

# PART B



# General Surgery Billing Guide July 2009

**J14 A/B MAC**

**NHIC, Corp.**

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### INTRODUCTION

The Provider Outreach and Education Team at NHIC, Corp. developed this guide to provide you with Medicare Part B General Surgery billing information. It is intended to serve as a useful supplement to other manuals published by NHIC, and not as a replacement. The information provided in no way represents a guarantee of payment. Benefits for all claims will be based on the patient's eligibility, provisions of the Law, and regulations and instructions from the Centers for Medicare & Medicaid Services (CMS). It is the responsibility of each provider or practitioner submitting claims to become familiar with Medicare coverage and requirements. All information is subject to change as federal regulations and Medicare Part B policy guidelines, mandated by the Centers for Medicare & Medicaid Services (CMS), are revised or implemented.

This information guide, in conjunction with the NHIC website ([www.medicarenhic.com](http://www.medicarenhic.com)), J14 A/B MAC Resource (monthly provider newsletter), and special program mailings, provide qualified reference resources. We advise you to check our website for updates to this guide. To receive program updates, you may join our mailing list by clicking on "Join Our Mailing List" on our website. Most of the information in this guide is based on Publication 100-04, Chapter 12 of the CMS Internet Only Manual (IOM) of the CMS Internet Only Manual (IOM). The CMS IOM provides detailed regulations and coverage guidelines of the Medicare program. To access the manual, visit the CMS website at <http://www.cms.hhs.gov/manuals/>

If you have questions or comments regarding this material, please call the appropriate NHIC Customer Service Center for your state. The telephone numbers are listed at the end of this guide.

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# General Surgery Billing Guide

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### GENERAL INFORMATION

The purpose of this guide is to present providers with information on billing for General Surgery services. Please reference the Specialty specific billing guides for specialty billing instructions. All billing guides may be found on our web site at [www.medicarenhic.com](http://www.medicarenhic.com).

Medicare covers only services which providers are legally authorized to perform under Federal and State laws. The performance of services must be consistent with the provider's scope of practice. Medicare covers items or services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part. By submitting a properly completed CMS-1500 claim form or an electronic equivalent, the provider certifies that the service or items billed were provided and were medically reasonable and necessary.

### GLOBAL SURGERY

Physician Payment Reform (PPR) established a national definition of a "global surgical package". A global surgical package of care consists of all necessary services performed by the provider before, during and after a surgical procedure. Medicare payment includes all applicable preoperative, intra-operative, and postoperative services, including care due to complications from the surgery.

The information that follows describes the components of a global surgical package and payment rules for major and minor surgeries, endoscopies, modifier use and surgeries that are shared between two or more providers.

The services included in the global surgical package may be furnished in any setting, such as hospitals, ambulatory surgical centers (ASCs) and provider offices. Visits to a patient in an intensive care or critical care unit are also included if made by the surgeon. However, critical care services (99291-99292) are payable separately in some situations (e.g., a seriously injured or burned patient who is critically ill and requires constant attendance by the provider).

All surgical procedure codes are subject to the global surgical provisions as either major or minor surgeries. These codes are listed in the Current Procedural Terminology (CPT) manual and the Healthcare Common Procedure Coding System (HCPCS) manual.

The difference between major and minor surgical procedures is reflected in the number of follow-up (postoperative) days after the surgery.

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- A surgery with 90 follow-up (postoperative) days is considered major surgery.
  - The global period for major surgeries includes 1 day immediately before the day of surgery and the 90 days immediately following the day of surgery.
- A surgery with 0 (zero) to 10 follow-up (postoperative) days is considered minor surgery.
  - The global period for minor surgeries includes the day of surgery and the appropriate number of days immediately following the day of surgery.

Some procedures in the surgical CPT range are strictly diagnostic (such as endoscopies), and may not involve actual surgery. Most of these have 0 (zero) follow-up days, and include an allowance for the normal pre- and postoperative care associated with the procedure.

### Services Included in the Global Surgical Package

The Medicare approved amount for surgical procedures includes payment for the following services related to the surgery when furnished by the provider who performs the surgery.

1. Preoperative Visits: preoperative visits begin with the day before the surgery for major procedures and the day of the surgery for minor procedures. The global package of care includes all visits related to the surgery, in or out of the hospital, on the day of the surgery.
2. Intraoperative Services: services that are normally a usual and necessary part of the surgical procedure.
3. Complications Following Surgery: include all additional medical or surgical services required of the surgeon during the postoperative period of the surgery due to complications that *do not* require additional trips to the operating room.
4. Postoperative Visits: are follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery.
5. Post surgical pain management by the surgeon.
6. Miscellaneous Services: includes items such as dressing changes, local incision care, removal of operative pack, 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, and changes and removal of tracheostomy tubes.

### Services Not Included in the Global Surgical Package

The following services can be billed separately:

1. The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery. Please note that this policy only applies to major surgical procedures. Use the proper procedure code followed by modifier 57. The initial evaluation is always included in the allowance for a minor surgical procedure.
2. Services of other physicians except where the surgeon and the other physician(s) agree on the transfer of care. This agreement may be in the form of a letter or an annotation in the discharge summary, hospital record, or ASC record.
3. Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications from the surgery.
4. Postoperative complications that require a return trip to the operating room. An operating room for this purpose is defined in Medicare regulations as:

A place of service specifically equipped and staffed for the sole purpose of performing surgical procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit unless the patient's condition was so critical there would be insufficient time for transportation to an operating room.
5. If a less extensive procedure fails and a more extensive procedure is required, the second procedure is payable separately.
6. Treatment for an underlying condition or an added course of treatment that is not part of the normal recovery from surgery.
7. Diagnostic tests and procedures, including diagnostic radiological procedures.
8. Clearly distinctive surgical procedures during the postoperative period that are not repeat operations or treatment of complications. In this case, follow the CPT code with modifier 79. A new postoperative period begins with the subsequent procedure.
9. Immunosuppressive therapy for organ transplants. Use modifier 24 for any visits related to this service.
10. Critical care services (procedure codes 99291 and 99292) unrelated to the surgery when a seriously injured or burned patient is critically ill and requires constant attendance by the provider. Use modifier 24 or 25 as appropriate.
11. Evaluation and management (E/M) services unrelated to a surgical procedure.

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The following evaluation and management codes are included in the global package.

92012	92014	99211	99212	99213	99214
99215	99217	99218	99219	99220	99221
99222	99223	99231	99232	99233	99234
99235	99236	99238	99239	99241	99242
99243	99244	99245	99251	99252	99253
99254	99255	99291	99292	99304	99305
99306	99307	99308	99309	99310	99315
99316	99318	99333	99334	99335	99336
99337	99347	99348	99349	99350	99374
99375	99377	99378			

## MODIFIERS

### Modifiers Used for Evaluation and Management (E/M) Services within a Global Surgical Period (Modifier 24, 25 and 57)

**Modifier 24:** Unrelated Evaluation and Management (E/M) Service by the Same Provider during a Postoperative Period

Modifier 24 was intended for use with services that are absolutely unrelated to the surgery. It is not to be used for medical management of a patient by the surgeon following surgery. This modifier is only to be used with an E/M visit. It is **not** valid when used with surgeries or other types of services. It is **not** necessary, or appropriate, for modifier 24 to be used with tests performed during the postoperative period. When using modifier 24, ensure that the patient's records and ICD-9-CM codes recorded on the claim clearly indicate that the E/M visit is unrelated to the original procedure.

When used with critical care codes (99291/99291), modifiers 24 and 25 must be accompanied by documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed.

If a surgeon is admitting a patient to a nursing facility for a condition unrelated to the surgery, the physician should bill the admission with a modifier 24. If the condition for which the patient is being admitted is related to the surgery, the admission is included in the global surgical fee.

### Billing Requirements

Services submitted with modifier 24 must be sufficiently documented to establish that the visit was unrelated to the condition for which the surgery was performed. Acceptable documentation is demonstrated when the reported ICD-9-CM code clearly indicates that the reason for the

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encounter was unrelated to the surgery. If the diagnosis does not clearly indicate the services were unrelated, additional documentation is required. When billing electronically use the “Comments/Notes” field to further document the medical necessity and required information.

**Modifier 25:** Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

Medicare allows payment for an E/M service performed on the same day as a surgical procedure if all requirements are met. The term surgery or service includes therapeutic injections and wound repairs.

The additional E/M service must be *separately identifiable* from the surgical procedure and the patient’s condition requires significant effort **above and beyond** the other services provided or beyond the usual pre and postoperative care routinely required for the procedure. The term *separately identifiable* means an additional service is **not** part of the surgery or procedure. Medical records should document the E/M service to such an extent that, upon review, the extra effort may be readily identifiable. The E/M service must require additional history, exam, knowledge, skill, work time, and risk above and beyond what is usually required for the surgery or procedure.

**Note: The E/M service may be prompted by the symptom or condition for which the procedure and/or service were provided. As such, different diagnoses are not required for reporting of the E/M services on the same day. (This modifier is not used to report an E/M service that resulted in a decision to perform major surgery. See modifier 57.)**

Generally documentation to support the use of modifier 25 need not be submitted with the claim. It must be clearly documented in the patient’s medical record and readily available if requested by the carrier.

Documentation supporting the use of modifier 25 must be submitted to the carrier in the following circumstances:

- When there is an inpatient dialysis service, certain E/M services provided on the same day, by the same physician, for the same beneficiary are considered bundled into the payment for that dialysis service.
- When the services are billed with modifier 25 to indicate that evaluation and management service is unrelated to the treatment of ESRD and was not and could not have been provided during the dialysis treatment. Separate payment can be made for:
  - Initial hospital visits (99221-99223)
  - Initial inpatient consultations (99251-99255)

- Hospital discharge (99238) when billed for the same date as an inpatient dialysis service
- When used in conjunction with critical care visits (99291 and 99292) for a patient who is seriously injured or burned and when the following conditions exist:
  - The patient is critically ill and requires the constant attention of the physician;
  - AND
  - The critical care is unrelated to the specific anatomic injury or general surgical procedure performed.

In lieu of submitting documentation of these conditions, ICD-9-CM codes in ranges 800.00-929.9 and 940.0-959.9 are acceptable (i.e., coded to the highest level of specificity). Visits by the same physician on the same day as a surgical procedure with 000 or 010 days postoperative period or endoscopy procedures that are *related* to the standard preoperative evaluation or recovery from the procedure are included in the global reimbursement for the procedure. However, if a significant separately identifiable service is performed and is clearly documented in the patient's records, payment can be made for the visit when billed with modifier 25.

**NOTE:** *The most common cause for claim denial of an unrelated Evaluation and Management service billed on the same day as another procedure is due to the omission of Modifier 25.*

### **Modifier 57: Decision for Surgery**

An E/M examination coded with modifier 57 indicates a visit that resulted in the initial decision to perform a **major** surgery. It is used the day before or the day of major surgery. Surgeries that have a 90-day follow-up period are considered major surgeries. When coding modifier 57, ensure that the patient's records clearly indicate when the initial decision to perform the surgery was made.

Do not use modifier 57 with an E/M service performed on the same day as minor surgery.

### **Modifiers Used with Surgical Codes Only During a Global Surgical Period (Modifier 58, 78 and 79)**

**Modifier 58:** Staged or Related Procedure or Service by the Same Provider during the Postoperative Period

Modifier 58 can be used when a second surgery is performed in the postoperative period of another surgery when the subsequent procedure was:

- Planned prospectively or anticipated (staged) at the time of the original procedure; or

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- More extensive than the original procedure; or
- For therapy following a diagnostic surgical procedure.

An example of when to use modifier 58 would be if a patient had a removal of a breast lesion (CPT 19120) followed in less than 90 days by the removal of the entire breast (CPT 19240). Bill CPT 19240-58 for the second procedure.

Another postoperative period begins when the second procedure in the series is billed.

**Modifier 78:** Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure during the Postoperative Period

Modifier 78 is used for a return trip to the operating or procedure room for an unplanned related surgical procedure during the postoperative period of a previous major surgery. Medicare reimbursement is based on the intra-operative percentage of the global surgery reimbursement for the procedures with 010 or 090 days postoperative periods. Procedures with 000 global surgery days are allowed the full value for the procedure since these procedures do not have pre or postoperative or intra-operative values.

An “operating room” is defined as a place of service specifically equipped and staffed for the sole purpose of performing surgical procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient’s room, a minor treatment room, a recovery room, or an intensive care unit unless the patient’s condition was so critical there would be insufficient time for transportation to an operating room.

**Modifier 79:** Unrelated Procedure or Service by the Same Physician during the Postoperative Period

Modifier 79 is used for unrelated procedures by the same physician (or physician of the same specialty in the same surgical group) during the postoperative period. Unrelated procedures are usually reported using a different ICD-9-CM diagnosis code. Another postoperative period begins when the second procedure in the series is billed.

**Note:** The use of **RT** and **LT** modifiers is helpful and should be used **following** Modifier 79, **not** in place of it.

Example of proper use of Modifier 79:

- On March 1<sup>st</sup> Dr. Smith performs procedure code 66984.
- Modifier LT is used to signify the procedure was done on the left eye.

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21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)												
1. <u>743 33</u>				3. _____				↓				
2. _____												
4. _____												
24. A. DATE(S) OF SERVICE												
From			To			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER
MM	DD	YY	MM	DD	YY			CPT/HCPCS		MODIFIER		
1	03	01	2008	03	01	2008	22	2	66984		LT	1
2												
3												

- Procedure code 66984 carries a 090 day global period.
- On March 15<sup>th</sup> Dr. Smith performs procedure code 66984 for the right eye.
- Because a second procedure is being performed within the global period of the first surgery, Modifier 79 must be used in conjunction with Modifier RT.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)												
1. <u>743 33</u>				3. _____				↓				
2. _____												
4. _____												
24. A. DATE(S) OF SERVICE												
From			To			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER
MM	DD	YY	MM	DD	YY			CPT/HCPCS		MODIFIER		
1	03	15	2008	03	15	2008	22	2	66984		79 RT	1
2												
3												

- The use of Modifier 79 indicates that there was an unrelated procedure or service performed by the same provider during the postoperative period of the initial procedure or service.

### Modifiers Used for Transfer of Care between Providers (Modifier 54 and 55)

Ordinarily, the global surgery fee schedule allowance includes preoperative evaluation and management services rendered the day of or the day before surgery, the surgical procedure, and the postoperative care services within the defined postoperative period. When a provider transfers the care of a patient to another provider within the global period, it is considered “a transfer of care”. Both the surgeon and the provider providing the postoperative care must document the transfer of care in the medical record and must keep a copy of the written transfer agreement in the beneficiary’s medical record. It may be in a letter or written as a notation in the discharge summary/hospital records or Ambulatory Surgical Center report.

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The appropriate modifiers must be added to the surgical procedure code:

- **Modifier 54** - Surgical Care Only
- **Modifier 55** - Postoperative Management Only

For claims where providers share postoperative care, the assumed and/or relinquished dates of care must be indicated. In Item 19 of the CMS-1500 claim form or electronic media claim equivalent enter "Assumed Post-Op Date = MMDDCCYY" or "Relinquished Post-Op Date = MMDDCCYY"

### Example of proper use of Modifiers 54 and 55 for the "transfer of care"

- Dr. Smith performs procedure code 66984 on March 1<sup>st</sup> and cares for the patient through April 29<sup>th</sup>.
- Procedure Code 66984 carries a 090 day global period.
- Dr. Smith's claim form must have the "Relinquished Post Operation Date" of 04-29-2008 entered in Item 19 of the CMS 1500 Claim Form or electronic equivalent.
- Dr. Smith's claim must also contain:
  - The date of the initial service, the procedure code performed and modifier 54 on line 1 of Items 24 A and 24 D respectively.
  - The date of the initial service, the procedure code performed and modifier 55 on line 2 of Items 24 A and 24 D respectively.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)													
1.   <b>743</b>   <b>33</b>		3.   _____											
2.   _____												4.   _____	
24. A.	DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER
	MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER			
1	03	01	2008	03	01	2008	22	2	66984	54		1	
2	03	01	2008	03	01	2008	22	2	66984	55		1	
3													

- Dr. Jones assumes responsibility for the patient on April 30<sup>th</sup> for the remainder of the global period.
- Dr. Jones' claim must have the "Assumed Post Operation Date" of 04-30-2008 entered in Item 19 of the CMS 1500 Claim Form or electronic equivalent
- Dr. Jones' claim must also contain:
  - The date of the initial service, the procedure code performed and modifier 55 on line 1 of Items 24 A and 24 D respectively.

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21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)											
1. <b>743 33</b>		3. _____									
2. _____											
4. _____											
24. A. DATE(S) OF SERVICE											
From To											
MM	DD	YY	MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER
								CPT/HCPCS	MODIFIER		
1	03	01	2008	03	01	2008	22	2	66984	55	1
2											
3											

When a transfer of postoperative care occurs, the receiving provider cannot bill for any part of the global services until he/she has provided at least one service. Once the receiving provider has seen the patient, that provider may bill.

When more than one provider bills for the postoperative care, the postoperative percentage is apportioned, based on the number of days each provider was responsible for the patient's care. Based on the example above, an example of reimbursement for the postoperative care is apportioned as follows:

**Example:**

The percentage of the total RVUs for postoperative care for 66984 is 20 percent, and the length of the global period is 90 days.

Fee schedule amount for 66984 = \$550.00 (not actual fee schedule amount)  
 Postoperative days 90  
 Postoperative care (20%) = \$110.00

Dr. Smith provided care for the first 60 days. To determine the allowed amount, divide the 60 days by the total number of postoperative days (90). This equals 66.7%. Multiply the 66.7% by the 20% postoperative care amount. Reimbursement would equal \$73.37.

60 days divided by 90 days (total postoperative) = 66.7%  
 66.7% x \$110.00 (20% postoperative) = \$73.37

Dr. Jones provided care for the last 30 days. To determine the allowed amount, divide the 30 days by the total number of postoperative days (90). This equals 33.3%. Multiply the 33.3% by the 20% postoperative care amount. Reimbursement would equal \$36.63.

**Example:**

30 days divided by 90 days (total postoperative) = 33.3%  
 33.3% x \$110.00 (20% postoperative) = \$36.63

Total postoperative care: \$73.37 + \$36.63 = \$110.00.

### Additional Modifiers

#### HCPCS Modifiers to all Lines Related to the Surgical Error:

As of January 15, 2009, CMS will not cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient. Medicare will also not cover hospitalizations and other services related to these non-covered procedures as defined in the Medicare Benefit Policy Manual (BPM) Chapter 1, sections 10 and 180 and Chapter 16, section 120.

#### The following modifiers must be used to submit a claim:

HCPCS modifiers to all lines related to the surgical error.

PA: Surgery Wrong Body Part

PB: Surgery Wrong Patient

PC: Wrong Surgery on Patient

### Increased Procedural Services (Modifier 22)

**Modifier 22** is used to identify services which are substantially greater than typically required.

- Claims submitted with modifier 22 **must** be accompanied by documentation which explains and supports the reason for the additional work.
- Documentation includes, but is not limited to:
  - Descriptive statements identifying the unusual circumstances, such as increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required.
  - Operative reports
  - Pathology reports
  - Progress notes, office notes, etc.

The submission of a service with modifier 22 does not ensure coverage or additional payment. All claims submitted with modifier 22 and appropriate documentation are reviewed by medical staff to determine whether payment is justified. Covered services submitted without supporting documentation will be paid at the fee schedule.

Modifier 22 is valid when submitted in conjunction with procedure codes that carry global periods of 000, 010, or 090 days when unusual circumstances warrant consideration of payment in excess of the fee schedule allowance.

### **Bilateral Procedure (Modifier 50)**

**Modifier 50** is used when a “unilateral” procedure code is performed bilaterally.

- Bilateral surgeries are procedures which are performed on both sides of the body during the same operative session or on the same day.
- For procedures that are being performed bilaterally, use modifier 50 on one detail line with the CPT or HCPCS code.
- If an individual procedure is identified by the terminology as being solely “bilateral” or is identified by the terminology as being either “bilateral or unilateral” do not report the modifier 50.

#### **Example:**

Procedure codes 66984-50 (Cataract extraction on both eyes): Indicate a unit value of “1” or “0010” in the Days/Units field (Item 24G on the CMS-1500 form).

Medicare will reimburse bilateral procedures at 150 percent of the normal Medicare fee schedule amount.

### Example for Billing Bilateral Procedures

Billed Procedure	Billed Amount	Fee Schedule Amount	Medicare Percentage	Medicare Allowed Amount	Medicare Paid
31255-50	\$450.00	\$300.00	150%	\$450.00	\$360.00

### Multiple Procedures (Modifier 51)

**Modifier 51** does not need to be reported to Medicare. The Carrier will determine multiple surgical procedures based on the procedure codes billed and add modifier 51 if appropriate.

### Discontinued Procedure (Modifier 53)

**Modifier 53** is used to indicate that a procedure was discontinued due to extenuating circumstances or those that threaten the well being of the patient.

- This modifier should **not** be used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating room. Documentation must be submitted for each use with the exception of procedure codes G0105-53; G0121-53, and 45378-53 which have allowances determined under the physician fee schedule.

**Note:** Ambulatory Surgical Centers see Modifier 73 and Modifier 74

### Distinct Procedural Service (Modifier 59)

**Modifier 59** is used to indicate that a service was distinct or independent from other services performed on the same day. It may also be used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances.

- Documentation must support a:
  - Different session or patient encounter
  - Different procedure or surgery
  - Different site or organ system
  - Separate incision or excision
  - Separate lesion
  - Separate injury
  - Separate area of surgery in extensive injuries, not ordinarily encountered or performed on the same day, by the physician.

### Cautions:

- Do not confuse modifier 59 with modifier 25.
  - Modifier 25 is to be used for a significant, separately identifiable E/M service by the same provider on the same day only.
- If none of the previously established anatomical or surgical modifiers can be used to appropriately describe the reason for the exception, then the modifier 59 can be attached.
- For codes subject to the National Correct Coding Initiative (NCCI), the placement of the modifier is on the COLUMN 2 code, for codes that meet the exception criteria.
- Modifier 59 is not valid with CPT code ranges 77419-77430 and 99201-99499.

### Notes:

- Please remember that modifier 59 is for “exceptions” to the normal rules. By using it incorrectly, or placing it on every service, you are telling Medicare that every service provided is an exception. That can lead to further review of a provider’s billing practices.
- Remember, inappropriate or indiscriminate use of the NCCI modifiers (including modifier 59) could be considered fraudulent or abusive.
- There is a great deal of information available on the CMS National Correct Coding website to assist you with proper coding and billing at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>.

### Two Surgeons/Surgical Team (Modifier 62 and 66)

Some surgical procedures may require the skill of two or more surgeons. The condition of the patient or the complexity of the surgery may warrant these services. In cases, the additional surgeons are not acting as assistants-at-surgery, but as equal “co-surgeons.”

**Modifier 62** is used to show that two surgeons (each having a different specialty) are required.

- This modifier can also be used to identify two surgeons performing distinct parts of a procedure simultaneously.
  - Each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code.
  - Each surgeon should also report the same procedure code.
  - If additional procedure(s), including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added, if appropriate and covered under the Medicare Physician Fee Schedule Data Base (MPFSDB).
- The payment for each co-surgeon is 62.5% of the surgery fee schedule.

**Modifier 66** is used by surgical team members when more than two surgeons, each of a different specialty, are required during a highly complex procedure.

- Each surgeon should report his/her distinct operative work by adding modifier 66 to the procedure code.
- Documentation must be submitted as the payment is based on this documentation.

### Repeat Procedures by Another Physician (Modifier 77)

**Modifier 77** is used to indicate that a basic procedure or service performed by another provider had to be repeated.

- This modifier must be used in conjunction with additional documentation entered in Item 19 of the CMS-1500 claim form or the Comment field of the electronic version.
- An example of appropriate documentation is, but is not limited to:
  - The exact time of day the second or repeat procedure was performed by the second physician.

### Assistant Surgeon (Modifier 80, 82 and AS)

#### Modifier 80

- Used when submitting a claim for a covered surgical assistant service.
- Medicare defines coverage for a surgical assistant for procedures in the MPFSDB.
- Refer to the appropriate year file at <http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp?listpage=3> for the codes which allow coverage

#### Modifier 82

- Used when a qualified resident surgeon is not available to act as an assistant and an assistant surgeon provides this service.
- This may only be used in a teaching hospital

#### Modifier AS

- Used when assistant at surgery services are performed by a:
  - Physician Assistant (PA)
  - Nurse Practitioner (NP)
  - Clinical Nurse Specialist (CNS)

### Reimbursement for Assistant Surgeon

For covered assistant surgeon services performed by physicians, the fee schedule amount is equal to 16 percent of the amount approved for the global surgery procedure.

For a physician assistant, nurse practitioner or clinical nurse specialist, payment equals 85% of the amount paid to a physician serving as an assistant surgeon.

In accordance with the provisions of Section 4107 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), Medicare does not make reimbursement for assistant surgeon's claim for procedures where assistants are used less than 5% nationally. Providers are precluded from billing the beneficiary. These services are not subject to an appeal.

Services that are non-covered because they are not considered to be medically necessary may be subject to an appeal. In addition, physicians who provide Medicare beneficiaries services that are determined to be "not medically necessary" may obtain payment from the beneficiary if, prior to furnishing the service, they have properly notified the beneficiary in writing that Medicare would not pay for the service through an Advance Beneficiary Notice, and after being so informed, the beneficiary agreed to pay for the service. When billing for services for which a waiver has been obtained, modifier GA should be submitted in conjunction with the procedure code.

### **Reimbursement for Physician Assistant Services**

The payment is equal to 80 percent of the lesser of the actual charge, or 85 percent of the physician fee schedule for an assistant surgeon.

- PA's services may only be made to the PA's employer.
- Under certain circumstances, a PA as an independent contractor qualifies as an employment relationship where payment is made to the employer.
- Medicare provides reimbursement for physician assistant (PA) services when:
  - The PA is legally authorized to practice within their respective state;
  - The services are those normally provided by a physician;
  - The PA is working under the supervision of a physician who must be available to the PA for consultation or communication;
  - The services are performed in a hospital, SNF, nursing facility (NF), as an assistant at surgery or in a designated rural health professional shortage area, regardless of site of service; and
  - The Medicare statute does not otherwise exclude the services.
  - All PA services must be billed by the physician supervisor (employer) on an assigned basis.

### **Billing Instructions:**

- Indicate the PA's NPI in Item 24J on the CMS-1500 claim form or electronic equivalent
- Enter the physician's or group's NPI in Item 33 or electronic equivalent.
- Enter the facility name, address and zip code in Item 32 of the CMS-1500 if the services were furnished in a facility other than the patient's home.

# HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) PAYMENTS

HPSA bonus payments may be made for global surgeries when the services are provided in HPSA's under the following guidelines:

- If the entire global package is provided in a HPSA, physicians should bill for the appropriate global surgical code with the applicable HPSA modifier.
- If only a portion of the global package is provided in a HPSA, the physician should bill using a HPSA modifier for the portion which is provided in the HPSA.

### Example:

The surgical portion of the global service is provided in a non-HPSA and the postoperative portion is provided in a HPSA. The surgical portion should be billed with the '54' modifier and no HPSA modifier. The postoperative portion should be billed with the '55' modifier and the appropriate HPSA modifier. The 10% bonus will be paid on the appropriate postoperative portion only. If a claim is submitted with a global surgical code and a HPSA modifier, it will be assumed that the entire global service was provided in a HPSA.

## SPECIAL COVERAGE INSTRUCTIONS

### Cosmetic Surgery

Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt repair of accidental injury or for the improvement of the functioning of a malformed body member. Cosmetic surgery or expenses incurred in connection with such surgery is not covered.

### Supplies

The allowance for reduction of a fracture includes an allowance for the application of the first cast or traction device. Therefore, castings put on at the time of surgery are included in the surgical procedure's fee schedule allowance, which also includes cast removal. Subsequent castings may be allowed separately. A casting is considered "subsequent" any time after the date of the surgery.

For subsequent castings, use the casting and splinting supply HCPCS codes Q4001 through Q4051 for the reduction of fractures and dislocations. These codes must be billed in conjunction with one of the following surgical codes:

23500-23680, 24500-24685, 25500-25695, 26600-26785, 27500-27566, 27750-27848, 28400-28675 and 29000-29750

### PAYMENT FOR MULTIPLE SURGERIES ON THE SAME DAY

Multiple surgeries are separate procedures performed by a single provider or providers in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed.

Multiple surgical procedures are paid according to multiple surgical guidelines. Most multiple surgical procedures are paid according to the standard, which allows the highest valued procedure at 100% and second through the fifth procedures at 50% of the fee schedule.

### Pricing Rules for Multiple Endoscopic Procedures

#### Related Endoscopic Procedures:

Medicare pays the full allowance of the highest valued endoscopy, plus the difference between the next highest and base endoscopy.

**Example:** (CPT 45387 is the base endoscopy and the fees are **not** actual fee schedule amounts)

CPT 45378 = \$255.40                      45380 = \$285.98                      45385 = \$374.56

Medicare would allow the full amount of 45385 (\$374.56) plus the difference between 45380 and 45378 (\$30.58), for a total of \$405.14.

#### Two Unrelated Endoscopic Procedures:

Medicare applies the usual multiple surgery rules.

**Example:** (**not** actual fee schedule amounts)

CPT 46606 = \$260.50                      CPT 43217 = \$278.18

Medicare would allow the full amount of 43217 (\$278.18) plus 50 percent of 46606 (\$130.25), for a total of \$408.43

### AMBULATORY SURGICAL CENTERS (ASC)

An ASC is a freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

#### ASC Services

ASC facility services are services furnished in an ASC, in connection with a covered surgical procedure, which are otherwise covered if furnished on an inpatient or outpatient basis in a hospital in connection with that procedure. **Not included** in the definition of facility services are medical and other health services, even though furnished within the ASC, which are covered under other portions of the Medicare program, or not furnished in connection with covered surgical procedures. This distinction between covered ASC facility services and services which are not covered ASC facility services is important, since the facility payment rate includes only the covered ASC facility services. Services, which are **not** covered ASC facility services, such as providers' and prosthetic devices other than intraocular lenses (IOLs), may be covered and billable under other Medicare provisions.

#### Covered ASC Procedures

Coverage of ambulatory surgical center services under Part B is based on a list of specific surgical procedures, which is developed and periodically revised. Medicare will only pay for procedures performed in an ASC that are on this list. Information pertaining to this listing may be found on the CMS website at <http://www.cms.hhs.gov/ASCPayment/>

#### Claim Submission Information for ASC Services

- An ASC must accept assignment for all services;
- Bilateral and multiple surgery guidelines apply to most services performed in an ASC;
- Services should be billed using Place of Service 24.

For more information on ASC services, refer to the [Ambulatory Surgery Center Billing Guide](#) on the NHIC website.

# PHYSICIANS IN TEACHING HOSPITALS

## The Teaching Physician

The teaching physician is responsible for the preoperative, operative, and postoperative care of the beneficiary.

- The teaching physician's presence is not required during the opening and closing of the surgical field unless these activities are considered to be key or critical portions of the procedure.
- The teaching physician may determine which postoperative visits are considered key and require his or her presence.
- If the postoperative period extends beyond the beneficiary's discharge and the teaching surgeon is not going to be involved in the beneficiary's care, the instructions on billing for less than the global package apply.

## Single Surgery

When the teaching physician is present for the entire period between the opening and closing of the surgical field, his or her presence may be demonstrated by notes in the medical records made by the physician, resident or operating room nurse. For purposes of the teaching physician policy, there is no required information that the teaching surgeon must enter into the medical records.

## Two Overlapping Surgeries

In order to bill for two overlapping surgeries, the teaching physician must be present during the key portions of both operations. Therefore, the key portions may not take place at the same time. When all of the key portions of the initial procedure have been completed, the teaching physician may begin to become involved in a second procedure.

The teaching physician must personally document the key portion of both procedures in his or her notes in order that a reviewer may clearly infer that the teaching physician was immediately available to return to either procedure in the event of complications. If the teaching physician leaves the operating room after the key portion(s) of the surgical procedure, or during the closing of the surgical field to become involved in another surgical procedure, he or she must arrange for another physician to be immediately available to intervene in the original case should the need arise, in order to bill for the original procedure.

In the case of three concurrent surgical procedures, the role of the teaching physician in each of the cases is classified as a supervisory service to the hospital, rather than a physician service to an individual beneficiary, and is not payable under the physician fee schedule. **This does not apply to an anesthesiologist.**

## Minor Procedures

For procedures that take only a few minutes (5 minutes or less) to complete, such as simple suture, and involve relatively little decision making once the need for the operation is

determined, the teaching surgeon must be present for the entire procedure in order to bill and receive payment for the procedure.

### The Teaching Anesthesiologist/Physician

The teaching anesthesiologist must document in the medical records that he or she was present during all critical (or key) portions of the procedure including induction and emergence. The teaching physician's presence is not required during the preoperative or postoperative visits with the beneficiary.

When the teaching anesthesiologist is supervising one resident, Medicare allows the full fee schedule amount.

If an anesthesiologist is involved in concurrent procedures with more than one resident or with a resident and a non-physician anesthetist, Medicare will pay for the anesthesiologist's services as "medical direction". Refer to the Anesthesia Guide.

### Endoscopic Procedures

When billing for an endoscopic procedure, the teaching physician must be present during the entire viewing, which includes insertion and removal of the device. Viewing of the entire procedure through a monitor in another room does not meet the teaching physician presence requirement.

### Teaching Physician Modifiers

**GC Modifier** – Resident /Teaching Physician Service:

- This service has been performed in part by a resident under the direction of a teaching physician.
- Teaching physician services billed using this modifier certify that the teaching physician was present during the key portion of the service, and was immediately available during other parts of the service.

**GE Modifier** – Resident Primary Care Exception:

- This service has been performed by a resident without the presence of a teaching physician under the primary care exception.
- Certain teaching physicians are allowed exceptions to the Medicare Teaching physician policy.
- The exception is for the requirement that the teaching physician be present during the key portion of the service.
- Teaching physicians who meet the requirements outlined for the exception to this policy must provide this carrier with an attestation that they meet the requirements.

### NONPARTICIPATING PHYSICIANS AND ELECTIVE SURGERY

If a nonparticipating physician does not accept assignment for elective surgery on a Medicare beneficiary, he or she must provide certain information, in writing, to the beneficiary before the surgery. This requirement only applies to elective surgery for which charges are \$500.00 or more. Elective surgery for Medicare purposes is defined, as surgery that can be scheduled in advance, is not an emergency, and, if delayed, would not result in death or permanent impairment of health.

The notice must include:

- The physician's estimated actual charge for the procedure;
- The estimated Medicare approved charges;
- The excess of the physician's actual charge over the approved amount, and
- The applicable coinsurance amount.

These instructions apply to the surgeon and assistant surgeon. The instructions do not apply to services furnished by nonparticipating anesthesiologists. If you do not notify the beneficiary prior to furnishing the services, you must refund any money collected from the beneficiary in excess of the Medicare payment.

### PAYMENT ALLOWANCES IN A FACILITY AND NON FACILITY SETTING

Payment for certain provider services commonly rendered more than 50% of the time in an office setting is reduced when the services are rendered in:

- Hospital inpatient departments (Place of Service 21);
- Hospital outpatient departments (Place of Service 22);
- Emergency rooms (Place of Service 23);
- Ambulatory surgical centers (Place of Service 24);
- Military Treatment center (Place of Service 26)
- Skilled Nursing Facility (Place of Service 31)
- Hospice (Place of Service 34)
- Psychiatric facility partial hospitalization (Place of Service 52);
- Community Mental Health Center (Place of Service 53)
- Psychiatric Residential Treatment Center (Place of Service 56)
- Comprehensive inpatient rehabilitation facilities (Place of Service 61);
- Comprehensive outpatient rehabilitation facilities (Place of Service 62); or
- Inpatient psychiatric facilities (Place of Service 51).

### NATIONAL CORRECT CODING INITIATIVE

The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to eliminate improper coding. CCI edits are developed based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practice.

For the NCCI Policy Manual and the latest version of the NCCI Edits refer to the following web site: <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>

If you have concerns regarding specific NCCI edits, please submit your comments in writing to:

National Correct Coding Initiative  
Correct Coding Solutions LLC  
P.O. Box 907  
Carmel, IN 46082-0907

### LIMITATION OF LIABILITY (ADVANCE BENEFICIARY NOTICE)

Services denied as not reasonable and medically necessary, under section 1862(a)(1) of the Social Security Act, are subject to the Limitation of Liability (Advance Beneficiary Notice (ABN)) provision. Thus, to be held liable for denied charge (s), the beneficiary must be given appropriate written advance notice of the likelihood of non-coverage and agree to pay for services. A written notice covering an extended course of treatment is acceptable, provided the notice identifies all services for which the provider believes Medicare will not pay.

If, as the course of treatment progresses, additional services are furnished for which the provider believes Medicare will not pay, the provider must separately notify the patient in writing that Medicare is not likely to pay for the additional services and obtain the beneficiary's signed statement agreeing to pay.

Complete instructions and the Advance Beneficiary Notice (ABN) forms can be found on the CMS website at the following address: <http://cms.hhs.gov/BNI/>

### ABN Modifiers

Modifier **GA** should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as reasonable and necessary and they have on file an Advance Beneficiary Notification (ABN) signed by the beneficiary.

Modifier **GY** should be used when physicians, practitioners, or suppliers want to indicate that the item or service is statutorily non-covered, or is not a Medicare benefit.

Modifier **GZ** should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not** had an Advance Beneficiary Notice (ABN) signed by the beneficiary.

### LOCAL COVERAGE DETERMINATION (LCD)

Local Coverage Determinations are developed by the local Medicare contractor in the absence of a national Medicare payment policy. These policies describe specific criteria which determine whether an item or service is covered by Medicare and under what circumstances. LCDs are updated as new information and technology occurs in the field of medicine. NHIC has Local Coverage Determinations providing guidelines for various types of services. The LCDs can be found on the CMS website. The links for each state can be found on our website at:

[http://www.medicarenhic.com/ne\\_prov/policies.shtml](http://www.medicarenhic.com/ne_prov/policies.shtml)

### NATIONAL COVERAGE DETERMINATION (NCD)

National Coverage Determinations are policies developed by CMS that indicates whether and under what circumstances certain services are covered under the Medicare program. NCDs are the same for all contractors across the country. More information about national coverage can be obtained through this website: <http://www.cms.hhs.gov/mcd/search.asp>

### MEDICARE FRAUD AND ABUSE

As the CMS J14 A/B MAC for Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont, NHIC fully supports the CMS initiative for program safeguards and shares the following information for your use:

**Fraud** is the intentional deception or misrepresentation that the individual knows to be false, or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. The most frequent line of fraud arises from a false statement or misrepresentation made, or caused to be made, that is material to entitlement or payment under the Medicare program. Attempts to defraud the Medicare program may take a variety of forms. Some examples include:

- Billing for services or supplies that were not provided;
- Misrepresenting services rendered or the diagnosis for the patient to justify the services or equipment furnished;
- Altering a claim form to obtain a higher amount paid;
- Soliciting, offering, or receiving a kickback, bribe, or rebate;
- Completing Certificates of Medical Necessity (CMNs) for patients not personally and professionally known by the provider; and
- Use of another person's Medicare card to obtain medical care.

**Abuse** describes incidents or practices of providers that are inconsistent with accepted sound medical practices, directly or indirectly resulting in unnecessary costs to the program, improper payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse takes such forms as, but is not limited to:

- Unbundled charges;
- Excessive charges;

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- Medically unnecessary services; and
- Improper billing practices.

Although these practices may initially be considered as abuse, under certain circumstances they may be considered fraudulent. Any allegations of potential fraud or abuse should be referred to Safeguard Services (SGS).

If you wish to report fraud, or have any questions on Medicare Fraud and Abuse, please contact:

**New England:**

Maureen Akhouzine, Manager  
Safeguard Services (SSG)  
75 William Terry Drive  
Hingham, MA 02043  
Phone 1-781-741- 3282  
Fax 1-781-741-3283  
[maureen.akhouzine@eds.com](mailto:maureen.akhouzine@eds.com)

A single number to report suspected fraud is the national OIG fraud hot line: **1-800-HHS-TIPS (1-800-447-8477)**. Information provided to hotline operators is sent out to state analysts and investigators.

## TELEPHONE AND ADDRESS DIRECTORY

### Provider Interactive Voice Response (IVR) Directory

All actively enrolled providers must utilize the IVR for: **Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date.** The IVR can also assist you with the following information: Seminars, Telephone Numbers, Addresses, Medicare News and Appeal Rights.

**Available 24 hours/day, 7 days/week (including holidays)**

**888-248-6950**

### Provider Customer Service Directory

Our Customer Service representatives will assist you with questions that cannot be answered by the IVR, such as policy questions, specific claim denial questions, 855 application status, redetermination status (formerly Appeals). Per CMS requirements, the Customer Service representatives may **not** assist providers with Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date unless we are experiencing IVR system problems. This rule applies even if the caller has obtained the code.

**Hours of Operation:**

**8:00 a.m. to 4:00 p.m. Monday - Friday**

**866-801-5304**

**Dedicated Reopening Requests Only**

**Hours of Operation:**

**8:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m. Monday - Friday**

**877-757-7781**

### MAILING ADDRESS DIRECTORY

Initial Claim Submission Maine	P.O. Box 2323 Hingham, MA 02044
Massachusetts	P.O. Box 1212 Hingham, MA 02044
New Hampshire	P.O. Box 1717 Hingham, MA 02044
Rhode Island	P.O. Box 9203 Hingham, MA 02044
Vermont	P. O. Box 7777 Hingham, MA 02044
EDI (Electronic Data Interchange)	P.O. Box 9104 Hingham, MA 02044
Written Correspondence	P.O. Box 1000 Hingham, MA 02044
Medicare Reopenings and Redeterminations **See note below	P.O. Box 3535 Hingham, MA 02044
Medicare B Refunds	P.O. Box 5912 New York, NY 10087-5912
Medicare Secondary Payer (Correspondence Only)	P.O. Box 9100 Hingham, MA 02044
Provider Enrollment	P.O. Box 3434 Hingham, MA 02044
Medicare Safeguard Services	P.O. Box 4444 Hingham, MA 02044

\*\* Requests may be faxed to NHIC at **1-781-741-3534** using the new fax cover sheet that can be downloaded from our Web site:

[www.medicarenhic.com](http://www.medicarenhic.com)

### Durable Medical Equipment (DME)

Durable Medical Equipment (DME) Medicare Administrative Contractor:

NHIC, Corp.

Provider Service Line: 1-866-419-9458

Please view the website to find the appropriate address:

<http://www.medicarenhic.com/dme/contacts.shtml>

### Reconsideration (Second Level of Appeal)

First Coast Service Options Inc.

QIC Part B North Reconsiderations

P.O. Box 45208

Jacksonville, FL 32232-5208

### INTERNET RESOURCES

The Internet is a very valuable tool in researching certain questions or issues. NHIC has a comprehensive website that serves as a direct source to Medicare as well as a referral tool to other related websites that may prove to be beneficial to you.

#### **NHIC, Corp.**

<http://www.medicarenhic.com>

Upon entering NHIC's web address you will be first taken straight to the "home page" where there is a menu of information. NHIC's web page is designed to be user-friendly.

We encourage all providers to join our website mailing list. Just click the link on the home page entitled "Join Our Mailing List". You may also access the link directly at:

<http://visitor.constantcontact.com/email.jsp?m=1101180493704>

When you select the "General Website Updates", you will receive a news report every week, via e-mail, letting you know what the latest updates are for the Medicare program. Other Web News selections (Updates, EDI, etc.) will be sent out on an as-needed basis.

#### **Provider Page Menus/Links**

From the home page, you will be taken to the License for use of "Physicians' Current Procedural Terminology", (CPT) and "Current Dental Terminology", (CDT). Near the top of the page are two buttons, "Accept" and "Do Not Accept". Once you click "Accept", you will be taken to the provider pages.

On the left side of the web page you will see a menu of topics that are available. Explore each one and bookmark those that you use most often.

#### **Medicare Coverage Database**

<http://www.cms.hhs.gov/center/coverage.asp>

<http://www.cms.hhs.gov/mcd/indexes.asp>

The Medicare Coverage Database is an administrative and educational tool to assist providers, physicians and suppliers in submitting correct claims for payment. It features Local Coverage Determinations (LCDs) developed by Medicare Contractors and National Coverage Determinations (NCDs) developed by CMS. CMS requires that local policies be consistent with national guidance (although they can be more detailed or specific), developed with scientific evidence and clinical practice.

### Medicare Learning Network

<http://www.cms.hhs.gov/MLNGenInfo/>

The Medicare Learning Network (MLN) website was established by CMS in response to the increased usage of the Internet as a learning resource by Medicare health care professionals. This website is designed to provide you with the appropriate information and tools to aid health care professionals about Medicare. For courses and information, visit the web site. For a list of the Training Programs, Medicare Learning Network Matters articles and other education tools available, visit the website.

### Open Door Forums

<http://www.cms.hhs.gov/OpenDoorForums/>

CMS conducts Open Door Forums. The Open Door Forum addresses the concerns and issues of providers. Providers may participate by conference call and have the opportunity to express concerns and ask questions. For more information, including signing up for the Open Door Forum mailing list, visit the website.

### Publications and Forms

<http://www.cms.hhs.gov/CMSForms/>

<http://www.cms.hhs.gov/MedicareProviderSupEnroll/>

For your convenience CMS has published optional forms, standard forms, and SSA forms. By linking onto this website, you can access numerous CMS forms such as:

- Provider Enrollment CMS 855 forms (CMS 855B, 855I, & 855R)
- Medicare Participating Physician or Supplier Agreement (CMS 460)
- Advanced Beneficiary Notices (ABN) (CMS R-131)
- Notice of Exclusion from Medicare Benefits (NEMB) (20007)
- Medicare Redetermination Request Form (CMS 20027)
- Request for Reconsideration (CMS 20033)
- Medicare Managed Care Disenrollment form (CMS 566)

Advance Beneficiary Notice (ABN)

<http://cms.hhs.gov/BNI/>

American Medical Association

<http://www.ama-assn.org/>

CMS

<http://www.cms.hhs.gov>  
<http://www.medicare.gov>

CMS Correct Coding Initiative

<http://www.cms.hhs.gov/NationalCorrectCodInitEd/>

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**CMS Physician's Information  
Resource for Medicare**

<http://www.cms.hhs.gov/center/physician.asp?>

**Evaluation and Management Documentation Guidelines**

[http://www.cms.hhs.gov/MLNEdWebGuide/25\\_EMDOC.asp](http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp)

[http://www.cms.hhs.gov/MLNProducts/downloads/eval\\_mgmt\\_serv\\_guide.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf)

**Federal Register**

<http://www.archives.gov/federal-register>

<http://www.gpoaccess.gov/index.html>

**HIPAA**

<http://www.cms.hhs.gov/HIPAAGenInfo/>

**National Provider Identifier (NPI)**

<http://www.cms.hhs.gov/NationalProvIdentStand/>

**NPI Registry**

<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>

**U.S. Government Printing Office**

<http://www.gpoaccess.gov/index.html>

### Revision History

Version	Date	Reviewed By	Approved By	Summary of Changes
1.0	02/2004	B. Bedard	K. Leary	Original guide
2.0	04/05/2004	B. Bedard	K. Leary	Revised contents of guide.
3.0	05/31/2005	K. Mahoney/ K. Rowe	K. Leary	Made National
4.0	10/27/2005	B. Bedard	K. Mahoney	Removed Modifier 52 information for NE.
5.0	09/28/2006	R. Moulton/ B. Bedard	K. Leary/ M. Kelly	Added billing examples.
6.0	5/08/2007	R. Moulton/ B. Bedard	Michele Kelly/Ken Leary	<b>Annual Review.</b> Updated Websites. Updated E/M Codes. Revised Modifier 25 requirement per CR 5025.
7.0	6/12/2007	R. Moulton	Michele Kelly/Ken Leary	Corrected place of service for ASC.
8.0	10/22/2007	Ryan Moulton	Michele Kelly	<b>Annual Review:</b> Removed Non-Functioning Internet Links
9.0	05/21/2008	Ryan Moulton	Michele Kelly	<b>Annual Review.</b> Updated procedure codes included in global package; modifier definitions, minor changes in text and formatting.
10.0	10/06/2008	Deanna Batstone	M. Clark	<b>Annual Review.</b> Removed CA references. Updated guide with new template
11.0	07/15/09	Deanna Batstone	Mylene Clark	<b>Annual Review</b> Updated to J14, updated addresses, added information on surgical errors

# **NHIC, Corp.**

**75 Sgt. William Terry Drive  
Hingham, MA 02044**

**Website:**

**<http://www.medicarenhic.com>**

**CMS Websites**

**<http://www.cms.hhs.gov>**

**<http://www.medicare.gov>**