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Chapter 4. Summary of Select Investigative Findings

This chapter contains a summary overview of current and previous investigations conducted by such agencies as the Office of Inspector General (OIG), Recovery Audit Contractors (RAC), and Comprehensive Error Rate Testing (CERT) contractors. Occasionally, other governmental agencies, such as the U.S. Government Accountability Office (GAO) or Federal Bureau of Investigation (FBI), may be included or referenced. The selected topics are considered to be of the greatest value to a physician practice in terms of compliance. Additional subjects will be included in future updates and can be found on the website.

Whenever possible, the findings of the investigation are included; though it should be noted that many of the investigations discussed in this publication are currently ongoing and, therefore, any conclusive findings are pending.

Strategies for recognizing and preventing risk factors are also discussed in this Guide. Official resources have been consulted and are cited at the end of each topic summary for convenience purposes. This enables a user to reference these resources, as needed, as a tool when developing or updating policies and procedures as part of a practice compliance plan.

Investigative summaries are assigned to categories such as evaluation and management and then further arranged alphabetically.

Topics may also be located by a main subject term in the alphabetic index of this Guide.

The categories and selected investigations are as follows:

- **Evaluation and Management**
  - Consultations
  - Evaluation and Management Codes Reported During the Global Period
  - Inappropriate Evaluation and Management Code Selection
  - Initial Preventive Physical Exam (IPPE)
  - New Patient Visits
  - Evaluation and Management Coding and the Anesthesia Package
- **Surgical Services**
  - Bronchoscopy Services
  - Facet Joint Injections
- **Radiology Services**
  - Business Arrangements, Magnetic Imaging Services and High Use of Service
  - Review of Ultrasound Services in Areas with High-Utilization Rates
  - Barium Swallow
- **Medical Services**
  - IV Hydration Therapy
  - Pegfilgrastim Injections
  - Sleep Testing (Polysomnography and CPAP Devices)
  - Untimed codes
  - Wound Care Services, Supplies, and Equipment: Negative Pressure Wound Therapy Pump
  - Billing Injections/Number of Units
- **Modifiers**
  - Use of Modifier GY
  - Using Modifier 59 to Bypass CCI Edits
- **Billing Issues**
  - Incident To Services
  - Once in a Lifetime Procedures
  - Place of Service Errors
  - Reassignment of Benefits
  - Separately Billing Part B for Services Furnished by a Clinical Social Worker in Skilled Nursing Facilities or Inpatient Settings
  - Duplicate Claims
  - CCI/MUE Billing Errors
  - Add-On Code Billing Errors
- **Other**
  - Durable Medical Equipment Paid Claim Errors
  - HIPAA Security Rule Audits
  - Medical Necessity
  - Medicare Payments for Unlisted Procedures
  - Outpatient Physical Therapy Services Provided by Independent Therapists
  - Pre- and Postpayment Reviews Remedied
  - Review of Payments for Psychiatric Services
  - Record Authentication
Chapter 4. Summary of Select Investigative Findings

Evaluation and Management Codes Reported During the Global Period

Investigating Agency:
Office of Inspector General

Source Documents:
2007-2011 OIG Work Plans
CGI Federal, Recovery Audit Contractor—Region B
CMS IOM Pub. 100-04, Chapter 12, Sections 30.6.6 and 40
Connolly Consulting Associates, Inc., Recovery Audit Contractor—Region C
Diversified Collection Services, Recovery Audit Contractor—Region A
HealthDataInsights, Recovery Audit Contractor—Region D

Start Date:
Ongoing

Explanation of Investigation:
The OIG has been evaluating whether industry practices have changed in relation to the number of E/M services provided during the global surgery period since the concept was first introduced in 1992. Additionally, the agency has sought to determine whether payments were made to physicians for evaluation and management services provided during the global surgery period. The OIG work plan has long focused on appropriate billing and documentation for evaluation and management services as a whole. Now, as an added component of this review, attention is being directed at those E/M services reported during the global surgery period and whether it is appropriate to do so under CMS guidelines. The OIG also expressed concern regarding this issue in the 2011 Office of Inspector General Work Plan.

The topic of E/M codes being reported during the global period has also been targeted for further review by RACs in both region B and C beginning in CY 2011. In region B, CGI Federal details the purpose of the review as wanting to identify E/M services provided by the surgeon on the day prior to as well as the day of surgery and the 90 days following a major procedure or up to 10 days for a minor surgery.

Region C notes that under the concept of a global surgery, a single fee encompasses all of the surgeon’s services typically associated with the surgery in addition to all related E/M services provided during the specified global period. The Medicare Claims Processing Manual is referenced as a policy source for both regions, as well as an OIG 2003 report titled “Review of Cataract Global Surgeries and Related Evaluation and Management Services” cited by RAC region C.

Background:
CMS established a national definition for a global surgical package to ensure consistent payment for the same services across all carrier regions thereby preventing Medicare payments for services that are more or less comprehensive than intended. The national global surgery policy became effective for surgeries performed on or after January 1, 1992.

The global surgery package, as defined by CMS, is comprised of the following components:

- Preoperative visits: Includes visits after the decision to operate has been made and beginning with the day before surgery for major procedures and the day of surgery for minor procedures
- Intraoperative services: Includes services that are normally a usual and necessary part of a surgical procedure
- Complications following surgery: Includes all additional medical or surgical services during the postoperative period due to complications that do not require additional trips to the operating room
- Postoperative visits: Includes all follow-up visits during the postoperative period for the surgery related to recovery
- Postsurgical pain management by the surgeon
- Supplies (except those identified as exclusions)
- Miscellaneous services, including:
  - dressing changes
  - local incisional wound care
  - removal of packing material
  - removal of cutaneous sutures, staples, lines, wires, tubes, drains, casts, and splints
  - insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes
  - changes and removal of tracheostomy tubes

In field 16 of the Medicare Fee Schedule Data Base (MFSDB), postoperative periods that apply to each surgical procedure are provided. Payment rules for surgical procedures apply to codes with entries of 000, 010, 090, and, sometimes, YYY.

Codes in field 16 are major surgeries and are identified with “090.” Codes with “000” or “010” are minor surgical procedures or endoscopies. Codes with “YYY” are carrier-priced codes, which means that carriers determine the global period (the global period for these codes will be...
0, 10, or 90 days). It should be noted that not all carrier-priced codes have a “YYY” global surgical indicator; sometimes the global period is specified. Codes with “ZZZ,” while still surgical codes, are add-on codes and, as such, are always reported with another service. Therefore, no postoperative work is included in the fee schedule payment for “ZZZ” codes. Payment is made for both the primary and the add-on codes, and the global period assigned is applied to the primary code.

In order to determine the global period for major surgeries, carriers count one day preceding the day of surgery, the day of surgery, and the 90 days immediately following the day of surgery.

**Example:**
- Date of surgery: January 5
- Preoperative period: January 4
- Last day of postoperative period: April 5

In determining the global period for minor procedures, carriers count the day of surgery and the appropriate number of days immediately following the date of surgery.

**Example:**
- Procedure with 10 follow-up days:
  - Date of surgery: January 5
  - Last day of postoperative period: January 15

**Case Study:**
In determining a global surgery fee, CMS estimates the number of E/M services a physician provides to a typical beneficiary during the global surgery period. CMS compensates physicians for the surgical service and the related E/M services included in the fee regardless of the number of E/M services actually provided during the global surgery period.

According to testimony given May 6, 2009 by Daniel R. Levinson before the Senate Special Committee on Aging, the OIG estimated that Medicare paid $97.6 million for E/M services that should have been included in the global surgery package for eye surgeries, but were not provided during the global surgery periods. A special report titled “Nationwide Review of Evaluation and Management Services included in Eye and Ocular Adnexa Global Surgery Fees for Calendar Year 2005” was the basis for the testimony provided. The objective of the OIG’s review was to determine if eye surgery global fees reflected the number of E/M services that physicians provided to beneficiaries during the global surgery time period.

The agency reviewed approximately $1.6 billion in Medicare payments made to physicians nationwide for 3,438,973 major eye surgeries and related E/M services provided during 2005.

The review was limited to internal controls around understanding CMS policies and procedures for reimbursing physicians for global surgeries and establishing and updating global surgery fees. Furthermore, the agency limited the review of RVUs to determine the number of E/M services included in global eye surgery fees. The medical necessity of the surgeries and related E/M services were not reviewed.

A sampling frame of 3,438,973 major eye surgeries approximating $1.6 billion was divided into three categories:

- Cataract surgeries (identified by CPT code 66984) represented around 60 percent of the total payments
- Other eye surgeries (identified by 119 CPT codes except 66984) that included four or more E/M services in the global surgery fee
- Other eye surgeries (identified by 75 CPT codes) that included less than four E/M services in the global surgery fee

Furthermore, 100 paid claims, representing 45 CPT codes, were randomly selected from each of the three aforementioned categories totaling $149,131. For each of the surgeries on the claim, medical records were requested from the provider. The number of office visits were counted and compared to the number of E/M services included in the global surgery fee for the procedure code to determine the net dollar value difference.

Finally, these sample results allowed the agency to estimate what the Medicare reimbursement was for E/M services included in the global surgery fee that were not provided to beneficiaries.

**Investigative Findings:**

The 300 claims reviewed, as outlined above, consisted of 60 global surgeries that adequately reflected the number of E/M services included in the global surgery fee. This left 240 surgeries rendered in which the designated numbers of E/M visits in the global surgery fee were not provided to beneficiaries. In fact, 201 of the 240 surgeries performed showed physicians provided fewer visits than those included in the global surgery fee; likewise, in the remaining 39 surgeries, physicians provided more E/M services than the amount included in the global surgery fee.

The OIG concluded that Medicare paid almost $98 million for E/M services bundled into the global surgery fee that were never provided.

The agency concluded that eye surgery fees did not include the appropriate number of E/M visits provided to beneficiaries, in part, because CMS had not made any RVU adjustments over the last few years to most of the 45 eye surgery codes in the sample.

The following list details specific findings from the report:
consider the following:
unnecessary audits and review of your billing practices, global period is a form of unbundling. In order to avoid E/M services related to the surgical procedure during the result of the significant costs associated with it. Reporting topic continues to require explanation and education as a routinely addressed the issue on their websites and the education programs. Both CMS and the OIG have in health care publications and topics for continuing Issues related to unbundling are consistently documented Strategies for Risk Prevention:

The OIG recommended that CMS adjust the estimated number of E/M services included in the global surgery fee for eye surgeries to reflect the actual number of services being provided or update the annual physician fee schedule applying the audit results and other information. However, CMS indicated that changes to the codes on the MPFS would be redistributed to all services and, thus, would not result in savings to the Medicare program because of the requirement in the Medicare statute that mandates all changes must be done in a budget neutral manner. CMS did state they will continue to work with the AMA RUC and relevant physician specialty societies to detect and revise services where the number of E/M services has changed in the global period.

Strategies for Risk Prevention:
Issues related to unbundling are consistently documented in health care publications and topics for continuing education programs. Both CMS and the OIG have routinely addressed the issue on their websites and the topic continues to require explanation and education as a result of the significant costs associated with it. Reporting E/M services related to the surgical procedure during the global period is a form of unbundling. In order to avoid unnecessary audits and review of your billing practices, consider the following:

- Always have the most current version of the national correct coding initiative (NCCI) edits readily available; if these edits can be integrated into the practice management system, even better.
- Educate all staff members, including clinical staff, on NCCI and demonstrate how to look up codes and determine the global period associated with the procedure code.
- Understand what is—and is not—included in the Medicare global surgery package vs. a commercial carrier global surgery fee. Many commercial carriers use CMS guidelines, but not all so it is important to note any differences. One example of differences in the global surgery package description is often reflected in complications. Medicare includes all complications except those requiring a return trip to the operating room in the global fee for the surgery; however, many commercial carriers pay for procedures such as incision and drainage performed in the physician office. Therefore, do not assume that all commercial carriers follow the same global surgery guidelines that Medicare does. Always know for certain by reviewing contracts and asking for clarification on anything that is unclear.
- Implement a process or mechanism, manual or automated, to indicate the start and stop dates for the global surgery period. This is helpful in knowing whether the type of visit is a preoperative visit and also to track the number of postoperative visits. Finally, if the patient is seen for reasons other than those related to the surgical service, it can serve as a reminder to the billing staff that modifier 24 Significant, separately identifiable E/M service, must be appended. When the patient is schedule for related or unrelated procedures during the postoperative period of another procedure, again, this can serve as a reminder to append the appropriate modifier to the procedure code.
- Download the Medicare Physician Fee Schedule or print it out. Each surgery code shows the global period associated with it. Knowing whether the surgery has a 0-, 10-, or 90-day postoperative period can ensure that the proper number of visits are provided and can also be helpful in determining proper modifier usage. For example, modifier 57 Decision for surgery is never used with “minor” surgical procedures or those with 0- or 10-day global periods. Receptionists or scheduling staff can reference this information in order to know the various types of return visits needed; oftentimes, the staff may not know by the name of the surgery or the code type how many follow-up visits are assigned to a specific service and this is a good resource to use.

Coverage
N/A

Coding Guidelines
N/A

Modifier Guidelines
The following modifiers are typically used to report evaluation and management services provided during the global period for surgical procedures:

- 24 Carriers pay for an E/M service (other than inpatient hospital care before discharge from the hospital following surgery) if the service was provided during the postoperative period of a surgical procedure by the same physician who performed the procedure and billed with modifier 24. Documentation must support the evaluation and management service is not related to the postoperative care of the procedure.
- 25 Medicare guidelines state that modifier 25 should only be appended to codes describing evaluation and management (E/M) services and only when the services are provided by the same physician (or same qualified nonphysician practitioner) to the same patient on the same day as another procedure or service.
Carriers will pay for an E/M service provided on the same day of a procedure with a global fee period if the physician documentation indicates that the service is for a significant, separately identifiable E/M service that is above and beyond the usual pre- and postoperative work of the procedure. It is not necessary to have a different diagnosis when reporting the E/M service on the same date as the procedure or other service. As stated above, append modifier 25 to the E/M code only.

Both the E/M service and the procedure must be appropriately and sufficiently documented by the physician (or qualified nonphysician practitioner) in the patient’s medical record demonstrating the medical necessity of the services reported; however, documentation is not required to be submitted with the claim.

- Carrier will pay for an evaluation and management service provided on the day of or the day before a surgery identified with codes assigned a 90-day global surgical period. Modifier 57 indicates the E/M service provided resulted in the surgeon’s decision to perform the procedure. Evaluation and management services reported with modifier 57 will not be paid if provided on the day of or the day before a procedure with a 0- or 10-day global surgical period.

It should be noted that the modifiers described above are used to bypass carrier edits and, as such, should be used only when appropriate. The inappropriate use of any modifier to receive payment without following the necessary guidelines and documentation requirements can subject the provider to scrutiny and possible audits. In addition, as previously stated, append these modifiers only to the evaluation and management service, not to the surgical procedure. Other modifiers that may be used in conjunction with the procedure or other service codes can be found in Appendix A of a current year CPT manual.

**Billing Guidelines**

The majority of billing guidelines associated with the subject can typically be handled by a good practice management software. Systems should have the ability to integrate NCCI edits into their programming; if this is not an option, the edits can be purchased in print form, on CD-rom, or downloaded from the National Technical Information Service (NTIS) on their website: www.ntis.gov. This helps prevent unbundling of services that should not be reported together.

As mentioned above, having the MPFS downloaded to the desktop or readily available is a great tool to know the postoperative periods assigned to specific surgery codes. This information can also be incorporated into many billing software programs as well and can be an excellent means of notifying the clinical staff and provider that the patient is currently in the global period and, as such, any unrelated services should be reported with the appropriate modifier.

Lastly, regular and ongoing review of the CMS IOM Pub.100-04 sections on global surgery guidelines and commercial payer contract requirements ensures that as any revisions or changes to policies take effect, you and your staff are informed and aware.

**Corrective Actions:**

As with most topics, periodically spot check surgical claims to verify that any services reported during the global period have been reported in compliance with the carrier guidelines. In many cases, when an E/M service is related to the surgery and inappropriately reported, the carrier edits reject the claim, but not always. Nonetheless, the edits are not designed or meant to serve as a “scrubbing” method that permits submission of erroneous claims and provides feedback for the practice. It is never appropriate to send in claims to CMS that are incorrect. There is always a possibility that carrier edits will not function properly and a claim will be processed when it should not have been accepted at all, let alone paid. Therefore, proactively reviewing claims prior to submission, as well as processed claims, allows identification of any recurrent errors or issues and allows a chance to correct them. In addition, always address billing issues with all staff members and providers to ensure that the problem has been remedied.

**Resources:**

- 2007 OIG Work Plan
- 2008 OIG Work Plan
- 2009 OIG Work Plan
- 2010 OIG Work Plan
- 2011 OIG Work Plan
- CMS IOM Pub. 100-04, Chapter 12, Sections 30.6.6 and 40
- OIG Reports: “Nationwide Review of Evaluation and Management Services included in Eye and Ocular Adnexa Global Surgery Fees for Calendar Year 2005” (A-05-07-0077)
Evaluation and Management Services: Use of Modifiers During the Global Surgery Period

Investigating Agency:
Office of Inspector General

Source Document:
CMS IOM Manual Pub. 100-04, Chapter 12, §30 and 40.1

Start Date:
Ongoing

Explanation of Investigation:
In the 2012 OIG Work Plan, CMS stated it will review claims for the appropriate use of certain modifiers reported during the global surgery period in order to determine if the Medicare payments made for said claims were in accordance with Medicare requirements.

Background:
Previous work performed by the Office of Inspector General (OIG) has shown that inappropriate use of modifiers during the global surgical period has resulted in erroneous payments. CMS's established national definition of the global surgical package includes payment for the following services related to surgery when furnished by the physician who performed the procedure:

- Preoperative visits: These visits occur after the decision for surgery has been made and begin on the day prior to a major procedure (those with a global period of 090 days) or the day of surgery for a minor procedure (those with a 000 or 010 global period).
- Intraoperative services: These services are normally considered to be a usual and necessary part of a surgical service.
- Complications following surgery: All additional medical and surgical services that are required of the surgeon during the postoperative period are included unless the complication requires a return trip to the operating room. This is a deviation from the global surgical package as described by the American Medical Association in the CPT manual.
- Postoperative visits: Follow-up visits related to the surgical procedure during the postoperative period.
- Postsurgical pain management when provided by the surgeon who performed the surgery.
- Supplies, with the exception of those identified as being excluded.
- Miscellaneous services, including:
  - local incisional care
  - removal of packing material
  - removal of cutaneous sutures, staples, lines, wires, tubes, drains, casts, and splints
  - insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous (IV) lines, and nasogastric and rectal tubes
  - changes and removal of tracheostomy tubes

The Medicare Fee Schedule Data Base (MFSDB) field 16 contains postoperative periods applicable to each surgical procedure. Payment rules for surgical procedures apply to codes with entries of 000, 010, 090, and, sometimes, YYY. Codes with indicator YYY are carrier-priced procedures and therefore the carrier determines the global period (the global period for these codes will be 0, 10, or 90 days). It should be noted that some carrier-priced codes may have a global period specified.

Major surgical procedures have an indicator of 090. Codes with an indicator of 000 or 010 are considered minor surgical procedures or endoscopies. Codes assigned a ZZZ global surgery indicator are add-on codes and, as such, are always reported with another service. The global period assigned to the primary procedure is applied to the add-on code.

The global period for major surgeries includes one day before the day of surgery, the day of surgery, and the 90 days immediately following the day of surgery.

Example:
Date of surgery: January 5
Preoperative period: January 4
Last day of postoperative period: April 5
For minor procedures, count the day of surgery and the appropriate number of days following the date of surgery.

Example:
Procedure with 10 follow-up days:
Date of surgery: January 5
Last day of postoperative period: January 15

Investigative Findings:
N/A

Strategies for Risk Prevention:
Reporting evaluation and management (E/M) services related to the surgical procedure during the global period is a form of unbundling. CMS, the OIG, and individual Medicare contractors consistently provide educational materials related to the prevention of, and significant costs associated with, unbundling. In order to avoid unnecessary audits and review of billing practices, consider the following:
• Maintain the most current version of the national correct coding initiative (NCCI) edits; integrate these edits directly into the practice management system if possible.

• Instruct and educate all staff members, including clinical staff, on NCCI edits and demonstrate how to determine the global period associated with the procedure code.

• Know the differences between the Medicare global surgery package versus a commercial payer’s global surgery package. While many commercial carriers use CMS guidelines, there may be variations as to what is included in the global surgical package or the number of postoperative days assigned to a specific procedure. One example of differences in the global surgery package description is often reflected in how a provider may bill for postoperative complications. Medicare includes all complications except those requiring a return trip to the operating room as part of the global fee for the surgery; however, many commercial carriers pay separately for procedures such as incision and drainage of a surgical incision when performed in the physician office or a treatment room at the hospital. Review contracts and ask for clarification on anything that is unclear.

• Employ processes or mechanisms, manual or automated, that flag start and stop dates for the global surgery period. It could be as easy as developing a tracking calendar. This is helpful in knowing whether a preoperative visit is separately reportable or to track the number of postoperative visits included in the global package. Finally, if the patient is seen for reasons other than those related to the surgical service, it can serve as a reminder to the billing staff that the encounter may be billed and that modifier 24 Significant, separately identifiable E/M service, must be appended. When the patient is scheduled for related or unrelated procedures during the postoperative period of another procedure, again, this can serve as a reminder to append the appropriate modifier to the procedure code.

• Download the Medicare Physician Fee Schedule or print it out. By knowing whether the surgery has a 0-, 10-, or 90-day postoperative period a practice can ensure that only those visits unrelated to or not included in the surgical package are billed and that any necessary modifiers are appended. For example, modifier 57 Decision for surgery, is never used with “minor” surgical procedures or those with 0- or 10-day global periods. Receptionists or scheduling staff can reference this information in order to know the various types of return visits needed; oftentimes, the staff may not know by the name of the surgery or the code type how many follow-up visits are assigned to a specific service and this is a good resource to use.

Coding Guidelines

N/A

Modifier Guidelines

Modifiers typically used to report E/M services provided during the global period for surgical procedures include the following:

• Modifier 24 allows for an E/M service to be reported (other than inpatient hospital care before discharge from the hospital following surgery) if the service was provided during the postoperative period of a surgical procedure by the same physician who performed the procedure. Documentation must support that the evaluation and management service is not related to the postoperative care of the procedure.

• Modifier 25 should only be appended to codes describing E/M services and only when the services are provided by the same physician (or same qualified nonphysician practitioner) to the same patient on the same day as another procedure or service. It is not necessary to have a different diagnosis when reporting the E/M service on the same date as the procedure or other service. Append modifier 25 to the E/M code only. Both the E/M service and the procedure must be appropriately and sufficiently documented by the physician (or qualified nonphysician practitioner) in the patient’s medical record demonstrating the medical necessity of the services reported; however, documentation is not required to be submitted with the claim.

• Modifier 57 indicates an evaluation and management service provided on the day of or the day before surgery for codes assigned a 90-day global surgical period. Modifier 57 indicates the E/M service provided resulted in the surgeon’s decision to perform the procedure. It is not appropriate to report E/M services with a 0- or 10-day global surgical period with modifier 57.

Note: The modifiers discussed above are reported to bypass carrier edits; therefore, it is very important to only use when appropriate. Inappropriate use of any modifier to receive payment without following the necessary guidelines and documentation requirements can subject the provider to scrutiny and possible audits.

Billing Guidelines

Normally, the vast majority of billing guidelines associated with the subject are already programmed into the practice management system used by the doctor’s office. Additionally, NCCI edits can be programmed into certain practice management systems; however, if this is not an option, the edits can be purchased in print form, on CD-rom, or downloaded from the National Technical Information Service (NTIS) on their website www.ntis.gov. By having the edits preprogrammed into any practice management software system, the likelihood of submitting a claim containing unbundled services—those that should not be reported together—is certainly minimized.
Downloading the MPFS to the desktop or having it readily available allows the postoperative periods assigned to specific surgery codes to be identified. This is information that, like the NCCI edits and other billing guidelines, is often easily incorporated into many billing software programs thereby ensuring automatic notification to clinical staff and the provider that the patient is currently in the global period and, as such, any unrelated services should be reported with the appropriate modifier.

Finally, regular and ongoing review of the CMS IOM Pub.100-04 sections on global surgery guidelines and commercial payer contract requirements ensures that as revisions or changes to policies take effect, staff remain informed and up to date with any new changes.

**Corrective Actions:**
Periodically perform spot check reviews of surgical claims to verify that any services reported during the global period have been reported in compliance with carrier guidelines. Oftentimes, an E/M service related to the surgery and inappropriately reported is rejected or denied by the carrier, but not always. Nonetheless, the edits are not intended to serve as a “scrubbing” method that permits submission of erroneous claims and provides feedback for the practice. Clearly, it should never be appropriate to send claims to CMS that are incorrect because no matter how remote the possibility, there is always a chance that carrier edits will not function properly and a claim will process when it should not have.

Proactively review claims prior to submission to identify reporting errors or issues and correct them. Always address billing issues with all staff members and providers to ensure that the problem has been remedied sufficiently.

**Resources:**
- 2012 OIG Work Plan
- CMS *IOM Manual* Pub. 100-04, Chapter 12, §30 and 40.1
Failure to Correctly Bill Codes on the Medically Unlikely List or Failure to Correctly Bill Column 1 and Column 2 Codes per the Correct Coding Initiative

Investigating Agencies:
CGI Federal, Recovery Audit Contractor—Region B
Connolly Consulting Associates, Inc., Recovery Audit Contractor—Region C
Diversified Collection Services, Inc., Recovery Audit Contractor—Region A
HealthDataInsights, Inc., Recovery Audit Contractor—Region D

Source Documents:
Current Issues, RAC Region A, Diversified Collection Services, Inc.
Current Issues, RAC Region B, CGI Federal
Current Issues, RAC Region C, Connolly Consulting Associates, Inc.
Current Issues, RAC Region D, HealthDataInsights, Inc.

Start Date:
Ongoing

Explanation of Investigation:
These are two similar yet different investigations. When auditing for National Correct Coding Initiative errors, the RAC will be examining claims to determine whether the claim was unbundled. When examining claims for Medically Unlikely Edit errors, the RAC is primarily focused on the number of units billed for the same patient for the same procedure performed on the same date of service by the same provider.

Background:

Correct Coding Initiative
In an effort to save Medicare Trust Funds, CMS determined that it should:

- Reduce the number of unbundled claims
- Cut down on abusive coding practices
- Standardize coding on a national level

In August 1995, CMS awarded a contract to Administar Federal to define coding practices that would be the basis of a national policy for claim payment. Using the CPT coding system, Administar developed correct coding combinations based on review of CPT descriptors, coding instructions, review of existing local and national edits, and review of Medicare billing history.

Administar developed a comprehensive narrative policy that outlines general and specific guidelines for the appropriate use of CPT codes for provider claims. This narrative policy was reviewed by physician specialty groups, the American Medical Association, nonphysician specialty groups, and Medicare Part B contractor medical directors.

Subsequently, upon receiving CMS approval, Administar developed a coding matrix to be embedded into the Medicare contractors’ claims processing systems. This matrix, based on the correct coding policy, automatically identifies inappropriate CPT coding combinations and properly determines payment.

Existing Medicare policy was not changed by the correct coding policy.

Currently the Correct Coding Initiative is being administered by Correct Coding Solutions, LLC. In addition, it should be noted that many other non-Medicare payers have adopted the CCI as their method in determining unbundled claims.

The following RACs are performing CCI related reviews:

- Diversified Collection Services, Inc., Recovery Audit Contractor—Region A
- HealthDataInsights, Inc., Recovery Audit Contractor—Region D

Medically Unlikely Edits
Effective January 1, 2007, in an effort to lower the Medicare fee-for-service paid claims error rate, CMS implemented edits referred to as the “medically unlikely edits” or MUEs. A medically unlikely edit for a HCPCS or CPT code is the maximum number of units of service allowable by the same provider for the same beneficiary on the same date of service. Units of service that are in excess of the MUE are denied.

The following RACs are performing MUE-related reviews:

- CGI Federal, Recovery Audit Contractor—Region B
- Connolly Consulting Associates, Inc., Recovery Audit Contractor—Region C
- HealthDataInsights, Inc., Recovery Audit Contractor—Region D

Investigative Findings:
N/A
Strategies for Risk Prevention:
In order to prevent a denial due to CCI or MUE coding errors, providers should become familiar with these edits and the related guidelines regarding when and how to use modifiers to override the edits.

Coverage
N/A

Coding Guidelines

Correct Coding Initiative
There are two basic types of correct code combinations:

- Column 1/Column 2 correct coding edits (formerly called comprehensive/component code combinations)
- Mutually exclusive coding combinations

All coding edits, whether mutually exclusive or column 1/column 2, are composed of code pairs arranged in two columns. For both types of edits, the column 2 code is not payable with the column 1 code unless the edit permits the use of an appropriate modifier to override the edit.

Code edits are classified into different “categories” depending on the rationale for why a column 2 code is not payable. Below is the type and rationale of each.

Column 1/Column 2 Correct Coding Edits: Medicare carrier bulletins should also be reviewed by the provider for changes affecting coding practices.

Although the column 1/ column 2 correct coding edits contain many edits where the column 2 code is a component of the column 1 comprehensive code, there are also many code combinations where there is no comprehensive or component relationship, but the column 1 code and column 2 code should not be reported together for other reasons. The following is a summary of general coding policies applicable to code combinations pertinent to physical therapy services.

HCPCS/CPT Procedure Code Definition: The CPT procedure code definition, or descriptor, is based upon the procedure being consistent with current medical practice. In order to submit a CPT code to Medicare, the provider must have performed all the services in the code descriptor. Remember that payment is based on having performed all the services. If you have not performed all the services within the descriptor, a less comprehensive code must be used. Providers must NOT submit codes describing components of a comprehensive code if the comprehensive code describes the services performed.

For example, it is not appropriate to report code combinations that report a procedure both “with” and “without” specific services. Along this same line, this policy states that a “partial” procedure is included in a “complete” or “total” procedure, “unilateral” is included in the “bilateral,” and “single” is included in the “multiple” procedure.

CPT Book and CMS Coding Manual Instructions: CMS publishes coding instructions in its rules, manuals, and notices that must be used when reporting services provided to Medicare patients.

The CPT book also contains instructions and guidelines that may appear in various places and are found at the beginning of each major section, at the beginning of subsections, and prior to or after a series of codes or individual codes. These instructions define items or provide explanations necessary to appropriately interpret and report the procedures or services and to define terms applicable to particular sections. CPT book instructions should be followed unless CMS provides different coding or reporting instructions.

Misuse of Column 2 with Column 1 Code: This represents an inappropriate interpretation of a CPT code definition, which is not to be used out of context. For this edit, CPT codes that describe procedures or services not usually performed with other procedures or services that may be interpreted to represent other services have been identified and paired with the column one CPT codes. In addition, code pairs have been identified that would not be reported together because another code more accurately describes the service provided.

Separate Procedure: When the HCPCS/CPT code descriptor includes the term “separate procedure,” the code is not to be reported separately with a related procedure. CMS interprets this designation to prohibit the separate reporting of a separate procedure when performed with another procedure in an anatomically related region.

When a HCPCS/CPT code with the separate procedure designation is performed at a separate patient encounter on the same date of service or at the same patient encounter by a different approach, it may be reported in addition to another procedure. Modifier 59 Distinct procedural service, may be appended to the separate procedure code to indicate that it qualifies as a separately reportable service.

More Extensive Procedure: When procedures are performed together that are basically the same, or performed on the same site but are qualified by an increased level of complexity, the less extensive procedure is included in the more extensive procedure.

Medical/Surgical Package: In general, most services have preprocedure and postprocedure work associated with them. When these services are performed at a single patient encounter, the preprocedure and postprocedure work does not change proportionately when multiple services are performed and the nature of the preprocedure and postprocedure work is reasonably consistent across the spectrum of procedures.

Mutually Exclusive Procedures: These codes represent services or procedures that would not or could not be performed at the same time, on the same patient, and by the same physician based on the CPT code descriptions or standard medical practice.
Under this edit, CPT codes that are mutually exclusive of one another based on the CPT definition or the medical impossibility/improbability that the procedures could be performed at the same patient encounter have been identified as code pairs, which should not be reported together. Many of the edits in the mutually exclusive edit table permit CCI-associated modifiers to be reported. For example, the two procedures of a code pair edit may be performed at different anatomic sites or separate patient encounters on the same date of service.

**Laboratory Panel:** Individual laboratory tests that are components of a multichannel test analysis should not be reported separately.

One principle of CPT coding is that if a service is routinely provided as part of a more comprehensive service, then it should be included in and be considered part of (or bundled into) the service.

**Note:** This rationale is a focus of the OIG 2010 Work Plan.

**Sequential Procedure:** This policy represents procedures often performed in sequence or when an initial approach is followed by a procedure that is more invasive during the same encounter. Only the procedure that accomplishes the expected result is reported, while the less extensive procedure is “bundled” into the more extensive one.

**Gender Specific Sex Procedure:** This indicates that the procedure denotes a conflict in sex classification by definition of the code description or by virtue of the fact that performing the procedure would be anatomically impossible.

**Family of Codes:** The CPT book groups codes that describe related procedures that may or may not be performed in various combinations. The following specific coding guidelines apply to these codes:

- A procedure code should only be reported when all services are described by the code.
- Multiple codes from within a family of codes should not be reported when a single code fully describes the entire service.
- HCPCS/CPT codes corresponding to component services of other more comprehensive services should not be reported separately.
- When a code does not correctly describe the procedure performed, the physician should report a not otherwise specified (unlisted) procedure code. The office should also consider the application of modifiers.

**Anesthesia Service Included in Surgical Procedure:** When provided by the same physician who performs the surgery requiring anesthesia, the anesthesia services are included in the procedure.

**Standard Preparation/Monitoring Services for Anesthesia:** Regardless of the types of anesthesia administered, preparation and monitoring services are not separately reportable when performed with the anesthesia service. However, if the provider of anesthesia service provides one or more of these services prior to and unrelated to the anesthesia service or after the patient is released from the anesthesia practitioner’s postoperative care, the service may be separately reportable with modifier 59.

**Medically Unlikely Edits**

These codes represent codes for which the units of service indicated in item 24G of the CMS 1500 claim form should not be greater than the number indicated in column two of the MUE code table.

**Modifier Guidelines**

CMS authorized the use of an indicator to specify whether a two-digit modifier can be used to bypass the CCI edits, when acceptable to do so. It should be noted, however, that this is not a method in which practices can simply circumvent the CCI edits; it is very important that a modifier only be used when it is appropriate to override the edit, such as in the case of a separate encounter, separate anatomic site, or separate specimens. Additionally, numerous coding combinations are denied, regardless of any modifiers that may be reported in addition to the code.

Modifiers that may be used under the appropriate clinical circumstances and when supported by the medical record documentation include:

- Anatomical modifiers: E1–E4, FA, F1–F9, TA, T1–T9, LT, RT, LC, LD, RC
- Surgical modifiers: 25, 58, 78, 79
- Other modifiers: 27, 59, 91

If a provider files a claim for services included in the CCI edits and the services are identified on the indicator list as payable only for the column 1 service, the column 2 service will be denied by Medicare as being part of the comprehensive service. The proper use of one of the above identified modifiers will bypass the denial of the service.

CMS created modifier GD Units of service exceeds medically unlikely edit value and represents reasonable and necessary service, to override the MUE edit. The application of CPT modifiers (e.g., 59, 76, 77, and 91) can also override the MUE edit. These CPT modifiers, as well as modifier GD, cause the procedure code to appear on separate lines in the Medicare contractors system and each line is separately adjudicated against the MUE value for that code. Additionally, whenever reporting repetitive services on a single line, the “from” and “to” date fields must be completed and in agreement with the number of units identified. Note that the “from” and “to” dates (CMS 1500 claim form item 24A) must be sequential.

**Billing Guidelines**

See Coding and Modifier Guidelines above.
Corrective Actions:

- Review remittance advice notices to determine if there is a significant number of services denied due to unbundling.

- CCI and MUE edits are updated quarterly. Maintain and refer to the most current copy of CCI and MUE edits. The edits may be found on the CMS website at http://www.cms.gov/NationalCorrectCodInitEd/.

- If a claim or service was denied because a modifier was omitted, you may appeal the claim denial with the Medicare contractor or simply amend the claim by adding modifier 59 and refile it. You may need to send documentation with the appeal. By using the modifier, you are certifying that you have appropriate documentation in the patient’s chart.

It should be noted that your Medicare carrier is unable to change the correct coding or medically unnecessary edits. Concerns regarding specific correct coding edits should be submitted in writing to:

National Correct Coding Initiative
Correct Coding Solutions, LLC
P.O. Box 907 Carmel, IN 46082-0907
Attention: Niles R. Rosen, M.D., Medical Director and Linda S. Dietz, RHIA, CCS, CCS-P, Coding Specialist Fax: 317.571.1745

- Medicare carrier bulletins should also be reviewed by the provider for changes affecting coding practices.

Resources:

2010 OIG Work Plan
http://www.cms.gov/NationalCorrectCodInitEd/

National Correct Coding Initiative, Version 16.2

Medicare Claims Processing Manual, Publication 104, Chapter 12, Section 30