the most current version of the Definition of Medicare Code Edits manual which is posted at:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software

Prior versions of the manual can be located at:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS
and select the final rule for the applicable Fiscal Year (FY) from the list on the left. Then select the FY(CCYY) Final Rule Data Files, and scroll down to the Definition of Medicare Code Edits link.

If the A/B MAC (A) edits online, it will return claims for a proper diagnosis or correction of age as applicable. If the A/B MAC (A) edits in batch operations after receipt of the admission query response, it uses the age based on CMS records and returns claims that fail this edit. The hospital must review the Electronic Health Record (EHR), paper medical record, and/or face sheet and enter the proper diagnosis or patient's age before returning the claim.

5. Sex Conflict

Deactivated as of 10/01/2024. Medicare Contractors shall no longer assign this edit for any dates of service.

6. Manifestation Code as Principal Diagnosis

A manifestation code describes the manifestation of an underlying disease, not the disease itself, and therefore, cannot be a principal diagnosis. The MCE contains listings of diagnosis codes identified as manifestation codes. The hospital should review the EHR, paper medical record, and/or face sheet and enter the proper diagnosis before returning the claim.

7. Nonspecific Principal Diagnosis

Effective October 1, 2007 (FY 2008), the non-specific principal diagnosis edit was discontinued and is only applicable when processing claims using MCE version 2.0-23.0 only.

8. Questionable Admission

There are some diagnoses which are not usually sufficient justification for admission to an acute care hospital.

The MCE contains a listing of diagnosis codes identified as "Questionable Admission" when used as principal diagnosis.

The A/B MACs (A) may review on a post-payment basis all questionable admission cases. Where the A/B MAC (A) determines the denial rate is sufficiently high to warrant, it may review the claim before payment.

9. Unacceptable Principal Diagnosis

There are selected codes that describe a circumstance which influences an individual's health status but is not a current illness or injury; therefore, they are unacceptable as a principal diagnosis. For example, the diagnosis code for family history of a certain disease would be an unacceptable principal diagnosis since the patient may not have the disease.

In a few cases, there are codes that are acceptable as a principal diagnosis if a secondary diagnosis is coded. If no secondary diagnosis is present the message "requires secondary dx" will be returned by the MCE. The A/B MAC (A) may review claims with codes from the Unacceptable Principal Diagnosis section and a secondary diagnosis. A/B MACs (A) may choose to review as a principal diagnosis if data analysis deems it a priority.

If codes from the unacceptable principal diagnosis edit code list are identified without a secondary diagnosis, the A/B MAC (A) returns the claim to the hospital and requests that the applicable secondary diagnosis be entered. Also, any claims containing other "unacceptable principal diagnosis" codes are returned.

The hospital reviews the EHR, paper medical record, and/or face sheet and enters the appropriate principal diagnosis that describes the illness or injury before resubmitting the claim.

10. Nonspecific O.R. Procedures

Effective October 1, 2007 (FY 2008), the non-specific O.R. procedure edit was discontinued and is only applicable when processing claims using MCE version 2.0-23.0 only.

11. Noncovered O.R. Procedures

There are some O.R. procedures for which Medicare does not provide payment.
The A/B MAC (A) will return the claim requesting that the non-covered procedure and its associated charges be removed from the claim, Type of Bill (TOB) 11X. If the hospital wishes to receive a Medicare denial, etc., the hospital may submit a non-covered claim, TOB 110, with the non-covered procedure/charges. (For more information on billing non-pay claims, see Chapter 1 of this Manual, Section 60.1.4).

12. Open Biopsy Check

Effective October 1, 2010, the open biopsy check edit was discontinued and is only applicable when processing claims using MCE version 2.0 - 26.0.

13. Bilateral Procedure

Effective October 1, 2015, the bilateral procedure edit was discontinued and is only used when processing claims using MCE version 2.0-33.0.

14. Invalid Age

If the hospital reports an age over l24, the A/B MAC (A) requests the hospital confirm if it made a claim preparation error. If the beneficiary's age is confirmed to be over l24, the hospital enters 123.

15. Invalid Sex

A patient's sex *may be necessary for appropriate DRG determination. The sex code reported must be 0 (unknown),* 1 (male), or 2 (female).

16. Invalid Discharge Status

A patient's discharge status is sometimes necessary for appropriate MS-DRG assignment. Discharge status must be coded according to the Form CMS-1450 and UB-04 conventions. See Chapter 25.

17. Limited Coverage

For certain procedures whose medical complexity and serious nature incur extraordinary associated costs, Medicare limits coverage to a portion of the cost.

18. Wrong Procedure Performed

Certain external causes of morbidity codes indicate that the wrong procedure was performed.

19. Procedure inconsistent with length of stay (LOS)

The following procedure code should only be coded on claims when the respiratory ventilation is provided for greater than four **consecutive** days during the length of stay.

Effective with discharges on and after October 1, 2015, ICD-10-PCS code, 5A1955Z - Respiratory Ventilation, Greater than 96 Consecutive Hours

Prior to this date, discharges on and after October 1, 2012, ICD-9-CM procedure code, 96.72, Continuous invasive mechanical ventilation for 96 consecutive hours or more

20. Unspecified Code

Unspecified codes exist for circumstances when documentation in the medical record does not provide the level of detail needed to support reporting a more specific code. However, in the inpatient setting, there should generally be very limited and rare circumstances for which the laterality (right, left, bilateral) of a condition is unable to be documented and reported.

Effective April 1, 2022, the Unspecified Code edit will be triggered for certain unspecified diagnoses codes currently designated as either a Complication or Comorbidity (CC) or Major Complication or Comorbidity (MCC), that include other codes available in that code subcategory that further specify the anatomic site, when entered on the claim. This edit message indicates that a more specific code is available to report. It is the

provider's responsibility to determine if a more specific code from that subcategory is available in the medical record documentation by a clinical provider.

If, upon review, additional information to identify the laterality from the available EHR or paper medical record, or documentation by any other clinical provider is unable to be obtained or there is documentation in the record that the physician is clinically unable to determine the laterality because of the nature of the disease/condition, then the provider must enter that information into the remarks section.

The provider should submit the billing note/remarks that best identifies the primary reason why specificity could not be determined:

Billing Note/Remarks	Definition
UNABLE TO DET LAT 1	Provider is unable to obtain additional information to specify laterality.
UNABLE TO DET LAT 2	Physician is clinically unable to determine laterality.

20.2.2 - DRG GROUPER Program

(Rev. 12961; Issued:11-14-24; Effective; 10-01-24; Implementation: 12-17-24)

The A/B MAC (A) pays for inpatient hospital services on the basis of a rate per discharge that varies according to the MS-DRG to which a beneficiary's stay is assigned. Each MS-DRG represents the average resources required to care for a case in that particular MS-DRG relative to the national average of resources consumed per case. The MS-DRG weights used to calculate payment are in the Pricer DRGX file.

The A/B MAC (A) uses the GROUPER program to assign the MS-DRG number. GROUPER determines the MS-DRG from data elements reported by the hospital. This applies to all inpatient discharge/transfer bills received from both PPS and non-PPS facilities, including those from waiver States, long-term care hospitals, and excluded units.

The Pricer (PPSMAIN) driver program calls the correct fiscal year GROUPER based upon the discharge date. If the A/B MAC (A) or shared system writes its own driver program, it must access the GROUPER for the correct FY based on discharge date. GROUPER does not determine the MS-DRG price. GROUPER input/output are specified below. The A/B MAC (A) determines the best place in its total system to place the GROUPER program.

Grouper requires the following items:

1. Principal and up to 24 other diagnoses

2. Principal and up to 24 additional procedures

3. Age at last birthday at admission

4. Sex (*0=unknown,* 1=male, and 2=female)

5. Discharge destination (patient status code from the claim)

The claim sex coding is M for male, F for female, *and U for Unknown,* while GROUPER is 1 for male, 2 for female, *and 0 for Unknown.* Discharge destination codes are similar to claim definitions for patient status

except codes 20-29 are summarized as 20. The A/B MAC (A) calculates age at admission. GROUPER needs age rather than date of birth.

Grouper responds with the following information:

1. Major diagnostic category
2. MS-DRG number
3. Grouper return code (a one position code indicating the action taken by the program)
4. Procedure code used in determining the MS-DRG
5. Diagnosis code used in determining the MS-DRG
6. Secondary diagnosis code used in determining the MS-DRG, if applicable

30 - Correct Coding Policy

(Rev. 12961; Issued:11-14-24; Effective; 10-01-24; Implementation: 12-17-24)

B3-15068

The Correct Coding Initiative was developed to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. Refer to Chapter 23 for additional information on the initiative.

The principles for the correct coding policy are:

- The service represents the standard of care in accomplishing the overall procedure;
- The service is necessary to successfully accomplish the comprehensive procedure. Failure to perform the service may compromise the success of the procedure; and
- The service does not represent a separately identifiable procedure unrelated to the comprehensive procedure planned.

For a detailed description of the correct coding policy, refer to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/How-To-Use-NCCI-Tools.pdf.

The CMS as well as many third party payers have adopted the HCPCS/CPT coding system for use by physicians and others to describe services rendered. The system contains three levels of codes. Level I contains the American Medical Association's Current Procedural Terminology (CPT) numeric codes. Level II contains alpha-numeric codes primarily for items and services not included in CPT. Level III contains A/B MAC (B) specific codes that are not included in either Level I or Level II. For a list of CPT and HCPCS codes refer to the CMS Web site.

The following general coding policies encompass coding principles that are to be applied in the review of Medicare claims. They are the basis for the correct coding edits that are installed in the claims processing systems effective January 1, 1996.

A. Coding Based on Standards of Medical/Surgical Practice

All services integral to accomplishing a procedure are considered bundled into that procedure and, therefore, are considered a component part of the comprehensive code. Many of these generic activities are common to virtually all procedures and, on other occasions, some are integral to only a certain group of procedures, but are

still essential to accomplish these particular procedures. Accordingly, it is inappropriate to separately report these services based on standard medical and surgical principles.
Because many services are unique to individual CPT coding sections, the rationale for rebundling is described in that particular section of the detailed coding narratives that are transmitted to A/B MACs (B) periodically.

B. CPT Procedure Code Definition

The format of the CPT manual includes descriptions of procedures, which are, in order to conserve space, not listed in their entirety for all procedures. The partial description is indented under the main entry. The main entry then encompasses the portion of the description preceding the semicolon. The main entry applies to and is a part of all indented entries, which follow with their codes.
In the course of other procedure descriptions, the code definition specifies other procedures that are included in this comprehensive code. In addition, a code description may define a rebundling relationship where one code is a part of another based on the language used in the descriptor.

C. CPT Coding Manual Instruction/Guideline

Each of the six major subsections include guidelines that are unique to that section. These directions are not all inclusive of nor limited to, definitions of terms, modifiers, unlisted procedures or services, special or written reports, details about reporting separate, and multiple or starred procedures and qualifying circumstances.

D. Coding Services Supplemental to Principal Procedure (Add-On Codes) Code

Generally, these are identified with the statement "list separately in addition to code for primary procedure" in parentheses, and other times the supplemental code is used only with certain primary codes, which are parenthetically identified. The reason for these CPT codes is to enable physicians and others to separately identify a service that is performed in certain situations as an additional service. Incidental services that are necessary to accomplish the primary procedure (e.g., lysis of adhesions in the course of an open cholecystectomy) are not separately billed.

E. Separate Procedures

The narrative for many CPT codes includes a parenthetical statement that the procedure represents a "separate procedure."
The inclusion of this statement indicates that the procedure, while possible to perform separately, is generally included in a more comprehensive procedure, and the service is not to be billed when a related, more comprehensive, service is performed. The "separate procedure" designation is used with codes in the surgery (CPT codes 10000-69999), radiology (CPT codes 70000-79999), and medicine (CPT codes 90000-99199) sections. When a related procedure from the same section, subsection, category, or subcategory is performed, a code with the designation of "separate procedure" is not to be billed with the primary procedure.

F. Designation of Sex

Inactivated as of October 1, 2024.

G. Family of Codes

In a family of codes, there are two or more component codes that are not billed separately because they are included in a more comprehensive code as members of the code family. Comprehensive codes include certain services that are separately identifiable by other component codes. The component codes as members of the comprehensive code family represent parts of the procedure that should not be listed separately when the complete procedure is done. However, the component codes are considered individually if performed independently of the complete procedure and if not all the services listed in the comprehensive codes were rendered to make up the total service.

H. Most Extensive Procedures

When procedures are performed together that are basically the same or performed on the same site but are qualified by an increased level of complexity, the less extensive procedure is bundled into the more extensive procedure.

I. Sequential Procedures

An initial approach to a procedure may be followed at the same encounter by a second, usually more invasive approach. There may be separate CPT codes describing each service. The second procedure is usually performed because the initial approach was unsuccessful in accomplishing the medically necessary service. These procedures are considered "sequential procedures." Only the CPT code for one of the services, generally the more invasive service, should be billed.

J. With/Without Procedures

In the CPT manual, there are various procedures that have been separated into two codes with the definitional difference being "with" versus "without" (e.g., with and without contrast). Both procedure codes cannot be billed. When done together, the "without" procedure is bundled into the "with" procedure.

K. Laboratory Panels

When components of a specific organ or disease oriented laboratory panel (e.g., codes 80061 and 80059) or automated multi-channel tests (e.g., codes 80002 - 80019) are billed separately, they must be bundled into the comprehensive panel or automated multi-channel test code as appropriate that includes the multiple component tests. The individual tests that make up a panel or can be performed on an automated multi-channel test analyzer are not to be separately billed.

L. Mutually Exclusive Procedures

There are numerous procedure codes that are not billed together because they are mutually exclusive of each other. Mutually exclusive codes are those codes that cannot reasonably be done in the same session.

An example of a mutually exclusive situation is when the repair of the organ can be performed by two different methods. One repair method must be chosen to repair the organ and must be billed. Another example is the billing of an "initial" service and a "subsequent" service. It is contradictory for a service to be classified as an initial and a subsequent service at the same time.

CPT codes which are mutually exclusive of one another based either on the CPT definition or the medical impossibility/improbability that the procedures could be performed at the same session can be identified as code pairs. These codes are not necessarily linked to one another with one code narrative describing a more comprehensive procedure compared to the component code, but can be identified as code pairs which should not be billed together.

M. Use of Modifiers

When certain component codes or mutually exclusive codes are appropriately furnished, such as later on the same day or on a different digit or limb, it is appropriate that these services be reported using a HCPCS code modifier. Such modifiers are modifiers E1 - E4, FA, F1 - F9, TA, T1 - T9, LT, RT, LC, LD, RC, -58, -78, -79, and -94.

Modifier -59 is not appropriate to use with weekly radiation therapy management codes (77427) or with evaluation and management services codes (99201 - 99499).

Application of these modifiers prevent erroneous denials of claims for several procedures performed on different anatomical sites, on different sides of the body, or at different sessions on the same date of service. The medical record must reflect that the modifier is being used appropriately to describe separate services.