Indiana State Medical Association – Coalition Meeting
November 7, 2014

Topics for Discussion

1. Documentation Timeliness

WPS Medicare remarks: There are several provisions that may affect "timeliness" when talking about documentation. A provider may not submit a claim to Medicare until the documentation is completed. Practitioners are expected to complete documentation of services "during or as soon as practicable after it is provided in order to maintain an accurate record." CMS does not provide any specific period, but a reasonable expectation would be no more than a couple of days away from the service itself. Providers should not add late signatures to the medical record (beyond the short delay that occurs during the transcription process). If a practitioner does not affix a signature at the time of the services (also allowing limited delay due to transcription), then the provider may complete a signature attestation statement.

For additional details, including links to CMS Internet-Only Manual citations that address this, please refer to "Documentation Timeliness," available at http://www.wpsmedicare.com/j8macpartb/claims/submission/documentation-timelines.shtml.

2. Provider Enrollment – does the provider have to submit an Electronic Data Interchange (EDI) enrollment form during the enrollment process?

WPS Medicare response: Section 17 of the application instructions, Supporting Documents, lists the documents that, if applicable, must be submitted with the enrollment application. It does not indicate that providers must submit an EDI enrollment form. Although WPS Medicare should not reject the application if we do not receive an EDI enrollment form, if we are developing for other items, we may request the EDI enrollment form. In the end, it is not required and the provider may file this at any time.

3. ICD-10 Testing

WPS Medicare remarks: Change Request 8858 instructs MACs to promote, implement and support three National Testing Weeks for ICD-10 Acknowledgement testing. Dates are:

November 17 – 21, 2014

March 2 – 6, 2015

June 1 – 5, 2015

Submitters can acknowledgement test at any time, provided the file is submitted as a test with an ISA15 = T.

- Test claims with ICD-10 codes must be submitted with current dates of service since testing does not support future dates of service.
- Claims will be subject to existing NPI validation edits.
- Test claims will be subject to all existing EDI front-end edits including Submitter authentication and NPI validation.
- Test claims will receive the 277CA or 999 acknowledgement as appropriate, to confirm that the claim was accepted or rejected by Medicare.
- Testing will not confirm claim payment or produce a remittance advice.

MACs and CMS EDI will be staffed to handle increased call volume during testing weeks. Watch the WPS Medicare and CMS websites for updates.

MACS will also offer limited end-to-end testing with certain volunteers.

CMS defines successful end-to-end testing as being able to demonstrate that:

- Testing entities are able to successfully submit ICD-10 claims to the shared systems,
- Software changes made to support ICD-10 result in appropriately adjudicated claims based on the pricing data employed for testing purposes; and
- An Electronic Remittance Advice (ERA) is produced (e.g. 837 in ➔ 835 out)

Potential volunteers previously registered in order to be considered for end-to-end testing. WPS Medicare will notify selected trading partners if they are chosen to participate.

4. Medicare Clerical Error Reopenings

WPS Medicare remarks: Section 937 of the Medicare Modernization Act required CMS to establish a process whereby provider, physicians, and suppliers could correct minor error or omissions outside of the appeals process. A reopening is performed to make a minor change or correction to a previously processed claim, if the original claim has been denied or reduced. For example, you omitted or incorrectly keyed the diagnosis code or a modifier which resulted in a claim denial. CMS provides the instructions for reopening activities conducted by MACs.

A helpful article on our website, entitled "How To Request a Clerical Error Reopening" includes the submission methods, what does and does not constitute a clerical error reopening, time limits, and instructions for completing and submitting the WPS Medicare Clerical Error Reopening Request Form, for when the request is submitted in writing. There

is also a link to a Reopening Calculator to determine the timeframe for submission of a valid reopening. The article is available at http://www.wpsmedicare.com/j8macpartb/departments/appeals/b_reopening.shtml.

Although the Clerical Error Reopening process is not a part of the formal appeals process, you will find information pertaining to these by viewing the Appeals web page on our website. To locate this page, choose the "Departments" tab, followed by "Appeals."

5. Medicare Appeals

WPS Medicare remarks: Medicare allows beneficiaries, providers, and suppliers the right to appeal Medicare coverage and payment decisions. There are five levels of Appeal.

1. Redetermination by a carrier, Fiscal Intermediary (FI), or MAC ➔ THIS IS THE ONLY LEVEL OF APPEAL PERFORMED BY WPS MEDICARE
2. Reconsideration by a Qualified Independent Contractor (QIC)
3. Hearing by an Administrative Law Judge (ALJ) in the Office of Medicare Hearings and Appeals
4. Departmental Appeals Board (DAB)/Appeals Council
5. Judicial Review in Federal District Court

For each level, there are time limits. For some levels, there are minimum amounts in controversy (AIC). The WPS Medicare Appeals web page (http://www.wpsmedicare.com/j8macpartb/departments/appeals/) includes an appeals overview, information, Frequently Asked Questions, Calculators/Tools and resources, including links to forms. CMS has published a helpful appeals process flowchart for original Medicare at http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Downloads/AppealsProcessFlowchart-FFS.pdf and a Medicare Appeals Process booklet, available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicareAppealsProcess.pdf, both excellent resources.

6. The Advisory Committee on Immunization Practices (ACIP) recommended an initial pneumococcal vaccine and a booster one year later for all adults 65 years or older regardless of health risk. Will Medicare cover pneumococcal vaccination when given according to the ACIP recommended vaccination schedule?

WPS Medicare response: In September 2014 the Advisory Committee on Immunization Practices (ACIP) issued a recommendation for pneumococcal vaccines for adults 65 years and older. They recommended an initial vaccination and a booster one year later for all adults 65 years or older regardless of health risk. Specifically, they recommend:

- If not previously vaccinated, administer PCV13 (90670) first; give PPSV23 (90732) 6-12 months after

- If previously received PPSV23 (90732), administer PCV13 ≥ 12 months after

Medicare will not cover pneumococcal vaccinations when given according to the ACIP recommended vaccination schedule. Medicare law only allows contractors to reimburse for a second pneumococcal vaccination 5 years after the initial vaccination is given and then only for those at highest risk.

In the October 23, 2014 CMS eNews, CMS reiterated the payments rules for influenza and pneumococcal vaccinations in the Protect Your Patients Against Influenza and Pneumonia article.

7. CMS Medicare Learning Network (MLN) Matters® Number MM8853, Revised Modification to the Medically Unlikely Edit (MUE) Program
   http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8853.pdf

8. CMS MLN Matters® Number MM8863, Specific Modifiers for Distinct Procedural Services
   http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8863.pdf

9. Comprehensive Error Rate Testing (CERT) Program Update
   WPS Medicare CERT Error Analysis Web Page
   http://www.wpsmedicare.com/j8macpartb/departments/cert/cert-error-analysis.shtml

WPS Medicare
HEALTH INSURANCE
A CMS Medicare Contractor

Medicare Part B - Current Updates

Disclaimer

Every reasonable effort has been made to ensure the accuracy of this information. However, the provider has the ultimate responsibility for compliance with Medicare rules and regulations. WPS Medicare bears no liability for the results or consequences of the misuse of this information. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

CMS Secure Net Access Portal (C-SNAP) New Functions Now Available

Part B Appeals Status

Check the status of your Part B Appeals with C-SNAP. All you need is the beneficiary's name, date of service or the Internal Control Number (ICN). Status is available within 10 days after request submission. Once completed, the Decision Date and the Decision are available.

For C-SNAP Technical Support assistance, please reference the C-SNAP On Demand trainings listed below. The training may provide you with the answer to your question. Also, review our new feature "Help Center."

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/training/on_demand/csnap-od.shtml
Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/training/on_demand/csnap-od.shtml

If you have questions that cannot be resolved after reviewing the C-SNAP On Demand Training, please call Medicare Customer Service at

Iowa, Kansas, Missouri, and Nebraska	Indiana and Michigan
(866) 518-3285	(866) 234-7331

C-SNAP User Manual is now available on the C-SNAP Home page at:

http://medicareinfo.com

Reopening feature

The current Clerical Error Reopen (CER) submissions in C-SNAP via the "Appeals" pages have been changed. This enhancement enables a provider to enter revised claim information that will be transmitted to the MCS through C-SNAP. The new CER feature allows you to change some specific claim information on a denied claim and receive immediate notification that the claim adjustment has been accepted into MCS. For more information, see the article "Change to CMS Secure Net Access Portal (C-SNAP) Reopening Feature Early September 2014," found on the WPS Medicare website at:

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/departments/appeals/_files/change-csnap-reopening-feature.pdf

Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/departments/appeals/_files/change-csnap-reopening-feature.pdf

Overpayment Claim Adjustments (OCA) feature
Overpayment Claim Adjustments (OCA) - Medicare Part B providers now access to an automated process to submit Medicare Secondary Payer (MSP) and non-MSP overpayment adjustments via C-SNAP. Additional information can be found at:

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/departments/payment-recovery/_files/csnap-oca.pdf

Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/departments/payment-recovery/_files/csnap-oca.pdf

ICD-10 Compliance Date is October 1, 2015

Providers are required to continue to use ICD-9-CM through September 30, 2015. As additional information becomes available from CMS, we will publish that information in the weekly eNews. Sign up for WPS Medicare eNews at:
http://visitor.r20.constantcontact.com/manage/optin/ea?v=001B5adRlY4IqajYzHtZeaOuQ%3D%3D

You can find ICD-10 information on the ICD-10 page of the WPS Medicare website at:

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/claims/icd-10/
Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/claims/icd-10/

Sign up for Medicare Learning Network

CMS national provider educational products, named The Medicare Learning Network® (MLN), share up-to-date educational information and accompany the release of new or revised Medicare program policies. Available educational tools include National Educational Articles, Brochures, Fact Sheets, Web-Based Training Courses, Videos and Podcasts.

For more details, please visit:
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html

Comprehensive Error Rate Testing (CERT) Program

CMS uses the CERT program to measure and improve the quality and accuracy of Medicare claims submission, processing, and payment. WPS Medicare uses the error rate information to ensure education will address and prevent the most common billing errors and claim denials.

CMS Comprehensive Error Rate Testing (CERT) Program web page

http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/index.html

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/departments/cert/
Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/departments/cert/

Internet-based Provider Enrollment, Chain and Ownership System (PECOS)

Submit your Medicare Enrollment Application using Internet-based PECOS, the fastest, easiest way to enroll in the Medicare program or update your Medicare program enrollment record.

You can access Internet-based PECOS at: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html

The CMS publication (ICN 903767), titled *"The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations"* helps you use internet-based PECOS. You can download it here: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf

The CMS publication (ICN 903764), titled *"The Basics of Internet-based PECOS for Physicians and Non-Physician Practitioners"* helps you use internet-based PECOS. You can download it here: http://www.cms.gov/outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_Pecos_PhysNonPhys_FactSheet_ICN903764.pdf

Revalidation of Medicare Provider Enrollment Information

The Affordable Care Act requires providers and suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria.

This requirement applies to providers and suppliers enrolled in Medicare prior to March 25, 2011. Providers and suppliers who submitted their Medicare enrollment on or after March 25, 2011, are not impacted.

Wait to submit revalidation until after your Medicare Administrative Contractor asks you to do so. Revalidation notices will be sent out on or before March 2015.

A MLN Matters article on the revalidation process is found at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads//SE1126.pdf

Customer Satisfaction Survey

WPS Medicare strives to continue to improve our website to meet our providers' needs. We use the ForeSee Customer Satisfaction Survey as a primary means to gather your feedback and input and gauge your satisfaction with our website. Please take time to complete the Website Satisfaction Survey that pops up when visiting the WPS Medicare website.

Medicare Quarterly Provider Compliance Newsletter

The Medicare Learning Network® (MLN) Products Provider Compliance page contains educational products informing Medicare Fee-For-Service (FFS) providers about how to avoid common billing errors and other improper activities when dealing with the Medicare Program. Since 1996, CMS has implemented several initiatives to prevent improper payments before a claim is processed and to identify and recoup improper payments after the claim is processed. The overall goal of CMS' claim review programs is to reduce payment error by identifying and addressing billing errors concerning coverage and coding made by providers.

To learn more, visit the CMS Provider Compliance page:
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html

eNews

WPS Medicare publishes our eNews Listserv three times a week. Monday's eNews contains the most current and vital information Medicare providers need to know including policy updates, current Medicare information, and changes as they happen. Wednesday second eNews contains educational opportunities and Thursday's the third eNews is a publication of a CMS Listserv. To sign up, visit the WPS Medicare website and select "eNews" in the upper right corner. We encourage everyone at provider offices to subscribe, as there are no restrictions on how many individuals can subscribe.

You can sign-up on the WPS Medicare website at: http://corp-ws.wpsic.com/apps/commercial/unauth/medicareListservUserWelcomeLoadAction.do

WPS Medicare Resources Web Page

WPS Medicare offers a wide range of resources to assist providers. We regularly develop and improve our online resources to decrease providers' costs and time spent contacting WPS Medicare. Easy Access to the following information can be found under the Resources tab: Acronyms Lookup, CMS/External Links, Modifiers, New Providers and Provider Specialties/Services, Tips for First Time Visitors and Website Updates. Information is available 24 hours a day, 7 days a week, at a time most suitable to providers' schedules.

Visit the WPS Medicare Resource Web Page:
Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/resources/
Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/resources/

Medicare Remit Easy Print (MREP)

MREP enables providers and suppliers to view and print 835 files, saves time and money, generates several useful reports, makes remittances easy to navigate and view**.**

Get easy Access to MREP by visiting the WPS Medicare website below.

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/departments/edi_/mrep.shtml
For assistance, please call (866) 518-3285 and follow the prompts for EDI assistance.

Indiana and Michigan

http://www.wpsmedicare.com/j8macpartb/departments/edi_/mrep.shtml
For assistance, please call (866) 234-7331 and follow the prompts for EDI assistance.

Medicare Incentive Programs

Incentive payments are available to eligible professionals who meet the eligibility and reporting requirements for each program. In 2014, eligible professionals may choose to participate in the following payment incentive programs.

1. Physician Quality Reporting System – Medicare eligible professionals who satisfactory report data on quality measures for covered professional services furnished to Medicare beneficiaries. Find more information on the Physician Quality Reporting System program on the CMS website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html

2. Electronic Health Records (EHR) – Medicare eligible professionals, hospitals, and critical access hospitals for the "meaningful use" of certified EHR technology. Medicare eligible professionals may not earn incentives under the eRX and Electronic Health Records incentive programs at the same time.

Find more information on the EHR Incentive Program on the CMS website:
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

CMS Offers Free Mobile Applications (apps) to Track Payments Under Open Payments

In July 2012, CMS introduced two free mobile applications (apps) to help physicians and health care industry users track their payments and other transfers of value that applicable manufacturers and applicable Group Purchasing Organizations (GPOs) will report under Open Payments. Created by a provision of the Affordable Care Act, Open Payments creates greater public transparency about the financial transactions among physicians, teaching hospitals, and drug and device manufacturers.

These apps are available to facilitate accurate reporting of required information, which will be available to the public and will be published annually on the Open Payments website. The mobile apps allow both industry and physician users to track payments and other transfers of value in real-time. One app is targeted specifically to physicians (*Open Payments Mobile for Physicians*) and the other one is for industry, including applicable manufacturers and applicable GPOs (*Open Payments Mobile for Industry*).

The mobile applications can be downloaded and used easily and conveniently on a mobile device. Both apps are compatible with the iOS (Apple™) and Android platforms; they are available free through the iOS Apple™ Store and Google Play™ Store.

For more information on Open Payments and the mobile app, please see the program website at http://go.cms.gov/openpayments

For more information regarding the enhancements made to the mobile apps based upon user feedback, please use the MLN Matters article on the topic. The article can be found online at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1402.pdf.

Revised Modifications to the Medically Unlikely Edit (MUE) Program

Additional modifications are being updated in the MUE program. The updates include clarifications, general processing instructions and detailed explanations of MUE requirements and specifications. Please advise your billing staff of these changes. For more information please refer to the Medicare Learning Network Matters Number MM8853 at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8853.pdf

Specific Modifiers for Distinct Procedural Services

Effective, January 1, 2015, new coding requirements related to Healthcare Common Procedure Coding System (HCPCS) modifier -59 could impact your reimbursement. Change Request (CR) 8863 notifies MACs and providers that the CMS is establishing four new HCPCS modifiers, (XE, XS, XP, XU) to define subsets of the -59 modifier, a modifier used to define a "Distinct Procedural Service." For additional information please read Medicare Learning Network Matters Number MM8863 at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8863.pdf

WPS Medicare Part B - Quarterly CERT Error Findings Report

~ INDIANA ~

This report contains details of Comprehensive Error Rate Testing (CERT) errors assessed July 2014 through September 2014 for Indiana providers. The findings below are reported based on the type of error assessed by the CERT contractor (e.g., insufficient documentation, incorrect coding, etc.).

Insufficient Documentation - 87% of total errors

Reasons for Errors:

- Provider billed for subsequent inpatient hospital encounter and submitted copies of progress notes for other dates. Missing the encounter note for billed date of service.
- Billed for initial hospital care Evaluation and Management (E/M) of a patient. Missing the note for this date of service. Received History and Physical note for a different date, subsequent hospital care progress notes for multiple dates, and discharge note. Insufficient documentation to support service billed.
- Billed Ambulance service, advanced life support, emergency transport, level 1 (ALS1-Emergency) and mileage (A0427-RH, A0425-RH). Missing the following: 1) the billing provider signed and dated signatures of the EMT staff on the ambulance transport form; 2) Signed and dated beneficiary consent form for ambulance transportation; 3) Attestation statements from the EMT staff; and 4) Signed and dated signature, date, and time of the receiving facility employee who received the beneficiary on this DOS. Submitted documentation included an unsigned ambulance report only.
- Claim billed for laboratory testing (alcohol; amitriptyline; amphetamine or methamphetamine; barbiturates; benzodiazepines; and cocaine). Submitted documentation is missing the order for or the clinical documentation to support the plan/intent for testing and the clinical documentation to support the medical necessity of testing. Documentation initially submitted included non-specific order for testing, progress note that only included the medications prescribed and diagnosis, and results of testing. No documentation returned from follow-up requests. Submitted documentation is insufficient to meet Medicare guidelines.
- Billed is column chromatography/mass spectrometry, methadone, and drug confirmation (each procedure) for date of service 09/13/13 (CPT 82544, 83840, 80102). Missing the following; 1) physician's order for or documentation to support intent to order each study; 2) physician's clinical documentation to support the reason/need for studies to be performed; 3) physician's signature attestation to the progress note of 09/12/13. Received order for elite screening urine test with illegible signature, unauthenticated progress note for 09/12 and laboratory results.
- Provider billed for qualitative drug screen and confirmation (G0431), one procedure and submitted copy of progress notes describing management of opiate dependence, results of tests,

and unsigned requisition for meds detection panel. Missing physician's order for the drug screen and confirmation testing.

- Provider billed for qualitative drug screen and confirmation, one procedure (CPT 80102) and quantitative drug test for opiates (CPT 83925). Submitted copy of progress notes describing management of opiate dependence, results of tests, and requisition for lab panels. Missing physician's order for the drug screen and confirmation testing.
- Provider billed for Total Thyroxine and free T-3 (CPT 84436, 84481) and submitted copy of order and results. Missing documentation describing medical necessity for tests, such as might be found in physician's progress notes.
- Billing for morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe; using computer-assisted technology (CPT 88367). Missing an order or the office visit or progress note that documents the plan to order and clinical documentation such as office visit or progress note that supports medical necessity and the need for lab test billed.
- Billed Therapeutic, Prophylactic, or Diagnostic Injection, Chemotherapy Administration - Palonosetron HCL, Diphenhydramine HCL, Dexamethasone Sodium Phosphate and Paclitaxel. Missing a copy of authenticated medication administration record that documents Palonosetron HCL, Diphenhydramine HCL, Dexamethasone Sodium Phosphate and Paclitaxel were given for date of service billed 10/30. Documentation received includes partly legible chemotherapy flow sheet, treatment plan/chemo orders with start day 10/23, lab results, and several visit notes dating from 06/17 to 10/30 documenting beneficiary with right breast carcinoma including one for DOS 10/30 but missing documentation of medication administration.

Incorrect Coding - 13% of total errors

Reasons for Errors:

- Billed CPT 99205, new patient office visit that requires 3 of 3 key components (comprehensive history, comprehensive exam, and high complexity medical decision making (MDM)). Documentation supports code change from 99205 to 99203 requires 3 of 3 key components (Detailed-History, Detailed-Exam, Low complexity-Medical decision making). Meets 99203 with detailed history, detailed exam and moderate complexity MDM per 1995 evaluation and management guidelines.
- Billed 99222, requires 3 out of 3 key components; comprehensive history, comprehensive exam, and moderate medical decision making (MDM). Submitted documentation supports a down code from 99222 to 99221 with detailed history (Limited ROS), detailed exam using 1995 E/M guidelines, and moderate complexity MDM.
- Provider billed for initial hospital encounter CPT 99223, requiring 3/3: Comprehensive history and exam, and medical decision making of high complexity. Submitted documentation supports CPT 99222 with comprehensive history and exam and MDM of moderate complexity.
- Billed CPT 99233 requires 2 of 3 key components (detailed history, detailed exam, and high complexity MDM). Documentation supports code change from 99233 to 99232 with expanded problem focused history, expanded problem focused exam and high complexity MDM.

Based on CERT error findings for this quarter, below are educational resources that can assist in avoiding these issues in your practice.

CMS Resources

- **Provider Signature Requirements** - CMS Internet-Only Manual (IOM), Publication 100-08, Chapter 3, Section 3.3.2.4
- **Requirements for Ordering and Following Orders for Diagnostic Tests–** CMS IOM, Publication 100-02, Chapter 15, section 80.6.1
- **Selection of Level of Evaluation and Management Service** – CMS IOM , Publication 100-04, Chapter 12, section 30.6.1
- **Ambulance** – CMS IOM, Publication 100-4, Chapter 15
- **Necessity and Reasonableness** – CMS IOM, Publication 100-2, Chapter 10, section 10.2, section 20.1.2 (Beneficiary Signature Requirements) and section 30.1.1(Ground Ambulances Services)

WPS Medicare Resources

Local Coverage Determinations (LCDs) for:

- Qualitative Drug Testing

Additional WPS Medicare web page resources:

- CERT Articles
- CERT Error Analysis
- Evaluation & Management Services (under Resources, Provider Specialties/Services)

Note: Review results are based on Medicare regulations in place at the time services were rendered. Medicare providers are responsible for compliance with all current applicable Medicare coverage, coding and billing regulations upon claim submission.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

REVISED products from the MLN

- "Medicare Learning Network® (MLN) Suite of Products & Resources for Compliance Officers", Educational Tool, ICN 908525, Downloadable only

MLN Matters® Number: MM8863 **Related Change Request (CR) #: CR 8863**

Related CR Release Date: August 15, 2014 **Effective Date: January 1, 2015**

Related CR Transmittal #: R1422OTN **Implementation Date: January 5, 2015**

Specific Modifiers for Distinct Procedural Services

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) and Durable Medical Equipment (DME) MACs for services provided to Medicare beneficiaries.

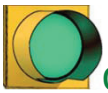
Provider Action Needed

STOP – Impact to You

New coding requirements related to Healthcare Common Procedure Coding System (HCPCS) modifier -59 could impact your reimbursement.

CAUTION – What You Need to Know

Change Request (CR) 8863notifies MACs and providers that the Centers for Medicare & Medicaid Services (CMS) is establishing four new HCPCS modifiers to define subsets of the -59 modifier, a modifier used to define a "Distinct Procedural Service."



GO – What You Need to Do

Make sure your billing staffs are aware of the coding modifier changes.

Background

The Medicare National Correct Coding Initiative (NCCI) has Procedure to Procedure (PTP) edits to prevent unbundling of services, and the consequent overpayment to physicians and outpatient facilities. The underlying principle is that the second code defines a subset of the work of the first code. Reporting the codes separately is inappropriate. Separate reporting would trigger a separate payment and would constitute double billing.

CR8863discusses changes to HCPCS modifier -59, a modifier which is used to define a "Distinct Procedural Service." Modifier -59 indicates that a code represents a service that is separate and distinct from another service with which it would usually be considered to be bundled.

The -59 modifier is the most widely used HCPCS modifier. Modifier -59 can be broadly applied. Some providers incorrectly consider it to be the "modifier to use to bypass (NCCI)." This modifier is associated with considerable abuse and high levels of manual audit activity; leading to reviews, appeals and even civil fraud and abuse cases.

The primary issue associated with the -59 modifier is that it is defined for use in a wide variety of circumstances, such as to identify:

- Different encounters;
- Different anatomic sites; and
- Distinct services.

The -59 modifier is

- Infrequently (and usually correctly) used to identify a separate encounter;
- Less commonly (and less correctly) used to define a separate anatomic site; and
- More commonly (and frequently incorrectly) used to define a distinct service.

The -59 modifier often overrides the edit in the exact circumstance for which CMS created it in the first place. CMS believes that more precise coding options coupled with increased education and selective editing is needed to reduce the errors associated with this overpayment.

CR8863 provides that CMS is establishing the following four new HCPCS modifiers (referred to collectively as -X{EPSU} modifiers) to define specific subsets of the -59 modifier:

- XE Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter,

- XS Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure,
- XP Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner, and
- XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service.

CMS will continue to recognize the -59 modifier, but notes that Current Procedural Terminology (CPT) instructions state that the -59 modifier should not be used when a more descriptive modifier is available. While CMS will continue to recognize the -59 modifier in many instances, it may selectively require a more specific - X{EPSU} modifier for billing certain codes at high risk for incorrect billing. For example, a particular NCCI PTP code pair may be identified as payable only with the -XE separate encounter modifier but not the -59 or other -X{EPSU} modifiers. The -X{EPSU} modifiers are more selective versions of the -59 modifier so it would be incorrect to include both modifiers on the same line.

The combination of alternative specific modifiers with a general less specific modifier creates additional discrimination in both reporting and editing. As a default, at this time CMS will initially accept either a -59 modifier or a more selective - X{EPSU} modifier as correct coding, although the rapid migration of providers to the more selective modifiers is encouraged.

However, please note that these modifiers are valid even before national edits are in place. MACs are not prohibited from requiring the use of selective modifiers in lieu of the general -59 modifier, when necessitated by local program integrity and compliance needs.

Additional Information

The official instruction, CR 8863 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1422OTN.pdf on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.