

CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.

Correct Coding Initiative: National – Claim Preparation

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This section contains tips and claim examples to help providers prepare claims that pass both National Correct Coding Initiative (NCCI) and Medi-Cal edits in the claims processing system.

Modifier Placement

Procedure-required modifiers should be positioned on the claim prior to NCCI-associated modifiers. For purposes of this manual, procedure-required and NCCI-associated modifiers are identified as follows.

Procedure-Required Modifier

Claims for some Medi-Cal procedures require inclusion of a modifier or the claim will be denied. These are procedure-required modifiers.

NCCI-Associated Modifier

The Centers for Medicare & Medicaid Services (CMS) has identified a set of national modifiers to facilitate claims processing in cases where there is appropriate reason to override an NCCI edit. These are NCCI-associated modifiers.

Modifiers Approved List

The *Modifiers Approved List* section in this manual contains information that helps identify whether a modifier is an NCCI-associated modifier, procedure-required modifier, or both.

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**Modifier Placement:
CMS-1500 Claim**

Figure 1. Modifier placement: Repeated radiology tests on CMS-1500 claim.

This is a sample only. Please adapt to your billing situation.

In this example radiology CPT-4 code 70491 (computed tomography, soft tissue neck; with contrast material[s]) is billed on the same claim as CPT-4 code 76380 (computed tomography, limited or localized follow-up study). Both services are medically necessary. If not billed with modifiers as illustrated, however, the code combination will be denied due to NCCI procedure-to-procedure edits.

To ensure claim reimbursement, code 70491 is entered on one claim line with modifier 26 (professional services) in the *Procedures, Services or Supplies/Modifier* field (Box 24D). Code 76380 is billed on a separate claim line with NCCI-associated modifier XU (unusual non-overlapping service) entered after procedure-required modifier 26.

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) SERVICE RENDERED										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ CHARGES															
SOC PORTION MEDI-CAL																											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind. 9		22. RESUBMISSION CODE		ORIGINAL REF. NO.													
A. XXXX																											
B. _____																											
C. _____																											
D. _____																											
E. _____																											
F. _____																											
G. _____																											
H. _____																											
I. _____																											
J. _____																											
K. _____																											
L. _____																											
23. PRIOR AUTHORIZATION NUMBER																											
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OF UNITS		H. EFSBT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From MM DD YY To MM DD YY										SERVICE				CPT/HCPCS		MODIFIER											
1 11 30 14										81				70491		26		50 00		1				NPI			
2 11 30 14										81				76380		26XU		50 00		1				NPI			
3																						NPI					
4																						NPI					

**Modifier Placement:
UB-04 Claim**

Figure 2. Modifier placement: Repeated radiology tests on UB-04 claim.

This is a sample only. Please adapt to your billing situation.

In this example radiology CPT-4 code 70491 (computed tomography, soft tissue neck; with contrast material[s]) is billed on the same claim as CPT-4 code 76380 (computed tomography, limited or localized follow-up study). Both services are medically necessary. If not billed with modifiers as illustrated, however, the code combination will be denied due to NCCI procedure-to-procedure edits.

To ensure claim reimbursement, code 70491 is entered on one claim line with modifier 26 (professional services) in the *Description* field (Box 43). Code 76380 is billed on a separate claim line with NCCI-associated modifier XU (unusual non-overlapping service) entered after procedure-required modifier 26.

38		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
a	b	c	d	e	f	g	h
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	CT, NECK, WITH CONTRAST	7049126	113014	1	50 00		1
2	CT, LIMITED FOLLOWUP	7638026XU	113014	1	50 00		2
3							3
4							4
5							5
6							6
23	001 PAGE OF	CREATION DATE	TOTALS	100 00			23
50 PAYER NAME		51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
O/P MEDI-CAL		HSC123256				100 00	0123456789
58 INSURED'S NAME		59 P REL	60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.
			90000000A95001				
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER			65 EMPLOYER NAME		
66 DX	XXXX						68
69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	73
74	PRINCIPAL PROCEDURE CODE	75	OTHER PROCEDURE CODE	76	OTHER PROCEDURE CODE	77	OTHER PROCEDURE CODE
	DATE		DATE		DATE		DATE
c	OTHER PROCEDURE CODE	d	OTHER PROCEDURE CODE	e	OTHER PROCEDURE CODE		
	DATE		DATE		DATE		
80 REMARKS		81 CC			76 ATTENDING	NPI	QUAL
DOCUMENTATION ATTACHED		a			LAST		FIRST
		b			77 OPERATING	NPI	QUAL
		c			LAST		FIRST
		d			78 OTHER	NPI 1234567890	QUAL
					LAST		FIRST
					79 OTHER	NPI	QUAL
					LAST		FIRST

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