Regulatory Edits for the Revenue Cycle Setup and Support Guide

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Your Responsibilities for Safe Use

This documentation will help guide you through the available software configuration options so you can decide the right configuration for your organization. Of course, safe and compliant use of the software in any configuration requires you and your users to use good judgment and perform certain responsibilities, including each of the following: enter and read information accurately and completely; be responsible for configuration decisions; ensure compliance with laws and regulations relevant for your organization; confirm the accuracy of critically important medical information (e.g., allergies, medications, results), just as you would with paper records; actively report suspected errors in the software to both Epic and affected personnel; thoroughly test the software to ensure it's accurate before using it; and use the software only according to standards of good medical practice. You also are responsible for training your personnel and other users to perform these responsibilities. Not performing any of these responsibilities may compromise patient safety or your compliance with applicable requirements.

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Regulatory Edits for the Revenue Cycle Setup and Support Guide

Regulatory edits are sets of rules that identify procedures that have been billed inappropriately because:

- Code definitions and guidelines prohibit billing certain procedures together.
- Code definitions and guidelines prohibit billing certain procedures without another primary procedure.
- Medical necessity criteria, such as the diagnosis, have not been met.
- The procedure is billed more times than allowed.

You can reduce denials from Medicare and other payers that have adopted these requirements by checking that these rules are satisfied in Epic before sending claims. This guide covers multiple sets of rules published by various organizations, including:

Type	Long Name (with external link)	Created by	What the Rules Do	Example
CCI	National Correct Coding Initiative Procedure-to-Procedure edits	CMS	Prevent pairs of HCPCS/CPT procedures on the same date of service from being billed on a claim together that shouldn't be due to code definitions or coding guidelines	Billing a lab panel and lab components on the same day is inappropriate.
Add-on Codes	National Correct Coding Initiative Add-on Code edits	CMS	Ensure the presence of the primary procedure required for add-on procedures to be billed.	Billing for a stent in an additional artery without billing for a stent in the first artery is inappropriate.
LCD	Local Coverage Determination edits, formerly known as Local Medical Review Policies (LMRP)	The A/B Medicare Administrative Contractors (MACs) for each A/B MAC jurisdiction.	Ensure that services meet certain criteria, including the associated diagnosis, to qualify as medically necessary. This includes LCDs with frequency limits.	Performing an appendectomy with a diagnosis of cough is inappropriate.

Type	Long Name (with external link)	Created by	What the Rules Do	Example
NCD	National Coverage Determination edits	CMS	Ensure that services meet certain criteria, including the associated diagnosis, to qualify as medically necessary. If CMS publishes coding guidelines for an NDC, most vendors include it in the LCD data. For the rest of this guide, information about LCD edits applies to NCD edits also unless stated otherwise.	
MUE	Medically Unlikely Edits	CMS	Prevent the number of units for a procedure from exceeding an established limits for either a single: • Claim line, for some edits • Date of service, for other edits	Performing a drainage procedure more than once per day is inappropriate.
OCE	Outpatient Code Editor	CMS	Ensure that hospital outpatient claims comply with correct coding and claims processing guidelines.	Billing multiple type S or T procedures on the same day is inappropriate.

Related Information

You might also be interested in these related guides:

- Advance Beneficiary Notices of Noncoverage Setup and Support Guide. The data you load for LCD edits is also used to trigger ABNs in EpicCare Ambulatory.
- To check OCE Edits in Epic during claims processing, you must use 3M's Core Grouping Software or 3M's Grouper Plus Content Services.
  - Core Grouping Software (3M) Integration Setup and Support Guide.
  - Grouper Plus Content Services (3M) Integration Setup and Support Guide.

Regulatory Edits for the Revenue Cycle Strategy

This section describes the considerations and decisions you need to make as you implement regulatory edit checking during go-live and optimization.

Choose a Vendor for Correct Coding Initiative (CCI) and Local Coverage Determination (LCD) Data

We recommend that you obtain CCI and LCD data from a third-party vendor so that it's easier to maintain the data over time.

Considerations for Choosing a Third-Party Data Vendor

Consider the following questions to help you compare quotes from third-party vendors for licensing the data:

Are you implementing ABNs in hospital and outpatient settings?

The data you import for LCD checks is also used to trigger Advanced Beneficiary Notices of Noncoverage (ABNs) in clinical applications. There can be different LCD rule sets for clinics and hospital outpatient departments. If you want to implement ABNs in the hospital, you typically need MAC - Part A (Fiscal Intermediary) rule sets. If you want to implement ABNs in non-hospital outpatient settings, you typically need MAC - Part B (Carrier) rule sets. Some contractors have a single MAC Part A and Part B rule set. For more information about ABNs, refer to the Advance Beneficiary Notices of Noncoverage Setup and Support Guide.

Are you submitting claims to payers that require LCD checks from sites in multiple states?

Each state can have different LCD rules, so you might need to obtain the data for each state that applies to the geographical scope of your implementation. Some states share a single Part A and Part B MAC jurisdiction and use the same rules.

Are you implementing Correct Coding Initiative (CCI) Procedure-to-Procedure edit checks, MUE checks, and Add-on code checks?

CMS develops CCI data for Medicare, but some other payers also require CCI edit checks, which are divided into the following categories:

- CCI procedure-to-procedure edit checks to check whether two CPT or HCPCS codes can appear on the same claim.
- CCI add-on code edits check for a required primary procedure when certain procedures are present.
- CCI MUE edits identify services that exceed defined limits for either a claim line or date of service.

MUE edit data is available from the CMS website, but CCI procedure-to-procedure edits and CCI add-on code edits require data in an Epic file format. Some vendors have CCI add-on code data, but others do not. While it's possible to create a CCI add-on code edit file based on information available on the CMS website, some vendors provide data for these edits and include edits that are more extensive than what CMS publishes.

Are you implementing both CCI checks and LCD checks concurrently?

CCI edit checks related to correct coding rather than medical necessity, so ABNs do not apply to services that fail a CCI edit check. Rather, you might implement CCI edit checks so your billing staff can ensure that the correct charges are filed to a claim to help you avoid denials and reduce your AR days. Although CCI edit checks and LCD edits for ABNs are different, many organizations find it convenient to implement both at the same time, and several vendors offer both CCI and LCD data.

Do you already have a relationship with a third-party vendor for billing information?

If you already have a relationship with a vendor that also offers LCD and/or CCI data in the required Epic format, you might choose to use that same vendor to provide the data files you need.

Consider the cost of licensing the data and whether the vendor also supplies data for any non-Medicare payers for which you also want to implement edit checking, such as a certain Blue Cross payer, TRICARE, or a state Medicaid program.

Customize CCI and LCD Data

You can create override records for specific procedures that your organization might choose to handle differently from the data provided by your third-party vendor. For more information about creating override records, refer to the following topics:

- Override CCI Data for Specific Procedures
- Override LCD Data for Specific Procedures

Decide When to Trigger Edits Based on Edit Ownership

Epic strongly recommends the following when implementing Regulatory Edits:

- Don't change which operational team at your organization owns specific regulatory edits for your go-live. Don't make any changes until edit volumes stabilize post-live.
  - Organizations struggle when they change ownership at go-live because users are learning both new Epic workflows and new operational workflows, such as how to read CMS bulletins and clinical documentation.
  - Instead, if you want to change ownership of edits, plan to do so during optimization and work with your Epic representative to develop a training plan.
- Run Regulatory Edits only for payers that require them for regulations or complete reimbursement. Running these edits for payers that don't need them creates unnecessary work and cost.
- Run each regulatory edit only once in the revenue cycle, including the clearinghouse.

We recommend running an edit at the stage of the revenue cycle where it is easiest for the edit owner to fix. Use the tables below to determine when each edit should be triggered.

Professional Billing Recommendations:

Edit Owners	Trigger CCI during…	Trigger LCD/NCD during…	Trigger MUE during…
Department	Charge Review	Charge Review	Charge Review
Coding	Charge Review	Charge Review	Charge Review
Billing	Claim Edit	Claim Edit	Claim Edit

Hospital Billing Recommendations:

Edit Owners	Trigger CCI during…	Trigger LCD/NCD during…	Trigger MUE during…	Trigger OCE during…
Department (only if you send edits back to departments)	DNB Edit	Coding Validation Check	Charge Router Review Edit (except for Willow Inpatient and Critical Access Hospitals)	Claim Edit
Coding	Coding Validation Check AND DNB Check	Coding Validation Check	Claim Edit	Claim Edit
Billing	DNB Edit	DNB Edit	Claim Edit	Claim Edit
Revenue Integrity	DNB Edit	DNB Edit	Claim Edit	Claim Edit

Epic does not recommend having your clearinghouse run regulatory edits, because you lose the ability to adjust the edits as needed as well as reporting capabilities. If your clearinghouse is unable to turn off the edits, contact your Epic clearinghouse representative to discuss the best approach for you.

Set Up CCI PTP Edits and Add-on Code Edits

Complete the setup in this section to start checking CCI procedure-to-procedure edits and add-on code edits in Epic during claims processing. You'll complete the following key steps:

1. Load CCI Data into Epic, including modifiers and add-on codes
2. Associate CCI Rule Sets with Payers and Plans
3. Assign Ownership of CCI Errors and route them to an appropriate workqueue

Load CCI Data into Epic

This topic describes loading the following data into Epic:

- CCI procedure-to-procedure (CCI PTP) edit data files from your vendor.
- CCI modifiers from a flat file that you create.
- Add-on codes from a flat file that you create or a vendor file in the Epic format, if available from your vendor.

Load CCI Edits into Epic

CCI procedure-to-procedure edits are published by CMS. These edits indicate when the CPT code for a particular service should not be billed with the code for another based on the code definitions or other coding guidelines. Some CPT codes can appear on claims with otherwise incompatible codes if a modifier is present and if the CCI procedure-to-procedure rules allow a particular edit to be overridden by the presence of that modifier.

There are two varieties of CCI edits: physician and hospital. Hospital CCI edits are those used in the Outpatient Code Editor (OCE), which Medicare payers use to process hospital outpatient claims. In addition, the hospital CCI edits exclude some or all of the physician CCI edits from several areas, such as anesthesiology, evaluation and management services, and mental health.

> **!** You cannot use Data Courier or Content Management to move CCI or LCD edit data between environments in Epic. You must complete the steps to load CCI and LCD data in each separate environment where it is needed.
>
> Also note that loading CCI or LCD data for a specific category overwrites all previous data for that category for your entire facility.

To perform CCI edit checks in Epic, you need to load CCI edits from a third-party vendor. Epic does not support using the CCI files directly from CMS. To load CCI edits, complete the following steps:

1. Use FTP (ASCII format) to move the data files to your Epic server.
2. Follow one of the following paths in text:
   - In Resolute Professional Billing, follow the path Administrator's Menu > Master File Maintenance > CCI/LCD Load Related.
   - In Resolute Hospital Billing, follow the path Main menu > Master File Maintenance > CCI/LCD Load Related.
   - In Clinical Administration, follow the path Billing, Coverage > CCI/LCD Load Related.
3. Select CCI Load.

4. Enter the CCI category for these rules. The standard categories are:
   - 1-General Physician Edits, for Medicare Physician CCI procedure-to-procedure (PTP) edits.
   - 2-General Hospital Edits, for Medicare Hospital CCI PTP edits.
   - If you have created custom categories for these rules or for other CCI rules, such as Medicaid CCI PTP Practitioner Services Edits or Medicaid CCI PTP Outpatient Hospital Services Edits, you can use those categories here. The list of CCI categories is stored in the Physician CCI (I EPM/EPP 18951) and the Hospital CCI (I EPM/EPP 18952) category lists.
5. At the CCI file prompt, enter the name of your CCI edit file.

Load CCI Modifiers

> **!** You cannot use Data Courier or Content Management to move CCI or LCD edit data between environments in Epic. You must complete steps to load CCI and LCD data in each separate environment where it is needed.
>
> Also note that loading a CCI modifier data file overwrites all existing CCI modifier data for your facility.

Considerations

CMS indicates that certain CCI PTP edits cannot be overridden by a modifier, so those edits cannot be overridden by a modifier in Epic, even if they are included in a your CCI modifier file. The rest of this topic assumes you are overriding CCI PTP edits for which an override by modifier is allowed.

For some CCI edits, users can add a modifier to a procedure code that adds information about the service performed and overrides the CCI checks. The modifier allows both services to be paid if appropriate. For more information on configuring modifiers, refer to the Configure Modifiers topic.

This step doesn't depend on data provided by your third-party vendor. You create CCI Modifier files in a comma-delimited flat file outside Epic to load into the system.

Create Your CCI Modifier File

Each line in the flat file specifies which CCI edits the system can override when a specific modifier is present for one set of CCI rules within a date range. One line from a CCI modifier file might look like this:

1,17,59,10/1/07,10/1/09

Typically, a modifier file contains multiple lines grouped together that indicate a set of modifier that can override CCI procedure-to-procedure edits for particular edit categories.

Each line contains, in order, the following information:

CCI rule set

Choose which set of CCI rules you are specifying modifiers for. The standard categories are:

- 1-General Physician Edits, for Medicare physician CCI procedure-to-procedure (PTP) edits.
- 2-General Hospital Edits, for Medicare hospital CCI PTP edits.

If you have created custom categories for these rules or for other CCI rules, such as Medicaid CCI PTP Practitioner Services Edits or Medicaid CCI PTP Outpatient Hospital Services Edits, you can use those categories here. The list

of CCI categories is stored in the Physician CCI (I EPM/EPP 18951) and the Hospital CCI (I EPM/EPP 18952) category lists.

Category of CCI errors to override

Specify the CCI error category to override when the indicated modifier is present.

Vendors' CCI data files include descriptions for each CCI PTP edit that indicate the type of edit. Each description usually corresponds to a section in Chapter 1 of the NCCI Policy Manual, such as "Coding Based on Standards of Medical/Surgical Practice" or "Misuse of Column Two Code with Column One Code." When CCI PTP data is loaded into Epic, the system creates category numbers for the edit descriptions in the file. The CCI edit category in the modifier file makes it possible to have a given modifier override CCI PTP edits for certain edit categories but not others.

Modifier code

Specify a modifier that can override a CCI PTP edit when associated with one of the procedure codes involved in that edit. Specify a modifier name as defined in the Modifier Code field (I MOD 40) in the modifier record.

- In the example line, CCI PTP edit checks with edit category 17 can be overridden when modifier 59 is present.

Effective from date

Set the initial service date for which this CCI rule is used. If this is left blank, the default effective date is 01/01/1840.

- In the example line, this CCI modifier is effective beginning October 1, 2007.
- To leave the Effective from date blank, enter a line such as 1,17,59,,10/1/09

Effective to date

Set the final service date for which this CCI rule is used. If this is left blank, the default end date is 01/01/2300.

- In the example line, this CCI modifier is effective until October 1, 2009.
- To leave the Effective to date blank, enter a line such as 1,17,59,10/1/07,

Load Your CCI Modifier File into Epic

After creating your flat file, follow these steps:

1. Access one of the following screens in text:
   - In Resolute Professional Billing, follow the path Administrator's Menu > Master File Maintenance > CCI/LCD Load Related.
   - In Resolute Hospital Billing, follow the path Main menu > Master File Maintenance > CCI/LCD Load Related.
   - In Clinical Administration, follow the path Billing, Coverage > CCI/LCD Load Related.
2. Choose CCI Modifier Load.
3. Enter the file path for the flat file you created.

Report on CCI Modifiers Loaded in Epic

Starting in May 2021

You can use a utility to generate a list of CCI modifiers you have loaded into Epic if you no longer have the original import file or want to see how they are formatted. You can also use this utility to generate a modifier import file based on the current data in Epic.

1. In Professional Billing Text, go to Master File Maintenance > CCI/LCD Load Related > CCI Modifier Report.
2. Choose from the following options:
    a. Print a detailed report to the screen.
    b. Print a detailed report to a file.
    c. Generate a modifier import file based on the current data in Epic.
3. If you choose to print the report, enter one or more CCI categories for which you want to run the report.
4. If you choose to print the report to a file or generate an import file, enter a file path when prompted.

Load Add-on Codes into Epic

Load add-on code information so Epic can perform add-on checks. You might receive this information in a file from a third-party vendor or create a flat file using the information available on the CMS website. Add-on procedures are procedures that require the presence of a primary procedure to be billed.

Create a Flat File

If you aren't using a file from a third-party vendor, you can create a comma-delimited flat file that contains a set of add-on codes that are associated with primary procedures outside of Epic. Each line in the flat file associates add-on codes with potential primary procedure codes. It contains the following information:

- Add-on Code. List the affected add on code.
- CPT Code Start Range. The start of the CPT code range for the associated primary procedures.
- CPT Code End Range. The end of the CPT code range for the associate primary procedures.
- Start Date. The start date for this line in the format of MM/DD/YYYY. This date is required.
- Term Date. The end date for this line in the format of MM/DD/YYYY. If there is no end date, you can leave this position empty by putting nothing between the fourth and fifth commas.
- Description. A description of the edit. The description is optional.
- (For future use). The last position in each line is not currently used for anything. You can omit the comma following the Description field.

For example, the file might begin:

- 99211,32651,32655,1/1/2014,12/31/2021,Current 2014,
- 99212,32652,32655,1/1/2014,12/31/2021,Current 2014,

The following lines are also valid:

- No end date:
    - 99211,32651,32655,1/1/2014,,Current 2014
- No description:
    - 99211,32651,32655,1/1/2014,12/31/2021,,
- No end date or description:
    - 99211,32651,32655,1/1/2014,,

Add Values to the Add-on Code Rule Set

1. In Hyperspace, open the Add-on Code Rule Set (I ECT 64400) category list in Category List Maintenance (search: Category List Maintenance).

2. Add a category value for each add-on code rule set that you're going to use.

For instructions, refer to the Modify a Category List's Values topic.

Run the Add-on Px Load Utility

1. Follow one of the following paths in text:
   - In Resolute Professional Billing, follow the path Master File Maintenance > CCI/LCD Load Related > Add-On Px Load
   - In Resolute Hospital Billing, follow the Master File Maintenance > CCI/LCD Load Related > Add-On Px Load
2. At the Rule set to save to prompt, specify a rule set like 1-Home State or a value you added in the previous section.
3. At the Add-On Code File prompt, enter a file path to the flat file you created earlier.

Associate CCI Rule Sets with Payers and Plans

For the system to perform CCI edit checks, you must link a CCI rule set you have loaded to payers or plans. Epic recommends performing CCI edit checks only for payers or plans that require them to avoid unnecessary work for charge reviewers, billers, coders, and claim edit users. In the Foundation System, CCI edit checks are set up at the payer level.

Specify Default CCI PTP Rule Sets

When you load CCI PTP edit data into Epic, you specify the CCI PTP category. To specify a default CCI category for payers and plans:

1. In Resolute Hospital Billing or Resolute Professional Billing Text, open a payer or plan record.
   - Payer: Master File Maintenance > Payor
   - Plan: Master File Maintenance > Benefit Plan Related > Benefit Plan
2. Go to the CCI Edits screen.
3. Make sure the Use CCI (I EPM 171/I EPP 191) field is set to 1-Yes, All to use a default CCI rule set.
4. In the Physician CCI Category (I EPM/EPP 18951) field, enter the set of CCI physician rule set you want to use for your payer or plan. The standard category is 1-General Physician Edits.
   - If you have created custom categories for these rules or for other CCI rules, such as Medicaid CCI PTP Practitioner Services Edits, you can use those categories here. The list of CCI categories is stored in the Physician CCI (I EPM/EPP 18951) category list.
5. In the Hospital CCI Category (I EPM/EPP 18952) field, enter the set of CCI hospital rule set you want to use for your payer or plan. The standard category for Medicare Hospital CCI PTP edits is 2-General Hospital Edits.
   - If you have created custom categories for these rules or for other CCI rules, such as Medicaid CCI PTP Outpatient Hospital Services Edits, you can use those categories here. The list of CCI categories is stored in the Hospital CCI (I EPM/EPP 18952) category list.

Specify Default CCI Add-on Codes

You can specify a default add-on code for a payer or benefit plan.

1. In Resolute Hospital Billing or Resolute Professional Billing Text, open a payer or plan record.

- Payer: Master File Maintenance > Payor
- Plan: Master File Maintenance > Benefit Plan Related > Benefit Plan

2. Go to the Add-On Rule Sets screen.
3. In the Default Rules for FI (I EPM/EPP 435) field, choose a set of add-on codes that apply to your Part A MAC.
    - Note: There might not be a distinction between Part A and Part B add-on code edits.
4. In the Default Rules for Carrier (I EPM/EPP 436) field, choose a set of add-on codes that apply to your Part B MAC.
    - Note: There might not be a distinction between Part A and Part B add-on code edits.

Configure CCI Edit System Settings

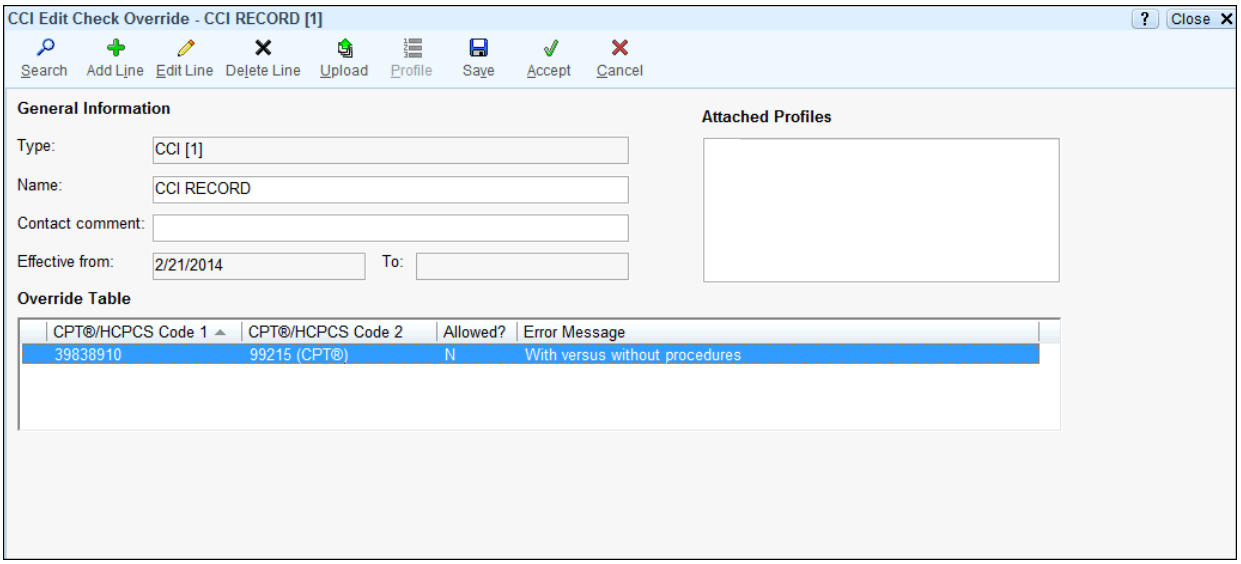
Override CCI Data for Specific Procedures

You customize the CCI data provided by your vendor to fit the policies of your facility by creating override records. An override can add an edit not present in the file or prevent an edit in the file from being applied. You can then associate these overrides with a benefit plan, payer, or service area. Because this override information is stored separately from vendor data, you do not need to customize the information again when you load new data from your vendor.

Alternative Method

This topic describes creating an override record in Hyperspace. You can also create override records by loading a comma-separated value (.csv) file or, starting in November 2022 and in May 2022 with special update E10211722, via an import specification in text. For more information on loading CCI override data with an import or .csv file, refer to the Upload Edit Check Information into an Override Record topic.

1. In Hyperspace, create a new CCI override record or open an existing one (search: CCI/LCD Edit Check Override or Regulatory Edit Override). If you're creating one, choose 1-CCI for the Type (I HCO 100) field.
2. Click Add Line and do the following:
    - Enter a pair of procedure codes you want to mark as allowed or not allowed in the CPT/HCPCS Code 1 and CPT/HCPCS Code 2 fields.
    - In the Allowed? (I HCO 205) field, enter 1-Yes, 2-No, or 3-Yes with modifier field. Option 3-Yes with modifier allows that pair of procedures only if at least one of the modifiers listed in the attached CCI/LCD edit check profile (called Regulatory Edit Profile in Nov 23 and newer) record is present.



3. Repeat step 2 as needed to override other specific procedure pairs.
4. Click Accept to save and close the override record.

Add Your CCI Override Record to Your Regulatory Edit Profile

1. In Hyperspace, open a CCI/LCD edit check or create a new one (search: CCI/LCD Edit Check Profile or Regulatory Edit Check Profile).
2. Enter your CCI override record in the CCI override (I HCP 100) field.
3. Enter one or more service areas, payers, or plans for which this CCI/LCD override applies.
4. Optionally, if you want to override LCD edits or ABN messages for the same service areas, payers, and plans, enter an LCD override record in the LCD override (I HCP 110) field or an ABN override record in the ABN override (I HCP 120) field.
    - For more information on creating an LCD override record, refer to the Override LCD Data for Specific Procedures topic.
    - For more information on creating an ANB override record, refer to the Display an Explanation for Why a Procedure or Service Isn't Covered topic.

Automate CCI Edits and Write-Offs

To make it easier for you to get this content, we've created a Turbocharger package for CCI Edits and Write-Offs. This package is available for download from February 2020. For information about importing this package, refer to the 274287-Automate CCI Modifiers and Write-Offs topic.

You can reduce the manual work of CCI edits by configuring your charge handler to automatically add CCI modifiers to qualifying charges. If you don't import the Turbocharger package, you can replicate the following Charge Handler Actions (VCSs) from Foundation System Charge Handler task 100229-Write Off and Add Modifiers – Compliance Discussion Needed:

- 100547-Abort If No CCI CPT Codes
- 100549-Write Off 84436 When 84439 Is Present
- 100555-Add XU Modifier to 81003 When 80307 Is Present

For more information about this build, refer to the Foundation System Charge Handler Inventory spreadsheet or

log in to the Foundation Hosted environment as your organization's hospital billing analyst (HBADM) to open the Charge Router Profile for the facility (search: Charge Router Profile). For more information about setting up Charge Handler tasks, refer to the Charge Handler Setup and Support Guide.

Compliance Review for CCI Pairs

For installing organizations, work with your compliance team and the team(s) that own CCI edit resolution to identify opportunities for automation. Potential areas include high volume edits and edits that your coding/billing teams are commonly adding modifiers to. For organization that are live on Epic, you can use SlicerDicer to view current CCI edit volume. Work with your compliance team to ensure that automation is compliant with CMS NCCI regulations.

Use a Component to Identify CPT Codes for CCI Edits

We recommend using a procedure component to identify CPT codes that should be automatically evaluated for CCI edits. The Foundation System includes component 945-CCI CPT In Handler Action for this purpose, which is configured in Charge Handler Action 100547-Abort If No CCI CPT Codes. To see the details of this component, log in to the Foundation Hosted environment as your organization's hospital billing analyst (HBADM) and open the Component Editor (search: Component).

Use Rules to Identify CCI Pairs

We recommend using rules to identify the Column One (billable) and Column Two (non-billable) codes for each CCI Edit pair. The Foundation System includes the following rules for this purpose:

- 731783-Procedure CPT Code=84439
- 731784-Procedure CPT Code=84436
- 731787-Procedure CPT Code=80307
- 731788-Procedure CPT Code=81003

These rules are used in Charge Handler Action 100549-Write Off 84436 When 84439 Is Present. To see the details of these rules, log in to the Foundation Hosted environment as your organization's hospital billing analyst (HBADM) and open the Rule Editor (search: Rule Editor).

Add CCI Modifier to Non-Billable Charges

We recommend adding the CCI modifier to Column Two (non-billable) charges that should be written off. To add the CCI modifier to qualifying charges, create a new Charge Handler Action for each CCI Edit Pair. The Foundation System uses Charge Handler Action 100549-Write Off Code 84436 When 84439 Is Present for this purpose.

To see details of this action, log in to the Foundation Hosted environment as your organization's hospital billing analyst (HBADM) to open the Charge Router Profile for the facility (search: Charge Router Profile).

Add X(EPSU) Modifier to Billable Charges

We recommend adding the X(EPSU) modifier to Column Two (non-billable) CCI charges that should be billed on the same claim as their respective Column One (billable) charges. To add the X(EPSU) modifier to qualifying charges, create a new Charge Handler Action for each CCI Edit Pair. The Foundation System uses Charge Handler Action 100555-Add XU Modifier to 81003 When 80307 Is Present for this purpose.

To see details of this action, log in to the Foundation Hosted environment as your organization's hospital billing analyst (HBADM) to open the Charge Router Profile for the facility (search: Charge Router Profile).

Write Off Modified CCI Charges

You can use an After Billing Extension Table to automatically write off the non-billable code in CCI Edit pairs. If you

don’t import the turbocharger package, you can replicate the following rules from Foundation System After Billing Extension Table 30841000301-HB Move Charges to New Bucket For WO or TTSP:

- 731805-Accounts for Auto CCI WO
- 731806-Charges with CCI Modifier

To see the details of the After Billing Extension Table, log in to the Foundation Hosted environment as your organization’s hospital billing analyst (HBADM) and open the Table Editor (search: Table). For more information about after billing write-offs, refer to the Define Write-Off Logic topic.

Suppress CCI Modifier on Claims

To suppress the CCI modifier on all claims, open your Procedure Modifier (search: Procedure Modifier) and set the Suppression Mode to Allow For List Below. Only add rows to the Suppression Table if you want the CCI modifier to appear on the specified claims.

Configure CCI Edit Checks

Run CCI Checks on Inpatient Accounts

Starting in August 2019

CCI edit checks can be configured to run on inpatient accounts for DNBs, coding validation, claim edits, or charge review by using an inclusion rule in your service area record. In the U.S., CCI edits can be run on inpatient Medicare Part B accounts for claim edits without this additional setup, but you might want to run CCI checks on other inpatient accounts if:

- Your organization has inpatient claims that use CPT codes, such as in benefits exhaust.
- Your organization wants to run CCI checks on inpatient accounts for DNBs, coding validation, claim edits, or charge review.

In the U.K., if you need to unbundle charges due to certain payer restrictions that require line-level service codes on inpatient accounts, you can use an inclusion rule to perform this unbundling.

1. In Hyperspace, create a rule (search: Rule Editor) in context 2004-Hospital Account to select the inpatient hospital accounts to run CCI checks for. For more information on creating rules, refer to the Create or Edit a Rule topic.
2. In Hospital Billing Text, open your service area profile and navigate to the Charge Entry Validation Check Profile screen.
3. In the IP HAR CCI Check Inclusion Rule (I EAF 173) field, enter the rule you created. If this item is left blank, CCI checks don’t run for inpatient accounts.

Allow CCI Checks for Non-Covered Charges

CCI edit checks, originally developed for Medicare compliance, can also be used for non-covered charges in Charge Capture, Charge Router Charge Entry, Charge Router Review workqueues, Hospital Billing DNB checks, and coding and abstracting checks. CCI edit checks are designed to find charges that don't make sense together, such as a lab panel and a lab components charge billed on the same day. You might want to use this functionality to create checks for charges that don't make sense together for self-pay patients. For more information on creating CCI edit checks, refer to the Set Up CCI PTP Edits and Add-on Code Edits topic.

Run CCI Edit Checks in Charge Router Workflows

To allow CCI edit checks to run on non-covered charges, you need to create a rule with a parameter that tells the system to allow CCI checks to run on charges without coverage attached. Follow these steps, which assume you have already created CCI requirements and checks in the CCI Edit Check Profile activity in Hyperspace:

1. In Hyperspace, access the Rule Editor.
2. Create a Universal Charge Line context rule that includes property 5790-CCI property with the Include Non-Covered Charges? parameter set to Yes.
3. In Clinical Administration, go to Management Options > Profiles (LPR) > Navigator.
4. On the Charge Capture Navigator Validation screen, enter the rule you created in steps 1 and 2 in the Rule (I LPR 5290) field.

In the corresponding Type field, enter whether this is a warning (that users can ignore) or an error (that users must address before filing).

Evaluate CCI Edits in Hospital Billing DNB Checks

You can configure discharged-not-billing (DNB) checks that evaluate CCI edits for non-covered charges:

1. In Chronicles, open the Extension (LPP) master file and duplicate extension 40780-HB DNB CCI/LCD Edits.
2. Set the Include Self-Pay CCI Checks parameter to 1-Yes.
3. Add the extension to a DNB check, as described in the Configure Discharged-Not-Billed Settings topic.

Evaluate CCI Edits in Hospital Billing Charge Review

Starting in May 2024, the following properties (HFPs) are available for use in Hospital Billing Charge review rules:

- 97151-CCI Check Failed
- 97214-LCD Check Failed
- 97216-CCI or LCD Check Failed
- 97217-LCD Check Failed + Frequency Warnings
- 97219-CCI or LCD Check Failed + Frequency Warnings
- 97220-MUE
- 97221-Multiple Procedure Indicator
- 97222-New vs Established Patient
- 97223-CCI Check Failed + Add-On Checks
- 97224-CCI or LCD Check Failed + Add-On Checks
- 97225-CCI or LCD Check + Frequency Warnings + Add-Ons
- 97230-MUE + ASC

In February 2024 and earlier, the following Hospital Billing properties (HSPs) in the Coverage context are available for use in Hospital Billing charge review rules:

- 900-CCI Check Failed
- 901-LCD Check Failed
- 902-CCI or LCD Check Failed
- 907-LCD Check Failed + Frequency Warnings

- 908-CCI or LCD Check Failed + Frequency Warnings
- 911-MUE
- 912-Multiple Procedure Indicator
- 913-New vs Established Patient
- 958-CCI Check Failed + Add-On Checks
- 959-CCI or LCD Check Failed + Add-On Checks
- 967-CCI or LCD Check Failed + Frequency Warnings + Add-On Checks
- 968-MUE + ASC

Refer to the Route Records to Workqueues with Rules topic for general information about rules.

Evaluate CCI Edits in Coding and Abstracting Checks

You can configure coding and abstracting checks that evaluate CCI edits for non-covered charges:

1. In Chronicles, open the Extension (LPP) master file and duplicate one or more of the following extensions:
   - 41253-Run CCI/LCD Edits
   - 41256-LCD Checks
   - 41257-Run CCI/LCD Edits + Frequency Warnings
   - 41258-LCD Checks + Frequency Warnings
   - 45787-LCD Checks - Alternate
   - 45788-LCD Checks + Frequency Warnings - Alternate
2. Set the Include Self-Pay CCI Checks parameter to 1-Yes.
3. Add the extensions to a coding or abstracting check, as described in the Configure Coding and Abstracting Validation Checks to Perform When Users Change an Account's Status topic.

Configure Custom Messages for CCI Edit Checks

Considerations

Any changes you make to CCI edit messages for physician edits appear to all users who encounter those edits when using any of the following applications or features:

- EpicCare Orders
- Professional charges in the Charge Router
- Resolute Professional Billing
- Resolute Professional Claims

Any changes you make to CCI edit messages for hospital edits appear to all users who encounter those edits when using any of the following applications or features:

- Hospital charges in the Charge Router
- Hospital Coding
- Hospital Billing
- Resolute Hospital Claims

Before making changes, consult with analysts from potentially affected applications.

Users who have to correct CCI edits, such as revenue integrity users and coders, might find that the standard messages generated in Epic using the data from your third-party vendor do not provide enough information about the edit and how to resolve it. If that's the case, you can help them by defining custom messages to replace these standard messages.

Standard CCI edit messages use the following format: CCI: For CPT codes (<column 1 code>), (<column 2 code); <edit message>. In this case:

- Column 1 code is eligible for payment.
- Column 2 code is not eligible for payment when billed with the column 1 code, unless the CCI edit specifies that adding a modifier to the column 2 code allows it be billed.
- The edit message is determined by the vendor supplying the CCI edit data files.

Example Standard CCI Message

Here's a typical example of such a message:

- "CCI: For CPT codes (0008T), (00740): Anesthesia Service Included in the Surgical Procedure."

This information might not be enough to help users resolve these edits.

Example Custom CCI Message

To provide more helpful information, you can configure this message to use the following format:

- "CCI: <column 1 code XXXXX> is eligible for payment but <column 2 code YYYYY> is not. <edit description message> <resolution/modifier message>."

For example, a detailed edit description message might look like this:

- "If CPT codes for anesthesia services (00100-01999) or services bundled into anesthesia are performed by the same physician who performed the medical or surgical procedure requiring anesthesia, they should not be reported separately."

And a more helpful modifier message would read like this:

- "Do not bill the ineligible code. Adding a modifier to the ineligible code will not allow it to be billed with the first."

Putting it all together in the suggested format looks like this:

- CCI: 0008T (CPT) is eligible for payment but 00740 (CPT) is not. If CPT codes for anesthesia services (00100-01999) or services bundled into anesthesia are performed by the same physician who performed the medical or surgical procedure requiring anesthesia, they should not be reported separately. Do not bill the ineligible code. Adding a modifier to the ineligible code will not allow it to be billed with the first."

Consider How You Want to Configure Custom Messages

You have the following options when configuring custom messages for CCI edits:

- You can create a single custom message for all edit categories or different ones for each edit category.
- You can include the code that fails the CCI edit in various places in the message.
- You can include a custom edit description that replaces the standard one for each edit category.
- You can include custom modifier messages to indicate whether adding a modifier can resolve a CCI edit error. Note that the system uses the same modifier message for all edit categories, but you can add information about particular modifiers appropriate for a particular type of edit in any custom edit

messages you use to replace the standard edit messages from your vendor.

Work with Your Epic Claims Representative to Create Custom CCI Messages

To reconfigure these messages:

1. Review CCI edit categories and the sections in Chapter 1 of the National Correct Coding Initiative Policy Manual for Medicare Services for each edit message category.
2. Determine whether you need additional or different text for each edit message.
3. Determine whether you need to include additional information about modifiers for any CCI edits in the custom modifier message or the edit description message.
4. Review the custom messages you want to implement with your organization's compliance department.
5. Contact your Epic representative and mention parent SLG 1640880 to enable these messages.

Notes:

- Standard edit description messages from third-party vendors often correspond to the section headers in Chapter 1 of the National Correct Coding Initiative Policy Manual for Medicare Services. You can use these sections when configuring more extensive custom messages.
- Vendor data also typically indicates when a modifier overrides a particular edit, but it doesn't specify the modifiers you can use. In a custom modifier message, you can specify which modifiers are appropriate for overriding an edit of the type corresponding to a vendor edit description. You can also configure your system to recognize only a particular set of modifiers for particular CCI edit messages. For more information, refer to the Load CCI Modifiers topic.

Assign Ownership of CCI Errors

Epic recommends that you trigger CCI edits once, at the part of the revenue cycle owned by those responsible for fixing that edit. If you aren't sure, refer to the Decide When to Trigger Claim Edits Based on Edit Ownership topic. After you've decided, complete one of the following:

If you trigger CCI during...	Refer to this topic:
Charge Review	Review CCI Errors in Charge Review Workqueues
DNB Edit	Perform CCI PTP and Add-On Checks During DNB Edit
Coding Validation	Perform CCI PTP and Add-On Checks During Coding Validation
Claims Processing	Perform CCI and LCD Checks During Claims Processing

> **!** Epic does not recommend having your clearinghouse run regulatory edits, because you lose the ability to adjust the edits as needed. If you clearinghouse is unable to turn off the edits, contact your Epic clearinghouse representative to discuss the best approach for you.

After you set up CCI edit checking in one of the listed topics, route CCI errors to the appropriate workqueue by completing the setup from the Route CCI Errors to Workqueues topic.

Review CCI Errors in Charge Review Workqueues

Prerequisites

Before completing the setup for this topic, ensure that CCI edits have been loaded and enabled for the payer or plan associated with the charges you want to check.

Charge reviewers can review CCI checks during coding in charge review workqueues. To do so, add the standard CCI rule to a charge review workqueue.

In Professional Billing Charge Review

1. Go to Epic button > Professional Billing > Workqueues. The Professional Billing Workqueue List opens.
2. On the Charge Review tab, select a workqueue and click Workqueue Settings.
3. On the Workqueue Rules form, click Add Rule.
4. Add rule 61-CCI. The 'Check charges in the same' parameter, available starting in August 2023, determines the scope of the CCI edits. The edits will evaluate pending or posted charges for a patient with the same service area, service date, coverage, and billing provider within the scope. If you need to change this parameter to something other than 0, you will need to create a copy of rule 61-CCI.
    - 0 - Same charge session (default value)
    - 1 - Same encounter
    - 2 - Same service date.

In Hospital Billing Charge Review

1. Create a Hospital Billing rule (search: Hospital Billing Rule) and configure it this way:
    - Property: Charge Session\CCI Check Failed
    - Operator: = (equal to)
    - Value: Yes
2. Add this rule to an HB charge review workqueue. For more information, refer to the Create a Workqueue topic.

Perform CCI PTP and Add-on Checks During DNB Edit

In the Foundation System

To see how we've configured a CCI PTP DNB check in the Foundation System:

1. Log in to the Foundation Hosted environment as your Hospital Billing administrator (HBADM).
2. Open extension 1084078002-CCI Edits or extension 1084078001-HIM CCI/LCD Edits (search: Extension).
3. Open rule 536-Coding Status = Complete (search: Rule Editor) to see the rule used to determine which accounts are ready for CCI error checking.

Perform CCI PTP checks during DNB Checking:

1. In Chronicles, create a copy of extension 40780-HB DNB CCI/LCD Edits.
2. Set the Type of Checks parameter to CCI.
3. If you want to check add-on code edits, add Add-On Codes to the Type of Checks parameter.
    - Optionally, you can also configure your extension to check LCD edits and modifiers. If you aren't

sure, refer to the Decide When to Trigger Claim Edits Based on Edit Ownership topic for help deciding.

4. In Hyperspace, open your Hospital Billing Profile (search: Hospital Billing Profile).
5. On the DNB Check form, add your extension in the DNB Check (I HSD 300) field.
6. Optionally, add a rule beside your extension. In the Foundation System, rule 536-Coding Status = Complete is used to qualify accounts for the CCI check extension.
7. Enter a type of Warning or Error, and enter an owning area according to your organization's workflows.

Decide Whether to Run CCI Checks for Inpatient Part B Accounts During DNB Edit

Most inpatient hospital accounts don't qualify for CCI checks. However, inpatient hospital accounts with Medicare Part B coverage often include services rendered after the Part A benefits exhaust date, and these might be eligible to be rebilled to Medicare Part B. To see how you can use Epic to proactively rebill charges with a Part A coverage to Medicare Part B, refer to the A/B Rebilling Setup and Support Guide. CCI checks apply to services billed to Medicare Part B.

Extension 40780-HB DNB CCI/LCD Edits and copies of it, which run during DNB edit, run on inpatient hospital accounts with charges eligible for Medicare Part B for charges after the exhaust date if the Include Part B? parameter is set to 1-Yes. To have these edits appear in workqueues, you must update your rules that identify CCI edits to include inpatient hospital accounts with Medicare Part B coverage.

The following general properties (HFP) have the Check Part B? parameter set to 0-No by default. We recommend setting it to 1-Yes to have these properties consider CCI edits for inpatient Part B accounts:

- 97151-CCI Check Failed
- 97216-CCI or LCD Check Failed
- 97219-CCI or LCD Check Failed + Frequency Warnings
- 97223-CCI Check Failed + Add-On Checks
- 97224-CCI or LCD Check Failed + Add-On Checks
- 97225-CCI or LCD Check + Frequency Warnings + Add-Ons

In February 2024 and earlier, the 12th parameter of the following Hospital Billing properties (HSP) controls whether they consider inpatient Part B accounts. We recommend setting it to 1 to check inpatient Part B accounts for CCI edits:

- 900-CCI Check Failed
- 902-CCI or LCD Check Failed
- 908-CCI or LCD Check Failed + Frequency Warnings
- 958-CCI Check Failed + Add-on Checks
- 959-CCI or LCD Check Failed + Add-on Checks
- 967-CCI or LCD Check Failed + Frequency Warnings + Add-on Checks

For any Rule Editor rules (CER) that you use to route DNB edits and coding validation edits related to CCI checks to workqueues, update the rule properties that identify CCI edits so that they consider inpatient Part B accounts:

1. In Hyperspace, go to the Rule Editor (search: Rule Editor) and open an affected rule.
2. Click the property that checks for CCI edits to open its parameters for editing.
3. Set the Check Part B? parameter to 1-Yes.

4. Click Accept to save and close your rule.

For any Hospital Billing rules (BWR) that you use to route DNB edits and coding validation edits related to CCI checks to workqueues, update the Hospital Billing rule properties so that they consider inpatient Part B hospital accounts.

Starting in May 2024:

1. If you already have a custom property, skip this step and use that one. Otherwise, in Hyperspace, open Property Editor (search: Property Editor) and create a copy of the property (HFP) you use to check CCI edits in your rule.
2. In the Check Part B? field, select Yes.
3. Click Save and Finish.
4. Edit your rule to use your edited property.

In February 2024 and earlier:

1. If you already have a custom HB property, skip this step and use that one. Otherwise, in Chronicles (HSP), create a copy of the property you use to check CCI edits in your rule.
2. In Hyperspace, go to the HB Property Editor activity (search: HB Property Editor).
3. Find the property you created in step 1 and click Edit.
4. Enter 1 for the 12th parameter, which controls checking inpatient Part B accounts.
5. Click Save and Finish.
6. Edit your rule to use your edited property.

Perform CCI PTP and Add-on Checks During Coding Validation

In the Foundation System

To see how we've configured a CCI coding validation check in the Foundation System:

1. Log in to the Foundation Hosted environment as your Hospital Billing administrator (HBADM).
2. Open extension 2314125301-Run CCI/LCD Edits with Addon Code Checks (search: Extension).

> **!** You can also use the extension used in this setup to perform LCD checks and add-on code checks during coding validation. For more information about LCD checks during coding validation, refer to the Perform LCD Checks During Coding Validation topic.

Run CCI edit checks during coding validation with coding validation extension in the Hospital Billing Profile:

1. In Chronicles, create a copy of extension 41253-Run CCI/LCD Edits.
2. In Hyperspace, open your extension for editing (search: Extension).
3. Using the help text to guide you, set the parameters for your use case. In particular:
   - Ensure that the Check CCI? parameter is set to 1-Yes.
   - If you want to perform Add-on checks as well, set the Check Add-On? parameter to 1-Yes.
4. Open your Hospital Billing Profile (search: Hospital Billing Profile).
5. On the Hospital Coding > Validation Checks form, enter your extension in the Validation Extension (I HSD

932) field.

6. Specify whether this validation check is an error or a warning in the Err/Warn (I HSD 936) field.

Decide Whether to Run CCI Checks for Inpatient Part B Accounts During Coding Validation

Considerations
Running CCI checks during coding validation can add delays to coding workflows.

Most inpatient hospital accounts don't qualify for CCI checks. However, inpatient hospital accounts with Medicare Part B coverage often include services rendered after the Part A benefits exhaust date, and these might be eligible to be rebilled to Medicare Part B. To see how you can use Epic to proactively rebill charges with a Part A coverage to Medicare Part B, refer to the A/B Rebilling Setup and Support Guide. CCI checks apply to services billed to Medicare Part B.

You can configure your copy of coding validation extension 41253-Run CCI/LCD Edits so it runs over inpatient accounts with charges eligible for Medicare Part B during coding validation:

1. In Hyperspace, open your copy of extension 41253.
2. Set the Include Part B? parameter to 1-Yes.
3. Click Accept.

To have these edits appear in workqueues, you must update your rules that identify CCI edits to include inpatient hospital accounts with Medicare Part B coverage. The following general properties (HFP) have the Check Part B? parameter set to 0-No by default. We recommend setting it to 1-Yes to have these properties consider CCI edits for inpatient Part B accounts:

- 97151-CCI Check Failed
- 97216-CCI or LCD Check Failed
- 97219-CCI or LCD Check Failed + Frequency Warnings
- 97223-CCI Check Failed + Add-On Checks
- 97224-CCI or LCD Check Failed + Add-On Checks
- 97225-CCI or LCD Check + Frequency Warnings + Add-Ons

In February 2024 and earlier, the 12th parameter of the following Hospital Billing properties (HSP) controls whether they consider inpatient Part B accounts. We recommend setting it to 1 to check inpatient Part B accounts for CCI edits:

- 900-CCI Check Failed
- 902-CCI or LCD Check Failed
- 908-CCI or LCD Check Failed + Frequency Warnings
- 958-CCI Check Failed + Add-on Checks
- 959-CCI or LCD Check Failed + Add-on Checks
- 967-CCI or LCD Check Failed + Frequency Warnings + Add-on Checks

For any Rule Editor rules (CER) that you use to route DNB edits and coding validation edits related to CCI checks to workqueues, update the rule properties that identify CCI edits so that they consider inpatient Part B accounts:

1. In Hyperspace, go to the Rule Editor (search: Rule Editor) and open an affected rule.
2. Click the property that checks for CCI edits to open its parameters for editing.

3. Set the Check Part B? parameter to 1-Yes.
4. Click Accept to save and close your rule.

For any Hospital Billing rules (BWR) that you use to route DNB edits and coding validation edits related to CCI checks to workqueues, update the properties so that they consider inpatient Part B hospital accounts.

Starting in May 2024:

1. If you already have a custom general property (HFP), skip this step and use that one. Otherwise, in Hyperspace, open Property Editor (search: Property Editor) and create a copy of the property (HFP) you use to check CCI edits in your rule.
2. In the Check Part B? field, select Yes.
3. Click Save and Finish.
4. Edit your rule to use your edited property.

In February 2024 and earlier:

1. If you already have a custom rule property, skip this step and use that one. Otherwise, in Chronicles (HSP), create a copy of the property you use to check CCI edits in your rule.
2. In Hyperspace, go to the HB Property Editor activity (search: HB Property Editor).
3. Find the property you created in step 1 and click Edit.
4. Enter 1 for the 12th parameter, which controls checking inpatient Part B accounts.
5. Click Save and Finish.
6. Edit your rule to use your edited property.

Perform CCI and LCD Checks During Claims Processing

Perform CCI and LCD edit checks during claims processing with copies of Epic-released extensions. There are many possible ways to configure these extensions. Consider the following questions:

- Should the extension check for CCI edits, LCD edits, or both?
- Should the extension check diagnoses at the line level or claim level in Resolute Hospital Billing?
- Should the extension check all diagnoses for each claim line, or only the first diagnosis, in Resolute Professional Billing?
- To which CCI or LCD rules do you want the extension to apply?
    - Fiscal Intermediate and Carrier rule sets refer to the LCD, MUE, and Add-on rule sets determined by the Part A MACs and Part B MACs, respectively.
- Should the extension check dash codes?
- Should the extension check only add-on codes?

Resolute Professional Billing

Use edit check extensions based on code template CLM CCI EDITS/LCD DIAGNOSIS IS NOT COVERED (PB CHECKS) to perform CCI and LCD edits in Professional Billing:

- 70315-CCI Edits/LCD Diagnosis Is Not Covered
- 70350-CCI Edits/LCD Diagnosis Is Not Covered (All Dx) (Part B Checks)

- 70351-CCI Edits/LCD Diagnosis Is Not Covered
- 70352-CCI Edits/LCD Diagnosis is Not Covered
- 70353-CCI Edits/LCD Diagnosis Is Not Covered (HB Checks)
- 70354 - CCI Edits/LCD Diagnosis Is Not Covered (All Dx) (Part A Checks)

To create your own:

1. In Chronicles, create a copy of one of the extensions.
2. Open your edit check extension for editing and set the parameters according to your needs. Starting in February 2021, you can configure all of the edit checks listed above to evaluate evaluate neither CCI or LCD edits and instead evaluate only add-on codes by setting the CCI or LCD Edits? parameter to 4-Neither CCI nor LCD Edits and the Check Add-On? parameter to 1-Yes.

Add the edit checks to your claim definition file (CDF):

1. In Hyperspace, open the Claim Definition Manager (search: Claim Definition Manager).
2. On the Add Edit Check tab, select the check you want to add and fill out other fields for that check, including the billing system, error type, and error code.
3. Select the CDFs that you want to add the check to.
4. Click Add Edit Check.

Resolute Hospital Billing

Use edit check extensions based on code template CLM HB CLAIM EDIT CHECK - HOSPITAL CCI/NON-SPECIFIC LCD EDITS (DX NOT CVD) to perform CCI and LCD edits in Hospital Billing:

- 70424-HB Claim Edit Check - Professional CCI/Specific LCD Edits (Dx Not Cvrd)
- 70426-HB Claim Edit Check - Professional CCI/Non-Specific LCD Edits (Dx Not Cvrd)
- 70482-HB Claim Edit Check - Hospital CCI/Specific LCD Edits (Dx Not Cvd)
- 70484-HB CLAIM EDIT CHECK - HOSPITAL CCI/NON-SPECIFIC LCD EDITS (DX NOT CVD)

To create your own:

1. In Chronicles, create a copy of one of the extensions.
2. Open your edit check extension for editing and set the parameters according to your needs. Starting in February 2021, you can configure extensions 70482 and 70484 to evaluate only add-on codes by setting the Check CCI? parameter to 0-No, the Skip LCD Check? parameter to 1-Yes, and the Check Add-On? parameter to 1-Yes.
    - Remember that Fiscal Intermediate and Carrier rule sets refer to the LCD, MUE, and Add-on rule sets determined by the Part A MACs and Part B MACs, respectively.

Add the edit checks to your claim definition file (CDF):

1. In Hyperspace, open the Claim Definition Manager (search: Claim Definition Manager).
2. On the Add Edit Check tab, select the check you want to add and fill out other fields for that check, including the billing system, error type, and error code.
3. Select the CDFs that you want to add the check to.
4. Click Add Edit Check.

Restrict Type II Add-on Code Edits to Professional Services on Critical Access Hospital Claims

Starting in February 2019

November 2018 by SU E8604387

August 2018 by SU E8509772

To make it easy for you to get this content, we've created a Turbocharger package for CCI Add-on Edits for Critical Access Hospitals starting in May 2021. To get this package, contact your Epic representative and mention project 239505.

If you perform add-on code edit checks on UB claims, restrict Type II add-on codes to professional services on Critical Access Hospital (CAH) claims.

There are three classifications for add-on codes edits, based on whether the associated primary codes are defined by:

- CMS only
- Medicare Administration Contractors (MAC) only
- CMS and the MACs

Edits for the Type II add-on codes, those where the primary codes are defined by MACs only, apply only to professional services on Critical Access Hospital (CAH) claims rather than all services on all UB claims.

Setup

Modify each edit check extension you use to check add-on codes to correctly identify Type II add-on codes:

1. If you don't have any add-on code edit check extensions in your system, refer to the Perform CCI and LCD Checks During Claims Processing topic for information on creating one.
2. Identify the Type II add-on procedure codes defined by your MAC. Each MAC defines their own Type II add-on codes.
3. In Hyperspace, create a component (search: Component) of procedures that includes all Type II add-on codes for your MAC.
4. Open your extension (search: Extension) and enter your Type II procedures component in the Add-On Type II Px Component/Component Group parameter.
5. If your organization bills professional services on Critical Access Hospital claims, you also need to complete the set-up in the Additional CCI Edit and Add-on Code Edit Setup for Critical Access Hospitals Using Method II Billing topic.

In the Foundation System, we've created shell component 718 - TYPE II ADD-ON CODE that you can populate with any Type II add-on codes defined by your MAC. This component has been entered in claim edit extension 3087048201-Claims HB Claim Edit Check - Hospital Specific LCD Only. You can log in to the Foundation Hosted environment as your organization's hospital billing analyst (HBADM) to see this component and the claim edit extensions.

Additional CCI Edit and Add-on Code Edit Setup for Critical Access Hospitals Using Method II Billing

Starting in February 2019

November 2018 by SU E8604387

August 2018 by SU E8509772

To make it easy for you to get this content, we've created a Turbocharger package for CCI Add-on Edits for Critical Access Hospitals starting in May 2021. To get this package, contact your Epic representative and mention project 239505.

Add-on professional procedures have the same date of service as the primary procedure. For Critical Access Hospital (CAH) claims only, CMS requires that:

- Add-on procedure code 99292 has a service date either on the same day as primary code 99291 or the day after the primary code service date.

Additionally for CAH claims only, CMS applies professional CCI edits to professional services only, and applies institutional CCI edits to institutional services only.

Here's how to configure your CCI edit and add-on code edit check extension to handle these cases appropriately:

1. In Hyperspace, create a component (search: Component) or component group (search: Component Group) of add-on procedures codes that, when sent on a CAH claim with a revenue code indicating that it is a professional charge, should have a date of service that is the same as the primary code's date of service or the next day. We recommend that this component group include CPT code 99292.
2. In Chronicles, open your extension for editing. To find all extensions that you could be using to perform add-on code edits and CCI edits, you can use a basic Chronicles search:
   a. In Chronicles, open the Extension (LPP) master file.
   b. Go to Search > Search.
   c. Use the following search conditions:
      - Condition A:
        - Item: 100
        - Relationship: 8-Contains
        - Value: $$ECciLmrp^KPECK325
        - or Value: $$ECCILMRP^KHSCE302
        - or Value: $$ECCILMRP^KHSCE312
      - Condition B:
        - Item: 17
        - Relationship: 4-NEQ-Not Equals
        - Value: 1-Epic
      - Logic: And
   d. Any extensions returned by this search are your copies of extensions that could be configured to check for add-on codes and CCI edits.
3. Configure the following parameters:
   a. Enter 851 in the CAH Type of Bill List parameter.
   b. Enter 960:989 in the CAH Revenue Code Range parameter.
   c. Enter your component or component group containing procedure code 99292 in the Add-On Component/Component Group parameter.

4. Repeat steps 2-3 for each CCI edit check extension and add-on code edit check extension in your system.

In the Foundation System, we've configured the following regulatory claim edit extensions with CAH types of bill and professional revenue codes:

- 3087031502-CCI Edits - Diagnosis is Not Covered (PB Checks)
- 3087048201-Claims HB Claim Edit Check - Hospital Specific LCD Only
- 3087048202-Claims HB Claim Edit Check - Hospital Specific CCI Only
- 3087048401-Claims HB CCI Edit Check.

In addition we've created component 715-CAH ADD-ON CODE CHECK for services with the same or next day service date exception. This component has been entered in claim edit extension 3087048201-Claims HB Claim Edit Check - Hospital Specific LCD Only.

You can log in to the Foundation Hosted environment as your organization's hospital billing analyst (HBADM) to see this component and the claim edit extensions.

Route CCI Errors to Workqueues

Based on which users at your organization are responsible for correcting CCI errors, you can route these errors to workqueues during DNB checking, coding validation, or claim edit checking. Rather than completing the setup in all three of these sections, set up only the method that routes errors to the right users.

Route CCI Errors to an HB Account Workqueue Using DNB Checks

In the Foundation System

To see our CCI and LCD rule for DNB errors in the Foundation System:

1. Log in to the Foundation Hosted environment as your Hospital Billing administrator (HBADM).
2. Open hospital billing rule 944-HIM DNB CCI/LCD Check (search: Hospital Billing Rule).

If you don't have that Foundation System record in your system, you can make a similar rule:

1. Create a hospital billing rule with a record type of Account (search: Hospital Billing Rule).
2. Add property Account\DNB Errors - Current.
   - Line #: Any
   - Operator: = (equals)
   - Value: Enter the extension you use to evaluate accounts for CCI errors. If you don't already have one, refer to the Perform CCI PTP and Add-On Checks During DNB Edit topic to create one.
   - Error Message: free-text message
3. Create a hospital billing account workqueue by completing the setup in the Create a Workqueue topic.
4. Add your rule to your workqueue by completing the setup in the Route Records to Workqueues with Rules topic.

Route CCI Errors to an HB Account Workqueue Using Coding Validation Checks

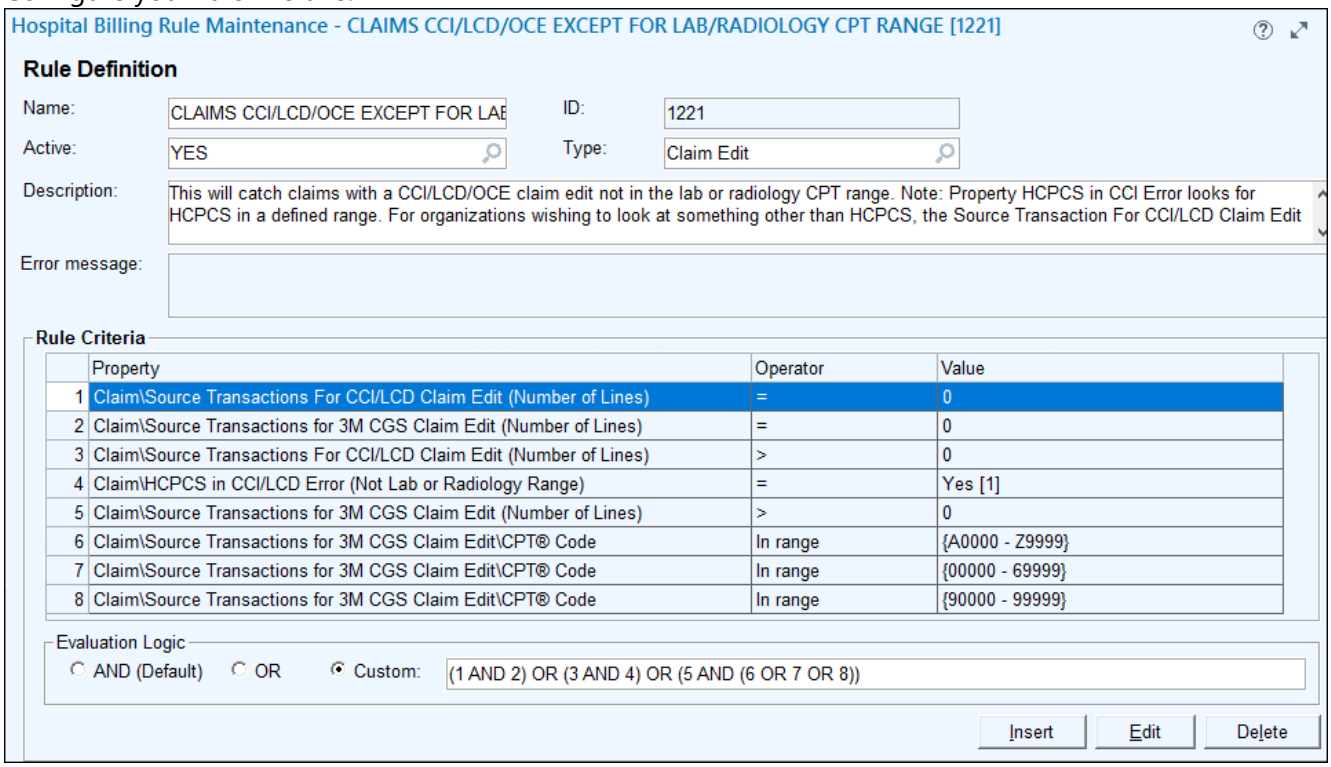
1. Create a hospital billing rule with a Record type of Account (search: Hospital Billing Rule).
2. Add property Account\Coding Validation Errors.
   - Line #: Any

- Operator: = (equals)
- Value: Enter the extension you use to evaluate accounts for CCI errors. If you don't already have one, refer to the Perform CCI PTP and Add-On Checks During Coding Validation topic to create one.
- Error Message: free-text message

3. Create a hospital billing account workqueue by completing the setup in the Create a Workqueue topic.
4. Add your rule to your workqueue by completing the setup in the Route Records to Workqueues with Rules topic.

Route CCI Errors to an HB Claim Edit Workqueue

1. Create a hospital billing rule with a Record type of Claim Edit (search: Hospital Billing Rule).
2. Configure your rule like this:



3. Create a hospital billing claim edit workqueue and add your rule to it by completing the setup in the Create Claim Edit Workqueues topic.

View CCI Edit Data Using a Text Utility

Starting in Epic 2018

You can easily review what CCI procedure-to-procedure edit information is loaded in an environment using a text report.

You can run the report for one or more CCI Categories; for lists, ranges, pairs, or all CPT/HCPCS codes; and for edits effective on the current date, within a date range, or at any point past, present, or future. The report shows:

- CCI Category
- Pairs of incompatible CPT/HCPCS codes
- Effective/Termination Dates
- CCI Error Message

- Modifiers that can clear the edit

Note that the report requires several minutes to shows results if you run it for all codes.

Go to Master File Maintenance > CCI/LCD Load Related > CCI Report and select 1-General Physician Edits or 2-General Hospital Edits. Then select from the following:

- 1-PAIR: Enter two CPT/HCPCS codes to report on.
- 2-LIST: Enter a list of CPT/HCPCS codes to report on.
- 3-RANGE: Enter a range of CPT/HCPCS codes to report on.
- 4-ALL: Report on all CPT/HCPCS codes.

Set Up LCD Edits

Complete the setup in this section to start checking LCD edits in Epic during claims processing. You'll complete the following steps:

- Load LCD data into Epic
- Load LCD modifier data into Epic
- Associate LCD rule sets with certain payers, plans, and areas
- Assign ownership for LCD errors
- Route edits to workqueues

Related Information

You might also be interested in the Advance Beneficiary Notices of Noncoverage Setup and Support Guide. The data you load for LCD edits is also used to trigger ABNs in EpicCare Ambulatory.

Overview of Potentially Confusing Terminology for LCD Edits and MUE Edits

"Fiscal Intermediaries" (FI) and "Carrier" previously described contractors who handled Medicare Claims prior to Medicare contracting reform. In general, FIs handled Medicare Part A claims and Carriers handled Medicare Part B claims. These contractors were different entities.

With Medicare contracting reform, individual Medicare Administrative Contractors (MACs) became responsible for both Medicare Part A and Medicare Part B claims. In some contexts Medicare nonetheless refers to Part A MACs (similar to FIs) and Part B MACs (similar to Carriers) even as it transitions to referring to "Part A and B MACs."

Because Medicare Part A LCD rule sets and MUE hospital outpatient rules correspond to hospital outpatient services, and those LCD rule sets were previously issued by the Fiscal Intermediaries, "FI" is used in both places for consistency. Likewise, Medicare Part B LCD rule sets and MUE practitioner rules correspond to the rules previously issued by Carriers, so we continue to use the term Carrier in the system.

Load LCD and NCD Data into Epic

Before you can check charge sessions or claims for Local Coverage Determination (LCD) and National Coverage Determination (NCD) errors in Epic, you must load medical necessity information from a third-party vendor. Epic uses this data to check whether the medical necessity requirements established by CMS and the Part A/Part B MACs for each A/B MAC jurisdiction are satisfied. These requirements examine both procedure and diagnosis combinations and, in some cases, criteria related to age, sex, and procedure frequency.

Each time your vendor releases updates versions of this data, load it again to stay up to date.

Specify the LCD File Format and Create LCD Rule Categories

Before you can import information from your vendor into Epic, you need to:

- Specify a content vendor in your facility record.
- Specify which rule sets apply to your organization. Because LCD rules vary according to factors such as region and coverage, vendors typically supply data for multiple rule sets. When loading vendor data, you must associate each rule set with a value in the LCD Category Value (I EPP 190) category list. During the loading process, you assign these categories to specific payers and plans for which your organization

needs to perform medical necessity checks. Choose names for the categories that are unique, related to the payer, and easy to recognize by users viewing medical necessity notifications.

Specify a Vendor

1. Open a facility or service area record:
   - In Resolute Professional Billing Text, go to Administrator Menu > Facility Profile > Facility Information. Access the Additional Information screen.
   - In Resolute Hospital Billing Text, go to Main Menu > Administrator Menu > Service Area Profile.
2. Go to the Additional Information screen.
3. In the CCI/LCD Vendor File Format (I EAF 19250) field, enter the category values specifying the file format.
   - All vendors provide files in an Epic-defined format. If you are using files delivered in an Epic-defined format, enter 2-Epic.
   - If you are using files from Experian Health, which you might have previously received from Passport Health Communications or Healthworks, then you could be receiving files in an Experian Health file format. If so, enter 1-Passport Health to load these files. Epic recommends that instead of loading files in the Experian format, you contact your Experian Health representative to request files in the Epic file format, which they support and provide by default to new customers.

Add Values to the LCD Category List

1. In Hyperspace, open the LCD Category Value (I EPP 190) category list (search: Category List Maintenance).
2. Add a category value for each LCD rule set that you're going to use.

For instructions, refer to the Modify a Category List's Values topic.

Load Local Coverage Determination (LCD) Data into Epic

You need to load your vendor's LCD data into your system. Vendors supply this information using the following types of files:

- Covered files, which list the diagnoses and other conditions for which Medicare covers certain procedures.
- Not-covered files, which list the diagnoses and other conditions for which Medicare does not cover certain procedures. These files also include data related to excluded services.

Vendors typically provide both a covered and a not-covered file, which work together:

- If a procedure appears only in the covered file, Epic treats any diagnoses not listed with that procedure as not-covered.
- If a procedure appears only in the not-covered file, Epic treats any diagnoses not listed with that procedure as covered.
- If a procedure appears in both files, Epic treats any diagnoses not listed with that procedure in the covered file as not-covered.
- If a procedure doesn't appear in either file, Epic treats that procedure as covered for any diagnoses. If a rule does exist for a certain procedure but a vendor doesn't include data for it in either file, the only way for Epic to generate an alert for that procedure is through an override. Refer to the Override LCD Data for Specific Procedures topic for more information.

Prerequisites

Epic can import only text files. Most vendors provide data in text files, but Experian Health might supply you with Microsoft Access files. To load these Access files, you need to export the Access tables to a text file before loading them into your system.

Depending on the data you've purchased, Experian Health supplies you with various types of Access tables. Epic supports information from the following:

- Tables beginning with the letter I contain the covered diagnoses.
- Tables beginning with the letter X contain the not-covered diagnoses.
- Tables beginning with the letter A contain CPT/HCPCS codes that appear in more than one medical necessity policy or have multiple meanings in a single policy.
- Tables beginning with the letter H contain supplemental mapping information for use with Resolute Hospital Billing.

Tables beginning with the letter Q contain the Advance Beneficiary Notice (ABN) statements.

Note: Tables beginning with the letter Q contain Advance Beneficiary Notice of Noncoverage (ABN) statements and information about rule criteria that are not handled in the Experian Health covered and not-covered tables, such as rules with frequency limits and/or age, sex, or multiple diagnosis requirements.

The Epic file format provides standard support for many of the additional criteria described in the Q table within covered and not-covered files.

If you receive files from Experian Health in an Epic file format, you have the following text files to load into the system:

- A covered file
- A not-covered file
- The A table
- In some cases, an H table

You also receive an Access version of the Q table for reference.

> **!** You cannot use Data Courier or Content Management to move CCI or LCD edit data between environments in Epic. You must complete the steps to load CCI and LCD data in each separate environment where it is needed.
>
> Also note that loading CCI or LCD data for a specific category overwrites all previous data for that category for your entire facility.

Load Covered and Not-covered Files

1. Use FTP (ASCII format) to move the data files to your Epic server.
2. Follow one of the following paths in text:
   - In Resolute Professional Billing, follow the path Administrator's Menu > Master File Maintenance > CCI/LCD Load Related.
   - In Resolute Hospital Billing, follow the path Main menu > Master File Maintenance > CCI/LCD Load Related.

- In Clinical Administration, follow the path Billing, Coverage > CCI/LCD Load Related.
- In Cadence Text, follow the path Cadence Management > System Definitions Edit > LCD Load.

3. Select LCD Load (Covered & Not Covered files).
4. At the LCD category prompt, enter the LCD Category Value (I EPP 190) associated with the vendor whose file you are loading.
5. At the Code set prompt, enter the code set, such as ICD-10, associated with the files from your vendor.
   - Code sets are stored in the Code Set (I EDG 95) category list. If you are using the standard ICD-10 code set, enter ICD-10-CM.
6. At the LCD Covered file prompt, enter the server path to the covered file from your vendor.
7. At the LCD Non-Covered file prompt, enter the server path to the not-covered file from your vendor. If your vendor did not provide a not-covered file, create an empty text file and enter the server path to that file.

Verify That the LCD Import Was Successful

You can run the LCD Report to view a summary of coverage information for specific CPT codes or for all CPT codes to verify that you've successfully loaded LCD information. The LCD Report shows information about all procedures for which you've loaded coverage information.

1. In text, follow one of the paths below:
   - From Resolute Professional Billing: Administrator's Menu > Master File Maintenance > CCI/LCD Load Related
   - From Resolute Hospital Billing: Main menu > Master File Maintenance > CCI/LCD Load Related
   - From Clinical Administration: Billing, Coverage > CCI/LCD Load Related
   - From Cadence: Cadence Management > System Definitions Edit > LCD Load
2. Select LCD Report.
3. Enter the following information:
   - In the LCD category field, enter the LCD Category Value (I EPP 190) associated with the payer whose file you loaded. You can specify multiple categories at this prompt, but you must enter them one at a time.
   - In the Code set field, enter the code set.
   - In the CPT® Code field, enter the CPT code for which you want to run the report. You can specify multiple CPT codes at this prompt in a comma-delimited list. To run the report for all CPT codes, enter ALL, which appears by default.
   - In the "Printout to" field, specify whether to view the report on the screen, print the report, or save the report as a file. Rather than printing the report, we recommend printing to the screen or saving the report to a file because the medical necessity files are very large.

Load Additional LCD Information into Epic

If you receive files from Experian Health, load the following additional files:

- LCD Description/A Tables files. These files contain tables beginning with the letter A. These tables contain information related to CPT/HCPCS codes that appear in more than one medical necessity policy or have multiple meanings in a single policy. Loading these files into Epic allows the system to check all rules and policies associated with the affected codes.

> **!** If you don't load the LCD Description/A Tables files into Epic, the system does not check against the rules for CPT/HCPCS codes that appear in it.

- LCD Dash Code/H Tables files. These files contain tables beginning with the letter H. When available and licensed, these files provide additional information for use in conjunction with Resolute Hospital Billing LCD claim edits. In conjunction with claims processing, the system in some cases can use the additional information in the file to identify which one of multiple policies, or which rule among multiple rules within a single policy, applies to a particular CPT/HCPCS code. You can improve the accuracy of your medical necessity checks by loading LCD Dash Code files to use this supplemental mapping information.

Load the Data

1. In text, follow one of these paths:
   - From Resolute Professional Billing: Administrator's Menu > Master File Maintenance > CCI/LCD Load Related
   - From Resolute Hospital Billing: Main menu > Master File Maintenance > CCI/LCD Load Related
   - From Clinical Administration: Billing, Coverage > CCI/LCD Load Related
   - From Cadence: Cadence Management > System Definitions Edit > LCD Load
2. Select LCD Descriptions - for dashed codes.
3. At the LCD Category prompt, enter the LCD Category Value (I EPP 190) associated with the payer whose file you are loading.
4. At the LCD description file prompt, enter the server path to the LCD description file from your vendor.
5. At the LCD dash code file prompt, enter the server path to the supplementary mapping file from your vendor.
   - If you don't have an H table file, leave this blank.
6. At the Effective Date prompt, enter the date on which Epic should start using the information you're loading.

> **i** The files contain effective dates for most of the data. The date you enter is used only if the data in the file:
>
> - Has an effective date that's older than the effective date you enter.
> - Has no effective date.
>
> To have the system use the effective dates in the file whenever they are present, enter a date far in the past, such as 10/1/2015, the date in the United States for the transition to ICD-10-CM.

(Optional) Map Procedures to a Specific Policy or Rule

Some CPT/HCPCS codes, particularly those that cover a range of distinct procedures, appear in multiple LCD policies or multiples rules within a single policy. For example, CPT 86316 refers to cancer antigen assay procedures in general, but there could be multiple policies that apply only to assays for a specific form of cancer.

Epic checks procedures against all associated policies and rules in the LCD data you've loaded into Epic, including the additional files described in the Load Additional LCD Information into Epic topic for organizations loading Experian LCD data files.

You can adjust this default behavior if needed to configure a procedure record such that your system checks that procedure against only a certain policy or rule when performing LCD checks. For example, a code for counseling might appear in two policies, one for clinic-based counseling and another for hospital outpatient counseling. If your organization offers clinic-based counseling only, you might want to map your existing procedure to the policy for clinic-based counseling, because the other policy cannot apply.

Map Procedures to Policies or Rules

> This setup configures a specific procedure (EAP) record only and doesn't affect LCD checks for different procedure records representing similar procedures, even if that procedure record uses the same CPT or HCPCS code.
>
> If your providers aren't selecting the right procedure record, you can make it easier to select the right procedure record with clear naming conventions, preference lists, and configuration of procedures in a panel procedure.

To map a procedure record to a single LCD policy or rule:

1. Identify the policy/rule key to check during LCD checks. You might identify the policy/rule key in one of the following ways:
   - If you received the Unmapped Dash Codes report after loading an LCD file, the code in the leftmost column has the format <CPT>-<Policy/Rule Key>
     - This report indicates that additional configuration is possible, but not required, for certain CPT/HCPCS codes. You might not need, or want, to map all unmapped dash codes if you receive this report. If you aren't sure, contact your Epic representative.
   - If your files are from Experian, contact your Epic representative and mention SLG 1159984.
   - If your files are from a vendor other than Experian, you can open and examine the Epic-format LCD file you loaded most recently. The policy/rule key for each LCD edit check is found in the field preceding the field containing policy or rule descriptions. For example, a row that links CPT 92002 to LCD Rule 885L123 might include these pieces (skipping over the middle part):
     - 92002, . . . ,885L123,Allergy Testing and Allergy Immunotherapy (LCD L19671)
2. In Hyperspace, open or create a procedure record representing a specific procedure that should be checked against only a single LCD policy or rule.
3. Go to the General form.
4. Enter the procedure code, a hyphen, and the policy/rule key you identified in step 1 in the LCD code (I EAP 2012) field. In the example above, you would enter 92002-885L123 in the LCD code field.

> If you populate the LCD code (I EAP 2012) field, Epic doesn't check this procedure against LCD edit checks with different policy/rule keys during LCD checking.

Load LCD Modifiers into Epic

> **!** You cannot use Data Courier or Content Management to move CCI or LCD edit data between environments in Epic. You must complete steps to load CCI and LCD data in each separate environment where it is needed.
>
> Also note that loading an LCD modifier data file overwrites all existing LCD modifier data for your facility.

Within medical necessity workflows, Epic can assign modifiers, such as a GA or GZ modifier, to orders and charges based on the status of the associated ABN. Modifiers indicate to Epic that an ABN has been collected and therefore additional medical necessity warnings or errors can be suppressed. Modifiers can also trigger a variety of billing actions. For UB billing, modifiers can trigger the addition of Occurrence Code 32 with the correct date or multiple instances of Occurrence Code 32 with different dates when necessary.

The ABN and LCD Modifier Loads can be used together to control how modifiers work in medical necessity workflows.

- Use the ABN Modifier Load to control how modifiers are automatically assigned to orders and charges based the ABN status.
  - For more information on loading ABN modifiers, refer to the Load ABN Modifiers into Epic topic.
- Use the LCD Load to control which modifiers allow an order or charge to bypass medical necessity checking.

For example, if the patient has signed an ABN, it's no longer necessary to show medical necessity warnings to Epic users. The system can attach a GA modifier for ABNs with a status of 3-ABN Signed, Service Accepted. The presence of the GA modifier prevents future medical necessity warnings from appearing.

Orders or charges with designated modifiers can bypass medical necessity checks in workflows such as order entry, coding, charge review, DNB/stop bill, and claims processing. Checks are bypassed because the presence of a modifier indicates that the ABN has been collected.

Create an LCD Modifier Flat File

As an initial step, create a comma-delimited flat file containing the following information. Each line in the flat file defines a single set of conditions where medical necessity checks are bypassed.

- LCD category. Determines which LCD rule set is affected. Specify a category number from the LMRP Category Value (I EPP 190) item.
- Error type. Determines which error type is affected. Specify type 2 to affect non-covered services. Specify type 4 to affect statutory exclusions.
- Modifier code. Determines which modifier causes medical necessity checking to be bypassed. Specify a modifier name as defined in the Modifier Code field (I MOD 40) in the modifier record.
- Effective date. Determines the initial service date for which this LCD rule is used. If set to null, the default effective date is 01/01/1840.
- Termination date. Determines the final service date for which this LCD rule is used. If set to null, the default end date is 01/01/2300.

In the following example, the load affects two LCD rule sets: 10001 and 10002. The load configures three modifiers (GA, GZ, and DBM) to bypass medical necessity checking. Modifier DBM might be a modifier created by your organization and applied in cases where the patient agrees to accept financial responsibility for the items or services without attempting to bill Medicare. DBM is used starting September 1, 2008, and the GA and GZ

modifiers are effective starting January 1, 2002.

10001,2,GA,1/1/2002, " "

10001,2,GZ,1/1/2002, " "

10001,2,DBM,9/1/2008, " "

10002,2,GA,1/1/2002, " "

10002,2,GZ,1/1/2002, " "

10002,2,DBM,9/1/2008, " "

Load Your LCD Modifier File into Epic

After creating your flat file, follow these steps.

1. Access one of the following screens in text:
   - In Resolute Professional Billing, follow the path Administrator's Menu > Master File Maintenance > CCI/LCD Load Related
   - In Resolute Hospital Billing, follow the path Main menu > Master File Maintenance > CCI/LCD Load Related
   - In Clinical Administration, follow the path Billing, Coverage > CCI/LCD Load Related
2. Select the LCD Modifier Load.
3. Enter the file path for the flat file you created.

Check Charges for Unnecessary Modifiers

Claim edit checks, by default, respect modifiers indicating that a charge should bypass medical necessity checking, so those charges aren't evaluated for medical necessity during claims processing. In some cases, you can add a modifier that's needed for a charge to bypass medical necessity checks, but later the charge would pass those medical necessity checks without the modifier. For example, charges that wouldn't initially pass medical review might later if:

- Rule or policy changes occur
- Subsequent coding review and changes cause the charge to meet medical necessity requirements.

Certain payers, such as Medicare, deny payment for charges with these unnecessary modifiers attached. Refer to the Check for Unnecessary Modifiers During Claim Processing topic to send those charges with unnecessary modifiers to claim edit workqueues.

Report on LCD Modifiers Loaded in Epic

Starting in May 2021

You can use a utility to generate a list of LCD modifiers you have loaded into Epic if you no longer have the original import file or want to see how they are formatted. You can also use this utility to generate a modifier import file based on the current data in Epic.

1. In Professional Billing Text, go to Master File Maintenance > CCI/LCD Load Related > LCD Modifier Report.
2. Choose from the following options:
   a. Print a detailed report to the screen
   b. Print a detailed report to a file

c. Generate a modifier import file based on the current data in Epic

3. If you choose to print the report, enter one or more LCD categories for which you want to run the report.
4. If you choose to print the report to a file or generate an import file, enter a file path when prompted.

(Optional) Create Your Own LCD Data Files

Although most organizations purchase data files from a vendor, it is possible to create your own and load them into Epic. You must have separate files for covered and non-covered services. In these text files, each line represents a separate LCD policy or rule, and every line is a comma-delimited string of the following 19 items:

1. CPT Code (Required). The CPT code for which the LCD policy applies.
2. Exclusion Type (Non-Covered Files Only). Leave this field blank for the covered file. Set it to 0 or leave it blank for services that don't require ABNs or services where the provider is liable for the cost. Set it to 1 for Statutory Exclusions.
3. ICD Code Range Start (Required). Enter the first diagnosis that is covered/non-covered in the policy represented by this line.
4. ICD Code Range End (Required). Enter the last diagnosis that is covered/non-covered in the policy represented by this line.
5. URL (Optional). For policies where a decision is necessary, enter a link to instructions on determining whether a claim should qualify for this policy.
6. Deprecated. Not used, leave blank.
7. Deprecated. Not used, leave blank.
8. Code Effective Date (Required). The first date the policy applies.
9. Code Termination Date (Optional). The last date the policy applies.
10. Deprecated. Not used, leave blank.
11. Frequency Procedure Limit (Optional). Enter the maximum number of procedures allowed within a specified duration.
12. Frequency Time Span Unit (Optional). Enter one of the following letters representing the unit of time for checking the frequency:
    - D (Day)
    - M (Month)
    - Y (Year)
    - C (Course of treatment)
    - L (Lifetime)
13. Frequency Time Span Number (Optional). Enter an integer number representing how many time span units to consider when checking the frequency limit.
14. Sex (Optional). Enter either M (for males) or F (for females) for policies that apply only for patients of that gender.
15. Age Min (Optional). For policies that apply only to patients above a specific age, enter the minimum age at which a patient can qualify for this policy.
16. Age Max (Optional). For policies that apply only to patients below a specific age, enter the maximum age at which a patient can qualify for this policy.
17. Age Unit (Optional). Specify the unit of time used by the Age Min and Age Max using one of the following

letters:

- D (Day)
- M (Month)
- Y (Year)

18. Policy/Rule Key (Required). The policy number defined by your Part A and B MAC.
19. Policy/Rule Name Description (Required). Enter the explanation of this policy that appears during coding validation.

Example Line

For example, a hypothetical policy 885L123 could be represented by the line:

92002,1,366.10,366.19,https://www.epic.com,,,09/01/1998,04/15/2001,,3,Y,1,F,35,62,Y,885L123,Allergy Testing and Allergy Immunotherapy (LCD L19671)

This fictional policy:

- Applies to CPT 92002 with a diagnosis in the range 366.10-366.19
- Was in effect between 09/01/1998-04/15/2001
- Has a limit of 3 procedures per year
- Applies only to female patients between the ages of 35-62

Associate LCD Rule Sets with Payers, Plans, and Service Areas

The LCD data you've loaded from your vendor includes rule sets based on regions and differences in Medicare plans, so you need to define which rule sets apply to your payers and plans. You can control which rule set your system uses for medical necessity checking based on:

- Payer
- Plan
- Service area or facility

Specify Which Rule Set Applies to a Payer or Plan

> **!** For the purposes of medical necessity checking, the terms “Medicare Part A rules” and “Medicare Part B rules” don’t correspond to Medicare Part A and Medicare Part B coverage. Both of these rule sets pertain to Medicare Part B services and the conditions under which Medicare deems services medically necessary. In general, the Medicare Part B rules pertain to Part B services that are delivered at a facility other than a hospital, such as a clinic. The Medicare Part A rules pertain to Part B services delivered by a hospital in an outpatient department.

You need to prepare the payer and plan records associated with Medicare to prompt for medical necessity checking. You can specify distinct rule sets for the Fiscal Intermediary (Medicare Part A) rules and Carrier (Medicare Part B) rules by payer or benefit plan and override the default rule sets for a particular place of service, location, or service area.

1. In Hospital Billing or Professional Billing Text, open a payer or benefit plan record.
   - Payer: Master File Maintenance > Payor
   - Plan: Master File Maintenance > Benefit Plan Related > Benefit Plan
2. Go to the LCD Settings screen.
3. If you are:
   - Using only a single rule set, enter the LCD rule set associated with this payer or benefit plan in the LCD Category (I EPM 170/I EPP 190) field.
   - Using distinct rule sets for Part A and Part B, enter them in the Default LCD for FI (I EPM 173/I EPP 193) field and the Default LCD for Carrier (I EPM 174/I EPP 194) field, respectively.
   - Using different Part A or Part B rule sets by location, fill out the LCD Rule Sets by Location table:
     - In the Rule Set Type (I EPM 175/I EPP 195) field, enter either 1-Fiscal Intermediary for Part A or 2-Carrier for Part B.
     - Enter a service area or location in the SA/Location (I EPM 176/I EPP 196) field or the POS (I EPM 178/I EPP 198) field. You can't enter something in both the SA/Location field and the POS field.
     - In the LCD Rule Set (I EPM 177/I EPP 197) field, enter the rule set associated with that service area, location, or place of service.

Specify Which Rule Set Applies to an Area of Your Facility

You can specify rule sets in department, location, or service area records to use different rule sets in different areas of your organization. For example, if your organization operates across different regions, you can use the same payer and plan records throughout your organization to use appropriate rule sets based on the service areas that correspond to each region.

Considerations

Before you begin, determine how your organization needs to use rule sets across different areas of your organization.

When determining whether to search for a fiscal intermediary or carrier rule set, Epic refers to the LCD Rule Set Types field on the LCD Rule Set Type screen of the department, location, or service area record. You can use this setting to specify fiscal intermediary, carrier, or both rule sets. You can define this value at the department level or at the place of service, location, or service area levels. Epic checks these settings in the following order: department > place of service > location > service area.

Next, Epic searches associated payer and plan records for a matching rule set. To determine which rule set to use, Epic refers to settings in the following order:

- Plan-level LCD Rule Sets by Location table
- Payer-level LCD Rule Sets by Location table
- Plan-level Default LCD for FI/Carrier fields
- Payer-level Default LMPR for FI/Carrier fields
- Plan-level LCD Cat field
- Payer-level LCD Cat field

1. Access the department, place of service, location, or service area for which you want to specify a rule set

type.

2. On the LCD Rule Set Type screen, enter the rule sets (fiscal intermediary, carrier, or both) to include in LCD checking.

Override LCD Data for Specific Procedures

Prerequisites

LCD overrides have no effect if you haven't yet loaded data for at least one LCD rule set into Epic, but you can create overrides for procedures without an associated rule in your LCD data file.

Customize the LCD data provided by your vendor to fit the policies of your facility by creating override records. Override records cause the system to treat a procedure-diagnosis combination as covered even if the data associated with an LCD rule set indicates that it is non-covered, or vice versa. You associate these overrides with a benefit plan, payer, or service area. Because this override information is stored separately from vendor data, you don't need to customize the information again when you load new data from your vendor.

For example, if a particular rule is not included in the rule set that your vendor provides or you interpret a rule differently from your vendor, you can configure an LCD override to perform LCD checking for that rule without it being included in the LCD data loaded into Epic.

Any particular benefit plan, payer, or service area can be associated with only one CCI/LCD edit check profile. The profile is tracked over time, which gives you the option of using different override records depending on service date. For instance, you might have one profile for Aetna and another for Blue Cross starting in 2016, but they can both share the same override profiles starting in 2018. Epic uses the service date of an entered procedure to determine which contact in a profile to use.

Alternative Method

This topic describes creating an override record in Hyperspace. You can also create override records by loading a comma-separated value (.csv) file or, starting in November 2022 and in May 2022 with special update E10211722, via an import specification in text. For more information on loading LCD override data with an import or .csv file, refer to the Upload Edit Check Information into an Override Record topic.

Consider How to Configure Your Override

For a procedure that is considered never medically necessary or is associated with a contraindicated diagnosis that always makes that procedure medically unnecessary, it's sufficient to specify not-covered conditions only.

More commonly, LCD rules consider a procedure medically necessary if it's associated with one of a particular set of diagnoses, regardless of any other associated diagnoses. For this kind of override, specify both covered and not-covered conditions for the service. Otherwise, the system incorrectly treats the service as not-covered if it is associated with a covered diagnosis and some other not-covered diagnosis.

Create an LCD Override Record

1. In Hyperspace, create an LCD override record or open an existing one (search: CCI/LCD Edit Check Override or Regulatory Edit Override). If you're creating one, choose 2-LCD for the Type (I HCO 100) field.
2. To override a specific procedure code and diagnosis combination, click Add Line and complete the following:
   - Enter a procedure code in the CPT®/HCPCS Code field.

- Enter a diagnosis code set, such as ICD-10-CM, in the Diagnoses Code Set (I HCO 210) field.
- Start diagnosis code range and End diagnosis code range.
  - Enter a diagnosis code range of 1-ZZZ to include all diagnoses in your override record.
- In the Allowed? (I HCO 205) field, enter 1-Yes or 2-No.

3. Repeat step 2 as needed to override other specific procedure and diagnosis combinations.
4. Click Accept to save and close the override record.

Add Your LCD Override Record to Your CCI/LCD Edit Check Profile

1. In Hyperspace, open a CCI/LCD edit check profile or create one (search: CCI/LCD Edit Check Profile or Regulatory Edit Profile).
2. Enter your LCD override record in the LCD override (I HCP 110) field.
3. Enter one or more service areas, payers, or plans for which this LCD/CCI override applies.
4. Optionally, if you want to override CCI edits or ABN messages for the same service areas, payers, and plans, enter a CCI override record in the CCI override (I HCP 100) field or an ABN override record in the ABN override (I HCP 120) field.
   - For more information on creating a CCI override record, refer to the Override CCI Data for Specific Procedures topic.
   - For more information on creating an ABN override record, refer to the Display an Explanation for Why a Procedure or Service Isn't Covered topic.

Notify Users of LCD Errors During Claims Processing

Starting in August 2018

If the diagnosis code set (for example, ICD-10-CM) used for medical necessity checks during claims processing or elsewhere does not match the code set for which the Local Coverage Determination (LCD) data was loaded in your system, you can send an error message to the analyst responsible for LCD data management.

1. In Resolute Hospital Billing Text or Resolute Professional Billing text, open your service area or facility profile (Administrator Menu > Service Area Profile > Service Area Settings).
2. Go to the MUE System-wide Settings screen.
   - You can press Home+F9 to navigate to item 19691.
3. In the LCD Error Notification Setting section, add the following:
   - User to Notify (I EAF 19691). Enter the user to send the LCD error notification to.
   - Email Type (I EAF 19692). Choose whether to send an external email or In Basket message to the user you choose to notify.
   - Error Email Sender Address (I EAF 93931). Starting in November 2020, enter the email address that emails are sent from. By default, emails come from epic.com. If your organization blocks emails from external domains, enter an email address with your organization's domain name so users receive messages.
4. If you choose External email or Both, verify that an email address is present in the user's user record. In Hyperspace, open a user record (search: User Security). Enter an email address in the E-mail address (I EMP 150) field under the Demographics section of the Basic Information activity

Assign Ownership of LCD Errors

Prerequisites
Before you perform this setup, refer to the Decide When to Trigger Edits Based on Edit Ownership topic to decide when to trigger LCD error checking.

Based on the stage of the revenue cycle at which you plan to trigger LCD error checking, complete the setup in one of the following topics:

- Review LCD Errors in Charge Review Workqueues
- Perform LCD Checks During DNB Edit
- Perform LCD Checks During Coding Validation
- Perform CCI and LCD Checks During Claims Processing

Then, complete the setup in the Route LCD Errors to a Workqueue to make sure that the appropriate users correct LCD errors. For example, you can use properties to route errors to the originating department.

Review LCD Errors in Charge Review Workqueues

Prerequisites
Before completing the setup for this topic, ensure that LCD edits have been loaded and enabled for the payer or plan associated with the charges you want to check.

Charge review staff can review LCD checks during coding in charge review workqueues. To do so, add a rule to identify LCD errors to your charge review workqueue.

In Professional Billing Charge Review

In the Foundation System
To see how we've configured an LCD check during charge review in the Foundation System: 1. Log in to the Foundation Hosted environment as your Professional Billing administrator (PBADM). 2. Open rule 208008701-(Coding) LCD Not Covered (All Dx) (PB Only) (search: Rule Editor).

1. Go to Epic button > Professional Billing > Workqueues. The Professional Billing Workqueue List opens.
2. On the Charge Review tab, select a workqueue and click Workqueue Settings.
3. On the Workqueue Rules form, click Add Rule. Add one of the following standard rules:
   - 75-LCD Not Covered (All Dx). This rule performs LCD checks for all diagnoses in the charge session.
   - 87-LCD Not Covered (All Dx) (PB Only). This rule performs medical necessity checks for all diagnoses in the charge session, using only the Carrier (Part B) LCD rule set.

In Hospital Billing Charge Review

1. Create a Hospital Billing rule (search: Hospital Billing Rule) and configure it this way:
   - Property: choose one of the following, depending on whether you want to check frequency warnings as well:
     - Charge Session\LCD Check Failed
     - Charge Session\LCD Check Failed + Frequency Warnings

- Operator: = (equal to)
- Value: Yes

2. Add this rule to an HB charge review workqueue. For more information, refer to the Create a Workqueue topic.

Perform LCD Checks During DNB Edit

In the Foundation System
To see how we've configured an LCD coding validation check in the Foundation System: 1. Log in to the Foundation Hosted environment as your Hospital Billing administrator (HBADM). 2. Open extension 1084078002-CCI Edits (search: Extension).

Perform LCD checks during DNB Checking:

1. In Chronicles, create a copy of extension 40780-HB DNB CCI/LCD Edits.
2. Set the Type of Checks parameter to LCD.
   - Optionally, you can also configure your extension to check CCI edits, modifiers, and add-on codes. If you aren't sure whether to do so, refer to the Decide When to Trigger Claim Edits Based on Edit Ownership topic for help deciding.
3. In Hyperspace, open your Hospital Billing Profile (search: Hospital Billing Profile).
4. On the DNB Check form, add your extension in the DNB Check (I HSD 300) field.
5. Enter a type of Warning or Error, and enter an owning area according to your organization's workflows.

Decide Whether to Run LCD Checks for Inpatient Part B Accounts During DNB Edit

Most inpatient hospital accounts don't qualify for LCD checks. However, inpatient hospital accounts with Medicare Part B coverage often include services rendered after the Part A benefits exhaust date, and these might be eligible to be rebilled to Medicare Part B. To see how you can use Epic to proactively rebill charges with a Part A coverage to Medicare Part B, refer to the A/B Rebilling Setup and Support Guide. LCD checks apply to services billed to Medicare Part B.

Extension 40780-HB DNB CCI/LCD Edits and copies of it, which run during DNB edit, run on inpatient hospital accounts with charges eligible for Medicare Part B for charges after the exhaust date if the Include Part B? parameter is set to 1-Yes. To have these edits appear in workqueues, you must update your rules that identify LCD edits to include inpatient hospital accounts with Medicare Part B coverage.

The following general properties (HFP) have the Check Part B? parameter set to 0-No by default. We recommend setting it to 1-Yes to have these properties consider LCD edits for inpatient Part B accounts:

- 97214-LCD Check Failed
- 97216-CCI or LCD Check Failed
- 97217-LCD Check Failed + Frequency Warnings
- 97219-CCI or LCD Check Failed + Frequency Warnings
- 97224-CCI or LCD Check Failed + Add-On Checks
- 97225-CCI or LCD Check + Frequency Warnings + Add-Ons

In February 2024 and earlier, the 12th parameter of the following Hospital Billing properties (HSP) controls

whether they consider inpatient Part B accounts. We recommend setting it to 1 to check inpatient Part B accounts for LCD edits:

- 901-LCD Check Failed
- 902-CCI or LCD Check Failed
- 907-LCD Check Failed + Frequency Warnings
- 908-CCI or LCD Check Failed + Frequency Warnings
- 959-CCI or LCD Check Failed + Add-on Checks
- 967-CCI or LCD Check Failed + Frequency Warnings + Add-on Checks

For any Rule Editor rules (CER) that you use to route DNB edits and coding validation edits related to LCD checks to workqueues, update the properties that identify LCD edits so that they consider inpatient Part B accounts:

1. In Hyperspace, go to the Rule Editor (search: Rule Editor) and open an affected rule.
2. Click the property that checks for CCI or LCD edits to open its parameters for editing.
3. Set the Check Part B? parameter to 1-Yes.
4. Click Accept to save and close your rule.

For any Hospital Billing rules (BWR) that you use to route DNB edits and coding validation edits related to LCD checks to workqueues, update the properties so that they consider inpatient Part B hospital accounts.

Starting in May 2024:

1. If you already have a custom general property, skip this step and use that one. Otherwise, in Hyperspace, open Property Editor (search: Property Editor) and create a copy of the property (HFP) you use to check LCD edits in your rule.
2. In the Check Part B? field, select Yes.
3. Click Save and Finish.
4. Edit your rule to use your edited property.

In February 2024 and earlier:

1. If you already have a custom rule property, skip this step and use that one. Otherwise, in Chronicles (HSP), create a copy of the property you use to check LCD edits in your rule.
2. In Hyperspace, go to the HB Property Editor activity (search: HB Property Editor).
3. Find the property you created in step 1 and click Edit.
4. Enter 1 for the 12th parameter, which controls checking inpatient Part B accounts.
5. Click Save and Finish.
6. Edit your rule to use your edited property.

Perform LCD Checks During Coding Validation

In the Foundation System

To see how we've configured an LCD coding validation check in the Foundation System:

1. Log in to the Foundation Hosted environment as your Hospital Billing administrator (HBADM).
2. Open extension 2314125301-Run CCI/LCD Edits with Addon Code Checks (search: Extension).

Run LCD edit checks during coding validation with a coding validation extension in the Hospital Billing Profile:

1. In Chronicles, create a copy of extension 41253-Run CCI/LCD Edits.
2. In Hyperspace, open your extension for editing (search: Extension).
3. Using the help text to guide you, set the parameters for your use case. In particular:
   - Ensure that the RUN LCD CHECKS? is set to 1-Yes.
4. Open your Hospital Billing Profile (search: Hospital Billing Profile).
5. On the Hospital Coding > Validation Checks form, enter your extension in the Validation Extension (I HSD 932) field.
6. Specify whether this validation check is an error or a warning in the Err/Warn (I HSD 936) field.

Decide Whether to Run LCD Checks for Inpatient Part B Accounts During Coding Validation

Considerations
Running LCD checks during coding validation can add delays to coding workflows.

Most inpatient hospital accounts don't qualify for LCD checks. However, inpatient hospital accounts with Medicare Part B coverage often include services rendered after the Part A benefits exhaust date, and these might be eligible to be rebilled to Medicare Part B. To see how you can use Epic to proactively rebill charges with a Part A coverage to Medicare Part B, refer to the A/B Rebilling Setup and Support Guide. LCD checks apply to services billed to Medicare Part B.

You can configure a copy of the following coding validation extensions so they run over inpatient accounts with charges eligible for Medicare Part B during coding validation:

- 41253-Run CCI/LCD Edits
- 41256-LCD Checks
- 41258-LCD Checks + Frequency Warnings
- 45787-LCD Checks - Alternate
- 45788-LCD Checks + Frequency Warnings - Alternate

Update your copy of one of these extensions to run on inpatient hospital accounts with charges eligible for Medicare Part B for charges after the exhaust date:

1. In Hyperspace, open your copy of extension 41253, 41256, 41258, 45787, or 45788. If you're not sure which one that is, you can use a report based on Reporting Workbench report template 34090-Extension Search to look for extensions where the code to execute (I LPP 100) field contains $$CCILCD^KHCODVC6.
2. Set the Include Part B? parameter to 1-Yes.
3. Click Accept.

To have these edits appear in workqueues, you must update your rules that identify LCD edits to include inpatient hospital accounts with Medicare Part B coverage. The following general properties (HFP) have the Check Part B? parameter set to 0-No by default. We recommend setting it to 1-Yes to have these properties consider LCD edits for inpatient Part B accounts:

- 97214-LCD Check Failed
- 97216-CCI or LCD Check Failed
- 97217-LCD Check Failed + Frequency Warnings

- 97219-CCI or LCD Check Failed + Frequency Warnings
- 97224-CCI or LCD Check Failed + Add-On Checks
- 97225-CCI or LCD Check + Frequency Warnings + Add-Ons

In February 2024 and earlier, the12th parameter of the following Hospital Billing properties (HSP) controls whether they consider inpatient Part B accounts. We recommend setting it to 1 to check inpatient Part B accounts for LCD edits:

- 901-LCD Check Failed
- 902-CCI or LCD Check Failed
- 907-LCD Check Failed + Frequency Warnings
- 908-CCI or LCD Check Failed + Frequency Warnings
- 959-CCI or LCD Check Failed + Add-on Checks
- 967-CCI or LCD Check Failed + Frequency Warnings + Add-on Checks

For any Rule Editor rules (CER) that you use to route coding validation edits related to LCD checks to workqueues, update the properties that identify LCD edits so that they consider inpatient Part B accounts:

1. In Hyperspace, go to the Rule Editor (search: Rule Editor) and open an affected rule.
2. Click the property that checks for LCD edits to open its parameters for editing.
3. Set the Check Part B? parameter to 1-Yes.
4. Click Accept to save and close your rule.

For any Hospital Billing rules (BWR) that you use to route coding validation edits related to LCD checks to workqueues, update the Hospital Billing rule properties so that they consider inpatient Part B hospital accounts.

Starting in May 2024:

1. If you already have a custom general property, skip this step and use that one. Otherwise, in Hyperspace, open Property Editor (search: Property Editor) and create a copy of the general property (HFP) you use to check LCD edits in your rule.
2. In the Check Part B? field, select Yes.
3. Click Save and Finish.
4. Edit your rule to use your edited property.

In February 2024 and earlier:

1. If you already have a custom HB property, skip this step and use that one. Otherwise, in Chronicles (HSP), create a copy of the property you use to check LCD edits in your rule.
2. In Hyperspace, go to the HB Property Editor activity (search: HB Property Editor).
3. Find the property you created in step 1 and click Edit.
4. Enter 1 for the 12th parameter, which controls checking inpatient Part B accounts.
5. Click Save and Finish.
6. Edit your rule to use your edited property.

Perform LCD Checks During Claims Processing

The same extensions control CCI and LCD edit checks during claims processing. Complete the setup in the Perform CCI and LCD Checks During Claims Processing topic to start running LCD edit checks during claims

processing.

Route LCD Errors to Workqueues

Based on which users at your organization are responsible for correcting LCD errors, you can route these errors to workqueues during DNB checking, coding validation, or claim edit checking. Rather than completing the setup in all three of these sections, set up only the method that routes errors to the right users.

Route LCD Errors to an HB Account Workqueue Using DNB Checks

In the Foundation System

To see our CCI and LCD rule for DNB errors in the Foundation System:

1. Log in to the Foundation Hosted environment as your Hospital Billing administrator (HBADM).
2. Open hospital billing rule 944-HIM DNB CCI/LCD Check (search: Hospital Billing Rule).

If you don't have that Foundation System record in your system, you can make a similar rule:

1. Create a hospital billing rule with a Record type of Account (search: Hospital Billing Rule).
2. Add property Account\DNB Errors - Current.
   - Line #: Any
   - Operator: = (equals)
   - Value: Enter the extension you use to evaluate accounts for LCD errors. If you don't already have one, refer to the Perform LCD Checks During DNB Edit topic to create one.
   - Error Message: free-text message
3. Create a hospital billing account workqueue and add your rule to it by completing the setup in the Create a Workqueue topic.

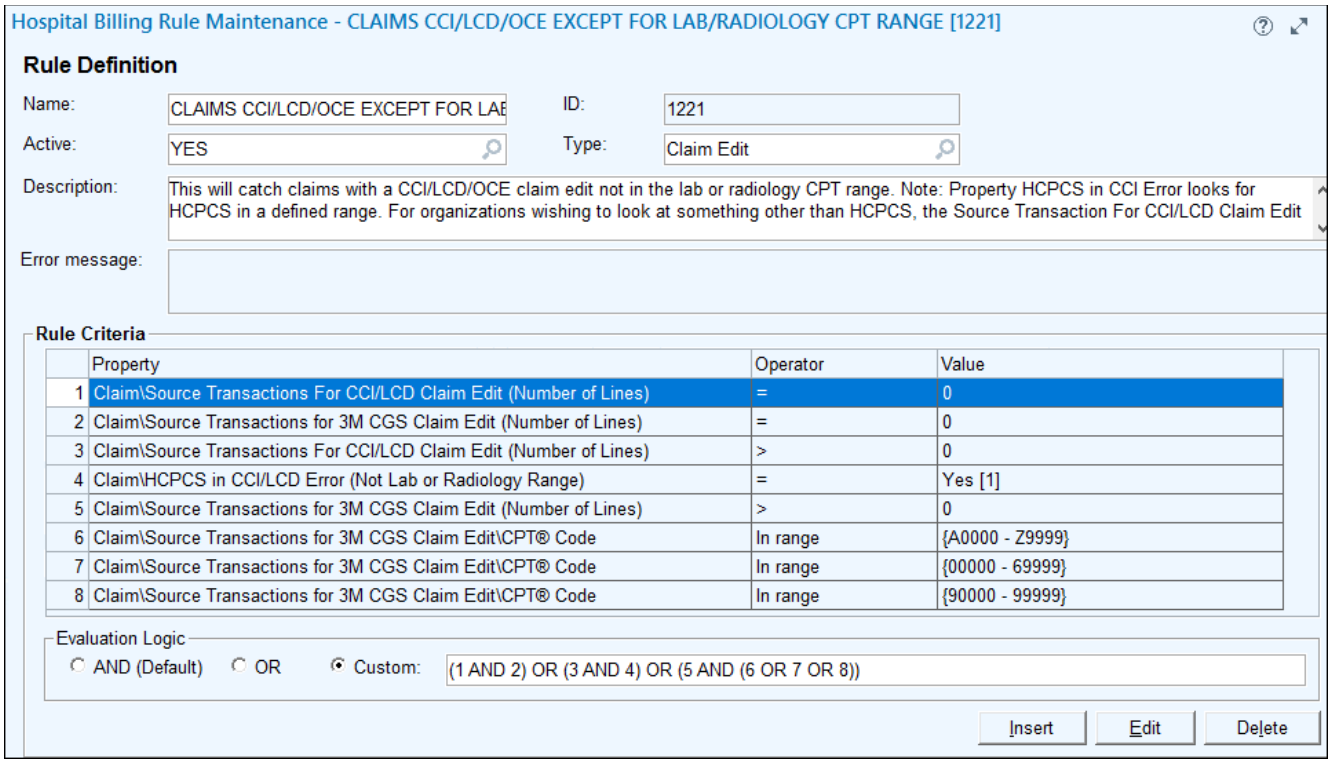
Route LCD Errors to an HB Account Workqueue Using Coding Validation Checks

1. Create a hospital billing rule with a Record type of Account (search: Hospital Billing Rule).
2. Add property Account\Coding Validation Errors.
   - Line #: Any
   - Operator: = (equals)
   - Value: Enter the extension you use to evaluate accounts for LCD errors. If you don't already have one, refer to the Perform LCD Checks During Coding Validation topic to create one.
   - Error Message: free-text message
3. Create a hospital billing account workqueue and add your rule to it by completing the setup in the Create a Workqueue topic.

Route LCD Errors to an HB Claim Edit Workqueue

Create a hospital billing rule with a Record type of Claim Edit (search: Hospital Billing Rule).If you don't have these Foundation System records in your system, you can make a similar rule:

1. Configure your rule like this:



2. Create a hospital billing claim edit workqueue and add you rule to it by completing the setup in the Create Claim Edit Workqueues topic.

Check Whether a Patient Has Exceeded the Frequency Limit for a Charge Code

Prerequisites

Before configuring LCD frequency checks, you must:

- Obtain LCD data from a vendor that includes frequency data.
- Complete the setup in the Load LCD Data and NDC Data into Epic topic.
- Complete the setup in the Perform CCI and LCD Checks During Claims Processing topic.

This topic discusses adding frequency edits in billing workflows after a medical service has been performed, which is most useful when used in addition to a pre-service alert that appears in clinical workflows. Before delivering a service with frequency limits, you can prompt the provider to present the Medicare beneficiary with an Advance Beneficiary Notice of Noncoverage (ABN) to take financial responsibility for any services outside of the frequency limits. To configure your system to generate ABNs for frequency limits, refer to the Determine When Frequency Check Errors Appear topic.

Note that frequency checks are not used for medication orders, so this topic applies only to procedures.

Check That Your LCD Edit Check Extensions Show Frequency Messages (HB Only)

You must configure the LCD edit check extensions for Hospital Billing to generate messages for frequency limits.

1. In Hyperspace, open your copy of extension 70482-HB Claim Edit Check - Hospital CCI/Specific LCD Edits (Dx Not Cvd) (search: Extension).
2. Set the Display Frequency Message? parameter in the extension to 1-Yes.

Professional Billing edit check extension 70315-CCI Edits/LCD Diagnosis Is Not Covered and copies of it always checks for frequency limits.

Add Rules to Your Charge Review Workqueue

1. In Hyperspace, access a charge review workqueue.
2. Add a rule with the following characteristics:
   - Set these parameters:
     - Check All Diagnoses: Enter 1-Yes or leave blank to count charges against the threshold using all diagnoses in the diagnosis table, regardless of the diagnoses that appear on a claim. Enter 0-No to use only the diagnoses that appear on a claim.
     - LCD Rule Set Type: Enter a value corresponding to the type of LCD rule set you loaded: 1-Fiscal Intermediary for Part A MACs, 2-Carrier for Part B MACs, or 3-Both.
     - Show Frequency Warning: Enter 1-Yes to show warnings.
   - Property: Charge Session >> LCD Not Covered
   - Operator: <> (not equal to)
   - Value: 0
   - Error Message: Charge Session >> LCD Not Covered

Add a Custom Claim Edit Check to Professional Billing Workflows

1. Identify the claim edit check extension you use to perform LCD checks on professional claims. For more information, refer to the Perform CCI and LCD Checks During Claims Processing topic.
2. In Hyperspace, go to the Claim Definition Manager (search: Claim Definition Manager).
3. In the Claim Edit Check tab, add your Professional Billing LCD claim edit check extension.
4. Access a charge review workqueue and create a workqueue rule:
   - Property: Charge Session >> Hospital Account >> Pending Hospital Temporary Charges (HTT) >> LCD Check Failed + Frequency Warning
   - Operator: =
   - Value: 1-Yes
   - Error message: Enter a free-text error message.

Add a Custom Claim Edit Check to Hospital Billing Workflows

1. Identify the claim edit check you use to perform LCD checks on hospital claims. For more information, refer to the Perform CCI and LCD Checks During Claims Processing topic.
2. In Hyperspace, go to Epic button > Admin > Hospital Billing Admin > Hospital Billing Profile.
3. Go to the Validation Checks form (in Epic 2017 and earlier versions, C&A Config > Validation Checks) and add your Hospital Billing LCD check extension.
4. Open the Charge Router Profile (search: Charge Router Profile). On the Review Workqueue Routing form, add an error rule:
   - Set these parameters:
     - Billing system: Enter 2-Resolute Hospital Billing.
     - Check all diagnoses: Enter 1-Yes to count charges against the threshold using all diagnoses in the diagnosis table, regardless of the diagnoses that appear on a claim. Enter 0-No to use

only the diagnoses that appear on a claim.

- LCD code type: Enter a value corresponding to the LCD rule set you loaded: 1-Fiscal Intermediary for Part A MACs, 2-Carrier for Part B MACs, or 3-Both.
- Show frequency warning: Enter 1-Yes.
- Set other parameters as needed.

- Property/Rule: Universal Chg Line >> LCD Not Covered
- Operator: <> (not equal to)
- Value: ""
- Error message: Universal Chg Line >> LCD Not Covered

Check for Unnecessary Modifiers During Claims Processing

Claim edit checks, by default, respect modifiers indicating that a charge should bypass medical necessity checking, so those charges aren't evaluated for medical necessity during claims processing. In some cases, you can add a modifier that's needed for a charge to bypass medical necessity checks, but later the charge would pass those medical necessity checks without the modifier. For example, charges that wouldn't initially pass medical review might later if:

- Rule or policy changes occur
- Subsequent coding review causes the charge to meet medical necessity requirements

Configure LCD Edit Check Extensions to Check for Unnecessary Modifiers

1. If you don't already have a copy of the following extensions to check for LCD errors, create a copy of the one for your billing system in text:
   - Hospital Billing: 70482-HB Claim Edit Check - Hospital CCI/Specific LCD Edits (Dx Not Cvd)
   - Professional Billing: 70315-CCI Edits/LCD Diagnosis Is Not Covered
2. In Hyperspace, open your copy of the appropriate LCD checking extension (search: Extension).
3. Set the Check Unnecessary Modifiers? parameter to 1-Yes.
4. If you edited a new copy, add it to your CDF by following the steps in the Add Edit Checks to Claim Definition Records section.

Set Up Medically Unlikely Edits (MUE)

Complete the setup in this section to start checking medically unlikely edits (MUE) in Epic during claims processing. A charge is considered to be medically unlikely based on a total allowed quantity of that procedure in a single day. You'll complete the following steps:

- Load MUE data from CMS into Epic
- Configure MUE checks
- Associate MUE checks with certain payers, plans, and areas
- Configure automatic evaluation of MUE limits

After obtaining medically unlikely edit (MUE) data from CMS and loading that data into your system as a rule set, you can set up MUE for individual payers and benefit plans. Starting in February 2023, you can set up your Hospital Billing service area to automatically evaluate MUE limits.

Starting in May 2024, use the Build Wizard in Hyperspace to add MUE-Adjudication Indicators (MAI) to rules with the following properties:

- 250-MUE (Charge session context)
- 253-MUE (Universal charge line context)
- 40224-MUE (Hospital account context)
- 97220-MUE (Hospital charge session context

As well as copies of the following extensions;

- 76390-HB Coding - Run Medically Unlikely Edit (MUE) Check
- 70526-Medically Unlikely Edit (MUE)
- 70355-Medically Unlikely Edit (MUE)

This Build Wizard also shows Charge Handler Profiles and Hospital Billing Profiles that can be updated with MAI. To get started, open the Build Wizard (search: Build Wizard) and search for feature 700016-Restrict Medically Unlikely Edits (MUEs) to Specific MUE Adjudication Indicators).

Overview of Potentially Confusing Terminology for LCD Edits and MUE Edits

"Fiscal Intermediaries" (FI) and "Carrier" previously described contractors who handled Medicare Claims prior to Medicare contracting reform. In general, FIs handled Medicare Part A claims and Carriers handled Medicare Part B claims. These contractors were different entities.

With Medicare contracting reform, individual Medicare Administrative Contractors (MACs) became responsible for both Medicare Part A and Medicare Part B claims. In some contexts, Medicare nonetheless refers to Part A MACs (similar to FIs) and Part B MACs (similar to Carriers) even as it transitions to referring to "Part A and B MACs."

Because Medicare Part A LCD rule sets and MUE hospital outpatient rules correspond to hospital outpatient services, and those LCD rule sets were previously issued by the Fiscal Intermediaries, "FI" is used in both places for consistency. Likewise, Medicare Part A LCD rule sets and MUE practitioner rules correspond to the rules previously issued by Carriers, so we continue to use the term Carrier in the system.

Load MUE Data from CMS into Epic

Loading medically unlikely edit (MUE) data into Epic requires that you:

1. Download MUE data from CMS.
2. Create MUE rule set categories.
3. Load MUE data into Epic.

Download MUE Data from CMS

To get the MUE data from CMS and prepare to load it into Epic:

1. From the CMS website, download the Practitioner Services MUE Table files if you're billing for professional services not delivered in a hospital and the Facility Outpatient Services MUE Table files if you're billing for services delivered in a hospital outpatient department. CMS releases these files quarterly.
2. Unzip the files and locate the files with the .csv extension.
3. If your Epic version is:
   - Epic 2018 or an earlier version, follow the steps in the Format MUE Data for Loading topic to convert the .csv files to tab-delimited text files.
   - August 2018 or a later version, you can directly import the .csv files into Epic, so you don't need to save the files as tab-delimited text.
4. For the Practitioner Services MUE Table files and the Facility Outpatient Services MUE Table files, follow the steps in the Load MUE Data into Epic topic using the:
   - Tab-delimited .txt files you created, for Epic 2018 and earlier versions.
   - Files with the .csv extension, for August 2018 and later versions.

(Optional) Apply DME Supplier MUE Limits to Applicable Services

If your organization operates as an accredited durable medical equipment (DME) supplier and you want to apply the DME supplier MUE limits to applicable services, you can copy DME Supplier MUE limits information into your MUE Data Files to load into Epic. Otherwise, skip this topic.

1. Download the DME Supplier Services MUE Table from the CMS website.
2. Paste the copied data at the end of the Practitioner Services MUE Table files and/or the Facility Outpatient Services MUE Table files, as applicable.
3. Follow the rest of the setup described in the Download MUE Data from CMS topic.

When these modified files are loaded as described in the Create New MUE Rule Set Categories for Your Organization section, the system uses the DME values for every service listed in the DME file instead of any data for those services in the Practitioner Services MUE and Facility Outpatient Services MUE files. If you want the system to use the DME value only for a subset of the supplies listed in the DME file, you must edit the values for the relevant services in the Practitioner Services MUE Table files and the Facility Outpatient Services MUE Table files so that they correspond to the values in the DME Supplier Services MUE Table file.

Format Medicare MUE Data for Loading

Epic 2018 and Earlier

Skip these steps in August 2018 and later versions.

Before you can load Medicare MUE Data into Epic, save the data as a tab-separated values file:

1. Open the files with the .csv extension in Excel.
2. Save the file with a file type of Text (Tab delimited).

2. Save the files with a file type of Text (Tab delimited).

Format Medicaid MUE Data for Loading

Complete this step if you need to load Medicaid MUE data in addition to Medicare MUE data.

Medicaid MUE rules differ from Medicare MUE rules, so it is not appropriate to use the Medicare MUE files for Medicaid payers. You can download Medicaid MUE files from the CMS.gov website. State Medicaid programs can request that individual edits in these files be deactivated for their state; so you need to contact your state Medicaid program to determine whether any such deactivations apply and, if so, whether alternative MUE files reflecting those deactivations are available. In the absence of any approved deactivation requests, however, the MUE rules as delivered in the Medicaid MUE files are relevant.

Unlike Medicare MUEs, Medicaid MUEs do not make a distinction between Line Level MUEs and Date of Service MUEs. All Medicaid MUEs are line-level edits. It is consequently necessary to edit the Medicaid MUE files so that they are handled properly by Epic's MUE loader, which provides support for the format of the Medicare MUE files.

Before you can load Medicaid MUE Data into Epic, format the data in Excel:

1. Save copies of the files with the .csv extension, modifying the name of each one to indicate that it is an edited copy.
2. Open your copies of the files in Excel.
3. Remove the first two rows of data.
4. Add a column between the MUE Value and MUE Rationale columns.
5. For each cell in the new column where there is data for the CPT/HCPCS and MUE Value columns, enter "1 Line Edit".
6. Save and exit the file.

Refer to the Load MUE Data into Epic topic for instructions on loading the data once it is formatted.

Create MUE Rule Set Categories

In the Foundation System

The Foundation System has the following Example Data categories with data that you can use to see how the feature works:

- MUE Outpatient: Foundation System Example Data
- MUE Practitioner: Foundation System Example Data

They are not for use in production. You can use the Professional MUE and Hospital MUE categories for the Practitioner Services MUE Table files and the Facility Outpatient Services MUE Table files respectively, or you can create your own categories for them. If you have additional MUE files, such as for the Medicaid MUE rules, that you want to load to apply to payers other than Medicare, you can also create categories for them.

1. In Hyperspace, open the Default Quantity DI Rule Set (I EPM 430) category list in Category List Maintenance (search: Category List Maintenance).
2. Add a category value for each rule set.

For instructions, refer to the Add a Value to a Category List topic.

Load MUE Data into Epic

1. In Resolute Professional Billing Text or Resolute Hospital Billing Text, go to Master File Maintenance > CCI/LCD Load Related > MUE/Quantity Loader.
2. Follow the prompts:
   - Rule set to save to: Enter the category value you chose or created while following the Create New MUE Rule Set Categories for Your Organization subtopic.
   - MUE file: Enter the location of the file you downloaded from the CMS Web site.
   - Date effective from: Enter the date when this rule set goes into effect.
   - Date effective to: Enter the date when this rule set stops applying. If you don't want to set an end date, leave this prompt blank.
3. Access your payer or benefit plan record and go to the MUE Settings screen.
4. Associate a rule set with each of these settings, as appropriate:
   - Default rules for FI. Enter the default quantity rule set to use for hospital outpatient services.
   - Default rules for Carrier. Enter the default quantity rule set to use for practitioner services.
5. If necessary, specify service area- or location-specific rules sets in the table.

Configure MUE System Settings

Considerations

The system counts charges to determine whether they pass medically unlikely edit (MUE) checks in the following way:

- By default, MUE edits do not count charges across locations or service areas, but you can change this with system configuration.
- MUE edits count professional charges and technical charges separately. A charge is identified as professional or technical based on the following, in order:
  - Modifier 26 (for professional) or TC (for technical)
  - The hospital claim procedure type (I EAP 2410) in the procedure record
  - Optionally, the billing system. This piece is configurable. You can determine whether the billing system should be used to identify a charge as technical or professional. By default, the system considers a charge as technical if it comes from Resolute Hospital Billing and professional if it comes from Resolute Professional Billing when it can't make that determination based on modifier or procedure type.
- For technical charges, MUE edits consider the hospital as the provider for the purpose of counting charges.

Refer to the Determine How to Count Charges topic for more information.

Determine How to Count Charges

Perform these steps if you want the system to consider charges across locations or service areas, or if you don't want to use the billing system as the third option when determining whether a charge should be considered technical or professional:

1. In Resolute Hospital Billing or Resolute Professional Billing Text, open your facility profile and go to the MUE System-wide Settings screen.

2. If you want the system to check across locations, enter 1-Yes in the Check MUE edits across Locations (I EAF 19686) field. The default value is 0-No. This setting is also available at the service area level.
3. If you want the system to check across service areas, enter 1-Yes in the Check MUE edits across Service Areas (I EAF 19687) field. The default value is 0-No.
4. If you don't want the system to use the billing system as the third option when determining whether a charge is professional or technical, enter 0-No in the Use Billing System for Charge type (I EAF 19688) field. The default value is 1-Yes.

Specify Modifiers for Which Medically Unlikely Edits Aren't Applied

You can specify a list of modifiers that, when on a claim line, cause MUEs to not run. You can configure these modifiers at the following levels: benefit plan, payer, and service area. This option is intended to allow modifier 55 to override MUEs, but could be used with other modifiers.

1. In Resolute Professional Billing Text or Resolute Hospital Billing Text, access the level where you want to configure modifiers for which MUEs aren't applied.
   - Service area.
     - In Resolute Professional Billing Text: Go to Service Area Profile > Service Area Information > LCD/MUE Rule Settings screen.
     - In Resolute Hospital Billing Text: Go to Administrator Menu > Service Area Profile > Service Area Settings > LCD/MUE Rule Settings screen.
   - Payer. Go to Master File Maintenance > Payor > MUE Settings screen.
   - Benefit plan. Go to Master File Maintenance > Benefit Plan Related > Benefit Plan > MUE Settings screen.
2. In the MUE Override Modifiers field, enter the modifier for which MUEs aren't applied.

Ignore Informational Modifiers While Counting Toward MUE Limits

Starting in May 2020

When running MUE checks, Epic groups procedures by CPT code, date, provider, and modifiers. While some modifiers identify a charge as professional or technical, others are merely informational and can disrupt your edit checks.

For example, you might have two procedures with CPT code 91122, which has an MUE limit of one. If one of the charges has an informational modifier and the other doesn't, they aren't grouped together and aren't caught by the edit check.

Perform the following setup so that informational modifiers you select are not considered for grouping purposes while running line-level MUE checks:

1. Access your service area record:
   - In Resolute Professional Billing Text, go to Service Area Profile > Service Area Information.
   - In Resolute Hospital Billing Text, go to Administrator Menu > Service Area Profile > Service Area Settings.
2. Go to the LCD/MUE Rule Settings screen.
3. In the MUE Informational Modifiers (I EAF 19682) field, enter the modifiers that should be ignored during MUE checks.

Configure MUE Checks

Epic recommends that you trigger most MUE checks during claims processing using claim edit checks. For more information about this recommendation, refer to the Decide When to Trigger Edits Based on Edit Ownership topic.

Note that wherever you choose to set MUE checks, you will need to specify the MUE rule set types to use for medical necessity checking in order for MUE edits to fire. You can set this at the Place of Service, Location, Service Area, or Facility level in the LCD/MUE rule set types field (I EAF 175). Select Fiscal Intermediary, Carrier, or both depending on what rule sets should be used.

Perform MUE Checks During Charge Review

In Resolute Professional Billing

1. In Hyperspace, access a charge review workqueue.
2. Add rule 208025001-(coding) MUE.

In Resolute Hospital Billing

1. In Hyperspace, access a charge review workqueue and build a workqueue rule:
   - Property: Charge Session\MUE
   - Operator: =
   - Value: Yes
2. In the Rule Set Type (I EPM 440) field of the payer record in text (Master File Maintenance > Payor), select either Fiscal Intermediary, Carrier, or Both, depending on the types of MUE checks this rule should use.

In Charge Router Charge Review

1. In Hyperspace, open the Charge Router Profile (search: Charge Router Profile).
2. In the Review Workqueue Routing section, add an error rule:
   - Property: Universal Chg Line.MUE
   - Operator: <>
   - Value: ""
   - Error message: Universal Chg Line.MUE

Perform MUE Checks During Coding Validation (Hospital Billing Only)

1. In Hyperspace, open your Hospital Billing Profile (search: Hospital Billing Profile).
2. Go to the Validation Checks form (in Epic 2017 and earlier versions, C&A Config > Validation Checks) and add validation check 76390-HB Coding - Run Medically Unlikely Edit (MUE) Check.

Perform MUE Checks During Claim Edit

In Resolute Professional Billing

1. In Hyperspace, open the Claim Definition Manager (search: Claim Definition Manager) and select the Add Edit Check tab.
2. Add claim edit check 70355-PB Claim Edit Check - Medically Unlikely Edit (MUE) or a copy of it to any claim definitions that should check for MUEs.

In Resolute Hospital Billing

1. In Hyperspace, open the Claim Definition Manager (search: Claim Definition Manager) and select the Add Edit Check tab.
2. Add claim edit check extension 70526-HB Medically Unlikely Edit (MUE) or a copy of it to any claim definitions that should check for MUEs, along with your condition rule.

Restrict MUE Checks to Primary Claims

If you perform MUE checks during claim edit, we recommend using a filter rule to restrict MUE checks so they are triggered only for primary claims. The Foundation System includes rule 708926-Claims Restrict MUE to Only Fire on Primary Claims for this purpose. If you don't already have this rule in your system, follow these steps to replicate it before adding the extension to your CDF.

1. Create a rule in the Claim Edit Conditions context.
2. For the criterion:
   - Property: Claim >> Current Coverage is Primary
   - Operator: = (equal to)
   - Value: Yes
3. Add this rule to the claim definition file on the same line as the claim edit check mentioned above.

Automatically Move Quantities that Exceed MUE Limits to Non-Covered Lines

Starting in February 2020

You can reduce the manual work of editing these claims that include services with quantities that exceed an MUE limit by configuring claim complete extension 75110-Modify Claim Lines Based on MUE Data to automatically move quantities that exceed MUE limits to non-covered claim lines for institutional claims. To add extension 75110 or a copy of it to CDFs for payers that require MUE checks:

1. Optionally, create a copy of extension 75110 in Chronicles and configure the parameters according to your use case, using the help text for guidance. For example, you might do this if you want to:
   - Automatically move only certain procedures to new claim lines when they exceed an MUE limit. You have to create a component of procedures to use this option. The Epic-released extension applies to all procedures that exceed an MUE limit.
   - Specify a maximum dollar amount of procedures that can be automatically moved to non-covered to resolve a single MUE. The Epic-released extension does not have a maximum dollar amount.
   - Restrict your copy of the extension to work for only Fiscal Intermediary or Carrier MUE rule sets. The Epic-released extension uses the Fiscal Intermediary type for Resolute Hospital Billing claims and the Carrier type for Resolute Professional Billing claims.
   - Move quantities that exceed MUE limits to a new line but you don't want to automatically move them to non-covered. You can use this option to automate part of the process for professional claims because it isn't possible to move quantities to non-covered on professional claims. For institutional claims, this option allows you to automate the first step of resolving an MUE error on a claim while still requiring a user to review the claim in a claim edit workqueue and move the surplus quantity to non-covered manually. The Epic-released extension handles both steps.
   - Starting in November 2022, you can choose to move date of service MUEs to a new line, or move to non-covered, based on date of service type 2 MUEs only, or by date of service type 3 MUEs only.
2. Optionally, create a rule in context 1053-Claim Complete Filter in Hyperspace (search: Rule Editor). Do this if you want to restrict when extension 75110 or a copy of it makes changes to a claim.
3. In Claims and Remittance Text, open a CDF and press F6 for Claim Processing options.
4. Go to the Claim Processing Options - 3 screen.
5. Enter extension 75110 or your copy it in the Claim Complete Extensions (I CDF 6611) column.
6. If you created a filter rule, enter it in the Filter Rules (I CDF 6612) column in the same row.

Exclude Some Services from MUE Claim Edit Checks

If you would like to exclude certain services from hitting MUE edits during claim processing you can configure claim edit check extensions 70526-HB Medically Unlikely Edit (MUE) and 70355-PB Claim Edit Check - Medically Unlikely Edit (MUE) to exclude those services for MUE edits.

Hospital Billing

Starting in August 2019

For Hospital Billing, perform the following:

1. If you don't already have a copy of extension 70526, make a copy of it in Chronicles.
2. In Hyperspace, create a component of procedures or revenue codes that you don't want your copy of extension 70526 to check for MUEs (search: Component).
3. Open your copy of extension 70526 for editing (search: Extension).
4. Enter your component of excluded services in the Excluded Service Component/Component Group - Optional parameter.
5. Configure the other parameters according to your use case, using the help text for guidance.

Professional Billing

Starting in May 2022

For Professional Billing, perform the following:

1. If you don't already have a copy of extension 70355, make a copy of it in Chronicles.
2. In Hyperspace, create a component of procedures or revenue codes for which you don't want your copy of extension 70355 to check for MUEs (search: Component).
3. Open your copy of extension 70355 for editing (search: Extension).
4. Enter your component of excluded services in the Excluded Service Component/Component Group - Optional parameter.
5. Configure the other parameters according to your use case, using the help text for guidance.

Add to Claim Definition File

Add this edit check to any claim definitions that should check for MUEs.

1. In Hyperspace, go to the Claim Definition Manager (search: Claim Definition Manager) and select the Add Edit Check tab.
2. Add your copy of claim edit check extension 70526-HB Medically Unlikely Edit (MUE) or 70355-PB Claim Edit Check - Medically Unlikely Edit (MUE) to any claim definitions that should check for MUEs.

If you're replacing Epic-released extension 70526 or 70355 or a previous copy, remove the old MUE claim edit check extension:

1. Go to the Remove Edit Check tab.
1. Remove the old extension from any claim definitions that now use your new copy of extension 70526 or 70355.

Additional Setup for Critical Access Hospitals Using Method 2 Billing (Optional Payment Method)

Starting in August 2018

Epic 2018 by SU E8402611

Epic 2017 by SU E8327830

Critical access hospitals (CAH) using Method 2 billing (the Optional Payment Method) need to create a copy of claim edit check 70526-HB Medically Unlikely Edit (MUE) to meet CMS regulations.

Set the two parameters in a copy of extension 70526-HB Medically Unlikely Edit (MUE). The first accepts a range of revenue codes indicating professional charges, and the second accepts a list of modifiers indicating assistant surgeon charges. To set them:

1. In Chronicles, access the Extension (LPP) master file and open your copy of extension 70526 or create a copy if you don't have one.
2. Edit the Revenue Code Range parameter. Set 0960 as the beginning of the range and 0989 as the end of the range. Codes 096x, 097x, and 098x specify professional charges.
3. Add the assistant surgeon modifiers AS, 80, 81, and 82 to the Modifiers parameter.
4. Add this claim edit check to your CDF. For detailed instructions, refer to the Add Edit Checks to Claim Definitions section.

Automatically Evaluate MUE Limits

Starting in February 2023, Epic recommends using the Charge Router macro to evaluate MUE limits on Professional Billing charges and configuring your service area to evaluate MUE limits on Hospital Billing charges.

Add Modifiers and Split Charges Using Charge Router Macro

You can use charge handler macro 203-MUE Split Charges to evaluate charges for Medically Unlikely Edits and split them if they exceed the limits established by CMS. The macro adds informational modifiers to charges that are over the limit and removes informational modifiers from charges that are under the limit.

For example, if you write off certain charges that are over the MUE limit, you can use this macro to apply write-off modifiers to them. You must specify either a payer or a plan with MUE settings for the macro to use. Refer to the help text for other configuration options.

For more information, refer to the Use Charge Handler Macros topic. Work with your Charge Router team to build a Charge Handler action using the macro, as described in the Build Actions in the Charge Handler topic. This macro should not be used to split Willow charges.

The modifier you use in the macro must also be listed in the MUE Informational Modifiers (I EAF 19682) field in your service area record. For more information, refer to the Specify Informational Modifiers to Ignore While Counting Toward MUE Limits topic.

Starting in May 2024, you can configure the macro to restrict based on the MUE adjudication indicator (MAI). In the Charge Handler, open the action with macro 203-MUE Split Charges and add the MAI you would like to split. Enter 1 to restrict to line edits, 2 to restrict to date of service policy edits, and 3 to restrict to date of service clinical edits.

Starting in November 2022, in May 2022 with special update E10207469, and in February 2022 with special update E10112410, you can configure the macro to respect alternate code logic in determining which charges contribute to the MUE limit. Create a copy of rule property (HFP) 5829-Procedure Code and set the Use Alternate CPT Logic parameter to Yes. In your Charge Handler action, enter this property in the With Same (I VCS 57) field.

If you void a charge while using the macro, existing charges for the same HCPCS/CPT code and service date are not reevaluated by the charge handler. We recommend that you create a rule using property (HFP) 40224-MUE to

route charges that are over the MUE limit, under the MUE limit, or both to an account workqueue.

To use this macro, you must have the CR_CHG_HANDLER_MUE_MACRO license, which is included in the standard Charge Router license. If you're unsure whether you have this license, contact your Epic representative and mention parent SLG 3550868.

Add Modifiers and Split Charges in Hospital Billing

Starting in February 2023

For hospital accounts and charges, you can configure your service area to evaluate MUE limits during billing rather than at charge routing. When billing is initiated, charges are evaluated against MUE limits of the account's primary coverage. If the quantity exceeds the MUE limit, the charge will split so that the allowed quantity can be billed separately from the non-allowed quantity. Note that this functionality does not apply to charges manually entered via HB Unit Charge Entry.

When the charges split, your MUE modifier is added to charges over the limit and removed from charges under the limit. If the original charge was priced in Hospital Billing, the split charges are repriced. If priced outside of Hospital Billing (for example, Willow charges), the split charges are prorated based on quantity.

If primary coverage on the account is updated, charges are re-evaluated for MUE limits when the account is re-billed.

Use the Build Wizard in Hyperspace to update your service area to automatically evaluate MUE limits during initiate billing. To get started, open the Build Wizard (search: Build Wizard) and search for feature 410044-Evaluate MUE Limits in Hospital Billing (application: Resolute Hospital Billing).

Starting in May 2023, the Foundation System is set up with modifier 545-MUE Exceeds Limit as an example for you to reference as you build out automatic MUE evaluation in your system. This modifier is used in Hospital Billing Profile 1-Facility and service area 10-EHS Service Area.

To manually configure your service area for automatic MUE limit evaluation, complete the following steps:

1. In Hyperspace, open your Hospital Billing Profile (Chart Search: Hospital Billing Profile).
2. Go to the MUE tab.
3. In the MUE Limit Modifier (I HSD 10001) field, enter a modifier to be added to charges which exceed the MUE limit. This modifier must also be listed in the MUE Informational Modifiers (I EAF 19682) field of your service area. For more information, refer to the Ignore Informational Modifiers While Counting Toward MUE Limits topic.
4. Optional: Specify which accounts and charges should qualify for MUE limit evaluation in the Rules to Include Accounts and Charges table (I HSD 10002-10004). If no rules are specified, all Hospital Billing accounts and charges are evaluated.
5. Optional: Specify a component that identifies bilateral procedures in the ASC Override Component (I HSD 10005) field. Procedures in this component will have their MUE limit doubled. This setting only applies to Ambulatory Surgical Centers.
6. Optional: Specify Assistant Surgery Modifiers (I HSD 10006). Charges with these modifiers are grouped separately from charges without them during MUE evaluation.
7. Optional: Available starting in May 2024. Specify MUE Adjudication Indicators (I HSD 10010). Only charges

with these indicators indicated in the list will be included in the rule. Enter 1 to restrict to line edits, 2 to restrict to date of service policy edits, and 3 to restrict to date of service clinical edits.

Write Off Charges Over the MUE Limit

Starting in May 2020

Considerations

For reporting purposes, it is not recommended to write off charges that exceed MUE limits. Charges that are written off are not reported to Medicare, so they will not be considered by CMS when evaluating and setting MUE limits for following years. This can negatively impact Medicare reimbursement long-term. Additionally, written-off charges might not be considered for cost reporting, which can also have a negative long-term impact on reimbursement.

Instead of writing off charges, you can add an extension to your payer's CDF to automatically move charges with the MUE modifier to non-covered claim lines for institutional claims. For more information, refer to the Automatically Move Quantities that Exceed MUE Limits to Non-Covered Lines topic.

In Hospital Billing, charges can be moved to a new liability bucket to be written off if they exceed MUE limits. If your system is configured to apply write-off modifiers to these charges, you can then configure a copy of extension 99199-HB Move Charges to New Bucket and WO or TTSP Using Multiple Rules to automatically write those charges off.

Extension 99199 uses a general table of hospital transaction-based rules to determine which charges to write off. You might already have a copy of this extension, in which case you can add a new rule identifying charges with the write-off modifier to your existing table. Refer to the Define Write-Off Logic topic for complete instructions on configuring the extension.

Add your copy of the extension to your Hospital System Definition Profile if you have not already done so:

1. In Resolute Hospital Billing Text, go to Administrator Menu > System Definition Profiles.
2. Go the Actions to Perform After Billing screen.
3. Enter your copy of the extension in the After Billing Extensions (I HSD 2180) field.

Correctly Bill Multiple Charge Units for a Single Procedure

To satisfy CMS and other payers' claim requirements, you can check whether you're correctly billing multiple units for a single provider on a single day according to the RVU multiple procedure indicator, as defined by CMS. This checking applies to specific procedure-modifier combinations that you load in an RVU data file.

This system of checking determines whether a charge with multiple units should appear on one charge line or multiple charge lines according to its RVU indicator value. For charges that should appear on multiple lines for one day, these checks can also ensure that you're using the correct modifiers on charge lines that appear after the first charge line.

Considerations

It's possible to automatically add the correct modifiers for multiple charges in the Charge Router or at claims processing. However, before automating this build, you need to have a discussion with your compliance team about whether this automation is right for your organization.

In the Foundation System, Charge Handler action 100002-Add 25 Modifier ---Compliance Discussion Needed--- adds modifier 25 to qualifying procedures. For more information, refer to the Foundation System Charge Handler Inventory spreadsheet.

The Foundation System also includes the following build to automatically add modifiers at claims processing. Some of these records aren't plugged in to any CDFs, but you can use them as models for your build.

- These rules and extensions can be used in the Modifier Specification table in the CDF:
  - Extension 3086401301-Claims Add Modifier 91 to Repeat Lab procedure on Same Date
  - Rule 704250-Claims Add 27 Modifier to 51X with 761 Rev Code
  - Rule 704251-Claims Add 25 Modifier to 450 with 32X or 35X Rev Code
- These extensions can be used in the Claim Complete Extensions on the Claim Processing Options - 3 form in the CDF to split claim lines when a single claim line has a quantity higher than the maximum allowed quantity. They then add modifier 59 to the additional line.
  - 3087128201-Claims HB Split Claim Lines - Max Quantity 1
  - 3087128202-Claims HB Split Claim Lines - Max Quantity 2
  - 3087128203-Claims HB Split Claim Lines - Max Quantity 3
- These extensions can be used in the Claim Complete Extensions on the Claim Processing Options - 3 form in the CDF to add modifiers:
  - 3086076801-Claims Add Modifier 91 based on CPT Range
  - 3086076802-Claims Add Modifier 25 Based on CPT Range
  - 3086076803-Claims Add Modifier 27 Based on CPT Range
  - 3086076804-Claims HB Add Modifier 25 when S or T type code is present
  - 3086076805-Claims Add Modifier 59 Based on CPT Range

To see the details of these rules and extensions, log in to the Foundation Hosted environment as your organization's hospital or professional billing analyst (HBADM or PBADM) and open the records in the Rule Editor (search: Rule Editor) or in the Extension activity (search: Extension).

Load RVU Files into Your System

To check whether you're correctly billing for multiple units, you need to populate charge procedures' Mult Px field on the CMS Information screen. You can do this manually, but it's much more efficient to do so by loading RVU information from CMS.

1. Download the appropriate PFS Relative Value .txt file from the CMS website.
2. In Resolute Professional Billing Text or Resolute Hospital Billing Text, go to Master File Maintenance > Procedure Related > Natl Phys Fee Sch Relative Value.
3. Follow the prompts:
   a. Enter the CMS file to be loaded into the procedure master file: Enter the location of the .txt file you

downloaded in step 1.

b. Date effective from: Enter the date when this RVU information goes into effect.

c. Date effective to: Enter the date when the RVU information stops applying.

Resolute Professional Billing Setup for Multiple Unit Checking

1. In Hyperspace, access a charge review workqueue.
2. Add released charge session rule 251-RVU Multiple Procedure Indicator Check.
3. Go to the Claim Definition Manager (search: Claim Definition Manager).
4. In the Add Edit Check tab, add claim edit check 70356-PB Claim Edit Check - Multiple Procedure Indicator Check.
5. In Resolute Professional Billing Text, open a facility, service area, payer, or plan record and go to the Multiple Procedure Coding Settings screen. In the Foundation System, these settings are at the facility level.
6. In the Multiple Line Indicators (I EAF/EPM/EPP 3451) field, enter the Mult Px value that corresponds to procedures with multiple units that should appear on multiple charge lines. In the Foundation System, this field is set to 2 and 3.
7. In the Single Line Indicators (I EAF/EPM/EPP 3450) field, enter the Mult Px value that corresponds to procedures with multiple units that should appear on a single charge line. In the Foundation System, this field is set to 1.
8. In the Multiple Line Modifiers (I EAF/EPM/EPP 3452) field, enter the charge modifier that charge lines need to use if they are subsequent to a charge line that uses a multiple line RVU indicator and are multiples of that charge. In the Foundation System, this field is set to 51-Multiple Procedures.

Resolute Hospital Billing Setup for Multiple Unit Checking

1. In Chronicles, create a copy of extension 70527-HB Claim Edit Check - Multiple Procedure Indicator.
2. Modify the record. In the Type of Bill List parameter, enter a comma-delimited list of types of bill (TOB) that claims should have for the system to check for the correct billing of multiple units of a single procedure.
3. In Hyperspace, go to the Claim Definition Manager (search: Claim Definition Manager).
4. In the Add Edit Check tab, add your copy of claim edit check 70527.
5. Access a charge review workqueue and build a workqueue rule:
   - Property: Charge Session\RVU Multiple Procedure Indicator
   - Operator: =
   - Value: Yes
6. Go to the Hospital Billing Profile (search: Hospital Billing Profile).
7. Go to the Validation Checks form (in Epic 2017 and earlier versions, C&A Config > Validation Checks) and add validation check 76391-HB Coding - Run Multiple Procedure Indicator Edits.

Charge Router Setup for Multiple Unit Checking

In Hyperspace, go to Epic button > Admin > Charge Router Admin > Charge Router Profile. In the Review Workqueue Routing section, add an error rule:

- Property: Universal Chg Line.RVU Multiple Procedure Indicator
- Operator: <>

- Value: ""
- Error message: Universal Chg Line.RVU Multiple Procedure Indicator

Set Up and Streamline OCE Edits

This topic applies to Resolute Hospital Billing only.

Outpatient code editor (OCE) edits are created and maintained by CMS to ensure that hospital outpatient claims comply with correct coding and claims processing guidelines.

Prerequisites
To check OCE Edits in Epic during claims processing, you must use 3M's Core Grouping Software or 3M's Grouper Plus Content Services. Before beginning this setup, work with 3M to license and implement the relevant software.

For more information on checking OCE Edits in Epic, refer to the appropriate guide:

- Core Grouping Software (3M) Integration Setup and Support Guide.
- Grouper Plus Content Services (3M) Integration Setup and Support Guide.

Support: Test Your Edits After Loading New Files

Organizations generally load updated data files for regulatory edits every quarter. Because this data is stored behind the scenes in Epic, it can be difficult to troubleshoot, so we recommend the following testing procedures after you import an updated file for CCI, LCD, or MUE data.

Always complete the testing steps for this section in your SUP environment. The testing procedure depends on which phase of the revenue cycle your organization has decided to trigger regulatory edits in. For more information about our recommendations for when to trigger different types of edits, refer to the Decide When To Trigger Edits Based on Edit Ownership topic.

Test That CCI, LCD, or MUE Data Files Loaded Correctly

In your support (SUP) environment, you can do the following to validate that data files load correctly:

1. Get a list of all current errors in your system.
2. Load your data files.
3. Refresh errors.
4. Get a list of all current errors in your system.
5. Compare the two lists.

Refer to the specific section below that corresponds to when you trigger specific regulatory edits for detailed instructions.

Test Edits That Are Triggered During Charge Review

1. Choose a representative Charge Review workqueue, such as a workqueue that holds all charge review errors for a department or bill area.
2. Export the contents of that workqueue to a spreadsheet.
3. Load file your file of edit data into your SUP environment.
4. Run a batch job using template 1154-Charge Review Automatic Processing to refresh all charge review session errors.
5. Repeat step 1-2.
6. Compare the list of errors you found in step 1 with the list of errors you found in step 5. Any differences are attributable to changes in the specific data file you loaded.

Test Edits That Are Triggered in Charge Router

1. Use the Charge Router Error Pool Detail dashboard component to get a list of current Charge Router errors. Print a copy of this report for later comparison.
2. Load file your file of edit data into your SUP environment.
3. Run a batch job using template 2002-Charge Router Review Workqueue Resubmission to refresh all charge router review errors.
4. Repeat step 1.
5. Compare the list of errors you found in step 1 with the list of errors you found in step 4. Any differences are attributable to changes in the specific data file you loaded.

Test Edits That Are Triggered During DNB

1. Run a report based on the HB Account Query Report Template. Export your results to a file for later comparison.
2. Load file your file of edit data into your SUP environment.
3. Run your Nightly Processing batch job to refresh all DNB errors.
4. Repeat step 1.
5. Compare the list of errors you found in step 1 with the list of errors you found in step 4. Any differences are attributable to changes in the specific data file you loaded.

Test Edits That Are Triggered During Coding Validation Check

1. Identify two test accounts:
   - One that your system identifies as having an error related to the specific kind of regulatory edit data you want to load.
   - One that is error-free.
2. Load file your file of edit data into your SUP environment.
3. Run coding validation on your test accounts and confirm that the account with an error still has an error, and the account without an error still has no errors.

Test Edits That Are Triggered During Claim Edit

1. Run a report based on the:
   - HB Claim Errors Report Template, in Hospital Billing
   - PB Claim Errors Report Template, in Professional Billing
2. Select the Detail view, and the click Options > Export to File to save your results for later comparison.
3. Load file your file of edit data into your SUP environment.
4. Refresh all claim errors by running a batch job based on:
   - Batch template 41004-CLAIMS HB Claims Testing, for Hospital Billing
   - Batch template 1151-CLAIMS PB Claim Testing, for Professional Billing
5. Repeat steps 1-2.
6. Compare the list of errors you found in step 1 with the list of errors you found in step 5. Any differences are attributable to changes in the specific data file you loaded.

Test That CCI or LCD Modifier Data Files Loaded Correctly

In your support (SUP) environment, do the following to test your modifier data loads:

1. Depending on when you trigger these edits, find a charge, hospital account, or claim that has an edit on it for a missing modifier.
2. Add the appropriate modifier and refresh the error. Confirm that the edit is resolved.
3. Find another charge, hospital account, or claim that has an edit on it for a missing modifier.
4. Add an inappropriate modifier to it and refresh the error. Confirm that the edit isn't resolved.