MAKING MODIFIERS MATTER: HOW MODIFIERS AFFECT PAYMENT

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ACKNOWLEDGMENT

- For purposes of this presentation we are utilizing the most publicly available code edits, the National Correct Coding Initiative (NCCI, commonly known as CCI) and the most publicly available relative value scale, the Resource Based Relative Value Scale (RBRVS).
- The presenter understands and acknowledges that these may not be the code edits nor the relative value scale that your contracted payers utilize in adjudicating and paying your claims.
- It is important to check the contract language for each individual payer contract to verify both the code edits and the relative value scale utilized to adjudicate and pay the claims under that contract. For purposes of payment, it is also important to know each contracted payer's conversion factor.

AGENDA

- The Surgical Package, CCI & RBRVS
- Modifiers for E/M
- Surgical Modifiers
- Modifiers for Radiology
- The ABN, NCDs & LCDs
- OIG Targets
- RAC Issues
- Strategies for Success

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The Surgical Package: CPT®

- Local infiltration, digital block, or topical anesthesia
- Following decision for surgery, one related E/M on date just prior or day of (including H&P)
- Immediate PO care
- Writing orders
- Evaluating patient in postanesthesia area
- **Typical** postoperative follow-up care

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The Medical/Surgical Package: Medicare

- Vascular/airway access
- Anesthesia
- Cardiopulmonary monitoring
- Non-diagnostic biopsy
- Exposure and exploration of surgical field
- Access through diseased tissue
- Incision and opening during removal
- Multiple approaches (exception: diagnostic endoscopy)
- Scouting endoscopy/failed endoscopy
- Complications during the operative session and those that do not require a return to the OR

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The Global Surgical Package: Medicare

- Services may be furnished in any setting
  - e.g., in hospitals, ASCs, physicians' offices
- Visits to a patient in an intensive care or critical care unit are also included if made by the surgeon
  - Critical care services (99291 and 99292) are payable separately in some situations
- Preoperative Visits
  - Preoperative visits after the decision is made to operate beginning with the day before surgery for major procedures and the day of surgery for minor procedures
- Intra-operative Services
  - Intra-operative services that are normally a usual and necessary part of a surgical procedure

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The Global Surgical Package: Medicare

- Complications Following Surgery
  - All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of **complications that do not require additional trips to the operating room**
- Postoperative Visits
  - Follow-up visits during the postoperative period of the surgery that are **related to recovery from the surgery**
- Postsurgical Pain Management
  - By the surgeon
- Supplies
  - Except for those identified as exclusions
- Miscellaneous Services
  - Items such as: dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes

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Not in The Global Surgical Package: Medicare

- **Initial consultation or evaluation** of the problem by the surgeon to determine the need for surgery (major surgery only)
- **Services of other physicians** except where the surgeon and the other physician(s) agree on the transfer of care
- **Visits unrelated to the diagnosis** for which the surgical procedure is performed, **unless the visits occur due to complications of the surgery**
- **Treatment for the underlying condition** or an **added course of treatment which is not part of normal recovery** from surgery
- **Diagnostic tests and procedures**, including diagnostic radiological procedures
- **Clearly distinct surgical procedures** during the postoperative period which are not re-operations or treatment for complications

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Not in The Global Surgical Package: Medicare

- Treatment for postoperative **complications that requires a return trip to the operating room**
- If a **less extensive procedure fails**, and a more extensive procedure is required, the second procedure is payable separately
- **Splints and casting supplies** are payable separately under the reasonable charge payment methodology
- **Immunosuppressive therapy** for organ transplants
- **Critical care services** (codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician

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Minor Surgeries & Endoscopies The Global Surgical Package: Medicare

- Visits by the same physician on the same day as a minor surgery (10 day global) or endoscopy
  - unless a significant, separately identifiable service is also performed
- Postoperative visits or services within 10 days of the surgery that are related to recovery from the procedure
- If a diagnostic biopsy with a 10-day global period precedes a major surgery on the same day or in the 10-day period, the major surgery is payable separately
- Services by other physicians are not included in the global fee for a minor procedure except as otherwise excluded
- **If the global days are 0, postoperative visits beyond the day of the procedure are not included in the payment amount for the surgery**
  - **Separate payment is made in this instance**

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NCCI (aka CCI): National Correct Coding Initiative

- http://www.cms.hhs.gov/NationalCorrectCodInitEd/
  - Scroll down and print
    - Modifier -59 Article
    - How to Use The National Correct Coding Initiative (NCCI) Tools
  - Click on NCCI Policy Manual for Medicare Services
    - Click open and print Intro & TOC 1st, then selected chapters, then close and scroll back up
  - Click on NCCI Edits – Physicians
    - Save selected chapters to your computer
      - Both Column 1 & Column 2 and Mutually Exclusive
      - Rename by quarter

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CCI: PURPOSE

- To promote national correct coding methodologies
- To control improper coding that leads to inappropriate payment of Part B claims
- To ensure the most comprehensive group of codes are billed rather than the component parts
- To ensure that only appropriate codes are grouped and priced
- To check for mutually exclusive pairs
- To encourage consistent and correct coding and reducing inappropriate payment

- Used by Medicare claims processing contractors to adjudicate provider claims for physician services, outpatient hospital services, and outpatient therapy services.
- Policies and edits represent CMS national policy but do not supersede any other CMS national coding, coverage, or payment policies

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CCI

- CPT® codes representing services denied based on NCCI edits **may not be billed to Medicare beneficiaries**
- Published quarterly
  - CMS notifies the AMA and national medical/surgical societies
- Changes come from three sources:
  - Additions, deletions or modifications to CPT® or HCPCS Level II codes or CPT® Manual Instructions
  - CMS policy initiatives
  - Comments from the AMA, national or local medical/surgical societies, Medicare contractor medical directors and staff, providers, billing consultants, etc.

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NCCI Contact Info

- Maintained for CMS by Correct Coding Solutions, LLC
- Submit concerns, inquiries, suggested edits to:
  - National Correct Coding Initiative
    Correct Coding Solutions LLC
    P.O. Box 907
    Carmel, IN 46082-0907

    Fax number: (317) 571-1745
- "CMS makes all decisions about the contents of NCCI and this manual. Correspondence from Correct Coding Solutions, LLC reflects CMS' policies on coding and NCCI."

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CCI: Services Integral to Large Number of Procedures

- Cleansing, shaving, and prepping
- Draping and positioning of patient
- Insertion of intravenous access
- Insertion urinary catheter
- Sedative administration
- Local, topical, or regional anesthesia
- Surgical approach
- Surgical cultures

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CCI: Services Integral to Large Number of Procedures

- Wound irrigation
- Insertion and removal of drains, etc.
- Surgical closure and dressings
- Application, management, and removal of postoperative dressings, etc.
- Institution of Patient Controlled Anesthesia (PCA)
- Preoperative, intraoperative and postoperative documentation
- Surgical supplies, with some exceptions

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CCI: Standards of Medical/Surgical Practice

Principles of the policy of inclusion:

- Service represents standard of care
- Service is necessary to complete the procedure
- Service does not represent a separately distinguishable procedure

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CCI: HCPCS/CPT Procedure Code Definition

HCPCS/CPT® Code Definition:

- "Partial" procedure included in "complete" procedure
- "Partial" procedure included in "total" procedure
- "Unilateral" included in "bilateral"
- "Single" procedure included in "multiple" procedure
- "With" procedure not separately reportable with a "without" procedure
- "Initial" procedure not separately reportable with a "subsequent" procedure

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CCI: Evaluation & Management (E&M) Services

- Reporting of E&M services defined by Medicare Global Surgery Rules
  - For surgeries with globals of 0 or 10 days (minor procedures), **decision is included**
  - All procedures on the Medicare Physician Fee Schedule are assigned a Global period of 000, 010, 090, XXX, YYY, or ZZZ (see RBRVS)
- CCI applies to **same date of service only**

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CCI:
MODIFIERS

- **Modifier should not be added to a HCPCS/CPT® code just to bypass an edit** (e.g. -25, -59)
- Anatomical modifiers:
  - Eyes: -E1 through –E4
  - Fingers: -FA, -F1 through –F9
  - Toes: -TA, -T1 through –T9
  - Coronary vessels: -LC, -LD, -RC
  - Side (laterality): -LT, -RT
- E/M modifiers: -25 (also -24)
- Surgical modifiers: -58, -78, -79
- Other modifiers: -59, -91

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CCI:
MODIFIER -59

"Modifier -59 is an important NCCI-associated modifier that is often used incorrectly. For the NCCI its primary purpose is to indicate that two or more procedures are performed at different anatomic sites or different patient encounters. **It should only be used if no other modifier more appropriately describes the relationships of the two or more procedure codes."**

Modifier -59 Article & General Correct Coding Policies, Ch. I.E, pg. I-15

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CCI: Modifier Indicators

CCI Modifier Indicators:

- 0 – CCI modifier cannot be used
- 1 – CCI modifier may be used
- 9 – edit has been deleted, not applicable

- http://www.cms.hhs.gov/NationalCorrectCodInitEd/

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CCI: Add-On Codes

- Describes a service that can only be reported in addition to a primary procedure
- Enables providers to separately identify a service performed in certain situations
- If edit prevents payment of primary procedure, add-on will also not be paid
- Edits are allowed for some add-on codes when allowed for their related primary procedures
- Remember add-on codes can only be used with the specified codes or ranges of codes

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CCI: Other Guidance

- HCPCS/CPT Guidelines – Do not report codes contrary to these instructions
- Separate Procedure – Do not report with a related procedure.
  - e.g. (separate procedure) after descriptor in CPT®
- Family of Codes – Do not report separate component codes individually; do not report component codes with comprehensive code
- More Extensive Procedure – If less complex and more complex done, report only more complex, unless separate session/site

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CCI: Other Guidance

- Sequential Procedures, same session – Only report more invasive procedure
- Lab Panels – When all tests of panel are performed, report only the panel tes
- Gender Specific – Policy pertains to male and female genital procedures. Edits are included in Mutually Exclusive Table

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CCI: Mutually Exclusive Procedures

- Cannot reasonably be performed at same anatomic site/same patient encounter
- Determined by CPT® code definition or medical impossibility/improbability
- Code pairs should not be reported together
- Table allows for modifiers (i.e.. different anatomic site or separate encounter/same day)
- http://www.cms.hhs.gov/NationalCorrectCodInitEd/

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CCI: Excluded, Unlisted, Changes

- Excluded Services
  - not addressed in CCI
- Unlisted Service or Procedure
  - not included in CCI because many different procedures can be reported using these codes (XXXX9/XXX99)
- Modified, Deleted, and Added Code Pairs/Edits
  - occur because of ongoing refinements, changes in technology and standards of medical practice, and continuous input from many sources, including individual providers

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CCI: MEDICALLY UNLIKELY EDITS

- The maximum number of units of service allowable by the
  - same provider
  - same patient
  - same date of service
- CMS established MUEs to lower the Medicare FFS Paid Claims Error Rate
- All claims (provider, outpatient facility, and supplier) are tested against MUEs
- http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp

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CCI: MEDICALLY UNLIKELY EDITS

- To request reconsideration of a MUE value or to suggest an alternative MUE, send request with rationale to:
  - National Correct Coding Initiative
    Correct Coding Solutions, LLC
    P.O. Box 907
    Carmel, IN 46082-0907

    Fax: 317-571-1745

CCI:
Shoulds/Should Nots Musts/Must Nots

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Procedures **should** be reported with the most comprehensive CPT® code that describes the services performed.

Although the emphasis in the manual is correct coding, there are certain types of improper coding that physicians **must avoid:**

- Physicians **must not** unbundle the services described by a HCPCS/CPT® code.
- A physician **should not** report multiple HCPCS/CPT® codes when a single comprehensive HCPCS/CPT code describes these services.
- A physician **should not** fragment a procedure into component parts.

CCI:
Shoulds/Should Nots Musts/Must Nots

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- A physician **should not** unbundle a bilateral procedure code into two unilateral procedure codes.
- A physician **should not** unbundle services that are integral to a more comprehensive procedure.
- Physicians **must avoid** downcoding.
- Physicians **must avoid** upcoding.
- Physicians **must** report units of service correctly.

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UNBUNDLING: INTENTIONAL/UNINTENTIONAL LANGUAGE REMOVED

NCCI (National Correct Coding Initiative) Policy Manual for Medicare Services, Intro –

- **"**Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code.
- Two types of practices lead to unbundling:
  - The first is **unintentional** and results from a misunderstanding of coding.
  - The second is **intentional** and is used by providers to manipulate coding in order to maximize payment."

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PERCEPTION

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RBRVS

MPFSDB – Medicare Physician Fee Schedule Database

- http://www.cms.hhs.gov/PhysicianFeeSched/
  - Click on PFS Relative Value Files
  - Scroll down to bottom of page
  - Click on Last
  - Choose RVU11AR (click on 2011 @ left)
  - Click on RVU11AR and then click Open
  - Double-click on RVUPUF11, open and print out
  - Double-click on PPRRVU11, the file that's 1904KB in size
  - For GPCIs, double-click on GPCI_2011, the file that's 15KB in size

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RBRVS

The Indicator List

Global Surgery 140-142 XXX Provides time frames that apply to each surgical procedure.

000=Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable.

010=Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10 day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during the 10-day postoperative period generally not payable.

090=Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule amount.

MMM=Maternity codes; usual global period does not apply.

XXX=The global concept does not apply to the code.

YYY=The carrier is to determine whether the global concept applies and establishes postoperative period, if appropriate, at time of pricing.

ZZZ=The code is related to another service and is always included in the global period of the other service.

Modifiers for E/M

-24

-25

-32

-33

-57

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Modifiers for E/M: -24

- "Unrelated evaluation and management service by the same physician during a postoperative period"
- Prompts payment for service (IP or O/P) that is not related to the postoperative care of the procedure
  - Critical care
  - Care for another medical condition
- Requires documentation that condition is unrelated to surgery
  - **Different diagnosis code is acceptable documentation**

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Modifiers for E/M: -25

- "Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service"
- "Above and beyond the other service"
- Beyond **usual** pre and postop care
- Substantiated in the documentation
- Different diagnoses not required (except critical care)
- Used to report E/M service done in addition to well visit
  - Portion of history/exam in well visit cannot be considered in E/M level
  - **Modifier applied to regular E/M, not to well visit code**

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Two E/Ms in One Day

- **Office/Outpatient E/M Visits Provided on Same Day for Unrelated Problems**
- Could also be provider of same specialty, same group practice, same day
- Provider(s) must document
  - Unrelated problems
  - Sufficiently to show that care could not be provided during the same encounter
    - e.g., office visit for blood pressure medication evaluation, followed five hours later by a visit for evaluation of leg pain following an accident.

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MODIFIERS FOR E/M: -32

- "Mandated services"
- Used if a service is required by
  - Third party payer
  - Government
  - Court
  - Regulatory requirement
- **No effect on payment by CMS**

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MODIFIERS FOR E/M: -57

- "Decision for surgery"
- Indicates that particular E/M (w/in global period) resulted in the decision for surgery
- Not to be used on E/M when surgery has 0-10 day globals (minor surgery)
  - Medicare may deny
- Surgeon may use in ER with New or Established Patient Office Visit codes when evaluation and decision for surgery is made prior to admission
- **Takes E/M out of the global surgery package**

-22 -47 -50 -51 -52 -53 -54 -55 -56 -58 -59

-62 -63 -66 -76 -77 -78 -79 -80 -81 -82

Surgical Modifiers

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Surgical Modifiers: -22

- "Increased procedural services"
- Work substantially greater than typically required
- Documentation must support the additional work and the reason for it specifically
- Not to be used with an E/M code
- Can only be used on codes with globals of 0, 10, or 90
- If submitted with documentation, priced individually
- **If submitted with no documentation, priced as w/o modifier**

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SURGICAL MODIFIERS: -50

- "Bilateral procedure"
- Do not use if descriptor includes the language "bilateral"
- Reported as a single line item
- **Reimbursed at 150% of allowed**

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SURGICAL MODIFIERS: -51

- "Multiple procedures"
- Appended to the additional code, never to the first sequenced code
- Never appended to add-on codes
- Do not use when two surgeons perform distinctly different surgeries on the same patient, same day – unless one performs multiple surgeries
- Claims for multiple surgeries are paid (allowed) as follows:
  - **100% fee schedule for highest value**
  - **50% fee schedule for 2nd -5th highest valued**
  - Suspend the 6th and subsequent for manual review

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SURGICAL MODIFIERS: -52

- "Reduced services"
- Part of service reduced or eliminated at the physician's discretion
- Report usual CPT® code that best describes the service with the modifier -52
- Do not report for hospital outpatient procedures that are partially reduced or cancelled
  - See modifiers 73 and 74
- **Reduced services, not reduced fee**
  - **Pricing not done without required documentation**
- Not to be used with an E/M service

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SURGICAL MODIFIERS: -54, -55, -56

- -54 "Surgical care only"
  - Includes the postop hospital visits
- -55 "Postoperative management only"
- -56 "Preoperative management only"
- All bill with the same procedure code and the same date of service (the date of the surgery)
- Date care relinquished or assumed in free text field on claim (Box 19 on CMS-1500)
- Providers must keep a written copy of the transfer of care in the patient's medical record
- Provider assuming postoperative care must see patient at least once before billing
- Providers each bill to the specific carrier servicing the locality in which the pre, intra, or postop care was performed, regardless of whether they are the same/different group

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Surgical Modifiers: -58

- "Staged or related procedure or service by the same physician during the postoperative period"
- Planned or anticipated (staged)
- More extensive than the original procedure
- For therapy following a (diagnostic) surgical procedure
- **Modifier added to staged procedure**
- **New postoperative period begins**

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1st Procedure on Monday

Postoperative Diagnosis:

1. Bilateral severe carotid occlusive disease
2. Acute right hip fracture

Operative Procedure: Right internal carotid, (5 cm), and common carotid, (10cm), endarterectomy with primary closure

Coding: 35301-22-RT

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2ND PROCEDURE ON WEDNESDAY

(Same Patient as Previous Slide)

Postoperative Diagnosis: Bilateral severe carotid occlusive disease, status post right carotid endarterectomy

Operative Procedure: Staged left carotid endarterectomy

Coding: 35301-58-LT

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SURGICAL MODIFIERS: -59

- "Distinct procedural service"
- Documentation must support: (**same day/same patient**)
  - Different session
  - Different procedure/surgery
  - Different site/organ system
  - Separate incision/excision
  - Separate lesion
  - Separate injury (or area of injury in multiple)
- **Modifier of last resort**
- Not appropriate to use with E/M codes

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Example of Separate Site

Postoperative diagnosis: Gunshot wound with injury to popliteal artery and popliteal vein of right leg

Operative Procedure:

1. Repair of popliteal artery with Gortex graft
2. Direct repair of popliteal vein

Coding: 35286-RT, 35226-59-RT

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Surgical Modifiers: -62

- "Two surgeons"
- Performing distinct parts of a procedure
- Surgeons both use same procedure code(s) with 62 modifier
- If one surgeon assist another for other procedures during same session, the assistant surgeon bills those procedures with -80 or -82
- **Allowed amount for each surgeon is 62.5% (half of 125% allowed)**

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Example of Co-Surgery

Postoperative Diagnosis: Adenocarcinoma of the esophagus. History of Barrett's esophageal epithelium.

Operative Procedure:

1. Ivor-Lewis esophagogastrectomy with intrathoracic reconstruction (Cosurgery)
2. Feeding jejunostomy (by general surgeon)
3. Pyloroplasty (43800 is bundled into 43117 by descriptor)
4. Partial resection of right sixth rib (by thoracic surgeon)

Coding for thoracic surgeon:	**Coding for general surgeon:**
43117-62, 21600-51-RT, 44015-80	43117-62, 44015, 21600-80

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Surgical Modifiers: -76 & -77

- -76 "Repeat procedure or service by same physician or other qualified health care professional"
- -77 "Repeat procedure or service by another physician or other qualified health care professional"
- **Modifiers do not affect payment**
- Should not be used with E/M codes

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Surgical Modifiers: -78

- "Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period"
- Unplanned following initial procedure
- Related to first procedure
- Performed in operating/procedure room
  - Medicare Claims Processing Manual states "operating room"
- Excluded from prepayment audit
- **When surgery is for complication, allowable is intraoperative portion**
  - **When surgery has a 000 global period allowable is full value**
- **Return to the operating room billed without modifier during a postop period will be denied**

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Surgical Modifiers: -79

- "Unrelated procedure or service by the same physician during the postoperative period"
- Must be unrelated to the original procedure performed at the start of the global period
- Excluded from prepayment audit
- **Surgeries billed in postop period without a modifier will be denied**
- **A new postop period begins (full allowed)**

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Example of Unrelated Procedure in Postop Period

Postoperative Diagnosis: Unstable angina, multivessel coronary artery disease

Operative Procedure:

1. Aortocoronary bypass time three (left internal mammary artery graft to left anterior descending, free left radial artery graft to the right coronary artery, left basilic vein graft to the obtuse marginal)

Coding: 33534, 33517, 35600

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Example of Unrelated Procedure in Postop Period

(Same patient as previous slide, in postop period of CABG)

Postoperative Diagnosis: Infrarenal abdominal aortic aneurysm

Operative Procedure: Resection, infrarenal abdominal aortic aneurysm (18-mm Dacron tube graft)

Coding: 35081-79

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Surgical Modifiers: -80, -81, -82

- -80 “Assistant surgeon”
- -81 “Minimum assistant surgeon”
- -82 “Assistant surgeon (when qualified resident surgeon not available)”
- Modifiers added to usual procedure number
- **Fee schedule for physicians = 16% allowed**
- **PAs bill Medicare with -AS modifier**
  - **Fee schedule for PAs = 85% of 16% or 10.4%**

Modifiers for Radiology

-26

-59

-LC

-LD

-RC

-TC

62

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Modifiers for Radiology: -26/-TC

- "Professional Component" / "Technical Component"
- Most codes in 70000 series have PC/TC components
  - 71020 Chest x-ray 0.86
    - The total RVUs for codes reported without a modifier include values for physician work, practice expense, and malpractice expense.
  - 71020 TC Chest x-ray 0.54
    - The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only.
  - 71020 26 Chest x-ray 0.32
    - The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense.
- Carriers use info in PC/TC Indicator Field of MPFSDB (PFS) to identify professional services eligible for HPSA and physician scarcity bonus payments

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Modifiers for Radiology: -26/-TC

- Important to understand contractual details when billing global radiology codes
  - Where is procedure performed?
  - Who owns the equipment?
  - What is the relationship between the radiologists and the facility?

For Example:

- If billing only for the radiologist doing supervision and interpretation, append -26 modifier.
- If billing only for the facility that owns the equipment, append the -TC modifier.
- If billing for a free-standing radiology facility that owns the equipment and employs the radiologists, bill the global code with no modifiers.
- Disclaimer: There are many different contractual relationships that would dictate how the radiology codes are billed.

THE ABN, NCDs & LCDs

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ADVANCE BENEFICIARY NOTICE (ABN)

- A written notice given to the Medicare FFS patient
  - When provider believes Medicare will not pay
  - Allows beneficiary to make an informed decision about receiving services for which they may be financially responsible
- Provider may bill and collect funds for non-covered items/services immediately after an ABN is signed
- If valid ABN (correct form w/ all blanks completed) not delivered to beneficiary, they cannot be billed for the service
- Coverage is limited by diagnoses outlined in National Coverage Determinations (NCDs) & Local Coverage Determinations (LCDs)
  - http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

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Advance Beneficiary Notice (ABN)

- If services are denied due to medical necessity, provider can bill patient only if:
  - Beneficiary chose to receive service
  - Beneficiary signed a valid ABN prior to service
- If services are denied due to CCI edits or MUE edits, **even if patient signed a valid ABN**:
  - **Beneficiary is not responsible**
  - **Provider cannot collect from the beneficiary and must refund any money collected for denied service or denied portion of bundled service**

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Advance Beneficiary Notice (ABN)

- ABNs are not required for excluded services
- Providers can issue an ABN voluntarily
- Routine ABNs are prohibited
  - Must be reasonable basis for issuing ABN
- ABNs should be kept on file for five years if no other state law exists regarding retention of records
  - Required even if beneficiary declined care, refused to complete or sign

http://www.cms.gov/BNI/02_ABN.asp

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ABN Modifiers

- GA Waiver of Liability Statement Issued as Required by Payer Policy
- GX Notice of Liability Issued, Voluntary Under Payer Policy
- GY Notice of Liability Not Issued, Not Required Under Payer Policy
- GZ Item or Service Expected to Be Denied as Not Reasonable and Necessary

http://www.cms.gov/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf

New Modifier -33

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NEW MODIFIER: -33

- (Mandated) Preventive Services
  - Used when the primary purpose of the service is preventive
  - Appended to each preventive service provided same day
  - Notifies payers that cost-sharing does not apply
    - **Would not collect deductibles, copayment or coinsurance**
  - Should not be used on services inherently preventive
- When an office visit is primary purpose for visit and covered preventive services are delivered at that visit, the office visit is billed separately
  - Cost sharing is permitted for the office visit:
    - If main purpose for visit was not preventive, OR
    - If services are provided out-of-network
  - **Would collect deductible, copayment or coinsurance for the office visit portion**

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OIG TARGETS

For OIG Annual Work Plan:

- http://oig.hhs.gov/publications/workplan.asp

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OIG Targets

Evaluation and Management Services During Global Surgery Periods
We will review industry practices related to the number of **E&M services provided by physicians and reimbursed as part of the global surgery fee**. CMS's *Medicare Claims Processing Manual, Pub. No. 100-04, ch. 12, § 40, contains the criteria for the global surgery policy. Under the global surgery fee concept, physicians bill a single fee for all of their services that are usually associated with a surgical procedure and related E&M services provided during the global surgery period. We will determine whether industry practices related to the number of E&M services provided during the global surgery period have changed since the global surgery fee concept was developed in 1992. (OAS; W-00-09-35207; various reviews; expected issue date: FY 2011; work in progress)*

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OIG Targets

Medicare Payments for Claims Deemed Not Reasonable and Necessary
We will review Medicare payments for Part B claims in 2009 that providers note as not reasonable and necessary on claim submissions.
The CMS *Claims Processing Manual states that providers may use* ***GA*** *or* ***GZ*** *modifiers on claims they expect Medicare to deny as not reasonable and necessary. A recent OIG study found that Medicare paid for 72 percent of pressure-reducing support surface claims with GA or GZ modifiers, amounting to $4 million in potentially inappropriate payments.* ***We will determine the extent to which Medicare paid for Part B claims with these modifiers, as well as the types of providers and the types of services associated with these claims.*** *We will also assess the policies and practices that Medicare contractors have in place with regard to these claims.*
(OEI; 02-10-00160; expected issue date: FY 2011; work in progress)

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OIG Targets

Medicare Billings With Modifier GY
We will review the appropriateness of providers' use of modifier GY on claims for services that are not covered by Medicare. CMS's *Medicare Carriers Manual, Pub. No. 14-3, pt. 3, § 4508.1, states that modifier GY is to be used for coding services that are statutorily excluded or do not meet the definition of a covered service. Beneficiaries are liable, either personally or through other insurance, for all charges associated with the provision of these services. Pursuant to CMS's Medicare Claims Processing Manual, Pub. No. 100-04, ch. 1, § 60.1.1, providers are not required to give beneficiaries advance notice of charges for services that are excluded from Medicare by statute. As a result, beneficiaries may unknowingly acquire large medical bills for which they are responsible. In FY 2008, Medicare received over 75.1 million claims with a modifier GY totaling approximately $820 million.* ***We will examine patterns and trends for physicians' and suppliers' use of modifier GY.***
(OEI; 00-00-00000; expected issue date: FY 2012; new start)

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OIG Targets

Error-Prone Providers: Medicare Part A and Part B
We will review Medicare Part A and Part B claims submitted by error-prone providers. CMS's *Medicare Claims Processing Manual, Pub. No. 100-04 requires providers to submit accurate claims for services provided to Medicare beneficiaries. Previous OIG work illustrated a methodology for identifying error-prone providers using CMS's Comprehensive Error Rate Testing (CERT) Program data. Using this methodology, we identified providers that consistently submitted claims found to be in error in a 4-year period. We will select the top error-prone providers based on expected dollar error amounts and match selected providers against the National Claims History file to determine the total dollar amount of claims paid.* ***We will then conduct a medical review on a sample of claims to determine their validity, project our results to each provider's population of claims, and request refunds on projected overpayments.***
(OAS; W-00-11-40044; various reviews; expected issue date: FY 2011; new start)

RAC Approved Issues

Region A

Region B

Region C

Region D

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RAC Contact Info

RAC	Website	E-mail	Telephone #
Region A: DCS	www.dcsrac.com	info@dcsrac.com	1-866-201-0580

CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI, VT
Go into website, click on Provider Portal and then Issues Under Review

RAC	Website	E-mail	Telephone #
Region B: CGI	http://racb.cgi.com	racb@cgi.com	1-877-316-7222

MN, WI, IL, IN, MI, OH, KY
Go into website, click on Issues

Region C: Connolly, Inc. www.connollyhealthcare.com/RAC RACinfo@connollyhealthcare.com
AL, AR, CO, FL, GA, LA, MS, NC, NM, OK, SC, TN, TX, VA, WV and the territories of Puerto Rico and U.S. Virgin Islands 1-866-360-2507
Go into website, click on Approved Issues

Region D: HDI http://racinfo.healthdatainsights.com racinfo@emailhdi.com
AK, AZ, CA, HI, IA, ID, KS, MO, MT, ND, NE, NV, OR, SD, UT, WA, WY, Guam, American Samoa, Northern Marianas Part A: 866-590-5598 Part B: 866-376-2319
Go into website, click on your state for Approved Issues

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RAC Audits

For Recovery Audit Contractor (RAC) Audits:

- http://www.cms.gov/RAC/02_ExpansionStrategy.asp#TopOfPage
  - Click on Recent Updates
    - Click on Provider Options Chart

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RAC Audits: Region A

- Technical Component of Radiology
  - A potential vulnerability may exist when the technical component (TC) of radiology services are furnished to patients in a Prospective Payment System (PPS) hospital setting and are billed separately to Part B. Therefore, an issue may exist when these codes are billed and are reimbursed under Medicare Part B in this manner.
    - IOM 100-04. Chapter 13. Section 20.2.1, OIG Report A-01-04-00528
- Global vs. TC/PC Split Reimbursements
  - A potential vulnerability may exist when providers are reimbursed for global procedures and then receive additional reimbursement for technical (modifier TC) and/or professional (modifier 26) components for the same service. Therefore, an issue may exist when these codes are billed and are reimbursed under Medicare Part B in this manner.
    - IOM 100-04, Chapter 1, Section 120; IOM 100-04, Chapter 12, Section 20.2; IOM 100-04, Chapter 13, Section 20.1-20.2.3; IOM 100-04, Chapter 16, pages 80.2.1

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RAC Audits: Region A

- Global Billing of Radiology or Diagnostic Tests in the Facility Setting
  - Providers should not bill diagnostic tests and radiology services globally in the facility setting. Therefore, an issue may exist when these services are billed globally and reimbursed under Medicare Part B
    - IOM 100-04 Chapter 13, Section 20.2.1; IOM 100-04 Chapter 23
- Global Surgery - Pre and Post-Operative Visits
  - E&M services are not allowed to be billed prior to a major surgical service without the proper modifiers. Therefore, an issue may exist when these services are billed and reimbursed under Medicare Part B without these modifiers.
    - IOM 100-04 Chapter 12, Section 40.1, 40.3

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RAC Audits: Region A

- National Correct Coding Initiative - Part B
  - A provider may not bill a Column II code when billed by the same provider and same date of service as a Column I code. Therefore, an issue may exist when Column II codes are billed and reimbursed under Medicare Part B in this manner.
    - IOM 100-04 Chapter 12, Section 30; IOM 100-04 Chapter 23, Section 20.9

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RAC Audits: Region B

- Failure to Correctly Bill Codes on the Medically Unlikely Edit List (Professional)
  - Certain codes on the MUE list are being incorrectly billed. An error was made in billing these codes, because more units were billed for same date of service for the same beneficiary by the same provider than what is medically likely and an appropriate modifier was not appended to the claim line.

NCCI Edits: Medically Unlikely Edits (MUEs)

CMS MUE Publication Announcement Letter / Office of Financial Management/Program Integrity Group

CMS Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and RAC

MLN Matters Number MM5402 / Medical Unlikely Edits

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RAC Audits: Region B

- Global Surgery
  - The purpose of this review procedure is to identify E&M services provided by the surgeon the day before, the day of, and 90 days after major surgery; 0-10 days after minor surgery.

Medicare Claims Processing Manual

NGS-National Government Services

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RAC Audits: Region B

- Multiple Surgery
  - The purpose of this automated review is to identify surgical claims that contain CPT code(s) with a "Multiple Procedure" Indicator Value of "2" or "3", that were incorrectly reported by the same physician, on the same patient on the same day, whether on different claims, different lines, or with a number greater than 1 in the units column for each code reported on the claim form and which resulted in an overpayment.

CMS Pub 100-04 Chapter 12

CMS Pub 100-04 Chapter 23

WPS – Wisconsin Physicians Services

Palmetto GBA

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RAC Audits: Region C

- Co-Surgery not billed with modifier 62
  - Improper payments exist when two surgeons perform surgery on the same patient; one surgeon added the co-surgeon modifier -62 and the other did not.
- Failure to Correctly Bill Codes on the Medically Unlikely Edit List – Carrier
  - Certain codes on the MUE list are being incorrectly billed. An error was made in billing these codes, because more units were billed for same date of service for the same beneficiary by the same provider than what is medically likely and an appropriate modifier was not appended to the claim line.

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RAC Audits: Region D

- Global vs TC/PC
  - An overpayment exists when providers are reimbursed for global procedures and then receive additional reimbursement for technical (modifier TC) and/or professional (modifier 26) components for the same service.
    - CMS Pub 100-04; Ch. 1, § 120 CMS Pub 100-04; Ch. 12, § 20.2 CMS Pub 100-04; Ch. 13, § 20.1 - 20.2.3 CMS Pub 100-04; Ch. 16, § 80.2.1

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RAC Audits: Region D

- TC of Radiology
  - Carriers/MACs may not pay for the technical component (TC) of radiology services furnished to patients in inpatient or outpatient hospital settings.
    - OIG Report A-01-04-00528; CMS Pub 100-04, Chapter 13, § 20.2.1; Med Learn Matters #MM537; Change Request 5675
- Medically Unlikely Edits
  - Medically Unlikely Edits were implemented January 1, 2007. These edits were developed to reduce the error rate and are used to adjudicate claims at Carriers, Fiscal Intermediaries, and DME MACs. As explained in CMS' announcement letter to providers and suppliers "An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service."
    - Medically Unlikely Edits; and, MLN Matters MM5402

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RAC AUDITS: REGION D

- NCCI Edits
  - National Correct Coding Initiative (NCCI) Edits identify CPT/HCPCS code combinations that should not be reported together by the same Provider for the same Beneficiary and the same date of service. Each NCCI edit has an assigned modifier indicator. A modifier indicator of "0" indicates that NCCI-associated modifiers cannot be used to bypass the edit. A modifier indicator of "1" indicates that NCCI-associated modifiers may be used to bypass an edit under appropriate circumstances. Overpayments due to NCCI edits may be identified under the same claim number or under different claim numbers.
    - National Correct Coding Initiative Coding Policy Manual for Medicare Services; CMS Pub 100-04, Chapter 23 § 20.9

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RAC AUDITS: REGION D

- TC of Radiology Reductions
  - When certain diagnostic imaging services are performed on contiguous body parts, full payment is allowed for the first procedure and a 25 percent reduction in the technical component (TC) payment is applied to additional imaging procedures. Improper payments exist when the reduction is not applied.
    - MedLearnMatters Article SE0587; and Change Request 5443; and MedLearnMatters Article SE0665; and CMS Pub 100-04; Chapter 23, Addendum - MPFSDB Record Layouts

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RAC AUDITS: REGION D

- Procedures performed during the Global Period of other Procedures
  - Medicare does not allow separate payment for an additional procedure(s) with a global surgery fee period of 010 and/or 090 days if the service(s) is(are) furnished during the postoperative period of a prior procedure and if billed without modifier "-58," "-78," or "-79." Separate payment in this situation is an overpayment.
    - Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 40.2, 40.3 and 40.4; and, Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 23, Addendum - MPFSDB Record Layouts

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RAC AUDITS: REGION D

- Multiple Surgery Reduction Errors – **Underpayments**
  - Multiple surgeries are separate procedures performed on the same patient at the same operative session or on the same day for which separate payment may be allowed. When multiple surgical procedures are performed Medicare Physician Fee Schedule (MPFS) rules state that the second and any subsequent procedures are subject to reduced reimbursement. The Medicare Physician Fee Schedule data Base (MPFSDB) Multiple Procedure Indicators reflect the reduction amount, if any, that is applicable for the surgical procedure. Reducible procedures are ranked in descending order by the Medicare fee schedule amount. Payment for the procedure with the highest value is based on 100% of the fee schedule amount. Subsequent procedures are paid based on 50% of the fee schedule amount. **Underpayments occur when claim lines are improperly reduced due to incorrect primary procedure ranking determinations and when modifier 51 is submitted for non-reducible procedures.**
    - CMS Pub 100-04, Chapter 12, § 40.6; and, CMS Pub 100-04; Chapter 23, § 30

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RAC AUDITS: REGION D

- Global Days
  - Under Medicare Physician Fee Schedule (MPFS) rules, most surgical procedures include pre-operative and post-operative Evaluation & Management services. These E&M services are referred to as 'Global Days'. Procedures with MPFS global days values of 000 include only E&M services rendered on the day of the surgery. Procedures with 010 global days include E&M services on the day of the procedure and up to 10 post-operative days. Procedures with 090 global days include E&M services the day before, the day of the procedure and up to 90 post-operative days. Physicians can indicate that E&M services rendered during the global period are unrelated to the surgical procedure by submitting modifiers 24 (Unrelated Evaluation and Management Service By Same Physician During Post-operative Period), 25 (Significant Evaluation and Management Service By Same Physician On Date of Global Procedure) and 57 (Decision For Surgery Made Within Global Surgical Period) on the E&M service.
    - Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 40

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RAC AUDITS: REGION D

- Multiple Surgery Reduction Errors: Single Line Modifier 51 **Underpayments**
  - Multiple surgeries are separate procedures performed on the same patient at the same operative session or on the same day for which separate payment may be allowed. When multiple surgical procedures are performed Medicare Physician Fee Schedule (MPFS) rules state that the second and any subsequent procedures are subject to reduced reimbursement. Providers are instructed to report modifier 51 (multiple procedures) to identify such services. The Medicare Physician Fee Schedule data Base (MPFSDB) Multiple Procedure Indicators reflect the reduction amount, if any, that is applicable for the surgical procedure. **When only one surgical procedure is performed and modifier 51 is claimed, the reimbursement is inappropriately reduced by 50%.**
    - Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 40.6; Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 23, § 30

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RAC AUDITS: REGION D

- Multiple Surgery Reduction Errors – **Overpayments**
  - Multiple surgeries are separate procedures performed on the same patient at the same operative session or on the same day for which separate payment may be allowed. When multiple surgical procedures are performed Medicare Physician Fee Schedule (MPFS) rules state that the second and any subsequent procedures are subject to reduced reimbursement. The Medicare Physician Fee Schedule data Base (MPFSDB) Multiple Procedure Indicators reflect the reduction amount, if any, that is applicable for the surgical procedure. Reducible procedures are ranked in descending order by the Medicare fee schedule amount. Payment for the procedure with the highest value is based on 100% of the fee schedule amount. Subsequent procedures are paid based on 50% of the fee schedule amount. **Overpayments occur when secondary/subsequent procedures claim lines are not properly reduced due to incorrect primary procedure ranking determinations.**
    - Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 40.6; Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 23, § 30

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RAC AUDITS: REGION D

- Co-Surgery not billed with modifier 62
  - Improper payments exist when two surgeons perform surgery on the same patient; **one surgeon added the co-surgeon modifier -62 and the other did not**.
    - CMS Pub 100-02 Chapter 12, § 40.8

Strategies for Success: Prepayment

- Obtain your bundling edits, RVUs and Conversion Factors or Fee Schedules, by contract if possible
  - Load data into practice management software that will help you track payments and denials
- Know your payers' medical payment policies
  - Can't keep 'em, can't check 'em, if you don't know 'em
  - Know ahead of time what you'll be held to in audit
- Use modifiers judiciously
  - **You would never use a modifier to bypass an edit that should be applied by contract**

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Strategies for Success: Postpayment

- Let you denials be your guide
- If you use bundling edit pre-claim, you will have better chance of winning appeal
  - Time won't be wasted filing appeal you can't win
- Copy documentation, op report, pathology if necessary
- Copy Explanation of Benefits, Remittance Advice
- Copy pertinent pages of CCI or other bundling edit (date of service driven)
- Write brief letter outlining reasoning
- Always sign with your credential

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Closing Remarks

Questions?

Thank you for the investment of your time.