New Coding Validation Process Coming Soon

Effective September 5, 2022, HAP is implementing a new code validation process to ensure specific modifiers have been used correctly. As you know, claims should always be coded to the level of specificity for the services rendered. Diagnosis codes and modifiers should be appropriately appended so they follow the national guidelines. Reported services should be supported in the patient's medical record.

Below is an overview of our new process.

Modifiers

We will review the following modifiers:

Modifier	Definition
25	Indicates a significant, separately identifiable evaluation and management (E/M) service was performed by the same physician or other qualified healthcare professional on the same day of a procedure or other services.
59	Distinct procedural service. Used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances.
XE	Separate Encounter, a service that is distinct because it occurred during a separate encounter. Only use XE to describe separate encounters on the same date of service.
XS	Separate Structure, a service that is distinct because it was performed on a separate organ/structure
XP	Separate Practitioner, a service that is distinct because it was performed by a different practitioner
XU	Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service

Resources

Here are national resources for more detailed information on these modifiers.

- American Medical Association *Coding with Modifiers, 6th edition*
- Current Procedural Terminology Manual
- The Center for Medicare and Medicaid Services National Correct Coding Initiative Policy Manual
- CMS Claims Processing Manual

Prepayment review

Claims submitted with the above modifiers on or after September 5, 2022 , will pend for a prepayment review. Registered nurses with coding credentials will use nationally sourced guidelines to review information on the claim and the patient's claim history.

Review outcome

After the review is completed, claims will either process for payment or deny. Providers can appeal a denial decision. Please refer to the Appeals Process section in HAP's Billing Manual. A nurse will review medical records and supporting documentation to determine if the denial was appropriate or if it should be overturned and processed for payment.

We are confident this new process will improve the accuracy of claims processing.